CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4332	**Date: July 3, 2019**
	Change Request 11230

Transmittal 4290, dated May 3, 2019, is being rescinded and replaced by Transmittal 4332 dated, July 3, 2019 to revise the background section to remove reference to rejections for FISS. All other information remains the same.

SUBJECT: Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program

I. SUMMARY OF CHANGES: This CR includes further modifications to the claims processing systems to ensure that the MSNs appropriately differentiate between QMB claims that are paid and denied.

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019 - 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: 4332	Date: July 3, 2019	Change Request: 11230

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SUBJECT: Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program

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I. GENERAL INFORMATION

A. Background: Through Change Requests (CRs) 9911 and 10433, the Centers for Medicare & Medicaid Services (CMS) modified the Claims Processing Systems to identify the Qualified Medicare Beneficiary (QMB) status of beneficiaries and exemption from Medicare Parts A and B cost-sharing charges.

The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program. Some QMBs (22 percent) receive state Medicaid assistance with Medicare premiums and costing alone, but most (78 percent) simultaneously qualify for full Medicaid coverage, which can pay for services that Medicare does not cover.

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing for covered items and services. (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 system updates are part of CMS' ongoing efforts to assist providers in complying with QMB billing prohibitions and to educate individuals enrolled in QMB that they cannot be billed for covered Parts A and B services.

As implemented through CRs 9911 and 10433, the Common Working File (CWF) transmits an 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 initiates changes to the Remittance Advice (RA) and Medicare Summary Notice (MSN) for QMB claims.

The RA includes two (2) Alert Remittance Advice Remark Codes (RARCs), if the individual is currently enrolled in QMB to designate that providers may not collect deductible and coinsurance amounts from these beneficiaries. The RAs contain the QMB RARCs only in conjunction with paid claims generating Claim Adjustment Group Patient Responsibility (PR) and Claim Adjustment Reason Codes (CARC) 1, 2, and 66, and report Medicare deductible and coinsurance amounts so that coordination of benefits activities may be successfully executed using copies of RAs if necessary.

The MSN includes changes to reflect QMB status and accurate patient liability amounts for beneficiaries enrolled in QMB. However, CMS has recently learned that the shared systems do not differentiate between

paid and fully denied claims or denied service lines, and initiate the changes whenever an individual is enrolled in QMB.

B. Policy: This CR includes further modifications to the claims processing systems to ensure that the MSNs appropriately differentiate between QMB claims that are paid and denied.

MSNs with QMB claims that are paid

If an MSN includes at least one detail line for a QMB that contains an allowed amount greater than zero, page one (the summary page), will use Message 62.0 to briefly explain the QMB billing protections (in the "Be Informed!" section). Also on page one, the patient's total liability amount (in the "Total You May Be billed" field) will omit the deductible and coinsurance amounts for details lines that are for a QMB and include an allowed amount greater than zero. Further, in the claims detail section of the MSN, if the detail line is for a QMB and includes an allowed amount greater than zero, such detail line will reflect $0 (in the "Maximum You May Be Billed" field) and include message 62.1 that informs the beneficiary of her/his QMB status and billing protections.

MSNs with QMB claims that are denied

In the claim detail pages of the MSN, if a detail line is for a QMB and contains an allowed amount of zero, the MSN will reflect the beneficiary's total liability amount in the "Maximum You May Be Billed" field and include new MSN 11.21 message to inform the beneficiary that even though Medicare has denied the claim, Medicaid may pay for care.

Note: For claims processed by VIPS Medicare System (VMS), if a detail line is flagged as QMB and contains an allowed amount of zero, and the beneficiary has not signed an Advance Beneficiary Notice or is subject to Waiver of Liability which has not been attached, the contractor shall not print MSN message 11.21.

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	
11230.1	Contractors shall display MSN message 62.0 in the "Be Informed!" section on page 1 of the Medicare Summary Notice (MSN) when at least one detail line is flagged as Qualified Medicare Beneficiary (QMB) by the Common Working File (through Trailer 51), and the allowed amount of such detail line is greater than zero: **English** – This notice contains claims covered by the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. When you're					X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	enrolled in the QMB program, providers and suppliers who accept Medicare aren't allowed to bill you for Medicare deductibles, coinsurance, and copayments. **Spanish-** Este aviso contiene reclamaciones cubiertas por el programa para Beneficiarios Calificados de Medicare (QMB en inglés), el cual paga sus costos de Medicare. Cuando está inscrito en el programa QMB, los proveedores y suplidores que aceptan Medicare no pueden cobrarle deducibles, coseguro y copagos de Medicare."									
11230.2	Contractors shall exclude the line's deductible and coinsurance amounts from the "Total You May Be billed" field, under the "Your Claims & Costs This Period" section on page 1 of the MSN if the detail line is flagged as QMB by CWF and the allowed amount of such detail line is greater than zero.					X	X	X		
11230.3	Contractors shall exclude the deductible and coinsurance for the line in the "Maximum You May Be Billed" field and will display Message 62.1 for detail lines that are flagged as QMB and contain an allowed amount greater than zero. **English** – You're in the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. Health care providers who accept Medicare can't bill you for the Medicare costs for this item or service, but you may be charged a small Medicaid copay. **Spanish** – Usted está en el Programa para Beneficiarios Calificados de Medicare (QMB), el cual paga sus costos de Medicare. Los proveedores de atención médica que aceptan Medicare no pueden facturarle los costos por este artículo o servicio, pero pueden cobrarle un pequeño copago de Medicaid.					X	X	X		
11230.4	In the claim detail pages in the MSN, contractors shall include the beneficiary's total liability amount in "Maximum You May Be Billed" field and display new MSN 11.21 for the details that are flagged as QMB by CWF and contained an allowed amount of zero: **English** – Medicare has denied payment for this service or item. But your Medicaid coverage may help	X	X		X	X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	pay for this service or item." **Spanish** - Medicare ha denegado el pago de este servicio o artículo. Pero su cobertura de Medicaid puede ayudar a pagar por este servicio o artículo.									
11230.4.1	If a claim line is flagged as QMB by CWF and contains an allowed amount of zero, and the beneficiary has not signed an Advance Beneficiary Notice or is subject to Waiver of Liability which has not been attached, the contractor shall not print MSN message 11.21.							X		
11230.5	Contractors shall test MSN changes with their print centers 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		
11230.6	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X		X	

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Brian Pabst, brian.pabst@cms.hhs.gov , Kim Glaun, 410-786-3849 or kim.glaun@cms.hhs.gov

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev.4332, Issued: 07-03-19)

200 - Qualified Medicare Beneficiary (QMB) Program

(Rev. *4332, Issued: 07-03-19, Effective: 10-01-19, Implementation: 10-07-19*)

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 *Part A and Part B cost-sharing for covered items and services.* 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 *for covered items and services.*

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 *(MSN)* generated for all QMB individuals will include information regarding their QMB status and lack of liability for *Medicare cost-sharing amounts for covered Parts A/B items and services.*

MSNs with QMB claims that are paid

- *If an MSN includes at least one detail line for a QMB that contains an allowed amount greater than zero, page one (the summary page), will use Message 62.0 to briefly explain the QMB billing protections (in the "Be Informed!" section). Also on page one, the patient's total liability amount (in the "Total You May Be billed" field) will omit the deductible and coinsurance amounts for details lines that are for a QMB and include an allowed amount greater than zero.*
- *In the claims detail section of the MSN, if the detail line is for a QMB and includes an allowed amount greater than zero, such detail line will reflect $0 (in the "Maximum You May Be Billed" field) and include message 62.1 that informs the beneficiary of her/his QMB status and billing protections.*

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Note: For claims processed by VIPS Medicare System (VMS), if a detail line is flagged as QMB and contains an allowed amount of zero, and the beneficiary has not signed an Advance Beneficiary Notice or is subject to Waiver of Liability which has not been attached, the contractor shall not print MSN message 11.21