

CURATIVE HEALTH PLAN

Retrospective Authorization Policy — PPO/EPO Commercial Plans

Document Title	Retrospective Authorization Policy
Policy Number	CHP-UM-RETRO-001
Effective Date	June 11, 2026
Version	3.1
Applies To	Commercial PPO/EPO — Fully Insured, Level Funded, ASO/Self-Funded
States	Texas, Florida, Georgia, Maryland, Indiana, District of Columbia
Owner	Utilization Management / Medical Policy
Supersedes	Version 3.0 and all prior versions

How to Use This Policy

This policy is organized by funding type. Go directly to the section that matches the member's plan:

Funding Type	How to Identify	Go to
Fully Insured	Plan ID indicates state-insured PPO/EPO. Premium is paid to Curative; Curative bears claims risk.	Part A
Level Funded	Plan ID indicates level-funded PPO/EPO. Employer pays a set monthly amount; arrangement includes stop-loss coverage.	Part B
ASO / Self-Funded (ERISA)	Plan ID indicates ASO. Employer bears claims risk; Curative provides administrative services only.	Part C

Each Part is self-contained and follows the same structure: the rule, when retrospective authorization will be reviewed, what the provider must submit, how the request is decided, the protections that limit the Plan, appeals, and member hold-harmless. You do not need to read the other Parts to administer your funding type. All legal citations appear together in the Sources appendix at the end.

Definitions Used Throughout This Policy

Term	Meaning
Prior Authorization (PA)	A coverage and medical-necessity determination made before a service is rendered.
Retrospective Authorization Request	A provider-initiated request submitted after a service was rendered, asking the Plan to authorize a service that required prospective PA.
Retrospective Review	A Plan-initiated medical-necessity or claim review conducted after a service was rendered.
Administrative Denial	A claim or request denial issued because a procedural requirement (timely PA, timely submission, complete documentation) was not met. Not an adverse determination on medical necessity unless law requires otherwise.
Emergency Services	Services as defined in the federal No Surprises Act and applicable state law. Prior authorization may never be required.

PART A

Fully Insured PPO/EPO

This Part applies to Commercial PPO/EPO members enrolled in fully insured plans issued in Texas, Florida, Georgia, Maryland, Indiana, or the District of Columbia. State insurance laws of the state of policy issue (situs) control. Federal ACA, No Surprises Act, HIPAA, and MHPAEA also apply.

A.1 The Rule

Prior authorization for a service that requires PA must be obtained prospectively or, where permitted, concurrently. A retrospective authorization request will be reviewed only if it meets one of the permitted grounds in Section A.2 and the submission requirements in Section A.3. Requests that do not meet both are administratively denied without merit review.

This rule does not override: (i) the federal emergency-services protections; (ii) services rendered under a Texas HB 3459 preauthorization exemption; (iii) prior authorizations the Plan is required to honor by state law; or (iv) other federal and state protections in Section A.6.

A.2 When Retrospective Authorization Will Be Reviewed

A retrospective authorization request is reviewed on the clinical merits only if the provider documents and certifies that one or more of the following applies:

- **(a) Retroactive eligibility** — the member was retroactively enrolled, retroactively assigned to Curative, or had COB primacy retroactively established.
- **(b) Unable to identify coverage at point of care** — the patient was unconscious, incapacitated, had no ID card, or there was a documented misrepresentation of coverage, and the provider used reasonable diligence to identify the payer.
- **(c) Urgent/emergent care below the federal NSA threshold** — the service was urgent/emergent in clinical character but did not meet the No Surprises Act definition of emergency services, and prospective PA was not clinically feasible.
- **(d) Unanticipated service during an authorized course of care** — services not anticipated at the time of the original PA but rendered during the authorized course.
- **(e) PA was issued but not recorded** — a PA was in fact issued (by Curative or by a prior carrier whose PA the Plan must honor) but was not recorded against the claim. Provide the authorization number, decision date, and approving entity.
- **(f) Continuity-of-care or transition-of-care** — services protected by federal or state continuity-of-care law.

- **(g) Texas HB 3459 exemption dispute** — the Plan has questioned whether a claimed gold-card exemption applied; clinical documentation may be submitted to support medical necessity.
- **(h) Plan administrative error** — the Plan's portal, fax line, or other designated channel was unavailable or malfunctioning, and the attempted submission was documented contemporaneously.
- **(i) Court order or regulator directive** — a court or state insurance regulator requires retrospective review.

A.3 What the Provider Must Submit

The request must include all of the following:

- **Submission window.** Submitted within the state-specific window in Section A.5.
- **Designated channel.** Submitted through Availity, the Plan portal, or another Plan-accepted electronic channel. Phone, fax, and email are not accepted unless the Plan has confirmed electronic-channel unavailability.
- **Permitted-ground attestation.** Identifies which Section A.2 ground(s) apply, with a signed provider attestation. False attestations are referred to Payment Integrity.
- **Clinical documentation.** Date of service, CPT/HCPCS and ICD-10 codes, place of service, rendering provider, medical records supporting medical necessity at the time of service, and any conservative-therapy or step-therapy documentation required by the applicable clinical policy.
- **Ground-specific evidence.** Documentation that supports the permitted ground (e.g., dated screenshots of portal unavailability for ground (h); the prior PA letter for ground (e)).
- **One request per service.** Duplicate submissions for the same date of service and CPT/HCPCS code are administratively denied. Disagreement is addressed through appeal.

A.4 How the Request Is Decided

If A.2 and A.3 are met, the Plan applies the same medical-necessity criteria, evidence-based guidelines, and benefit terms that would have applied to a prospective PA request for the same service, as those criteria existed on the date of service. The reviewer holds the appropriate specialty match. AI-assisted tools, if used, comply with Maryland Chapter 747 (HB 820).

Decision timeframes by state apply (see Section A.6). If A.2 or A.3 is not met, the request is administratively denied with a written notice that identifies the missing ground or requirement and the provider's appeal rights (see Section A.7).

A.5 Submission Window by State

The window matches the state claim-submission statute (where one exists) or the provider agreement (where state law is silent). The Plan does not set a window shorter than the state floor; the longer of the state floor or the provider agreement controls.

State	Window from Date of Service	Authority	Notes
Texas	95 calendar days	Tex. Ins. Code § 1301.102	Provider forfeits payment if claim is not submitted within 95 days, absent catastrophic event. Plan and provider may agree by contract to a longer (not shorter) window.
Florida	6 months	Fla. Stat. § 627.6131(5)	90 days from primary determination if Curative is the secondary payer (COB).
Georgia	Per provider agreement; 180-day default if agreement is silent	O.C.G.A. § 33-24-59.5 / § 33-24-59.14	Georgia statute regulates carrier turnaround but sets no provider claim-submission floor.
Maryland	180 calendar days	Md. Ins. Article § 15-1005(e)(1)	§ 15-1005(e)(3): claims erroneously denied for processing error are reprocessed without timely-filing limit if provider notifies the Plan within 1 year.
Indiana	Per provider agreement; 180-day default if agreement is silent	IC 27-8-5.7	Indiana statute regulates carrier turnaround but sets no provider claim-submission floor.
D.C.	180 calendar days from date of service or inpatient discharge	D.C. Code § 31-3132(g)	Statutory minimum.

When the Window Clock Starts Later (Tolling)

- **Plan administrative error** — ground (h) tolls the window for the documented period of channel unavailability.
- **Retroactive eligibility** — grounds (a) and (b) start the clock when the provider received notice of Curative's responsibility for the claim, not date of service.
- **PA issued but not recorded** — ground (e) starts the clock at the original claim denial date.

A.6 State Protections That Limit the Plan

The following state rules apply to fully insured PPO/EPO business and may not be overridden by this policy. These are situations where a retrospective authorization is not needed because the claim is payable by operation of law.

Texas

- **Emergency services.** No PA may be required. (Tex. Ins. Code §§ 1271.155, 1301.155; federal NSA.)
- **Gold-card exemption (HB 3459).** Providers with a 90%+ approval rate for a specific service over the evaluation period are exempt from PA for that service. Exempt services may be retrospectively reviewed only as part of rescission or investigation under § 4201.659. (Tex. Ins. Code §§ 4201.651–4201.660.)
- **Retrospective UR decision timeframe.** Written notice of an adverse determination on retrospective utilization review must be issued within 30 days of claim receipt, extendable once by 15 days. (Tex. Ins. Code § 4201.305.)
- **Member penalties.** The member may not be penalized solely because the provider failed to obtain preauthorization.

Florida

- **Emergency services.** No PA may be required; prudent layperson standard applies.
- **Retroactive denial of paid claims.** A paid claim may not be retroactively denied more than 1 year after payment, except for fraud, ineligibility for payment, or other statutory exceptions. (Fla. Stat. § 627.6131(6).)
- **Standardized PA process.** PA must use the state's standardized electronic process. (Fla. Stat. § 627.42392.)

Georgia

- **No PA for unanticipated emergency, urgent, or incidental services.** (O.C.G.A. § 33-46-21.)
- **PA honored if service rendered within 45 business days.** If initial services are performed within 45 business days of PA approval, the Plan may not revoke, limit, condition, or restrict the authorization, except for Schedule II controlled substances, billing error, fraud, material misrepresentation, or loss of coverage. (O.C.G.A. § 33-46-23.)
- **30-day cross-plan PA continuity.** Curative must honor a PA granted by a previous review entity for at least the first 30 days of new coverage. (O.C.G.A. § 33-46-28.)
- **No claim reopening after precertification.** Once precertification is obtained, the Plan may not contest, request refund of, or reopen the claim, except as allowed by § 33-20A-7.1. (O.C.G.A. § 33-20A-62(f).)

- **PA decision timeframe.** 7 calendar days from receipt of all necessary information. (O.C.G.A. § 33-46-26.)

Maryland

- **Emergency services.** No PA may be required.
- **Adverse decision process.** Adverse decisions on medical necessity follow Subtitle 10A including written notice, reviewer specialty disclosure, grievance and appeal rights, and quarterly carrier reporting. (Md. Ins. Article § 15-10A-06.)
- **Prescription drug PA continuity.** Curative must honor PAs across plan changes for the first 30 days and may not require new documentation for reauthorization in defined circumstances. (Md. Ins. Article § 15-854; 2024 Chapters 847/848.)
- **AI-assisted UR.** AI tools in UR are subject to 2025 Chapter 747 (HB 820), effective October 1, 2025.

Indiana

- **Emergency services.** No PA may be required. (IC 27-1-37.5-24.)
- **No retroactive denial of authorized services.** A previously authorized service may not be retroactively denied except for false/incorrect information provided with the PA or non-coverage on the date of service. (IC 27-1-37.5-25.)
- **Unanticipated services.** A claim may not be denied for lack of PA when the service was unanticipated during a separately authorized service.
- **PA decision timeframe.** 72 hours for urgent, 7 business days for non-urgent. (IC 27-1-37.5-11.)

District of Columbia

- **Emergency services.** No PA may be required, including pre-hospital transport. Greater restrictions for out-of-network services are prohibited. (D.C. Code § 31-3875.03.)
- **Presumption of medical necessity.** If the provider certifies in writing within 72 hours that emergency care was needed, medical necessity is presumed and rebuttable only by clear and convincing evidence.
- **PA honored if service rendered within 45 business days.** Curative may not revoke, limit, condition, or restrict an issued PA if care is provided within 45 business days, except for fraud.
- **PA validity.** PA is valid for at least 1 year or the course of treatment; chronic-condition PAs remain valid as long as medically necessary.
- **60-day cross-plan PA continuity.** A new utilization review entity must honor a PA for at least 60 days after enrollment in a new plan.
- **PA decision timeframes and deemed approval.** 24 hours expedited urgent; 72 hours inpatient; 3 business days electronic portal; 5 business days other channels. Service is deemed approved if these timeframes are missed.

A.7 Appeals

Both administrative denials under Section A.4 and adverse determinations on medical necessity are appealable through the internal appeal and external review processes of the state of policy issue:

- Texas — Tex. Ins. Code Chapter 4201, Subchapter I.
- Florida — Fla. Stat. § 627.6471 / § 408.7056.
- Georgia — O.C.G.A. § 33-20A-30 et seq. and Chapter 46 Article 2.
- Maryland — Md. Ins. Article Subtitles 10A and 10D.
- Indiana — IC 27-8-29.
- D.C. — D.C. Code §§ 31-3875.05 through 31-3875.07.

Providers appealing a Section A.4 administrative denial should identify the Section A.2 ground asserted and attach the Section A.3 documentation.

A.8 Member Hold-Harmless Protections

An administrative denial of a retrospective authorization request under Section A.4, or a denial of any claim, is not by itself a determination that the member owes the billed amount. Member liability is determined by the EOB, the certificate of coverage, the participating provider agreement, applicable federal law, and applicable state surprise-billing law. The following protections apply to fully insured PPO/EPO members and may not be reduced by this policy.

Federal No Surprises Act

- **Emergency services.** For emergency services, including services from out-of-network providers and out-of-network emergency facilities (and air ambulance), member cost-sharing is limited to the in-network amount. The member may not be balance billed. (45 C.F.R. Part 149.)
- **Non-emergency services at in-network facilities.** For non-emergency services from out-of-network providers rendered at in-network facilities (including ancillary services such as anesthesiology, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist), member cost-sharing is limited to the in-network amount and the member may not be balance billed, unless a valid notice-and-consent waiver was obtained under 45 C.F.R. § 149.420. Waivers may not be obtained for the protected ancillary categories.
- **Post-stabilization services.** Post-stabilization services are protected on the same terms as emergency services until the patient is able to travel safely or able to give informed consent to out-of-network billing.

In-Network Provider Hold-Harmless

- **Hold-harmless under the provider agreement.** Under the participating provider agreement, an in-network provider may not balance bill the member for amounts denied because the provider failed to obtain required prospective PA. The member's financial responsibility is limited to applicable copayment, coinsurance, and deductible. This hold-harmless obligation is independent of the administrative denial in Section A.4.
- **Member penalty prohibited.** The member may not be penalized solely because the provider failed to obtain preauthorization. Where state law expressly prohibits the member penalty (Texas, for example), the prohibition controls; the Plan applies the same principle uniformly.

State Surprise-Billing Protections

Texas — SB 1264 / Tex. Ins. Code Chapter 1467

- Out-of-network providers may not balance bill the member for: (i) emergency services; (ii) non-emergency facility-based services at an in-network facility; or (iii) lab and diagnostic imaging in connection with an in-network service.
- Member cost-share is limited to the in-network copayment, coinsurance, and deductible.
- The member is removed from the payment dispute; the dispute is resolved between the Plan and the out-of-network provider through the TDI mediation/arbitration process. Self-funded plans may opt in.

Florida — Fla. Stat. §§ 627.64194, 641.513, 641.3154

- PPO and EPO members: out-of-network providers may not balance bill for emergency services or for non-emergency services rendered at an in-network facility. (§ 627.64194.)
- HMO members: a provider may not collect from a subscriber any amount that is the responsibility of the HMO; emergency copay is limited per § 641.31(12). (§ 641.3154.)
- Member cost-share is limited to the in-network amount.

Georgia — Surprise Billing Consumer Protection Act, O.C.G.A. Chapter 20E of Title 33

- Out-of-network providers may not balance bill the member for: (i) emergency medical services; or (ii) non-emergency services rendered by an out-of-network provider at an in-network facility. (§§ 33-20E-4, 33-20E-5.)
- The Plan may not deny or restrict covered benefits solely because the member obtained treatment from a non-participating provider leading to a balance bill. (§ 33-20E-6.)
- Disputes are resolved between the Plan and the out-of-network provider through the OCI arbitration process. Member cost-share is limited to the in-network amount.

Maryland — Md. Ins. Article § 14-205.2 and related provisions

- Out-of-network on-call physicians and hospital-based physicians who accept assignment of benefits from a PPO insured may not balance bill the member for covered services. Member liability is limited to in-network cost-share. (§ 14-205.2(b).)

- HMO members: a provider may not collect from a subscriber any amount that is the responsibility of the HMO.
- Out-of-network providers referred by an in-network provider for covered services may not balance bill the member.

Indiana — IC 27-17 (HEA 1004, 2020)

- Out-of-network providers at in-network facilities may not balance bill the member beyond in-network cost-share, unless the provider issued a written good-faith estimate at least 5 days in advance and the member consented in writing to the out-of-network charge.
- Emergency services are governed primarily by the federal No Surprises Act.

District of Columbia

- The federal No Surprises Act provides the primary balance-billing protection for D.C. members.
- Under D.C. Code § 31-3875.03, the Plan may not impose greater restrictions on out-of-network emergency services and may not consider non-participating-provider status in determining medical necessity or appropriateness. The Plan does not deny coverage for out-of-network emergency services.

Where a balance-billing protection applies, member cost-share is calculated using the in-network amount and the Plan resolves the payment amount with the provider directly. The member should not pay any amount in excess of the in-network cost-share shown on the EOB.

PART B

Level Funded PPO/EPO

This Part applies to Commercial PPO/EPO members enrolled in level funded plans. A level funded arrangement is a self-insured plan combined with stop-loss insurance. ERISA generally governs, and state insurance mandates are generally preempted under ERISA § 514(a). One state-law exception applies: Florida level funded business with stop-loss coverage less than 100% follows Part A (Fully Insured) instead of Part B. See Section B.6.

B.1 First, Determine Which Part Applies

Before applying this Part, confirm the arrangement is properly treated as level funded under ERISA:

- **Stop-loss coverage.** Confirm stop-loss is in place and the attachment points leave meaningful claims risk with the plan sponsor.
- **Florida situs check.** If the group is Florida-situs and stop-loss coverage is less than 100% (failing the attachment-point thresholds in Fla. Stat. § 627.66997), administer the group under Part A (Fully Insured). Do not apply Part B.

If the arrangement is properly level funded, continue with this Part. The plan document and administrative services agreement control where they speak; this Part is the Plan's default administrative position where they do not.

B.2 The Rule

Prior authorization for a service that requires PA must be obtained prospectively or, where permitted, concurrently. A retrospective authorization request will be reviewed only if it meets one of the permitted grounds in Section B.3 and the submission requirements in Section B.4. Requests that do not meet both are administratively denied without merit review.

This rule does not override federal protections in Section B.7 (emergency services, ERISA claims procedure, MHPAEA, continuity of care) or plan-sponsor-adopted state protections in Section B.8.

B.3 When Retrospective Authorization Will Be Reviewed

A retrospective authorization request is reviewed on the clinical merits only if the provider documents and certifies that one or more of the following applies:

- **(a) Retroactive eligibility** — the member was retroactively enrolled or had COB primacy retroactively established.

- **(b) Unable to identify coverage at point of care** — patient unconscious, incapacitated, or no ID, with documented diligence to identify the payer.
- **(c) Urgent/emergent care below the federal NSA threshold** — clinically urgent/emergent but not meeting the NSA emergency definition, with no clinical feasibility of prospective PA.
- **(d) Unanticipated service during an authorized course of care.**
- **(e) PA was issued but not recorded.**
- **(f) Continuity-of-care or transition-of-care under federal or adopted state law.**
- **(g) Plan administrative error.**
- **(h) Court order or regulator directive.**
- **(i) Plan sponsor instruction.** The plan sponsor has, in writing, authorized retrospective review under additional defined circumstances.

B.4 What the Provider Must Submit

The request must include all of the following:

- **Submission window.** Per the plan document or administrative services agreement; 180-day default from date of service if both are silent. Florida-situs level funded with stop-loss <100% follows Part A.5 instead.
- **Designated channel.** Submitted through Availity, the Plan portal, or another Plan-accepted electronic channel.
- **Permitted-ground attestation.** Identifies which Section B.3 ground(s) apply, with signed provider attestation.
- **Clinical documentation.** Date of service, CPT/HCPCS and ICD-10 codes, place of service, rendering provider, medical records supporting necessity at the time of service, and any conservative-therapy or step-therapy documentation.
- **Ground-specific evidence.** Documentation supporting the ground asserted.
- **One request per service.** Duplicates are administratively denied.

When the Window Clock Starts Later (Tolling)

- Plan administrative error — ground (g) tolls for the documented period of channel unavailability.
- Retroactive eligibility — grounds (a) and (b) start when the provider received notice of Curative's responsibility.
- PA issued but not recorded — ground (e) starts at the original claim denial date.

B.5 How the Request Is Decided

If B.3 and B.4 are met, the Plan applies the same medical-necessity criteria, evidence-based guidelines, and benefit terms that would have applied to a prospective PA request for the same

service, as those criteria existed on the date of service. Decision timeframes follow ERISA: 30 days post-service, extendable once by 15 days, under 29 C.F.R. § 2560.503-1. If B.3 or B.4 is not met, the request is administratively denied with written notice identifying the missing requirement and the provider's appeal rights.

B.6 Florida Stop-Loss Carve-Out

Florida regulates stop-loss insurance under Fla. Stat. § 627.66997. A Florida-situs level funded arrangement with stop-loss coverage less than 100% — meaning attachment points are low enough that the plan sponsor does not retain meaningful claims risk consistent with a true self-insured plan — is treated as a health insurance policy under Florida law. The thresholds for a small employer policy are the greatest of \$2,000 multiplied by the number of employees, 120% of expected claims, or other statutory thresholds; and stop-loss must cover 100% of claims above the aggregate attachment point.

- Florida-situs level funded groups with stop-loss less than 100% are administered under Part A (Fully Insured) in full, including the Florida state requirements in Part A.6 and the Florida submission window in Part A.5.
- Florida-situs level funded groups whose stop-loss meets § 627.66997 thresholds and covers 100% of claims above the aggregate attachment point are administered under this Part B.
- Curative determines stop-loss status at underwriting and at each renewal. A mid-year change that lowers attachment points below the statutory thresholds triggers re-classification effective on the change date.
- This carve-out is specific to Florida and does not extend to Texas, Georgia, Maryland, Indiana, or D.C.

B.7 Federal Protections That Limit the Plan

The following federal rules apply to all level funded business and may not be overridden by the plan sponsor or this policy.

- **Emergency services.** PA may not be required for emergency services, including out-of-network emergency providers and facilities. Retrospective denial for failure to obtain PA is prohibited for any service covered by the federal emergency-services protections. (No Surprises Act, 42 U.S.C. § 300gg-111; ERISA § 716, 29 U.S.C. § 1185f; ACA § 2719A.)
- **ERISA claims-procedure timeframes.** Pre-service urgent decisions within 72 hours; pre-service non-urgent within 15 days (extendable once by 15 days); post-service within 30 days (extendable once by 15 days). Adverse benefit determinations must include specific reasons, plan provisions, missing information, and appeal rights. (29 C.F.R. § 2560.503-1.)

- **MHPAEA parity.** UM practices including retrospective review applied to MH/SUD must be comparable to and no more stringent than those applied to medical/surgical benefits in the same classification. (29 U.S.C. § 1185a; 2024 Final Rule.)
- **Continuity of care.** Continuing-care patients receive applicable transition-of-care benefits regardless of any failure to obtain a new PA. (PHS Act § 2799A-3.)
- **Internal appeal and external review.** Claimants have at least 180 days for internal appeal and external IRO review for adverse determinations involving medical judgment or rescission of coverage. (29 C.F.R. § 2590.715-2719; 45 C.F.R. § 147.136.)

B.8 Plan Sponsor Adoption of State Protections

Plan sponsors may adopt state-law-equivalent protections through the plan document, SPD, or administrative services agreement (for example, a 45-business-day PA-honoring window or a 1-year minimum PA validity). Where adopted, those protections apply. Where not adopted, this Part B controls. The plan sponsor cannot narrow the federal protections in Section B.7.

B.9 Appeals

Administrative denials under Section B.5 and adverse determinations on medical necessity are appealable under 29 C.F.R. § 2560.503-1 and the ACA internal claims and appeals and external review framework at 29 C.F.R. § 2590.715-2719 and 45 C.F.R. § 147.136. State external review applies where adopted by the plan sponsor.

B.10 Member Hold-Harmless Protections

An administrative denial of a retrospective authorization request under Section B.5, or a denial of any claim, is not by itself a determination that the member owes the billed amount. Member liability is determined by the EOB, the SPD, the participating provider agreement, applicable federal law, and (where applicable) state surprise-billing law. The following protections apply to all level funded PPO/EPO members and may not be reduced by this policy.

Federal No Surprises Act (Applies to All Level Funded Plans)

- **Emergency services.** Out-of-network emergency services (and air ambulance) — member cost-sharing limited to the in-network amount; balance billing prohibited. (45 C.F.R. Part 149.)
- **Non-emergency services at in-network facilities.** Out-of-network ancillary providers (anesthesiology, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, intensivist) at in-network facilities — member cost-sharing limited to the in-network amount; balance billing prohibited; notice-and-consent waivers not available for these categories. (45 C.F.R. § 149.420.)
- **Post-stabilization services.** Protected on the same terms as emergency services.

In-Network Provider Hold-Harmless

- **Hold-harmless under the provider agreement.** An in-network provider may not balance bill the member for amounts denied because the provider failed to obtain required prospective PA. The member's financial responsibility is limited to applicable copayment, coinsurance, and deductible. This obligation is independent of the administrative denial in Section B.5.
- **Member penalty principle.** The member is not penalized solely because the provider failed to obtain preauthorization. This principle is applied uniformly regardless of state situs.

Florida Stop-Loss Carve-Out

Florida-situs level funded business with stop-loss coverage less than 100% (failing Fla. Stat. § 627.66997 thresholds) is administered under Part A. The Florida state surprise-billing protections in Section A.8 (Fla. Stat. §§ 627.64194, 641.513, 641.3154) apply in full to those groups in addition to the federal NSA protections above.

Plan Sponsor Adoption of State Balance-Billing Protections

Where the plan sponsor has adopted state surprise-billing protections through the plan document or administrative services agreement (for example, opting into Texas Chapter 1467 for a Texas-situs level funded group), those protections apply to that group on the terms adopted. Federal NSA protections apply regardless of adoption.

Where a balance-billing protection applies, member cost-share is calculated using the in-network amount and the Plan resolves the payment amount with the provider directly.

PART C

ASO / Self-Funded PPO/EPO (ERISA)

This Part applies to Commercial PPO/EPO members enrolled in ASO/Self-Funded plans. The plan sponsor bears claims risk; Curative provides administrative services only. ERISA governs. State insurance mandates are preempted under ERISA § 514(a) and apply only as adopted by the plan sponsor through the plan document, SPD, or administrative services agreement.

C.1 The Rule

Prior authorization for a service that requires PA must be obtained prospectively or, where permitted, concurrently. A retrospective authorization request will be reviewed only if it meets one of the permitted grounds in Section C.2 and the submission requirements in Section C.3. Requests that do not meet both are administratively denied without merit review.

This rule does not override the federal protections in Section C.6 or any plan-sponsor-adopted state protections in Section C.7. The plan document, SPD, and administrative services agreement control where they speak; this Part is the Plan's default administrative position where they do not.

C.2 When Retrospective Authorization Will Be Reviewed

A retrospective authorization request is reviewed on the clinical merits only if the provider documents and certifies that one or more of the following applies:

- **(a) Retroactive eligibility** — retroactive enrollment, retroactive assignment to Curative, or retroactive COB primacy.
- **(b) Unable to identify coverage at point of care** — patient unconscious, incapacitated, or no ID, with documented diligence to identify the payer.
- **(c) Urgent/emergent care below the federal NSA threshold** — clinically urgent/emergent but not meeting the NSA emergency definition, with no clinical feasibility of prospective PA.
- **(d) Unanticipated service during an authorized course of care.**
- **(e) PA was issued but not recorded.**
- **(f) Continuity-of-care or transition-of-care.**
- **(g) Plan administrative error.**
- **(h) Court order or regulator directive.**
- **(i) Plan sponsor instruction.** The plan sponsor has, in writing, authorized retrospective review under additional defined circumstances.

C.3 What the Provider Must Submit

The request must include all of the following:

- **Submission window.** Per the plan document or administrative services agreement; 180-day default from date of service if both are silent. ERISA does not set a fixed provider claim-submission window but requires the plan's procedure to be reasonable.
- **Designated channel.** Availity, the Plan portal, or another Plan-accepted electronic channel.
- **Permitted-ground attestation.** Identifies which Section C.2 ground(s) apply, with signed provider attestation. False attestations are referred to Payment Integrity.
- **Clinical documentation.** Date of service, CPT/HCPCS and ICD-10 codes, place of service, rendering provider, medical records supporting necessity at the time of service, and any conservative-therapy or step-therapy documentation.
- **Ground-specific evidence.** Documentation supporting the ground asserted.
- **One request per service.** Duplicates are administratively denied.

When the Window Clock Starts Later (Tolling)

- Plan administrative error — ground (g) tolls for the documented period of channel unavailability.
- Retroactive eligibility — grounds (a) and (b) start when the provider received notice of Curative's responsibility.
- PA issued but not recorded — ground (e) starts at the original claim denial date.

C.4 How the Request Is Decided

If C.2 and C.3 are met, the Plan applies the same medical-necessity criteria, evidence-based guidelines, and benefit terms that would have applied to a prospective PA request for the same service, as those criteria existed on the date of service. Decision timeframes follow ERISA: 30 days post-service, extendable once by 15 days, under 29 C.F.R. § 2560.503-1. If C.2 or C.3 is not met, the request is administratively denied with written notice identifying the missing requirement and the provider's appeal rights.

C.5 Adverse Benefit Determination Content

Where the determination constitutes an adverse benefit determination under ERISA, the notice includes:

- The specific reasons for the denial.
- Reference to the specific plan provisions on which the denial is based.
- A description of any additional material or information needed to perfect the claim.

- A description of the plan's internal appeal procedures and external review rights, including time limits.
- If applicable, the specific internal rule, guideline, protocol, or medical-necessity criterion relied upon, or a statement that a copy is available free of charge on request.

C.6 Federal Protections That Limit the Plan

The following federal rules apply to all ASO/Self-Funded business and may not be overridden by the plan sponsor or this policy.

- **Emergency services.** PA may not be required for emergency services, including out-of-network emergency providers and facilities. Retrospective denial for failure to obtain PA is prohibited for any service covered by the federal emergency-services protections. (No Surprises Act, 42 U.S.C. § 300gg-111; ERISA § 716, 29 U.S.C. § 1185f; ACA § 2719A.)
- **ERISA claims-procedure timeframes.** Pre-service urgent within 72 hours; pre-service non-urgent within 15 days (extendable once by 15 days); concurrent care sufficiently in advance of reduction or termination to allow appeal; post-service within 30 days (extendable once by 15 days). (29 C.F.R. § 2560.503-1.)
- **MHPAEA parity.** The eligibility criteria in Section C.2, the submission requirements in Section C.3, and all other UM practices must be applied to MH/SUD benefits in parity with medical/surgical benefits in the same classification. (29 U.S.C. § 1185a; 2024 Final Rule.)
- **Continuity of care.** Continuing-care patients receive applicable transition-of-care benefits. (PHS Act § 2799A-3.)
- **Internal appeal and external review.** At least 180 days to file an internal appeal; external IRO review for adverse determinations involving medical judgment or rescission of coverage. (29 C.F.R. § 2590.715-2719; 45 C.F.R. § 147.136.)

C.7 Plan Sponsor Adoption of State Protections

Plan sponsors may adopt state-law-equivalent protections through the plan document, SPD, or administrative services agreement. Common options include:

- Honoring previously issued PAs for a defined window (for example, the Georgia 45-business-day rule, the D.C. 45-business-day rule, or the D.C. 60-day cross-plan rule).
- Adopting a minimum PA validity period (for example, the D.C. 1-year minimum).
- Adopting a state's standard PA decision timeframes (for example, Georgia's 7-calendar-day rule or D.C.'s tiered timeframes).
- Adopting a single multi-state set of protections drawn from Part A for administrative consistency.
- Authorizing retrospective review under additional defined circumstances beyond Section C.2.

- Limiting Plan-initiated retrospective review to specific defined circumstances (fraud, waste, abuse, eligibility error, COB).

Where the plan sponsor has not provided written instruction, this Part C controls. The plan sponsor cannot narrow the federal protections in Section C.6.

C.8 Appeals

Administrative denials under Section C.4 and adverse determinations on medical necessity are appealable under 29 C.F.R. § 2560.503-1 and the ACA internal claims and appeals and external review framework at 29 C.F.R. § 2590.715-2719 and 45 C.F.R. § 147.136. State external review applies where adopted by the plan sponsor.

C.9 Member Hold-Harmless Protections

An administrative denial of a retrospective authorization request under Section C.4, or a denial of any claim, is not by itself a determination that the member owes the billed amount. Member liability is determined by the EOB, the SPD, the participating provider agreement, and applicable federal law. State surprise-billing statutes are preempted under ERISA § 514(a) and apply only where adopted by the plan sponsor.

Federal No Surprises Act (Applies to All ASO/Self-Funded Plans)

The federal No Surprises Act applies directly to ASO/Self-Funded non-grandfathered group health plans and may not be overridden by the plan sponsor.

- **Emergency services.** Out-of-network emergency services (and air ambulance) — member cost-sharing limited to the in-network amount; balance billing prohibited. (45 C.F.R. Part 149.)
- **Non-emergency services at in-network facilities.** Out-of-network ancillary providers (anesthesiology, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, intensivist) at in-network facilities — member cost-sharing limited to the in-network amount; balance billing prohibited; notice-and-consent waivers not available for these categories. (45 C.F.R. § 149.420.)
- **Post-stabilization services.** Protected on the same terms as emergency services.
- **Plan obligations.** The Plan calculates the member's cost-share using the Qualifying Payment Amount (QPA) or the recognized state-law amount, sends payment to the out-of-network provider, and resolves the payment dispute through the federal Independent Dispute Resolution (IDR) process.

In-Network Provider Hold-Harmless

- **Hold-harmless under the provider agreement.** An in-network provider may not balance bill the member for amounts denied because the provider failed to obtain required prospective PA. The member's financial responsibility is limited to applicable copayment,

coinsurance, and deductible. This obligation is contractual and is independent of the administrative denial in Section C.4.

- **Member penalty principle.** The member is not penalized solely because the provider failed to obtain preauthorization.

Plan Sponsor Adoption of State Balance-Billing Protections

ASO/Self-Funded plan sponsors may, through the plan document, SPD, or administrative services agreement, opt into state surprise-billing protections (for example, Texas Chapter 1467 opt-in for Texas-situs groups; Georgia O.C.G.A. Chapter 20E equivalents). Where adopted, those protections apply to the group on the terms adopted. The plan sponsor cannot reduce or waive the federal NSA protections in this section.

Where a balance-billing protection applies, member cost-share is calculated using the in-network amount (or the QPA where the federal NSA applies) and the Plan resolves the payment dispute with the provider directly. The member should not pay any amount in excess of the in-network cost-share shown on the EOB.

Plan-Initiated Retrospective Review (All Funding Types)

This policy governs provider-initiated retrospective authorization requests. Curative retains the right to conduct Plan-initiated retrospective review of any claim for medical necessity, coding accuracy, level of care, eligibility, and benefit determination, within the timeframes set by Tex. Ins. Code § 4201.305, Fla. Stat. § 627.6131, O.C.G.A. § 33-20A-62, Md. Ins. Article Subtitle 10, IC 27-1-37.5-25, D.C. Code § 31-3875.03, and 29 C.F.R. § 2560.503-1. Plan-initiated retrospective review is independent of the provider-initiated process in this policy.

Outcomes That Are Not Retrospective Authorization

The following are not processed as retrospective authorization requests:

- Emergency services and other services for which PA cannot be required by law.
- Claims for services within the Georgia 45-business-day window (O.C.G.A. § 33-46-23), the D.C. 45-business-day or 60-day windows (D.C. Code § 31-3875.03), or other state-mandated protections for previously issued PAs. These are paid in accordance with the existing PA.
- Texas HB 3459 exempt services, which are not subject to preauthorization.
- Deemed-approval outcomes where the Plan failed to meet statutory PA decision timeframes (e.g., D.C. Code § 31-3875.03).
- Plan-initiated retrospective utilization review.
- Post-payment audits and recoupment activities, governed by Payment Integrity policies and applicable state prompt-pay and overpayment recovery statutes.

Compliance, Monitoring, and Review

- This policy is reviewed at least annually by the Plan's Utilization Management and Medical Policy committees.
- The policy will be updated promptly upon any material change in federal or state law or regulation.
- Performance metrics — PA decision turnaround, retrospective authorization eligibility rates, denial rates, and overturn rates on appeal — are reported quarterly consistent with applicable state requirements, including Md. Ins. Article § 15-10A-06.
- AI-assisted review tools comply with Md. Chapter 747 (HB 820, eff. October 1, 2025) and Plan AI governance.
- Provider-attestation accuracy is monitored through routine sampling; patterns of inaccurate attestations are referred to Payment Integrity.

Scope Exclusions

This policy does not apply to: ACA Marketplace (Exchange) plans, Medicare Advantage, Medicaid managed care, CHIP, small group fully insured plans, workers' compensation, dental-only, vision-only, or other excepted benefits.

Sources

The following federal and state statutes, regulations, and reference materials inform this policy. Internal Curative Health Plan policies and provider agreements are also incorporated by reference.

Federal

- Affordable Care Act, Pub. L. No. 111-148, § 2719A, codified at 42 U.S.C. § 300gg-19a.
- No Surprises Act, Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. BB, Title I, codified at 42 U.S.C. § 300gg-111 et seq., 29 U.S.C. § 1185f et seq., and 26 U.S.C. § 9816 et seq.
- ERISA, 29 U.S.C. § 1001 et seq., including § 514 (preemption).
- ERISA Claims Procedure Regulation, 29 C.F.R. § 2560.503-1.
- ACA Internal Claims and Appeals and External Review, 29 C.F.R. § 2590.715-2719; 45 C.F.R. § 147.136.
- MHPAEA, 29 U.S.C. § 1185a; 26 U.S.C. § 9812; 42 U.S.C. § 300gg-26; 2024 Final Rule (89 Fed. Reg. 77586).
- No Surprises Act implementing regulations, 45 C.F.R. Part 149; 86 Fed. Reg. 36872 (July 13, 2021); 86 Fed. Reg. 55980 (Oct. 7, 2021), including § 149.410 (post-stabilization), § 149.420 (notice-and-consent waiver for non-emergency services), and federal Independent Dispute Resolution (IDR) provisions.
- PHS Act § 2799A-3 (continuity of care), 29 U.S.C. § 1185f-3.
- CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), 89 Fed. Reg. 8758 (Feb. 8, 2024). <https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f>.
- U.S. Department of Labor Group Health Plan Benefit Claims Procedure Regulation FAQ. <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/group-health-and-disability-plans-benefit-claims-procedure-regulation>.

Texas

- Texas Insurance Code Chapter 4201, including § 4201.305 (retrospective utilization review notice) and Subchapter N (§§ 4201.651–4201.660, gold-card exemptions, added by HB 3459, 87th Leg., R.S., 2021).
- Texas Insurance Code Chapter 1301 (PPO Benefit Plans), including § 1301.102 (95-day claim submission), § 1301.103 (clean-claim turnaround), and § 1301.155 (emergency care).
- Texas Insurance Code Chapter 1271, including § 1271.155.
- Texas Insurance Code Chapter 1467 (Out-of-Network Claim Dispute Resolution; surprise-billing protections; member balance-billing prohibition for OON emergency, facility-based, and lab/imaging services; added by SB 1264, 86th Leg., R.S., 2019).

- 28 Texas Administrative Code Chapter 19, Subchapter R (§§ 19.1701–19.1741); 28 TAC § 21.2806.
- TDI FAQ on Preauthorization Exemptions (HB 3459).
<https://www.tdi.texas.gov/health/hb3459-faq.html>.
- TDI Prompt Pay FAQ. <https://www.tdi.texas.gov/hprovider/ppsb418faq.html>.
- TDI Proposed PPO Rule, 28 TAC Chapter 3, Subchapter X, Proposal No. 33038.
- SB 1742, 86th Legislature, R.S. (2019).

Florida

- Florida Statutes § 627.42392 (Prior Authorization).
- Florida Statutes § 627.6131 (Payment of Claims), including § 627.6131(5) (6-month provider submission window; 90-day secondary submission window) and § 627.6131(6) (retroactive denial limits).
- Florida Statutes § 627.638 (Direct Payment for Hospital Emergency Services).
- Florida Statutes § 627.64194 (PPO/EPO member balance-billing protection for OON emergency and non-emergency services at INN facilities).
- Florida Statutes § 627.6699 (Employee Health Care Access Act).
- Florida Statutes § 627.66997 (Stop-Loss Insurance; small employer attachment-point thresholds; 100% coverage above aggregate attachment).
- Florida Statutes § 641.3154 (HMO subscriber hold-harmless).
- Florida Statutes § 641.31094 (HMO Emergency Services).
- Florida Statutes § 641.513 (Requirements for Providing Emergency Services and Care; HMO emergency copay limits).

Georgia

- O.C.G.A. Title 33, Chapter 46, Article 2 (§§ 33-46-20 through 33-46-32), including § 33-46-21, § 33-46-23, § 33-46-26, and § 33-46-28.
- O.C.G.A. Title 33, Chapter 20A (Patient Protection), including § 33-20A-62 and § 33-20A-7.1.
- O.C.G.A. Title 33, Chapter 20E (Surprise Billing Consumer Protection Act, HB 888, eff. Jan. 1, 2021), including § 33-20E-4 (emergency services), § 33-20E-5 (non-emergency services at INN facility), and § 33-20E-6 (no denial or restriction based on balance bill).
- O.C.G.A. § 33-24-59.5 and § 33-24-59.14 (prompt payment of claims; no statutory provider claim-submission floor).
- Ga. Comp. R. & Regs. Chapter 120-2-58 (Private Review Agents).
- Ga. Comp. R. & Regs. Chapter 120-2-80 (Patient Protection Act), including Rule 120-2-80-.07.
- Ga. Comp. R. & Regs. Subject 120-2-106 (Surprise Billing).

- Georgia Office of Commissioner of Insurance final rules and bulletins.
<https://oci.georgia.gov>.

Maryland

- Maryland Insurance Article Title 15, Subtitle 10 (Claims and Utilization Review), including § 15-1005 (Prompt Payment of Claims; § 15-1005(e)(1) 180-day provider claim-submission floor; § 15-1005(e)(3) re-processing protection).
- Maryland Insurance Article Subtitle 10A (Adverse Decisions/Grievances), including § 15-10A-06.
- Maryland Insurance Article Subtitles 10B (Private Review Agents), 10C (Medical Directors), 10D (Coverage Decisions).
- Maryland Insurance Article § 14-201 (definitions: balance bill, assignment of benefits, cost-sharing amounts).
- Maryland Insurance Article § 14-205.2 (PPO out-of-network on-call and hospital-based physician balance-billing prohibition with assignment of benefits).
- Maryland Insurance Article § 14-205.3 (provider disclosure requirements).
- Maryland Insurance Article § 15-854 (Prescription Drug PA).
- Maryland Health-General Article § 19-108.5 (Electronic PA).
- 2024 Md. Laws Chapters 847 and 848 (HB 932/SB 791).
- 2025 Md. Laws Chapter 747 (HB 820; AI in UR; eff. Oct. 1, 2025).
- Maryland Insurance Administration Bulletin 24-15.
<https://insurance.maryland.gov/Insurer/Documents/bulletins/24-15-Summary-of-Insurance-Laws-Enacted-in-2024.pdf>.

Indiana

- Indiana Code Title 27, Article 1, Chapter 37.5 (Health Care Service Prior Authorization), including § 11, § 13.5, § 13.7, § 19, § 20, § 23, § 24, and § 25.
- Indiana Code Title 27, Article 1, Chapter 37.4 (Electronic Prescription Drug PA).
- Indiana Code § 27-8-5.7 (Accident and Sickness Insurance Provider Payment; prompt-pay; no statutory provider claim-submission floor).
- Indiana Code Title 27, Article 17 (Surprise Billing; OON balance-billing protections at INN facilities with good-faith-estimate consent carve-out; enacted by HEA 1004, 2020).
- HEA 1143 (2018); SEA 400 (2023, P.L.190-2023).

District of Columbia

- D.C. Code Title 31, Chapter 38F (§§ 31-3875.01–31-3875.10), enacted by the Prior Authorization Reform Amendment Act of 2023 (D.C. Law 25-100, eff. March 13, 2024).
- D.C. Code § 31-3875.03.

- D.C. Code § 31-3132(g) (180-day provider claim-submission floor from date of service or inpatient discharge).
- D.C. Code § 31-3201.
- D.C. Law Library, Chapter 38F overview.
<https://code.dccouncil.gov/us/dc/council/code/titles/31/chapters/38F>.

Reference Materials

- American Medical Association, Prior Authorization State Law Chart. <https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf>.
- National Association of Insurance Commissioners, Prior Authorization White Paper (Dec. 4, 2025).
- Triage Cancer, Health Insurance State Laws: Prior Authorizations.
<https://trriagecancer.org/state-laws/health-insurance-prior-authorization>.
- Managed Care Legal Database, state-specific prior authorization summaries.
- CMS, CMS-0057-F resource page. <https://www.cms.gov/priorities/burden-reduction/overview/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f>.

Disclaimer: This policy is a Plan administrative policy and does not constitute legal advice. In the event of a conflict between this policy and applicable federal or state law, the controlling certificate of coverage, summary plan description, administrative services agreement, or provider agreement, the law and the governing document control.