§ 131E-214.13. Disclosure of prices for most frequently reported DRGs, CPTs, and HCPCSs.

(a) The following definitions apply in this Article:

(1) Ambulatory surgical facility. – A facility licensed under Part 4 of Article 6 of this Chapter.

(2) Commission. – The North Carolina Medical Care Commission.

(3) Health insurer. – An entity that writes a health benefit plan and is one of the following:

a. An insurance company under Article 3 of Chapter 58 of the General Statutes.

b. A service corporation under Article 65 of Chapter 58 of the General Statutes.

c. A health maintenance organization under Article 67 of Chapter 58 of the General Statutes.

d. A third-party administrator of one or more group health plans, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1167(1)).

(4) Hospital. – A medical care facility licensed under Article 5 of this Chapter or under Article 2 of Chapter 122C of the General Statutes.

(5) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Beginning with the reporting period ending September 30, 2015, and annually thereafter, each hospital shall provide to the Department of Health and Human Services, utilizing electronic health records software, the following information about the 100 most frequently reported admissions by DRG for inpatients as established by the Department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges.

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.

(3) The amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments.

(4) The amount of Medicare reimbursement for each DRG.

(5) For each of the five largest health insurers providing payment to the hospital on behalf of insureds and teachers and State employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the Department, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

A hospital shall not be required to report the information required by this subsection for any of the 100 most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(c) The Commission shall adopt rules on or before March 1, 2016, to ensure that subsection (b) of this section is properly implemented and that hospitals report this information to the Department in a uniform manner. The rules shall include all of the following:

(1) The method by which the Department shall determine the 100 most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection (b) of this section.

(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the Department's website.

(d) Beginning with the reporting period ending September 30, 2015, and annually thereafter, each hospital and ambulatory surgical facility shall provide to the Department, utilizing electronic health records software, information on the total costs for the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical facilities, along with the related CPT and HCPCS codes. Hospitals and ambulatory surgical facilities shall report this information in the same manner as required by subdivisions (b)(1) through (5) of this section, provided that hospitals and ambulatory surgical facilities shall not be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(e) The Commission shall adopt rules on or before March 1, 2016, to ensure that subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical facilities report this information to the Department in a uniform manner. The rules shall include the method by which the Department shall determine the 20 most common surgical procedures and the 20 most common imaging procedures for which the hospitals and ambulatory surgical facilities must provide the data set out in subsection (d) of this section.

(e1) The Commission shall adopt rules to establish and define no fewer than 10 quality measures for licensed hospitals and licensed ambulatory surgical facilities.

(f) Upon request of a patient for a particular DRG, imaging procedure, or surgery procedure reported in this section, a hospital or ambulatory surgical facility shall provide the information required by subsection (b) or subsection (d) of this section to the patient in writing, either electronically or by mail, within three business days after receiving the request.

(g) G.S. 150B-21.3 does not apply to rules adopted under subsections (c) and (e) of this section. A rule adopted under subsections (c) and (e) of this section becomes effective on the last day of the month following the month in which the rule is approved by the Rules Review Commission. (2013-382, s. 10.1; 2014-100, s. 12G.2; 2015-241, s. 12A.15(a); 2025-25, s. 29(5).)