Outpatient. Hierarchical Condition Categories (HCC). Quality. Value-based purchasing. Pediatric. Interdisciplinary, integrated CDI response and analysis. Such topics have been the buzzwords of the industry for many years, and for good reason.

Regulatory shifts associated with the 2010 Patient Protection and Affordable Care Act put reimbursement penalties and benefits in place in exchange for meeting certain quality measures. CMS has further defined these measures within its various payment systems over the past several years—making the capture of documentation related to patient safety indicators, hospital acquired conditions, readmissions, and so forth ever more important.

Similarly, in an attempt to reduce expensive hospital costs CMS put bundled payments and accountable care organization programs into play. It also increased scrutiny of the medical necessity of inpatient admissions—all of which has been pushing a larger volume of patient care to the outpatient setting.

Many believe these previously emerging topics hit a critical mass of interest in 2017, with more CDI programs expressing an interest in, or expanding to, these areas. No doubt this trend will continue to contribute to the CDI discussion in 2018 and beyond.

And yet, just as these regulatory shifts have had a profound effect on CDI focus and expansion, CDI professionals need to annually reassess their program priorities in light of the expected shifts in the healthcare landscape for the coming year.

**Coding terrain**

“CDI [originally] defined its value in the CC/MCC, case–mix index, etc. world because there is a direct financial demonstrated impact,” explains ACDIS Advisory Board member James P. Fee, MD, CCS, CCDS, vice president of Enjoin, based in Collierville, Tennessee. That impact became calcified after the implementation of MS-DRGs and ICD-10-CM/PCS, he says.

Successful programs need to consistently provide evidence of meeting (if not exceeding) CDI expectations in these core competencies, but they also need to keep an eye on how code assignment may shift and the effect of those shifts on MS-DRGs.
and their relative weights. And, in turn, programs must consider what education might be needed for CDI staff, physicians, and coders.

“We have been coding with the ICD-10-CM/PCS code set for more than two years now,” says Laurie Prescott, MSN, RN, CCDS, CDIP, CRC, CDI education director, for HCPro/ACDIS, based in Middleton, Massachusetts. “I think in 2018 the [inpatient prospective payment system (IPPS)] Final Rule is going to bring huge changes.”

Armed with years’ worth of statistics from ICD-10-CM/PCS implementation to the present, CMS can leverage that data to analyze resource consumption and evaluate it against the MS-DRG system, she says.

That could mean dramatic shifts in determining what conditions qualify for a CC/MCC. For example, the National Institutes of Health Stroke Scale may affect the value of a cerebrovascular accident; the depth of a non-pressure chronic ulcer may determine whether the condition qualifies as a CC or MCC; so too might the Gustilo–Anderson scale for open fractures affect CC/MCC assignment, Prescott says.

“The increased specificity we see with the ICD-10 codes will affect which diagnoses will provide more value or severity,” Prescott says.

**Clinical constructs**

Similarly, CDI Education Specialist Allen Frady, RN-BSN, CCDS, CCS, CRC, encourages CDI professionals to stay abreast of changing clinical literature. Principal clinical criteria for a number of high-volume/high-cost conditions get updated roughly every four or five years, he says.

For example, the American Society for Parenteral and Enteral Nutrition (ASPEN) criteria for malnutrition, the Kidney Disease: Improving Global Outcomes (KDIGO) Clinical Practice Guideline, and the Third Universal Definition of Myocardial Infarction were last updated in 2012, he says, with the Surviving Sepsis clinical criteria updated in 2016 (also previously updated in 2012).

“If I had to predict right now, I would say we should be on the lookout for some major updates in the coming years to some of these standardized clinical definitions/criteria which deeply impact the CDI practice,” Frady says.

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The recent sepsis criteria change, for example, led to much confusion over which guidelines to follow as code assignment rules failed to mirror clinical changes, and the elemental approaches “to improve health—administrative and clinical—are not always in sync, [which has] led to unintended consequences,” according to an ACDIS White Paper “Where are we now with sepsis?” written by Advisory Board member Sam Antonios, MD, FACP, SFHM, CPE, CCDS.

For CDI specialists, changes principally led to the need for increased communication and collaboration with internal stakeholders such as specialty physicians, coders, quality, and even ED staff to determine facility-based policies defining the medical staff’s preferred uniform definitions for sepsis and its related conditions. It also meant CDI staff needed to amend queries to reflect those changes and be ready to defend the facility’s efforts in the face of audits or claim denials.

Furthermore, changes in clinical criteria often require in-depth research and collaboration from a variety of specialty-specific societies and international associations, as was the case with malnutrition criteria published in a consensus statement of the American Academy of Nutrition and Dietetics and ASPEN. As another example, a specific set of criteria for sepsis garnered the support of dozens of medical authorities including the American Association of Critical Care Nurses and the American Thoracic Society.

CDI teams need to keep up with medical literature and stay connected with their specialty-related physicians and physician champions, as well as publications related to coding and documentation such as AHA’s Coding Clinic for ICD-10-CM/PCS, Journal of AHIMA, and the CDI Journal, as these frequently include advice on how to handle any conflicting coding/clinical conundrums.
Typically, as CDI professionals well know, the recommendation is often to query for clarification.

**Regulatory movement**

With the White House administration aimed at governmental deregulation, including within the healthcare sector, CDI programs may want to consider pivoting back to core, financially focused incentives. After all, the 2018 IPPS Final Rule included relatively few changes to value-based purchasing or other quality-related measures. Perhaps future changes could be few as well.

“We are in a world of transition where organizations have to look to the future but pay for today,” Fee says, suggesting that CMS will “learn more from the successful pay-for-performance business models of payers such as [BlueCross BlueShield], United, Humana, etc., and continue to modify programs to yield better patient outcomes as well as financial incentives for providers.”

This will continue to push CDI programs into the outpatient/physician practice setting, but “like everything in healthcare, limitations are set because of resources,” Fee says.

So, while CDI efforts will need to “focus on providers in the near future,” program managers will also need to do a better job of understanding the “value” of that effort “in this space and translate that to [hospital] leadership,” he says.

Too many in the field are “speaking in buzzwords but do not truly understand the intricacies of alternative payment models or the direct impact on finance and quality that CDI plays. Those who run these programs can see the holes and lack of understanding in those who are trying to apply old CDI concepts,” says Fee.

Further, Fee says, “organizations will not deploy resources for CDI in these spaces until the value proposition can be clearly identified and aligned with the organization’s risk models.”

But, Fee says, there is good news for those ready to do the research.

“You will see innovative leaders step out in front of the rest in the CDI profession. And you will see the inpatient CDI playground change drastically with unified technology across the continuum,” notes Fee.

“I think this is a great learning time for CDI professions, trailblazing the future of CDI dynamically as healthcare is revolutionized,” he says. “We will define the future of CDI and not let others define it for us. Unifying technology with people and process allow for efficiency, consistency, and growth. CDI is fundamental to a provider’s measurable success. It’s my prediction that we will see interesting things in 2018.” 🌟

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**CC/MCCS for CDI: Clinical Indicators & Query Opportunities**

Join William Haik, MD, FCCP, CDIP

01.25.18 / 1-2:30 P.M.