EXHIBIT C

Transparency in Health Care Costs

Hospital Rules

10A NCAC 13B .2101 is proposed for adoption as follows:

SECTION .2100 – TRANSPARENCY IN HEALTH CARE COSTS

10A NCAC 13B .2101 DEFINITIONS

The following definitions shall apply throughout this section, unless text otherwise indicates to the contrary:

(1) "Commission" means the North Carolina Medical Care Commission.

(2) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association.

(3) "Diagnostic Related Group (DRG)" means a system to classify hospital cases assigned by a grouper program based on ICD (International Classification of Diseases) diagnoses, procedures, patient's age, sex, discharge status, and the presence of complications or co-morbidities.

(4) "Department" means the North Carolina Department of Health and Human Services.

(5) "Financial Assistance" means a policy, including charity care, describing how the organization will provide assistance at its hospital(s) and any other facilities, Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Financial assistance does not include:

(a) bad debt;

(b) uncollectable charges that the organization recorded as revenue but wrote off due to a patient's failure to pay;

(c) the cost of providing such care to such patients;

(d) the difference between the cost of care provided under Medicare or other means-tested government programs or under Medicare; and

(e) the revenue derived therefrom or contractual adjustments with any third-party payors.

(6) "Governing Body" means the authority as defined in G.S. 131E-76.

(7) "Healthcare Common Procedure Coding System (HCPCS)" means a three tiered medical code set consisting of Level I, II and III services and contains the CPT code set in Level I.

(8) "Health Insurer" means service benefit plans, managed care organizations, or other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service as a condition of doing business in the State. This excludes self-insured plans and group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.

(9) "Hospital" means a medical care facility licensed under Article 5 of Chapter 131E or under Article 2 of Chapter 122C of the General Statutes.

(10) "Public or Private Third Party" means the State, federal government, employers, health insurers, third-party administrators and managed care organizations.

History Note: *Authority G.S. 131E-214.7; S.L. 2013-382(s.10.1),(s.13.1);*
Eff. November 1, 2014.

10A NCAC 13B .2102 is proposed for adoption as follows:

10A NCAC 13B .2102 REPORTING REQUIREMENTS

(a) The lists of the statewide 100 most frequently reported DRGs, 20 most common outpatient imaging procedures, and 20 most common outpatient surgical procedures performed in the hospital setting to be used for reporting the data required in Paragraphs (b) through (d) of this Rule are provided in rules .2103, .2104, and .2105 of this Subchapter. The lists are also available on the Commission's website at: http://www.ncdhhs.gov/dhsr/ncmcc.

(b) In accordance with G.S. 131E-214.7 and quarterly per year all licensed hospitals shall report the data required in Paragraph (d) of this Rule related to the statewide 100 most common DRGs to the certified statewide data processor in a format provided by the certified statewide processor. The data reported shall be from the quarter ending three months previous to the date of reporting and includes all sites operated by the licensed hospital.

(c) In accordance with G.S. 131E-214.7 and quarterly per year all licensed hospitals shall report the data required in Paragraph (d) of this Rule related to the statewide 20 most common outpatient imaging procedures and the statewide 20 most common outpatient surgical procedures to the certified statewide data processor in a format provided by the certified statewide processor. This report shall include the related primary CPT and HCPCS codes. The data reported shall be from the quarter ending three months previous to the date of reporting and includes all sites operated by the licensed hospital.

(d) The reports as described in Paragraphs (b) and (c) of this Rule shall be specific to each reporting hospital and shall include:

(1) the average gross charge for each DRG or procedure if all charges are paid in full without any portion paid by a public or private third party;

(2) the average negotiated settlement on the amount that will be charged for each DRG or procedure as required for patients defined in Paragraph (d)(1) of this Rule. The average negotiated settlement is to be calculated using the average amount charged all patients eligible for the hospital's financial assistance policy, including self-pay patients;

(3) the amount of Medicaid reimbursement for each DRG or procedure, including all supplemental payments to and from the hospital;

(4) the amount of Medicare reimbursement for each DRG or procedure; and

(5) on behalf of insured and teachers and State employees, report the lowest, average, and highest amount of payments made for each DRG or procedure by the hospital's top five largest health insurers.

(A) each hospital shall determine its five largest health insurers based on the dollar volume of payments received from those insurers;

(B) the lowest amount of payment shall be reported as the lowest payment from any of the five insurers on the DRG or procedure;

(C) the average amount of payment shall be reported as the arithmetic average of all of the five health insurers payment amounts;

(D) the highest amount of payment shall be reported as the highest payment from any of the five insurers on the DRG or procedure; and

(E) the identity of the top five largest health insurers shall be redacted prior to submission.

(e) The data reported, as defined in Paragraphs (b) through (d) of this Rule, shall reflect the payments received from patients and health insurers for all closed accounts. For the purpose of this Rule, closed accounts are patient accounts with a zero balance at the end of the data reporting period.

(f) A minimum of three data elements shall be required for reporting under Paragraphs (b) and (c) of this Rule.

(g) The information submitted in the report shall be in compliance with the federal "Health Insurance Portability and Accountability Act of 1996."

(h) The Department shall provide the location of each licensed hospital and all specific hospital data reported pursuant to this Rule on its website. Hospitals shall be grouped by category on the website. On each quarterly report, hospitals shall determine one category that most accurately describes the type of facility. The categories are:

(1) "Academic Medical Center Teaching Hospital," means a hospital as defined in Policy AC-3 of the N.C. State Medical Facilities Plan. The N.C. State Medical Facilities Plan can be accessed at the Division's website at: http://www.ncdhhs.gov/dhsr/ncsmfp.

(2) "Teaching Hospital," means a hospital that provides medical training to individuals provided that such educational programs are accredited by the Accreditation Council for Graduated Medical Education to receive graduate medical education funds from the Centers for Medicare & Medicaid Services.

(3) "Critical Access Hospital," means a hospital defined in the Centers for Medicare & Medicaid Services' State Operations Manual, Chapter 2 – The Certification Process, 2254D – Requirements for Critical Access Hospitals (Rev. 1, 05-21-04), including all subsequent updates and revisions. The manual may be accessed at no cost at the internet website: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

(4) "Community Hospital," means a general acute hospital that provides diagnostic and medical treatment, both surgical and nonsurgical, to inpatients with a variety of medical conditions, and that may provide outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services, and pharmacy services, that is not defined by the categories listed in Items (1) – (4).

(5) "Mental Health Hospital," means a hospital providing psychiatric services as defined in G.S. 131E-176(21).

History Note: *Authority G.S.131E-214.4; S.L. 2013-382(s.10.1);*
Eff. November 1, 2014.

10A NCAC 13B .2103 is proposed for adoption as follows:

10A NCAC 13B .2103 100 MOST FREQUENTLY REPORTED DIAGNOSTIC RELATED GROUPS (DRGS)

(a) The list of the statewide 100 most frequently reported DRGs, specific to North Carolina and established by the Commission, is based on data provided by the certified statewide data processor. Hospitals shall report data specific to each DRG in the list pursuant to Rule .2102 of this Section.

(b) The statewide 100 most frequently reported DRGs with associated medical descriptions are:

Number	DRG Code	Description
1	57	Degenerative nervous system disorders without major complications and comorbidities
2	64	Intracranial hemorrhage or cerebral infarction with major complications and comorbidities
3	65	Intracranial hemorrhage or cerebral infarction with complications and comorbidities
4	66	Intracranial hemorrhage or cerebral infarction without complications and comorbidities or major complications and comorbidities
5	69	Transient ischemia
6	74	Cranial and peripheral nerve disorders without major complications and comorbidities
7	101	Seizures without major complications and comorbidities
8	153	Otitis media and upper respiratory infection without major complications and comorbidities
9	176	Pulmonary embolism without major complications and comorbidities
10	177	Respiratory infections and inflammations with major complications and comorbidities
11	178	Respiratory infections and inflammations with complications and comorbidities
12	189	Pulmonary edema and respiratory failure
13	190	Chronic obstructive pulmonary disease with major complications and comorbidities
14	191	Chronic obstructive pulmonary disease with complications and comorbidities
15	192	Chronic obstructive pulmonary disease without complications and comorbidities or major complications and comorbidities
16	193	Simple pneumonia and pleurisy with major complications and comorbidities
17	194	Simple pneumonia and pleurisy with complications and comorbidities

18	195	Simple pneumonia and pleurisy without complications and comorbidities or major complications and comorbidities
19	202	Bronchitis and asthma with complications and comorbidities or major complications and comorbidities
20	203	Bronchitis and asthma without major complications and comorbidities or major complications and comorbidities
21	207	Respiratory system diagnosis with ventilator support 96+ hours
22	208	Respiratory system diagnosis with ventilator support less than 96 hours
23	238	Major cardiovascular procedures without major complications and comorbidities
24	247	Percutaneous cardiovascular procedure with drug-eluting stent without major complications and comorbidities
25	249	Percutaneous cardiovascular procedure with non-drug-eluting stent without major complications and comorbidities
26	280	Acute myocardial infarction, discharged alive with major complications and comorbidities
27	281	Acute myocardial infarction, discharged alive with complications and comorbidities
28	282	Acute myocardial infarction, discharged alive without complications and comorbidities or major complications and comorbidities
29	287	Circulatory disorders except acute myocardial infarction, with cardiac catheterization without major complications and comorbidities
30	291	Heart failure and shock with major complications and comorbidities
31	292	Heart failure and shock with complications and comorbidities
32	293	Heart failure and shock without complications and comorbidities or major complications and comorbidities
33	300	Peripheral vascular disorders with complications and comorbidities
34	305	Hypertension without major complications and comorbidities
35	308	Cardiac arrhythmia and conduction disorders with major complications and comorbidities
36	309	Cardiac arrhythmia and conduction disorders with complications and comorbidities
37	310	Cardiac arrhythmia and conduction disorders without complications and comorbidities or major complications and comorbidities
38	312	Syncope and collapse
39	313	Chest pain

40	314	Other circulatory system diagnoses with major complications and comorbidities
41	329	Major small and large bowel procedures with major complications and comorbidities
42	330	Major small and large bowel procedures with complications and comorbidities
43	331	Major small and large bowel procedures without complications and comorbidities or major complications and comorbidities
44	372	Major gastrointestinal disorders and peritoneal infections with complications and comorbidities
45	377	Gastrointestinal hemorrhage with major complications and comorbidities
46	378	Gastrointestinal hemorrhage with complications and comorbidities
47	379	Gastrointestinal hemorrhage without complications and comorbidities or major complications and comorbidities
48	389	Gastrointestinal obstruction with complications and comorbidities
49	390	Gastrointestinal obstruction without complications and comorbidities or major complications and comorbidities
50	391	Esophagitis, gastroenteritis and miscellaneous digestive disorders with major complications and comorbidities
51	392	Esophagitis, gastroenteritis and miscellaneous digestive disorders without major complications and comorbidities
52	394	Other digestive system diagnoses with complications and comorbidities
53	418	Laparoscopic cholecystectomy without common duct exploration with complications and comorbidities
54	419	Laparoscopic cholecystectomy without common duct exploration without complications and comorbidities or major complications and comorbidities
55	439	Disorders of pancreas except malignancy with complications and comorbidities
56	440	Disorders of pancreas except malignancy without complications and comorbidities or major complications and comorbidities
57	460	Spinal fusion except cervical without major complications and comorbidities
58	470	Major joint replacement or reattachment of lower extremity without major complications and comorbidities
59	473	Cervical spinal fusion without complications and comorbidities or major complications and comorbidities
60	481	Hip and femur procedures except major joint with complications and comorbidities

61	491	Back and neck procedures except spinal fusion without complications and comorbidities or major complications and comorbidities
62	494	Lower extremity and humerus procedures except hip, foot, and femur without complications and comorbidities or major complications and comorbidities
63	552	Medical back problems without major complications and comorbidities
64	603	Cellulitis without major complications and comorbidities
65	621	Operating room procedures for obesity without complications and comorbidities or major complications and comorbidities
66	637	Diabetes with major complications and comorbidities
67	638	Diabetes with complications and comorbidities
68	639	Diabetes without complications and comorbidities or major complications and comorbidities
69	640	Miscellaneous disorders of nutrition, metabolism, and fluids and electrolytes with major complications and comorbidities
70	641	Miscellaneous disorders of nutrition, metabolism, and fluids and electrolytes without major complications and comorbidities
71	682	Renal failure with major complications and comorbidities
72	683	Renal failure with complications and comorbidities
73	689	Kidney and urinary tract infections with major complications and comorbidities
74	690	Kidney and urinary tract infections without major complications and comorbidities
75	743	Uterine and adnexa procedures for non-malignancy without complications and comorbidities or major complications and comorbidities
76	765	Cesarean section with complications and comorbidities or major complications and comorbidities
77	766	Cesarean section without complications and comorbidities or major complications and comorbidities
78	767	Vaginal delivery with sterilization and/or dilation and curettage
79	774	Vaginal delivery with complicating diagnoses
80	775	Vaginal delivery without complicating diagnoses
81	781	Other antepartum diagnoses with medical complications
82	791	Prematurity with major problems
83	792	Prematurity without major problems
84	793	Full term neonate with major problems
85	794	Neonate with other significant problems

86	795	Normal newborn
87	811	Red blood cell disorders with major complications and comorbidities
88	812	Red blood cell disorders without major complications and comorbidities
89	847	Chemotherapy without acute leukemia as secondary diagnosis with complications and comorbidities
90	853	Infectious and parasitic diseases with operating room procedure with major complications and comorbidities
91	871	Septicemia or severe sepsis without mechanical ventilation 96+ hours with major complications and comorbidities
92	872	Septicemia or severe sepsis without mechanical ventilation 96+ hours without major complications and comorbidities
93	881	Depressive neuroses
94	885	Psychoses
95	897	Alcohol/drug abuse or dependence without rehabilitation therapy without major complications and comorbidities
96	917	Poisoning and toxic effects of drugs with major complications and comorbidities
97	918	Poisoning and toxic effects of drugs without major complications and comorbidities
98	945	Rehabilitation with complications and comorbidities or major complications and comorbidities
99	946	Rehabilitation without complications and comorbidities or major complications and comorbidities
100	948	Signs and symptoms without major complications and comorbidities

History Note: *Authority G.S. 131E-214.4; G.S.131E-214.7; S.L. 2013-382(s.10.1);*
Eff. November 1, 2014.

10A NCAC 13B .2104 is proposed for adoption as follows:

10A NCAC 13B .2104 20 MOST COMMON OUTPATIENT IMAGING PROCEDURES

(a) The list of the statewide 20 most common outpatient imaging procedures, specific to North Carolina and established by the Commission, is based on data provided by the certified statewide data processor. Hospitals shall report data specific to each CPT code in the list pursuant to Rule .2102 of this Section.

(b) The statewide 20 most common outpatient imaging procedures by CPT code with associated medical descriptions are:

Number	CPT Code	Description
1	70450	Computed tomography, head or brain; without contrast material
2	70553	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material followed by contrast material(s) and further sequences
3	71010	Radiologic examination, chest; single view, frontal
4	71020	Radiologic examination, chest; two views, frontal and lateral
5	71260	Computed tomography, thorax; with contrast material(s)
6	71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing
7	72100	Radiologic examination, spine, lumbosacral; two or three views
8	72110	Radiologic examination, spine, lumbosacral; minimum of four views
9	72125	Computed tomography, cervical spine; without contrast material
10	73030	Radiologic examination, shoulder; complete, minimum of two views
11	73110	Radiologic examination, wrist; complete, minimum of three views
12	73130	Radiologic examination, hand; minimum of three views
13	73510	Radiologic examination, hip, unilateral; complete, minimum of two views
14	73564	Radiologic examination, knee; complete, four or more views
15	73610	Radiologic examination, ankle; complete, minimum of three views
16	73630	Radiologic examination, foot; complete, minimum of three views
17	74000	Radiologic examination, abdomen; single anteroposterior view
18	74022	Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest
19	74176	Computed tomography, abdomen and pelvis; without contrast material
20	74177	Computed tomography, abdomen and pelvis; with contrast material(s)

History Note: Authority G.S. 131E-214.4; G.S.131E-214.7; S.L. 2013-382(s.10.1);

Eff. November 1, 2014.

10A NCAC 13B .2105 is proposed for adoption as follows:

10A NCAC 13B .2105 20 MOST COMMON OUTPATIENT SURGICAL PROCEDURES

(a) The list of the statewide 20 most common outpatient surgical procedures, specific to North Carolina and established by the Commission, is based on data provided by the certified statewide data processor. Hospitals shall report data specific to each CPT code in the list pursuant to Rule .2102 of this Section.

(b) The statewide 20 most common outpatient surgical procedures by CPT code with associated medical descriptions are:

Number	CPT Code	Description
1	29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
2	29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
3	29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
4	42820	Tonsillectomy and adenoidectomy; younger than age 12
5	42830	Adenoidectomy, primary; younger than age 12
6	43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
7	43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple
8	43248	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire
9	43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)
10	45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
11	45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
12	45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

13	45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
14	62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
15	64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography); lumbar or sacral, single level
16	64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
17	66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)
18	66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
19	66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (stage one procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)
20	69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia

History Note: *Authority G.S. 131E-214.4; G.S.131E-214.7; S.L. 2013-382(s.10.1);*
Eff. November 1, 2014.

10A NCAC 13B .3110 is proposed for amendment as follows:

10A NCAC 13B .3110 ITEMIZED CHARGES

(a) The facility shall either present an itemized list of charges to all discharged patients or the facility shall include on patients' ~~bills, which~~ bills that are not itemized, notification of the right to request an itemized bill within ~~30 days~~ three years of receipt of the non-itemized ~~bill.~~ bill or so long as the hospital, a collections agency, or other assignee asserts the patient has an obligation to pay the bill.

(b) If requested, the facility shall present an itemized list of charges to each ~~patient,~~ patient or the patient's ~~responsible party.~~ representative. This list shall detail in language comprehensible to an ordinary layperson the specific nature of the charges or expenses incurred by the patient.

(c) The itemized listing shall ~~include, at a minimum, those charges incurred~~ include each specific chargeable item or service in the following service ~~areas:~~ areas:

(1) room rates;
(2) laboratory;
(3) radiology and nuclear medicine;
(4) surgery;
(5) anesthesiology;
(6) pharmacy;
(7) emergency services;
(8) outpatient services;
(9) specialized care;
(10) extended care;
(11) prosthetic and orthopedic appliances; and
(12) professional services provided by the facility. ~~other independently billing medical personnel.~~

History Note: *Authority G.S. 131E-79; 131E-91; S.L. 2013-382(s.13.1);*
Eff. January 1, 1996;
Temporary Amendment Eff. May 1, ~~2014.~~ 2014;
Amended Eff. November 1, 2014.

10A NCAC 13B .3502 is proposed for amendment as follows:

10A NCAC 13B .3502 REQUIRED POLICIES, RULES, AND REGULATIONS

(a) The governing body shall adopt written policies, rules, and regulations in accordance with all requirements contained in this Subchapter and in accordance with the community responsibility of the facility. ~~As a minimum, the~~ The written policies, rules, and regulations shall:

(1) state the ~~general and specific goals~~ purpose of the facility;

(2) describe the powers and duties of the governing body officers and committees and the responsibilities of the chief executive officer;

(3) state the qualifications for governing body membership, the procedures for selecting members, and the terms of service for members, officers and committee chairmen;

(4) describe the authority delegated to the chief executive officer and to the medical staff. No assignment, referral, or delegation of authority by the governing body shall relieve the governing body of its responsibility for the conduct of the facility. The governing body shall retain the right to rescind any such delegation;

(5) require Board approval of the bylaws of any auxiliary organizations established by the hospital;

(6) require the governing body to review and approve the bylaws of the medical staff organization;

(7) establish a procedure for processing and evaluating the applications for medical staff membership and for the granting of clinical privileges;

(8) establish a procedure for implementing, disseminating, and enforcing a Patient's Bill of Rights as ~~described~~ set forth in Rule .3302 of this Subchapter and in compliance with ~~G.S. 131E-117 where applicable; and~~ G.S. 131E-117; and

(9) require the governing body to institute procedures to provide for:

(A) orientation of newly elected board members to specific board functions and procedures;

(B) the development of procedures for periodic reexamination of the relationship of the board to the total facility community; and

(C) the recording of minutes of all governing body and executive committee meetings and the dissemination of those minutes, or summaries thereof, on a regular basis to all members of the governing body.

(b) The governing body shall assure written policies and procedures to assure billing and collection practices in accordance with G. S. 131E-91. These policies and procedures shall include:

(1) a financial assistance policy as defined in Rule .2101 of the Subchapter;

(2) how a patient may obtain an estimate of the charges for the statewide 100 most frequently reported DRGs, where applicable, and 20 most common outpatient imaging procedures, and 20 most common outpatient surgical procedures. The policy shall require that the information be provided to the patient in writing, either electronically or by mail, within three business days;

(3) how a patient or patient's representative may dispute a bill;

(4) issuance of a refund within 45 days of the patient receiving notice of the overpayment when a patient has overpaid the amount due to the hospital;

(5) providing written notification to the patient or patient's representative, at least 30 days prior to submitting a delinquent bill to a collections agency;

(6) providing the patient or patient's representative with the facility's charity care and financial assistance policies, if the facility is required to file a Schedule H, federal form 990;

(7) the requirement that a collections agency, entity, or other assignee obtain written consent from the facility prior to initiating litigation against the patient or patient's representative;

(8) a policy for handling debts arising from the provision of care by the hospital involving the doctrine of necessaries, in accordance with G.S. 131E-91(d)(5); and

(9) a policy for handling debts arising from the provision of care by the hospital to a minor, in accordance with G.S. 131E-91(d)(6).

~~(b)~~ (c) The written policies, rules, and regulations shall be reviewed ~~at least~~ every three years, revised as necessary, and dated to indicate when last reviewed or revised.

(d) To qualify for licensure or license renewal, each facility must provide to the Division, upon application, an attestation statement in a form provided by the Division verifying compliance with the requirements of this Rule.

(e) On an annual basis, on the license renewal application provided by the Division, the facility shall provide to the Division the direct website address to the facility's financial assistance policy. This Rule applies only to facilities required to file a Schedule H, federal form 990.

History Note: *Authority G.S. 131E-79; S.L. 2013-382(s.10.1),(s.13.1); G.S. 131E-91;*
Eff. January 1, 1996;
Temporary Amendment Eff. May 1, ~~2014.~~ 2014;
Amended Eff. November 1, 2014.