

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