249A.37 Duties of third parties.

1. For the purposes of this section, *"Medicaid payor"*, *"recipient"*, *"third party"*, and *"third-party benefits"* mean the same as defined in section 249A.54.

2. The third-party obligations specified under this section are a condition of doing business in the state. A third party that fails to comply with these obligations shall not be eligible to do business in the state.

3. A third party that is a carrier, as defined in section 514C.13, shall enter into a health insurance data match program with the department for the sole purpose of comparing the names of the carrier's insureds with the names of recipients as required by section 505.25.

4. A third party shall do all of the following:

a. Cooperate with the Medicaid payor in identifying recipients for whom third-party benefits are available including but not limited to providing information to determine the period of potential third-party coverage, the nature of the coverage, and the name, address, and identifying number of the coverage. In cooperating with the Medicaid payor, the third party shall provide information upon the request of the Medicaid payor in a manner prescribed by the Medicaid payor or as agreed upon by the department and the third party.

b. (1) Accept the Medicaid payor's rights of recovery and assignment to the Medicaid payor as a subrogee, assignee, or lienholder under section 249A.54 for payments which the Medicaid payor has made under the Medicaid state plan or under a waiver of such state plan.

(2) In the case of a third party other than the original Medicare fee-for-service program under parts A and B of Tit. XVIII of the federal Social Security Act, a Medicare advantage plan offered by a Medicare advantage organization under part C of Tit. XVIII of the federal Social Security Act, a reasonable cost reimbursement contract under 42 U.S.C. §1395mm, a health care prepayment plan under 42 U.S.C. §1395l, or a prescription drug plan offered by a prescription drug plan sponsor under part D of Tit. XVIII of the federal Social Security Act that requires prior authorization for an item or service furnished to an individual eligible to receive medical assistance under Tit. XIX of the federal Social Security Act, accept authorization provided by the Medicaid payor that the health care item or service is covered under the Medicaid state plan or waiver of such state plan for such individual, as if such authorization were the prior authorization made by the third party for such item or service.

c. If, on or before three years from the date a health care item or service was provided, the Medicaid payor submits an inquiry regarding a claim for payment that was submitted to the third party, respond to that inquiry not later than sixty days after receiving the inquiry.

d. Respond to any Medicaid payor's request for payment of a claim described in paragraph *"c"* not later than ninety business days after receipt of written proof of the claim, either by paying the claim or issuing a written denial to the Medicaid payor.

e. Not deny any claim submitted by a Medicaid payor solely on the basis 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 third party other than the original Medicare fee-for-service program under parts A and B of Tit. XVIII of the federal Social Security Act, a Medicare advantage plan offered by a Medicare advantage organization under part C of Tit. XVIII of the federal Social Security Act, a reasonable cost reimbursement contract under 42 U.S.C. §1395mm, a health care prepayment plan under 42 U.S.C. §1395l, or a prescription drug plan offered by a prescription drug plan sponsor under part D of Tit. XVIII of the federal Social Security Act, solely on the basis of a failure to obtain prior authorization for the health care item or service for which the claim is submitted if all of the following conditions are met:

(1) The claim is submitted to the third party by the Medicaid payor no later than three years after the date on which the health care item or service was furnished.

(2) Any action by the Medicaid payor to enforce its rights under section 249A.54 with respect to such claim is commenced not later than six years after the Medicaid payor submits the claim for payment.

5. Notwithstanding any provision of law to the contrary, the time limitations, requirements, and allowances specified in this section shall apply to third-party obligations under this section.

6. The department may adopt rules pursuant to chapter 17A as necessary to administer this section. Rules governing the exchange of information under this section 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 the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and regulations promulgated in accordance with that Act and published in 45 C.F.R. pts. 160 – 164.

2008 Acts, ch 1187, §124; 2023 Acts, ch 19, §809, 810; 2023 Acts, ch 158, §1

With respect to proposed amendments by 2023 Acts, ch 19, §809, 810, see Code editor's note on simple harmonization at the beginning of this Code volume

Section stricken and rewritten