Guidelines for Achieving a Compliant Query Practice (2026)

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Section I. Introduction

Note: This version of *Guidelines for Achieving a Compliant Query Practice* supersedes all previous versions, including the 2022 version. Organizations that developed query policies, templates, and audit tools under the 2022 guidelines should review those materials against the updated standards in this brief. Key areas of substantive update include the definition of noncompliant multiple queries (Section IX), the role of prior encounters in query initiation (Section X), the compliance framework for technology-generated queries (Section XI), and the scope of applicability for external reviewers (Section I). Organizations should document their review and any resulting policy updates as part of their standard compliance program activities. This brief is intended to provide best-practice standards for the clinical documentation integrity query process, driven by the underlying goal of ensuring that the clinical documentation within the health record accurately represents the clinical status of the patient.

This practice brief, developed by the American Health Information Management Association (AHIMA) and the Association of Clinical Documentation Integrity Specialists (ACDIS), serves as an essential resource for coding and clinical documentation integrity (CDI) professionals and for all others who participate in the query and documentation clarification process across all healthcare settings. When establishing a compliant query practice, it is essential to use this brief as a foundational resource. The practice brief's guidance applies equally across inpatient, outpatient, ambulatory, and professional fee environments, with specific considerations for outpatient and ambulatory contexts noted throughout.

This practice brief should be shared and discussed with all healthcare professionals whose work intersects with health record documentation, including quality, compliance, revenue cycle, patient financial services, physician groups, facility leaders, care management, informatics, and information technology (IT). These disciplines impact the health record regarding reimbursement, medical necessity, professional billing, and quality, including complications, mortalities, clinical coding, and coded data.

While this brief may inform the understanding of payer review agencies, auditors, and compliance agencies in the context of health record reviews—including those involving DRG assignment, risk adjustment, medical necessity, and code assignment (Current Procedural Terminology® [CPT], ICD-10-CM/PCS)—it is not intended for use as a basis for denying claims or disputing clinical queries. Any use of this brief as a stand-alone rationale for claim denial, post-payment recovery, or adverse audit finding is inconsistent with its

purpose and scope. Substantial compliance with the principles in this brief, rather than rigid technical adherence to any specific element, is the appropriate standard for external review.

For purposes of this brief, "substantial compliance" means that a query addresses the core requirements of a compliant query practice: It is nonleading, includes clinically relevant and sourced indicators, does not reference reimbursement or quality outcomes, and provides the provider an opportunity to exercise independent clinical judgment. Isolated technical deviations—such as a minor formatting inconsistency, a missing source date on a single indicator, or a query title visible to the provider that is descriptive but not diagnosis-directing—do not, standing alone, render a query noncompliant when the overall query satisfies these core requirements.

In particular, the query response option(s) selected by a treating provider in response to a clinical validation query represent that provider's clinical judgment at the time of documentation and do not constitute independent admissions, stand-alone grounds for post-payment recovery, or evidence of fraudulent billing absent other supporting findings.

The purpose of this practice brief is to establish and support industrywide best practices for the clinical documentation query process. It should be used to guide organizational policy and process development for a compliant query practice. This brief implements the directives of the ICD-10-CM and ICD-10-PCS *Official Guidelines for Coding and Reporting* and official advice in the American Hospital Association (AHA)'s *Coding Clinic® for ICD-10-CM/PCS*. It is intended to serve as a general educational resource for all stakeholders, including external reviewers such as the Office of Inspector General, government contractors, and payer review agencies. This brief does not establish a rigid compliance checklist, and deviation from any specific element of the brief does not, standing alone, constitute evidence of a noncompliant query or support for a claim denial.

Specific applications of this practice brief include:

- Developing and updating compliant query policies and practices
- Providing query education for new and experienced staff across all roles and settings
- Understanding the organizational impact of compliant and noncompliant query practices
- Standardizing query audits and monitoring processes
- Providing a reference tool for compliance, legal, and denial defense matters
- Informing external or third-party stakeholders and consultants

Section II. Definitions

The following definitions are provided to establish a standardized understanding of key terms used throughout this practice brief. These definitions are intended to support consistent application of compliant query practices across healthcare settings.

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. Queries may be initiated by a healthcare professional or generated through computer-assisted processes and are utilized to support accurate, complete, and clinically valid documentation.

Provider

A provider is a physician or any qualified healthcare professional who is legally accountable for establishing the patient's diagnosis. The term "provider" within this practice brief refers to any treating clinician who meets this definition and is responsible for documentation within the health record.

Encounter

An encounter refers to all patient visit types across inpatient and outpatient settings. This includes admissions, hospital stays, and office visits, and represents the full continuum of care in which documentation and query practices apply.

Ambiguous documentation

Ambiguous documentation is documentation that fails to reflect the provider's intent and impacts the clinical scenario, the accuracy of code assignment, or the ability to assign a code. Such documentation may require clarification to ensure the integrity and completeness of the health record.

Query professional

A query professional is any individual who initiates queries to resolve documentation issues or has oversight or involvement in the query process. This includes CDI professionals, coding professionals, quality improvement nurses, utilization review professionals, Hierarchical Condition Category (HCC) coders operating in physician group or risk adjustment settings, and any vendor or technology platform acting in a query-generating capacity on behalf of a covered organization.

Clinical indicators

Clinical indicators are documentation elements that support a diagnosis as reportable or establish the presence of a condition. These may include provider assessments, diagnostic findings, treatments, medications, clinical trends, and relevant documentation from ancillary healthcare professionals. The number and type of clinical indicators required may vary based on the clinical scenario, and the provider determines their clinical significance.

Unable to determine

“Unable to determine” as a query response indicates that the provider is clinically unable to determine whether they can supply a diagnosis or further clarification based on the available information. This term represents true clinical uncertainty and is distinct from terms such as “possible,” “probable,” or “unable to rule out.”

Problem list

A problem list is a compilation of active diagnoses that are relevant to the current episode of care. The problem list should accurately reflect clinically significant conditions and should be maintained in accordance with organizational policies and procedures.

Clinical validation

Clinical validation is the process of ensuring that a documented diagnosis is supported by clinical indicators within the health record. When a diagnosis is documented but lacks sufficient supporting evidence, clarification may be necessary to confirm its clinical validity.

Compliant query

A compliant query adheres to established professional guidelines to ensure accurate, complete, and unbiased documentation clarification. A compliant query is nonleading, includes relevant clinical indicators, excludes references to reimbursement or quality outcomes, and allows the provider to exercise independent clinical judgment.

Verbal query

A verbal query is conducted through spoken communication that is documented in accordance with organizational policy. Verbal queries must include the clinical indicators and response options discussed and must be recorded and tracked in a manner consistent with written queries. The provider’s response must be documented in the health record to support code assignment.

Written query

A written query is a documented communication that includes relevant clinical indicators and allows the provider to clarify documentation in a clear and concise manner. Written

queries must include clinically supported answer options and provide the opportunity for the provider to supply an alternative response when appropriate.

Yes/no query

A yes/no query is a query format used to clarify an already-documented diagnosis or clinical relationship. This format may not be used to introduce a new diagnosis and is typically utilized for confirming existing documentation, such as present on admission (POA) status or cause-and-effect relationships.

Information from prior encounters may be used to support a query when it is clinically relevant to the current encounter. However, prior encounter documentation cannot serve as the sole basis for a query, and sufficient supporting information must be present within the current encounter. The use of prior documentation should support continuity and accuracy without introducing unrelated conditions. See Section X.

Section III. Scope of Application

The documentation query process is used for several initiatives, which include reimbursement methodologies, data stewardship and collection, quality measures, medical necessity, denial prevention, and related initiatives. Any professional or technology that reviews the medical record, whether in the inpatient, outpatient, or professional fee setting, should take into account compliant practices and follow the instructions within the brief. Additionally, any party seeking oversight, auditing, query review, or education based on query and/or claims data must demonstrate well-developed knowledge of compliant query practices. Technology-driven "prompts," "alerts," or "nudges" to clarify diagnoses for code assignment should also follow the instructions within this brief.

Examples of where this brief should be applied include:

- Quality team members seeking diagnosis clarification from providers related to quality measures
- An outpatient program implementing HCC prompts in the electronic health record (EHR)
- Sepsis coordinators seeking diagnosis validation

All query professionals, regardless of skill set, profession, or location, are to use this practice brief to create an educational and training platform for compliant querying. Additionally, this brief may be used as a reference for evaluating compliance in legal matters, and as guidance for consultants, vendors, and IT professionals.

In outpatient, ambulatory, and professional fee settings, the query process applies with the following contextual modifications:

- Concurrent review may be impractical given the limited duration of many encounters. Queries are often initiated based on prior documentation and the problem list.
- HCC risk adjustment queries must meet all requirements of this brief and are subject to the same nonleading and clinical indicator standards as inpatient queries.
- The Uniform Hospital Discharge Data Set (UHDDS) reporting criteria applicable to inpatient encounters do not govern outpatient code assignment. Outpatient queries should be evaluated against the outpatient coding guidelines found in the ICD-10-CM *Official Guidelines for Coding and Reporting*.
- POA status does not apply in the outpatient setting.

Where this brief references inpatient-specific standards, those standards do not apply in outpatient or professional fee contexts unless otherwise noted.

For matters regarding compliance, risk management, and legal applications, this practice brief serves as the framework for query structure and application. Questions related to the application and guidance from this brief should be referred to the department designated by your organization.

Section IV. How to Use This Practice Brief

This practice brief provides expert-informed guidance designed to assist healthcare organizations in developing compliant and effective query policies and procedures. It is a resource to inform best practices—not an authoritative policy, and not legally binding or prescriptive. Healthcare organizations should shape their query practices within the parameters of their own facility policies and applicable regulatory requirements. This brief establishes the professional standard for query practice as developed by AHIMA and ACDIS. It does not supersede or limit the independent authority of federal or state regulatory agencies, Medicare Administrative Contractors, Recovery Audit Contractors, or other oversight bodies, whose audit criteria and standards are established through separate regulatory and contractual frameworks.

This brief is intended to be scalable to the size and complexity of the organization. Smaller organizations, including critical access hospitals, rural health clinics, and solo or small-group physician practices, should apply the principles of this brief in proportion to their

operational capacity. The core compliance requirements—nonleading queries, clinically sourced indicators, prohibition on reimbursement references, and independent provider judgment—apply universally regardless of organizational size. Governance structures, template approval processes, and audit methodologies should be designed to fit the organization's resources while achieving the same substantive compliance outcomes.

Section V. General Query Guidelines and Standards

This section is intended to provide clear guidance to ensure consistency across all situations. If these requirements are not met, the query may be considered noncompliant, even if it does not overtly direct or lead the provider to a specific answer. Requirements within Section V.I use the following citation format: Main items are labeled I.A. through I.I.; sub-items under I.C. are labeled I.C.1., I.C.2., and I.C.3.; and sub-examples under I.D. are labeled I.D.i. and I.D.ii. These designations may be used to cite specific requirements in organizational policy, audit findings, or legal proceedings.

I. Required elements of a compliant query

The purpose of a provider query is to seek clarification of an otherwise unclear record. In order for a query response to be utilized to support code assignment, the query and response must be incorporated as part of the health record; otherwise the provider must incorporate the answer within their documentation (progress notes, discharge summary, etc.) or apply an addendum to the existing health record if the query is applied retrospectively. Organizations should have a policy in place to define approved locations for query responses.

If a compliant query has been properly answered and authenticated by a responsible provider and is part of the permanent health record, it is sufficient for code assignment. The response to the query is not required to be repeated elsewhere in the health record. However, if subsequent information conflicts with the query response, additional clarification may be needed.

A. No influencing information in query titles

Query titles or tracking/reference numbers, as visible to providers, must not include information or direction that could influence the response.

- Compliant example: The provider opens a query with the visible title "CDI Provider Query - Respiratory Status"
- Noncompliant example: The provider opens a query with the visible title "Query for acute hypoxic respiratory failure"

B. No mention of impact on reimbursement, quality measures, or reporting initiatives

Queries must never include information on reimbursement impact, quality measures, denial mitigation, or other reporting initiatives based on documentation and claim submission in relation to requested clarification or specific answer options.

C. Clinical indicators

Clinical indicator(s) justifying the need for clarification must be included. These indicators should support a more complete or accurate diagnosis/procedure or identify a reported diagnosis that lacks support in the health record and requires clinical validation.

While organizations, payers, and other entities may establish guidelines for clinical indicators for a diagnosis, providers make the final determination as to what indicators define a diagnosis.

Relevant clinical indicators may be sourced from anywhere in the current encounter or relevant prior visit, including:

- Emergency services documentation (e.g., emergency service transport, emergency department [ED] provider, ED nursing)
- Diagnostic studies (e.g., laboratory, imaging)
- Provider impressions (e.g., history and physical [H&P], progress notes, consultations)
- Ancillary professional documentation and assessments (e.g., nurses; nutritionists; wound care; physical, occupational, speech, and respiratory therapists)
- Procedure/operative notes and care management/social services

When clinically pertinent to the present encounter, information from a prior health record can be used to support a query (see Section X). Code assignment is not determined by documentation from previous encounters. However, using evidence from a previous encounter is appropriate when relevant to the current encounter.

Sourcing of clinical indicators:

1. Citation of location

Clinical indicators should include a citation of where they were found within the health record (e.g., “nursing admission assessment x/xx”).

2. No subjective interpretation by the query professional

Data or documentation sourced from the health record must not be accompanied by subjective interpretation from the query professional. The query professional should not insert diagnoses or their own interpretation or wording into the body of

the query for findings not yet identified. For example, if the record indicates a heart rate of 120, it should be communicated as such; the query should not indicate the presence of tachycardia. Similarly, if hemoglobin is reported at 10 g/dL, the query professional should not write "anemia" as a clinical indicator.

3. Use of quotation marks

Quotation marks should be used to identify information that has been pulled directly from the record and has not been edited or changed (e.g., Radiology interpretation states, "left lower lobe opacification indicating consolidation with…"). Quoting a provider statement or a nursing assessment is compliant. All entries of clinical indicators should be accompanied by sourcing within the medical record, allowing the provider to further investigate their meaning if needed.

It is not appropriate for the query professional to add formatting to emphasize a clinical indicator or documentation. It is best practice not to highlight any information within the query that could be construed as leading, and highlighting should never be used within the answer options of a query. However, it is appropriate to preserve direct health record source formatting if the provider's documentation included such emphasis. For example, if the health record documentation is bolded or colorized to highlight an abnormal lab result, symptom, or condition of concern, the information may be left in its original format. Organizational policy can offer direction as to whether such emphasis should be removed or left unchanged within the query.

A statement must be included that provides a clear, concise, and nonleading explanation of the necessity for the query as it relates to the specific encounter. For example: "Please further clarify the diagnosis…" or "Can a diagnosis be provided…?"

D. Uncertain diagnoses when supported by clinical indicators

Query questions/statements and answer options that indicate an uncertain diagnosis as defined by the *Official Guidelines for Coding and Reporting* and AHA *Coding Clinic* are permissible in the inpatient setting when supported by the presence of clinical indicators significant to the present encounter. Organizations may develop policies indicating the circumstances under which such queries should be initiated.

Common examples:

i. Documented term of uncertainty

The diagnosis in question has been documented by a provider using a term of uncertainty (e.g., "likely," "probable," "possible," "suspected," "compatible with," or similar terms).

ii. Possible need for confirmation of thought process or treatment plan

There is a circumstance in which the provider may need to confirm their thought process and applied treatment plan in the absence of concrete data needed for

diagnosis confirmation (e.g., acute tubular necrosis without a kidney biopsy, the type of pneumonia in the absence of a sputum culture, an unexpected death without confirming diagnostics).

E. Appropriate answer options

Query answer options must meet the criteria specific to the format used.

F. Clinical definitions and diagnostic criteria

When composing a query, it is permissible and nonleading to include clinical definitions or diagnostic criteria within the template. Nationally recognized or standardized organizational criteria (including hyperlinks) may be placed at the bottom or end of the template. This allows the provider to easily refer to widely accepted criteria when selecting their response. For example, query templates containing Kidney Disease: Improving Global Outcomes criteria, American Society for Parental and Enteral Nutrition criteria, chronic kidney disease (CKD) staging, or pressure injury staging are permissible with a citation of the source.

The organization may determine when or if to include criteria in templates. The criteria and/or definition must be provided without any indication of preferred choice, meaning the information should not be highlighted or bolded and should not indicate a desired answer.

G. Incorporation into the health record or business record

While organizations are free to determine the specifics of their query process, compliant practice requires that all queries (i.e., actual queries) either be a permanent part of the health record or be retrievable in the business record.

H. Best practice for incorporating queries into provider documentation

Best practice is for providers to incorporate query answers within their documentation, speaking to the significance and relevance of diagnoses described. If there is any question as to the meaning of a provider's co-signature, a query is likely needed. When a provider declines to respond to a query regarding co-signature meaning, the query professional should escalate per organizational policy. In the absence of a clarifying response, the co-signature should be interpreted conservatively, and the code assignment should reflect only what is unambiguously supported by the remainder of the health record. Organizations are encouraged to work collaboratively with medical staff leadership to establish shared expectations around co-signature documentation practices before reliance on the query process becomes necessary.

I. No required location or frequency for a diagnosis to be reportable

There is no specific direction as to where a diagnosis must be documented or how often the diagnosis must be documented to allow it to be reported. Organizations may need to develop facility-based policies reflecting reportability of information that is clarified only within a query response versus elsewhere in the record.

II. Query formats

A. Multiple choice

This format can be used in any circumstance. Relevant clinical indicator(s) must accompany a nonleading statement that identifies the issue requiring clarification. A nonleading statement is one that simply asks the question, without direction toward the desired answer. The statement is followed by answer option(s). Providing answer options that are supported or substantiated by the clinical indicators sourced from the clinical record is not introducing new information and is not thought to be leading in nature.

Answer options:

- Must not suggest or direct the provider to a preferred response by using emphasis (e.g., arrows, bolding, highlighting, underlining).
- Can be listed in any order.
- Can be as numerous as the query warrants. There is no required minimum or maximum number of diagnosis/procedure answer options.
- Must be considered reportable based upon UHDDS requirements and as outlined in Section III of the ICD-10-CM *Official Guidelines for Coding and Reporting*.
- Must include only clinically relevant options, meaning those supported by clinical indicators sourced from the health record. Clinically irrelevant options must be excluded. For example, if a sodium level is 122 and a query is sent to determine whether a diagnosis can be provided, hypernatremia would not be an appropriate answer option.
- Must allow the provider the opportunity to offer an alternative explanation or diagnosis (e.g., through addition of the option "Other, please specify" or "Other explanation of clinical findings, please specify")

Other answer options that may be used if suitable for the circumstances (but are not required) include “unknown,” “unable to determine,” “not clinically significant,” “integral to,” “inherent to,” “unable to rule out,” or similar wording. Note the following:

- The wording "unable to determine" or "clinically unable to determine" is defined as the provider being clinically unable to reach a conclusion or determine whether a requested diagnosis or further clarity can be provided. This wording allows the provider to communicate that there is presently not enough evidence to accurately provide the requested information.
- The wording "unable to determine" does not equate to "unable to rule out" and does not indicate an uncertain diagnosis (e.g., possible, probable, likely). The options of "unable to determine," "possible," and "unable to rule out" are NOT synonymous.

See sections II.H, III.C, and IV.H of the ICD-10-CM *Official Guidelines for Coding and Reporting* for more information on uncertain diagnoses.

- The option of "unable to determine" is required in POA and yes/no queries.
- "Unable to determine" responses may be reviewed on a case-by-case basis to determine whether further escalation of the query should be performed. If the response to a query does not provide the clarity requested, the organization's escalation policy should be followed.

A query can be considered noncompliant without being leading. Compliance requires that clinical indicators are specific to the patient and episode of care, support a more complete or accurate diagnosis or procedure, and are free from subjective interpretation by the query professional.

B. Yes/no

This format is most appropriate for clarifying already-documented diagnoses that need further specification and determination of POA status. It should not be used to obtain documentation for new, previously undocumented diagnoses. The query must reference the diagnosis and include relevant clinical indicators, and it should be phrased so the response is simply "yes" or "no." There should be no indication of the desired answer.

Yes/no queries should include an appropriate third option allowing the provider to indicate the inability to reach a determination, or allowing the provider to supply further information through free text.

Yes/no queries may be used in:

- Determining POA status. A yes/no query seeking to determine POA must also include an answer option of "unable to determine."
- Substantiating a medical diagnosis that is already present within provider documentation, such as pathologist documentation of a biopsy-confirmed malignancy or radiologist interpretation of diagnostic findings.
    - Documentation by clinicians who are not authorized to establish a medical diagnosis per their scope of practice is excluded from this provision. Examples include documentation of wound etiology by the wound care nurse, or documentation of malnutrition by the dietitian.
- Establishing or negating a cause-and-effect relationship between two conditions, such as:
    - Linkage of the underlying cause to the associated manifestation(s)
    - Confirming or negating a complication of care such as a procedural complication or an adverse reaction to a medication

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Examples of yes/no queries

Example 1: Yes/no query to clarify POA indicator

Admitted from ED, s/p fall with fractured femur, AKI and dehydration. Nursing admission assessment describes productive cough, with complaints of low-grade temperature for 1-2 days. CXR on admission indicates no noted consolidation or opacities. Repeat order on day 2 demonstrates consolidation in left lower lobe. Progress note day 3 indicates left lower lobe pneumonia.

Was the pneumonia present on admission?

- *Yes*
- *No*
- *Unable to determine*

Example 2: Yes/no query to substantiate a diagnosis already present in provider documentation

Dr. Smith's pathology report dated xx/xx indicates renal cell carcinoma, please confirm based on your review and assessment.

- *Yes, the patient has confirmed renal cell carcinoma*
- *No, there is other explanation of clinical findings*
- *Unable to determine*

Example 3: Yes/no query to establish a relationship (cause and effect)

Patient presents to ED with indwelling catheter. Symptoms include confusion, abdominal pain, urinary frequency and burning. Urine culture obtained on arrival positive for E. coli. Catheter exchanged and antibiotics initiated. H&P states E. coli UTI with foley catheter.

Is the UTI due to the indwelling catheter?

- *Yes*
- *No*
- *Unable to determine*

C. Open-ended

Open-ended queries may be used in any circumstance; however, because they can be difficult to interpret, they are not the preferred format.

An open-ended format may be helpful when documenting a compliant verbal query or when the situation is complex and appropriate answer options are unclear.

A nonleading statement identifying the issue requiring clarification must be accompanied by relevant clinical indicator(s). Because no specific answer options are provided, providers may respond to open-ended queries using free text.

Examples of open-ended queries

Example 1

The medical record reflects lethargy and confusion, respiratory rate of 32, heart rate of 96, and admission temperature of 38.5°C. Admission laboratory findings include a WBC of 16,500/µL with 12% bands and a lactate of 2.25 mmol/L. Blood and urine cultures are positive for E. coli, and treatment with piperacillin tazobactam has been initiated. The current documented diagnoses include metabolic encephalopathy and urinary tract infection. Based on your clinical judgment, please clarify the condition or conditions being monitored and treated during this encounter and document accordingly in the medical record.

Example 2

The medical record indicates the patient was admitted with complaints of severe chest pain, later described as nonischemic. Documentation includes consideration of possible GERD, gastritis, or esophageal spasm. Based on your clinical judgment, please clarify the condition or conditions determined to be responsible for the patient's presenting symptoms and document accordingly in the medical record.

III. Verbal queries

Not every spoken interaction with a provider related to documentation is a verbal query. General discussions related to documentation practices or de-identified case reviews used for educational purposes are not considered queries. Verbal queries are conversations that request further specificity or clarification regarding documentation opportunities associated with a specific patient encounter. Verbal queries (CDI to provider or peer to

peer) must follow the instructions listed in Section V.I related to required elements of query compliance. A response to a verbal query must be documented in the permanent health record to allow code assignment.

Verbal queries or conversations must be recorded with notation of:

- The date/time and individuals involved
- The clinical indicator(s) and the source from which they were obtained
- The nonleading query statement providing explanation of the necessity of the query related to the specific encounter (e.g., "Please further clarify the diagnosis…", "Can a diagnosis be provided…?")
- The answer options provided (if applicable)
- The provider's verbal response

Organizational policy can direct where such notations should be placed and how they can be accessed. This allows verbal queries to be recorded and tracked in the same manner as written queries and to be discoverable to other departments and external agencies.

A response to a verbal query must be documented in the permanent health record to be coded. Please refer to the 2026 ACDIS white paper *Safeguarding Ethical Documentation Practices in Querying, Peer-to-Peer Discussion, and Technological Initiatives* for additional guidance.

If a verbal query response is not documented in the permanent health record, the code supported by that response may not be assigned. In such cases, the query professional should work with the provider to obtain written documentation through an addendum, or initiate a written query to obtain the clarification through a documented channel. Organizations should establish escalation processes for cases in which a provider has verbally responded to a query but declined or failed to document that response in the health record.

Example of a verbal query

Date/time: XX/XX/XXXX
CDI specialist: MK
Provider: Attending JG
Clinical indicators presented to provider: *O2 saturation 88% on room air, respiratory rate 24-32 in ED. Admission H&P states use of accessory muscles and marked dyspnea. Respiratory therapy ordered to maintain oxygen saturations above 90%. Admission diagnosis is pneumonia.*

Query: *Based upon the identified clinical indicators, can you clarify the condition you are monitoring and treating?*

Physician response: *Acute hypoxic respiratory failure*

Dr. JG agreed to document the response within the health record.

IV. Clinical validation queries

The treating provider ultimately decides which clinical indicators confirm a diagnosis. Because each patient is unique, the purpose of organizational definitions is not to limit how a diagnosis is defined, but rather to promote consistency in the determination of a minimal threshold that has been met to support the presence of the diagnosis.

Clinical validation queries seek to confirm or refute the presence of a documented diagnosis that appears to lack supportive documentation within the record. The purpose of these queries is not to simply confirm or negate the presence of a documented diagnosis, but to also request documentation of additional clinical data or clinical decision-making by the provider to support the diagnosis.

Clinical validation queries must follow the instructions listed above related to required elements of query compliance. Clinical indicators supporting the purpose of the query should be listed accompanied by their location within the medical record.

The multiple-choice format is the optimal choice for clinical validation queries. Query answer options must follow the direction in Section V.II.A related to multiple-choice query format.

In addition to the required answer option of "Other" such as "Other explanation of clinical findings, please specify," possible answer options include the following (or similar wording):

- The diagnosis in question has been ruled out.
- After further study, this diagnosis is no longer valid.
- The diagnosis in question is present (please provide supportive evidence):
- The diagnosis in question is confirmed as evidenced by the following clinical indicators (please provide additional supporting documentation):
- Alternative diagnoses supported by listed clinical indicators to be used in lieu of the diagnosis in question.

Note: The above options represent the treating provider's clinical judgment at the time of the query and are not intended to serve as the basis for retroactive claim denial, post-

payment audit findings, or adverse coverage determinations by payers or external reviewers.

Examples of clinical validation queries

The following examples are provided only as a guide. Organizations should follow their policies and procedures when developing queries. Any query should include all pertinent clinical indicators identified in the health record.

Example 1: Diagnosis that is documented but appears to lack clinical support

Acute respiratory failure on H&P dated xx/xx and progress notes dated xx/xx and xx/xx.

Clinical indicators: *Acute respiratory failure is documented in H&P dated xx/xx and progress notes dated xx/xx and xx/xx. The H&P states underlying pneumonia, respiratory rate of 12, no accessory muscle use, and arterial blood gases showing pH 7.40, pCO_2 36, and pO_2 75 on room air. Based on these clinical indicators and your clinical judgment, please clarify the patient's respiratory status during this encounter.*

- *Acute respiratory ruled out*
- *Acute respiratory failure confirmed (please document type and additional supporting information)*
- *Other explanation of clinical findings (please specify)*

Example 2: Documentation in the present and prior health record that provides evidence to support the presence of a condition

Clinical indicators: *Documentation in the progress note xx/xx/xxxx indicates renal dosing applied to metronidazole dosing. Current H&P states Type 2 diabetes and patient on insulin. Previous encounter discharge summary (dated xx/xx) documents CKD stage 4. Trending eGFR (dates x/xx, x/xx, x/xx) ranging 17-20 mL/min.*

Please clarify the condition requiring renal dosing:

- *CKD, stage 4 due to Type 2 diabetes*
- *CKD due to other condition (please specify CKD stage and etiology)*
- *Other explanation of clinical findings (please specify)*

Example 3: Evidence in a prior health record that supports further specification of a condition

Acute congestive heart failure was documented on progress note dated xx/xx.

Clinical indicators: *Echo from last week's office visit indicates ejection fraction of 35% and diastolic dysfunction.*

Please further specify the diagnosis of heart failure:

- *Acute systolic congestive heart failure*
- *Acute systolic and diastolic congestive heart failure (combined)*
- *Other explanation of clinical findings (please specify)*

Example 4: Medical diagnosis that is clinically evident

Clinical indicators: *Respiratory therapy (dated xx/xx) documentation states continuous home O2 at 2L/min, baseline O2 88-92%. During this encounter, the patient remained on 2 L nasal cannula with oxygen saturations within baseline range. H&P (dated xx/xx) indicates history of COPD, GOLD stage 4.*

Please clarify the patient's respiratory status based on these clinical indicators:

- *Chronic respiratory failure*
- *Other explanation of clinical findings (please specify)*

Example 5: Uncertainty of a cause-and-effect relationship between related conditions

Clinical indicators: *H&P (dated xx/xx) states lung cancer with bone metastasis, undergoing chemotherapy. Pancytopenia was documented on progress note (dated xx/xx).*

Please clarify etiology of pancytopenia:

- *Pancytopenia due to chemotherapy*
- *Pancytopenia due to other cause (please specify):*
- *Pancytopenia, etiology unknown at this time*

Section VI. When to Query

The following outlines common circumstances in which a query should be initiated; however, the list is not all-inclusive.

- When a diagnosis or condition is supported by clinical indicators and meets UHDDS reporting requirements but has not been explicitly documented by the provider

- When documentation is unclear, incomplete, or does not reflect the provider's intent, resulting in uncertainty regarding the patient's clinical condition or the ability to accurately assign codes
- When diagnostic or procedural documentation contains inconsistencies or contradictions among providers that require clarification
- When a documented diagnosis does not appear to be supported by the available clinical indicators
- When a condition, recommendation, or assessment is documented by an individual who does not meet the definition of a qualified healthcare professional in the applicable setting
- When clarification is needed to establish a relationship between medical conditions, including etiology or associated complications
- When additional detail is required to clarify the clinically supported acuity or specificity of a documented diagnosis
- When clarification is needed to determine whether a condition documented as "history of" is active and relevant to the current encounter
- When clarification is needed to support accurate POA indicator assignment
- When clarification is needed to determine whether a condition documented as part of a differential diagnosis has been ruled in or ruled out
- When clarification is needed regarding the objective, intent, or extent of a procedure
- When clarification is required to determine the presence or absence of a complication associated with a procedure or medical intervention

Section VII. Whom to Query

Queries should be directed to and answered by the provider(s) who delivered direct, face-to-face care to the patient during the specific encounter. It is inappropriate to query a provider who is not directly involved in the patient's care (for example, sending a query to the physician advisor for a response). Just as inpatient documentation from a pathologist or radiologist cannot be used to establish a medical diagnosis for the encounter, documentation from a physician advisor, medical director, or other administrative role who did not provide face-to-face care to the patient cannot be used for query response.

When multiple providers, from different specialties, are involved in the patient's care, the query should be sent to the provider most appropriate for the queried subject matter. For example, a query should not be sent to the consulting nephrologist for skin ulcer etiology or the hospitalist for extent of excisional debridement performed by the surgeon. When

conflicting documentation is present, the attending provider should be queried to resolve any discrepancies. Refer to Section I.B.14 of the ICD-10-CM *Official Guidelines for Coding and Reporting* for additional clarification, as this guidance has been expanded and updated as of 2022.

Additional diagnostic specificity or new diagnoses by other providers (for example, consultants, specialists, advanced practice providers, ED providers) are accepted as reportable without additional query, unless the documentation results in a conflict with the attending provider's documentation.

In some cases, it is appropriate to query clinicians who are not classified as providers for additional information (other than a diagnosis). Organizational guidelines or policies should determine when such queries are permissible. Examples include:

- Nurse for administration of infusions
- Clinician for provision of wound care
- Respiratory therapist for mechanical ventilation
- Nurse for administration of medication that has been ordered by the provider
- Dietitian for body mass index
- Social worker, community health worker, case manager, or nurse for any clarification regarding social determinants/drivers of health
- Radiologist for laterality or location of a lesion

All individuals who are likely to receive a query should be educated about the reasons for the query process and the expectations for documentation completion.

In telehealth, virtual care, and remote patient monitoring encounters, the provider who established the diagnosis and is responsible for documentation within that encounter is the appropriate query recipient, regardless of whether care was delivered in person. The face-to-face requirement refers to the provider's direct clinical involvement with the patient during the encounter, not to the provider's physical presence. Organizations should define in their query policies how query workflows apply to telehealth-specific documentation structures, including asynchronous encounters and remote patient monitoring programs.

Section VIII. How to Query

The following outlines how to construct and present a compliant query.

General principles

All queries, regardless of timing or setting, must adhere to established compliant query practices. Queries must be nonleading, objective, and supported by relevant clinical indicators. They must allow the provider to exercise independent clinical judgment and must not suggest a preferred diagnosis or response.

Query guidelines apply to all query types, including concurrent, retrospective, and prospective queries. For prospective chart reviews that are not associated with a specific encounter and do not request changes to prior documentation, queries must still follow the same standards. In the outpatient setting, the limited duration of an encounter may make concurrent review impractical. In these cases, the need for a query may be identified based on current and prior documentation, including the problem list and available diagnostic data. Queries should only be initiated when clinically relevant to the planned encounter.

Clinical indicators

Clinical indicators must be objective, sourced from the health record with citations, and free from subjective interpretation by the query professional. Code assignment is based on documentation from the current encounter; when clinically relevant, information from a prior encounter may be used to support a query provided sufficient supporting evidence exists within the current encounter. Prior documentation must not serve as the sole basis for a query. See Section V.I.C for complete requirements and Section X for full guidance on prior encounter information.

Query construction and format

Queries must be constructed in a clear, concise, and grammatically correct manner. They should include patient-specific clinical indicators and a clear question identifying the documentation gap.

Query formats may include open-ended, multiple-choice, or yes/no formats, depending on the clinical scenario. Multiple-choice queries must include only clinically supported response options and should provide an “other” option to allow for provider free text response. “Unable to determine” should be included when clinically appropriate. Yes/no queries should only be used to clarify a condition or relationship that is already documented and must not introduce new diagnoses.

Nonleading query practices

Queries must present information in an objective and unbiased manner. A query is considered leading if it directs or influences the provider toward a specific diagnosis or procedure rather than allowing independent clinical judgment.

To ensure compliance, queries must not:

- Suggest or imply a preferred response
- Interpret clinical data for the provider
- Include language referencing reimbursement, quality outcomes, or external incentives

Regardless of query format, information within a query must not be presented in a manner that could be construed as leading. Highlighting, bolding, underlining, or other forms of emphasis must not be used to suggest a preferred response. When clinical information is extracted from the health record, it must be presented accurately and without alteration to content or meaning and should include appropriate source attribution such as date and author when applicable.

Use of clinical definitions or criteria

Clinical definitions or diagnostic criteria may be included in a query when presented neutrally, cited appropriately, and positioned so as not to direct the provider toward a specific response. See Section V.I.F for complete requirements governing inclusion, placement, and organizational governance.

Documentation and retention

Query responses must be incorporated into the health record or available in the business record. They are not required to be repeated elsewhere, but they must remain consistent with the overall clinical record. If subsequent documentation conflicts with a query response, additional clarification is required.

Provider documentation considerations

See Section V.I.H for guidance on provider documentation of query responses. Best practice is for providers to incorporate query responses into their documentation, addressing clinical significance.

Section IX. Sending Multiple Queries

Noncompliance in the context of multiple queries is defined by intent and pattern, not by number alone. It is noncompliant to issue the same or a substantially similar query to the same or different providers when the intent is to pressure, override, or circumvent a provider's clinical judgment in order to obtain a preferred documentation outcome. However, the mere issuance of multiple queries in a single encounter or the sending of a follow-up query after an initial response does not constitute noncompliance. Organizations and external reviewers should evaluate whether repeated queries reflect improper pressure on providers—not simply whether more than one query was sent.

A subsequent query may be appropriate when additional clarification is needed based on new or evolving clinical information, or when a prior response requires further specificity to accurately reflect the patient's condition. Multiple queries may also be necessary when different elements of a diagnosis must be clarified to support accurate code assignment, such as acuity, specificity, or associated conditions. For example, separate clarification may be needed to establish both the presence and the type of a condition, such as heart failure.

Organizations may develop policies to guide the appropriate use and timing of multiple queries within an episode of care, including prioritization of query focus and the number of concurrent queries issued. These policies should support efficient and clinically relevant communication without creating unnecessary burden for providers.

When supported by shared clinical indicators, multiple related conditions may be addressed within a single query, provided the query remains clear, clinically appropriate, and nonleading. For example, a query may address related conditions such as severe protein-calorie malnutrition and cachexia, or include clarification of POA status when applicable.

Organizations should monitor query volume as part of their audit and compliance programs and should evaluate whether high query rates for specific providers, units, or diagnoses reflect documentation education opportunities rather than the need for continued querying. Where possible, concurrent education and real-time feedback to providers should be used to reduce the need for repeated queries on the same documentation patterns. Provider concerns about query volume or process should be directed to the designated organizational authority identified in the query governance policy.

While specific response time frames are appropriately determined by organizational policy, best practice suggests that concurrent queries receive a response before or at the time of

discharge, that retrospective queries are assigned a defined response window, and that unanswered queries may trigger an escalation process rather than remaining open indefinitely. Queries that remain unanswered after the escalation process is exhausted should be closed per organizational policy, with code assignment based on the existing health record documentation. Organizations should track query response rates and average response times as part of their compliance monitoring program, as significant delays or low response rates may indicate provider education needs or workflow barriers that should be addressed proactively.

Section X. Role of Prior Encounters

Code assignment is based on provider documentation within the current encounter and not solely on documentation from prior encounters. However, it is appropriate to issue a query using relevant information from prior encounters when that information supports clarification of the current clinical picture. The use of prior records in this manner supports continuity of care and promotes accurate and complete documentation.

Systematically searching prior records for diagnoses to import into the current encounter without a specific, documented clinical trigger present in the current-encounter record is inappropriate. This practice—sometimes called "mining"—is distinguished from a CDI review by the absence of any current-encounter clinical indicator that prompted the review. CDI review of the current-encounter record, including review of prior-encounter data to provide clinical context, is appropriate and does not constitute mining. A current-encounter clinical indicator is sufficient to support review of prior records when it reflects any documentation—including a diagnosis, symptom, treatment, medication, or clinical finding—that a reasonable query professional would recognize as potentially related to a condition documented in a prior encounter. The sufficiency of a clinical trigger is determined by reference to the clinical record as a whole, not by whether the trigger ultimately proves to establish a reportable diagnosis. When utilizing prior-encounter information, the query must be supported by the current clinical scenario. For example, if CKD is documented in the current encounter, reviewing prior records to determine staging based on historical glomerular filtration rate values may be appropriate, provided the information remains clinically relevant. While there is no defined time frame for how far back CDI may review, the information used must reflect the patient's current clinical condition.

Queries supported by prior-encounter information may be appropriate in circumstances including the following:

- Supporting diagnostic criteria to establish the presence or further specificity of a currently documented diagnosis (e.g., type of heart failure, specific arrhythmia, stage of CKD)
- Establishing a patient baseline to allow comparison with the current presentation (e.g., prior creatinine to support acute kidney injury, baseline cognitive status to support encephalopathy)
- Clarifying cause-and-effect relationships (e.g., postoperative complications, exposure to causative organisms)
- Determining etiology when current documentation reflects signs, symptoms, or treatment that may be related to a prior condition or encounter
- Verifying POA status
- Clarifying whether a condition is current versus historical or acute versus chronic (e.g., neoplasm, deep vein thrombosis, ostomy, ventilator dependence)

When considering whether to issue a query based on prior-encounter information, Section III of the ICD-10-CM *Official Guidelines for Coding and Reporting* should be applied. As defined there, additional diagnoses are defined as conditions that affect patient care by requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. It would be inappropriate to issue a query for a diagnosis that, if documented, would not meet these criteria.

Section XI. Query Technology

Technology is becoming increasingly integrated into provider documentation and the healthcare record. Technologically generated or automated queries, including those referred to as prompts, nudges, advisories, alerts, or similar terms, must include all elements of compliant query practice outlined in this brief. Regardless of patient setting, care type, or the role of the individual receiving the query, technology-generated queries are subject to the same compliance standards as manually constructed queries.

Technology-generated queries necessitate ongoing, comprehensive organizational vetting and oversight during their development and implementation. Organizations should not assume that a vendor-supplied or EHR-integrated tool produces compliant queries by default. Query professionals and compliance leaders must be involved in the evaluation, configuration, and ongoing monitoring of any technology that generates queries or influences the query process.

I. Scope of technology-generated queries

Technology tools used in the query process include computer-assisted physician documentation (CAPD) operating in real time during an encounter, computer-assisted coding (CAC) identifying post-encounter documentation opportunities, large language models (LLM) and generative artificial intelligence (AI) platforms drafting or delivering query language, and EHR-integrated advisories and alerts surfacing documentation gaps across all healthcare settings.

This oversight responsibility extends to tools and functions that may not be immediately recognized as queries but meet the definition outlined in this brief. If a communication meets the definition of a query, it must be treated as one regardless of how it is labeled or where it originates within the technology platform. For the purposes of this brief, a communication constitutes a query when it presents a provider with a specific diagnosis or documentation option for consideration in connection with a specific patient encounter, regardless of how the communication is labeled or where it appears within the technology platform. Passive clinical decision support that surfaces reference information without directing the provider toward a specific response for a specific patient does not constitute a query under this definition. When in doubt, the communication should be treated as a query and must meet all applicable compliance standards.

II. Compliance standards

Any query generated or initiated through a technology-driven process is subject to the same compliance requirements as a manually constructed query, including all elements outlined in Section V of this brief. Specifically:

- Technology-generated queries must include relevant clinical indicators sourced from the health record, cited with location, and free from subjective interpretation
- Query titles, tracking identifiers, or subject lines visible to providers must be nonleading and must not reference a specific desired diagnosis, reimbursement impact, or quality measure
- Answer options generated by technology must include only clinically relevant choices supported by the clinical indicators present in the record, and must include an "other" option or provide the ability for an alternate explanation of findings
- Answer options must not use formatting, emphasis, or ordering that directs the provider toward a preferred response
- If a technology-generated query does not yield a desired response, it is noncompliant to send a follow-up manual query for the same diagnosis or condition solely to override the provider's prior response, in the absence of new clinical indicators

III. Human oversight and query professional responsibility

Even with technology assisting in query generation, humans remain responsible for ensuring that queries are compliant. Organizations should establish processes for multidisciplinary leaders, including query and compliance professionals, to review technology-generated queries for compliance. This review may be conducted prior to delivery or through ongoing structured auditing of query output. Organizational process owners retain accountability for every query delivered to a provider, including those generated through automated or AI-assisted processes. Organizations using automated or AI-assisted query delivery without pre-delivery human review should conduct structured auditing of technology-generated query output on a regular basis.

Staff using technology-driven query tools should receive training specific to the capabilities and limitations of those tools and how to evaluate output against the compliance standards in this brief. Query professionals must remain capable of distinguishing between legitimate query opportunities identified by technology and inappropriate triggers.

IV. Risk of noncompliant technology-generated queries

Technology tools carry a risk of producing queries that are leading, incomplete, or otherwise noncompliant. This may result from tool configuration, training data, or system design that introduces directional bias or prioritizes reimbursement outcomes over clinical accuracy. Organizations should build review and audit processes that specifically evaluate technology-generated queries for leading language, inappropriate clinical indicator sourcing, and undesired construction of answer options. Identification of a noncompliant technology-generated query should trigger the same escalation and corrective action processes applicable to any noncompliant query.

V. Organizational policy

Organizations using technology in the query process should develop and maintain policies that address the following:

- Vendor vetting and compliance review of technology query tools
- Processes for human review of technology-generated queries
- Audit frequency and methodology specific to technology query output
- Staff training requirements for users of technology query tools
- Processes for reporting and correcting noncompliant technology-generated queries

Section XII. Query Templates

I. Standards of use and governance

Organizations should establish policies and procedures governing the development, approval, implementation, and maintenance of query templates. These policies should ensure that all templates are designed and used in a manner consistent with compliant query practices.

Policies should address:

A. Creation and approval of templates

Establish a defined process for creating and approving query templates. Obtain input and feedback from providers and other relevant disciplines (e.g., coding, compliance, clinical leadership) as appropriate. Designate responsibility for template oversight, including approval authority and version control.

B. Review and maintenance

Review and update query templates on a regular schedule (e.g., annually) and when:

- Coding or regulatory updates are published
- Clinical criteria or definitions change
- Organizational processes are modified
- Audit findings identify areas for improvement

Retire or revise outdated templates to maintain compliance and relevance.

C. Instructions for use

Provide clear guidance on when and how templates should be used. Reinforce that templates are tools to support compliant query practices and do not replace clinical judgment.

D. Modality

Regardless of the modality of a query (manual, automated, or technology-assisted), template formatting, elements, and response options must align with this practice brief and applicable compliance standards.

II. Template format

Query templates should be structured in a clear, concise, and efficient manner to facilitate provider review and response.

Templates should follow these standards:

A. Patient identification

Queries should include appropriate patient identification, if this information has not already been auto-populated within the EHR.

B. Editable or customizable fields

Queries must contain fields that the query professional can customize to ensure patient-specific information is included.

C. Clear, concise wording

Query wording should be streamlined to promote efficient provider review.

D. Naming conventions

An organization may configure its query templates so that the template names are not visible to the provider. If template names are visible, they must be non-descriptive and must not identify a diagnosis that has not already been documented.

E. Neutral formatting

Plain text is best practice for all query content created by the query professional. Do not use bold, underlined, italicized, or colored text in query content unless this formatting appears exactly as it does in the original health record documentation. Query professionals are not required to modify formatting of text directly extracted from the health record.

III. Template elements

Query templates should include the necessary elements to support compliant and effective documentation clarification.

A. Clinical indicators

Query templates must allow for inclusion of relevant clinical indicators that support the need for clarification. Clinical indicators must be clinically relevant, presented without interpretation, and include a citation of their source within the health record. When referencing provider documentation, include the date and author of the documentation.

B. Neutral presentation

Clinical indicators and/or answer choices must not be selectively included, omitted, or presented in a manner that could influence the provider toward a specific diagnosis or response.

C. Provider judgment

Templates must be constructed in a manner that allows the provider to apply independent clinical judgment in determining the appropriate diagnosis or procedure.

IV. Use of clinical definitions or criteria

See Section V.I.F for complete requirements governing the use of clinical definitions or diagnostic criteria in queries and templates, including neutrality standards, citation and placement requirements, and governance expectations. All template-based use of definitions or criteria must conform to those standards.

V. Template response options

Response options included in query templates must support accurate and compliant documentation clarification.

A. Relevancy, support, and wording

Answer options must be clinically credible and relevant, be supported by the clinical indicators in the health record, and be worded to allow for accurate code assignment.

B. Introduction of new diagnoses

Response options may introduce a new diagnosis when clinically appropriate and supported.

C. “Other” and “unable to determine” options

Templates should include an “other” option that allows for free text response. When appropriate based on the clinical scenario, they should also include an “unable to determine” option.

D. No minimum number of response options

There is no required minimum number of response options to constitute a compliant multiple-choice query.

E. No leading, unsupported, or irrelevant options

Response options must not be structured in a manner that directs the provider toward a specific diagnosis. A query should not include options that are not clinically supported or relevant.

VI. Technology and automation

Query templates used within electronic systems, including automated or technology-assisted query tools, must adhere to the same standards as manually generated queries.

Automated query templates must be nonleading and clinically supported, allowing providers to exercise independent clinical judgment. Queries should not auto-populate the answer field or suggest diagnoses without provider validation.

Organizations should establish governance for technology-driven query processes, monitor and audit automated query templates for compliance, and ensure multidisciplinary involvement in implementation and oversight.

VII. Monitoring and education

Organizations should implement processes to ensure the ongoing compliance and effectiveness of query templates.

Templates and their use should be regularly audited. During the audit, organizations should evaluate for compliance, clarity, and clinical relevance.

Organizations must also provide training for individuals responsible for creating and using query templates, and periodically reinforce compliant query practices and expectations.

Section XIII. Query Policies and Procedures

Organizations should develop policies and procedures to manage and monitor query practice compliance. All queries should be retained according to state regulations and organizational policies (e.g., regulatory or policy guidance for written, verbal, and technology-generated queries).

Below are sample policies and procedures that may be included, though this is not an exhaustive list:

Query governance and oversight

Define ownership and governance of the query process, including:

- Approval and maintenance of query templates within the EHR
- Roles authorized to create, submit, and respond to queries (including staff and vendors)
- Oversight of query workflows to ensure consistency and compliance

Query standards and structure

Define expectations for compliant query practices, including:

- When a query is appropriate, such as ambiguity, need for clarification, specificity, acuity, or clinical validation
- Required components of a query, including use of clinical indicators and balanced response options (e.g., “other,” “unable to determine”)
- Parameters for multiple queries, including number of questions per template and number of queries per encounter

Clinical support and diagnostic criteria

Define expectations for clinical support of queries, including:

- Type and number of clinical indicators required to support a query
- Use of standardized, evidence-based diagnosis definitions where applicable
- Consideration of organizational definitions to support consistent clinical practice and documentation

Query workflow and timing

Define when and how queries are initiated and managed, including:

- Timing of queries across the continuum (concurrent, retrospective, pre-bill, post-bill)
- Whether post-bill queries are permitted and under what circumstances
- Expectations for a consistent and unbiased query workflow

Audit and compliance monitoring

Define processes for monitoring query compliance, including:

- Audit methodology, frequency, and sample selection
- Evaluation criteria such as template use, compliance with standards, clinical support, and documentation linkage
- Inclusion of all individuals and vendors involved in query submission

Escalation and resolution processes

Define how queries are managed when issues arise, including:

- Escalation pathways and roles involved
- Time frames for provider response, escalation, and closure
- Expectations for resubmission and management of unanswered queries

Noncompliant query management

Define processes for identifying and addressing noncompliant queries, including:

- Alignment with this practice brief and organizational policies
- Management of queries already answered by providers
- Use of health information management (HIM) amendment processes when appropriate

Query retention and technology use

Define how queries are stored and managed, including:

- Whether queries are part of the legal medical record or business record

- Inclusion in release of information processes, in collaboration with HIM
- Governance of technology, including AI tools, automated prompts, and documentation nudges outside of the formal query workflow

Section XIV. Conclusion and References

Healthcare professionals who collaborate with providers to ensure the accuracy and completeness of health record documentation play a critical role in supporting patient care, data reliability, and compliant reporting practices. The query process remains a foundational component of CDI, serving as a mechanism to clarify ambiguous, incomplete, or conflicting documentation.

This practice brief reinforces the importance of consistency, transparency, and professional judgment in documentation clarification. Queries must be utilized as a communication tool to support clinical accuracy and integrity, not as a mechanism to influence reimbursement, quality outcomes, or reporting metrics.

The healthcare environment is increasingly emphasizing clinical validity, documentation credibility, and defensibility. Organizations are continuing to shift away from volume-driven documentation practices toward a more clinically grounded approach that prioritizes the accurate representation of patient complexity, medical decision-making, and treatment. This evolution further elevates CDI and coding professionals as stewards of documentation integrity, requiring the consistent application of clinical judgment, critical thinking, and established guidelines.

Ethical practice remains central to all CDI and query activities. Professionals are expected to ensure that documentation practices accurately represent the patient's condition and care, while avoiding any actions that may misrepresent data or inappropriately influence outcomes. Ethical principles in query practice support trust in the health record and reinforce the integrity of healthcare data.

Ongoing collaboration across clinical, coding, quality, compliance, and leadership teams is essential to maintaining effective query processes. Healthcare organizations should regularly review and update policies, procedures, and educational initiatives to ensure alignment with current regulatory guidance, professional standards, and industry expectations. Through continued commitment to compliant and ethical practices, organizations can support accurate documentation, reliable data reporting, and high-quality patient care.

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