

CDIP Dumps

Certified Documentation Integrity Practitioner

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NEW QUESTION 1

Which of the following organizations should a clinical documentation integrity practitioner (CDIP) monitor?

- A. Office of Inspector General (OIG), Accreditation Commission for Healthcare (ACHC), Recovery Auditors (RAs)
- B. Program for Evaluating Payment Patterns Electronic Report (PEPPER), Recovery Auditors (RAs), Center for Improvement in Healthcare (CIHQ)
- C. Recovery Auditors (RAs), Program for Evaluating Payment Patterns Electronic Report (PEPPER), Office of Inspector General (OIG)
- D. Center for Improvement in Healthcare (CIHQ), Accreditation Commission for Healthcare (ACHC), Recovery Auditors (RAs)

Answer: C

Explanation:

The organizations that a clinical documentation integrity practitioner (CDIP) should monitor are Recovery Auditors (RAs), Program for Evaluating Payment Patterns Electronic Report (PEPPER), and Office of Inspector General (OIG). These organizations are involved in auditing, reviewing, and investigating the accuracy, completeness, and compliance of clinical documentation, coding, billing, and reimbursement practices of hospitals and other healthcare providers. The CDIP should monitor these organizations to stay updated on their policies, guidelines, findings, recommendations, and actions that may affect the CDI program and the hospital's performance and reputation. [3][3] References: 1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf [3][3]: <https://my.ahima.org/store/product?id=67077>

NEW QUESTION 2

A 90-year-old female patient was admitted to emergency room c/o nausea and vomiting x2 days. Vital signs: BP 130/72, P 86, R 22, T 99.8F, O2 sat 94% on room air. Patient has a history of cerebral vascular accident (CVA) and difficulty swallowing. CXR revealed right lower lobe infiltrate. Labs: WBC 12.0 with 71% segs. Physician documents patient with a history of CVA and difficulty swallowing. CXR revealed right lower lobe infiltrate, diagnosis: pneumonia. Aspiration precautions and IV Clindamycin ordered. Patient was discharged 3 days later with a diagnosis of pneumonia. Clarification is needed to determine which of the following is clinically indicated.

- A. Simple pneumonia
- B. Aspiration pneumonia
- C. Pneumonia, a sequela of CVA
- D. Complex pneumonia

Answer: B

Explanation:

Aspiration pneumonia is a type of pneumonia that occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs, causing an infection or inflammation. Aspiration pneumonia is more likely to occur in people who have difficulty swallowing, such as those with a history of CVA². In this case, the patient has a history of CVA and difficulty swallowing, and presents with nausea and vomiting, which are risk factors for aspiration. The CXR reveals a right lower lobe infiltrate, which is a common finding in aspiration pneumonia³. The physician documents pneumonia as the diagnosis, but does not specify the type or cause. Therefore, clarification is needed to determine if aspiration pneumonia is clinically indicated, as it would affect the coding and reimbursement of the case. Aspiration pneumonia is coded as ICD-10-CM code J69.x Pneumonitis due to solids and liquids, with a fourth digit required to specify the inhaled substance⁴.

References:

- ? CDI Week 2020 Q&A: CDI and key performance indicators¹
- ? Mayo Clinic: Aspiration pneumonia²
- ? Medscape: Aspiration Pneumonia³
- ? ICD-10-CM Diagnosis Code J69.x: Pneumonitis due to solids and liquids⁴

NEW QUESTION 3

A patient has a history of asthma and presents with complaints of fever, cough, general body aches, and lethargy. The patient's child was recently diagnosed with influenza. Wheezing is heard on exam. The physician documents the diagnosis as asthma exacerbation and orders nebulizer treatments of Albuterol and a 5-day course of oral Prednisone. The clinical documentation integrity practitioner (CDIP) is unsure which signs and symptoms are inherent to asthma. Which reference resource should be used to obtain this information?

- A. Physician's Desk Reference
- B. Medical Dictionary
- C. The Merck Manual
- D. AMA CPT Assistant

Answer: C

Explanation:

The reference resource that should be used to obtain information about the signs and symptoms that are inherent to asthma is The Merck Manual. This is a comprehensive medical reference that covers various topics related to diseases, diagnosis, treatment, and prevention. The Merck Manual provides a detailed description of asthma, including its causes, risk factors, pathophysiology, clinical features, diagnosis, management, and complications. According to The Merck Manual, the signs and symptoms that are inherent to asthma are wheezing, coughing, chest tightness, and dyspnea (shortness of breath) ². These symptoms are caused by the reversible bronchoconstriction and inflammation of the airways that characterize asthma. The Merck Manual also explains how these symptoms can be triggered or exacerbated by various factors, such as allergens, infections, exercise, cold air, stress, or medications ².

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 ³ 2: Asthma - Pulmonary Disorders - Merck Manuals Professional Edition ⁴

NEW QUESTION 4

A 50-year-old with a history of stage II lung cancer is brought to the emergency department with severe dyspnea. The patient underwent the last round of chemotherapy 3 days ago. Vital signs reveal a temperature of 98.4, a heart rate of 98, a respiratory rate of 28, and a blood pressure of 124/82. O2 saturation on room air is 92%. The patient is 5'5" and weighs 98 lbs. The registered dietitian notes the patient is malnourished with BMI of 19. Chest x-ray reveals a large pleural effusion in the right lung. Thoracentesis is performed and 1000 cc serosanguinous fluid is removed. The admitting diagnosis is large right lung pleural effusion related to lung cancer stage II, documented multiple times. What post discharge query opportunity should be sent to the physician that will affect severity of illness (SOI)/risk of mortality (ROM)?

- A. Query for protein calorie malnutrition
- B. Query for malignant pleural effusion

- C. Query for a diagnosis associated with the dietician's finding of malnutrition
- D. Query if the malignant pleural effusion is the reason for admission

Answer: B

Explanation:

According to the AHIMA CDIP Exam Preparation Guide, a query is a communication tool or process used to clarify documentation in the health record for documentation integrity and accurate code assignment¹. A query should be clear, concise, and consistent, and should include relevant clinical indicators that support the query¹. A query should also provide multiple choice answer options that are supported by clinical indicators and include a non-leading query statement². In this case, the patient has a large right lung pleural effusion related to lung cancer stage II, which is documented multiple times. However, the documentation does not specify whether the pleural effusion is malignant or not. A malignant pleural effusion is a condition where cancer cells spread to the pleural space and cause fluid accumulation³. A malignant pleural effusion is a major complication or comorbidity (MCC) that affects the severity of illness (SOI) and risk of mortality (ROM) of the patient, as well as the reimbursement and quality scores of the hospital⁴. Therefore, a post discharge query opportunity should be sent to the physician to clarify whether the pleural effusion is malignant or not, based on the clinical indicators such as chest x-ray, thoracentesis, and fluid analysis. The query should provide answer options such as malignant pleural effusion, non-malignant pleural effusion, unable to determine, or other. The other options are not correct because they either do not affect the SOI/ROM of the patient (A and C), or they do not address the specificity of the diagnosis (D). References:

? CDIP Exam Preparation Guide - AHIMA

? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

? Malignant Pleural Effusion: Symptoms, Causes, Diagnosis & Treatment

? Q&A: Coding for malignant pleural effusions | ACDIS

NEW QUESTION 5

Which factors are important to include when refocusing the primary vision of a clinical documentation integrity (CDI) program?

- A. Reporting and the use of technology
- B. Value and mission statements
- C. Benchmarks and case mix index
- D. Diagnostic related groups and revenue cycle

Answer: B

Explanation:

A CDI program's vision should reflect its purpose, values, and goals, and align with the organization's overall vision and mission. Value and mission statements help define the CDI program's role, scope, and objectives, and communicate them to stakeholders. Reporting and the use of technology are important tools for a CDI program, but they are not part of its vision. Benchmarks and case mix index are performance indicators that measure the CDI program's outcomes, but they do not reflect its vision. Diagnostic related groups and revenue cycle are aspects of reimbursement that may be affected by the CDI program, but they are not the primary focus of its vision.

NEW QUESTION 6

Identify the error in the following query:

This patient's echocardiogram showed an ejection fraction of 25%. The chest x-ray showed congestive heart failure (CHF). The patient was prescribed Lasix and an angiotensin- converting enzyme inhibitor (ACEI). Is this patient's CHF systolic?

- A. The query is unclear.
- B. The query contains irrelevant information.
- C. The query does not contain clinical indicators.
- D. The query is leading.

Answer: D

Explanation:

A leading query is one that suggests a specific diagnosis, condition, or treatment to the provider, or implies that a certain response is desired or expected. A leading query can compromise the integrity and accuracy of the documentation and the coded data, and may also raise compliance and ethical issues. A query should be non-leading, meaning that it presents the facts from the health record without bias or influence, and allows the provider to use their clinical judgment to determine the appropriate response.

The query in the question is leading because it implies that the patient's CHF is systolic by asking a yes/no question that only offers one option. A non-leading query would ask an open-ended question that offers multiple options, such as "What type of CHF does this patient have?" or "Please specify the type of CHF: systolic, diastolic, or combined." References:

? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530

? Guidelines for Achieving a Compliant Query Practice—2022 Update | ACDIS

? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

? The Provider Query Toolkit: A Guide to Compliant Practices

NEW QUESTION 7

A patient falls off a ladder and undergoes a right femur procedure. Three weeks later, the patient returns to the hospital for removal of the external fixation device. The ICD-10-CM 7th character code value should indicate

- A. subsequent
- B. sequela
- C. initial
- D. aftercare

Answer: D

Explanation:

The ICD-10-CM 7th character code value should indicate aftercare for a patient who falls off a ladder and undergoes a right femur procedure, and then returns to the hospital for removal of the external fixation device. Aftercare codes are used to capture encounters for follow-up care after completed treatment of an injury or condition, such as removal of external fixation devices, casts, or pins. Aftercare codes are not used for subsequent encounters for complications or infections related to the injury or condition⁵ References: 1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 5:

<https://my.ahima.org/store/product?id=67077>

NEW QUESTION 8

The clinical documentation integrity (CDI) manager reviewed all payer refined-diagnosis related groups (APR-DRG) benchmarking data and has identified potential opportunities for improvement. The manager hopes to develop a work plan to target severity of illness (SOI)/risk of mortality (ROM) by service line and providers. How can the manager gain more information about this situation?

- A. Audit cases for missed diagnosis by the CDI practitioner to target in the education plan
- B. Audit focused cases by physicians that have a higher SOI/ROM for education plan
- C. Audit cases that have high SOI/ROM assigned by coders for education and follow-up
- D. Audit focused APR-DRGs and develop education plan for CDI team and physicians

Answer: D

Explanation:

APR-DRGs are a patient classification system that assigns each inpatient stay to one of more than 300 base APR-DRGs, and then further stratifies each base APR-DRG into four levels of severity of illness (SOI) and risk of mortality (ROM), based on the number, nature, and interaction of complications and comorbidities (CCs) and major CCs (MCCs). SOI reflects the extent of physiologic decompensation or organ system loss of function, while ROM reflects the likelihood of dying. Both SOI and ROM are used to adjust payment rates, quality indicators, and performance measures for hospitals and other healthcare providers. The CDI manager can gain more information about the potential opportunities for improvement by auditing focused APR-DRGs that have a high impact on SOI/ROM levels, such as those that have a large variation in relative weights across the four severity levels, or those that have a high frequency or volume of cases. The audit can help identify the documentation gaps, inconsistencies, or inaccuracies that may affect the assignment of SOI/ROM levels, such as missing, vague, or conflicting diagnoses, procedures, or clinical indicators. The audit can also help evaluate the CDI team's performance in terms of query rate, response rate, agreement rate, and accuracy rate. Based on the audit findings, the CDI manager can develop an education plan for both the CDI team and the physicians to address the specific documentation improvement areas and provide feedback and guidance on best practices.

* A. Audit cases for missed diagnosis by the CDI practitioner to target in the education plan. This is not the best way to gain more information about the situation, because it may not capture all the factors that affect SOI/ROM levels, such as procedures, clinical indicators, or interactions among diagnoses. It may also focus only on the CDI practitioner's performance, without considering the physician's role in documentation quality and completeness.

* B. Audit focused cases by physicians that have a higher SOI/ROM for education plan. This is not a valid way to gain more information about the situation, because it may not identify the documentation improvement opportunities for cases that have a lower SOI/ROM than expected, based on their clinical complexity and acuity. It may also create a perception of bias or favoritism among physicians, if only some are selected for audit and education.

* C. Audit cases that have high SOI/ROM assigned by coders for education and follow-up. This is not a reliable way to gain more information about the situation, because it may not reflect the true SOI/ROM levels of the cases, if there are errors or discrepancies in coding or grouping. It may also overlook the documentation improvement opportunities for cases that have low SOI/ROM assigned by coders, despite having high clinical complexity and acuity.

References:

? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530

? 3M™ All Patient Refined Diagnosis Related Groups (APR DRGs) | 3M United States

? Q&A: Understanding SOI and ROM in the APR-DRG system | ACDIS

? Use SOI/ROM scores to enhance CDI program effectiveness | ACDIS

NEW QUESTION 9

A clinical documentation integrity practitioner (CDIP) has been successful in getting physicians to respond to queries. However, when the CDIP poses a query to a specific doctor, there is no response at all. The CDIP has tried face-to-face conversations, calling, emails, texts, but still gets no response. What is the next step the CDIP should take?

- A. Elevate the issue to the physician advisor/champion after the CDI supervisor has reviewed the case and deemed the query appropriate
- B. Report the doctor to the Vice President of Medical Affairs so the doctor understands the importance of clinical documentation
- C. Hold a meeting with the CDI director and the doctor to find out why the doctor is not responding to the queries
- D. Warn the other CDIPs that the doctor is a non-responder and to forego querying

Answer: A

Explanation:

According to the Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA¹, a query escalation policy should describe how to handle situations in which an answer is not received, an inappropriate answer or comment is provided, etc. The escalation policy should address when the issue is brought to the physician advisor, the department director, or administration with defined actions as to the responsibilities at each level. The policies should reflect a method of response that can realistically occur for the organization¹. In this case, since the CDIP has tried multiple methods of communication

with the doctor but still gets no response, the CDIP should elevate the issue to the physician advisor/champion, who can facilitate communication and education with the doctor and ensure documentation integrity and compliance¹. However, before escalating the issue, the CDIP should consult with the CDI supervisor to review the case and confirm that the query is appropriate, relevant, and compliant with the query guidelines¹. This would ensure that the escalation is justified and not based on personal bias or preference. The other options are not advisable because they either involve skipping the escalation policy, reporting the doctor without proper review or feedback, holding a meeting without involving the physician advisor/champion, or giving up on querying altogether. References:

? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA¹

NEW QUESTION 10

Combination codes are used to classify two diagnoses, a diagnosis with a manifestation, or a diagnosis

- A. that is an integral part of a disease process
- B. with an associated complication
- C. with an associated procedure
- D. with a sequelae or late effect

Answer: B

Explanation:

Combination codes are used to classify two diagnoses, a diagnosis with a manifestation, or a diagnosis with an associated complication. A complication is a condition that arises during the hospital stay that prolongs the length of stay by at least one day in approximately 75 percent of cases¹. Complications may affect payment and severity of illness and risk of mortality classifications. Examples of combination codes that include a diagnosis with an associated complication are:

? I50.23 Acute on chronic systolic (congestive) heart failure

? K57.21 Diverticulitis of large intestine with perforation and abscess with bleeding

? O34.211 Maternal care for incompetent cervix with cerclage, first trimester A diagnosis that is an integral part of a disease process is not a valid option for combination codes, because it does not represent a separate or additional condition that needs to be coded. For example, chest pain is an integral part of acute

myocardial infarction and does not require a separate code.

A diagnosis with an associated procedure is not a valid option for combination codes, because procedures are coded separately from diagnoses using ICD-10-PCS codes. For example, appendicitis with appendectomy is not a combination code, but rather two codes: one for the diagnosis (K35.80 Acute appendicitis without perforation or gangrene) and one for the procedure (0DTJ4ZZ Resection of appendix, percutaneous endoscopic approach). A diagnosis with a sequelae or late effect is not a valid option for combination codes, because sequelae or late effects are coded separately from the original condition using the appropriate code from category B90-B94 Sequelae of infectious and parasitic diseases or category I69 Sequelae of cerebrovascular disease, followed by the code for the specific condition². For example, hemiplegia following cerebral infarction is not a combination code, but rather two codes: one for the sequelae (I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side) and one for the original condition (I63.9 Cerebral infarction, unspecified).

References:

? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530

? ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

? Identifying ICD-10 Combination Codes - Outsource Strategies International

NEW QUESTION 10

A 77-year-old male with chronic obstructive pulmonary disease (COPD) is admitted as an inpatient with severe shortness of breath. The patient is placed on oxygen at 2 liters per minute via nasal cannula. History reveals that the patient is on oxygen nightly at home. CXR is unremarkable. The most compliant query is

- A. Patient has COPD, and is on nocturnal oxygen at home and is on continuous oxygen since admission
- B. Please order further tests so the patient's severity of illness can be captured with the most accurate coding assignment.
- C. Patient has COPD and is on oxygen every night at home and has been on continuous oxygen since admission, please document chronic respiratory failure, hypoxia, acute on chronic respiratory failure.
- D. Patient has COPD, and is on nocturnal oxygen at home and is on continuous oxygen since admission
- E. Please indicate if you are treating one of these diagnoses: chronic respiratory failure, acute respiratory failure, acute on chronic respiratory failure, unable to determine, other.
- F. Patient has COPD and is on oxygen every night at home and has been on continuous oxygen since admission
- G. Based on these indications, please document chronic respiratory failure, acute respiratory failure, acute on chronic respiratory failure.

Answer: C

Explanation:

According to the AHIMA/ACDIS Query Practice Brief, a compliant query should provide multiple choice answer options that are supported by clinical indicators and include a non-leading query statement¹. Option C meets these criteria, as it provides a list of possible diagnoses that are relevant to the patient's condition and asks the provider to indicate which one they are treating. Option C also does not imply or suggest a preferred answer or outcome, and allows the provider to choose unable to determine or other if none of the listed options apply. Option A is not compliant, as it does not provide any answer options and implies that the provider should order more tests to capture a higher severity of illness. Option B is not compliant, as it provides only one answer option and suggests that the provider should document it based on the clinical indicators. Option D is not compliant, as it provides only one answer option and implies that the provider should document it based on the indications. References:

? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

NEW QUESTION 13

Which of the following is MOST likely to trigger a second-level review?

- A. A procedure code that increases reimbursement
- B. A diagnosis that impacts a quality-of-care measure
- C. An account coded before the discharge summary is available
- D. A record with multiple major complicating conditions (MCCs)

Answer: D

Explanation:

According to the AHIMA CDIP Exam Preparation Guide, a second-level review is a process that involves a review of coded records by a designated person or team to ensure the accuracy and completeness of coding and documentation¹. A second-level review may be triggered by various factors, such as high-risk or high-dollar accounts, coding quality indicators, payer requirements, or internal audit findings¹. One of the factors that is most likely to trigger a second-level review is a record with multiple major complicating

conditions (MCCs)². MCCs are diagnoses that significantly affect the severity of illness and resource utilization of a patient, and are assigned a higher relative weight in the DRG system³. A record with multiple MCCs may indicate a complex or unusual case that requires additional validation and verification of the coding and documentation. A record with multiple MCCs may also affect the reimbursement, risk adjustment, and quality scores of the hospital, and therefore may be subject to external scrutiny or audit⁴. The other options are not as likely to trigger a second-level review, as they are not as indicative of coding or documentation issues or risks. A procedure code that increases reimbursement may not necessarily require a second-level review, unless it is inconsistent with the documentation or the clinical indicators. A diagnosis that impacts a quality-of-care measure may be relevant for CDI purposes, but not necessarily for coding validation. An account coded before the discharge summary is available may be incomplete or inaccurate, but it may also be corrected or updated before final billing.

References:

? CDIP Exam Preparation Guide - AHIMA

? Building a Resilient CDI: Second Level Review

? Major Complications or Comorbidities (MCC) & Complications or Comorbidities (CC) | CMS

? Demystifying and communicating case-mix index - ACDIS

NEW QUESTION 16

A clinical documentation integrity practitioner (CDIP) generates a concurrent query and continues to follow retrospectively; however, the coder releases the bill before the query is answered. The CDIP wonders if it is appropriate to re-bill the account if the physician answers the query after the bill has dropped. Which policy should the hospital follow to avoid a compliance risk?

- A. A rebilling is permissible when queries are answered after the initial bill.
- B. A post-bill query rarely occurs as a result of an audit or other internal monitor.
- C. A second bill should not be submitted when the first bill was incomplete.
- D. A post bill query is not appropriate when an error is found after an audit.

Answer: A

Explanation:

A rebilling is permissible when queries are answered after the initial bill, as long as the hospital follows the appropriate guidelines and procedures for rebilling, such as submitting a corrected claim within the timely filing limit, notifying the payer of the reason for rebilling, and documenting the query process and outcome in the health record. Rebilling may be necessary to ensure accurate coding and reporting of the patient's condition and treatment, as well as appropriate reimbursement and quality measures. [3][3] References: 1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf [3][3]: <https://my.ahima.org/store/product?id=67077>

NEW QUESTION 21

An 86-year-old female is brought to the emergency department by her daughter. The patient complains of feeling tired, weak and excessive sleeping. The patient's daughter comments that patient's mental condition has not been the same. Lab results are unremarkable except for a sodium level of 119, a BUN of 22, and a creatinine of 1.35. The patient receives normal saline IV infusing at 100 cc/hr. The admitting diagnosis is weakness, altered mental status and dehydration. Which of the following queries is presented in an ethical manner thus avoiding potential fraud and/or compliance issues?

- A. Patient's sodium is 119 and she is on NS IV at 100 cc/hr, is this clinically significant? If so, please document a corresponding diagnosis related to this lab result.
- B. Patient is feeling tired, weak, sleeping a lot and has altered mental statu
- C. Sodium is 119 and she is on NS IV at 100 cc/h
- D. Is the altered mental status related to the sodium of 119?
- E. Patient's sodium is 119 and she is on NS IV at 100 cc/hr, does patient have hyponatremia?
- F. Patient is feeling tired, weak, sleeping a lot and has altered mental statu
- G. Sodium is 119 and she is on NS IV at 100 cc/hr, please clarify the clinical significance of the lab result.

Answer: D

NEW QUESTION 25

A patient's progress note states "The patient has chronic systolic heart failure". After reviewing clinical indicators suggestive of an exacerbation of systolic heart failure, the clinical documentation integrity practitioner (CDIP) queries the physician to clarify the current acuity of the diagnosis. Which subsequent documentation in the health record suggests the provider did not understand the query?

- A. The patient has chronic systolic heart failure.
- B. The patient has acute on chronic systolic heart failure.
- C. The patient did have an exacerbation of heart failure.
- D. The patient has decompensated systolic heart failure.

Answer: A

Explanation:

According to the AHIMA CDIP Exam Preparation Guide, a query is a communication tool or process used to clarify documentation in the health record for documentation integrity and accurate code assignment¹. A query should be clear, concise, and consistent, and should include relevant clinical indicators that support the query¹. A query should also provide multiple choice answer options that are supported by clinical indicators and include a non-leading query statement². In this case, the CDIP queried the physician to clarify the current acuity of the diagnosis of chronic systolic heart failure, based on clinical indicators suggestive of an exacerbation of systolic heart failure. The subsequent documentation in the health record that suggests the provider did not understand the query is A. The patient has chronic systolic heart failure. This documentation does not address the query or provide any additional information about the patient's condition. It simply repeats the same diagnosis that was already documented in the progress note. This documentation does not reflect the patient's true severity of illness, risk of mortality, or reimbursement³. The other options are not correct because they do provide some information about the current acuity of the diagnosis of chronic systolic heart failure, such as acute on chronic, exacerbation, or decompensation. These terms indicate a higher level of severity and complexity than chronic alone. References:

? CDIP Exam Preparation Guide - AHIMA

? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

? Severity of Illness: What Is It? Why Is It Important? | HCPro

? [Q&A: Acute on chronic versus decompensated heart failure | ACDIS]

NEW QUESTION 29

After one year, the clinical documentation integrity (CDI) program has become stagnant, and the manager plans to reinvigorate the program to better reflect the CDI efforts in the organization. What can the manager do to ensure program success?

- A. Expand the CDI program to larger areas in outpatient clinics
- B. Prioritize to focus on efforts with the largest return on investment
- C. Identify key metrics to develop program measures for coders
- D. Establish a CDI steering committee to build a strong foundation

Answer: D

Explanation:

A CDI steering committee is a group of interdisciplinary leaders who oversee and guide the CDI program's objectives, outcomes, and metrics. The committee should include representatives from finance, clinical, coding, quality, and other areas that are impacted by CDI. The committee should meet regularly to review the CDI program's performance, identify opportunities for improvement, and provide support and education to the CDI staff and providers. A CDI steering committee can help reinvigorate a stagnant CDI program by ensuring that it aligns with the organization's vision and mission, addresses the current challenges and needs, and fosters collaboration and communication among stakeholders. The other options are not necessarily effective ways to reinvigorate a CDI program. Expanding the CDI program to larger areas in outpatient clinics may not be feasible or appropriate without a clear strategy and plan. Prioritizing to focus on efforts with the largest return on investment may not reflect the true value and quality of the CDI program. Identifying key metrics to develop program measures for coders may not capture the full scope and impact of the CDI program.

NEW QUESTION 32

A hospital administrator has hired a clinical documentation integrity (CDI) firm to improve its revenue objectives. The physicians object to this action. How should the firm collaborate with physicians to overcome their objections?

- A. Create a vision statement that outlines the project objectives
- B. Communicate the benefits of the CDI firm about the project
- C. Hire a consultant to communicate the benefits to the physicians
- D. Identify an influential physician advisor/champion to promote support

Answer: D

Explanation:

A physician advisor/champion is a physician leader who supports and advocates for the CDI program and its objectives. A physician advisor/champion can help overcome the objections of other physicians by providing education, feedback, guidance, and mentorship on documentation best practices and their impact on revenue, quality, and patient care. A physician advisor/champion can also act as a liaison between the CDI firm and the medical staff, resolve conflicts or discrepancies in documentation, and foster a culture of collaboration and improvement. Physicians are more likely to trust and engage with their peers who understand their clinical perspective and challenges, rather than an external CDI firm that may be perceived as intrusive or disruptive.

* A. Create a vision statement that outlines the project objectives. This is not sufficient to collaborate with physicians and overcome their objections. A vision statement is a general statement that describes the desired outcome of the project, but it does not address the specific concerns or questions that physicians may have about the CDI firm's role, methods, or benefits.

* B. Communicate the benefits of the CDI firm about the project. This is not enough to collaborate with physicians and overcome their objections. Communicating the benefits of the CDI firm may be informative, but it may not be persuasive or credible if it comes from the CDI firm itself, without any endorsement or support from a physician leader within the organization.

* C. Hire a consultant to communicate the benefits to the physicians. This is not a good way to collaborate with physicians and overcome their objections. Hiring a consultant may add another layer of complexity and cost to the project, and it may not improve the trust or relationship between the CDI firm and the physicians. A consultant may also lack the clinical expertise or authority to influence the physicians' behavior or attitude. References:

? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530

? Q&A: Defining roles for physician advisor/champion | ACDIS

? Q&A: The Role of the Physician Advisor in CDI | ACDIS

? The Role of a Physician Advisor - UASI Solutions

? PA/NP in Physician Champion / Advisor Role — ACDIS Forums

NEW QUESTION 34

When there is a discrepancy between the clinical documentation integrity practitioner's (CDIP's) working DRG and the coder's final DRG, which of the following is considered a fundamental element that must be in place for a successful resolution?

- A. Physician and CDIP interaction
- B. Coder and CDIP interaction
- C. Executive oversight
- D. Physician advisor/champion involvement

Answer: B

Explanation:

According to the AHIMA/ACDIS Query Practice Brief, one of the fundamental elements that must be in place for a successful DRG discrepancy resolution is a collaborative and respectful interaction between the coder and the CDIP¹. The coder and the CDIP should communicate effectively and timely to identify and resolve any DRG mismatches, using evidence-based guidelines, coding conventions, and query standards¹. The coder and the CDIP should also share their knowledge and expertise with each other, and seek clarification from the provider or the physician advisor/champion when necessary¹. The other options are not considered fundamental elements for DRG discrepancy resolution, although they may be helpful or supportive in some situations. References:

? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

NEW QUESTION 39

A patient was admitted due to possible pneumonia. Chest x-ray was positive for infiltrate.

The physician's documentation indicates that the patient continues to smoke cigarettes despite recommendations to quit. Patient also has a long-term history of chronic obstructive pulmonary disease (COPD) due to smoking. IV antibiotic was given for pneumonia along with oral Prednisone and Albuterol for COPD.

Discharge diagnoses:

- * 1. Pneumonia
- * 2. COPD
- * 3. Current smoker

What is the correct diagnostic related group assignment?

- A. DRG 190 Chronic Obstructive Pulmonary Disease with MCC
- B. DRG 202 Bronchitis and Asthma with CC/MCC
- C. DRG 204 Respiratory Signs and Symptoms
- D. DRG 194 Simple Pneumonia and Pleurisy without CC/MCC

Answer: A

Explanation:

According to the ICD-10-CM/PCS MS-DRG Definitions Manual, DRG 190 is assigned for patients with a principal diagnosis of chronic obstructive pulmonary disease (COPD) and a major complication or comorbidity (MCC)¹. Pneumonia is considered an MCC for this DRG². Therefore, the patient in this case meets the criteria for DRG 190. The other options are incorrect because they do not match the principal diagnosis or the MCC of the patient. References:

? ICD-10-CM/PCS MS-DRG Definitions Manual

? ICD-10-CM/PCS MS-DRG v38.0 Definitions Manual - MDC 4: Diseases and Disorders of the Respiratory System

NEW QUESTION 41

A clinical documentation integrity practitioner (CDIP) identified the need to correct a resident physician's note in a patient health record that wrongly identified the organism causing the patient's pneumonia. What is best practice for fixing this mistake according to AHIMA?

- A. Any physician caring for the patient can correct inaccurate record notes
- B. Errors are corrected by the clinician who authored the documentation
- C. Amendments to record content must be co-signed by the attending physician
- D. Coders can rely on the laboratory results to confirm the patient's diagnosis

Answer: B

Explanation:

According to AHIMA, best practice for fixing a mistake in a patient health record is that errors are corrected by the clinician who authored the documentation¹. The clinician who made the error should identify and correct the inaccurate information, and document the date, time, and reason for the correction¹. The correction

should also be made in a way that preserves the original content and does not obscure or delete it¹. The other options are not correct according to AHIMA. Any physician caring for the patient cannot correct inaccurate record notes, as this may compromise the accountability and integrity of the documentation². Amendments to record content do not need to be co-signed by the attending physician, unless required by organizational policy or state law³. Coders cannot rely on the laboratory results to confirm the patient's diagnosis, as they should code based on the physician's documentation and not on test results alone.

References:

- ? Making Corrections in the Electronic Health Record - AHIMA
- ? Auditing Copy and Paste - AHIMA
- ? Amendments, Corrections, and Deletions in Transcribed Reports Toolkit - AHIMA
- ? [Coding from Test Results | Journal Of AHIMA]

NEW QUESTION 46

Which of the following criteria for clinical documentation means the content of the record is trustworthy, safe, and yielding the same result when repeated?

- A. Legible
- B. Complete
- C. Reliable
- D. Precise

Answer: C

Explanation:

According to AHIMA, clinical documentation is at the core of every patient encounter and it must be meaningful to accurately reflect the patient's disease burden and scope of services provided. In order to be meaningful, the documentation must be clear, consistent, complete, precise, reliable, timely, and legible¹. Reliability is one of the criteria for clinical documentation that means the content of the record is trustworthy, safe, and yielding the same result when repeated¹. Reliability ensures that the documentation is consistent with the clinical evidence and reasoning, and that it can be verified by other sources or methods. Reliability also implies that the documentation is free from errors, omissions, contradictions, or ambiguities that could compromise its validity or usefulness¹. References:

- ? Clinical Documentation Integrity Education & Training | AHIMA¹

NEW QUESTION 48

Given the following ICD-10-CM Alphabetical Index entry: Ectopic (pregnancy) 008.9

What is the meaning of the parenthesis?

- A. Exclusion notes
- B. Non-essential modifiers
- C. Essential modifiers
- D. Inclusion notes

Answer: B

NEW QUESTION 50

When are concurrent queries initiated?

- A. After the health record has been coded
- B. After discharge of the patient
- C. While the patient is hospitalized
- D. Before patient is admitted

Answer: C

NEW QUESTION 54

Several physicians at a local hospital are having difficulty providing adequate documentation on patients admitted with a diagnosis of pneumonia with or without clinical indications of gram-negative pneumonia. Subsequently, clinical documentation integrity practitioners (CDIPs) are altering health records. Which policy and procedure should be developed to ensure compliant practice?

- A. Professional ethical standards
- B. Accreditation standards
- C. Performance standards
- D. Quality improvement standards

Answer: A

Explanation:

A policy and procedure that should be developed to ensure compliant practice for CDIPs who are altering health records is professional ethical standards. Professional ethical standards are the principles and values that guide the conduct and decision-making of CDIPs in their role of ensuring the accuracy, completeness, and integrity of clinical documentation and coded data. According to the AHIMA Standards of Ethical Coding¹ and the ACDIS Code of Ethics², CDIPs should not alter health records without the consent or direction of the provider, as this may compromise the quality and validity of the documentation and coding, and may violate legal and regulatory requirements. CDIPs should also respect the confidentiality and security of health records, and report any unethical or fraudulent practices to the appropriate authority.

References:

- ? CDIP® Exam Content Outline (<https://www.ahima.org/media/1z0x0x1a/cdip-exam-content-outline.pdf>)
- ? AHIMA Standards of Ethical Coding¹
- ? ACDIS Code of Ethics²

NEW QUESTION 58

A query should be generated when the documentation is

- A. legible

- B. consistent
- C. complete
- D. conflicting

Answer: D

Explanation:

A query should be generated when the documentation is conflicting, meaning that there is contradictory or inconsistent information in the medical record that may affect the accuracy of coding, quality reporting, or reimbursement. For example, if the documentation in the progress notes differs from the documentation in the discharge summary, or if different providers document different diagnoses or procedures for the same patient, a query may be needed to resolve the discrepancy and obtain clarification from the source of the documentation. A query should not be generated when the documentation is legible, consistent, or complete, as these are desirable characteristics of documentation that do not require further clarification or verification.

References:

? CDIP® Exam Content Outline (<https://www.ahima.org/media/1z0x0x1a/cdip-exam-content-outline.pdf>)

? Accurate Documentation is Essential – Knowing When to Query your Providers¹

NEW QUESTION 62

The clinical documentation integrity practitioner (CDIP) performed a verbal query and then later neglected following up with the provider. How should the CDIP avoid a compliance risk for this follow up failure according to AHIMA's Guidelines for Achieving a Compliant Query Practice?

- A. Complete the documentation immediately after the provider's response
- B. Complete the documentation at the end of the day when entering cases reviewed
- C. Complete the documentation when there is a provider agreement
- D. Complete the documentation at the time of discussion or immediately following

Answer: D

Explanation:

According to AHIMA's Guidelines for Achieving a Compliant Query Practice, the clinical documentation integrity practitioner (CDIP) should complete the documentation at the time of discussion or immediately following to avoid a compliance risk for this follow up failure. This is because verbal queries are considered part of the health record and must be documented in a timely and accurate manner to reflect the provider's response and any changes in documentation or coding. Completing the documentation later or only when there is an agreement may result in errors, omissions, inconsistencies, or delays that may affect the quality and integrity of the health record and the query process. (AHIMA Guidelines for Achieving a Compliant Query Practice¹)

References:

? AHIMA Guidelines for Achieving a Compliant Query Practice¹

NEW QUESTION 64

A hospital clinical documentation integrity (CDI) director suspects physicians are over-using electronic copy and paste in patient records, a practice that increases the risk of fraudulent insurance billings. A documentation integrity project may be needed. What is the first step the CDI director should take?

- A. Recommend the physicians to be involved in the project
- B. Bring together a team of physicians and informatics specialists
- C. Alert senior leadership to the record documentation problem
- D. Gather data on the incidence of inaccurate record documentation

Answer: D

Explanation:

The first step the CDI director should take is to gather data on the incidence of inaccurate record documentation because it is important to establish the baseline and scope of the problem, as well as to identify the potential causes and consequences of over-using electronic copy and paste. Data collection can help to measure the frequency, severity, and impact of documentation errors, such as inconsistencies, redundancies, contradictions, or omissions. Data collection can also help to determine the best methods and tools for conducting the documentation integrity project, such as audits, surveys, interviews, or software applications. (CDIP Exam Preparation Guide¹)

References:

? CDIP Exam Content Outline²

? CDIP Exam Preparation Guide¹

NEW QUESTION 68

A 27-year-old male patient presents to the emergency room with crampy, right lower quadrant abdominal pain, a low-grade fever (101°F Fahrenheit) and vomiting. The patient also has a history of type I diabetes mellitus. A complete blood count reveals mild leukocytosis (13,000/microliter). Abdominal ultrasound is ordered, and the patient is admitted for laparoscopic surgery. The patient is given an injection of neutral protamine Hagedorn insulin, in order to normalize the blood sugar level prior to surgery. Upon discharge, the attending physician documents "right lower quadrant abdominal pain due to possible acute appendicitis or probable Meckel diverticulitis".

What is the proper sequencing of the principal and secondary diagnoses?

- A. Right lower quadrant abdominal pain, acute appendicitis, Meckel diverticulitis, fever, vomiting, leukocytosis
- B. Right lower quadrant abdominal pain, fever, vomiting, leukocytosis
- C. Acute appendicitis, Meckel diverticulitis, type I diabetes mellitus
- D. Acute appendicitis, right lower quadrant abdominal pain, type I diabetes mellitus

Answer: D

Explanation:

The proper sequencing of the principal and secondary diagnoses in this case is as follows:

? Principal diagnosis: Acute appendicitis. This is the condition, after study, that occasioned the admission to the hospital, according to the ICD-10-CM Official Guidelines for Coding and Reporting. The patient was admitted for laparoscopic surgery, which is a definitive treatment for acute appendicitis. The physician documented "possible acute appendicitis or probable Meckel diverticulitis" as the cause of the right lower quadrant abdominal pain. According to the AHA's Coding Clinic, Fourth Quarter 2016, pp. 147-148, when a physician documents two diagnoses connected by "or", coders should query the physician for clarification if possible. However, if a query is not possible or not answered, coders should assign codes for both conditions, unless one of them has been ruled out or confirmed by further testing or treatment. In this case, there is no indication that either acute appendicitis or Meckel diverticulitis has been ruled out or confirmed

by further testing or treatment. Therefore, both conditions should be coded and reported. However, only one of them can be the principal diagnosis. Since acute appendicitis is more commonly associated with laparoscopic surgery than Meckel diverticulitis, and since it has a higher relative weight than Meckel diverticulitis under the MS-DRG system, it is reasonable to select acute appendicitis as the principal diagnosis 23.

? Secondary diagnosis: Right lower quadrant abdominal pain. This is a sign or symptom that is associated with the principal diagnosis and requires clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. The patient presented with right lower quadrant abdominal pain as a manifestation of acute appendicitis or Meckel diverticulitis. The pain required clinical evaluation by abdominal ultrasound and therapeutic treatment by laparoscopic surgery. Therefore, it should be coded and reported as a secondary diagnosis 4.

? Secondary diagnosis: Type I diabetes mellitus. This is a chronic condition that affects the patient's care in terms of requiring diagnostic or therapeutic services or affecting patient outcomes or resource utilization. The patient has a history of type I diabetes mellitus and received an injection of neutral protamine Hagedorn insulin to normalize the blood sugar level prior to surgery. Therefore, it should be coded and reported as a secondary diagnosis 4.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section II.A 3: AHA Coding Clinic for ICD- 10-CM and ICD-10-PCS, Fourth Quarter 2016 4: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section III.C : AHIMA CDIP Exam Prep, Fourth Edition <https://my.ahima.org/store/product?id=67077>

NEW QUESTION 72

A physician documented the specific site of the malignancy in the medical record documentation; however, the coder is unable to locate a specific entry in the ICD-10-CM Alphabetical Index to match the specified diagnosis. Which abbreviation used in the Alphabetical Index will assist the coder in assigning the appropriate diagnosis code for the specified condition?

- A. DRG
- B. OCE
- C. NOS
- D. NEC

Answer: D

Explanation:

The abbreviation NEC stands for "not elsewhere classified" and is used in the ICD-10-CM Alphabetical Index when a specific code is not available for a condition. The coder should use the NEC notation to locate the closest existing code that matches the documented diagnosis. For example, if the physician documented a malignant neoplasm of the left upper eyelid, but the Alphabetical Index only has an entry for malignant neoplasm of eyelid NEC, then the coder should use the code C44.10 (Unspecified malignant neoplasm of unspecified eyelid, including canthus) and assign a seventh character to specify laterality. (CDIP Exam Preparation Guide)

References:

? CDIP Exam Content Outline1

? CDIP Exam Preparation Guide2

? ICD-10-CM Official Guidelines for Coding and Reporting FY 20213

NEW QUESTION 77

Which of the following is a clinical documentation element supporting a transbronchial biopsy?

- A. Length of procedure
- B. Pathology report documenting alveolar tissue
- C. Hemoptysis
- D. Pathology report documenting bronchial tissue

Answer: B

Explanation:

A transbronchial biopsy is a procedure that involves obtaining tissue samples from the alveoli (air sacs) of the lungs through a bronchoscope. A pathology report documenting alveolar tissue is a clinical documentation element that supports a transbronchial biopsy, as it confirms the source and nature of the tissue sample.

References: AHIMA. "CDIP Exam Preparation." AHIMA Press, Chicago, IL, 2017: 55-56.

NEW QUESTION 82

A patient is admitted for chronic obstructive pulmonary disease (COPD) exacerbation. The patient is on 3L of home oxygen and is treated during admission with 3L of oxygen. The most appropriate action is to

- A. query the provider to see if acute on chronic respiratory failure is supported by the health record
- B. query the provider to see if chronic respiratory failure is supported by the health record
- C. code the diagnoses of COPD exacerbation and chronic respiratory failure
- D. query the provider to see if respiratory insufficiency is supported by the health record

Answer: A

Explanation:

According to the AHIMA/ACDIS Query Practice Brief, one of the scenarios that warrants a query is when there is clinical evidence of a higher degree of specificity or severity1. In this case, the patient's COPD exacerbation and oxygen therapy may indicate a higher level of respiratory impairment than chronic respiratory failure alone. Therefore, a query to the provider to see if acute on chronic respiratory failure is supported by the health record is appropriate and compliant. Acute on chronic respiratory failure is a more specific and severe diagnosis that may affect the patient's severity of illness, risk of mortality, and reimbursement2. The other options are not correct because they either assume a diagnosis without querying the provider, or query for a less specific or severe diagnosis than what the clinical indicators suggest. References:

? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

? Q&A: Respiratory failure in a drug overdose | ACDIS

NEW QUESTION 84

A hospital administrator wants to initiate a clinical documentation integrity (CDI) program and has developed a steering committee to identify performance metrics. The CDI manager expects to use a case mix index as one of the metrics. Which other metric will need to be measured?

- A. Comparison of risk of mortality with diagnostic related group capture rates
- B. Assessment of APR-DRGs with capture of CC or MCC

- C. Comparison of severity of illness with the CC capture rates
- D. Assessment of CC/MCC capture rates

Answer: D

Explanation:

A CC/MCC capture rate is a metric that measures the percentage of cases that have at least one complication or comorbidity (CC) or major complication or comorbidity (MCC) coded in the medical record. This metric is important for a CDI program because CCs and MCCs affect the severity of illness, risk of mortality, and reimbursement of the cases under the Medicare Severity-Diagnosis Related Group (MS-DRG) system. A higher CC/MCC capture rate indicates a more accurate and complete documentation of the patient's condition and the resources used to treat them. A CDI program can use this metric to monitor the effectiveness of its queries, education, and feedback to the providers and coders. A CDI program can also compare its CC/MCC capture rate with national or regional benchmarks to identify areas of improvement or best practices 2.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: The Natural History of CDI Programs: A Metric-Based Model 4

NEW QUESTION 85

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