

INSIDE THE MAC MINDSET

What CEOs and CFOs must know about Medicare's escalating documentation expectations before the Trust Fund crisis hits in 2033

Hospital Association Annual Conference

Executive Session

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EXECUTIVE PREMISE

Documentation has become a balance-sheet control

The medical record now determines whether earned revenue survives review.

Revenue at risk

Unsupported medical necessity, weak severity narratives and inconsistent diagnoses invite denials, downgrades and recoupments.

Cost to defend

Appeals consume physician, CDI, coding, utilization review and legal capacity after care has already been delivered.

Enterprise exposure

Documentation affects payment, compliance, quality reporting and the credibility of organizational data.

Executive mandate: govern documentation with the same discipline applied to cash, compliance and clinical quality.

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MEDICARE OUTLOOK

The Part A financing clock now points to 2033

2033 Q2

PROJECTED HI RESERVE
DEPLETION

89%

OF SCHEDULED BENEFITS
PAYABLE THEN

69.3M

MEDICARE ENROLLEES AT END OF
2025



Projection, not inevitability. Congress can change financing or payment policy.

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HOW REVIEW WORKS

The MAC mindset starts with payment integrity

1 Target

Use claims data, billing patterns and program priorities to select risk.

2 Request

Obtain the record or apply prepayment edits and documentation requirements.

3 Test

Compare the service and payment to coverage, coding and medical necessity rules.

4 Act

Pay, deny, downcode, educate, recoup or escalate based on findings.

A diagnosis on a claim is an assertion. The record must supply the contemporaneous evidence and physician reasoning behind it.

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ESCALATION PATHWAY

Small documentation defects can compound into large exposure

Ambiguous clinical story

Claim selected for review

Denial or DRG downgrade

Appeal cost and delayed cash

Pattern recognition and broader scrutiny

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DOCUMENTATION STANDARD

A defensible record answers five reviewer questions

- 01 What condition is being treated?
- 02 What clinical facts support it?
- 03 How severe is it today?
- 04 Why does the patient need this level of care?
- 05 What treatment, monitoring and response prove the plan?

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CDI 1.0 VERSUS DOCUMENTATION EXCELLENCE

Diagnosis capture alone leaves the claim exposed

RETROSPECTIVE CAPTURE

Query issued after the clinical story has passed

Single diagnosis added without supporting rationale

Success measured by query response and CC/MCC capture

Appeal team inherits the documentation gap

PROACTIVE DEFENSIBILITY

Physician explains the diagnosis during care

Evidence, severity and causal links appear in the note

Success measured by denial avoidance and sustained behavior

Final claim reflects a coherent record

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AI AND PATTERN DETECTION

Analytics increase the speed and scale of scrutiny

Outlier patterns

Provider, diagnosis and service patterns can concentrate review.

Documentation variance

Contradictions and cloned text weaken credibility.

**CLAIM +
CLINICAL
RECORD**

Coding signals

Unexpected DRG or diagnosis combinations raise questions.

Utilization signals

Level of care and length of stay require a clear rationale.

Executive inference: scalable review makes weak documentation easier to find and more expensive to defend.

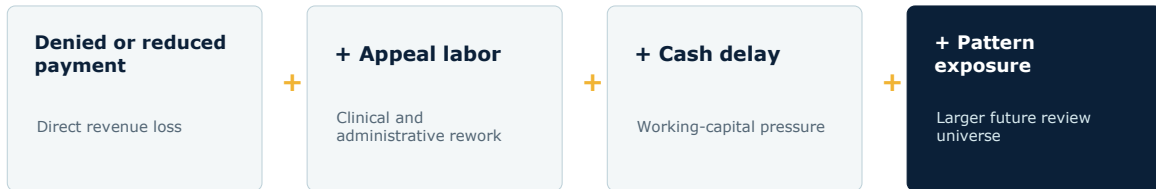
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ENTERPRISE FINANCIAL IMPACT

The denial cost exceeds the amount on the remittance



True exposure per denial = payment + rework + delay + recurrence

Build the CFO dashboard around net dollars protected, not gross theoretical uplift.

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WHERE TO LOOK FIRST

Executives need a documentation risk heat map

	Clinical severity	Medical necessity	Record consistency	Financial concentration
High-volume DRGs	PRIORITY	PRIORITY	ELEVATED	PRIORITY
High-risk diagnoses	PRIORITY	ELEVATED	PRIORITY	PRIORITY
Short stays	ELEVATED	PRIORITY	ELEVATED	ELEVATED
Outlier physicians	ELEVATED	ELEVATED	PRIORITY	ELEVATED

Illustrative framework. Populate with your organization's denial, audit and physician-level data.

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OPERATING MODEL

Documentation governance needs clinical ownership

Physician leaders

Set clinical expectations and coach peers

**CMO + CFO
JOINT
ACCOUNTABILITY**

Physician advisor + UR

Connect level of care to clinical necessity

CDI + coding

Identify gaps and test record consistency

Revenue integrity + compliance

Measure exposure and verify controls

Shared scorecard • common definitions • routine case review

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EXECUTIVE SCORECARD

Five questions reveal whether CDI protects margin

1 Do notes support medical necessity throughout the stay?

YES / NO

2 Do high-risk diagnoses carry clinical evidence and physician reasoning?

YES / NO

3 Are inconsistent and copied-forward statements corrected before billing?

YES / NO

4 Does the dashboard report upheld denials, net recovery and recurrence?

YES / NO

5 Can leaders show durable physician behavior change by service line?

YES / NO

Three or more "No" answers indicate an enterprise control gap worthy of executive review.

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EXECUTIVE ACTION PLAN

A 90-day reset can expose risk and start behavior change

DAYS 1–30

Establish the baseline

Quantify denial exposure. Sample high-risk records. Map ownership and current metrics.

DAYS 31–60

Set the clinical standard

Define note expectations. Select priority diagnoses and service lines. Align query and escalation policy.

DAYS 61–90

Deploy and govern

Coach physicians in workflow. Review cases weekly. Report net financial and compliance outcomes.

Day 90 output: named owners, measured baseline, priority interventions and a board-ready scorecard.

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METRICS THAT MATTER

The board dashboard should measure revenue durability

DENIAL RATE

By reason and payer

UPHELD LOSS

After all appeals

TIME TO CASH

Days from service to resolution

REPEAT RATE

Same defect, service line or physician

NOTE QUALITY

Evidence-based audit sample

BEHAVIOR CHANGE

Sustained without repeat queries

Retire vanity metrics that cannot show whether earned revenue survives payer review.

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THE EXECUTIVE DECISION

Will your record defend the claim before the reviewer arrives?

Documentation excellence protects earned revenue because it makes medical necessity, severity and physician judgment visible in real time.

Make documentation a clinical control

CEO / CFO / CMO ACTION

Sponsor the 90-day baseline and governance reset.

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HIGHER WEIGHTED DRG PROGRAM

Higher-weighted DRGs require clinical and coding alignment

01 • IPPS

MS-DRG Payment System



02 • DRG WEIGHT

Higher-weighted DRG



03 • PAYMENT TIMING

60 days after initial payment

Higher-weighted DRG payment

PROGRAM CONTROL POINTS

Medical necessity

Quality care

Coding

Medical necessity, quality care and coding support the payment pathway.

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HOSPITAL-WIDE DIAGNOSIS RELATED GROUP REVIEW

Review scope spans the full payment landscape

FOCUSES ON

EVERY

payment-driving
area

01 **MS-DRG**

02 **SERVICE LINE**

03 **DIAGNOSIS AFFECTING PAYMENT**

Every MS-DRG • every service line • every diagnosis affecting payment

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HOSPITAL-WIDE DRG REVIEW

A complete review tests every payment-defining element

REVIEWS INCLUDE

01 **Principal diagnosis**

02 **Secondary diagnoses**

03 **MCCs**

04 **CCs**

05 **Procedures**

06 **Medical necessity**

07 **Physician documentation**

Diagnosis selection, severity, procedures and clinical support are reviewed together.

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DEFINITION

A manufactured diagnosis prioritizes reimbursement over clinical judgment

MANUFACTURED DIAGNOSIS

A diagnosis added primarily to increase reimbursement rather than accurately represent physician clinical judgment supported by documentation.

FREQUENT ORIGINS

- 01 Retrospective chart mining
- 02 AI-generated diagnosis suggestions
- 03 Unsupported coding assumptions
- 04 Diagnosis reconstruction
- 05 Excessive querying

The record should reflect supported clinical judgment—not a reconstructed path to payment.

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HOW MANUFACTURED DIAGNOSES DEVELOP

A retrospective workflow can turn suggestions into higher reimbursement

COMMON WORKFLOW • STEPS 01–04

- 01 Patient discharged
- 02 AI scans chart
- 03 Software identifies missing CC/MCC
- 04 Diagnosis recommended

COMMON WORKFLOW • STEPS 05–08

- 05 Retrospective query generated
- 06 Diagnosis added
- 07 DRG changes
- 08 Higher reimbursement

QUESTION

Was this physician clinical judgment—or documentation reconstruction?

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POSSIBLE EXAMPLES

The diagnosis alone does not determine whether it is supported

01 Acute respiratory failure

02 Severe protein-calorie malnutrition

03 Acute kidney injury

04 Acute blood loss anemia

05 Encephalopathy

06 Sepsis

ALL MAY BE COMPLETELY LEGITIMATE

OR

MAY BE UNSUPPORTED

depending upon physician documentation

Clinical validity depends on the physician's documented judgment and supporting record.

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WHY MANUFACTURED DIAGNOSES MATTER

Unsupported diagnoses can trigger payment, enforcement and audit exposure

POTENTIAL CONSEQUENCES

PAYMENT

01 Improper Medicare payments

02 RAC recoupments

03 MAC denials

ENFORCEMENT

01 False Claims Act exposure

02 OIG scrutiny

AUDIT + INVESTIGATION

01 UPIC investigations

02 HWDRG audit selection

A diagnosis that cannot withstand review can convert revenue into enterprise risk.

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CMS POSITION

Payment follows the physician-documented clinical condition

CMS PAYS HOSPITALS BASED UPON

Physician documentation of the patient's clinical condition

NOT

- 01 Software inference
- 02 Coding assumptions
- 03 Retrospective diagnosis reconstruction

DOCUMENTATION MUST ACCURATELY DESCRIBE

Severity

Complexity

Medical decision making

Accurate payment starts with accurate physician documentation—not reconstructed inference.

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QUERIES ARE APPROPRIATE WHEN...

Query the record to resolve uncertainty—not to manufacture severity

THE MEDICAL RECORD IS

- 01 **Conflicting**
- 02 **Incomplete**
- 03 **Ambiguous**
- 04 **Inconsistent**

NOT APPROPRIATE SIMPLY BECAUSE

"An MCC is missing."

Payment impact alone is not a documentation gap.

A compliant query clarifies the record; it does not begin with a desired DRG outcome.

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WARNING SIGNS OF MANUFACTURED DIAGNOSES

Repeated patterns can reveal diagnosis reconstruction

WATCH FOR

REPEATED PATTERNS

across cases, clinicians
and service lines

- 01 **Identical diagnosis recommendations**
- 02 **Software-generated CC/MCC lists**
- 03 **Diagnosis added after discharge**
- 04 **Diagnosis not discussed during hospitalization**
- 05 **No treatment changes**
- 06 **No physician assessment**

A repeated payment-focused pattern warrants review of clinical support and physician judgment.

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MEDICARE IMPROPER PAYMENT RISK

Payment-changing diagnoses receive the greatest scrutiny

IMPROPER PAYMENTS MAY RESULT FROM

- 01 **Insufficient documentation**
- 02 **Unsupported diagnoses**
- 03 **Incorrect DRG assignment**
- 04 **Lack of medical necessity**
- 05 **Coding errors**

GREATEST SCRUTINY



The diagnosis changing payment

must be supported by clear physician
documentation and clinical evidence.

The closer a diagnosis is to the payment outcome, the stronger its support must be.

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Minimal, post-discharge queries weaken DRG defensibility

ONE-AND-DONE CDI QUERIES

Rapid-fire, minimal-content queries

can be seen as leading—or designed to manufacture a diagnosis.

WHY THIS MATTERS

01 Medicare contractors have stated these queries are noncompliant.

02 Hospitals cannot rely on them to justify a higher-weighted DRG.

RETROSPECTIVE QUERIES

Post-discharge? Don't go there.

A defensible query clarifies care in context—it does not reconstruct a diagnosis after discharge.

A diagnosis first appearing in a query signals creation—not clarification

MAJOR AUDIT RED FLAG

! The diagnosis appears nowhere in the record—until the query.

Contractors interpret this as “diagnosis creation,” not documentation clarification.

A DEFENSIBLE QUERY STARTS WITH

01 Clinical facts

02 Clinical information

03 Clinical context

Support must exist in the medical record before the query is issued.

Under the program, these cases are ineligible for higher-weighted DRG rebilling.

MEDICARE CONTRACTOR PERSPECTIVE

Contractors expect diagnoses to reflect real-time clinical judgment

CONTRACTORS NOW EXPLICITLY EMPHASIZE

- 01 **Authenticity of documentation**
- 02 **Timing of physician notes**
- 03 **Clinical justification for diagnoses**

THE RECORD SHOULD SHOW

Consideration from the beginning

- ✓ **Clinical judgment**
- ✓ **Medical decision-making**

—not a rationale added after the outcome is known.

Documentation timing and clinical context are part of the evidence—not administrative details.

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MEDICARE CONTRACTOR PERSPECTIVE

Queries must communicate clinical truth—not optimize reimbursement

CONTRACTORS REJECT QUERIES THAT

- 01 **Introduce new diagnoses**
- 02 **"Patch" insufficient documentation**
- 03 **Optimize the DRG rather than accurately represent the case**

THE OPERATING TEST

COMMUNICATION TOOL

Clarifies the documented clinical picture.

REIMBURSEMENT TOOL

Attempts to change the payment outcome.

Contractors distinguish the first from the second.

Expect increased post-payment review, TPE audits, and crosswalk reviews comparing the original claim with the rebilled claim.

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KEY TAKEAWAYS

Documentation integrity protects hospitals

Documentation drives coding.

- ✓ Clinical judgment belongs to physicians
- ✓ Coding follows documentation
- ✓ Queries clarify—not create—diagnoses
- ✓ Manufactured diagnoses create compliance risk
- ✓ Documentation integrity protects hospitals

CEO / CFO / CMO ACTION

Keep clinical judgment, documentation and coding aligned.

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FINAL THOUGHT

“The objective of documentation improvement is not to maximize reimbursement.

It is to ensure the medical record accurately reflects the patient’s true clinical condition.”

Accuracy is the objective. Integrity is the method.

THE INTEGRITY CHAIN

Documentation Integrity



Coding Integrity



Payment Integrity



Compliance

Each link protects the next.

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CONTACT INFORMATION

Continue the conversation

Documentation integrity starts with accountable clinical leadership.

Glenn Krauss

BBA, RHIA, CCS, CCS-P, CPUR, CCDS, C-CDI, C-DAM, C-PA

glenn.krauss@core-cdi

Ednann Naz

MD, MBA, MPH

enazzmd@gmail.com

Thank you

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