

**3M**

# Navigator

3M Health Information Systems



## 3M System Codifies Hospital Reimbursement

**A new Medicare ruling on how hospitals are paid creates new opportunities for 3M.**

If you felt the earth move this summer, chances are you work in health care. There was a major shift in the U.S. government's Medicare reimbursement policy—the most significant change in nearly a quarter of a century. It was big news for hospitals. And it has huge ramifications for 3M Health Information Systems.

### How Hospitals Get Paid

To appreciate this, it helps to understand how hospitals get paid. It's a complex system, but here are the basics: After a patient leaves the hospital, a medical records employee assigns "codes" based upon documentation in the medical record, which identify the patient's medical diagnoses and procedures. These diagnostic codes are important because they trigger the amount of reimbursement a hospital receives for services.

That's where 3M comes in. 3M Health Information Systems provides diagnosis-related grouping (DRG) software, which is used by the government and hospitals to assign the appropriate DRG. The DRG assignment drives reimbursement.

For example, the Centers for Medicare and Medicaid Services (CMS), the U.S. government's health insurance program for senior citizens and people with disabilities, uses a Medicare DRG

system to pay all Medicare claims. 3M is contracted to update and maintain this DRG system for CMS.

### Severity Adjustments Are More Equitable

Since up to 50 percent of a hospital's revenues may come from Medicare patients, hospitals are well-motivated to code their services correctly. The products and consulting services from 3M help hospitals use the Medicare DRG system properly. The 3M™ Coding and Reimbursement System, for example, supports coders with expert coding logic so that the patient record is accurately coded.

Yet another grouping methodology applies to the entire patient population. The 3M™ APR DRG Classification System is used by more than 2,000 hospitals, payers, quality organizations, and state agencies. It is designed to help facilities measure the severity of illness (how ill patients are)

and risk of mortality (how likely patients are to die) of their inpatient populations.

Through severity adjustment, patient populations between different hospitals can be compared more equitably and payment systems can be designed to reimburse for care based on the level of severity assigned to patients.

### Medicare's New System

So, what was the big change? While 3M remains under contract to assist CMS with various work related to the prospective payment system, CMS announced in August it is moving to a new system called Medicare Severity DRGs (MS-DRGs).

Compared to the current system, MS-DRGs do a better job of describing the severity of a patient's illness so a hospital can be reimbursed more fairly for the resources it devotes to a patient.

"Let's say two patients go into the hospital for an appendectomy," says

» CONTINUED ON PAGE 2

# In This Issue



Spotlight | 1-2  
3M System Codifies Hospital Reimbursement

Industry Insight | 3-5  
CMS Awards Contract For ICD-10 Impact Analysis

Customer Profile | 6-7  
Kettering Cuts Write-offs, Reclaims Revenue with 3M™ Ambulatory Revenue Management Software

Product Updates | 7  
3M™ ChartView™ 5.0 Software Enhanced with Microsoft® Smart Client Technology

News and Views | 8-9  
Product Updates, Industry Insights, and More

Event Calendar | 10  
Conferences and Tradeshows Schedules

3M at HIMSS 2008 | 11  
Experience Firsthand How 3M Health Information Systems Helps Organizations Solve Critical Business Issues

» CONTINUED FROM PAGE 1 | 3M SYSTEM CODIFIES HOSPITAL REIMBURSEMENT

Anne Boucher, 3M Clinical Research Systems Content Manager. “One is a healthy 25-year-old man. The other is a 50-year-old man who also has diabetes and congestive heart failure. Both patients have the same medical procedure. In the past, the procedure would be coded the same and the hospital would get paid the same amount of money for each hospitalization. But the older patient with more serious health complications is going to use more hospital resources during his stay. With the MS-DRG coding system, the severity of the patient’s illness is more accurately accounted for and the hospital is reimbursed accordingly.”

It is not about winners or losers. Rather, it is about paying hospitals fairly. Medicare estimates that, using this new severity system, up to \$100 million of Medicare payments will be redistributed in 2008.

Hospitals caring for more severely ill

patients will get more money. Other hospitals will get less. That means every hospital has a vested interest in coding correctly.

## New Ruling Means Big Changes

“The Medicare ruling potentially changes everything,” says Caroline Piselli, 3M Performance Systems Program Manager. “In the past, some payers other than Medicare used the Medicare DRG system for all of their patients. The new MS-DRG system focuses exclusively on Medicare patients and is not applicable for all patients. Other payers, such as Blue Cross-Blue Shield organizations or state Medicaid agencies, will be looking for other systems, such as 3M™ APR DRGs to drive their payment strategies.

“So, hospitals need to understand the new Medicare Severity DRG system,” Piselli concludes. “And they also need to transition to an all-patient coding system.

That opens up new growth opportunities for us. Hospitals have an even greater need for our products and expertise.”

## Everyone Benefits

Coding systems are extremely important to hospitals and payers, but virtually all healthcare stakeholders feel the impact. The wealth of data derived from these systems has many benefits. It helps measure the overall quality of care. It enhances public reporting. And it gives clinicians and patients valuable insight into effective healthcare practices.

“Healthcare costs are spiraling out of control,” says Boucher. “And many people are concerned about the quality of the health care they receive. These coding systems link pay and performance, and help address critical healthcare issues. 3M is at the forefront of this work, and it is a very exciting place to be.”



## Industry Insight: CMS Awards Contract For ICD-10 Impact Analysis

The Centers for Medicare and Medicaid Services (CMS) announced it has contracted with the American Health Information Management Association (AHIMA) to begin assessing the impact on CMS of replacing the ICD-9 code sets now used in reporting healthcare transactions with the ICD-10 versions.

The AHIMA will analyze CMS' systems, policies, and operations to determine potential effects of a transition, including the ICD-10's ability to support more accurate payment for new procedures, more efficient claims processing, and improved disease management.

"The awarding of this contract reflects CMS' commitment to ensuring the transition from the ICD-9 to the ICD-10 code sets will be thoughtfully planned and implemented throughout CMS and

the healthcare community," CMS Acting Administrator Kerry Weems said. "While we are still assessing the implementation and timing of the ICD-10, our proactive approach should send a signal to hospitals and other stakeholders who use the ICD-9 coding set to begin making their own transition plans."

CMS anticipates replacing the ICD-9 diagnosis codes with the ICD-10 diagnosis codes, and the ICD-9 codes for inpatient hospital procedures with the ICD-10 procedural codes. The ICD-9 diagnosis and procedural codes were designated by the Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for use in administrative transactions in both the government and private sectors to report diagnoses and inpatient hospital procedures.

ICD-9, which was developed nearly three decades ago, has a total of 17,000 codes, which limits its ability to accommodate new procedures and diagnoses. By comparison, ICD-10 is a more robust, descriptive set of approximately 210,000 diagnosis and procedure codes, allowing more room for growth reflecting new diagnoses, procedures, and technologies. Currently, all G-7 countries except the U.S. have adopted ICD-10.

The ICD-10-CM code set is maintained by the National Center for Health Statistics, part of the Centers for Disease Control and Prevention, for use in the U.S., and is based on ICD-10, which was developed by the World Health Organization and is used internationally.

Source: CMS 2007

### ICD-10-CM and ICD-10-PCS: Frequently Asked Questions

#### GENERAL QUESTIONS

#### 1. HOW LONG HAS THE ICD-9-CM BEEN IN USE?

ICD-9-CM (International Classification Of Diseases 9th Revision Clinical Modification) has been in use since 1979. The World Health Organization (WHO) developed the international standard. ICD-9-CM is based on the medical knowledge of the 1970s.

#### 2. WHAT CODE SET DOES ICD-9-CM and ICD-10-CM DEFINE?

ICD-9-CM volumes 1 and 2 define the code set used to report inpatient and outpatient diagnoses. ICD-9-CM volume 3 defines the code set used to report inpatient procedures.

ICD-10-CM defines the code set used to report inpatient and outpatient diagnoses.

#### 3. WHEN WAS ICD-10-CM CREATED?

The WHO created the base ICD-10<sup>®</sup> in 1994. The clinical modification (CM) was added in the U.S. by the National Center for Health Statistics to create ICD-10-CM for use in inpatient and outpatient diagnosis coding.

#### 4. WHAT CODE SET DOES ICD-10-PCS DEFINE?

ICD-10-PCS (Procedure Coding System) defines the code set used to report inpatient procedures.

#### 5. WHAT CODE SET DOES CPT<sup>®</sup> (CURRENT PROCEDURE TERMINOLOGY) DEFINE?

CPT defines the code set used to report physician services and outpatient procedures.

#### 6. HOW DO THE NUMBERS OF DIAGNOSIS CODES COMPARE FROM ICD-9-CM TO ICD-10-CM?

ICD-9-CM contains approximately 13,000 3-5-character alphanumeric

diagnosis codes. ICD-10-CM contains approximately 68,000 3-7-character alphanumeric diagnosis codes.

#### 7. HOW DO THE NUMBERS OF PROCEDURE CODES COMPARE FROM ICD-9-CM TO ICD-10-PCS?

ICD-9-CM contains approximately 4,000 3-4-character numeric procedure codes. ICD-10-PCS contains approximately 87,000 7-character alphanumeric procedure codes.

#### 8. WHEN DID DEVELOPMENT OF ICD-10-PCS BEGIN?

In 1992, CMS funded a project to produce a preliminary design for a replacement for volume 3 of ICD-9-CM. CMS in 1995 awarded 3M HIS a three-year contract to complete the development of a replacement system, ICD-10-PCS. The final draft of ICD-10-PCS was completed by 3M in 1998, and the current annual update is available on the CMS website: [www.cms.gov](http://www.cms.gov)

#### 9. WHAT IS THE CURRENT STATUS OF ICD-10?

On November 4, 2003, the National Committee on Vital and Health Statistics (NCVHS) voted to make a formal recommendation to the U.S. Secretary of Health and Human Services proposing that ICD-10-CM/ ICD-10-PCS be adopted to replace ICD-9-CM.

#### 10. WHERE CAN I OBTAIN MORE INFORMATION ON THE CODE SETS AND IMPLEMENTATION PROCESS?

3M is providing educational materials at [www.3Mhis.com](http://www.3Mhis.com) about the design and structure of ICD-10-PCS and preparation strategies for a successful transition. Customers and other interested parties can also find more information at the CMS website: [www.cms.gov](http://www.cms.gov)

### 1. WHAT ARE THE FIRST STEPS IN PREPARING FOR ICD-10?

For HIM professionals, the first step is to determine the educational needs of the coding staff, including:

- Expertise in medical terminology
- Detailed knowledge of anatomy
- Better comprehension of operative reports
- Comprehension, interpretation, and application of ICD-10-PCS definitions
- Increased collaboration with medical staff

### 2. WHO IS GOING TO TRAIN ALL THE CODERS?

The AHIMA has taken the lead in the planning to provide training to all coders. An E-alert (Volume 5, Issue 47, December 4, 2003) provides a road map to ICD-10. Many other professional organizations, schools, and vendors plan to provide training as implementation grows closer.

### 3. WHAT IS THE CURRENT USE OF ICD-10?

The WHO has authorized the publication of ICD-10 in 42 different languages. The 2002 information on the global implementation of ICD-10 states that 99 countries are using it for both mortality and morbidity. ICD-10 has been used in the U.S. since 1999 for mortality reporting.

### 4. WHAT ARE THE MAJOR CHANGES IN ICD-10-CM?

Major changes include:

- Alphanumeric codes
- Expanded injury codes, grouped according to site rather than type of injury
- Combination of diagnosis/symptom codes
- Addition of a sixth character with some codes extended out to the seventh character
- Laterality (left and right specified where applicable)
- V and E codes incorporated into the main classification
- Obstetric codes that identify trimester
- Diabetes category that differentiates between Type I and Type II diabetes, diabetes due to underlying condition, and drug or chemical induced diabetes
- The additions of ambulatory and managed care encounter information
- Postoperative complications are expanded and located within the individual chapters

### 5. WHAT IS THE ICD-10-CM STRUCTURE?

The ICD-10-CM structure consists of:

- 21 chapters
- V and E codes are incorporated into the main classification
- Code blocks begin chapters
- Valid codes can be 3, 4, 5, 6, or 7 characters
- The first character is always a letter, and the following two characters are always numbers
- The fourth and fifth characters can be numbers or letters
- In some cases, the fourth, fifth, or sixth characters can be placeholders, represented by an "x"

- There are two excludes:

- Excludes 1 designates a true excludes situation ("Not coded here!")
- Excludes 2 designates the excluded condition is not represented by the code in question, but that the patient may have both conditions at the same time, and both may be coded ("Not included here.")

- Injury codes have been expanded:

- Fifth character defines type of injury
- Sixth character defines laterality
- Seventh character defines encounter

### 6. WHAT IS THE FORMAT OF ICD-10-CM CLASSIFICATION?

The format of the ICD-10-CM classification consists of three parts:

- Tabular List of Diseases and Injuries
- Index to Diseases and Injuries
- Draft Official Guidelines

### 7. WHAT TESTING HAS BEEN DONE ON ICD-10-CM?

The American Hospital Association (AHA) and AHIMA conducted a field study of ICD-10-CM, the results of which were reported to the Standards and Security Subcommittee of the NCVHS. The duration of the study was from June 2003 to August 2003. The study is necessary to support any recommendation on implementation of the systems established to replace ICD-9-CM diagnosis and procedure codes. Information collected in this study will be used toward the proposed rule, which is necessary for the regulatory process to move forward.

### 8. WHAT WERE THE RESULTS OF THE ICD-10-CM STUDY?

The purpose of testing was to assess implementation and training issues associated with ICD-10. This study also looked at the benefits and costs associated with implementation. ICD-10-CM and ICD-10-PCS should be implemented separately. The full report can be viewed at the AHIMA website: [www.ahima.org/icd10/documents/FinalStudy\\_000.pdf](http://www.ahima.org/icd10/documents/FinalStudy_000.pdf)

### 9. WHERE CAN I OBTAIN MORE INFORMATION ON ICD-10-CM?

The NCVHS is a good resource. Their website is:

[www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm](http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm)

### 10. WHAT ARE THE CHARACTERISTICS OF ICD-10-PCS?

ICD-10-PCS has four essential characteristics:

- Completeness—There should be a unique code for all substantially different procedures.
- Expandability—As new procedures are developed, the structure of ICD-10-PCS should allow them to be easily incorporated as unique codes.
- Multi-axial—ICD-10-PCS should consist of independent characters, with each individual component retaining its meaning across broad ranges of codes to the extent possible.
- Standardized Terminology—ICD-10-PCS should include definitions of the terminology used. Each term must be assigned a specific meaning.



## » HIM DEPARTMENT QUESTIONS CONTINUED

### 11. WHAT GUIDELINES WERE FOLLOWED IN DEVELOPING ICD-10-PCS?

ICD-10-PCS followed these guidelines:

- Diagnostic information is not included in procedure description—The diagnosis codes, not the procedure codes, contain the specific information regarding the nature of the disease or disorder.
- Explicit Not Otherwise Specified (NOS) options are not provided—A minimal level of specificity is always required for each component of the procedure.
- Limited use of Not Elsewhere Classified (NEC) option—All possible components of a procedure are specified in ICD-10-PCS.
- Level of specificity—Based on the combinations of the seven alphanumeric characters, all procedures currently performed are defined.

### 12. WHAT IS THE CODE STRUCTURE OF ICD-10-PCS?

ICD-10-PCS has a seven-character alphanumeric code structure. Each character has up to 34 values. They are the ten digits 0-9 and the 24 letters A-H, J-N, and P-Z. The letters O and I are not used to avoid confusion with the digits 0 and 1. The first character of the procedure code specifies the section. Possible sections are as follows:

- 0 – Medical and Surgical
- 1 – Obstetrics
- 2 – Placement
- 3 – Administration
- 4 – Measurement and Monitoring
- 5 – Extracorporeal Assistance and Performance
- 6 – Extracorporeal Therapies
- 7 – Osteopathic
- 8 – Other Procedures
- 9 – Chiropractic
- B – Imaging
- C – Nuclear Medicine
- D – Radiation Oncology
- F – Physical Rehabilitation and Diagnostic Audiology
- G – Mental Health
- H – Substance Abuse Treatment

The second through seventh characters have a consistent meaning within each section, but may have different meanings across sections. In most sections, the third character specifies the type of procedure being performed, while the other characters specify additional information, such as the body part on which the procedure is being performed.

## ICD-10-CM and ICD-10-PCS: Frequently Asked Questions

### EXECUTIVE QUESTIONS

#### 1. WHY SHOULD A HEALTHCARE ORGANIZATION BE CONCERNED WITH ICD-10 TRANSITION NOW WHEN THE IMPLEMENTATION DATE IS NOT YET KNOWN?

Given the potential financial and clinical impact of ICD-10 and the system and information system changes, 3M encourages healthcare organizations to take steps now to understand how to successfully prepare for ICD-10 implementation.

#### 2. WHAT AREAS WITHIN A HEALTHCARE ORGANIZATION WILL THE NEW CODES IMPACT?

The areas that will be impacted by the new codes include, but are not limited to, Health Information Management (HIM), Patient Financial Services (PFS), Information Systems (IS), and Clinical Systems.

#### 3. WHAT ARE THE FIRST STEPS IN PREPARING FOR ICD-10?

For executives, first steps include:

- Creating ICD-10 awareness throughout the organization
- Determining educational needs for each department
- Determining scope and project management for all areas involved
- Developing and approving capital and multi-year budgets

## ICD-10-CM and ICD-10-PCS: Frequently Asked Questions

### IS QUESTIONS

#### 1. WHAT IS THE CODE STRUCTURE OF ICD-10-PCS?

ICD-10-PCS has a 7-character alphanumeric code structure.

#### 2. WHAT ARE THE FIRST STEPS IN PREPARING FOR ICD-10?

- Assess each system that currently holds an ICD-9-CM code. Be sure to inventory databases and decision support systems.
- Evaluate interfaces that lie between code entry in the HIM department and electronic billing of UB-04.
- Determine if the ability to retain both ICD-9-CM codes and ICD-10-CM and ICD-10-PCS is necessary by:
  - Researching data
  - Trending clinical data and comprehensive clinical studies
  - Performing case mix analysis
  - Reviewing financial information connected with reimbursement
- Interact with all vendors to ensure each one is planning to provide a system update for new code sets.



## Customer Profile: Kettering Health Network Dayton, Ohio

**Facility Type:** 50 state-of-the-art facilities and services, including two major medical center hospitals, three other hospitals, and a college of medical arts

**Beds:** 1,260

**Outpatient Diagnostic:** 296,000

**Emergency Visits:** 91,500

**Inpatient Visits:** 47,000

**Ambulatory Surgeries:** 33,200

**Services:** Neuroscience, cardiology, oncology, orthopedics, sports medicine, rehabilitation, wound treatment, maternity, reproductive medicine, senior services, sleep disorders, behavioral health services

### The Challenge

When Kettering Health Network set out to reengineer its outpatient revenue cycle, the organization knew it had to address an increasing rate of denials while finding a way to capture revenue tied up in bill holds or write-offs. At the outset, however, it wasn't clear where to begin.

"We didn't know what we didn't know. It was a journey," recalls Debbie Schrub, Director of Medical Records for the five-hospital health system based in Dayton, Ohio.

Schrub suspected that inefficient coding and billing processes were causing claims errors, while problems with medical necessity review were triggering extensive rework and write-offs. "We were seeing our A/R days increase, and there was an obvious impact on revenue," she recalls. "We knew that the financial health of our organization depended on fixing our outpatient claims process and getting the full reimbursement to which we were entitled."

To help tackle the challenges, Kettering chose the 3M™ Ambulatory Revenue Management Software (3M ARMS) from 3M Health Information Systems.

### The Approach

Kettering's first step was to analyze its existing outpatient claims process. The project team examined each functional step of the revenue cycle, looking for process challenges such as duplication, non-value-added steps, and system bottlenecks. Once problem areas were identified, 3M consultants helped the Kettering project team expedite billing and reduce A/R days by designing a new, streamlined workflow process, using the advanced features of the 3M ARMS software.

With a clearly defined process integrated with 3M's powerful outpatient revenue management software, coders were able to review critical edits and charges, while monitoring corrective actions—all at the point of coding. The 3M ARMS solution surfaces OCE, NCCI, NCD, and LCDs edits for all codes on the claim and allows coders to view both hard-coded chargemaster codes (including corresponding charge department codes), revenue codes, units, and other key data elements together with the soft-coded HCPCS/CPT® codes assigned in the HIM department.

### The Results

While every major process change has a learning curve, results were seen almost immediately. During the initial implementation phase, dollars being held during rework totaled \$2.4 million; six months later, the number was cut in half, to \$1.2 million.

"The dollars we were holding before implementing the 3M software represent a significant amount of revenue," says Susan Knight, Director of Patient Financial Services for Kettering Health Network. "After implementation, referrals fell by 50 percent, and medical necessity write-offs also saw a sharp reduction, falling from a high of over \$80,000 a month to an average of \$10,000 a month after the software was up and running."

Post go-live evaluations produced some startling realizations, including the discovery that some services had been consistently undercharged, while others never made it onto the bill at all. Line-item service date errors were also a common cause of rework. "The volume of charging errors was much greater than we realized," Schrub notes.



Teamwork and ongoing communication are key components of any effort to reengineer the revenue cycle. Mapping revenue codes with CPT® codes and clinical terms created challenges, as did obtaining full engagement in the effort from different departments. “There were hurdles to overcome in terms of departmental perceptions about the program,” says Schrubb. “When the numbers began to change dramatically, perceptions shifted.”

Kettering’s clean claim rate (the percentage of claims that arrive in the business office error free) is now at 90 percent—15 percent higher than the national average for a high-performing facility, and is expected to climb higher. Rework has been reduced substantially, with bill holds averaging fewer than one to three accounts per day. Recovery of reimbursement at risk has risen steadily from a 62 percent recovery rate at the

start of implementation to 88 percent nine months later.

“We knew the dollars were out there,” says Schrubb. “And we haven’t even realized the full potential. We’re still seeing gains,

and we’ll continue to see gains. The 3M software has great potential, not only for us, but for many facilities.”

Visit statistics are based on annual numbers.



For more information on how 3M solutions can assist your organization, contact your 3M sales representative, call us toll-free at **800-367-2447**, or visit us online at [www.3Mhis.com](http://www.3Mhis.com).

## Product Update:

### 3M™ ChartView™ 5.0 Software Enhanced with Microsoft® Smart Client Technology

3M Health Information Systems has announced new enhancements to the ChartView software (formerly developed by SoftMed Systems, Inc.). 3M ChartView Software grants secure, concurrent access to complete and accurate patient data instantly, from anywhere, while increasing productivity.

In response to client feedback, 3M is implementing a range of new features into the ChartView software. The new 3M ChartView 5.0 / 3M™ Electronic Signature Authentication™ (3M ESA) Software version lets you:

- Take advantage of new advanced 3M ESA markup tools that empower your providers to do more than just sign scanned documents, giving them tools such as check marks, arrows, text boxes, and more.
- Enjoy advanced security and improved user set-up.
- Improve provider workflow through the newly merged web and desktop versions with an updated look and even greater integration between 3M ChartView, 3M ESA, and 3M™ VoiceScript™ Software.
- Benefit from enhanced options relating to how both charts and patient information are organized and presented.

For more information on how 3M ChartView 5.0 can assist your organization, contact 3M by calling toll-free, **800-367-2447**.

## Did you know?

Medicare was signed into law in 1965 by President Lyndon Johnson. At the bill-signing ceremony, he enrolled former President Harry Truman as the first Medicare beneficiary and presented him with the first Medicare card.

Medicare is administered by the Centers for Medicare and Medicaid Services, a part of the U.S. Department of Health and Human Services.





## News and Views: Product Updates, Industry Insights, and More

### 3M Expert is Honored

Rich Averill was recently named one of the 100 most powerful people in the healthcare industry.

Averill might be considered one of the most powerful people in health care, but he will tell you he didn't get there on his own.

Every year, *Modern Healthcare* compiles a list of the top 100 people in health care. This year, Averill was named 39th on the list, surrounded by a "Who's Who" of national leaders.

When asked, Averill said he sees this as a tribute to his 3M Health Information Systems team and other 3M colleagues. "It's a collective effort," said Averill, senior vice president, Clinical and Economic Research. "It's a reflection of the impact we've had in the industry."

For those who know Averill, the honor comes as little surprise. "Over the past 25 years, Rich has made tremendous and sustained contributions in the healthcare industry," says Nancy Larson, president, 3M Health Information Systems. "He's an international authority on healthcare reimbursement technologies. The technical innovations developed and championed by Rich and his team have changed the way the world views healthcare financing and the analysis of healthcare data."

#### Redefining How Hospitals Are Paid

Averill's first exposure to health care was at Yale University. After receiving a master's degree in management, he was

named director of the Yale School of Management's health-related research. The seminal research done at Yale redefined how healthcare providers are paid for patient care—and forever changed the industry.

"Healthcare costs were exploding," Averill recalls, "and we were looking for some effective solutions—a more equitable and efficient system. Federal and state governments were very interested in our work."

Averill oversaw the development of the diagnosis-related group (DRG) system. In 1983 that system was adopted by Medicare as the basis for payment for all hospitals. Averill and several colleagues established a company, Health Systems International, to pursue this work. And when that company was acquired by 3M in 1990, Averill joined 3M.

Today, Averill heads up a team of economists, statisticians, healthcare professionals and technology experts. He works closely with 3M lobbyists to present public policy recommendations to government officials.

"It's been very gratifying because we've really been able to make a difference," Averill says. "Health care is more efficient and of a higher quality for the Medicare population because of the work we've done. Experts estimate that, as a result of implementing DRGs, for example, Medicare has been able to save \$17 billion a year."



Rich Averill  
Senior Vice President  
Clinical and Economic Research, 3M

Averill and his team have developed software products and tools that are core to the 3M product portfolio. These products help hospitals manage the data and payment rules associated with healthcare regulations and payment policies in the U.S. and around the world.

3M Health Information Systems continues to be at the forefront of public policy, concentrating on ways to strengthen the link between what hospitals are paid and the quality of services delivered.

"We try to influence good public policy while creating good business opportunities for 3M," Averill concludes. "3M has very high visibility among researchers, regulators, and public policy makers."

This is actually the second time Averill has been named among the top 100 in health care. And with his commitment to the industry, it doesn't take a statistician to figure out that it won't be the last.



### Integrated Software Solutions from 3M Support Medical Necessity Compliance

Software enhancements from 3M Health Information Systems promote medical necessity compliance across the outpatient revenue cycle. 3M™ Medical Necessity Online, used for pre-service medical necessity validation, now integrates with 3M™ Ambulatory Revenue Management Software (ARMS) to provide comprehensive access to all pre-service medical necessity data.

» CONTINUED ON PAGE 9

The combined solution offers greater control over revenue cycle processes by making it possible to review and correct medical necessity during coding and billing. The result is fewer billing errors and reduced payment denials, rework, and write-offs.

3M™ ARMS unites medical necessity data from 3M™ Medical Necessity Online with coded data from the chargemaster, HIM department, UB04 and remittance advice, plus industry-standard and 3M-proprietary edits, into a central data source for analysis and reporting. Using this powerful solution, staff can review and verify critical edits and charges in one consolidated view. Problems can be identified, corrected, and monitored over the long-term.

3M Medical Necessity Online alerts staff in centralized and ancillary department registration and scheduling if proposed patient care does not meet Medicare

medical necessity and commercial payer preauthorization requirements. It helps resolve potential medical necessity failures, alerts staff when payer pre-certification is required, or creates and stores Advanced Beneficiary Notices (ABNs) for Medicare patients. It also provides secure, password-protected, enterprise-wide access via the Internet to authorized users.

“Addressing medical necessity errors after a claim is denied is a time-consuming and expensive process,” says Jerry Kolosky, 3M vice president, Medical Necessity and Compliance Solutions. “Providing access to medical necessity data at key checkpoints of the revenue cycle—from

scheduling and point-of-service, to coding and billing—promotes efficient workflow and accurate, timely reimbursement.”

Medicare, state Medicaid organizations, and commercial payers have established policies to determine whether provider services are medically necessary and eligible for reimbursement. The complex regulations that define Medicare medical necessity include National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Non-compliance with medical necessity regulations and pre-certification policies carry heavy penalties and can cause claims errors which have a significant impact on the revenue cycle.

For more information about the 3M Medical Necessity Online and 3M Ambulatory Revenue Management Software solution, visit [www.3Mhis.com/medicalnecessityonline](http://www.3Mhis.com/medicalnecessityonline) or [www.3Mhis.com/arms](http://www.3Mhis.com/arms) or call 800-367-2447.



## 3M™ Advanced Analyzer Software Helps Hospitals Transition to New Medicare Payment System

3M Health Information Systems has upgraded its 3M Advanced Analyzer Software with new expert content to support coding and reimbursement under Medicare's new severity-adjusted payment system, launched by CMS on October 1, 2007. The enhanced software helps coders and documentation specialists accurately account for patient severity of illness when coding Medicare Severity DRGs (MS-DRGs).

3M Advanced Analyzer helps hospitals address the complexities of coding for severity. “Accurate reimbursement under MS-DRGs depends on careful, in-depth review of the patient record documentation,” says Tom Anastasio, 3M senior vice president, Provider Markets. “With 3M Advanced Analyzer, coders can be confident they are capturing the right information and coding precisely for proper reimbursement.”

3M Advanced Analyzer is an add-on module of the 3M™ Coding and Reimbursement System and efficiently analyzes the coding process, helping coders uncover secondary diagnoses in the physician documentation. The software prompts the coder to investigate

clinical conditions that should be coded with greater specificity—not only for accurate reimbursement, but for better understanding of the clinical complexity of patient mix.

By evaluating codes submitted by the coder—along with patient attributes such as gender and age, risk factors, conditions, and symptoms—the software identifies conditions that can impact the patient's severity of illness (SOI) and risk of mortality (ROM) assignment. The result is more accurate performance reports to support documentation improvement programs and public reporting

of hospital outcomes.

“Research shows that hospitals under-report patient severity of illness and risk of mortality by as much as 25 percent,” Anastasio says. “As more comparative information on hospital performance becomes available to the public, it is critically important for an organization to make sure its performance data is adjusted to account for patient severity and risk of mortality.”

For more information about 3M Advanced Analyzer Software, visit [www.3Mhis.com/advancedanalyzer](http://www.3Mhis.com/advancedanalyzer) or call 800-367-2447.

## Events & Trade Shows

American Academy for Professional Coders (AAPC)	January 9-12 June 8-11	Anaheim, CA Orlando, FL
Military Health Systems (MHS)	January 28-30	Washington, DC
Health Information Management Systems Society (HIMSS) Annual Conference and Exhibition	February 24-28	Orlando, FL
National Association of Psychiatric Health Systems (NAPHS)	April 6-8	Washington, DC
American Healthcare Radiology Administrators (AHRA)	April 15-17	Tampa Bay, FL
Medical Transcription Industry Alliance (MTIA)	April 23-25	Long Beach, CA
National Association of Healthcare Access Management (NAHAM)	May 3-6	Dallas, TX
Healthcare Financial Management Association (HFMA ANI)	June 24-25	Las Vegas, NV
American Hospital Association Health Forum (AHA)	July 24-26	San Diego, CA
3M Health Data Management National User Group Conference	August 4-7	Park City, UT
CHIME	October 7-12	Henderson, NV
American Health Information Management Association (AHIMA) National Convention	October 11-16	Seattle, WA
Medical Group Management Association (MGMA)	October 19-22	San Diego, CA

## Presentations by 3M Clients

### 15th Annual NICM Clinical Case Management Conference & 9th Annual ACMA Meeting

April 28-May 1

#### “Does Your Hospital Report Card Accurately Reflect Your Patient Complexity?”

**Karen Houston, RN, MS**  
Director, Quality & Continuum of Care Service,  
HIPAA Privacy Officer  
Albany Medical Center, Albany, NY

**Mary McLaughlin, BSN, MBA**  
Assistant Director of Case Management  
Albany Medical Center, Albany, NY

#### “An Integrated Approach to Case Management, HIM, and Performance Improvement”

**Sue Thompson, RN, MS, CPUR**  
Director of Outcomes Management  
PinnacleHealth, Harrisburg, PA

NOTE: All dates are for calendar year 2008.



## 3M at HIMSS 2008

### Experience firsthand how 3M Health Information Systems helps organizations solve critical business issues

For healthcare professionals—including IT managers, physicians, nurses, HIT executives, pharmacists, and vendors—the Healthcare Information and Management Systems Society (HIMSS) annual trade show event provides a platform of learning on how to improve healthcare through IT. But it's more than that. It's about connecting with others through learning, sharing, and networking. For proof, look no further than to this year's theme: Innovation with Shared Vision.

Sharing what you know and learning how others have solved similar problems are what make HIMSS an invaluable experience. This year, hot discussion topics will include themes like interoperability, electronic patient information, quality, pay for performance, the retail health phenomenon, and more. Through it all, HIMSS attendees will have the chance to experience firsthand how 3M Health Information Systems helps organizations solve critical business issues.

For more than two decades, 3M has delivered innovative solutions. At HIMSS 2008, we will demonstrate how our proven solutions can help healthcare organizations enable an electronic medical record and improve their performance along the entire care continuum. We'll share how we help organizations like yours deliver quality care and achieve appropriate reimbursement through solutions that create, manage, and store patient documents; coordinate patient care; streamline the revenue cycle; and help facilitate compliance efforts.

This year 3M will also be participating in the Interoperability Showcase. Showcase visitors will view demonstrations of clinician/patient information access and

sharing; Health Information Exchange (HIE) operational infrastructure and deployments in practice; the impact of HIEs on patient involvement and financial transactions; and much more.

Ready to share in the 3M vision for the future of healthcare? Then be sure to join us at HIMSS on Feb. 24-28, 2008, at the Orange County Convention Center

in Orlando, FL. You'll find 3M in Booth #1463, along with our wide array of solutions that connect you with your patient information, your productivity, your revenue cycle, and more. Be on the lookout for more information from 3M at HIMSS. See you in Orlando!

Be sure to join us at HIMSS, this February 24-28, 2008, at the Orange County Convention Center in Orlando, FL. You'll find 3M in Booth #1463.



To find out more about 3M Health Information Systems activities at HIMSS 2008, visit us online at [www.3MatHIMSS.com](http://www.3MatHIMSS.com).



**Health Information Systems**

575 West Murray Boulevard  
Salt Lake City, UT 84123-4611  
U.S.A.  
800.367.2447  
[www.3Mhis.com](http://www.3Mhis.com)

© 3M 2008. All rights reserved. 3M, ChartView, Electronic Signature Authentication, and VoiceScript are trademarks of the 3M Company. The International Statistical Classification of Disease and Related Health Problems – Tenth Revision (ICD-10) is copyrighted by the World Health Organization, Geneva, Switzerland 1992-2008. CPT is a registered trademark of the American Medical Association. Microsoft is a registered trademark of Microsoft, Inc., in the U.S. and other countries.

Please recycle. Printed in U.S.A.  
70-2009-8963-3

