Qualified Medicare Beneficiary Program – FAQ on Billing Requirements

(July 2018)

QMB Billing Rules

Q1: What is the Qualified Medicare Beneficiary (QMB) Program?

A1: The QMB program provides Medicaid coverage of Medicare Part A and Part B premiums and cost sharing to low income Medicare beneficiaries. QMB is an eligibility category under the Medicare Savings Programs.

In 2016, 7.5 million individuals (more than one out of eight Medicare beneficiaries) were enrolled in the QMB program. Of that total, about twenty-two percent received Medicaid coverage of their Medicare expenses only (QMB Only), and seventy-eight percent received full Medicaid benefits in addition to coverage of their Medicare expenses (QMB Plus).

Q2. What is CMS changing about the QMB program?

A2. None of the QMB billing requirements are new. However, CMS is making it easier for providers to comply by updating CMS systems to inform providers to identify a patient's QMB status and exemption from cost-sharing charges.

Q3: What billing requirements apply to providers and suppliers for QMB patients?

A3: All original Medicare and Medicare Advantage providers and suppliers – not only those that accept Medicaid – must refrain from charging individuals enrolled in the QMB program for Medicare cost sharing for covered Parts A and B services.

Note that that individuals enrolled in QMB cannot elect to pay Medicare deductibles, coinsurance, and copays, but may have a small Medicaid copay.

For more information, see Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters® Article.

Q4: I am enrolled in Medicare but do not accept Medicaid patients. Do I need to follow the QMB billing rules?

A4: Yes. All Medicare suppliers and providers -- even those that do not accept Medicaid -- must refrain from billing QMBs for Medicare cost-sharing for Parts A and B covered services.

Q5: Do QMB billing requirements apply to beneficiaries enrolled in all Medicare Advantage plans?

A5: Yes. The QMB billing restrictions apply to all QMB, including those enrolled in Medicare Advantage plans and original Medicare.

Q6: Do QMB billing prohibitions apply to Part B-covered prescription drugs?

A6: Yes. The QMB billing prohibitions apply to all Part A and B services, including Part B-covered prescription drugs.

Q7: May pharmacies still collect Medicare Part D copayments from QMBs?

A7: Yes, the prohibition on collecting Medicare copayments is limited to services covered under Parts A and B. Pharmacists may still collect the Low Income Subsidy copayment amounts from QMBs for Part D-covered prescription drugs.

Q8: Can Medicare providers and suppliers seek payment for Medicare cost-sharing for QMBs from State Medicaid Programs?

A8: Yes, but as permitted by federal law, most States limit their payment of Medicare deductibles, coinsurance, and copays for QMBs. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

Understand the processes you need to follow to request payment for Medicare cost-sharing amounts if they are owed by your State. States require all providers, including Medicare providers, to enroll in their Medicaid system for provider claims review, processing, and issuance of the Medicaid Remittance Advice. If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.

Steps to Promote Compliance

Q9: What are key ways that providers and suppliers can promote compliance with QMB billing rules?

A9: Providers can take the following steps:

1. Establish processes to routinely identify the QMB status of your patients prior to billing (*please see Q10 for details on how to do so*).

2. Ensure that billing procedures and third-party vendors exempt QMBs from Medicare charges and that remedy billing problems should they occur. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid.

3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided to individuals enrolled in the QMB program. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recover Center (BCRC) to

automatically receive Medicare-adjudicated claims. If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.

For more information, see Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article.

Identification of QMB Status

Q10: How can providers identify the QMB status of their patients?

A10: Providers can take the following steps:

1. Effective November 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HETS to verify a patient's QMB status and exemption from cost-sharing charges. Providers can ask their third party eligibility-verification vendors how their products reflect the new QMB information from HETS. For more information, visit the HETS website.

2. Starting July 2018, original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions from the Medicare Provider Remittance Advice, which will contain new notifications and information about a patient's QMB status. For more information, see Reinstating the QMB Indicator in the Medicare Fee-For-Service (FFS) Claims Processing System from CR 9911 MLN Matters Article.

3. MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.

4. Providers and suppliers may also verify a patient's QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards, Medicare Summary Notices (starting July 2018) and documents issued by the State proving the patient is enrolled in the QMB program.

Q11: What information does the Medicare Summary Notice (MSN) include for QMBs?

A11:Starting July 2018, the Medicare Summary Notice (MSN)will contain new information for QMBs that informs them of their QMB status and billing protections and accurately reflects their cost-sharing liability ($0 for the period enrolled in the QMB program).

Q12: What is the HETS system and how do I access it?

A12: The HIPPA Eligibility Transaction System (HETS) is a CMS system that releases real-time Medicare eligibility data to users for the purpose of preparing accurate Medicare claims, determining beneficiary liability, and checking eligibility for specific services.

Medicare providers, suppliers, or their authorized billing agents (including clearinghouses and third party vendors) can register as HETS users. Providers can either connect to HETS directly or through their clearinghouses and third-party eligibility verification products/software.

HETS users submit HIPAA-compliant 270 eligibility request files over a secure connection, and receive 271 response files that address the status of eligibility (active or inactive) and patient financial responsibility for Medicare Part A and Part B. For more information, visit the HETS website.

Q13: What happened to the QMB Remittance Advice changes from October 2017?

A13: On October 2, 2017, the Provider Remittance (RA) and the Medicare Summary Notice (MSN) for QMB claims began identifying the QMB status of beneficiaries' and reflecting their zero cost-sharing liability. However, the RA changes caused unforeseen issues affecting the processing of QMB cost-sharing claims by States and other payers secondary to Medicare. To address these unanticipated consequences, beginning December 8, 2017, CMS temporarily suspended the QMB system changes.

In March 2018 – MACs begin issuing replacement RAs through non-monetary mass adjustments for Qualified Medicare Beneficiary (QMB) claims paid after October 2 and up to December 31, 2017, that have not been voided or replaced. Providers can use the replacement RAs to resubmit Medicaid QMB cost-sharing claims that states initially failed to pay due to the RA changes. Read MLN Matters Article MM10494 for more information.

In July 2018, CMS will reintroduce QMB information in the RA in a way that avoids disrupting the claims processing systems of secondary payers. For more information, see Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article.

Q14: How will the RA reflect a beneficiary's QMB status starting July 2, 2018?

A14: Starting July 2, 2018, for original Medicare claims, the RA will reintroduce revised QMB-specific Alert Remittance Advice Remark Codes (RARC).

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

The RAs will retain the display of monetary values for deductible and coinsurance amounts in conjunction with Group Code "PR" and associated Claim Adjustment Group

Codes (CARC) for cost-sharing amounts ("1" and "2"). This will avoid disrupting the claims processing systems.

For more information, see Reinstating the QMB Indicator in the Medicare Fee-For-Service (FFS) Claims Processing System from CR 9911 MLN Matters Article.

Revised Q15: If I am a Medicare Advantage (MA) provider, how can I verify the QMB status of plan members?

A15: This will depend on the plan. CMS strongly recommends that plans affirmatively inform providers about enrollee QMB status and exemption from cost-sharing liability, but does not mandate specific methods to facilitate QMB verification by providers.

MA providers and suppliers are advised to contact the MA plan to learn the best way to identify the QMB status of plan members both before and after claims submission.

Recommended measures for plans to share QMB information include the use of:

- Real-time eligibility verification responses
- Provider portals and phone query mechanisms
- Remittance Advice (Explanation of Payment)

If the MA plan does not share QMB information with providers on a real-time basis, providers can use other means to verify the QMB status of members prior to claims submission.

- Providers and suppliers can verify beneficiaries' QMB status through automated Medicaid eligibility-verification systems in the State in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card, or other documentation of their QMB status.

- Providers and suppliers can now verify QMB status through Medicare's HIPAA Eligibility Transaction System (HETS) eligibility query system or Medicare Administrative Contractor self-service tools (interactive voice response units or secure internet portals) as long as the provider supplies the beneficiary's Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI). Starting January 1, 2020, providers must use the MBI to get a beneficiary's QMB status from these sources.

Advance Beneficiary Notices and Statutorily Excluded Services

New Q16: What billing limits apply if a provider issues an Advance Beneficiary Notice (ABN) to a dual eligible beneficiary, based on the expectation that Medicare will deny the item or service because it is not medically reasonable and necessary or constitutes custodial care?

A16: Providers give an ABN, in order to transfer potential financial liability, to a Medicare beneficiary before providing a Medicare-covered item or service that is expected to be denied by Medicare because it is not medically reasonable and necessary or custodial care. See ABN form and ABN form instructions at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

If the provider has any indication that the beneficiary is a dually eligible beneficiary (has QMB and/or Medicaid coverage) special guidelines apply.

- When the beneficiary signs the ABN, s/he must be instructed to check Option Box 1 on the ABN in order for a claim to be submitted for Medicare adjudication. This is the only instance where the provider may indicate what option the beneficiary should choose.

- Even though the ABN indicates the beneficiary may be asked to pay now and is responsible for the payment if Medicare doesn't pay, the provider cannot bill the dual eligible beneficiary when the ABN is furnished. Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid in light of federal laws affecting coverage and billing of dual eligible beneficiaries. If Medicare denies a claim as not medically reasonable and necessary and a Remittance Advice (RA) is received, the claim may be crossed over to Medicaid for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue an RA based on this determination.

- Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the beneficiary in the following circumstances.

    - If Medicare denies the claim as not reasonable and medically necessary and the beneficiary has QMB coverage without full Medicaid coverage, the ABN would allow the provider to shift liability to the beneficiary per Medicare policy.

    - If Medicare denies the claim as not reasonable and medically necessary for a beneficiary with full Medicaid coverage, and subsequently, Medicaid denies coverage (or will not pay because the provider does not participate in Medicaid,) the ABN would allow the provider to shift liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.

Note that, depending upon state laws and policy, Medicaid providers can bill dually eligible beneficiaries a small Medicaid co-payment for services covered by Medicare and Medicaid.

New Q17: Can a provider bill a dual eligible beneficiary for statutorily excluded services that Medicare never covers?

A17: If Medicare expressly excludes coverage for a given item or service and the beneficiary has QMB coverage without full Medicaid coverage, the provider could bill the beneficiary for the full cost of care.

However, if the beneficiary has full Medicaid coverage, Medicaid coverage may be available for excluded Medicare services **if** the State Medicaid policy covers these services and the provider who delivers the service participates in Medicaid. Since Medicare coverage is excluded, Medicaid will cover the service as it would for any another Medicaid beneficiary who does not have Medicare coverage. The Medicaid Remittance Advice will reflect what Medicaid will pay for the service the nominal Medicaid copay amount (if any). If the Medicaid Remittance Advice indicates that Medicaid will not cover the service, the provider can bill the beneficiary for care, subject to any state laws that limit patient liability.

Please keep in mind that for statutorily excluded services that Medicare never covers, an ABN does not have to be issued. We encourage providers to issue an ABN as a courtesy to the beneficiary so they are aware of their potential financial liability.