10A NCAC 13C .0206 is proposed for temporary adoption as follows:

10A NCAC 13C .0206 REPORTING REQUIREMENTS

(a) The Department shall establish the lists of the statewide 20 most common outpatient imaging procedures and 20 most common outpatient surgical procedures performed in the ambulatory surgical facility setting to be used for reporting the data required in Paragraphs (b) through (c) of this Rule. The lists shall be based on data provided by the certified statewide data processor. The Department shall make the lists available on its website at: http://www.ncdhhs.gov/dhsr/ahc.

(b) In accordance with G.S. 131E-214.13 and quarterly per year all licensed ambulatory surgical facilities shall report the data required in Paragraph (c) 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.

(c) The report as described in Paragraphs (b) of this Rule shall be specific to each reporting ambulatory surgical facility 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 (c)(1) of this Rule. The average negotiated settlement is to be calculated using the average amount charged all patients eligible for the facility'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 ambulatory surgical facility;

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

(5) on behalf of patients who are covered by a Department of Insurance licensed third-party and teachers and State employees, report the lowest, average, and highest amount of payments made for each DRG or procedure by each of the facility's top five largest health insurers.

(A) each ambulatory surgical facility 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 each of the five insurers on the DRG or procedure;

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

(D) the highest amount of payment shall be reported as the highest payment from each 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 (c) 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 Paragraph (b) 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 all specific ambulatory surgical facility data reported pursuant to this Rule on its website.

History Note: *Authority G.S.131E-214.4; 131E-214.13; S.L. 2013-382(s.10.1); S.L. 2014-100; Temporary Adoption Eff. January 31, 2015.*