Query practice and compliance

As part of the sixteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Katherine Wachs, BSN, RN, CCDS, CDI specialist at Honor Health in Arizona, answered these questions. Wachs is a member of the ACDIS Furthering Education Committee and the Arizona ACDIS chapter. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (jess.fluegel@hcpro.com).

Q: According to the 2026 CDI Week Industry Survey results, most respondents report that an average inpatient CDI specialist completes 6–10 patient new reviews per day (62.50%), followed by an average of 11–15 reviews (18.06%). In comparison, 57.87% are expected to complete 6–10 new reviews by their department, while 22.38% are expected to complete 11–15 reviews. How does your CDI program handle chart review expectations with its staff? Do you think a specific goal can be helpful, and/or are there other metrics helpful to track? Why or why not?

A: CDI program establishes an expectation of 6–8 new case reviews per day for each CDI specialist. To support this goal, we utilize prioritized work queues that help CDI staff identify and select the most appropriate cases for review.

I believe having a specific productivity goal is beneficial because it provides clear expectations for staff and helps ensure consistent case coverage across the hospital or health system. Defined targets also assist leaders in monitoring workload distribution and maintaining program effectiveness.

In addition to tracking new review volumes, it can be valuable to monitor broader coverage metrics, such as Medicare, Medicaid, commercial payer, and self-pay case review rates across the system. These measures provide insight into whether the CDI program is achieving comprehensive and equitable case coverage, helping to identify potential gaps and opportunities for improvement. Balancing productivity expectations with coverage and quality metrics creates a more complete picture of program performance.

Q: Survey results showed 31%–40% was the most common personal average query rate (i.e., the percentage of charts that have at least one query opportunity found during CDI review) reported by respondents, followed by 21%–30%, though results otherwise were spread evenly across the board. Can tracking your personal average query rate be beneficial? Why or why not? What other ways can CDI professionals personally measure success?

A: Tracking a personal average query rate can be beneficial because it helps CDI specialists assess their ability to identify documentation improvement opportunities compared to program benchmarks and peers. It can also provide insight into areas for professional growth and help identify trends in review practices. Monitoring personal metrics gives CDI professionals a measurable way to evaluate performance and focus on continuous improvement.

However, query rate alone does not fully capture a CDI specialist's effectiveness or overall impact. Other measures of success can provide a more comprehensive view

of performance, including MCC/CC capture, SOI/ROM improvement, Hierarchical Condition Category (HCC) capture, quality metric outcomes, query agreement rates, and denial prevention or reduction efforts. These metrics help demonstrate the value and impact of CDI activities beyond simply the number of queries issued.

A high query rate does not necessarily indicate a successful CDI practice if the queries are not clinically meaningful or do not result in improved documentation quality. Conversely, a CDI specialist with a lower query rate may have a significant positive impact through targeted, high-quality queries that improve severity capture, risk adjustment accuracy, quality reporting, and reimbursement integrity. Evaluating both productivity and outcomes provides a more complete picture of individual CDI success and program value.

Q: According to survey results, 31%–40% was the most common query rate goal of CDI departments, followed by 21%–30%, though the third most common response indicated that their department doesn't have a set expectation. Does your CDI program have a specific goal, and if so, how was that number decided on? What other strategies can a CDI program use to encourage personal accountability and best query practices?

A: Our CDI program has a query rate goal of 20%–30%, which was established to balance the identification of meaningful documentation opportunities with overall business and program needs. While the goal provides a helpful benchmark, we place greater emphasis on query quality and impact rather than volume alone.

Query rate can be a useful metric for encouraging accountability and identifying opportunities for improvement, but it does not tell the whole story. A high query rate does not necessarily reflect effective CDI practice if the queries are not clinically meaningful, while a lower query rate may still demonstrate significant value through targeted, high-impact queries.

To encourage best practices, we also monitor metrics such as MCC/CC capture, SOI/ROM improvement, HCC capture, quality outcomes, and query agreement rate. Together, these measures provide a more complete picture of CDI performance and the overall impact of documentation improvement efforts.

Q: When asked what types of queries they send on a weekly basis, the three most popular types selected by respondents were clinical validation (88.89%), any clarification of documentation required (83.18%), and uncertain diagnoses (70.52%). In the free responses section, conflicting documentation and risk adjustment were also mentioned by many respondents. Which types of queries do you and/or your team focus on? Have there been any you've branched out to in recent years (quality measure criteria, problem list verification, etc.)? If so, do you have any tips for writing these types of queries?

A: Our team primarily focuses on queries that have a financial, risk adjustment, or quality impact, including clinical validation, diagnosis clarification, specificity, and risk adjustment opportunities. In recent years, we have also expanded our focus to include quality-related reviews, particularly Patient Safety Indicator verification, to help ensure accurate quality reporting and appropriate representation of patient severity.

When writing these types of queries, my biggest recommendation is to focus on high-quality, clinically supported queries that are clear, concise, and easy for providers to respond to. Present the relevant clinical indicators, avoid including unnecessary information, and offer response options that align with the clinical evidence while remaining compliant and nonleading.

Other tips I employ include:

- Ensuring the query clearly demonstrates the documentation gap
- Using objective clinical evidence to support the query
- Making response options specific and actionable
- Considering the impact on quality metrics, risk adjustment, and patient representation, not just reimbursement
- Collaborating with quality, coding, and physician advisor teams to maintain consistency in query practices

Ultimately, the most effective queries are those that improve the accuracy of the medical record and help ensure the patient's true clinical picture is reflected.

Q: When asked if their organization has an escalation policy or other policy requiring physicians to respond to queries/CDI clarifications, about 90% of respondents said they do, continuing a slow but steady increase year-over-year since the first time ACDIS asked this question. Most respondents said their physician advisor is at the top of their query escalation process (34.57%), followed by senior leadership/C-suite (27.01%). Does your CDI program have a query escalation policy, and if so, how is it structured and what have been your struggles and successes while using it? If you don't have an escalation policy, what other tactics do you have in place to increase response rates? What advice would you give a CDI program wanting to improve or create such a policy?

A: Our department does have a query escalation policy. At the top of the escalation process is our physician advisor, though they may choose to further escalate concerns to senior leadership or the C-suite when appropriate. Our process is structured as CDI specialist → CDI lead → physician advisor → senior leadership (as needed).

One challenge we have encountered is ensuring that CDI staff fully communicate the clinical and organizational impact of a query when bringing concerns forward for escalation. Without a complete understanding of the issue, it can be more difficult for leaders and physician advisors to determine the appropriate next steps. To address this, our CDI leads work closely with staff prior to physician advisor escalation to ensure the situation and its significance are clearly understood and accurately conveyed.

Our successes have been significant. Our physician advisors have been instrumental in having one-on-one, peer-to-peer conversations with providers and offering direct education on CDI principles and the importance of query response. As a result, our query answer/agreement rates are greater than 90%.

For programs looking to create or improve a query escalation policy, my advice would be to establish a clear, standardized process with defined timelines and roles for everyone involved. Strong physician advisor engagement is critical, as peer-to-peer education is often more effective than administrative escalation alone. It is also important to focus on education and collaboration first, using escalation as a tool to remove barriers and improve understanding rather than as a punitive measure. When providers understand the impact of CDI on quality, risk adjustment, reimbursement, and accurate patient representation, response rates and engagement often improve naturally.

Q: This year, the most-used CDI software solution by respondents was computer-assisted coding (CAC, 79.10%), surpassing chart prioritization (74.09%) and electronic grouper software (73.06%). What kind of software solutions would you say have become common practice to use by CDI departments, and which, if any, have you noticed growing in popularity over the last few years? What type(s) has your organization implemented, and have they impacted your query process? How do you think evolving technology has affected query compliance now and in the future?

A: Common practice today definitely includes CAC, chart prioritization tools, and electronic grouper software, all of which help CDI teams work more efficiently and focus efforts on high-value reviews. Over the last few years, I have also seen artificial intelligence (AI)–driven CDI technology grow significantly in popularity, particularly tools that assist with chart review prioritization, identify documentation opportunities, and suggest potential queries.

Our organization has implemented CAC, chart prioritization, and electronic grouper software. CAC and grouper technology have improved our ability to identify the business need behind queries and better understand the potential impacts on reimbursement, risk adjustment, quality metrics, and severity capture. These tools help our team focus on the opportunities that provide the greatest value while supporting accurate patient representation.

As technology continues to evolve, I believe it will increasingly support query compliance by helping CDI specialists identify opportunities more consistently and efficiently. However, technology should complement, not replace, clinical judgment. CDI professionals will still play a critical role in evaluating clinical evidence, ensuring queries are compliant, and determining whether a documentation opportunity is truly meaningful.

Looking ahead, I expect AI and advanced analytics to continue enhancing workflow efficiency, prioritization, and opportunity identification. At the same time, maintaining strong query compliance practices will remain essential. Organizations should ensure that technology-driven recommendations are supported by clinical evidence and

aligned with industry query guidelines. The most successful CDI programs will likely be those that combine technology with the expertise of CDI specialists, coders, physician advisors, and providers to achieve accurate, compliant, and high-quality documentation.

Q: According to survey results, the majority (84.97%) of CDI departments have some kind of regular staff auditing process in place to assess staff competency and query compliance. Respondents indicated the most popular process types involved their CDI educators (46.76%), their departmental leadership team (41.51%), peer-to-peer audits (20.37%), or an external vendor/consulting company (18.83%). As far as how often they conduct audits, quarterly and monthly were the most common answers. Does your program have a process in place, and if so, how is it structured? For the 14.97% of respondents that do not have a staff auditing process in place, or for those who want to improve their existing process, what advice would you give to make it as effective and helpful as possible for CDI staff?

A: Our program does have a formal auditing process in place. Historically, CDI leadership has conducted quarterly chart and query audits to assess both staff competency and query compliance. More recently, we have begun partnering with an external vendor that will perform comprehensive quarterly chart audits for every CDI specialist. The audit findings are reviewed by senior leadership and then shared with individual CDI staff as part of an educational and professional development process.

I believe the most effective staff auditing programs are those that are consistent, objective, and focused on education rather than punishment. Audits should provide actionable feedback and identify opportunities to strengthen both foundational CDI skills and more advanced concepts, such as clinical validation, quality indicators, risk adjustment, and complex query opportunities.

For organizations looking to implement or improve an auditing program, my advice would be to establish a standardized review process, conduct audits regularly, and ensure feedback is timely and constructive. Including examples of best practices and opportunities for growth can help staff better understand expectations and improve performance. When approached as a coaching and development tool, auditing can strengthen CDI practice, promote query compliance, and support continuous learning across the team.

Q: Query compliance is a continual focus for CDI programs. What factors and/or concerns have you noticed dominating the conversation around compliance in 2026 (e.g., technology, regulatory changes)? What concerns do you think will be considered in the near future?

A: I believe AI is the dominant topic in CDI compliance discussions in 2026 and will continue to be for the foreseeable future. As organizations increasingly adopt AI-driven tools for chart prioritization, opportunity identification, and query generation, CDI programs must ensure that efficiency gains do not come at the expense of clinical accuracy or query compliance.

While AI can help identify potential documentation opportunities more quickly and consistently, it cannot replace the clinical judgment of CDI specialists. Human review remains essential to validate the clinical evidence, determine whether a query is appropriate, and ensure that documentation improvement efforts accurately reflect the patient's condition.

Moving forward, I think CDI programs will focus heavily on developing policies and workflows that balance technology with compliance. Questions around AI oversight, accountability, data integrity, and appropriate use of automated recommendations will likely become increasingly important. The challenge will not be whether organizations use AI, but how they use it responsibly and compliantly.

Overall, I see technology as a tremendous opportunity for the CDI profession. As AI takes on more routine tasks, CDI specialists can spend more time applying critical thinking, collaborating with providers, and focusing on complex clinical, quality, and risk adjustment opportunities. The future of CDI will likely be a combination of advanced technology and strong clinical expertise, with compliance remaining at the center of both.