 <b>JOHNS HOPKINS</b> MEDICINE JOHNS HOPKINS HEALTH SYSTEM	<b>The Johns Hopkins Health System          Policy &amp; Procedure</b>	<i>Policy Number</i> FIN112
	<i>Subject</i>	<i>Effective Date</i> 11-01-06
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		<i>Supersedes</i> 08-01-04

## POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) and the following affiliated entities: The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center, Inc. (JHBMC), and Howard County General Hospital (HCGH).

### Purpose

The Charge Description Master (CDM) is a computerized list of charge codes for all available hospital services. The purpose of this policy is to provide uniform guidance to JHH, JHBMC and HCGH regarding the maintenance of their respective CDMs in terms of procedure codes and billing codes. As all facilities have an interest in the accuracy of coding assignments and the timing of coding updates, this policy intends to facilitate a coordinated approach to CDM maintenance among the hospitals.


The procedure coding for most outpatient non-surgical services and tests is generally maintained through the hospitals' respective CDM. Therefore, the codes contained in the CDM must be accurate and, when necessary, updated timely to ensure proper billing submissions to Medicare, Medicaid and other third party payers. Recognizing that the accuracy of hospital bills is heavily dependent on the accuracy of coding assignments within the CDM, it is the policy of JHH, JHBMC, and HCGH to maintain adequate controls over the process of adding, changing or deleting procedure codes and revenue codes to their respective CDM.

Because the CDM not only contains service descriptions and related billing codes, but prices, general accounting data, and other information as well, its maintenance is of common interest to many departments. Therefore, maintaining the CDMs for all facilities requires a team approach. In this regard, the Revenue Operations Committee, whose members include representatives from Patient Financial Services, Case Mix Information Management, Ambulatory Services, Medical Records, Finance and Compliance, will assume responsibility for developing and maintaining appropriate controls over CDM maintenance for all hospitals. In terms of coding assignments, day-to-day responsibility for CDM maintenance rests with the Director of Case Mix Information Management for the Johns Hopkins Health System.

### Background

The CDMs for JHH, JHBMC, and HCGH include:

- **Hospital Department Code:** the department code (revenue center) is specific to each entity and identifies the department where the service is performed.
- **Hospital Procedure Code:** the procedure code is specific to each entity and identifies the specific service rendered to the patient. This charge code also appears on the charge slips used in ordering services.
- **Service Description:** this is a brief description of the procedures, services or supplies that a specific department delivers.
- **Procedure Code:** the procedure code is the Center for Medicare & Medicaid Services' (CMS – formerly known as HCFA) Common Procedure Coding System (HCPCS) code assigned to each procedure, service or product as appropriate. The majority of these codes are HCPCS level I codes, more commonly referred to as CPT-4 codes (short for Common Procedure Terminology, volume 4).
- **Revenue Code:** the revenue code, also known as the UB-92 code, is assigned to each procedure, service or product.

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- **Charge Amount:** this is the fee that the hospital charges for specific procedures, services, and supplies.

The American Medical Association and CMS update CPT and HCPCS codes annually. These updates can include revisions to the codes' narrative descriptions, additional codes and/or codes to be deleted. Medicare and other third party payers require the use of CPT/HCPCS codes by hospitals when submitting claims for a majority of outpatient services. In addition, Medicare notifies providers of coding changes throughout the year which require timely updates to the CDM.


### PROCEDURES – JHH

The following steps should be followed when updating the CDM:

1. The department where the service is provided must complete and submit one of three following Johns Hopkins Health System (JHHS) request forms. If the request is related to:
  - Supplies – submit the “JHHS Request for Medical & Surgical Supply Code” form.
  - Procedures – submit the “JHHS Request for Procedure Code” form.
  - Pharmaceuticals – submit the “JHHS Request for CDM Pharmacy Code” form.

These forms are used for adding, deleting or changing any JHH procedure/service, supply or pharmaceutical associated information in the CDM. When requesting that a new service be added, the form must include a detailed description of the procedure or service in question, along with an explanation of the procedure's purpose. Providing this detailed purpose and description will help ensure the accuracy of the assigned CPT and UB92 revenue codes. DSM Cost Standards are required with the initial form as well. The unit administrator or his/her designee must approve the form. Once approved, the form is e-mailed to [JHH\\_CDM\\_Request@jhmi.edu](mailto:JHH_CDM_Request@jhmi.edu) for processing.

2. The CDM Coordinator for the Case Mix Information Management Department (CIMD) will screen the form for completeness, making certain that all the data elements needed to add, change or delete information in the CDM have been provided. If the form is incomplete, the CDM Coordinator will contact the requestor to obtain the missing information. The CDM Coordinator either assigns the CPT code and/or UB04 revenue code or validates the codes provided by the department. Additionally, when relative value units (RVUs) are recommended and documented in appendix D, the CDM Coordinator will verify this information for accuracy. If a discrepancy is identified, the CDM Coordinator will contact the department representative for clarification. The CDM Coordinator will illustrate his/her approval by signing the CDM Request form.
3. Once approved, the CDM Coordinator forwards the form to JHH Regulatory Compliance staff for further processing. The Director of Regulatory Compliance is responsible for approving pricing and HSCRC RVU assignment (by report, operating room minutes and supply cost). The Director of HSCRC Regulatory Compliance will illustrate his/her approval by signing the CDM Request form.
4. Once approved, the form is forwarded to CIMD for data entry into Keane. When the RPC is created or updated in Keane, the form is validated by the Casemix Systems Manager. Following entry, the Casemix Systems Manager notifies the requestor via e-mail that their request to add, change or delete an item is complete. The completed form (with all signatures of approval) is then forwarded to Patient Financial Services for coverage determination and to Decision Support for DSM cost review.

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- Each department will undergo an annual review of their portion of the CDM. The CDM coordinator will work with departmental staff to review the current CDM items, their usage, the encounter forms used in the department to capture charges, and the charge capture procedure to determine if all charges are being captured completely and correctly. The CDM Coordinator shall provide a report of findings and changes made. Follow up reports shall be provided to departments twice a year that they shall review to assure that processes are working.

### PROCEDURES – JHBMC

The following steps should be followed when updating the CDM:

- The requesting department must complete and submit one of three following Johns Hopkins Health System request forms. If request related to:
  - Supplies – submit the “JHHS Request for Medical & Surgical Supply Code” form.
  - Procedures – submit the “JHHS Request for Procedure Code” form.
  - Pharmaceuticals – submit the “JHHS Request for CDM Pharmacy Code” form.


These forms are used for adding, deleting, or changing any JHBMC procedure, service, or supply. When requesting that a new service be added, the form must include a detailed description of the procedure or service along with an explanation of the procedure’s purpose. This detailed information is critical to assigning accurate CPT and UB04 revenue codes. Once completed, the form is emailed as indicated on the request form to [BMC\\_CDM\\_Request@jhmi.edu](mailto:BMC_CDM_Request@jhmi.edu) ensuring that it is received by both Regulatory Compliance and the CDM Coordinator.

- The CDM Coordinator will review the request form for completeness, ensuring that all data elements required to add change, or delete information in the CDM have been provided. If it is determined that the form is incomplete, the CDM Coordinator is responsible for contacting the requestor to obtain and record the missing information. The CDM Coordinator either assigns the CPT code and/or UB04 revenue, or validates the codes provided by the department on the request form. If a discrepancy is identified, the CDM Coordinator should contact the department representative for clarification. The CDM Coordinator evidences his/her approval of the assigned CPT, HCPCS and/or UB04 revenue codes by signing the CDM Request form.
- Once approved, the CDM Coordinator forwards the form to the JHBMC’s Revenue Assistant for Regulatory Compliance for further processing and records the date. In turn, the Revenue Assistant obtains the necessary approvals from the Manager of Regulatory Compliance regarding pricing and HSCRC revenue assignment (relative value units and operating room minutes), and ultimately enters the changes into the CDM.

### PROCEDURES - HCGH

- The requesting department must complete and submit one of three following Johns Hopkins Health System request forms. If request related to:
  - Supplies – submit the “JHHS Request for Medical & Surgical Supply Code” form.
  - Procedures – submit the “JHHS Request for Procedure Code” form.
  - Pharmaceuticals – submit the “JHHS Request for CDM Pharmacy Code” form.

These forms are used for adding, deleting, or changing any HCGH procedure, service, or supply. When


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requesting that a new service be added, the form must include a detailed description of the procedure or service along with an explanation of the procedure's purpose. This detailed information is critical to assigning accurate CPT and UB04 revenue codes. Once completed, the form is emailed as indicated on the request form to [HCGH\\_CDM\\_Request@jhmi.edu](mailto:HCGH_CDM_Request@jhmi.edu) ensuring that it is received by both Regulatory Compliance and the CDM Coordinator.

2. The CDM Coordinator will review the request form for completeness, ensuring that all data elements required to add change, or delete information in the CDM have been provided. If it is determined that the form is incomplete, the CDM Coordinator is responsible for contacting the requestor to obtain and record the missing information. The CDM Coordinator either assigns the CPT code and/or UB04 revenue, or validates the codes provided by the department on the request form. If a discrepancy is identified, the CDM Coordinator should contact the department representative for clarification. The CDM Coordinator evidences his/her approval of the assigned CPT, HCPCS and/or UB04 revenue codes by signing the CDM Request form.
3. Once approved, the CDM Coordinator forwards the form to the HCGH Regulatory Compliance staff for further processing. The Manager of Regulatory Compliance is responsible for approving pricing and HSCRC revenue assignment (relative value units and operating room minutes), and ultimately for entry of the changes into the CDM.


#### PROCEDURES -- JHH, HCGH & JHBMC

1. In November and December of each year, the Case Mix Information Management Department will execute a program which electronically compares the CPT and HCPCS codes currently contained within each hospital's CDM to a file containing a list of all codes approved by the American Medical Association which are scheduled to go into effect on January 1<sup>st</sup> of that year. This program will identify any codes within the CDMs which are either incorrect or scheduled to be obsolete and should therefore be either corrected or deleted altogether. The CDM Coordinator will review the CDM for needed changes. Upon detection, the CDM Coordinator will document the changes needed, make the changes to the CDM and send a form letter with changes made and effective date to department administration (keeping a copy). The department will be required to sign and return the form to indicate acceptance and to indicate agreement that the necessary internal changes (e.g., encounter form modifications) will be made within 60 days (or some appropriate time frame based on the effective date). If a large number of ancillary department CPT/HCPCS codes become obsolete, the CDM Coordinator will work with ancillary department personnel to verify appropriate coding before making changes to the CDM.
2. The Case Mix Information Management Department will execute a program each November to identify those revenue and procedure codes which have not been used during the previous two calendar years and are therefore candidates for deletion. The CDM Coordinator will contact the departments whose services have been identified by this program to find out if the services in question are indeed no longer provided and can therefore be deleted.
3. Departmental management is responsible for operationalizing any changes resulting from adding, changing or deleting codes within the CDM. This includes modifying charge slips, encounter forms, requisition forms, etc. to reflect new codes or delete obsolete codes. The CDM Coordinator shall provide support to the department as needed.
4. Departments at each entity will undergo a Department Review once every three years. The Departmental Review will include the following components: Billing, Charge Description Master, Charge Tickets, and Claims Auditing. Every effort will be made to do the same departments at each entity

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at the same time. The Departments of Casemix Information Management, Regulatory Compliance, Corporate Compliance, Patient Financial Services, Internal Audits and Outpatient Administration will collaborate to develop an annual work plan to include complete charge capture reviews of high risk areas, those areas that represent financial or compliance risk. Results will be reported to the Revenue Operations Committee. Resulting Reports shall be forwarded through the appropriate committee structures up to the Board.

5. Patient Financial Services personnel who are experiencing claims being suspended or rejected for payment due to apparent coding inaccuracies should notify the CDM Coordinator. The CDM Coordinator will research the issue in question and either determines that the code(s) is accurate as submitted, or work with the department to expedite assignment of the correct code in the CDM.
6. The Revenue Operations Committee shall meet periodically to discuss provider bulletins, claim rejections, and other relevant reimbursement information. After identifying reimbursement issues related to coding; necessary changes may be recommended to the CDM using the process described above. The Revenue Operations Committee shall also develop a communication mechanism to educate all staff impacted by the change.
7. The Revenue Operations Committee will evaluate the results of periodic audits of the claims submission process. A sample of claims will be audited semi-annually to determine the accuracy and completeness of data from the point of registration to the period of time when the claim is submitted. The focus of the audit shall be threefold: 1) to ensure the accurate flow of data through multiple systems involved in the billing process; 2) to ensure all procedures and supplies are appropriately reflected on all billing instruments (charge slips, encounter forms, computer screens); and 3.) To ensure the appropriate usage of CPT/HCPCS and revenue code assignments.
8. The CDM Coordinator shall submit an annual report to the Revenue Operations Committee on the "state of the union" of the CDM detailing reviews performed, results of the review in terms of financial or compliance impact, outstanding issues related to those reviews, and a work plan for the next year, which would contain a risk assessment of changes pending in regulatory, HSCRC, etc., issues and key areas of focus related to billing issues or department concerns.
9. The Revenue Operations Committee should periodically determine if any hospital's CDM warrants a comprehensive coding review and, subject to approval from the Johns Hopkins Health System's Compliance Oversight Committee, engage the appropriate resources needed to conduct such a review.

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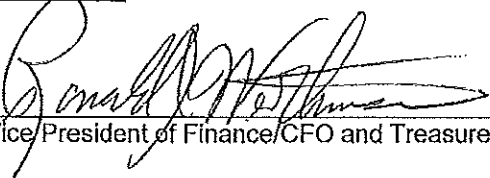
**SPONSOR**

Director, Casemix Information Management (JHHS)

**REVIEW CYCLE**

Three (3) years

**APPROVAL**

  
 Vice President of Finance/CFO and Treasurer, JHHS

7-9-09  
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 Date