10A NCAC 13B .2101 is adopted as published in NCR 29:18, pp. 2132-2136 as follows:

SECTION .2100 – TRANSPARENCY IN HEALTH CARE COSTS

10A NCAC 13B .2101 DEFINITIONS

In addition to the terms defined in G.S. 131E-214.13, the following terms shall apply throughout this Section, unless text indicates to the contrary:

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

(2) "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.

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

(4) "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 the patients in Sub-Item (4)(b) of this Rule; or

(d) the difference between the cost of care provided under Medicare or other government programs, and the revenue derived therefrom.

(5) "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.

History Note: *Authority G.S. 131E-214.13; S.L. 2013-382, s.10.1; S.L. 2013-382, s.13.1; S.L. 2014-100, s. 12G.2; Temporary Adoption Eff. December 31, ~~2014.~~ 2014;*
Eff. September 30, 2015.

10A NCAC 13B .2102 is adopted as published in NCR 29:18, pp. 2132-2136 as follows:

10A NCAC 13B .2102 REPORTING REQUIREMENTS

(a) The Department shall establish 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 (c) through (e) of this Rule. The lists shall be determined annually based upon data provided by the certified statewide data processor. The Department shall make the lists available on its website. The methodology to be used by the certified statewide data processor for determining the lists shall be based on the data collected from all licensed facilities in the state in accordance with G.S. 131E-214.2 as follows:

(1) the 100 most frequently reported DRGs shall be based upon all hospital's discharge data that has been assigned a DRG based on the Centers for Medicare and Medicaid Services grouper for each patient record, then selecting the top 100 to be provided to the Department;

(2) the 20 most common imaging procedures shall be based upon all outpatient data for both hospitals and ambulatory surgical facilities and represent all occurrences of the diagnostic radiology imaging codes section of the CPT codes, then selecting the top 20 to be provided to the Department; and

(3) the 20 most common outpatient surgical procedures shall be based upon the primary procedure code from the ambulatory surgical facilities and represent all occurrences of the surgical codes section of the CPT codes, then selecting the top 20 to be provided to the Department.

(b) All information required by Paragraphs (a), (c) and (d) of this Rule shall be posted on the Department's website at: http://www.ncdhhs.gov/dhsr/ahc and may be accessed at no cost.

(c) In accordance with G.S. 131E-214.13 and quarterly per year, all licensed hospitals shall report the data required in Paragraph (e) of this Rule related to the statewide 100 most frequently reported DRGs to the certified statewide data processor in a format provided by the certified statewide processor. Commencing September 30, 2015, a rolling four quarters data report shall be submitted that includes all sites operated by the licensed hospital. Each report shall be for the period ending three months prior to the due date of the report.

(d) In accordance with G.S. 131E-214.13 and quarterly per year, all licensed hospitals shall report the data required in Paragraph (e) 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. Commencing September 30, 2015, a rolling four quarters data report shall be submitted that includes all sites operated by the licensed hospital. Each report shall be for the period ending three months prior to the due date of the report.

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

(1) the average gross charge for each DRG, CPT code, or procedure for all payer sources;

(2) the average negotiated settlement on the amount that will be charged for each DRG, CPT code, or procedure as required for patients defined in Subparagraph (e)(1) of this Rule. The average

negotiated settlement shall 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, CPT code, or procedure, including all supplemental payments to and from the hospital;

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

(5) on behalf of patients who are covered by a Department of Insurance licensed third-party and teachers and State employees, the lowest, average, and highest amount of payments made for each DRG, CPT code, or procedure by each of 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 each of the five insurers on the DRG, CPT code, 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, CPT code, or procedure; and

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

(f) The data reported, as defined in Paragraphs (c) through (e) 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.

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

(h) The information submitted in the report shall be in compliance with the federal Health Insurance Portability and Accountability Act of 1996, 45 CFR Part 164.

(i) 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 may be accessed at: http://www.ncdhhs.gov/dhsr/ncsmfp at no cost.

(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) "Community Hospital," means a general acute hospital that provides diagnostic and medical treatment, either surgical or nonsurgical, to inpatients with a variety of medical conditions, and that may provide outpatient services, anatomical pathology services, diagnostic imaging services,

clinical laboratory services, operating room services, and pharmacy services, that is not defined by the categories listed in this Subparagraph and Subparagraphs (i)(1), (2), or (5) of this Rule.

(4) "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 the website: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf at no cost.

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

History Note: *Authority G.S.131E-214.4; 131E-214.13; S.L. 2013-382, s.10.1; S.L. 2014-100, s. 12G.2;*
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