REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13B .2101

DEADLINE FOR RECEIPT: Monday, August 10, 2015

***NOTE WELL:* This request when viewed on computer extends several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In the History Note, please delete the references to the Session Laws.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: July 27, 2015

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.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13B .2102

DEADLINE FOR RECEIPT: Monday, August 10, 2015

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Paragraph (a), line 9, "State" should be capitalized.

In Subparagraph (a)(1), line 12, you state "Centers for Medicaid and Medicare Services." In Subparagraphs (i)(2) and (4), Page 2, line 34 and Page 3, line 4, you state "Centers for Medicare & Medicaid Services." Please be consistent with using "and" or the ampersand.

In Paragraph (b), in order to capture the website reference in Paragraph (i), why not state, "Information required or reported in Paragraphs (a), (c), (d), and (i) of this Rule…"?

In Paragraphs (c) and (d), lines 24-25 and 31, what is a "rolling four quarters data report"?

So that I understand – in Paragraph (d), you require both the CPT and HCPCS codes. However, in Paragraph (e), you refer to only CPT codes. I note that HCPCS is defined in Rule .2101 to state that the Level I of the HCPCS contains the CPT code. Is that why you are only referring to the CPT code in Paragraph (e)?

In the History Note, please delete the references to the Session Laws.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: July 27, 2015

10A NCAC 13B .2102 is adopted with changes 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;~~ without a public or private third party payer source;

(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;*
Temporary Adoption Eff. December 31, ~~2014.~~ 2014;
Eff. September 30, 2015.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13C .0103

DEADLINE FOR RECEIPT: Monday, August 10, 2015

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Item (1), line 8, does your regulated public know what "professional standards of practice" are?

In Item (14), Page 2, line 7, please insert a comma after "elected"

In the History Note, please delete the references to the Session Laws.

Also in the History Note, please italicize "September"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: July 27, 2015

10A NCAC 13C .0103 is amended as published in NCR 29:18, pp. 2132-2136 as follows:

10A NCAC 13C .0103 DEFINITIONS

In addition to the terms defined in G.S. 131E-214.13, the following terms shall apply throughout ~~As used in~~ this Subchapter, unless the context clearly requires ~~otherwise, the following terms have the meanings specified:~~ otherwise:

(1) "Adequate" means, when applied to various areas of services, that the services are ~~at least~~ satisfactory in meeting a referred to need when measured against ~~contemporary~~ professional standards of practice.

(2) "AAAASF" means American Association for Accreditation of Ambulatory Surgery Facilities.

(3) "AAAHC" means Accreditation Association for Ambulatory Health Care.

(4) "Ancillary nursing personnel" means persons employed to assist registered nurses or licensed practical nurses in the care of patients.

(5) "Anesthesiologist" means a physician whose specialized training and experience qualify him or her to administer anesthetic agents and to monitor the patient under the influence of these agents. For the purpose of ~~these Rules~~ this Subchapter, the term "anesthesiologist" shall not include podiatrists.

(6) "Anesthetist" means a physician or dentist qualified, as defined in ~~Item~~ Items (10) and ~~(22)~~ (24) of this Rule, to administer anesthetic agents or a registered nurse qualified, as defined in ~~Item~~ Items ~~(22)~~ (25) and (27) of this Rule, to administer anesthesia.

(7) "Authority ~~Having Jurisdiction"~~ having jurisdiction" means the Division of Health Service Regulation.

(8) "Chief executive officer" or "administrator" means a qualified person appointed by the governing authority to act in its behalf in the overall management of the facility and whose office is located in the facility.

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

~~(9)~~ (10) "Dentist" means a person who holds a valid license issued by the North Carolina Board of Dental Examiners to practice dentistry.

~~(10)~~ (11) "Department" means the North Carolina Department of Health and Human Services.

~~(11)~~ (12) "Director of nursing" means a registered nurse who is responsible to the chief executive officer or administrator and has the authority and direct responsibility for all nursing services and nursing care for the entire facility at all times.

(13) "Financial assistance" means a policy, including charity care, describing how the organization will provide assistance at its facility. 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 (13)(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.

~~(12)~~ (14) "Governing authority" means the individual, ~~agency or group~~ agency, group, or corporation appointed, elected or otherwise designated, in which the ultimate responsibility and authority for the conduct of the ambulatory surgical facility is vested.

(15) "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.

~~(13)~~ (16) "JCAHO" or "Joint Commission" means Joint Commission on Accreditation of Healthcare Organizations.

~~(14)~~ (17) "Licensing agency" means the Department of Health and Human Services, Division of Health Service Regulation.

~~(15)~~ (18) "Licensed practical ~~nurse" (L.P.N.)~~ nurse (L.P.N.)" means any person licensed as such under the provisions of ~~G.S. 90-171.~~ G.S. 90-171.20(8).

~~(16)~~ (19) "Nursing personnel" means registered nurses, licensed practical ~~nurses~~ nurses, and ancillary nursing personnel.

~~(17)~~ (20) "Operating room" means a room in which surgical procedures are performed.

~~(18)~~ (21) "Patient" means a person admitted to and receiving care in a facility.

~~(19)~~ (22) "Person" means an individual, a trust or estate, a partnership or corporation, including associations, joint stock companies and insurance companies; the ~~state,~~ State, or a political subdivision or instrumentality of the state.

~~(20)~~ (23) "Pharmacist" means a person who holds a valid license issued by the North Carolina Board of Pharmacy to practice pharmacy in accordance with ~~G.S. 90-85.~~ G.S. 90-85.3A.

~~(21)~~ (24) "Physician" means a person who holds a valid license issued by the North Carolina Medical Board to practice medicine. For the purpose of carrying out these Rules, a "physician" may also mean a person holding a valid license issued by the North Carolina Board of Podiatry Examiners to practice podiatry.

~~(22)~~ (25) "Qualified ~~person"~~ person," when used in connection with an occupation or ~~position~~ position, means a person:

(a) who has demonstrated through ~~relevant~~ experience the ability to perform the required functions; or

(b) who has certification, ~~registration~~ registration, or other professional recognition.

~~(23)~~ (26) "Recovery area" means a room used for the ~~post-anesthesia~~ post-anesthesia recovery of surgical patients.

~~(24)~~ (27) "Registered nurse" means a person who holds a valid license issued by the North Carolina Board of Nursing to practice nursing as defined in ~~G.S. 90-171.~~ G.S. 90-171.20(7).

~~(25)~~ (28) "Surgical suite" means an area ~~which~~ that includes one or more operating rooms and one or more recovery rooms.

History Note: *Authority G.S. 131E-149; 131E-214.13; S.L. 2013-382, s.10.1; S.L. 2013-382, s.13.1; S.L. 2014-100, s. 12G.2;*
Eff. October 14, 1978;
Amended Eff. April 1, 2003; November 1, 1989;
Temporary Amendment Eff. December 31, ~~2014.~~ 2014;
Eff. September *30, 2015.*

REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13C .0206

DEADLINE FOR RECEIPT: Monday, August 10, 2015

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Paragraph (a), line 10, "State" should be capitalized.

In Paragraph (c), lines 23, what is a "rolling four quarters data report"?

So that I understand – in Paragraph (e), you require both the CPT and HCPCS codes. However, in Paragraph (d), you refer to only CPT codes. I note that HCPCS is defined in Rule .2101 to state that the Level I of the HCPCS contains the CPT code. Is that why you are only referring to the CPT code in Paragraph (d)?

In the History Note, please delete the references to the Session Laws.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: July 27, 2015

10A NCAC 13C .0206 is adopted with changes as published in NCR 29:18, pp. 2132-2136 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 (c) and (d) of this Rule. The lists shall be determined annually based upon data provided by the certified statewide data processor. ~~The lists shall be 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 20 most common imaging procedures shall be based upon all outpatient data for 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

(2) 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 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 ambulatory surgical facilities 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. Commencing September 30, 2015, a rolling four quarters data report shall be submitted. Each report shall be for the period ending three months prior to the due date of the report.

(d) The report as described in Paragraph (c) of this Rule shall be specific to each reporting ambulatory surgical facility and shall include:

(1) the average gross charge for each CPT code or procedure ~~for all payer sources;~~ without a public or private third party payer source;

(2) the average negotiated settlement on the amount that will be charged for each CPT code or procedure as required for patients defined in Subparagraph (d)(1) of this Rule. The average negotiated settlement shall 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 CPT code or procedure, including all supplemental payments to and from the ambulatory surgical facility;

(4) the amount of Medicare reimbursement for each 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 CPT code 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 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 CPT code 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 (c) and (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 Paragraph (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 45 CFR Part 164.

(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-147.1; 131E-214.4; 131E-214.13; S.L. 2013-382, s.10.1; S.L. 2014-100, s. 12G.2;*
Temporary Adoption Eff. December 31, ~~2014.~~ 2014;
Eff. September 30, 2015.