Haven’t we (the CDI profession and those who perform the job) proven that the CDI role requires a wholly unique set of skills? While there is overlap with coding and nursing, the CDI profession is not defined by the backgrounds of those who perform the work, but by the expertise those backgrounds bring to the skill set required by the role.

I concur with my colleagues and sincerely hope that we will continue to work together in a collaborative manner and will not find ourselves at the crest of a job/responsibility/role shift of grand proportions.

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PHYSICIAN ADVISOR’S CORNER

Your CMI: What is (and isn’t) in your control

by Trey La Charité, MD, FACP, CCDS

Your CDI program successfully obtained consistent results over the last few years, and all is right within the CDI world. Then, the facility case-mix index (CMI) unexpectedly drops. Provided it rebounds, one or two months below its usual average is probably not cause for a great deal of concern. But what happens when the CMI shows an overall downward trend for six months, or a year, or two years?

To be blunt, making an initial positive impact with your new CDI program is the easy part. Maintaining that momentum over the long haul, year after year, is a more difficult task. After reviewing the CMI trends seen at my facility and investigating the causes of those trends, I have some insight to share if your facility, too, is experiencing this problem.

Getting a handle on CMI fluctuations can be difficult. First, note that your facility’s CMI is not solely attributable to you, as the CDI physician advisor, nor is it solely attributable to your CDI program. Too many factors that directly affect your results are beyond your influence. You have no control over the patients that walk into your hospital on a daily or monthly basis, for example. Sometimes, this week’s patients simply aren’t as sick as last week’s (or last month’s) patients were. Sometimes, the physicians in your most profitable service line go on vacation.

Despite these facts, administrators generally attribute the facility’s CMI results solely to you and your CDI program. So when hospital management comes looking for answers, you need a comprehensive understanding of the variables at play.

For simplicity’s sake, I will lump the considerations affecting your facility’s CMI into two buckets—those that are extrinsic to your CDI program, and those that are intrinsic. To adequately address both categories, I will examine the extrinsic factors in this article, and I will review the intrinsic factors in a future article.

Examining extrinsic factors is a complicated and time-consuming process. Since big data is a component of this investigation, you need input from various sources outside your program. Undoubtedly, your revenue cycle staff, including your chief financial officer, will share their insight. Quality control, development, and operations also have a keen grasp on the healthcare market forces at play, and can be a valuable resource. Sadly, investing the time and effort to discover and decipher the extrinsic factors that affect your program often reveals those elements as, like many other factors, beyond your department’s ability to influence.
Hospital status

Hospital status determination is the beginning point of the extrinsic review. If you interact with your facility’s case management, utilization review, or compliance departments, you’ve likely experienced the pressure of this seemingly simple designation—the implications of not getting it correct are staggering.

Too many observation cases lead to unhappy patients and lower hospital reimbursement. Too many inpatient stays lead to increased auditing and regulatory inspections. Your facility may have initiated intensive efforts to get this admittedly arbitrary determination as accurate as possible.

One result of strict scrutiny is a higher percentage of observation cases being converted to inpatient hospitalizations. Since observation cases are billed under Part B services, they normally have no impact on the CMI. However, once observation cases are converted to inpatient stays, they fall within Part A billing.

This results in lower-weighted MS-DRG submissions, since those observation patients are probably not “as sick” as your usual inpatient population (after all, they weren’t sick enough to immediately warrant admission). Therefore, while the number of inpatient stays increases, the overall CMI drops.

While a decrease in CMI is generally perceived as a negative, in this instance, it is actually a positive because lower-weighted MS-DRGs reimburse more appropriately than observation stays. Additionally, Medicare beneficiaries do not lose their three-day skilled nursing facility benefits and have no hospital copays or medication expenses as they would if kept under observation status. My facility and CDI department have experienced this challenge and “setback” firsthand.

Patient population

The third extrinsic factor that affects the CMI is the makeup of your patient population. If you haven’t heard, the United States is aging. Every day, 10,000 people in our country turn 65. And because the human condition naturally deteriorates with time, more hospitalizations naturally occur with this older patient population.

More hospitalizations are generally considered a good thing for your medical institution, right? However, the more important question is what kind of admissions these hospitalizations will be.

To be sure, an older patient population will result in an increased percentage of medical MS-DRG admissions as opposed to surgical admissions. This is another situation my facility has encountered firsthand. And it will continue to be an issue for my hospital, since East Tennessee is one of the retirement capitals for the United States.

Located out of state for their specialty care needs. Second, since surgical MS-DRGs are the main financial drivers of any acute care facility, the more surgeries we perform, the more resources we generate to further our patient care goals.

However, these surgical sub-specialists do not operate on urgent or emergent patients; they only take medically optimized surgical candidates to the operating room. Therefore, the patients who go to the operating room at my facility now have a lower percentage of acute or decompensated problems (i.e., MCCs) as opposed to chronic or medically optimized problems (i.e., CCs).

This causes a lower surgical CMI, which drives down the facility’s overall CMI. While more patients having more procedures performed at your facility is positive, it may have the unwanted side effect of reducing the apparent effectiveness of your CDI program.
The area’s moderate climate and absence of state income tax will continue to result in an increased percentage of medical admissions, further decreasing our overall CMI.

**Healthcare reform**

The last extrinsic factor to understand is the current reform-driven effort to keep patients out of the hospital. Falling under the moniker of “population health,” everyone has determined that it is cheaper to treat patients in the lower-cost outpatient arena than through an expensive inpatient hospitalization.

Therefore, there has been a tremendous effort to keep all but the sickest medical admissions out of the hospital, including “unnecessary readmissions.”

While this seemingly is positive since lower-weighted medical MS-DRGs dilute the CMI, please do not ignore the concurrent transition of many surgical cases from the inpatient operating room to the outpatient day-surgery center.

While the total number of surgical procedures performed at my hospital grows significantly every year, the inpatient surgical volume makes up an increasingly smaller percentage of the total number of surgical cases. The outpatient surgical volume, meanwhile, is growing at a greater pace.

Again, at my facility, overall patient volume has increased due to the numerous demographic factors previously mentioned. However, inpatient surgical MS-DRG submissions have decreased in comparison to the number of inpatient medical MS-DRG submissions.

Obviously, there are substantial outside forces which shape your CMI, and this is certainly not an exhaustive list of those forces. Other potential considerations that I did not address include commercial carriers’ contracting strategies and changes in your local market competition.

Furthermore, the things that affect my facility may not be the same as those that matter to yours. And, as mentioned earlier, there are intrinsic factors that affect the CMI as well (which I will address in my next article).

The bottom line is that, while you may not be able to alter the outside influences from within your CDI program, you must be able to understand and explain those influences to your hospital administrators when they start asking just how effective your program is.

**Editor’s note:** La Charité is a hospitalist with the University of Tennessee Medical Center (UTMC) at Knoxville. He is board-certified in internal medicine and has been a practicing hospitalist since 2002. He is also a clinical assistant professor with the department of internal medicine, serves as the medical director for UTMC’s clinical documentation integrity program and coding, and is a past ACDIS Advisory Board member. His comments and opinions do not necessarily reflect those of UTMC or ACDIS. Contact him at Clachari@UTMCK.EDU.