



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

MLN Matters Number: MM11230 **Revised**

Related Change Request (CR) Number: 11230

Related CR Release Date: **July 3, 2019**

Effective Date: October 1, 2019

Related CR Transmittal Number: **R4332CP**

Implementation Date: October 7, 2019 for claims processed on or after this date

**Note: We revised this article on July 9, 2019, to reflect the revised CR 11230 issued on July 3. In the article, we deleted a reference to FISS rejections that was on page 3. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.**

### PROVIDER TYPE AFFECTED

---

This MLN Matters Article is for providers and suppliers who serve Qualified Medicare Beneficiaries (QMBs).

### WHAT YOU NEED TO KNOW

---

CR 11230 alerts providers of further modifications to Medicare's claims processing systems to ensure that the Medicare Summary Notice (MSN) appropriately differentiates between QMB claims that are paid and denied and to show accurate patient payment liability amounts for beneficiaries enrolled in QMB. Please make sure your billing staffs are aware of these modifications.

### BACKGROUND

---

Through CRs 9911 and 10433, the Centers for Medicare & Medicaid Services (CMS) modified its claims processing systems to identify the QMB status of beneficiaries and exemption from Medicare Parts A and B cost-sharing charges. Articles related to CRs 9911 and 10433 are available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9911.pdf> and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10433.pdf>, respectively.

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, there were 7.5 million individuals (more than one out of eight beneficiaries) enrolled in the QMB program. Some QMBs (22 percent) get state Medicaid assistance with Medicare premiums and cost sharing alone, but most (78 percent) simultaneously have full Medicaid coverage, which may cover care 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 help providers comply with QMB billing prohibitions. The updates also educate QMBs that they cannot be billed for Medicare deductibles and coinsurance.

As implemented through CRs 9911 and 10433, the Common Working File (CWF) identifies that a beneficiary has active QMB status, which results in Remittance Advice (RA) and Medicare Summary Notice (MSN) messages for QMB claims.

The RA includes two (2) Alert Remittance Advice Remark Codes (RARCs) that identify an individual currently enrolled in QMB and tells providers they 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 Code 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 result using copies of RAs if necessary.

The MSN generated for all QMB individuals includes information regarding their QMB status and lack of liability for Medicare cost-sharing amounts for covered Parts A and B items and services. However, CMS has recently learned that the claims processing 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. .

CR 11230 includes the following 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 MSN 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 the care.
- Since most QMBs also have full Medicaid coverage, it's important to convey that their full Medicaid coverage may cover care that Medicare has denied.

**Note:** For supplier 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 Medicare Administrative Contractor (MAC) will not print MSN message 11.21.

## ADDITIONAL INFORMATION

The official instruction, CR11230, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4332CP.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

For more information, refer to the Qualified Medicare Beneficiary (QMB) Program at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html>.

## DOCUMENT HISTORY

Date of Change	Description
July 9, 2019	We revised this article to reflect the revised CR 11230 issued on July 3. In the article, we deleted a reference to FISS rejections that was on page 3. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
May 7, 2019	Initial article released.

**Disclaimer:** This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2018 American Medical Association. All rights reserved.

Copyright © 2013-2019, the American Hospital Association, Chicago, Illinois. Reproduced by CMS with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816. You may also contact us at [ub04@healthforum.com](mailto:ub04@healthforum.com)

The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.