441—80.2(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to the Iowa Medicaid enterprise on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after end of the calendar month in which the services are provided. Following audit of the claim, the Iowa Medicaid enterprise will make payment to the provider of care.

80.2(1) Electronic submission. Providers are encouraged to submit claims electronically whenever possible.

a. Ambulance service providers may bill electronically only when the procedures performed are identified by codes based on the ones that Medicare recognizes as emergency and support medical necessity without a review by the Iowa Medicaid enterprise.

b. When filing electronic claims, pharmacies shall use the format prescribed by the National Council for Prescription Drug Programs.

c. Claims submitted electronically after implementation of the Health Insurance Portability and Accountability Act of 1996 shall be filed on the Accredited Standards Committee (ASC) X12N 837 transaction, Health Care Claim. The department shall send all providers written notice when the Act is implemented.

(1) Providers listed as filing claims on Form CMS-1500 or on the Claim for Targeted Medical Care shall file claims on the professional version of the Health Care Claim.

(2) Providers listed as filing claims on Form CMS-1450 or on the Iowa Medicaid Long-Term Care Claim shall file the institutional version of the Health Care Claim.

(3) Dentists shall file the dental version of the Health Care Claim.

(4) Pharmacists providing drugs and injections shall use the format prescribed by the National Council for Prescription Drug Programs.

d. If a claim submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3969, Claim Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3969 the attachment control number submitted on the ASC X12N 837 electronic transaction.

80.2(2) Claim forms. Claims for payment for services provided recipients shall be submitted on Form CMS-1500, Health Insurance Claim Form, except as noted below.

a. The following providers shall submit claims on Form UB-04, CMS-1450:

(1) Home health agencies providing services other than home- and community-based services.

(2) Hospitals providing inpatient care or outpatient services, including inpatient psychiatric hospitals.

(3) Psychiatric medical institutions for children.

(4) Rehabilitation agencies.

(5) Hospice providers.

(6) Medicare-certified nursing facilities.

(7) Nursing facilities for the mentally ill.

(8) Special population nursing facilities as defined in rule 441—81.6(249A).

(9) Out-of-state nursing facilities.

(10) Health insurance premium payment (HIPP) providers.

b. All other nursing facilities and intermediate care facilities for persons with an intellectual disability shall file claims using an electronic version of Form UB-04 CMS-1450.

c. Pharmacies shall submit claims on the Universal Pharmacy Claim Form when filing paper claims.

d. Dentists shall submit claims on the dental claim form approved by the American Dental Association.

e. Rescinded IAB 8/1/07, effective 9/5/07.

f. Providers of home- and community-based waiver services, including home health agencies, shall submit claims on Form 470-2486, Claim for Targeted Medical Care. In the event of the death of

the member, the case manager or service worker shall sign and date the claim form if the services were delivered.

g. Case management providers shall submit claims on Form 470-2486, Claim for Targeted Medical Care, for services provided pursuant to 441—Chapter 90 and on FACS-generated claims for services provided pursuant to 441—Chapter 186.

h. For fee-for-service members, providers billing claims for Medicare beneficiaries that do not cross over electronically to the Iowa Medicaid enterprise must submit the following electronically, in accordance with the All Providers, IV. Billing Iowa Medicaid manual, located at dhs.iowa.gov/sites/default/files/All-IV.pdf:

(1) Form UB-04.

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

i. For managed care members, providers billing claims for Medicare beneficiaries that do not cross over electronically must submit the following electronically:

(1) Form UB-04 and the Explanation of Medicare Benefits (EOMB); and

(2) Form CMS-1500 and the Explanation of Medicare Benefits (EOMB).

j. Health insurance premium payment (HIPP) providers shall submit Form 470-5475, Health Insurance Premium Payment (HIPP) Provider Invoice, along with an explanation of benefits (EOB).

80.2(3) Providers shall purchase their supplies of forms CMS-1450 and CMS-1500 for use in billing.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9724B**, IAB 9/7/11, effective 9/1/11; **ARC 9889B**, IAB 11/30/11, effective 1/4/12; **ARC 2165C**, IAB 9/30/15, effective 12/1/15; **ARC 3159C**, IAB 7/5/17, effective 7/1/17; **ARC 3296C**, IAB 8/30/17, effective 10/4/17; **ARC 3494C**, IAB 12/6/17, effective 1/10/18; **ARC 4751C**, IAB 11/6/19, effective 12/11/19]