Case Study L– Breakout

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

Case Study M– Breakout

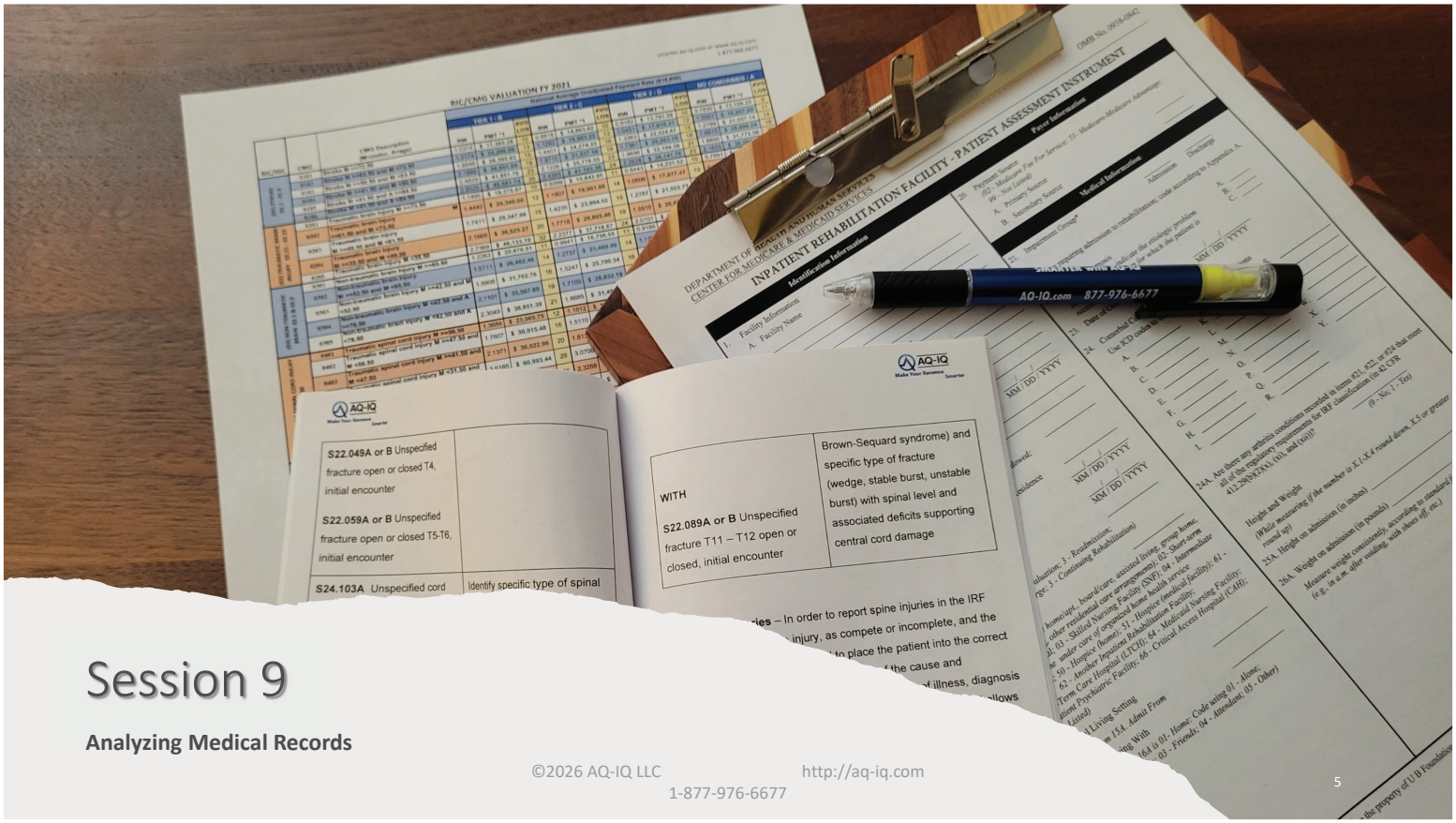
IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

Case Study N– Breakout

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

Case Study O– Breakout

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:



Session 9

Analyzing Medical Records

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Case Study P– Breakout

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

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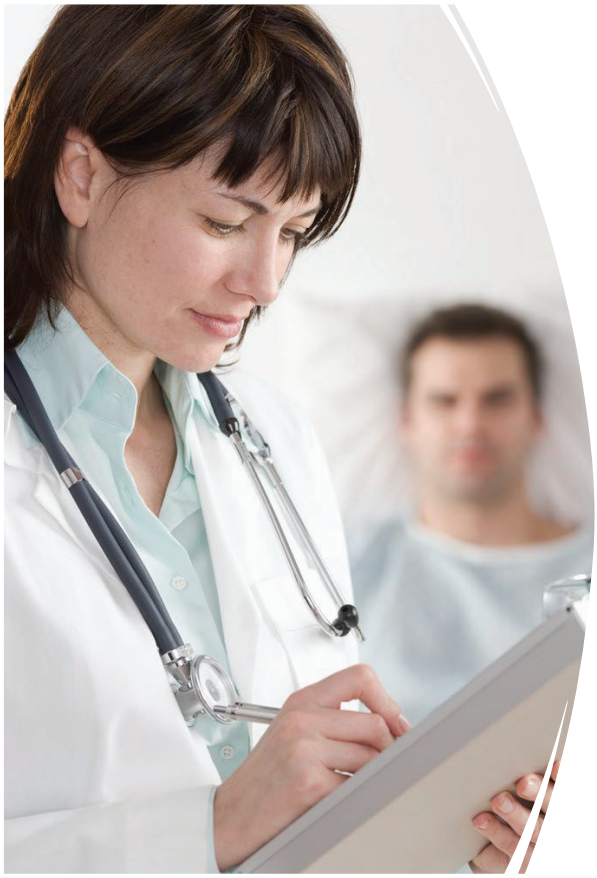
Case Study Q– Breakout

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:



IRF Record Analysis & Documentation Improvement



CDI Clarifies……

- Diagnosis Specificity
- Description of Conditions
- Association of Conditions/Treatments
- Validation of Diagnoses
- Clarifies conflicts
- Technical Components
- Medical Reasonableness and Necessity

Def: Query

"A query is a communication tool or process used to clarify documentation in the health record to ensure documentation integrity and the accuracy of diagnosis, procedure, or service code assignment for an individual encounter in any healthcare setting." *2026 ACDIS/AHIMA Practice Brief*



How to Seek… and Find

1

Back to the Basics

- IGC rules
- Understand diagnosis definitions & anatomy
- ICD-10 Guidelines

2

Understand clinical indicators

- Use resources/CDI/ Physician and Nursing Staff

3

Query the unknown or unclear!

Who Can Query?

- Coders
- CDS/CDI
- CMG/PPS Coordinators
- Case Managers/UR Staff
- Others





Can You Just Tell Me What to Say?

Coders rules:

- **No clinical decisions;**
- **No leading to an answer;**
- **No guessing conditions based on symptoms or treatment/medications;**
- **Must use only PHYSICIAN documentation and physician validated diagnoses.**
  - Labs, x-rays, therapy, nursing not utilized.

We Are Detail Junkies!

Coders vs Clinical Staff

- Is there a difference?
- Can Clinical Staff LEAD the physician?



CMS Guidance

Queries should not be leading or introduce new information

Should be:

- Clearly /concisely written
- Contain precise language
- Present the facts
- Identify why clarification needed
- Present the scenario

CMS Guidance

The query form:

- Should be phrased so the physician is allowed to specify the correct diagnosis;
- Should not indicate a financial effect of the response;
- Should not be designed so that the only thing required is a signature.

ICD-10-CM Official Guidelines

- *"Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes"*
- *"If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.."*
- *"If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider."*
- *"If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification."*
- *"Coders are encouraged to query the providers when the documentation is unclear."*

Coding Clinic

*"Any **clinical information published in Coding Clinic**, is provided as background material to aid the coder's understanding of disease processes. The information is intended to provide the coder with 'clues' to identify possible gaps in documentation where additional physician query may be necessary. **It is not intended to replace the need for specific physician documentation to substantiate code assignment**."*

AHIMA

"Query provider (physician or other qualified healthcare practitioner) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g., present on admission indicator)."



To Query or Not to Query?

Conditions that affect:

- Clinical Evaluation
- Care/Treatment/Procedures
- Extends the Length of Stay
- Increases Nursing Care Monitoring
- Severity of Illness
- Medical Reasonableness and Necessity

Types of Questions

- Open Ended
- Closed Ended
- Leading



How to Ask an Effective Question?

- Start Simple
- Define exactly what it is you want to know.
- Never ask in an aggressive manner
- Ask politely and second guess carefully
- Be gracious



How to Ask an Effective Question?

- Personalize
- List the clinical findings
- Indicate tests ordered, medications given, treatment give quotes
- Findings from other physician
- Be Specific
- Own It!





Is There a Wrong Way?

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Good Queries or Bad?

The patient had anemia, was it acute blood loss anemia?

The patient was on Lasix. Were you treating him for CHF?

Good or Bad Queries?

The H&P indicates the patient had swallowing issues, orders reflected speech evaluation and swallowing exercises. Patient was on modified liquid diet. Please clarify the swallowing issue treated.

Please document the indication for the (named) antibiotic given?

Good or Bad and Why?

If the patient's diagnosis is sepsis, please document sepsis 2nd to UTI, this increases revenue by $2500.

In the H&P you state the patient had swallowing difficulties and also pneumonia. Was the pneumonia due to aspiration or an organism?

Compliance and Effectiveness

- Compliance plan rules

Queries should not:

- Inappropriately increase reimbursement
- Misrepresent quality of care
- Be without clinical info to support the query
- Include coder lingo

Tips & Cues for an Effective Query

- Don't OVER Query
- Have a defined process

Flattery gets you Everywhere, Build that relationship!

- Set-up
- Question
- Review





Documentation Must!

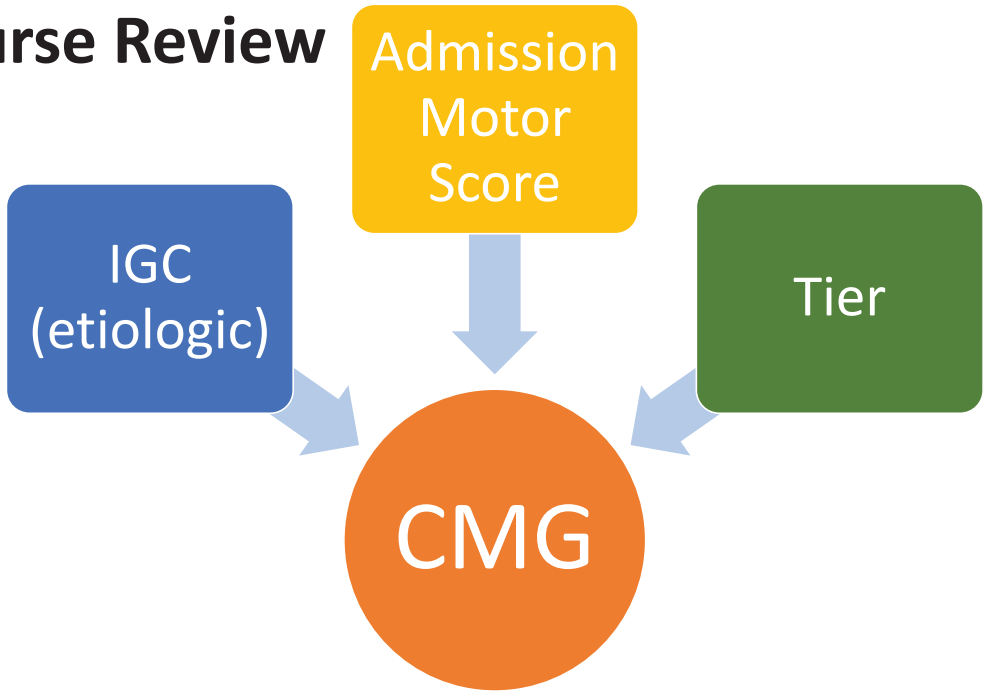
- **Clearly state the "condition causing the impairment" on admission & consistently throughout.**
- **Document all comorbidities at admission.**
- **Document complications AS THEY OCCUR!**
- **Conditions recognized the last two days are not reported.**
- **Unconfirmed Diagnoses not reported (possible, probable, likely, suspected).**



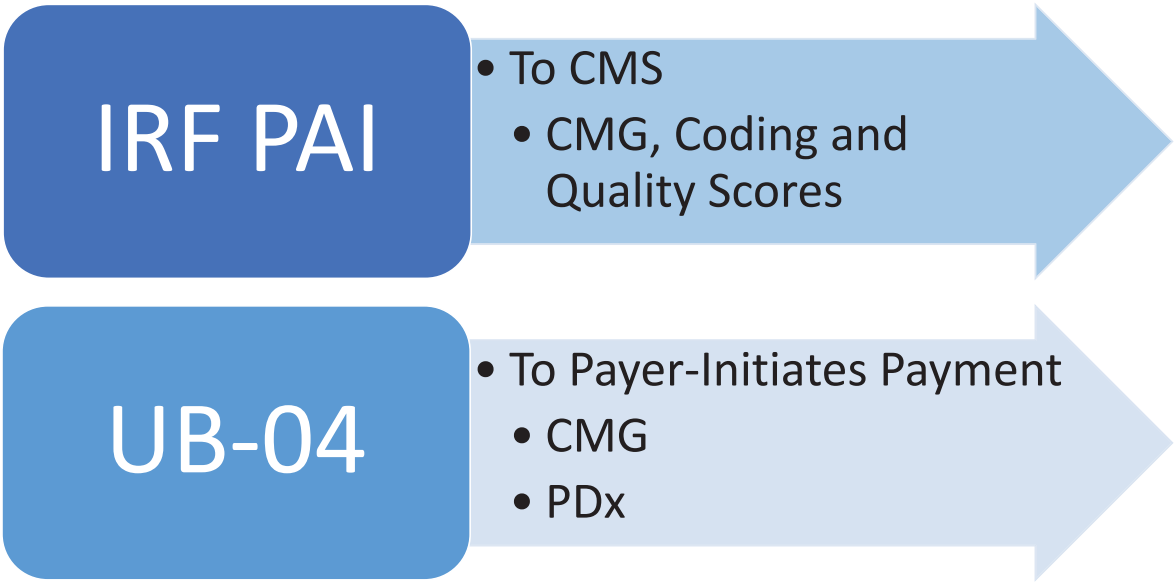
2026 ACDIS/ AHIMA Practice Brief

*" **Core requirements** of a compliant query practice: It is nonleading, includes clinically relevant and sourced indicators, does not reference reimbursement or quality outcomes, and gives the provider an opportunity to exercise independent clinical judgment. ."*

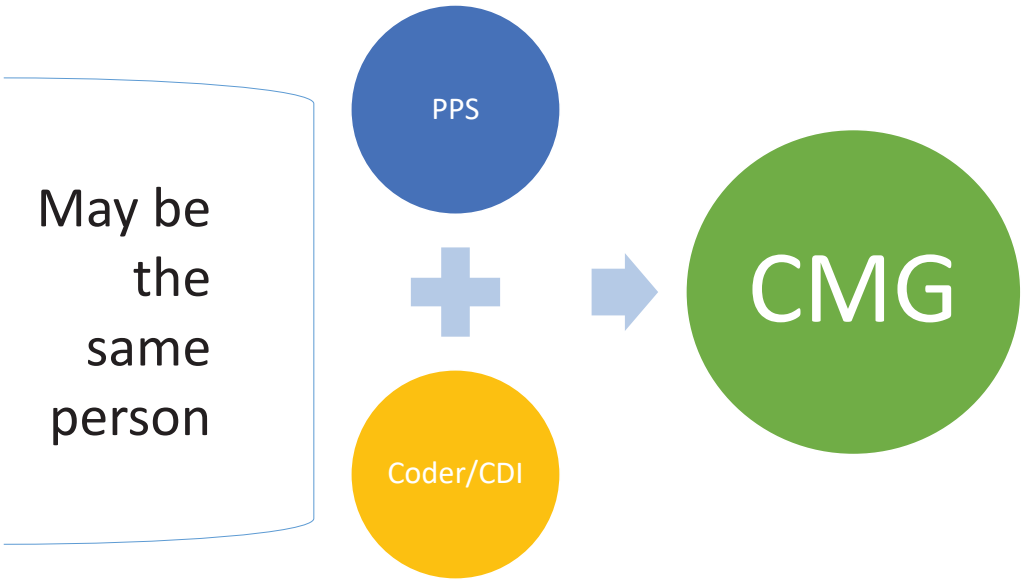
Quick Course Review



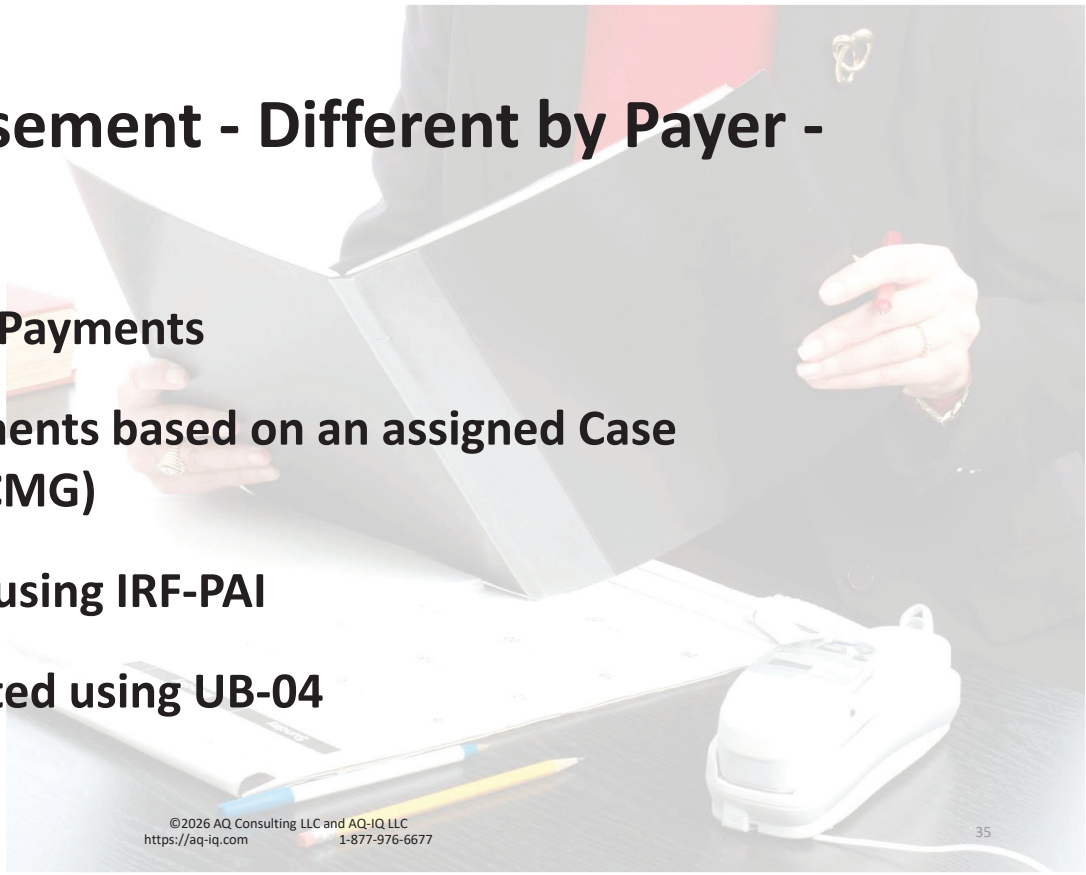
Quick Course Review



Quick Course Review



IRF Reimbursement - Different by Payer - Review



Non-Medicare Payments

Medicare Payments based on an assigned Case Mix Group (CMG)

CMG assigned using IRF-PAI

Payment initiated using UB-04

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Quick Review – IRF (CMS)

- **Paid on CMG** (non-Medicare = contract rate)
- **IRF-PAI determines CMG** – submitted to CMS
  - Admission IGC + Admission Motor Score + Tier = CMG
- **UB-04 initiates payment** – submitted to state Medicare contractor
  - CMG translated to claim with Revenue Code 0024 (Required)
- **Must meet 60%** during qualifying period to maintain payment under IRF PPS (CMG's) or risk payment under DRG's
- **Certain documentation requirements** different than other settings
  - Technical components, medical necessity and support for coding/IGC selection

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Questions or Comments about what we've talked about?

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IRF (Physician) Requirements - Review



- **IRF Criteria - MUST prove interdisciplinary approach; need for inpatient services; ability to participate as required**
  - Pre-Admission Screen (PAS)
  - History & Physical (H&P)
  - Individual Overall Plan of Care (IOPOC)
  - 3 Face to Face visits per week (minimum requirement) and progress notes for additional visits
    - Functional and Medical Addressed
  - Team Conference – 1 every 7 days
  - Orders

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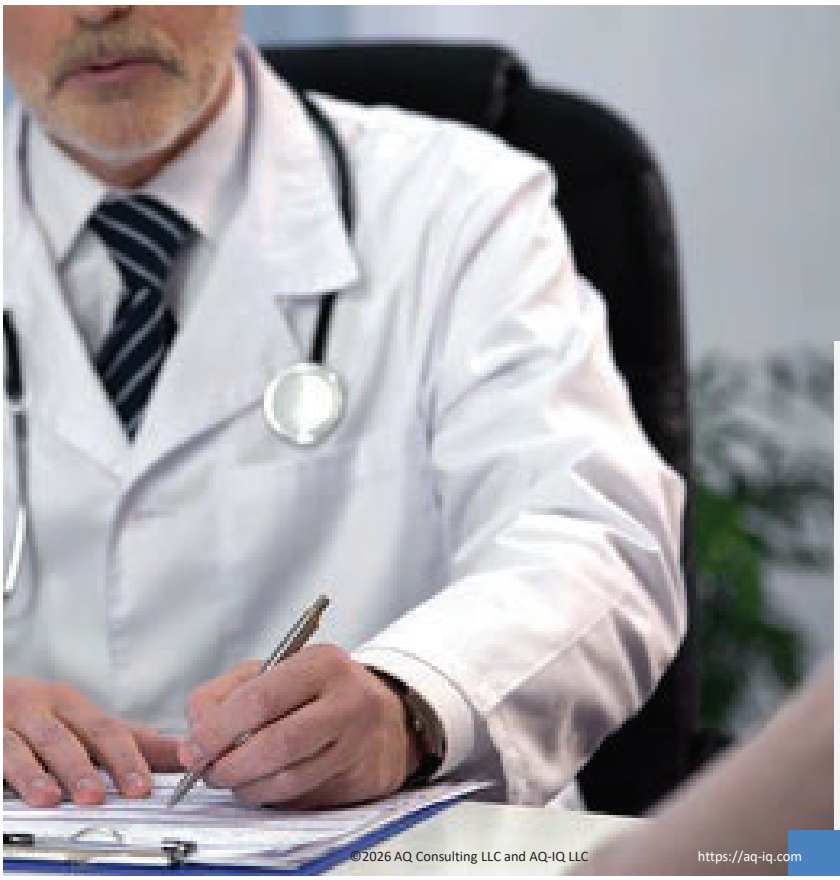
IRF Physicians Must Document-Review



- Underlying Reason for Impairment/Admission
- Accuracy and Details **(INCLUDING DEFICITS AND CLINICAL INDICATORS)** to support coding of each existing comorbidity
  - Treated/Utilizing a Resource
  - Impacting Treatment
  - Extending the Length of Stay
- Association of ALL treated diagnoses to medications/treatment



IRF Physicians Must Document-Review

- Status of conditions (History/Current/Resolved/Active)
- Relevance of lab tests
- ICD-10-CM Diagnosis statements (Specificity is Key to Success)
- Functional and Medical and the interrelationship between them
- Clarify any reasons for interruption in expected therapy
- Overall Note – History; Exam; Medical Decision Making

CMS Other IRF Documentation Requirements

Three hours of therapy 5 of 7 days

- ALL THERAPIES initiated w/in 36 hours of admission (FY2027 Final Rule).
- Fifteen hours over 7 days - documented medical reason a MUST!
- Reason for missed minutes MUST BE documented

Team conference at least every 7 days

- First team conference - By Day 4 (Admission Day = Day 1) FY2027 Final Rule
- RN, PT, OT, CM and Rehab Physician must attend
- Speech if on the team

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The Challenges

- Documenting the interdisciplinary team discussion
- Documentation supports the medical necessity criteria/continued stay criteria
- Documentation justifies the decisions made
- Documentation tends to be discipline specific
  - Current status
  - Barriers
  - Goals
  - Interventions
- Nursing report typically limited to bowel, bladder, skin

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Continued Stay

- To justify the patient's continued stay MUST document:
  - Medical status/changes
  - Progress toward interdisciplinary (team) goals
  - Interdisciplinary goals/revised interdisciplinary goals
  - Barriers with actions
  - Discharge plan
  - Discharge planning needs
    - Family training/conference
    - Transitional living apartment
    - Community re-entry activities

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OIG's focus on IRFs

- IRF Nationwide Audit OIG https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000729.asp
- AHIMA/ACDIS Query Brief - posted in Hub

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Have you used what you learned to assist or educate another?

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Who in your organization have you identified you need to connect with and how do you expect it to impact the org?

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What changes have you made or plan to make as a result of what you've learned?

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Who else needs to know this information firsthand?

Stay Involved!

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Session 9 Assignments

Connect with Kristine and take the quiz

Post in the group who does queries in your organization and if there are challenges in your query process.

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