NORWOOD

The State of Physician Queries

www.norwood.com

The State of Physician Queries
Introduction

The old-timers—and perhaps a few relatively recent-timers
—will recall a recent past when a query was pretty straightforward.
Discrete to the encounter. Fee-for-service. Reimbursement driven.
Ask the question, get a response. Dusted and done.
Those days are long gone. A query isn't just a query, anymore. And that's a good thing.

A Query or a Clarification

has become a means of delivering clinical precision and cohesion, ensuring regulatory compliance, and above all strengthening the integrity of an increasingly longitudinal record.

We query for chronic conditions in risk adjustment methodologies to move care up the chain to outpatient, preventive settings.

We query to clean up conflicting documentation, cloned or irrelevant AI summarized office visit and progress notes, and to remove invalid, outdated conditions from problem lists.

We query for inclusion and exclusion criteria to improve quality reporting and ultimately drive better patient outcomes.

With sweeping changes gripping healthcare, coupled with the arrival of a new ACDIS/AHIMA query practice brief, it was time for a special report. *The State of Physician Queries* is intended to bring clarity to CDI and HIM directors and ensure their teams are operating at their "top of license" and querying for impact.

Finally, it's also reminder that mid-revenue cycle leaders are called to lead the way in this space.

The new query guidance applies to everyone involved in the query process, from front-line attendings all the way down to the vendor community and AI-powered query tools.

For the query message to get out, it must be carried and promulgated
—and that message must come from you.

Why We Must Query Compliantly

Before we get into what/how type questions, we need to ground ourselves in the why. Why are queries such a big deal—or not?

At the most basic level, we need guidelines because providers are overworked and can succumb to "just tell me what to write." Historically, some organizations have done just that.

In 2000 HCA (formerly Columbia/HCA) paid $840M in total civil and criminal penalties to the U.S. government for fraud, in part for telling physicians to document more complex pneumonias when they weren't clinically appropriate.

In January of this year Kaiser Permanente affiliates agreed to pay $556 million to resolve allegations that it violated the False Claims Act by submitting invalid diagnosis codes for their Medicare Advantage Plan enrollees in order to receive higher payments from the government.

Per a Department of Justice (DOJ) release, "the United States alleged that Kaiser systematically pressured its physicians to alter medical records after patient visits to add diagnoses that the physicians had not considered or addressed at those visits, in violation of CMS rules."

Busy providers need to exercise independent clinical judgment, and the guidelines provide a framework for that. But as we also know, healthcare is fragmented—and that includes acceptance of query guidelines.

The ACDIS/AHIMA brief is a guideline, not a regulation.

Does anyone care (payers? big tech)?

We think they ought to, due to the legal precedents cited above.

While there isn't any courtroom ruling of which we're aware that directly cites adherence to ACDIS/AHIMA query guidance, the clear implication exists.

And, if the DOJ comes knocking, the healthcare organization ultimately has to answer.

Compliant use of a AI-powered tool—or hammering a non-compliant tool into shape—is the responsibility of the user.

More to come in this space, we're sure.

New Query Guidance: What Has Changed

The biggest news of the year is the release of the ACDIS/AHIMA G*uidelines for Achieving a Compliant Query Practice* (2026), an update to the 2022 physician query practice brief. We recommend reading this in full, but to summarize the highlights:

- **It reinforces that the goal of a query is clinical precision.**
- **It states that auditors must not use it to deny claims. It's a reminder that the brief is a guideline, not a regulation. Does that mean it can be skirted?**
- **It applies to any setting, inpatient or outpatient.**
- **Yes/no queries are permitted for verifying a dx that already exists elsewhere in provider documentation. The option of "unable to determine" is required in POA and all yes/no queries.**
- **MEAT is not used as a basis for code support, but is implicit in this statement: "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."
- **It permits coding from a query response alone, as long as the query form is retained as part of the permanent medical record. If not, the provider must document his/her response in the medical record.**
  One response seems enough. "The response to the query is not required to be repeated elsewhere in the health record."
- **Finally, it puts the onus for following its guidance on the CDI or HIM director him/herself. But we'll get to that later in the paper.**

You still have time to comment:

ACDIS/AHIMA is Open to Public Commentary through June 12

Your voice matters!

What Is (Typically) Being Queried?

What are your most common CDI or coding queries these days?

There are always a few at or near the top (you probably know the culprits), but we're always interested to see if there have been any shifts based on the continued growth of Medicare Advantage/HCCs, social determinants of health, changes in provider terminology, pro-active denial prevention/auditor targets, etc.

Here are some we see, in no particular order/alphabetical:

- **Acute Blood Loss Anemia**
- **Acute Respiratory Failure Validation**
- **AKI Validation**
- **Altered Mental Status**
- **ATN**
- **Cachexia Etiology**
- **Catheter-associated Urinary Tract infection**
- **Cause/Effect**
- **Cerebral Edema and Brain Compression**
- **CHF Specificity/Acuity**
- **Clinical Validation (in general) Coma**
- **Diabetes Mellitus with Hyperglycemia**
- **Elevated Troponins**
- **Encephalopathy**
- **Functional Quadriplegia**
- **Hypo/Hypernatremia**
- **Malnutrition**
- **Medication without a Specified Diagnosis**
- **Obesity**
- **Pneumonia Type**
- **Post-op Respiratory Failure**
- **Present on Admission Confirmation**
- **Pressure Ulcers**
- **Renal Failure**
- **Rule In/Rule Out For Diagnoses Documented as Possible**
- **Sepsis Validation**

What are yours?
Any interesting recent examples from your chart reviews?
Leave a comment.

Asking Direct (But Not Leading) Queries is OK

Sometimes we get so fixated on query format we fail to see forest through the trees.

The point of a query is to ask a pointed, clinically relevant question and allow the physician to exercise his/her independent judgement.

We should be asking direct no-nonsense queries, especially in the outpatient setting when chronic disease treatment and YOY RAF capture are the principal goals.

There is ample support from the new ACDIS/AHIMA query guidance to support it.

Per ACDIS/AHIMA, you can't ask a yes/no question to obtain a new or undocumented diagnosis or condition… but you can certainly ask a yes/no question to clarify an existing one.

The brief specifically states "substantiating a diagnosis that is present within the current medical record" with a yes/no query is permissible.

If a query like this feels too directive, well, how else should it be directed? The question must be asked. Just include where the question is derived. This can be from prior records.

The 2022 AHIMA-ACDIS Compliant Clinical Documentation Integrity Technology Standards paper says the question can for example derive from an ongoing treatment plan, if an organizational policy allows it.

"Additionally, a query may be generated based on a provider's treatment plan as long as it is authenticated, unless the organization's policies and procedures prohibit this process."

Just cite your work.

The query brief stresses concision. It states that one should remove answer options that are not clinically credible or relevant from multiple choice queries, and there may only be one valid option.

Per the brief: "Multiple-choice query formats should include clinically significant and reasonable option(s) as supported by clinical indicator(s) in the health record, recognizing that occasionally there may be only one reasonable option."

CDI professionals should never feel like they have to ask terrible, non-clinical questions with a long list of options for the sake of "compliance." That practice loses credibility, fast.

The guidelines state it is inappropriate to "mine" a previous encounter to generate queries not related to the current encounter.

But of course, ongoing chronic conditions managed in the OP encounter almost certainly will always be related to why the patient is in the office.

Any medical record should have the patient's medications listed, which meets the query brief requirement:

"A query cannot be based solely on the information from a prior encounter, there must be relevant information within the current encounter to substantiate the query."

TL;DR Version:

Do Not Document on Behalf of the Physician.

Allow him or her to exercise their independent clinical judgement. But asking them a direct question to confirm whether a prior chronic condition is still clinically relevant?

That's good CDI practice. Have at it.

Note: Separate OP query guidance exists (see below), although it's from 2018 and the new guidance supersedes. But it does contain an example of a direct question about prior diagnoses based solely on PMH and ongoing treatment, and concludes by asking the provider to redocument them:

Your patient, Mr. Jones, has a past medical history of CAD, CHF, and COPD, as noted on his previous office visit. Current medications include albuterol, nitroglycerin PRN, and Lasix.

Please review this encounter and these conditions for relevancy and document within Mr. Jones' upcoming appointment if these are still relevant, and please provide clinical support of how they are affecting his care and/or if these conditions are being managed.

Query Compliance Is On You

The biggest takeaway from the new ACDIS/AHIMA query guidelines, from our perspective at least, is its directive as a call to action. Action which may be difficult for you, HIM or CDI Director.

Because it reinforces that EVERYONE engaged in the query process must follow it. So…

1

If you have outsourced your CDI function, are your contractors following the query guidelines?

2

What if they are managed by another company? Or, are overseas?

3

Are you prepared to have uncomfortable conversations, up and down the chain of your organization?

Including with your high-priced consulting firm who promised outsized ROI, or your even higher priced tech platform (and the C-suite execs who authorized its purchase)?

This is what the brief is calling us to do.
The guidelines are not a pat answer to point to and say, "follow this."
It's a call to action, to say "follow me, and ACDIS/AHIMA."

The Brief Says:

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).

You are that sharer.

Should ACDIS/AHIMA be presenting this brief to the likes of Epic?
I think so. It will be interesting if that organization offers a comment.

Which is the last important takeaway:
If you disagree with the brief, or love it, leave a comment.

References & Resources

- ACDIS/AHIMA, Draft for Public Comment: ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice —2026 Update: https://acdis.org/resources/acdisahima-guidelines-achieving-compliant-query-practice%E2%80%942026-update

- ACDIS, Queries in outpatient CDI: Developing a compliant, effective process: https://acdis.org/resources/queries-outpatient-cdi-developing-compliant-effective-process

- Department of Justice: Attorney General Announces Largest Department of Justice Fraud Settlement in History:https://www.justice.gov/archive/opa/pr/2000/December/697ag.htm

- Norwood, A very bad start to the year for Medicare Advantage: https://www.norwood.com/a-very-bad-start-to-the-year-for-medicare-advantage-whistleblowers-and-government-officials-expose-questionable-risk-adjustment-coding-practices/

NORWOOD

Your Mid-revenue Cycle Problems, Our Solutions

Norwood helps you solve your most difficult revenue cycle challenges.
Partner with us and become the hero of your healthcare organization.

Our suite of services includes:

On-demand Talent

- Facility and Profee Coders
- Clinical Documentation Integrity
- HCC Auditors and Coders
- Trauma Registry Professionals
- Oncology Registry Professionals
- Department Leadership

CDI

Inpatient | Outpatient

Pediatric CDI

Chart Reviews & Compliance

CDI Program Implementations

Inpatient | Outpatient

Data Analysis

Payer Partnerships

Denials Management

Supplemental Diagnosis Submissions

Coding Audits

- CPT
- E/M
- HCPCS
- ICD-10-CM
- ICD-10-PCS
- HCC

MS-DRG

Optimization & Compliance

Managed Services

Outsourced Revenue Cycle Management

Risk Adjustment Factor (RAF)

Optimization & Compliance

Education

Live and Remote/Online

- CDI
- Coding
- Providers
- Outpatient CDI Boot Camp

If you don't see something here, ask. We're all about customization. You wouldn't expect to pluck an EHR off the shelf and use it. We feel the same about our solutions.

What Makes Us Different?

FLEXIBILITY

Whether implementing an outpatient CDI program, staffing your department, or auditing charts, we deliver flexibility with exceptional performance.

PEOPLE

We offer big-corporation resources with a small-company feel—Norwood is privately owned, independent, and values-driven.