CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3764	**Date: April 28, 2017**
	Change Request 9911

Transmittal 3715, dated February 3, 2017 is being rescinded and replaced by Transmittal 3764, dated April 28, 2017,to revise business requirement 9911.5 to refer to the claim rather than the line. All other information remains the same.

SUBJECT: Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to create an indicator of Qualified Medicare Beneficiary (QMB) status in the claims processing systems (shared systems - CWF, FISS, MCS, and VMS). Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. The new claims processing systems QMB indicator will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through their Medicare Summary Notice) to reflect that the beneficiary is a QMB individual and lacks Medicare cost-sharing liability.

EFFECTIVE DATE: October 2, 2017 - for claims processed on or after this date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2017 - CWF: Implementation of BRs 9911.1, 9911.1.1, 9911.1.2, and 9911.1.3; Design only and draft trailer layout provided to SSMs for BR 9911.2.1;VMS, MCS: analysis, design, and coding; FISS: analysis and design; October 2, 2017 - CWF: Implementation of remaining BRs; FISS, VMS, MCS: coding, testing and implementation.

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
N	1/200/ Qualified Medicare Beneficiary (QMB) Program Individuals

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: 3764	Date: April 28, 2017	Change Request: 9911

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EFFECTIVE DATE: October 2, 2017 - for claims processed on or after this date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2017 - CWF: Implementation of BRs 9911.1, 9911.1.1, 9911.1.2, and 9911.1.3; Design only and draft trailer layout provided to SSMs for BR 9911.2.1; VMS, MCS: analysis, design, and coding; FISS: analysis and design; October 2, 2017 - CWF: Implementation of remaining BRs; FISS, VMS, MCS: coding, testing and implementation.

I. GENERAL INFORMATION

A. Background: The Medicare-Medicaid Coordination Office (MMCO) is submitting an implementation CR to create an indicator of Qualified Medicare Beneficiary (QMB) status to the Medicare Fee-For-Service claims processing systems to assist providers and beneficiaries in determining which individuals are enrolled in QMB and thus exempt from Medicare cost-sharing charges. QMB is a Medicaid program that assists low-income beneficiaries with Medicare cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Federal law bars Medicare providers from billing a QMB individual for Medicare deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances. Regardless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to a QMB individual.

A July 2015 CMS study found that, despite Federal law, erroneous billing of individuals enrolled in QMB continues, and confusion about billing rules persists amongst providers and beneficiaries. (See *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)*, Centers for Medicare & Medicaid Services July 2015 at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.)

Neither the Medicare eligibility systems (the HIPAA Eligibility Transaction System (HETS)), nor the claims processing systems (the FFS Shared Systems), notify providers about their patient's QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare Summary Notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

B. Policy: This CR includes modifications to the claims processing systems and the Medicare Claims Processing Manual to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing. The State Medicare Modernization Act (MMA) File of Dual Eligibles is the source file for information on dual-eligible beneficiaries (Medicare-Medicaid enrollees), including QMB individuals, and can be migrated to other data systems within CMS. These files are stored in the CMS Mainframe, within the Common Medicare Environment. The State MMA File is considered to be the most current, accurate, and consistent source of information on dual-eligible beneficiaries given that it is used for operational purposes related to the administration of Part D benefits.

(See *Data Analysis Brief, Attachment B Defining Medicare-Medicaid Enrollees in CMS Data Sources,* https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment20062013.pdf) States must submit these data files to CMS on, at least, a monthly basis to identify which of their Medicaid beneficiaries are also eligible to receive Medicare. The MMA File classifies dual-eligible beneficiaries according to seven categories of benefits or codes. Two Dual Status codes apply to individuals who are enrolled in the QMB program: *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).* (The other Dual Status Codes ("03", "04", '05", "06", "08") apply to other categories of benefits for dual-eligible beneficiaries).

With the implementation of this CR, the Common Working File (CWF) will obtain the MMA dual status codes from the Enrollment Database (EDB). If the dual status codes denote the beneficiary is enrolled in the QMB program (Dual Status Codes "01" and "02"), CWF will transmit QMB indicators ("01" and "02") to the shared systems through a new trailer that contains the applicable QMB START and END dates (and up to 12 occurrences). CWF will transmit the QMB indicators 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 "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims.

QMB indicators will initiate new messages on the remittance advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with three new Remittance Advice Remark Codes (RARC) that are specific to those enrolled in QMB. Additionally, the MSN will show QMB status and accurate patient liability amounts for beneficiaries enrolled in QMB. Page one (the summary page) of MSN will contain a new message 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 any cost-sharing amounts that coincide with a QMB coverage period. Further, in the claims section of the MSN, the detail line will reflect the true liability (in the "Maximum You May be Billed" field) and include a new message for that informs the beneficiary of their QMB status and billing protections.

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	
9911.1	The contractor shall create a new beneficiary auxiliary file that contains information on the beneficiary's Dual-Eligible Benefit status.								X	
9911.1.1	The contractor shall update the auxiliary file based on data received from the Enrollment Database (EDB). MD3078 EDBSS EDB Access to New MBD Medicaid Period Table for Dual Status Codes and Eligibility Periods (July 2017) directs EDB to send the data for all data elements (listed in MAPD 3078) to CWF and the File format/layout obtained from EDB will be attached in eChimp.								X	EDB

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9911.1.2	The contractor shall maintain up to 40 occurrences of the following information from EDB on the new beneficiary auxiliary file: • MMA Dual Status Codes (values 01, 02, 03, 04, 05, 06, 08) • Dual status start date • Dual status end date • State code								X	
9911.1.3	The contractor shall create new HIMR screen(s) to display information on the new beneficiary auxiliary file.								X	
9911.1.3.1	The contractor shall utilize the new HIMR screen(s) provided by CWF.	X	X	X	X	X	X			RRB-SMAC
9911.2	The contractor shall compare incoming claims to the new auxiliary file to determine whether dates of service fall within a period with Dual Status Codes for QMB benefits (QMB indicator "01" or "02.")								X	
9911.2.1	The contractor shall return trailer information indicating any applicable QMB periods based on the line item date of service for the following claim types: • Professional claims • DMEPOS claims • Institutional outpatient TOBs 012x, 013x, 014x, 022x, 023x, 034x, 071x 072x, 074x, 075x, 076x, 077x and 085x.								X	
9911.2.2	The contractor shall return trailer information indicating any applicable QMB periods based on the line item date of service for home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x or 060x.								X	
9911.2.3	The contractor shall return trailer information indicating any applicable QMB periods based on the								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	occurrence code 50 date for revenue code 0022 lines for SNF inpatient claims (TOB 018x or 021x).									
9911.2.4	The contractor shall return trailer information indicating any applicable QMB periods based on the "through" date for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).								X	
9911.3	Upon receipt of the new QMB trailer for a line item for outpatient TOB 012x, 013x, 014x, 022x, 023x, 034x, 071x 072x, 074x, 076x, 075x, 077x and 085x, the contractor shall apply Group Code Other Adjustment (OA), Claim Adjustment Reason Code (CARC) 209 and Remittance Advice Remark Code (RARC) N781 to the line if deductible applies.	X		X		X				BCRC
9911.4	Upon receipt of the new QMB trailer for a line item for any outpatient TOB 012x, 013x, 014x, 022x, 023x, 032x, 034x, 071x 072x, 074x, 075x, 076x, 077x and 085x, the contractor shall apply Group Code OA, CARC 209 and RARC N782 to the line if coinsurance applies.	X		X		X				BCRC
9911.5	Upon receipt of the new QMB trailer for a revenue code 0022 line item for TOB 018x, 021x, the contractor shall apply Group Code OA, CARC 209 and RARC N782 to the claim if coinsurance applies.	X				X				BCRC
9911.6	Upon receipt of the new QMB trailer for a claim with TOB 011x or 041x, the contractor shall apply Group Code OA, CARC 209 and RARC N781 to the claim if deductible applies and RARC N782 to the claim if coinsurance applies.	X				X				BCRC
9911.7	When RARC N781 or N782 are present on an institutional claim or line item, the contractor shall make these values available to users on Provider Statistical and Reporting (PS&R) system reports.									PS&R
9911.8	The contractor shall accept a new trailer from CWF with QMB information for eligible Medicare beneficiaries.					X	X	X		
9911.9	The contractor shall compare the claim line item “from date” to the CWF QMB trailer “start/end date” and if the line item “from date” falls on or within the						X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	"start/end date" of the QMB period, contractors shall apply a QMB indicator on the line item.									
9911.10	The contractor shall use new RARC N781 for the deductible and new RARC N782 for the coinsurance with group code OA, CARC 209, for all claim lines that have a "from date" of service that falls in the dates that the beneficiary was identified as a QMB when creating the Standard Paper Remittance (SPR) and Electronic Remittance Advice (ERA).	X	X	X	X	X	X	X		BCRC, RRB-SMAC
9911.11	Contractors shall send CARC 209 for the deductible and the coinsurance with group code OA when the beneficiary has been identified as a QMB. 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 patient if collected. (Use only with Group code OA)	X	X	X	X	X	X	X		BCRC, RRB-SMAC
9911.12	Contractors shall use the following Alert RARCs to inform the supplier when a beneficiary is a QMB in the Standard Paper Remittance (SPR) and Electronic Remittance Advice (ERA) as applicable. N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected co-payments. **Note:** FISS will only update the ERA, not the SPR.	X	X	X	X	X	X	X		RRB-SMAC
9911.13	Contractors shall ensure that in the Standard Remittance Advice the coinsurance and deductible	X	X	X	X		X	X		RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	contains 0 (zero) in the fields for details that are associated with a QMB and display CARC 209. Alert RARCs N781, N782, N783 (as applicable) will display a message indicating the provider cannot bill the beneficiary for the deductible and coinsurance amounts.									
9911.14	Contractors shall ensure that all MSNs that include a date of service that falls within a QMB period trigger **new MSN message 62** to appear in the "Be Informed!" section on page 1 of the MSN.: English – This notice contains claims covered by the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. When you're 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**.**"]					X	X	X		
9911.15	For the "Total You May Be Billed" amount, under the "Your Claims & Costs This Period" section, on page 1 of the MSN, contractors shall reflect that the QMB beneficiary is not responsible for claim amounts with a from date of service that fall within the dates the beneficiary is identified as a QMB.					X	X	X		
9911.16	For the claim detail pages in the MSN, contractors shall not include the deductible and coinsurance for the line in the total patient responsibility per claim for all lines with a date of service that fall within the dates the beneficiary is identified as a QMB.					X	X	X		
9911.17	Contractors shall ensure for the claim detail pages in the MSN, all claims with a from date of service that fall within the dates a beneficiary is identified as a QMB, trigger **new MSN message 62.1**:					X		X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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."]									
9911.18	Contractors shall test MSN changes with their print centers to ensure the changes will process and print as intended.	X	X	X	X					RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9911.19	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	X	X	X	X	

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	program correctly.					

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Vinay Vuyyuru, 410-786-9111 or Vinay.Vuyyuru@cms.hhs.gov , Bridgitte Davis-Hawkins, 410-786-4573 or bridgitte.davis-hawkins@cms.hhs.gov , Diana Motsiopoulos, 410-786-3379 or diana.motsiopoulos@cms.hhs.gov , Wilfried Gehne, 410-786-6148 or wilfried.gehne@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: 1

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicare Enrollment and Premium Billing Systems (MEPBS)

MAPD3078 – EDB Access to New MBD Medicaid Period Table for Transmission of Dual Status Codes and Eligibility Periods to the Shared Systems (FISS, MCS, VMS) via the Common Working File (CWF)

Requirements Document

Version 2.1

April 10, 2017

Document Number: MMA.CWF.3402.02.1.0417

Contract Number: HHSM-500-2007-00014I

Table of Contents

1. Introduction 1

1.1 Purpose 1
1.2 Document Management 1
1.3 Intended Audience 1

2. Overview 1

2.1 Business Purpose 1
2.2 Functional Purpose 2
2.3 Measures of Success 2
2.4 Stakeholders 2
2.5 Project Priorities 3
2.6 Project Diagrams 3
2.6.1 Work Context Diagram 3
2.6.2 System Diagram 4
2.6.3 Other Diagrams/Artifacts 4

3. Assumptions/Constraints/Risks 4

3.1 Assumptions 4
3.2 Constraints 5
3.3 Risks 5

4. Business Requirements & Rules 5

4.1 Business Process: EDB to CWF 5
4.1.1 EDB/CWF Business Requirements (BRs) 5

5. Global Requirements/Functional Requirements 6

5.1 Global Standards 6
5.1.1 General 6
5.1.2 Design 7
5.1.3 Performance Requirements/Performance Engineering 7
5.1.4 Security 7
5.1.5 Privacy 7
5.1.6 Section 508 7
5.1.7 Records Management 8
5.1.8 Archiving Requirements 8
5.1.9 Reporting Requirements 8
5.1.10 Other Non-Functional Requirements 8

6. User 1 User Requirements 8

6.1 User Requirement Summary 8
6.1.1 Associated Business Requirement 8
6.1.2 Requirement Source 8

6.1.3 Priority 9
6.1.4 Purpose 9
6.1.5 Requirement Context Diagram 9
6.1.6 Event Diagram 9
6.1.7 User Level Requirements 9
6.1.8 Functional Scenario 1 – EDB Sends the Initial DEB Status Information to CWF 9
6.1.9 Functional Scenario 2 – EDB Sends Updated DEB Status Information to CWF 10

7. User 2 User Requirements 11

7.1 User Requirement Summary 11

Appendix A: Record of Changes 12

Appendix B: Acronyms 13

Appendix C: Glossary 16

Appendix D: Referenced Documents 17

Appendix E: Requirements Traceability Matrix 18

Appendix F: Approvals 19

Appendix G: XLC Template Revision History 20

Appendix H: Email Exchange Regarding Occurrence Order. 21

Appendix I: HIQM file layout 23

List of Figures

Figure 1: Flow of DEB Information 4

List of Tables

Table 1: Stakeholders 2

Table 2: Project Priorities 3

Table 3: Business Requirements 5

Table 4: Global/Functional Requirements 6

Table 5: Design Requirements 7

Table 6: Security Requirements 7
Table 7: Privacy Requirements 7
Table 8: Section 508 Requirements 7
Table 9: Records Management Requirements 8
Table 10: Archiving Requirements 8
Table 11: Reporting Requirements 8
Table 12: Other Non-Functional Requirements 8
Table 13: Scenario 1 Steps 9
Table 14: Scenario 2 Steps 10
Table 15: Record of Changes 12
Table 16: Acronyms 13
Table 17: Glossary 16
Table 18: Referenced Documents 17
Table 19: Requirements Traceability Matrix 18
Table 20: XLC Template Revision History 20

1. Introduction

1.1 Purpose

This document provides all requirements that the Centers for Medicare & Medicaid Services (CMS) Enrollment Database (EDB) will be responsible for implementing under Change Request (CR) MAPD3078: EDB Access to New MBD Medicaid Period Table for Transmission of Dual Status Codes and Eligibility Periods to the Shared Systems (FISS, MCS, VMS) via the Common Working File (CWF). This document lists the business requirements, business rules, user requirements, and functional/nonfunctional requirements for the project. It also contains use case scenarios to help clarify the process required for the project.

1.2 Document Management

The requirements in this Requirements Document shall be traced to the appropriate deliverables in the development and testing phases to ensure that all requirements are properly implemented and tested.

1.3 Intended Audience

The target audience for this Requirements Document includes business, technical, governance and project management stakeholders. Specific users shall include software or system developers and testers.

2. Overview

2.1 Business Purpose

Currently, 50 states send Medicare Modernization Act (MMA) State Phase Down (SPD) files to the Medicare Beneficiary Database (MBD) as part of the Dual Eligible process to report beneficiaries' Medicaid eligibility status at least once a month. States' month-to-month dual status codes are stored in the Dual Medicare Table in the Common Medicare Environment (CME). With CR MAPD2079 (May 2017 Release), MBD will create a new Medicaid Period Data file for EDB in order to obtain the beneficiaries' latest dual status code and Medicaid period data. MAPD3078 directs EDB to obtain beneficiary Dual Eligibility Benefit (DEB) Status codes and periods from the CME and transmit them to CWF (July 2017 Release). CWF will transmit the dual status codes that are indicative of Qualified Medicare Beneficiary (QMB) status to the shared systems (CR9911 Fee-for-Service [FFS] CR July 2017 and October releases). The DEB indicators will trigger notifications to Medicare providers regarding patient's DEB status and billing protections from Medicare cost-sharing.

2.2 Functional Purpose

The purpose of this CR is for EDB to obtain DEB codes and periods from the new Combined Medicaid Eligibility file in the CME. EDB system will transmit DEB codes to the Medicare Fee-for-Service (FFS) Shared Systems (FISS, MCS, VMS) via CWF. EDB access to the MBD Medicaid Period Data file and transmission of DEB codes and periods to CWF is necessary to implement FFS CR 9911 (July and October 2017 releases) which adds an indicator of QMB status in the FFS Claims Processing systems. Beneficiaries enrolled in QMB are not liable to pay Medicare cost-sharing for all Medicare A/B claims. Through CR 9911, CWF will send a QMB indicator to the Medicare FFS Shared Systems. The QMB indicator will trigger notifications to providers (through their Provider Remittance Advice) and to beneficiaries (through their Medicare Summary Notice) to reflect that the beneficiary is enrolled in the QMB program and lacks Medicare cost-sharing liability.

2.3 Measures of Success

The following are considered measures of success:

- EDB successfully accesses the DEB codes and periods from the CME, and
- EDB successfully transmits DEB codes and periods to CWF.

2.4 Stakeholders

Table 1: Stakeholders

Name	Company	Phone Number	Email
Bridgitte Davis-Hawkins	CMS-CM	410-786-4573	Bridgitte.Davis-Hawkins@cms.hhs.gov
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2.5 Project Priorities

This section is not applicable for this CR.

Table 2: Project Priorities

Product Quality Dimension	Priority Level (High, Medium, Low)
Scope (Features)	N/A
Schedule	N/A
Defects	N/A
Resources (manpower, budget)	N/A

2.6 Project Diagrams

2.6.1 Work Context Diagram

Figure 1 shows the work context diagram for the transfer of information. MBD will add the DEB codes and periods to the CME. EDB will access those periods on the CME and pass the information to CWF.

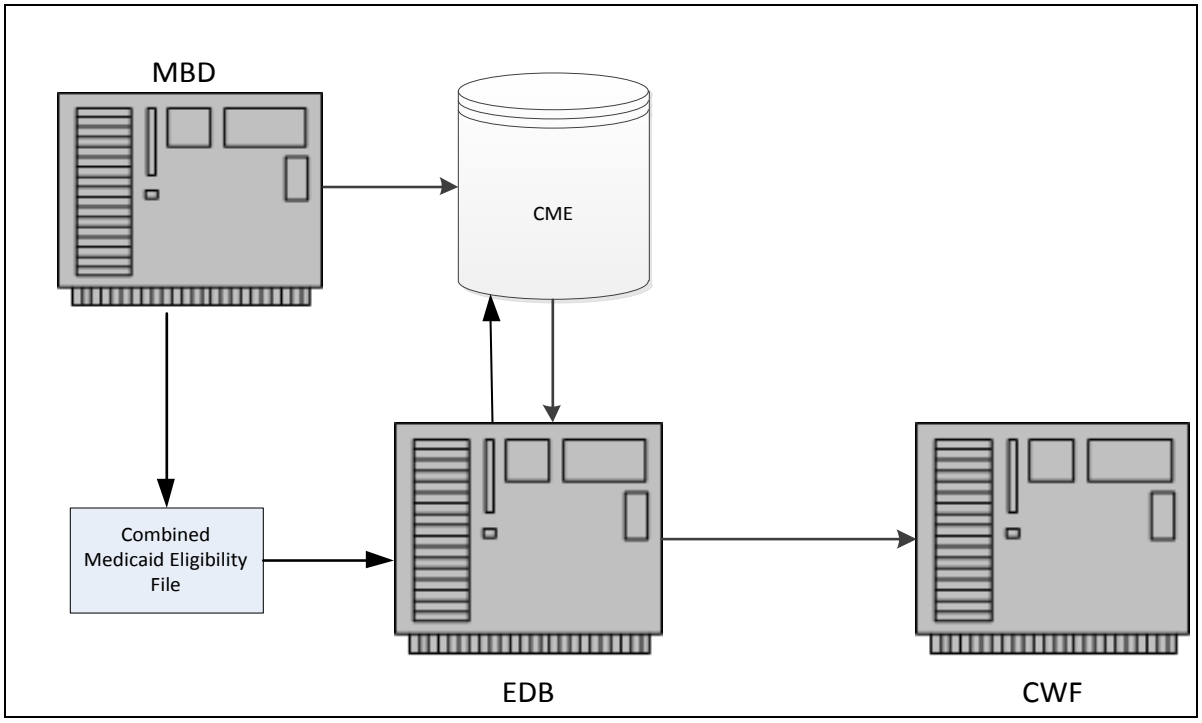

Figure 1: Flow of DEB Information

2.6.2 System Diagram

There are currently no other diagrams or artifacts associated with this CR.

2.6.3 Other Diagrams/Artifacts

There are currently no other diagrams or artifacts associated with this CR.

3. Assumptions/Constraints/Risks

3.1 Assumptions

Listed below are the assumptions that guided the identification and development of the requirements stated in this document. These assumptions are intended to promote mutual understanding, partnership, and quality communication between CMS and the project team. They are:

- EDB will create a new record type for the DEB codes and periods (proposed type name HIQM).
- The first file EDB sends will have all the initial load information. This file will be sent to the nine CWF host sites on the normally Saturday morning scheduled to allow CWF adequate processing time.
- The first file sent will contain about 50 million DEB records. Each DEB record will be 1,253 bytes.

- Subsequent update files will be smaller in volume.

3.2 Constraints

Listed below are the constraints that exist for this project. These constraints may prevent or restrict reaching the desired results (e.g., satisfying requirements, meeting project goals and priorities, achieving measures of success) stated in this document. They are:

- Implementation of this CR is contingent upon implementation of MBD CR MAPD3079.
- Work for this CR needs to consider the planned changes to CWF for Social Security Number Removal Initiative (MAPD3019, scheduled for February 2018).

3.3 Risks

Listed below are the risks that can create issues for the project. These risks may create issues that have an uncertain effect on the project which in turn effect achieving the desired results (e.g., satisfying requirements, meeting project goals and priorities, achieving measures of success) stated in this document. They are:

- No risks have been identified at this point.

4. Business Requirements & Rules

4.1 Business Process: EDB to CWF

4.1.1 EDB/CWF Business Requirements (BRs)

Table 3: Business Requirements

ID	Requirement	N/C/D/E*
EDB-CWF-BR-1	EDB shall accept the Dual Eligibility Benefit Status codes, State Source codes and Medicaid eligibility periods (start and end date) from the MBD and send to CWF.	N
EDB-CWF-BR-2	EDB shall send to CWF the Dual Eligibility Benefit Status codes, State Source codes and Medicaid eligibility periods (start and end date) for the 40 most recent occurrences.	N
EDB-CWF-BR-3	EDB shall accept a full replacement file of Dual Eligibility Benefit Status codes, State Source codes and Medicaid eligibility periods (start and end date) when a beneficiary's DEB periods are first added and any time they are updated and send to CWF.	N
EDB-CWF-BR-4	EDB shall create a new record to transmit the Dual Eligibility Benefit Status codes, States Source codes and Medicaid eligibility period data to CWF.	N

*New, Changed, Deleted, Existing

5. Global Requirements/Functional Requirements

This section is to be completed at a later date.

5.1 Global Standards

5.1.1 General

Table 4: Global/Functional Requirements

ID	Requirement	N/C/D/E*
EDB-CWF-SR-1	EDB shall accept the following fields from the Combined Medicaid Eligibility file from MBD and map the data to the HIQM file according to the layout in the EDB to CWF Interface Control Document: • CAN, • BIC, • Last Name, • First Initial, • Date of Birth, • Sex Code, • MBD Run Date, • Number of DEB Periods, • DEB Start Date, • DEB End Date, • DEB Status, and • DEB State.	N
EDB-CWF-SR-2	EDB shall send the Dual Eligibility Benefit Status information to CWF in descending order of the Start Date.	
EDB-CWF-SR-3	EDB shall send up to 40 most recent occurrences of Dual Eligibility Benefit Status information to CWF via the HIQM file.	N
EDB-CWF-SR-4	EDB shall send a full replacement file of Dual Eligibility Benefit Status information via the HIQM file whenever there is a change to the Dual Eligibility Benefit Status codes and periods.	N

ID	Requirement	N/C/D/E*
EDB-CWF-SR-5	EDB shall convert the Combined Medicaid Eligibility File it receives from MBD from a fixed block to a variable block format before sending the Dual Eligibility Benefit Status information to CWF.	N
EDB-CWF-SR-6	EDB shall split the HIQM file and send to the nine CWF Host Sites, using the Host Site indicator from the Combined Medicaid Eligibility file to determine the Host Site location. EDB will remove the Host Site Indicator from the file before sending to CWF.	N

*New, Changed, Deleted, Existing

5.1.2 Design

Table 5: Design Requirements

ID	Requirement	N/C/D/E*
N/A	N/A	N/A

*New, Changed, Deleted, Existing

5.1.3 Performance Requirements/Performance Engineering

This section is not applicable for this CR.

5.1.4 Security

Table 6: Security Requirements

ID	Requirement	N/C/D/E*
N/A	N/A	N/A

*New, Changed, Deleted, Existing

5.1.5 Privacy

Table 7: Privacy Requirements

ID	Requirement	N/C/D/E*
N/A	N/A	N/A

*New, Changed, Deleted, Existing

5.1.6 Section 508

Table 8: Section 508 Requirements

ID	Requirement	N/C/D/E*
N/A	N/A	N/A

*New, Changed, Deleted, Existing

5.1.7 Records Management

Table 9: Records Management Requirements

ID	Requirement	N/C/D/E*
N/A	N/A	N/A

*New, Changed, Deleted, Existing

5.1.8 Archiving Requirements

Table 10: Archiving Requirements

ID	Requirement	N/C/D/E*
N/A	N/A	N/A

*New, Changed, Deleted, Existing

5.1.9 Reporting Requirements

Table 11: Reporting Requirements

ID	Requirement	N/C/D/E*
N/A	N/A	N/A

*New, Changed, Deleted, Existing

5.1.10 Other Non-Functional Requirements

Table 12: Other Non-Functional Requirements

ID	Requirement	N/C/D/E*
N/A	N/A	N/A

*New, Changed, Deleted, Existing

6. User 1 User Requirements

6.1 User Requirement Summary

N/A

6.1.1 Associated Business Requirement

N/A

6.1.2 Requirement Source

N/A

6.1.3 Priority

N/A

6.1.4 Purpose

N/A

6.1.5 Requirement Context Diagram

N/A

6.1.6 Event Diagram

N/A

6.1.7 User Level Requirements

N/A

6.1.8 Functional Scenario 1 – EDB Sends the Initial DEB Status Information to CWF

6.1.8.1 Scenario Flowchart/Use Case Diagram

See Figure 1.

6.1.8.2 Precondition

MBD has entered the initial DEB Status information into the Combined Medicaid Eligibility File

6.1.8.3 Trigger

The previously agreed-upon date of first transmission occurs.

6.1.8.4 Expected Result

EDB creates the HIQM file and sends the information to the nine individual CWF Host Sites.

6.1.8.5 Steps

The following steps are taken:

Table 13: Scenario 1 Steps

Step	Description
0	DEB Status codes and periods are available on the Combined Medicaid Eligibility File.
1	EDB accepts the DEB Status codes and periods from the Combined Medicaid Eligibility file.

Step	Description
2	EDB converts the Combined Medicaid Eligibility file from a fixed block format to a variable block format and append the HIQM records to the CWF Reply file.
3	EDB transmits the HIQM file to CWF as part of its Reply file process.

6.1.8.6 Scenario/Use Case Functional & Nonfunctional Requirements

None.

6.1.9 Functional Scenario 2 – EDB Sends Updated DEB Status Information to CWF

6.1.9.1 Precondition

CWF has received the initial DEB information from EDB

6.1.9.2 Trigger

There is a change to a beneficiary's DEB status.

6.1.9.3 Expected Result

MBD send the updated information to EDB. EDB sends a full Replace file, including the beneficiary change, to CWF.

6.1.9.4 Steps

The following steps are taken:

Table 14: Scenario 2 Steps

Step	Description
0	A beneficiary's DEB Status changes.
1	MBD sends an updated Combined Medicaid Eligibility file to EDB. The updated file is a full Replace file, containing the current DEB change information as well as up to 40 of the most recent occurrences of DEB codes and periods.
2	EDB accepts the updated Combined Medicaid Eligibility file from MBD.
3	EDB converts the Combined Medicaid Eligibility file from a fixed block format to a variable block format and adds the information to the HIQM file, using the layout listed in the Interface Control Document.
4	EDB transmits the HIQM file to CWF as part of its Reply file process.

6.1.9.5 Scenario/Use Case Functional & Nonfunctional Requirements

N/A

7. User 2 User Requirements

7.1 User Requirement Summary

N/A.

Appendix A: Record of Changes

Table 15: Record of Changes

Version Number	Date	Author/Owner	Description of Change
1.0	02/17/2017	Suzin Schneider/NGC	Initial baselined version
1.1	03/17/2017	Suzin Schneider/NGC	Changes after BR Walkthrough and follow up meeting with CWF. • Update FFS CR number to 9911 and Release to be July and October 2017, • Replace mention of QMB periods with Dual Status Periods, • Dual Status codes are not limited to Code “01” and “02”, and • The first file sent to CWF will be considered the Initial Load file. There will not be a separate, special load file.
2.0	04/03/2017	Suzin Schneider/NGC	• Added System Requirements and Functional Scenarios, • Added information to the Requirements Traceability Matrix, and • Updated Figure 1.
2.1	04/10/2017	Suzin Schneider/NGC	Added Appendices H and I: • Email Exchange about Change in Occurrence order, and • HIQM Layout.

Appendix B: Acronyms

Table 16: Acronyms

Acronym	Literal Translation
ALT	Alternative
BA	Business Analyst
BIC	Beneficiary Identfication Code
Blvd	Boulevard
BR	Business Requirement
CAN	Claim Account Number
CCYYDDD	Calendar year and day number (ex. December 31, 2016 = 2016365)
CM	Center for Medicare
CMDE	Combined Medicaid Extract File
CME	Common Medicare Environment
CMS	Centers for Medicare & Medicaid Services
COTR	Contractor
CR	Change Request
CWF	Common Working File
CWFM	CWF Maintainer
DD	Deputy Director
DEB	Dual Eligibility Benefit
DOB	Date of Birth
DPM	Deputy Project Manager
DPPIG	Division of Policy, Program Integration, & Governance
EDB	Enrollment Database
FFS	Fee-for-Service
FISS	Fiscal Intermediary Shared System
FM	Functional Manager
FR	Functional Requirement
GOV	Government
GTL	Government Task Lead
HHS	Department of Health and Human Services
HIMR	Health Insurance Master Record
HIQM	New record type for QMB records

Acronym	Literal Translation
ID	Identification or Identifier
ILC	Integrated IT Investment & System Life Cycle Framework
MAPD	Medicare Advantage Part D
MBD	Medicare Beneficiary Database
MCS	Managed Care Systems
MEPBS	Medicare Enrollment and Premium Billing System
MMA	Medicare Modernization Act
N/A	Not Applicable
NGC	Northrop Grumman Corporation
NR	Non-functional Requirement
NUM	Number
OA	Office of the Administrator
OEI	Office of Enterprise Information
OIT	Office of Information Technology
OTS	Office of Technology Services
PMP	Project Management Professional
QDWI	Qualified Disabled and Working Individuals
QI	Qualified Individual
QMB	Qualified Medicare Beneficiary
REQ	Requirement
RU	Business Rule
SCL	System Change request Lead
SLMB	Specified Low-Income Medicare Beneficiary
SMS	System Modernization and Services
SPD	State Phase Down
SR	System Requirement
TA	Technical Advisor
TBD	To Be Determined
TM	Technical Manager
TS	Technology Services
UR	User Requirement
URL	Uniform Resource Locator
US	United States
VMS	Viable Medicare Systems

Acronym	Literal Translation
XLC	eXpedited Lifecycle

Appendix C: Glossary

Table 17: Glossary

Term	Definition
Business Requirement (BR)	A BR is a statement of the functions needed in order to accomplish the business objectives. It is the highest level of requirement, developed through the dictation of policy and process by the business owner.
Business Rule (RU)	An RU is a statement that defines or constrains some aspect of the business. It is intended to assert business structure, or to control or influence the behavior of the business. The RUs that concern the project are atomic in that they cannot be further decomposed and they are not process-dependent, so that they apply at all times. Business rules typically fall into one of five categories: terms, facts, derivations, assertions or action enablers.
Functional Requirement (FR)	An FR is a statement of an action or expectation of what the system will take or do. It is measured by concrete means like data values, decision making logic and algorithms.
Non-functional Requirement (NR)	An NR is a low-level requirement that focuses on the specific characteristics that must be addressed in order to be acceptable as an end product. NRs have a focus on messaging, security, and system interaction.
Scenario	A scenario is a sequence of steps taken to complete a user requirement, similar to a use case.
Use Case	A use case is a description of a system's behavior as it responds to a request that originates from outside of that system. The use case is made up of a set of possible sequences of interactions between systems and users in a particular environment and related to a particular goal. The use case should contain all system activities that have significance to the users. Use cases typically avoid technical jargon, preferring instead the language of the subject matter expert.
User Requirement (UR)	A UR is a statement of what users need to accomplish. It is a mid-level requirement describing specific operations for a user (e.g., a business user, system administrator, or the system itself). They are usually written in the user's language and define what the user expects from the end product.

Appendix D: Referenced Documents

Table 18: Referenced Documents

Document Name	Document Location and/or URL	Issuance Date
TBD	TBD	TBD

Appendix E: Requirements Traceability Matrix

Table 19: Requirements Traceability Matrix

BR	SR
EDB-CWF-BR-1	EDB-CWF-SR-1, EDB-CWF-SR-2, EDB-CWF-SR-3, EDB-CWF-SR-4, EDB-CWF-SR-5, EDB-CWF-SR-6
EDB-CWF-BR-2	EDB-CWF-SR-2, EDB-CWF-SR-3
EDB-CWF-BR-3	EDB-CWF-SR-2, EDB-CWF-SR-3, EDB-CWF-SR-4
EDB-CWF-BR-4	EDB-CWF-SR-1

Appendix F: Approvals

The undersigned acknowledge that they have reviewed the Requirements Document and agree with the information presented within this document. Changes to this Requirements Document will be coordinated with, and approved by, the undersigned, or their designated representatives.

Signature: _____ Date: _____

Print Name: _____

Title: _____

Role: _____

Signature: _____ Date: _____

Print Name: _____

Title: _____

Role: _____

Signature: _____ Date: _____

Print Name: _____

Title: _____

Role: _____

Appendix G: XLC Template Revision History

Table 20: XLC Template Revision History

Version Number	Date	Author/Owner	Description of Change
3.0	11/04/2010	ILC Steering Committee	Baseline version.
4.1	08/14/2014	Celia Shaunessy, XLC Steering Committee	Changes made per CR 14-012.
4.2	10/21/2014	XLC Steering Committee	Added Section 5.1.3 (Performance Requirements/Performance Engineering) per CR 14-007.
4.3	02/02/2015	Surya Potu, CMS/OEI/DPPIG	Updated CMS logo.
4.4	05/07/2015	Rick Buske, CMS/OEI/DPPIG	Fixed formatting errors in Sections 4, 5, and 6. Added Alt Text to CMS logo on p.1.

Appendix H: Email Exchange Regarding Occurrence Order.

The following email exchange details the reason for the change in the order of Occurrences.

Marilyn,

Our programmer states that CWFM is handling the sort order on our end regardless of the order received. We will then display HIMR in descending order (REQ 2) (Most current period first). No change is needed to any CWFM requirement.

Thanks

Scott Frye
Release Coordinator, Common Working File Maintenance

MAXIMUS Federal
7275 Windsor Blvd., Suite 120
Baltimore, MD 21244
Office: 717.652.3829

ScottFrye@maximus.com

From: Mattes, Marilyn L [US] (TS) [mailto:Marilyn.Mattes@ngc.com]
Sent: Thursday, March 30, 2017 10:18 AM
To: Scott Frye/MAXIMUS; Kim.Glaun@cms.hhs.gov; Motsiopoulos, Diana S. (CMS/CM); Miller, LuAnn E. (CMS/OTS) (LuAnn.Miller1@cms.hhs.gov); Bridgitte.Davis-Hawkins@cms.hhs.gov
Cc: CWF RWT Invitation List; David Altman/MAXIMUS; Margarita Podyachev/MAXIMUS; Harish Chava/MAXIMUS; Maddineni, Ajay [US] (TS); Schneider, Suzin [US] (TS); Felder, Donna R [US] (TS); Hahn, William L [US] (TS); Luca, Blair [US] (TS) (Contr); CMS - DMEPS EDBSS Staff; Saxena, Raj [US] (TS); Hodel, Rose [US] (TS)
Subject: RE: July 2017 Release - 9911A/31780 QUALIFIED MEDICARE BENEFICIARY INDICATOR FOR FFS CLAIM requirements *** EDB change ***

Scott,

NGC is working on the EDB requirements for FFS 9911. NGC has 2 CR's: MAPD3079-MBD creates a file for EDB (May 2017 Release), and MAPD3078 – EDB creates a file for CWF (July 2017 Release). CWF had approved an MBD requirement to send the DEB periods in Ascending date order:

MBD CMDE-SR-4, states: "The MBDSS CMDE process shall include in the file it sends to EDB, up to 40 of the beneficiary's most recent occurrences of Dual Eligibility Benefit periods, sorted by the Medicaid Period Start Date, Medicaid Period End Date, Medicaid Dual Status Code, and the Postal State Code in *ascending* order."

The EDB team is now writing the requirements for MAPD3078. We have reviewed the associated CWF requirements for FFS CR 9911, received on March 29, 2017.

From the FFS CR 9911, Requirement 1 (BR 9911.1.1) contains:

For ADD/OVERLAY EDB will send all 40 occurrences. DEB Periods Count will reflect how many periods will be populated. Rest of DEB periods will be initialized.

Example:

DEB periods count = 5.

Occurrences 1 thru 5 will be populated in **ascending** order,

Occurrences 6 thru 40 will be initialized, spaces/zeros based on

the field definition."

Another requirement contains:

(BR 9911.1.2) states:

" The new 'DEBS' Auxiliary file will maintain 40 occurrences of data identified in Requirement 2. The occurrences will be displayed in **descending order** with the most current Start Date."

MBD has coded the DEB periods to be in descending order in the file to EDB. We want to retain that sort order and provide the DEB periods in descending order on the EDB file.

We will update the MBD requirement and provide the EDB requirement to state 'descending order'. The EDB requirements walkthrough will be scheduled for next week.

Please let us know if you agree with the change.

Thank you,

Marilyn Mattes, **PMP**

EDB/MBD Functional Manager

System Modernization and Services: SMS-TS

Office: 410-265-4740 Mobile: 410-487-3859

marilyn.mattes@ngc.com

Appendix I: HIQM file layout

The following file layout will be added to the Interface Control Document for EDB to CWF.

Field	Size	Usage	Location	Definition/Remarks
LRECL	5	C3 3	1-3	Value 1253
MASK	4	X	4-7	Constant 'HIQM'
Bene-Claim-Num	11	X	8-18	CAN and BIC
Bene-Surname	6	X	19-24	Beneficiary Last Name
Bene-First-Initial	1	X	25	Beneficiary First Initial
Bene-DOB	7	9	26-32	CCYYDDD
Bene-Sex	1	9	33	0, 1, or 2 (Unknown, Male, Female)
Run Date	7	9	34-40	CCYYDDD
Filler	11	x	41-51	N/A
DEB Periods	N/A	N/A	52-1253	Beginning of the DEB periods
DEB Periods Count	2	x	52-53	Number of DEB periods being sent
DEB Start Date #1	7	9	54-60	CCYYDDD
DEB End Date #1	7	9	61-67	CCYYDDD
DEB Status #1	2	9	68-69	• 01-QMB without other Medicaid (QMB Only), • 02-QMB With full Medicaid (QMB Plus), • 03-Specified Low-Income Medicare Beneficiary (SLMBs) Without other Medicaid (SLMB Only), • 04-SLMBs with full Medicaid (SLMB Plus), • 05-Qualified Disabled and Working Individuals (QDWIs), • 06-Qualified Individuals (1) (QI-1s), and • 08-Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1 or QI-2).
DEB State #1	2	X	70-71	Postal State Code
Filler	12	X	72-83	Spaces
DEB Start Date #2	7	9	84-90	CCYYDDD
DEB End Date #2	7	9	91-97	CCYYDDD
DEB Status #2	2	9	98-99	'01' through '08'

Field	Size	Usage	Location	Definition/Remarks
DEB State #2	2	x	100-101	Postal State Code
Filler	12	x	102-113	Spaces
DEB Start Date #3	7	9	114-120	CCYYDDD
DEB End Date #3	7	9	121-127	CCYYDDD
DEB Status #3	2	9	128-129-	‘01’ through ‘08’
DEB State #3	2	x	130-131	Postal State Code
Filler	12	x	132-143-	Spaces
DEB Start Date #4	7	9	144-150	CCYYDDD
DEB End Date #4	7	9	151-157	CCYYDDD
DEB Status #4	2	9	158-159	‘01’ through ‘08’
DEB State #4	2	x	160-161	Postal State Code
Filler	12	x	162-173	Spaces
DEB Start Date #5	7	9	174-180	CCYYDDD
DEB End Date #5	7	9	181-187	CCYYDDD
DEB Status #5	2	9	188-189	‘01’ through ‘08’
DEB State #5	2	x	190-191	Postal State Code
Filler	12	x	192-203	Spaces
DEB Start Date #6	7	9	204-210	CCYYDDD
DEB End Date #6	7	9	211-217	CCYYDDD
DEB status	2	9	218-219	‘01’ through ‘08’
DEB State	2	x	220-221	Postal State Code
Filler	12	x	222-233	Spaces
DEB Start Date #7	7	9	234-240	CCYYDDD
DEB End Date #7	7	9	241-247	CCYYDDD
DEB Status #7	2	9	248-249	‘01’ through ‘08’
DEB State #7	2	x	250-251	Postal State Code
Filler	12	x	252-263	Spaces
DEB Start Date #8	7	9	264-270	CCYYDDD
DEB End Date #8	7	9	271-277	CCYYDDD
DEB Status #8	2	9	278-279	‘01’ through ‘08’
DEB State #8	2	x	280-281	Postal State Code
Filler	12	x	282-293	Spaces
DEB Start Date #9	7	9	294-300	CCYYDDD
DEB End Date #9	7	9	301-307	CCYYDDD
DEB Status #9	2	9	308-309	‘01’ through ‘08’

Field	Size	Usage	Location	Definition/Remarks
DEB State #9	2	x	310-311	Postal State Code
Filler	12	x	312-323	Spaces
DEB Start Date #10	7	9	324-330	CCYYDDD
DEB End Date #10	7	9	331-337	CCYYDDD
DEB Status #10	2	9	338-339	‘01’ through ‘08’
DEB State #10	2	x	340-341	Postal State Code
Filler	12	x	342-353	Spaces
DEB Start Date #11	7	9	354-360	CCYYDDD
DEB End Date #11	7	9	361-367	CCYYDDD
DEB Status #11	2	9	368-369	‘01’ through ‘08’
DEB State #11	2	x	370-371	Postal State Code
Filler	12	x	372-383	Spaces
DEB Start Date #12	7	9	384-390	CCYYDDD
DEB End Date #12	7	9	391-397	CCYYDDD
DEB Status #12	2	9	398-399	‘01’ through ‘08’
DEB State #12	2	x	400-104	Postal State Code
Filler	12	x	402-413	Spaces
DEB Start Date #13	7	9	414-420	CCYYDDD
DEB End Date #13	7	9	421-427	CCYYDDD
DEB Status #13	2	9	428-429	‘01’ through ‘08’
DEB State #13	2	x	430-431	Postal State Code
Filler	12	x	432-443	Spaces
DEB Start Date #14	7	9	444-450	CCYYDDD
DEB End Date #14	7	9	451-457	CCYYDDD
DEB Status #14	2	9	458-459	‘01’ through ‘08’
DEB State #14	2	x	460-461	Postal State Code
Filler	12	x	462-473	Spaces
DEB Start Date #15	7	9	474-480	CCYYDDD
DEB End Date #15	7	9	481-487	CCYYDDD
DEB Status #15	2	9	488-489	‘01’ through ‘08’
DEB State #15	2	x	490-491	Postal State Code
Filler	12	x	492-503	Spaces
DEB Start Date #16	7	9	504-510	CCYYDDD
DEB End Date #16	7	9	511-517	CCYYDDD
DEB Status #16	2	9	518-519	‘01’ through ‘08’

Field	Size	Usage	Location	Definition/Remarks
DEB State #16	2	x	520-521	Postal State Code
Filler	12	x	522-533	Spaces
DEB Start Date #17	7	9	534-540	CCYYDDD
DEB End Date #17	7	9	541-547	CCYYDDD
DEB Status #17	2	9	548-549	‘01’ through ‘08’
DEB State #17	2	x	550-551	Postal State Code
Filler	12	x	552-563	Spaces
DEB Start Date #18	7	9	564-570	CCYYDDD
DEB End Date #18	7	9	571-577	CCYYDDD
DEB Status #18	2	9	578-579	‘01’ through ‘08’
DEB State #18	2	x	580-581	Postal State Code
Filler	12	x	582-593	Spaces
DEB Start Date #19	7	9	594-600	CCYYDDD
DEB End Date #19	7	9	601-607	CCYYDDD
DEB Status #19	2	9	608-609	‘01’ through ‘08’
DEB State #19	2	x	610-611	Postal State Code
Filler	12	x	612-623	Spaces
DEB Start Date #20	7	9	624-630	CCYYDDD
DEB End Date #20	7	9	631-637	CCYYDDD
DEB Status #20	2	9	638-639	‘01’ through ‘08’
DEB State #20	2	x	640-641	Postal State Code
Filler	12	x	642-653	Spaces
DEB Start Date #21	7	9	654-660	CCYYDDD
DEB End Date #21	7	9	661-667	CCYYDDD
DEB Status #21	2	9	668-669	‘01’ through ‘08’
DEB State #21	2	x	670-671	Postal State Code
Filler	12	x	672-683	Spaces
DEB Start Date #22	7	9	684-690	CCYYDDD
DEB End Date #22	7	9	691-697	CCYYDDD
DEB Status #22	2	9	698-699	‘01’ through ‘08’
DEB State #22	2	x	700-701	Postal State Code
Filler	12	x	701-713	Spaces
DEB Start Date #23	7	9	714-720	CCYYDDD
DEB End Date #23	7	9	721-727	CCYYDDD
DEB Status #23	2	9	728-729	‘01’ through ‘08’

Field	Size	Usage	Location	Definition/Remarks
DEB State #23	2	x	730-731	Postal State Code
Filler	12	x	732-743	Spaces
DEB Start Date #24	7	9	744-750	CCYYDDD
DEB End Date #24	7	9	751-757	CCYYDDD
DEB Status #24	2	9	758-759	‘01’ through ‘08’
DEB State #24	2	x	760-761	Postal State Code
Filler	12	x	762-773	Spaces
DEB Start Date #25	7	9	774-780	CCYYDDD
DEB End Date #25	7	9	781-787	CCYYDDD
DEB Status #25	2	9	788-789	‘01’ through ‘08’
DEB State #25	2	x	790-791	Postal State Code
Filler	12	x	792-803	Spaces
DEB Start Date #26	7	9	804-810	CCYYDDD
DEB End Date #26	7	9	811-817	CCYYDDD
DEB Status #26	2	9	818-819	‘01’ through ‘08’
DEB State #26	2	x	820-821	Postal State Code
Filler	12	x	822-833	Spaces
DEB Start Date #27	7	9	834-840	CCYYDDD
DEB End Date #27	7	9	841-847	CCYYDDD
DEB Status #27	2	9	848-849	‘01’ through ‘08’
DEB State #27	2	x	850-851	Postal State Code
Filler	12	x	852-863	Spaces
DEB Start Date #28	7	9	864-870	CCYYDDD
DEB End Date #28	7	9	871-877	CCYYDDD
DEB Status #28	2	9	878-879	‘01’ through ‘08’
DEB State #2	2	x	880-881	Postal State Code
Filler	12	x	882-893	Spaces
DEB Start Date #29	7	9	894-900	CCYYDDD
DEB End Date #29	7	9	901-907	CCYYDDD
DEB Status #29	2	9	908-909	‘01’ through ‘08’
DEB State #29	2	x	910-911	Postal State Code
Filler	12	x	912-923	Spaces
DEB Start Date #30	7	9	924-930	CCYYDDD
DEB End Date #30	7	9	931-937	CCYYDDD
DEB Status #30	2	9	938-939	‘01’ through ‘08’

Field	Size	Usage	Location	Definition/Remarks
DEB State #30	2	x	940-941	Postal State Code
Filler	12	x	942-953	Spaces
DEB Start Date #31	7	9	954-960	CCYYDDD
DEB End Date #31	7	9	961-967	CCYYDDD
DEB Status #31	2	9	968-969	‘01’ through ‘08’
DEB State #31	2	x	970-971	Postal State Code
Filler	12	x	972-983	Spaces
DEB Start Date #32	7	9	984-990	CCYYDDD
DEB End Date #32	7	9	991-997	CCYYDDD
DEB Status #32	2	9	998-999	‘01’ through ‘08’
DEB State #32	2	x	1000-1001	Postal State Code
Filler	12	x	1002-1013	Spaces
DEB Start Date #33	7	9	1014-1020	CCYYDDD
DEB End Date #33	7	9	1021-1027	CCYYDDD
DEB Status #33	2	9	1028-1029	‘01’ through ‘08’
DEB State #33	2	x	1030-1031	Postal State Code
Filler	12	x	1032-1043	Spaces
DEB Start Date #34	7	9	1044-1050	CCYYDDD
DEB End Date #34	7	9	1051-1057	CCYYDDD
DEB Status #34	2	9	1058-1058	‘01’ through ‘08’
DEB State #34	2	x	1060-1061	Postal State Code
Filler	12	x	1062-1073	Spaces
DEB Start Date #35	7	9	1074-1080	CCYYDDD
DEB End Date #35	7	9	1081-1087	CCYYDDD
DEB Status #35	2	9	1088-1089	‘01’ through ‘08’
DEB State #35	2	x	1090-1091	Postal State Code
Filler	12	x	1092-1103	Spaces
DEB Start Date #36	7	9	1104-1110	CCYYDDD
DEB End Date #36	7	9	1111-1117	CCYYDDD
DEB Status #36	2	9	1118-1119	‘01’ through ‘08’
DEB State #36	2	x	1120-1121	Postal State Code
Filler	12	x	1122-1133	Spaces
DEB Start Date #37	7	9	1134-1140	CCYYDDD
DEB End Date #37	7	9	1141-1147	CCYYDDD
DEB Status #37	2	9	1148-1149	‘01’ through ‘08’

Field	Size	Usage	Location	Definition/Remarks
DEB State #37	2	x	1150-1151	Postal State Code
Filler	12	x	1152-1163	Spaces
DEB Start Date #38	7	9	1164-1170	CCYYDDD
DEB End Date #38	7	9	1171-1177	CCYYDDD
DEB Status #38	2	9	1178-1179	‘01’ through ‘08’
DEB State #38	2	x	1180-1181	Postal State Code
Filler	12	x	1182-1193	Spaces
DEB Start Date #39	7	9	1194-1200	CCYYDDD
DEB End Date #39	7	9	1201-1207	CCYYDDD
DEB Status #39	2	9	1208-1209	‘01’ through ‘08’
DEB State #3	2	x	1210-1211	Postal State Code
Filler	12	x	1212-1223	Spaces
DEB Start Date #40	7	9	1224-1230	CCYYDDD
DEB End Date #40	7	9	1231-1237	CCYYDDD
DEB Status #40	2	9	1238-1239	‘01’ through ‘08’
DEB State #40	2	x	1240-1241	Postal State Code
Filler	12	x	1242-1253	Spaces

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev.3764, 04-17)

200- Qualified Medicare Beneficiary (QMB)

200-Qualified Medicare Beneficiary (QMB) Program

(Rev. 3764, Issued: 04-28-17; Effective: 10-02-17; Implementation: 07-03-17 - CWF: Implementation of BRs 9911.1, 9911.1.1, 9911.1.2, and 9911.1.3; Design only and draft trailer layout provided to SSMs for BR 9911.2.1; VMS, MCS: analysis, design, and coding; FISS: analysis and design; 10-02-17 - CWF: Implementation of remaining BRs; FISS, VMS, MCS: coding, testing and implementation.)

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.

State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, States can limit provider payments for Medicare cost-sharing, under certain circumstances. Regardless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to a QMB individual. 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.)

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 three Remittance Advice Remark Codes (RARC) that are specific to those enrolled in QMB. Additionally, a QMB version of the MSN will be generated for all QMB individuals, to show QMB status and accurate patient liability amounts.

The Medicare Administrator Contractor (MAC) shall use the following codes for the Medicare Remittance Advice:

- *Group Code OA (Other Adjustments)*
- *Claim Adjustment Reason Code (CARC) 209*
    - *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 patient if collected. (Use only with Group code OA)*
- *Remittance Advice Remark Code (RARC) N781 to the line if deductible applies.*
    - *N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.*
- *Remittance Advice Remark Code RARC N782 to the claim if coinsurance applies.*
    - *N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.*
- *Remittance Advice Remark Code RARC N783 to the claim if a copayment applies.*
    - *N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.*