

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1747	Date: November 4, 2016
	Change Request 9817

SUBJECT: Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of Qualified Medicare Beneficiaries (QMBs) for Medicare Cost-Sharing

I. SUMMARY OF CHANGES: The purpose of this Change Request is to instruct Medicare Administrative Contractors (MACs) to accept Beneficiary Contact Center (BCC) referrals of beneficiary inquiries involving Qualified Medicare Beneficiary (QMB) billing problems, issue Compliance letters to named providers and send a copy of the provider Compliance letter to the named beneficiary with an explanatory cover letter.

Federal law bars Medicare providers from charging Qualified Medicare Beneficiary Program (QMB) individuals for Medicare Part A and B deductibles, coinsurances, or copays. Medicare providers must accept the Medicare payment and Medicaid payment (if any) 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. Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.

Effective, September 19, 2016, Beneficiary Contact Center (BCC) Customer Service Representatives (CSRs) will implement protocols to identify a caller's QMB status and advise them about QMB billing protections. Within 30 days of implementing this Emergency CR, BCC CSRs will escalate certain beneficiary inquiries involving improper QMB billing to the appropriate MAC through the Next Generation Desktop (NGD) in accordance with the Complex Inquiry Escalation National Operating Procedures. MACs are instructed by CMS to issue a compliance letter within applicable complex inquiry timeframes (within 25 business days for at least 75 percent and within 45 business days for 100 percent of all inquiries referred) instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing.

EFFECTIVE DATE: December 6, 2016

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: March 8, 2017

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/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

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IMPLEMENTATION DATE: March 8, 2017

for all other requirements

I. GENERAL INFORMATION

A. Background: Federal law bars Medicare providers from charging individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) for Medicare Part A and B deductibles, coinsurances, or copays. QMB is a Medicaid program that assists low-income beneficiaries with Medicare cost-sharing. In 2013, approximately 7 million Medicare beneficiaries were enrolled in the QMB program.

State Medicaid programs are liable to pay Medicare providers who serve QMB individuals for the Medicare cost-sharing. However, as permitted by federal law, states can limit provider payment for Medicare cost-sharing to the lesser of the Medicare cost-sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service. 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); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

A July 2015 CMS study found that, despite federal law, erroneous balance billing of QMB individuals is relatively common place and that 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.)

Medicare & You 2017, which is mailed to all beneficiaries in September 2016, contains new language to advise QMB individuals about their billing protections and to call 1-800-MEDICARE if they cannot resolve billing problems with their providers. In addition, effective September 17, 2016, Beneficiary Contact Center (BCC) Customer Service Representatives (CSRs), will identify a caller's QMB status and advise them about their billing rights.

B. Policy: BCC CSRs will begin escalating beneficiary inquiries involving QMB billing problems that the beneficiary has been unable to resolve with the provider to the appropriate MAC through the Next Generation Desktop (NGD) in accordance with the Complex Inquiry Escalation National Operating Procedures. MACs are instructed by CMS to issue a compliance letter within applicable complex inquiry timeframes (within 25 business days of receipt for at least 75 percent and within 45 business days of receipt for 100 percent of all inquiries referred, in accordance with Pub.100-09, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2, Section 20.2.6) instructing named providers and suppliers to refund any erroneous charges and recall any past or existing QMB billing. (See letter attached). CMS estimates that MACs will issue ten QMB billing Compliance letters each month.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C S	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
9817.1	MACs shall accept BCC referrals of beneficiary inquiries involving QMB billing problems that the beneficiary has been unable to resolve with the provider through the Next Generation Desktop (NGD) in accordance with the Complex Inquiry Escalation National Operating Procedures. Once a referral is received, the MACs shall issue a Compliance letter that instructs named providers and suppliers to refund any erroneous charges and recall any past or existing QMB billing.	X	X		X					
9817.2	The MAC shall issue Compliance letters to named providers and suppliers within 25 business days of receipt for at least 75 percent of inquiries referred and within 45 business days of receipt for 100 percent of all inquiries referred.	X	X		X					
9817.3	The MAC shall issue a copy of the Compliance letter to the named beneficiary, with a beneficiary cover letter, within 25 business days of receipt for at least 75 percent of inquiries referred and within 45 business days of receipt for 100 percent of all inquiries referred.	X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C S	C E D I
		A	B	H H H		
9817.4	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	X	X		X	

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H	M A C	
	with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"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): KIM GLAUN, 410-786-3849 or kim.glaun@cms.hhs.gov , GIMAN KIM, 410-786-8845 or giman.kim@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: 2

[month] [day], [year]
[address]
[City] [ST] [Zip]

Reference ID: (NPI, etc.)

Dear [Beneficiary Name]:

You contacted Medicare about a bill you got from [Provider/Supplier Name]. Then we sent [Provider/Supplier Name] the letter on the next page.

You are in the Qualified Medicare Beneficiary (QMB) program. It helps pay your Medicare costs. **Medicare providers cannot bill you for Medicare deductibles, coinsurance, or copays for covered items and services.**

The letter tells the provider to stop billing you and to refund you any amounts you already paid. **Here's what you can do:**

1. Show this letter to the provider to make sure they fixed your bill.
2. Tell all of your providers and suppliers you are in the QMB program.
3. Show your Medicare and your Medicaid or QMB cards each time you get items or services.

If you have questions about this letter, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

Sincerely,

[Name]

[Title]

[MAC name]

[REMOVE PRIOR TO SENDING: Compliance Letter to Providers]

[month] [day], [year]
[address]
[City] ST [Zip]

Reference ID: (NPI, etc.)

Dear [Provider/Supplier Name]:

The Centers for Medicare & Medicaid Services (CMS) received information that [Provider/Supplier Name] is improperly billing [Medicare beneficiary name/HICN number] for Medicare cost-sharing.

This beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that helps low-income beneficiaries pay their Medicare cost-sharing. Federal law says Medicare providers can't charge individuals enrolled in the QMB program for Medicare Part A and B deductibles, coinsurances, or copays for items and services Medicare covers.

- **Promptly review your records for efforts to collect Medicare cost-sharing from [Medicare beneficiary name/HICN number], refund any amounts already paid, and recall any past or existing billing (including referrals to collection agencies) for Medicare-covered items and services**
- Ensure that your administrative staff and billing software exempt individuals enrolled in the QMB program from all Medicare cost-sharing billing and related collection efforts

Medicare providers must accept Medicare payment and Medicaid payment (if any) as payment in full for services given to individuals enrolled in the QMB program. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

Finally, please refer to this Medicare Learning Network (MLN) Matters® article for more information on the prohibited billing of QMBs: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf>. If you have questions, please contact [MAC information].

Sincerely,

[Name]

[Title]

[MAC name]