Humana's National Gold Card Program

Frequently Asked Questions

Simplifying access for providers who consistently deliver

Overview

The National Gold Carding Program is a performance-based initiative that modernizes outpatient prior authorization by recognizing providers who consistently demonstrate high adherence to clinical and utilization standards. The program waives traditional prior authorization requirements for select services and replaces them with advance notification, streamlining workflows while maintaining strong clinical oversight and ensuring patient safety.

This design aligns with enterprise commitments to reduce prior authorization burden, improve member access to care and strengthen provider partnerships without compromising clinical quality or affordability.

What is changing?

From prior authorization to advance notification

- Eligible providers submit a notice of intent rather than a full prior authorization request
- No upfront medical records or clinical review at time of submission
- Services proceed without awaiting a decision
- Humana retains transparency, data visibility and utilization control through monitoring

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Overview

Q: What is Humana's National Gold Card Program?

The National Gold Card Program is a performance-based initiative that streamlines outpatient prior authorization processes by recognizing providers who consistently demonstrate high adherence to clinical and utilization standards.

The program waives traditional prior authorization requirements for select services and replaces them with an advance notification process, streamlining workflows while maintaining appropriate clinical oversight and supporting patient safety.

Eligibility and participation

Q: Do providers need to apply for the Humana National Gold Card Program?

Eligible providers are automatically identified and included based on established program criteria, including historical performance and prior authorization approval rates.

Q: How were providers selected for the Humana National Gold Card Program?

Providers were evaluated using historical prior authorization submission and utilization patterns for designated services. Eligibility is based on meeting established program criteria and maintaining consistently high approval rates.

Q: How will providers know if they are eligible?

Providers who qualify for Humana's National Gold Card Program will be proactively notified.

Q: Will providers have future opportunities to qualify?

Providers who do not currently qualify may be considered during future evaluation cycles if program eligibility criteria are met.

Q: Are there differences in process for primary care physicians versus specialists?

No. Program eligibility and operational requirements are applied consistently based on the designated services and established program criteria.

Q: What if a provider changes Tax Identification Numbers (TINs) or joins a new organization?

Program eligibility is associated with the participating provider organization (TIN). Changes in organizational structure, ownership or TIN may impact eligibility and could require reassessment.

Q: How often will provider eligibility and participation be reevaluated?

Humana conducts ongoing monitoring of participating providers. Formal participation reviews are performed annually, with interim monitoring conducted throughout the year to identify significant performance changes or emerging trends. Humana reserves the right to modify, suspend or discontinue the Program, or a provider's participation in the Program, at any time.

Q: Can providers regain eligibility if they are removed from the program?

Providers may be reconsidered for participation after demonstrating sustained improvement and meeting program eligibility requirements during a future evaluation cycle. Eligibility for, and continued participation in, the Program is at Humana's discretion.

Q: What happens if a provider loses eligibility mid-year?

Providers whose performance no longer meets program expectations may have their participation adjusted before the next annual review. If that occurs, Humana will communicate the change and any transition back to standard prior authorization requirements.

Process and submission

Q: What is advance notification?

Advance notification is a simplified process through which providers notify Humana of a planned service rather than submitting a traditional prior authorization request.

Q: How is advance notification different from prior authorization?

Advance notification does not require upfront clinical review or supporting documentation and does not result in a medical necessity determination. The process serves as a streamlined alternative for eligible providers and designated services.

Q: How is the notification submitted?

For applicable services, providers submit an advance notification through Availity Essentials™ rather than through the traditional prior authorization workflow. If the provider organization (TIN), member and designated Current Procedural Terminology (CPT®) code qualify for the program, the provider will receive confirmation that no additional information is required.

Q: How will providers receive confirmation or status updates for notifications?

Providers will receive confirmation and status updates through Availity Essentials.

Q: Should notifications be submitted before the service date?

Yes, advance notifications must be submitted before the date of service, consistent with existing utilization management requirements. Failure to timely submit a notification may result in denial of payment.

Q: What specific information is required for advance notification submission?

Advance notification submissions require member ID, TIN, CPT code and service date needed to identify the provider, member, requested service and planned date of service. Additional clinical context may be requested as applicable.

Q: Is there a step-by-step guide or demo for using Availity Essentials for notifications?

Humana plans to provide supporting materials, such as a Quick Start guide, to assist providers with the advance notification process in Availity Essentials. Additional training resources may be made available as the program evolves.

Q: Can providers still request prior authorization?

Participation in the National Gold Card Program is voluntary. Providers may continue to submit a standard prior authorization request if they prefer to receive an advanced coverage determination.

Q: Can a provider still request an advanced coverage determination?

Participation in the National Gold Card Program does not limit a provider's ability to request a coverage determination. Providers may submit a standard prior authorization request when a medical necessity review or traditional coverage determination is preferred. Standard prior authorization requirements and review processes will apply in those situations.

Q: Can providers still request prior authorization or a formal coverage determination?

Yes. Participation in the National Gold Card Program does not limit a provider's ability to submit a standard prior authorization request when a medical necessity review or coverage determination is preferred. Standard prior authorization requirements and review processes will apply.

Q: What happens if a provider submits a prior authorization instead of an advance notification?

Standard prior authorization requests will continue to be accepted and processed through existing workflows.

Q: What happens if an advance notification is submitted incorrectly?

If an advance notification is submitted incorrectly, it may need to be corrected or resubmitted. If the submission includes services that are not eligible for the program, standard prior authorization requirements will apply to the ineligible service(s).

Services and scope

Q: What services are included in the program?

The initial program includes select Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET) and physical therapy/occupational therapy services. A complete list of designated CPT codes is maintained by Humana.

Q: Will services change over time?

Designated services may be added, modified or removed based on clinical evidence, regulatory requirements, operational considerations and program performance.

Q: How will providers know when service codes change or are updated?

Humana will communicate service code updates through provider bulletins, portal updates and related program materials, as appropriate.

Q: Will Gold Card status ever apply to additional CPT codes?

Humana may expand the program to include additional services over time based on program performance, clinical appropriateness and operational considerations.

Q: Does Gold Card status apply to all Humana members and products?

The Gold Card Program is in scope for Medicare Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) and Dual Eligible Special Needs Plan (DSNP) products and applies only to designated services and applicable Humana products. Certain products, markets, delegated arrangements may be excluded.

Q: Could Humana still request medical documentation?

Humana still may request medical documentation for medical necessity reviews we conduct or for other purposes.

Q: What happens if provider performance changes?

Humana will monitor provider performance, utilization patterns and program outcomes on an ongoing basis. Providers who originally meet eligibility criteria but whose performance falls outside expected parameters at a later date may receive education, undergo additional review or have participation suspended or eliminated. Humana reserves the right to modify, suspend or discontinue any provider's participation in the Program at any time.

Member impact

Q: Will patients be notified of Gold Card status or process changes?

The National Gold Card Program is primarily a provider-facing administrative process change. Members are not expected to receive direct notification of a provider's Gold Card status.

Q: How does this impact patient appeals or grievances?

The National Gold Card Program does not change member rights or existing processes for appeals and grievances. Standard appeal and grievance processes remain in place.

Q: Are there member cost-sharing changes associated with Gold Card status?

No. Member benefits, copays, coinsurance and other cost-sharing amounts are not changed by provider participation in the National Gold Card Program.

Governance and compliance

Q: Why is Humana implementing the National Gold Card Program?

The program is intended to reduce administrative burden for providers who consistently demonstrate high-quality utilization management performance while maintaining appropriate oversight, supporting provider experience and improving operational efficiency.

Q: Can Humana make changes to the National Gold Card Program?

Humana reserves the right to modify, suspend or discontinue the program, including eligibility criteria, participating services, operational requirements and review processes. Providers will be notified of material program changes as appropriate.

Q: What is the cadence for performance reviews and reporting?

Reporting will occur monthly, with more frequent monitoring as needed to identify early trends. Reporting cadence may be adjusted as the program matures.

Q: Where can providers find ongoing updates or training materials?

Humana will share available program updates, reference materials and training resources through provider communications and related program materials.

Q: Who should providers contact with additional questions about the program?

For specific questions, providers can email nationalgoldcard@humana.com.