

Concurrent Chart Review: Provider Query Best Practices

A RISK ADJUSTMENT BEST PRACTICE SERIES FOR PROVIDERS

A concurrent provider query is used to clarify documentation in a patient's medical record for accurate and complete diagnosis code assignment prior to claim submission. The documentation and final diagnosis code selections should accurately and completely reflect the patient's true health status at the time of the encounter. A compliant query process should result in documentation that is clear, precise, complete, legible, and consistent, and also serves as a method to educate providers on documentation improvement and diagnostic specificity.

Best Practices for Compliant Provider Queries:

- Adhere to ICD-10-CM Official Guidelines for Coding and Reporting.
- Query the provider for clarification when the documentation is conflicting, imprecise, illegible, ambiguous, or inconsistent.
- A query should never lead the provider towards a specific diagnosis; the query should include only the facts that indicate why the clarification from the provider is needed.
- Query the provider as quickly as possible after the encounter.ⁱ
- All queries should contain the following components:
 - Provider name
 - Location name
 - Patient name
 - Patient date of birth
 - Date of service
- Query templates should allow for documentation updates and provide clear instructions to the provider for answering the query. For example:

"Breast cancer/status post radiation" was noted in the patient's Annual Wellness Visit documentation. Would you please document the laterality of the breast, the specific quadrant, and if the cancer has been completely eradicated or is still under active treatment?

For questions or to learn about how Premera Blue Cross Blue Shield of Alaska can support concurrent chart reviews and compliant provider queries in your practice, email ProviderClinicalConsulting@Premera.com.

ⁱ 2004 Risk Adjustment Regional Training for Medicare Advantage Organizations Questions and Answers session