Texas gold card exemptions

Frequently asked questions

Overview

As of Oct. 1, 2022, the initial preauthorization exemptions required by Texas House Bill 3459, also known as the "Texas gold card exemptions," took effect. This law reduces prior authorization requirements helping members get the treatment they need when they need it.

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

What this means

For initial exemptions, we analyzed approval rates for providers that submitted at least 5 prior authorization requests for a service where **decisions were final between, Jan. 1, 2024 and Dec. 31, 2024.** If you have a 90% or greater final approval rate for those requests, you're exempt from requesting reauthorizations for that service. You can receive exemptions for multiple services.

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

We'll continue to review approval rates for health care professionals every 12 months.

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 Texas health care professionals subject to UnitedHealthcare's prior authorization requirements who serve fully insured, UnitedHealthcare 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 5 prior authorization requests for a service on the prior authorization list where you had a 90% or higher approval rate, you're exempt for that service. You must meet this criterion for each exempted service. According to the Texas law, this is evaluated every 12 months. The evaluation periods run from Jan. 1 through Dec. 31 every 12 months. Health plans must complete their prior authorization analysis and send notices to providers within 2 months of the end of the evaluation period.

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

Every 12 months, we'll send you a notice if you qualify. Health plans must complete their prior authorization analysis and send notices to health care professionals within 2 months of the end of the evaluation period.

Why didn't I qualify?

You don't qualify for an exemption if you requested fewer than 5 prior authorization during the review period or you didn't have a high enough approval rate for the requested service.

Can I appeal the denials? If so, how?

Yes, appeal by submitting a letter within 30 days of receipt of the denial notice explaining why you believe you should receive the exemption. Mail or fax your letter to:

UnitedHealthcare Appeals
P.O. Box 30573
Salt Lake City, UT 84130-0573
Fax: 1-801-994-1345

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

Don't submit prior authorizations for exempted services.

What are UnitedHealthcare's responsibilities when I qualify?

We pay claims for exempted services without a pre-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 professional with an exemption requests your services and you don't have an exemption for that service, the requesting health care professional must include their name and National Provider Identifier (NPI) on the claim:

- 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

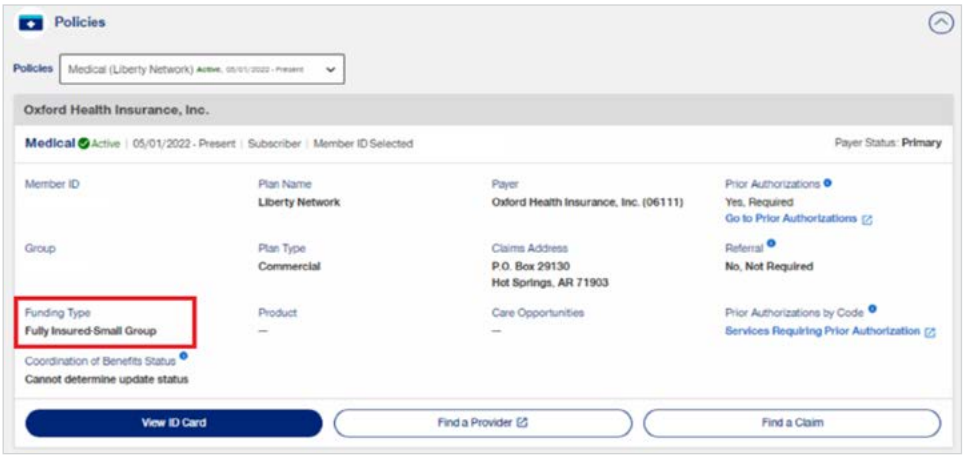
If this information is not included, we require a prior authorization.

How do I tell if my patient is fully insured?

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

- The member ID card has the letters "DOI" in the lower left corner if the member is in a fully insured plan

- 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.



United Healthcare®

If I am exempt, can I still submit a pre-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 preauthorization for services for which I am not gold carded?

Yes. Services without a gold card exemption require prior authorization.

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 | UHCprovider.com**.

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 health care professionals and/or new services for existing health care professionals are added or removed based on the results.

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

Beginning in June 2023, and each January and June thereafter, we'll 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 Texas law, the 12 month evaluation period is Jan. 1 through Dec. 31 of every year. Health plans must complete their prior authorization analysis and send notices to health care professionals within 2 months of the end of the evaluation period.

PCA-1-25-01734-POE-FAQ_08012025

United Healthcare®