



News Flash - The Centers for Medicare & Medicaid Services (CMS) reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work—approximately 15 work days after Medicare’s reimbursement is made, as stated in MLN Matters Article SE0909 (<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0909.pdf>) — before attempting to balance bill their patients’ supplemental insurers. That is, do not balance bill until you have received written confirmation from Medicare that your patients’ claims will not be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance Advice Remark Codes MA18 or N89 on your Medicare Remittance Advice (MRA) represent Medicare’s intention to cross your patients’ claims over.

MLN Matters® Number: SE0930 **Revised**

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: January 1, 2010

Related CR Transmittal #: N/A

Implementation Date: As soon as possible

Note: This article was updated on January 25, 2013, to reflect current Web addresses. This article was previously revised and re-issued on March 31, 2010, to reflect the impact of the Patient Protection and Affordable Care Act on these IHS services. In essence, the new Act permanently extends Section 630 of the MMA retroactive to January 1, 2010. See the rest of this article to see how the new law impacts your claims.

Section 2902 of the Patient Protection and Affordable Care Act Permanently Extends Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 for the Payment of Indian Health Services (IHS)

Provider Types Affected

Indian Health Service (IHS) tribe and tribal organizations and facilities submitting claims to Medicare contractors

Provider Action Needed

This special edition article was initially issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected IHS physicians, IHS providers, and IHS suppliers that, per the provisions of section 630 of the MMA, certain Part B

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services were no longer covered for Medicare payment when the provisions sunset as of December 31, 2009.

However, on March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. Section 2902 of the new law permanently extends Section 630 of the MMA, retroactive to January 1, 2010.

The services involved include the following:

- Durable Medical Equipment, prosthetics, and orthotics;
- Therapeutic shoes;
- Clinical laboratory services;
- Surgical dressings, splints and casts;
- Drugs (those processed by the J4 A/B Medicare Administrative Contractor (MAC) and the DME MACs);
- Ambulance services;
- Influenza and pneumonia vaccinations; and
- Screening and preventive services.

Indian Health Service providers, suppliers, physicians and other practitioners should contact their Medicare Contractor for further guidance regarding IHS claims affected by the new law, for dates of service January 1, 2010, and after, that were denied, prior to implementation of the new law.

Note: It will take approximately two weeks for your Medicare Contractor to update their systems to be able to pay correctly for these services. You may want to wait until the claims processing system is updated before submitting any new claims containing these IHS services. CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue.

Please be on the alert for more information pertaining to the Patient Protection and Affordable Care Act.

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