QMB Remittance Advice Issue

CMS is alerting you to an issue where payers secondary to Medicare aren't able to process some of your direct billed claims due to patient responsibility deductible and coinsurance amounts on the Medicare Remittance Advice (RA) showing zero. Claims automatically crossed over from Medicare to secondary payers aren't impacted.

On October 2, 2017, Change Request (CR) 9911 modified the Medicare RA for Qualified Medicare Beneficiary (QMB) claims to indicate the QMB status of patients and reflect zero cost-sharing liability. For these beneficiaries, Medicaid is responsible for covering Medicare cost-sharing, though the beneficiary may also have other secondary payers (e.g., VA, tribes, Medigap). The change is part of our ongoing effort to give providers tools to comply with the statutory prohibition on collecting Medicare A/B cost-sharing from approximately 7 million QMBs. The change resulted in unanticipated issues for providers, states and other secondary payers who are used to seeing the Medicare deductible and coinsurance amounts in specific fields on the Medicare RA.

On December 8, 2017, CMS systems will revert back to the previous display of patient responsibility for QMBs on the Medicare RA. You may want to hold QMB related claims and submit them after December 8. In the interim for Medicare claims received between October 2 and December 7, 2017, and subsequently processed, you can identify Medicare cost-sharing amounts on the Medicare RA:

- Group Code OA – Other Adjustment
- Claim Adjustment Reason Code (CARC) 209 - Per regulatory or other agreement
    - The provider cannot collect this amount from the patients. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)
- The following Remittance Advice Remark Codes under Inpatient Adjudication Information (MIA) or Outpatient Adjudication Information (MOA):
    - N781 - Alert: No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible.
    - N782 -Alert: No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance.

When billing Medicaid and other secondary insurers, RARC N781 equates to CARC 1 – Deductible Amount and RARC N782 equates to CARC 2 – Coinsurance Amount. If a claim contains both RARC N781 and N782, this means the beneficiary deductible and coinsurance amounts have been combined. To get a breakdown of these amounts, institutional providers can access the Direct Data Entry (DDE) system. CMS is in the process of identifying how professional providers can get a breakdown; we'll share this information soon.