CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3715	**Date: February 3, 2017**
	Change Request 9911

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: 3715	Date: February 3, 2017	Change Request: 9911

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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		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
9911.1.2	The contractor shall maintain up to 40 occurrences of the following information from EDB on the new beneficiary auxiliary file:								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• MMA Dual Status Codes (values 01, 02, 03, 04, 05, 06, 08) • Dual status start date • Dual status end date • State code									
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 occurrence code 50 date for revenue code 0022 lines for SNF inpatient claims (TOB 018x or 021x).								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
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 line 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 “start/end date” of the QMB period, contractors shall apply a QMB indicator on the line item.						X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
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 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	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	
	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**: English – ["You're in the Qualified Medicare					X		X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 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:

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

V. CONTACTS

Pre-Implementation Contact(s): 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: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev.)

200-Qualified Medicare Beneficiary (QMB) Program

***(Rev. 3715, Issued: 02-03-17; Effective: 10-02-17; Implementation:* 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.)**

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.*