Clinical Documentation Excellence Part 1: Compliance & Risk Mitigation
Building an Integrated Framework for Regulatory Alignment & Audit Readiness

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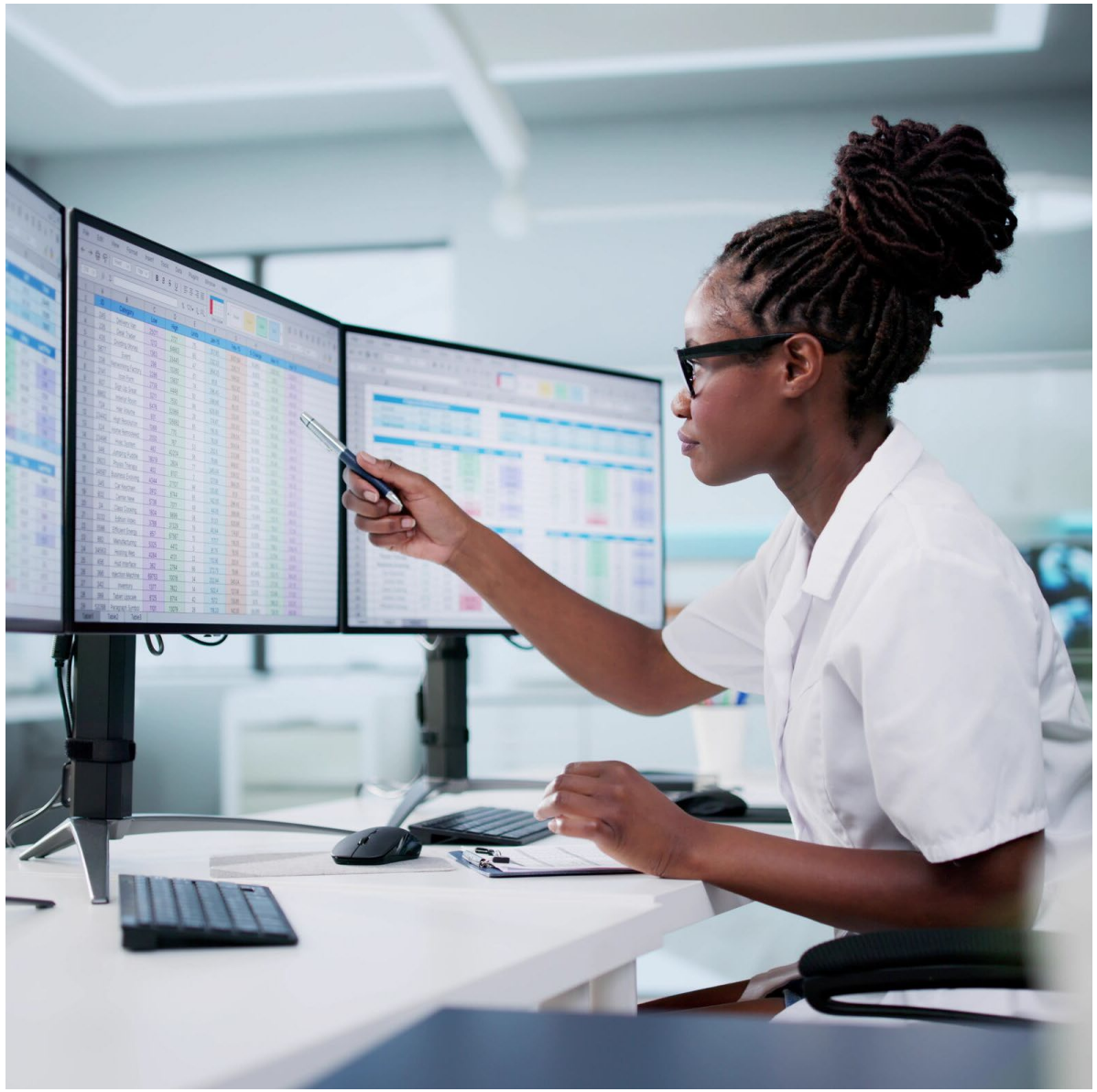
Overview

1. Intersection of Regulation, Legal Accountability, & Documentation
2. Documentation to Drive Compliance & Risk Mitigation
3. Clinical Documentation Integrity: Reflecting Clinical Status in Documentation
4. Documentation Strategies



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Why Clinical Documentation Excellence Matters Now

- Heightened payor scrutiny
- 2026 documentation standards
- Increased legal/audit exposure

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Learning Objectives

Recall compliance framework

Identify risk-reducing practices

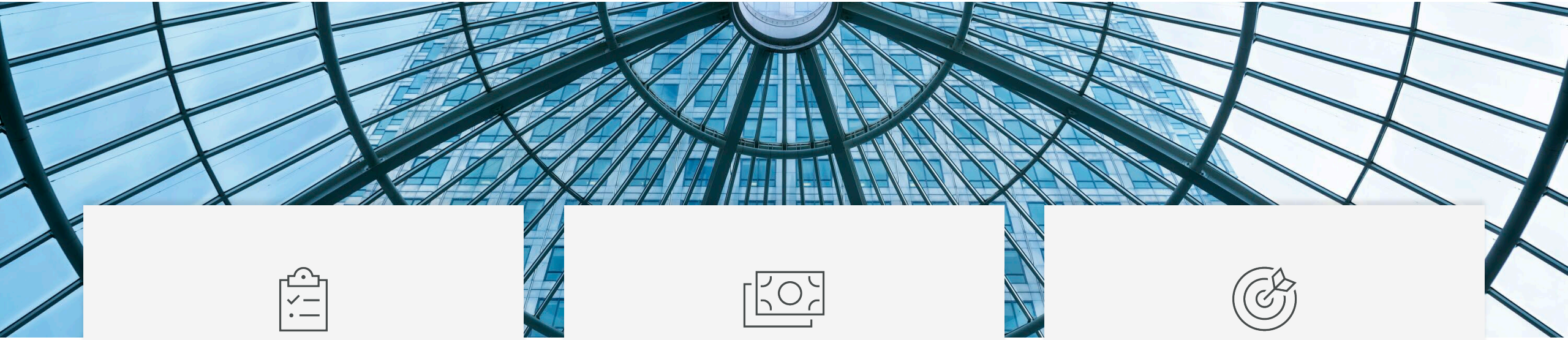
Apply accuracy/ completeness strategies

1

Section 1

Intersection of Regulation, Legal Accountability, & Documentation

Oversight Entities
CMS

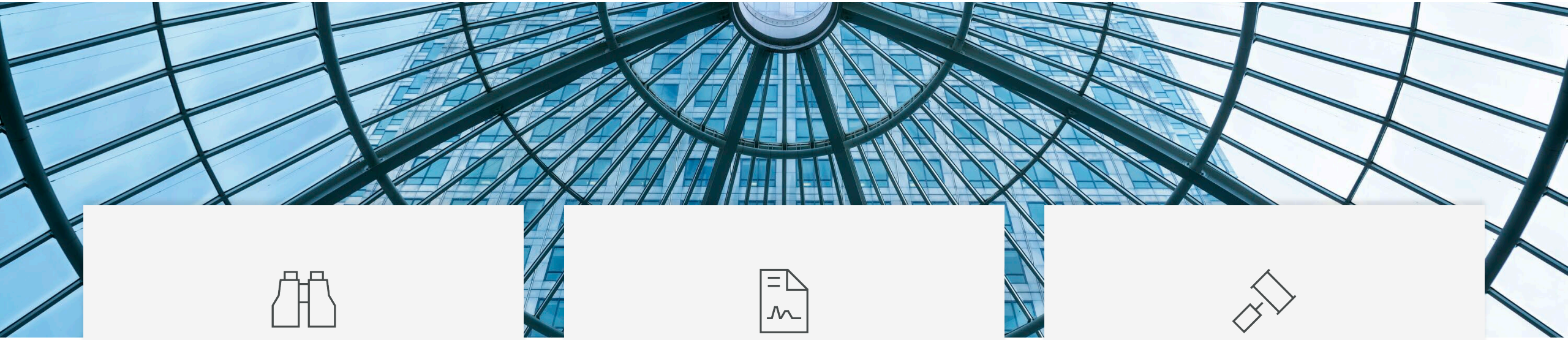


Conditions of Participation (CoPs)

Billing & medical necessity rules

Targeted audits
(Targeted Probe & Educate, Comprehensive Error Rate Testing)

Oversight Entities
Office of Inspector General (OIG)

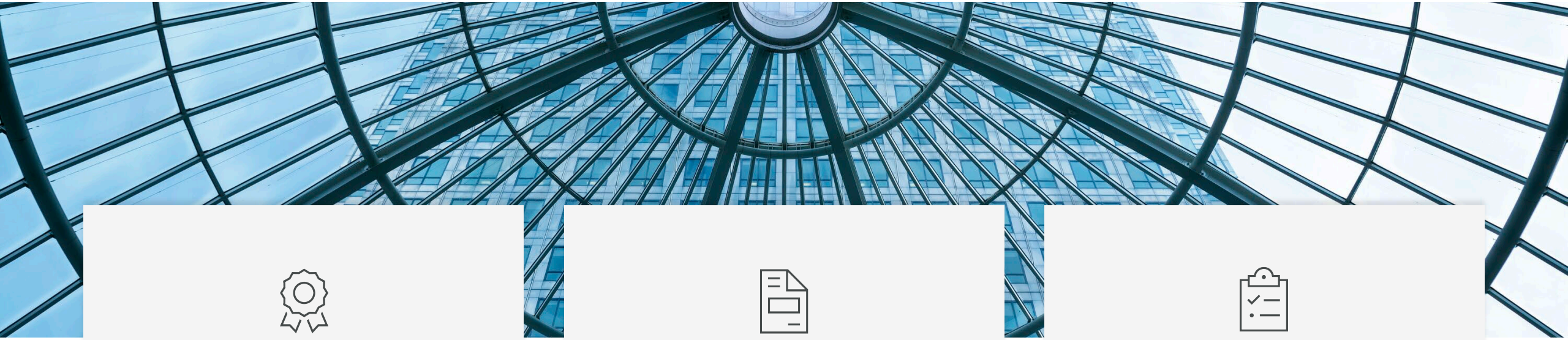


Fraud, waste, & abuse oversight

OIG Work Plan

Enforcement actions

Oversight Entities
Accreditation Organizations

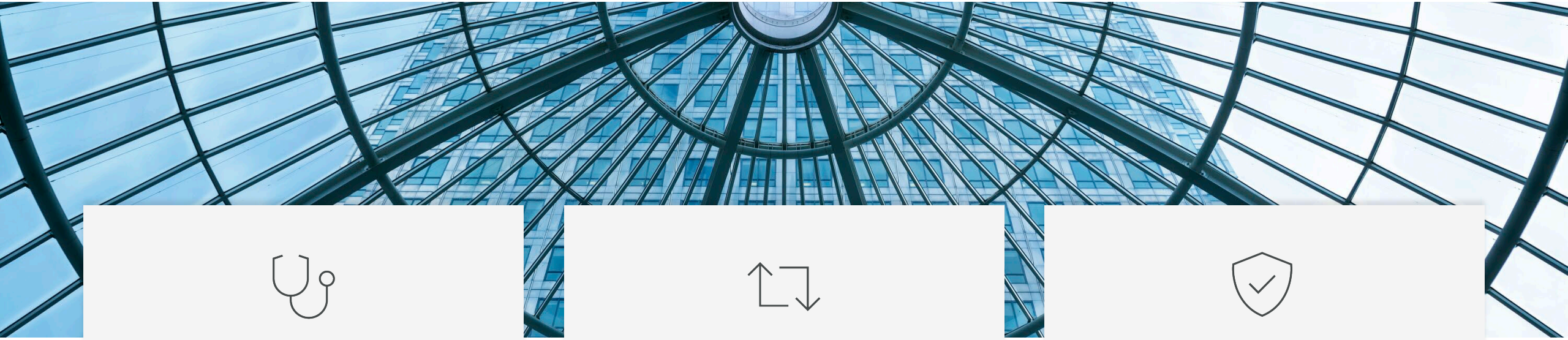


Accreditation documentation standards

Clinical decision-making documentation

2026 standards

Oversight Entities
MACs/RACs/UPICs



Medicare Administrative Contractor (MAC) medical necessity review

Recovery Audit Contractor (RAC) retrospective audits

Unified Program Integrity Contractor (UPIC) investigations

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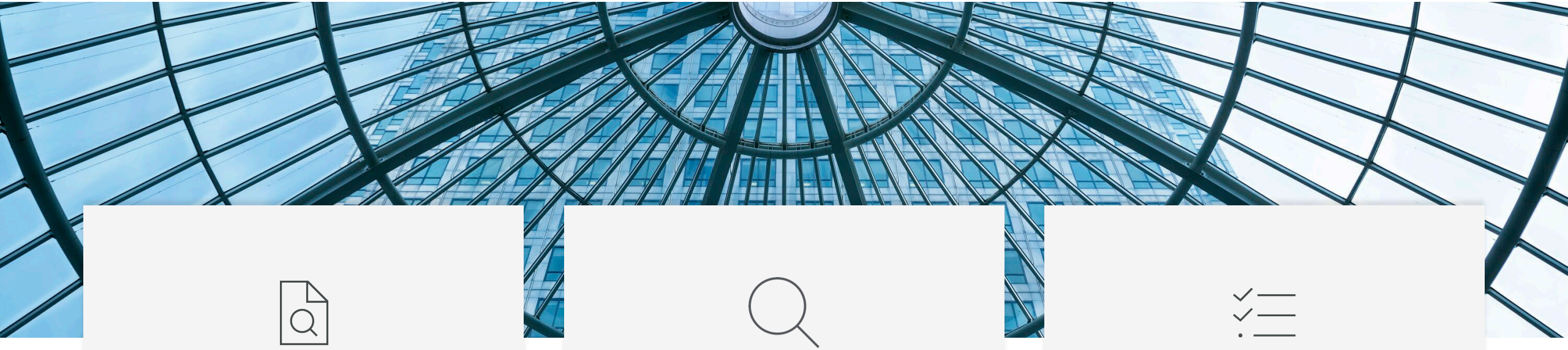
Oversight Entities
Commercial/State



MA plan reviews

State DOH investigations

Payor-specific documentation rules

2

Section 2

Documentation to Drive Compliance & Risk Mitigation

2026 Requirements

- Timeliness & legibility
- Standardized problem lists
- Transitions-of-care documentation
- Reinforced medical necessity
- Status determination scrutiny
- Two-Midnight rule, Medicare Outpatient Observation Notice (MOON)

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Compliance Framework

Supports consistent, defensible documentation

Addresses provider & organization documentation behavior

Qualities of Effective Documentation

Accuracy

- Reflects true condition
- Captures complexity/severity

Completeness

- History of Present Illness (HPI), exam, Medical Decision Making (MDM) rationale
- Response to treatments

Clarity & Consistency

- Avoid contradictions
- Align across disciplines

Specificity

- Acuity, type, stage
- Complications, status indicators

Timeliness & Legibility

- Real-time entry
- Proper late entry rules

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Audit Readiness Standard

Can the documentation alone support medical necessity?

Risk Drivers

- Medical necessity disputes
- Missing rationale
- Incorrect status placement
- Nonspecific diagnoses
- Copy/paste documentation
- Scope-of-practice issues
- Medication reconciliation failures
- Missing time documentation

Scenario 1

Documentation Denial Risk

- Missing inpatient rationale
- Denied for lack of medical necessity

Scenario 2

Documentation/ Coding Risk

- Evaluation & Management (E/M) upcoding
- Cloned documentation

Scenario 3

Discharge Planning Documentation Risk

- Poor discharge documentation
- Patient safety implications

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Section 3

Clinical Documentation Integrity: Reflecting Clinical Status in Documentation

Clinical Documentation Integrity (CDI) Functions

- Clarify queries
- Accurately capture acuity
- Identify validation risks
- Partner with Utilization Review & Case Management (UR/CM)

CDI & Audit Readiness

- Trend analysis
- Denial reduction
- Interdisciplinary bridge

CDI & Provider Education

Regulatory education

Behavior reinforcement

Documentation Do's & Don'ts

VS

Essential Behaviors

- Document clinical reasoning
- Use evidence-supported terminology
- Align orders with documentation
- Avoid ambiguous language

Red Flags

- Contradictions
- Inconsistent multidisciplinary notes
- Documentation exceeding service
- Missing time documentation

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Section 4

Documentation Strategies

Documentation Strategies

Organization-Level

- CDI across settings
- Standardized templates
- Scorecards
- Communication between CDI/UR/CM/risk coding

Provider-Level

- Point-of-care documentation
- Structured templates
- Timely queries

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Audit Checklist

Medical necessity support

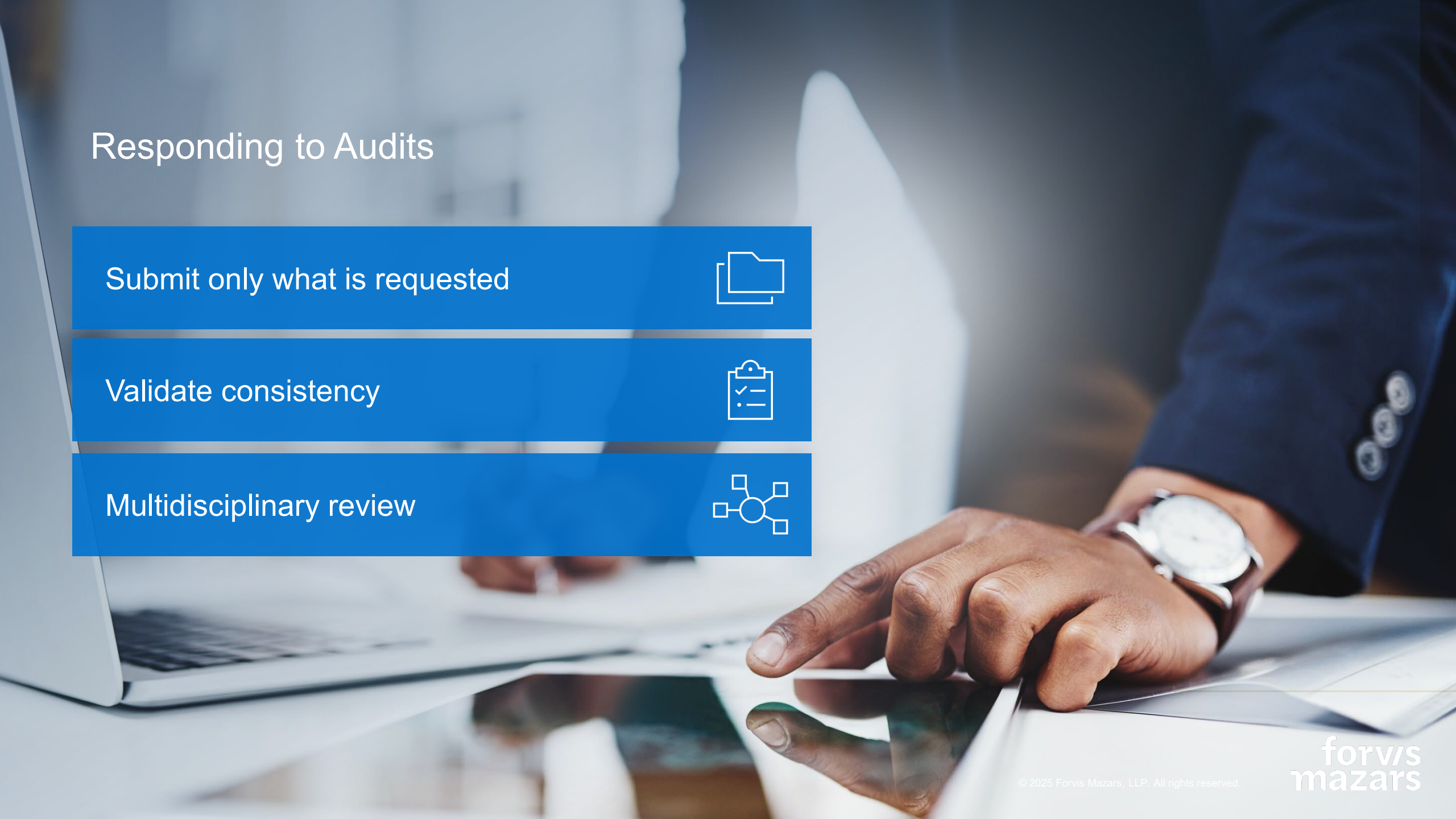
Status determination

Standardized templates

Query/addendum policies

Responding to Audits

- Submit only what is requested
- Validate consistency
- Multidisciplinary review



01

Case Study

- Inpatient vs. observation failure
- Root cause & better documentation

02

Case Study

- Sepsis/heart failure validation denial
- Documentation gaps

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Case Study

- Behavioral health documentation gap
- Regulatory consequences

04

Case Study

- E/M overcoding
- Copy/paste & exam gaps

Conclusion

- Documentation = Clinical + Legal Safeguard
- CDI Helps Strengthen Audit Readiness
- Start Preparing for 2026

Other sessions in this series:

Clinical Documentation Excellence Pt. 2: Reimbursement & Revenue

January 15, 2026
11 a.m.–12 p.m. ET

Clinical Documentation Excellence Pt. 3: Complex & Clinical Denials

February 19, 2026
11 a.m.–12 p.m. ET

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