Status **Active** PolicyStat ID **15249315**

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Next Review	12/31/2024

Area	Provider Delivery Services
Lines Of Business	All Lines of Business

Payment Policy: Gold Card Program

DISCLAIMER

This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification, and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any case. No part of this policy may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, whether electronic, mechanical, photocopying or otherwise, without express written permission from THP. When printed, this version becomes uncontrolled. For the most current information, refer to the following website: healthplan.org.

DEFINITIONS, ACRONYMS, TERMS

BMS	Bureau for Medical Services (BMS) is the designated single state agency responsible for the administration of the State's Medicaid program. BMS provides access to appropriate health care for Medicaid-eligible individuals.
CMS	The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program, and health insurance portability standards.
Covered Service	Medically necessary services, as determined by the plan and described in the applicable benefit plan, for which a member is eligible for coverage
CPT	Current Procedural Terminology
NPI	National Provider Identifier
Fee Schedule	The complete listing of rates for services that represents payment for each unit of service allowed based on applicable coded service identifier(s) for covered services
Outpatient Care	Procedure, treatment, or other service that is administered without an overnight stay at a hospital or medical facility.
Prior Authorization	Process through which a request for provisional confirmation of coverage is submitted for review prior to the service is rendered to patient and before a claim is submitted for payment. Prior authorization is determined by eligibility, plan benefits, and medical necessity of the service being requested.
Payment Recovery	Request to return payment or retraction of payment by offsetting future payments
Physician	Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO)
Practitioner	Physician Assistant (PA-C), Nurse Practitioner

BACKGROUND:

The Health Plan’s (THP’s) Gold Card program recognizes and rewards health care physicians and practitioners who meet outpatient prior authorization volume and approval criteria by eliminating the outpatient prior authorization process for twelve months following initial Gold Card Program enrollment.

THP’s Gold Card Program outpatient prior authorization volume and approval criteria are defined as:

When a practitioner has requested greater than or equal to thirty (30) prior authorizations in a twelve-month period and obtained a greater than or equal to 90% initial approval rating, THP will not require outpatient prior authorizations from that practitioner for the next twelve-month period , except for outpatient medical drugs, experimental / investigational services or procedures, services where the state code or Bureau for Medical Services (BMS) policy limits the number of services to be rendered, services not covered, and all out of network service requests.

During a physician or practitioner's Gold Card Program enrollment, THP will periodically audit charts to ensure services rendered continue to be medically necessary.

Prior to the end of the twelve-month Gold Card Program enrollment, THP will audit charts to determine Gold Card Program renewal for an additional twelve-month period.

To identify new practitioners to enroll in the Gold Card Program, THP will assess prior authorization data annually in the fourth quarter of every year.

THP's Gold Card program is available to all participating physicians and practitioners in THP's direct contracted network, in all states, and for all product lines (Commercial, Self-Funded/ASO, Mountain Health Trust [West Virginia Medicaid, West Virginia Children's Health Insurance Program], and Medicare Advantage).

Those physicians and practitioners will be featured in THP's online provider directory as being "Gold Card". Physicians and practitioners are still responsible for checking member eligibility and benefits during Gold Card Program enrollment.

POLICY:

The rendering facility claim must include the referring provider NPI number. If information is missing or incorrect, the claim will be denied for no prior authorization.

THP does not require outpatient prior authorizations from a Gold Card physician or practitioner for a twelve-month period, **except for**:

1. Outpatient medical drugs
2. Experimental/ investigational services or procedures
3. Services where policy or state code outlines maximum or minimum number of service levels (benefit limits)
    - When a service has a benefit limit and a claim is received for a service exceeding that benefit limit, THP will review for a prior authorization.
        - If a prior authorization was not obtained, THP will manually deny the service.
        - If a prior authorization was obtained, THP will adjudicate the service in accordance with the member's benefit plan.
4. Services not covered
5. Out of network service requests

Examples of services with Benefit Limits

1. Chiropractic Services
2. Physical Therapy
3. Occupational Therapy
4. Speech Therapy
5. Pulmonary/ Cardiac Rehab
6. Medical Nutritionist Services
7. Durable Medical Equipment (DME)
8. Drug Testing

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All Revision Dates

1/1/2024