

**HUMAN SERVICES DEPARTMENT[441]**

**Adopted and Filed**

**Rulemaking related to procedure and method of payment**

The Department of Health and Human Services hereby rescinds Chapter 80, “Procedure and Method of Payment,” Iowa Administrative Code, and adopts a new Chapter 80 with the same title.

*Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 249A.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 249A.

*Purpose and Summary*

This chapter underwent a Red Tape Review in response to Executive Order 10. As a result of the review, the Department:

- Eliminated restrictive terms.
- Standardized use of acronyms.
- Added and updated dates certain.
- Referred items back to the applicable CFR or Iowa Code section.
- Removed references to the integrated health home program, which is sunsetting.
- Reordered rules.
- Referred items back to the appropriate provider manual.
- Removed references to specific form numbers.
- Eliminated references to specific areas of the Department and replaced with “Iowa Medicaid” or “the Department.”
- Eliminated outdated references.

This chapter provides guidance on claim format and submission for providers of medical and remedial care that participate in Iowa’s medical assistance program.

*Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 24, 2025, as **ARC 9851C**. Public hearings were held on the following date:

- January 13, 2026

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

*Adoption of Rulemaking*

This rulemaking was adopted by the Department on April 16, 2026.

*Fiscal Impact*

This rulemaking has no fiscal impact to the State of Iowa.

*Jobs Impact*

After analysis and review of this rulemaking, no impact on jobs has been found.

*Waivers*

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 2504.

*Review by Administrative Rules Review Committee*

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee’s meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

*Effective Date*

This rulemaking will become effective on July 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind 441—Chapter 80 and adopt the following **new** chapter in lieu thereof:

CHAPTER 80  
PROCEDURE AND METHOD OF PAYMENT

**441—80.1(249A) Submission of claims.** Providers of medical and remedial care participating in the program shall submit claims for services rendered to Iowa Medicaid on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after the end of the calendar month in which the services are provided. Following audit of the claim, Iowa Medicaid will make payment to the provider of care. The provider manual, Chapter IV, Billing Iowa Medicaid, found on the department’s website and as amended to July 1, 2026, will detail the specific manner and frequency in which claims are to be submitted.

**80.1(1)** Electronic submission. Providers are required to submit claims electronically whenever possible.

**80.1(2)** For fee-for-service members, providers billing claims for Medicare beneficiaries that do not cross over electronically to Iowa Medicaid must submit the following electronically, in accordance with the All Providers manual, Chapter IV, Billing Iowa Medicaid, located on the department’s website and as amended to July 1, 2026:

a. Form UB-04.

b. Form CMS-1500. The Explanation of Medicare Benefits (EOMB) is only required when requested by Iowa Medicaid.

**441—80.2(249A) Payment from other sources.** This rule applies to claims for the department, managed care organizations, and the Public Health Associate Program (PHAP).

**80.2(1)** *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source will be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

**80.2(2)** *Third-party liability.*

a. When a third-party liability for medical expenses exists, this resource will be utilized for payment of a claim before the Medicaid program makes payment unless:

(1) The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This “pay and chase” provision applies to claims for:

1. Preventive pediatric services, and

2. All services provided to a person for whom there is court-ordered medical support.

(2) Otherwise authorized by the department.

b. All claims must be clean claims. A clean claim is defined as a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim.

**80.2(3)** *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. No later than 60 days after receiving any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service, respond to such inquiry, pursuant to 42 U.S.C. Section 1396a(25)(I)(iii) as amended to July 1, 2026.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point of sale that is the basis of the claim, or, in the case of a responsible third party (other than the original Medicare fee-for-service program under Parts A and B of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026, a Medicare Advantage plan offered by a Medicare Advantage organization under Part C of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026, a reasonable cost of reimbursement plan under 42 U.S.C. Section 1395mm as amended to July 1, 2026, a health care prepayment plan under 42 U.S.C. Section 1395l as amended to July 1, 2026, or a prescription drug plan (PDP) offered by a PDP sponsor under Part D of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026), a failure to obtain a prior authorization for the item or service for which the claim is being submitted, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

d. Agree not to deny any claim submitted by the state solely because of lack of prior authorization.

#### **441—80.3(249A) Time limit for submission of claims and claim adjustments.**

**80.3(1)** *Submission of claims.* Payment will not be made on any claim when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by Iowa Medicaid exceeds 365 days. The department will consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

**80.3(2)** *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by Iowa Medicaid within 365 days from the date the claim was last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

**80.3(3)** *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

#### **441—80.4(249A) Authorization process.**

**80.4(1)** *Identification cards.* The department will issue a medical assistance eligibility card to members for use in securing medical and health services available under the program except as provided in 441—Chapter 76.

a. The department will issue the medical assistance eligibility card:

(1) When the member's eligibility is initially determined.

(2) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The medical assistance eligibility card is valid only for months in which the member has established eligibility as indicated on the department's eligibility verification system (ELVS). Payment

will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

**80.4(2)** Reserved.

**441—80.5(249A) Payment to provider—exception.** Payments for medical services may be made only to the provider of the services except as provided below.

**80.5(1)** *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with 441—Chapter 75.

**80.5(2)** *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

**80.5(3)** *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

- a. Related to the cost of processing the billing.
- b. Not related on a percentage or other basis to the amount that is billed or collected.
- c. Not dependent upon the collection of the payment.

**441—80.6(249A) Health care data match program.** As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406 as amended to July 1, 2026), service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

**80.6(1)** *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. A data use agreement shall prescribe the specific detail elements required, any privacy protections, the manner in which information shall be provided to the department or its designee, and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department or its designee to match covered persons and identify third-party payors for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

**80.6(2)** *Confidentiality of data.* The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended to July 1, 2026; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164 as amended to July 1, 2026.

These rules are intended to implement Iowa Code chapter 249A.

[Filed 5/4/26, effective 7/1/26]

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.