New Mexico gold card exemptions

Frequently asked questions

Overview

On Jan. 1, 2025, UnitedHealthcare will be continuing the process for prior authorization exemptions required by New Mexico Administrative Code, N.M. Code R. § 13.10.31.12, known as Evaluation of Prior Authorization Policy and Provider Performance.

This law applies to New Mexico providers subject to UnitedHealthcare's prior authorization requirements and that serve fully insured UnitedHealthcare commercial plan members, commercial plan members in the individual, small and large group markets.

What this means

For exemptions, we analyze approval rates for providers that submitted at least 10 prior authorization requests for a service where **decisions were final between, Jan. 1, 2023, and Dec. 31, 2023.** If you have a 90% or greater final approval rate for those requests, you are exempt from requesting prior authorizations for that service. You can receive exemptions for multiple services.

If your approval rate for a service is below 90%, you must keep submitting prior authorization requests for that service.

Please continue to submit advance notification for Kidney, Transplant, Bariatric and Ventricular device services to Optum at 888-936-7246.

Frequently asked questions

What plans are eligible for exemption?

This law applies to New Mexico providers subject to UnitedHealthcare's prior authorization requirements who serve fully insured, commercial plan members in the individual, small and large group markets.

How do I qualify for one of these exemptions?

If you submitted at least 10 prior authorization requests for a service on the prior authorization list where the **decision was finalized between Jan. 1, 2023, and Dec.31, 2023,** and had a 90% approval rate, you are exempt for that service. You must meet this criterion for each exempted service.

When and how will I know if I qualify for an exemption?

For qualification, we will send you a notice in December 2024, explaining which services are exempt from prior authorization, if any. To check which services are exempt from prior authorization log in to the UnitedHealthcare Provider Portal and UnitedHealthcare Insights. If you have questions, use the available resources on **UnitedHealthcare National Gold Card program | UHCprovider.com.**

Why didn't I qualify?

You don't qualify for an exemption if you requested fewer than 10 prior authorizations during the review period and your approval rate was below 90%.

Can I request a review of the non-exempt status? If so, how?

You have until Jan. 31, 2025, to request a review of the non-exempt status. Start the process through the Chat function in the UnitedHealthcare Provider Portal. You will be given a reference number to track progress. Review times may vary based on complexity of the request.

What do I need to do when I qualify for an exemption?

Don't submit prior authorization requests for exempted services.

What are UnitedHealthcare's responsibilities when I qualify?

We pay claims for exempted services without a prior authorization.

Does this apply to all services and plans?

No. Only prior authorization for gold carded services for fully insured plans are exempt.

How do I submit claims when I have an exemption?

Submit claims normally, but don't include a prior authorization number on the claims for the exempted services.

How do I submit claims if an exempted provider requests my services, but I don't have an exemption?

If a health care provider with an exemption requests your services and you don't have an exemption for that service, the requesting provider must include their name and TIN on the claim, either:

- In fields 17 and 17B of CMS Form 1500
- In fields 76–79 or another appropriate field in Form UB-04 or
- In the corresponding fields for electronic claims using the ASC X12N 837 format

If this information is not included, we require a prior authorization.

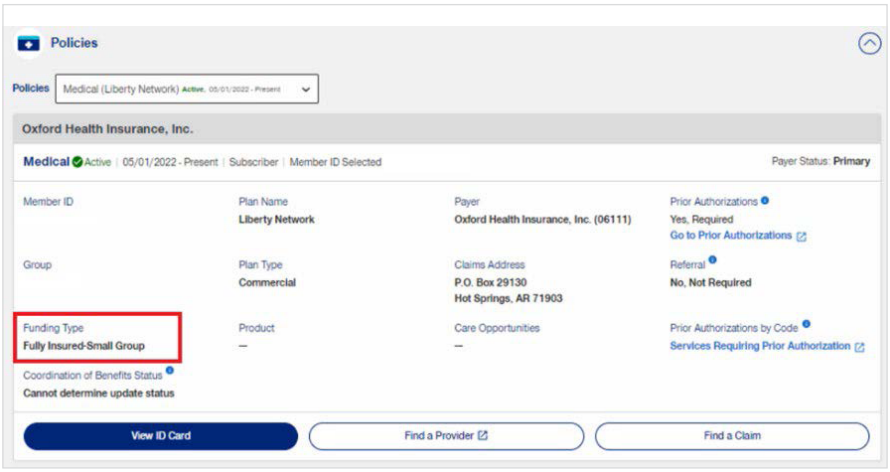
How do I tell if my patient is fully insured?

You have 2 ways to determine if a member is fully insured:

1. The Member ID card has the letters “DOI” in the lower left corner if the member is in a fully insured plan.

Sample member ID card for illustration only; actual information varies depending on payer, plan and other requirements.

2. Search for your patient in the Eligibility and Benefits section of **UHCprovider.com.** Funding type, “Fully insured” displays, letting you know your patient’s eligibility.



If I am exempt, can I still submit an authorization request anyway?

No. Submitting a prior authorization request for an exempted service triggers a rejection message that reminds you about the exemption.

If I am exempt, do I need prior authorization for services for which I am not gold carded?

Yes. You need to request prior authorizations for non-exempt services.

How do I know if the service is covered under the member’s benefit plan?

Regardless of the exemption, to obtain reimbursement for this service, a member must meet their plan’s eligibility requirements and the service must be a covered benefit under the plan. We strongly encourage you to check the member’s eligibility and covered benefit status for the exempted service(s). You may check benefits and eligibility at UnitedHealthcare’s Provider Portal at **EDI 270/271: Eligibility and Benefit Inquiry and Response.**

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How long are these exemptions in place?

Exemptions are open ended if you comply with plan medical policies. Every 12 months, we may retroactively review those services that were performed subject to a gold card exemption. If the review shows your approval rate dropped below 90% for the specific service during the review period, we may rescind the exemption. After each 12-month review period, new providers and/or new services for existing providers are added or removed based on the results.

How and when will I know if my exemption is rescinded?

Beginning in January 2025, and each January thereafter, we will send you a notice if you no longer qualify for an exemption as to a service.

When can I qualify for an exemption?

According to the New Mexico law, the 12-month evaluation periods run from Jan. 1 through Dec. 31 every year. Providers must submit at least 10 prior authorization requests for a service and have a 90% or greater approval rate to qualify. Health plans must complete their prior authorization analysis and send notices to providers within 2 months of the end of the evaluation period.

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