Coordination of Benefits
April 18, 2006

Q. May Part D plan sponsors implement 30-day filing limits for beneficiaries to provide documentation to plans of amounts incorrectly paid by the beneficiary or for other payers to provide information for the coordination of benefits?

A. Prior to the implementation of the Medicare prescription drug program, the conventional time limit in the industry for claims filing was 15 to 30 days. This convention was predicated on an environment in which all payers were primary. With the implementation of the Medicare drug program, new circumstances involving multiple payers, payer order issues, and retroactive eligibility have created more complex billing situations which have been compounded by various issues related to program startup.

As a result, CMS does not believe the conventional 15 to 30 day claims filing timeframes address these new circumstances, and looks to Part D plan sponsors to refrain from imposing the conventional time limits on the more complex billing situations existing under Medicare Part D. At this point CMS is not establishing what those less restrictive timeframes should be, but is expecting the industry to establish appropriate new claims filing rules that recognize the complexities associated with Part D claims billing and not impose artificially strict time limits.

Under 42 CFR 423.464(a), Part D plans must comply with all administrative processes and requirements established by CMS to ensure effective COB, including payments related to coverage. In anticipation of the longer timeframes that we believed would likely be required, CMS did not impose timely claims filing limits on Part D plan sponsors. Instead we allow plans up to three months after the end of the coverage year to pay for claims for covered Part D drugs (42 CFR 423.308), up to May 31st following the coverage year to submit prescription drug claims, including adjustments, and up to June 30th following the coverage year to submit cost information.

Q. What process should plans follow when they receive an N1 transaction, but have no supplemental payer information on file to identify who the payer is?

A. Part D plans should accept N1 transactions even in those instances where they have no supplemental payer information on file to identify the payer. The plan should then contact the beneficiary (which may be accomplished in conjunction with the annual coordination of benefits (COB) survey of plan enrollees if that survey will be conducted within the next 2 months) to identify the supplemental payer. Once the plan receives this information, it should be transmitted via the Electronic Correspondence Referral System (ECRS) to the CMS Coordination of Benefits Contractor (COBC) for verification of the secondary coverage.

In its contact with the beneficiary, the plan should specify that until the beneficiary identifies the payer and the coverage is verified, the presumption will be that the costs incurred for drugs covered by the secondary payer will not count toward the beneficiary's true out-of-pocket expenditures.