**Definition of Database Categories**

**I. Payment issues**

**Fee schedules:** laws requiring health insurers to disclose fee schedules and other payment-related information to physicians.

**Liability-insurer shifting to physicians:** laws that prohibit health insurers from shifting liability for their mistakes to physicians.

**Most-favored nation:** laws that prohibit a health insurer from putting most favored nation clauses in their provider contracts. State laws are often more specific, but generally a most favored nation clause requires a physician to give the health insurer payment terms that are at least as favorable as those that the physicians has given, or will give, other health insurers or payers.

**Overpayments/recoupments:** laws that restrict or otherwise address circumstances where a health insurer attempts to collect money previously paid to a physician. Laws identified may also address retroactive denial, but only to the extent to which those laws also discuss overpayment.

**Payment edits**: laws that address health insurers’ use of payment edits to manipulate the codes billed by physicians in ways that reduce physician reimbursement. Claims bundling or downcoding are examples of payment edit use. “Payment edits” also identifies laws that require health insurers to disclose edits or claims editing software.

**Payment rules:** laws requiring health insurers to disclose global surgery payment periods, payment for multiple surgical procedures, and similar rules to physicians.

**Prohibited financial incentives:** laws that prohibit the use of financial incentives that encourage physicians to provide less than medically necessary care.

**Risk-physicians taking:** laws addressing when physicians can assume financial risk for providing health care services, for example, via capitation, withholds, etc.

**II. Network issues**

**Continuity of care post-contract:** laws governing situations where the contract between the physician and health insurer ends, and the physician and/or the physician’s patient wants to continue treatment.

**Credentialing deadlines:** laws that specify deadlines by which a health insurer must approve or deny a complete credentialing application.

**Credentialing-due process-denial of contract:** laws conferring hearing and other due process rights on a physician when a health insurer refuses to grant the physician participation privileges.

**Credentialing-patient demographics:** laws that prohibit a health insurer from denying a physician’s credentialing application solely because the physician’s patient population includes a substantial number of patients who have severe or expensive medical conditions or similar characteristics.

**Credentialing-payment issues:** laws that discuss how a physician is, or will be, paid for providing health care services while the health insurer is processing the physician’s credentialing application.

**Directories:** laws pertaining to provider directories.

**Network Adequacy:** laws imposing network adequacy requirements on health insurers.

**Participation in products, plans, and networks:** laws regulating physician participation in multiple products such as an HMO, PPO, automobile or homeowners’ insurance policies, Medicare or Medicaid managed care, workers’ compensation, etc. The category refers to “plans” and “networks” in addition to “products” because some state laws use terms like “plans,” “networks,” “panels,” or “coverages” rather than “products.” State laws that fall under this category include those regulating all products clauses as well as those that require health insurers to disclose to physicians the products, plans, or networks in which the physician is, or will be, participating.

**Profiling:** laws addressing situations where health insurers compares, rates, measures, or otherwise evaluates a physician’s quality and/or cost performance for purposes such as network tiering, narrow network participation, publication of performance data, credentialing, etc.

**Rental Networks:** laws regulating preferred provider organizations that leases a contracted physician’s discounted rates to a third party.

**III. Contract changes/disputes**

**Amendments:** laws governing circumstances where a health insurer proposes a change to a managed care agreement, changes to payment terms or prior authorization requirements.

**Anti-gag Clause:** laws prohibiting a health insurer from restricting a physician from having open conversations with patients and, in some cases, legislators or regulators.

**Anti-retaliation:** laws prohibiting a health insurer from penalizing a physician for talking openly with patients, and, in some cases, engaging in advocacy activities or communications.

**Termination:** laws addressing without-cause termination and for-cause termination of managed care agreements.

**Termination-due process:** laws that confer hearing or other “due process” rights on physicians when a health insurer intends to terminate its contract with a physician.

**IV. Coverage/utilization review**

**ERISA-medical necessity appeals-deadlines**: provisions in the ERISA claims procedure regulation that impose deadlines on how quickly a health insurer must decide an appeal of an initial denial of medical necessity. (Sometimes state law incorporates the ERISA claims procedure).

**ERISA-medical necessity decisions-deadlines:** provisions in the Employee Retirement Income Security Act (ERISA) claims procedure regulation that impose deadlines on how quickly a health insurer must determine whether a health care item or services is, or was, medically necessary. (Sometimes state law incorporates the ERISA claims procedure.)

**Medical necessity appeals-deadlines:** state law provisions imposing deadlines on how quickly a health insurer must decide an appeal of an initial denial of medical necessity.

**Medical necessity decisions-deadlines:** state law provisions imposing deadlines on how quickly a health insurer must decide whether a health care item or service is, or was, medically necessary.

**Medical necessity-definition:** laws that define the term “medical necessity” for purposes of coverage and health insurer internal review of the medical necessity of health care items or services. The term does not typically include the definition of “medical necessity” as that term applies to the external or independent review of final medical necessity denials by health insurers.

**Preemption-ERISA:** sections of the federal Employee Retirement Income Security Act and the ERISA claims procedure regulation that describe when ERISA preempts state law.

**Preemption-Medicare Advantage:** sections of the Medicare Advantage statute and Medicare Advantage regulations that describe when ERISA preempts state law.

**Retroactive Denial:** state laws that prohibit or place limits on a health insurer’s ability to retract a previously issued preauthorization, authorization, certification, or other approval of a health care item or service. “Retroactive denial” also identifies laws that prohibit or place limits on a health insurer’s ability to retract prior eligibility determinations. “Retroactive denial” also identifies state laws that address health insurer’s efforts to recover overpayments of mistaken payments from physicians, but only in those cases where the law specifically discusses overpayment recovery.

**U.R. Criteria**: states laws that define the information upon which health insures must base their medical necessity decisions.

**V. Claims Processing**

**Claims filing deadlines:** state laws that address deadlines by which a physician must submit a reimbursement claim to a health insurer.

**Prompt payment deadlines:** state laws that place deadlines by which health insurers must pay clean claims.