



AHIMA

Exam Questions CDIP

Certified Documentation Integrity Practitioner

About ExamBible

[Your Partner of IT Exam](#)

Found in 1998

ExamBible is a company specialized on providing high quality IT exam practice study materials, especially Cisco CCNA, CCDA, CCNP, CCIE, Checkpoint CCSE, CompTIA A+, Network+ certification practice exams and so on. We guarantee that the candidates will not only pass any IT exam at the first attempt but also get profound understanding about the certificates they have got. There are so many alike companies in this industry, however, ExamBible has its unique advantages that other companies could not achieve.

Our Advances

* 99.9% Uptime

All examinations will be up to date.

* 24/7 Quality Support

We will provide service round the clock.

* 100% Pass Rate

Our guarantee that you will pass the exam.

* Unique Gurantee

If you do not pass the exam at the first time, we will not only arrange FULL REFUND for you, but also provide you another exam of your claim, ABSOLUTELY FREE!

NEW QUESTION 1

When writing a compliant query, best practice is to

- A. direct the physician to a specific diagnosis
- B. include all relevant clinical indicators
- C. use the term "possible" to describe a condition or diagnosis when uncertain if the diagnosis is present
- D. use a yes/no query format for specificity of a diagnosis

Answer: B

Explanation:

One of the best practices for writing a compliant query is to include all relevant clinical indicators from the health record that support the need for clarification and the query options. Clinical indicators are objective and measurable signs, symptoms, laboratory results, diagnostic test results, medications, treatments, and other documented findings that are related to a specific diagnosis or condition. Including clinical indicators helps to provide the rationale for the query, avoid leading or suggesting a desired response, and ensure that the query is based on evidence and not assumptions. The other options are not best practices for writing a compliant query. Directing the physician to a specific diagnosis is leading and noncompliant. Using the term "possible" to describe a condition or diagnosis when uncertain if the diagnosis is present is vague and imprecise. Using a yes/no query format for specificity of a diagnosis is discouraged, as it limits the provider's choices and may not capture the true clinical picture.

NEW QUESTION 2

Tracking denials within the clinical documentation integrity program is important to

- A. determine coding inaccuracies and educate as necessary
- B. file a timely appeal if the medical center disagrees with the RAC findings
- C. identify documentation improvement opportunities and educate as necessary
- D. confirm reimbursement was appropriate

Answer: C

Explanation:

Tracking denials within the clinical documentation integrity program is important to identify documentation improvement opportunities and educate as necessary because it helps to analyze the root causes of denials, improve the quality and specificity of clinical documentation, and reduce the risk of future denials. Denials can also provide feedback on the effectiveness of the CDI program and the areas that need more attention or intervention. (CDIP Exam Preparation Guide)

References:

? CDIP Exam Content Outline1

? CDIP Exam Preparation Guide2

NEW QUESTION 3

Which of the following can be evidence of physician-hospital alignment?

- A. A high physician agreement rate
- B. A low physician agreement rate
- C. A high clinical documentation integrity practitioner (CDIP) query rate
- D. A high physician response rate

Answer: A

Explanation:

A high physician agreement rate can be evidence of physician-hospital alignment because it indicates that the physicians are supportive of the clinical documentation integrity (CDI) program and its goals, and that they are willing to provide accurate and complete documentation in response to CDI queries. A high physician agreement rate also reflects a positive relationship and communication between the CDI team and the physicians, as well as a mutual understanding of the benefits of CDI for patient care, quality reporting, and reimbursement. (CDIP Exam Preparation Guide)

References:

? CDIP Exam Content Outline1

? CDIP Exam Preparation Guide2

NEW QUESTION 4

A resident returns to the long-term care facility following hospital care for pneumonia. The physician's orders and progress note state "Continue IV antibiotics for pneumonia - 3 more days, after which time the resident is to have a repeat x-ray to determine status of the pneumonia". Is it appropriate to code the pneumonia in this scenario?

- A. Yes J18.8, Pneumonia, other specified organism
- B. No, since the patient needed a repeat x-ray, the condition does not clarify as a diagnosis
- C. Yes, J18.9, Pneumonia, unspecified organism, should be coded until the condition is resolved
- D. Yes, J18.9, Pneumonia, unspecified organism, Z79.2 should be coded along with long term antibiotics

Answer: D

Explanation:

It is appropriate to code the pneumonia in this scenario because the condition is still present and being treated at the time of admission to the long-term care facility. According to the ICD-10-CM Official Guidelines for Coding and Reporting, a diagnosis is reportable if it is documented as "present on admission" or "active" by the provider, or if it requires or affects patient care treatment or management 2. In this case, the pneumonia is still active and requires IV antibiotics and a repeat x-ray, which indicates that it affects the patient care treatment and management. Therefore, the pneumonia should be coded as J18.9, Pneumonia, unspecified organism, which is the default code for pneumonia when no causal organism is identified 3. In addition, the code Z79.2, Long term (current) use of antibiotics, should be coded to indicate that the patient is receiving long term antibiotic therapy as part of the treatment plan 4.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 138 5 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section I.B.14 3:

ICD-10-CM Code J18.9 - Pneumonia, unspecified organism 4: ICD-10-CM Code Z79.2 - Long term (current) use of antibiotics

NEW QUESTION 5

Which of the following is the definition of an Excludes 2 note in ICD-10-CM?

- A. Neither of the codes can be assigned
- B. Two codes can be used together to completely describe the condition
- C. Only one code can be assigned to completely describe the condition
- D. This is not a convention found in ICD-10-CM

Answer: B

Explanation:

An Excludes 2 note in ICD-10-CM indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together to completely describe the condition. For example, under code R05 Cough, there is an Excludes 2 note for whooping cough (A37.-). This means that a patient can have both a cough and whooping cough at the same time, and both codes can be used together to capture the full clinical picture.

References:

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

? ICD-10-CM Features | Diagnosis Coding: Using the ICD-10-CM1

NEW QUESTION 6

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 7

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 dietitian'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 8

Collaboration between the physician advisor/champion and the clinical documentation integrity practitioners (CDIPs) would likely include

- A. performing data analysis
- B. developing query forms
- C. educating physicians
- D. querying physicians

Answer: C

Explanation:

Collaboration between the physician advisor/champion and the clinical documentation integrity practitioners (CDIPs) would likely include educating physicians on the importance and impact of clinical documentation on coding, reimbursement, quality measures, compliance, and patient care. The physician advisor/champion can act as a liaison between the CDIPs and the medical staff, provide feedback and guidance on query development and resolution, and facilitate peer-to-peer education sessions on documentation best practices and standards⁶ References: 1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 6: <https://my.ahima.org/store/product?id=67077>

NEW QUESTION 9

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 10

A clinical documentation integrity practitioner (CDIP) is looking for clarity on whether a diagnosis has been "ruled in" or "ruled out". Which type of query is the best option?

- A. Yes/No
- B. None
- C. Open-ended
- D. Multiple-choice

Answer: C

Explanation:

An open-ended query is a type of query that allows the provider to respond with free text, rather than choosing from a list of options or answering yes or no. An open-ended query is appropriate when the CDIP is looking for clarity on whether a diagnosis has been "ruled in" or "ruled out", because it allows the provider to document the final diagnosis or impression based on the clinical evidence and reasoning. An open-ended query also avoids leading or suggesting a specific diagnosis to the provider, which could compromise the integrity and validity of the documentation. (Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA¹)

References:

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

NEW QUESTION 10

Patient is admitted with oliguria, pulmonary edema, and dehydration. Labs are remarkable for an elevated creatinine of 2.4, with a baseline of 1.1. Patient was hydrated for 48 hours with drop in creatinine. What would the appropriate action be?

- A. No query is needed because the patient was dehydrated
- B. Query the physician to see if acute renal failure is clinically supported
- C. Query the physician to see if acute renal failure with tubular necrosis is supported
- D. Code acute renal failure since symptoms are there and documented

Answer: B

Explanation:

The appropriate action in this case is to query the physician to see if acute renal failure is clinically supported. This is because the patient has signs and symptoms of acute renal failure, such as oliguria, pulmonary edema, and elevated creatinine, but the diagnosis is not documented in the medical record. Acute renal failure is a clinical syndrome characterized by a rapid decline in kidney function and accumulation of metabolic waste products. It can be caused by various factors, such as dehydration, hypovolemia, sepsis, nephrotoxins, or obstruction. Acute renal failure can be classified according to the RIFLE criteria (Risk, Injury, Failure, Loss, End-stage kidney disease) or the AKIN criteria (Acute Kidney Injury Network), which are based on changes in serum creatinine and urine output²³. A query to the physician is needed to confirm or rule out the diagnosis of acute renal failure, specify the etiology and severity of the condition, and document any associated complications or comorbidities. A query to the physician will also improve the accuracy and completeness of the documentation and coding, and reflect the true clinical picture and resource utilization of the patient.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: Acute Kidney Injury: Diagnosis and Management | AAFP 3: AKIN Classification for Acute Kidney Injury (AKI) - MDCalc

NEW QUESTION 11

An increase in claim denials has prompted a clinical documentation integrity (CDI) manager to engage the CDI physician advisor/champion in an effort to avoid future denials. How does this strategy impact the goal?

- A. The CDI manager will exclusively provide education.
- B. Physicians will learn documentation integrity practices from peers.
- C. Physicians can manage the documentation integrity process.
- D. Clinicians will not require documentation integrity education.

Answer: B

Explanation:

Engaging the CDI physician advisor/champion in an effort to avoid future denials is a strategy that impacts the goal of improving documentation integrity by leveraging the influence and expertise of a physician leader who can educate, mentor, and advocate for other physicians on documentation best practices. The CDI physician advisor/champion can act as a liaison between the CDI team and the medical staff, provide feedback and guidance on complex or challenging cases, resolve conflicts or discrepancies in documentation, and promote a culture of collaboration and quality improvement. Physicians are more likely to learn and adopt documentation integrity practices from their peers who understand their clinical perspective and challenges, rather than from non-physician CDI staff or managers.

* A. The CDI manager will exclusively provide education. This is incorrect because engaging the CDI physician advisor/champion implies that the CDI manager will not be the sole source of education, but rather will partner with the physician leader to deliver effective and tailored education to the medical staff.

* C. Physicians can manage the documentation integrity process. This is incorrect because engaging the CDI physician advisor/champion does not mean that physicians will take over the responsibility of managing the documentation integrity process, which involves multiple stakeholders, such as CDI specialists, coders, quality analysts, and auditors. Rather, physicians will be more involved and supportive of the documentation integrity process as a result of the education and mentorship provided by the CDI physician advisor/champion.

* D. Clinicians will not require documentation integrity education. This is incorrect because engaging the CDI physician advisor/champion does not eliminate the need for documentation integrity education for clinicians, but rather enhances and facilitates it by using a peer-to-peer approach that can increase awareness, engagement, and compliance among physicians.

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 13

A modifier may be used in CPT and/or HCPCS codes to indicate

- A. a service or procedure was increased or reduced
- B. a service or procedure was performed in its entirety
- C. a service or procedure resulted in expected outcomes
- D. a service or procedure was performed by one provider

Answer: A

Explanation:

According to the AHIMA CDIP Exam Preparation Guide, a modifier is a two-digit numeric or alphanumeric code that may be used in CPT and/or HCPCS codes to indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code¹. One of the reasons to use a modifier is to indicate that a service or procedure was increased or reduced in comparison to the usual service or procedure². For example, modifier 22 can be used to report increased procedural services that require substantially greater time, effort, or complexity than the typical service³. The other options are not correct because they do not reflect the purpose of using modifiers. A service or procedure performed in its entirety does not need a modifier, as it is assumed to be the standard service or procedure. A service or procedure resulting in expected outcomes does not affect the coding or reimbursement of the service or procedure. A service or procedure performed by one provider may need a modifier depending on the type of provider, the place of service, and the payer rules, but it is not a general reason to use a modifier.

References:

? CDIP Exam Preparation Guide - AHIMA

? Modifiers: A Guide for Health Care Professionals - CMS

? CPT® Modifiers: 22 Increased Procedural Services | AAPC

NEW QUESTION 18

A query should be generated when documentation contains a

- A. postoperative hospital-acquired condition
- B. principal diagnosis without an MCC
- C. diagnosis without clinical validation
- D. problem list with symptoms related to the chief complaint

Answer: C

Explanation:

A query should be generated when documentation contains a diagnosis without clinical validation, meaning that there is no evidence in the health record to support the diagnosis or that the diagnosis is inconsistent with other clinical indicators. A diagnosis without clinical validation may affect the accuracy and completeness of coding, quality measures, reimbursement, and patient care.

References: AHIMA/ACDIS. ??Guidelines for Achieving a Compliant Query Practice (2019 Update).?? Journal of AHIMA 90, no. 2 (February 2019): 20-29.

NEW QUESTION 21

Which of the following is used to measure the impact of a clinical documentation integrity (CDI) program on Centers for Medicare and Medicaid Services quality performance?

- A. Risk of mortality
- B. Case mix index
- C. Severity of illness
- D. Outcome measures

Answer: D

Explanation:

Outcome measures are indicators of the quality of care provided by a healthcare organization, such as mortality rates, readmission rates, hospital-acquired conditions, patient safety indicators, and patient satisfaction scores. These measures are used by CMS to evaluate and compare the performance of hospitals and other providers under various pay-for-performance programs, such as value-based purchasing, hospital readmissions reduction program, hospital-acquired condition reduction program, and hospital inpatient quality reporting program. A CDI program can influence these outcome measures by ensuring that the clinical documentation accurately reflects the severity of illness, risk of mortality, and complexity of care of the patients. This can help to improve the risk adjustment and

case mix index of the organization, as well as to identify and prevent potential quality issues.

References:

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

? CDIP® Exam Preparation Guide (<https://my.ahima.org/store/product?id=67077>)

NEW QUESTION 25

A 45-year-old female is admitted after sustaining a femur fracture. Orthopedics is consulted and performs an open reduction internal fixation (ORIF) of the femur without complication. Nursing documents the patient has a body mass index of 42 kg/m².

The clinical documentation integrity practitioner (CDIP) determines a query is needed to capture a diagnosis associated with the body mass index so it can be reported. Which of the following is the MOST compliant query based on the most recent AHIMA/ACDIS query practice brief?

A. Nursing documents the BMI is 42 kg/m². In order to capture a co-morbid condition (CC) to increase reimbursement, please add 'morbid obesity with BMI 42 kg/m²' to your next progress note.

B. Nursing documents the BMI is 42 kg/m². To increase the severity of illness and risk of mortality, please add 'morbid obesity with BMI 42 kg/m²' to your next progress note.

C. Nursing documents the BMI is 42 kg/m². Can you please clarify if the patient's morbid obesity was present on admission and add the diagnosis to future progress notes?

D. Nursing documents the BMI is 42 kg/m². Please consider if any of the following diagnoses should be added to the health record to support this finding: morbid obesity; obesity; other diagnosis (please state)

Answer: D

Explanation:

This is the most compliant query based on the most recent AHIMA/ACDIS query practice brief because it is non-leading, non-suggestive, and provides multiple options for the physician to choose from. It also does not imply any financial or quality implications for adding a diagnosis associated with the BMI.

References: AHIMA/ACDIS. ??Guidelines for Achieving a Compliant Query Practice (2019 Update).?? Journal of AHIMA 90, no. 2 (February 2019): 20-29.

NEW QUESTION 27

Which of the following sources provide external benchmarks to examine the effectiveness of a facility's clinical documentation program?

A. Health Care Financing Administration

B. American Health Information Management Association

C. Agency for Healthcare Research and Quality

D. Medicare Provider Analysis and Review

Answer: C

Explanation:

The Agency for Healthcare Research and Quality (AHRQ) provides external benchmarks to examine the effectiveness of a facility's clinical documentation program by developing and disseminating quality indicators (QIs) that measure various aspects of health care quality, such as patient safety, outcomes, efficiency, and effectiveness. These QIs are based on administrative data and can be used to compare the performance of different health care providers or facilities across the nation. The QIs include inpatient quality indicators (IQIs), patient safety indicators (PSIs), prevention quality indicators (PQIs), and pediatric quality indicators (PQIs). These QIs can help clinical documentation improvement (CDI) programs identify areas of improvement, monitor trends, and evaluate the impact of CDI interventions on health care quality.

References: 1: Clinical Documentation Improvement Programs: Quality, Efficiency | Deloitte US Analysis 2 2: AHRQ Quality Indicators 3

NEW QUESTION 29

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 32

The key component of the auditing and monitoring process to ensure provider query response is to

A. audit individual providers to indicate improvement in health record documentation

B. have a process in place for ongoing education and training of the staff involved in conducting provider queries

C. make sure that the language in the query is not leading or otherwise inappropriate

D. review queries retrospectively to ensure that they are completed according to documented Policies and procedures

Answer: D

NEW QUESTION 33

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 34

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 37

Which entity has the following regulation?

A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

- A. Centers for Medicare & Medicaid Services
- B. Office for Civil Rights
- C. Office of the National Coordinator for Health Information Technology
- D. Office of Inspector General

Answer: A

Explanation:

The entity that has the following regulation is the Centers for Medicare & Medicaid Services (CMS), which is the federal agency that oversees the Medicare and Medicaid programs and sets the Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) for health care organizations that participate in these programs. The regulation that requires a medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, is part of the CoPs for Hospitals, which are located in 42 CFR ?? 482.24. This regulation was revised in 2007 to align with the Joint Commission's standard and to provide more flexibility and consistency for hospitals and practitioners. (CDIP Exam Preparation Guide)

References:

? CDIP Exam Content Outline¹

? CDIP Exam Preparation Guide²

? 42 CFR ?? 482.24³

NEW QUESTION 39

Which of the following individuals is the first line of escalation for an unanswered query?

- A. CDI Manager
- B. CDI Steering Committee
- C. Medical Director
- D. HIM/Coding Manager

Answer: A

Explanation:

The first line of escalation for an unanswered query is the CDI Manager because they are responsible for overseeing the CDI program and ensuring compliance with query policies and procedures. The CDI Manager can monitor the query response rates, identify the providers who are not responding, and communicate with them to address any issues or barriers. The CDI Manager can also provide education and feedback to the providers on the importance and benefits of timely query responses. If the CDI Manager is unable to resolve the problem, then they can escalate it to the next level, such as the Medical Director or the CDI Steering Committee. (CDIP Exam Preparation Guide)

References:

? CDIP Exam Content Outline¹

? CDIP Exam Preparation Guide²

? Q&A: Establishing an escalation policy for inappropriate queries³

NEW QUESTION 40

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 45

Hospital policy states that physician responses to queries should be no longer than timely payer filing requirements. A physician responds to a query after the final bill has been submitted. How should administration respond in this situation?

- A. Evaluate the payer's timeframe for billing and reasons for the physician's delayed response
- B. Review the record to determine any potential data integrity impact and/or rebilling implications
- C. Maintain the original billing as supported by documentation in the medical record
- D. Report the physician's delayed response to the Ethics and Compliance Committee

Answer: B

Explanation:

Administration should respond to this situation by reviewing the record to determine any potential data integrity impact and/or rebilling implications. According to the AHIMA Practice Brief on Managing an Effective Query Process, post-bill queries are generally initiated as a result of an audit or other internal monitor, and healthcare entities can develop a policy regarding whether they will generate post-bill queries and the timeframe following claims generation that queries may be initiated. The practice brief also states that healthcare entities should consider the following three concepts in the development of a post-bill (including query) policy: applying normal course of business guidelines, using payer-specific rules on rebilling timeframes, and determining reliability of query response over time 2. Therefore, administration should review the record to see if the physician's response to the query affects the quality of care, patient safety, severity of illness, risk of mortality, or reimbursement, and if so, whether it is appropriate and feasible to rebill the account based on the payer's rules and the normal course of business guidelines. Administration should also evaluate the reasons for the physician's delayed response and provide feedback and education to prevent future occurrences.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: AHIMA Practice Brief: Managing an Effective Query Process 4

NEW QUESTION 47

Which of the following should be shared to ensure a clear sense of what clinical documentation integrity (CDI) is and the CDI practitioner's role within the organization?

- A. Productivity standards
- B. Review schedule
- C. Milestones
- D. Mission

Answer: D

Explanation:

Sharing the mission of the CDI program should be done to ensure a clear sense of what CDI is and the CDI practitioner's role within the organization. The mission statement defines the purpose, goals, and values of the CDI program, and how it aligns with the organization's vision and strategy. The mission statement also communicates the benefits and expectations of the CDI program to various stakeholders, such as providers, executives, coders, quality staff, and patients. The mission statement can help establish the credibility, professionalism, and identity of the CDI practitioners, and guide their daily activities and decisions 2.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: Mission CDI: Guiding goals, values, and principles 1

NEW QUESTION 51

Which of the following committees should determine the chain of command that will be used to manage physicians who are either unresponsive or uncooperative with the clinical documentation integrity (CDI) program?

- A. Oversight
- B. Communications
- C. Operations
- D. Compliance

Answer: A

Explanation:

The oversight committee is responsible for establishing the policies, procedures, and guidelines for the CDI program, as well as monitoring its performance and outcomes. The oversight committee should include representatives from senior leadership, medical staff, coding, quality, compliance, and other relevant stakeholders. The oversight committee should determine the chain of command that will be used to manage physicians who are either unresponsive or uncooperative with the CDI program, as well as the consequences for non-compliance. The other committees are not directly involved in setting the chain of command or the disciplinary actions for the CDI program. The communications committee is responsible for facilitating the information flow and feedback among the CDI staff, providers, coders, and other departments. The operations committee is responsible for managing the day-to-day activities and functions of the CDI staff, such as staffing, training, productivity, and workflow. The compliance committee is responsible for ensuring that the CDI program adheres to the ethical and legal standards and regulations, such as query compliance, documentation integrity, and privacy and security.

NEW QUESTION 55

A 50-year-old male patient was admitted with complaint of 3-day history of shortness of breath. Vital signs: BP 165/90, P 90, T 99.9°F, O2 sat 95% on room air. Patient has history of asthma, chronic obstructive pulmonary disease (COPD), and hypertension (HTN). His medicines are Albuterol and Norvasc. CXR showed chronic lung disease and left lower lobe infiltrate. Labs: WBC 9.5 with 65% segs. Physician documented that patient has asthma flare and admitted with decompensated COPD, ordered IV steroids, O2 at 2L/min via nasal cannula, Albuterol inhalers 4x per day, and Clindamycin. Patient improved and was discharged 3 days later. Which action would have the highest impact on the patient's severity of illness (SOI) and risk of mortality (ROM)?

- A. Query the physician to clarify if CXR result means patient has pneumonia.
- B. Query the physician to clarify for type of COPD such as severe asthma.
- C. Query the physician to clarify for clinical significance of the CXR results.
- D. Query the physician to clarify if patient has acute COPD exacerbation.

Answer: A

NEW QUESTION 59

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 61

A patient presents to the emergency room with acute shortness of breath. The patient has a history of lung cancer that has been treated previously with radiation and chemotherapy. The patient is intubated and placed on mechanical ventilation. A chest x-ray is remarkable for a pleural effusion. A thoracentesis is performed, and the cytology results show malignant cells. Diagnoses on discharge: Acute respiratory failure due to recurrence of small cell carcinoma and malignant pleural effusion. Which coding reference takes precedence for assigning the ICD-10-CM/PCS codes?

- A. Conventions and instructions of the classification for ICD-10-CM/PCS
- B. AMA CPT Assistant
- C. AHA Coding Clinic for ICD-10-CM/PCS
- D. ICD-10-CM Official Guidelines for Coding and Reporting

Answer: A

Explanation:

According to the CDIP® Exam Content Outline, one of the tasks of a clinical documentation integrity practitioner (CDIP) is to apply coding conventions, guidelines, and definitions for ICD-10-CM/PCS. Coding conventions are the general rules for the use of the classification system, such as the use of abbreviations, punctuation, symbols, and sequencing instructions. Coding guidelines are the official rules for selecting and reporting codes based on the documentation in the health record. Coding definitions are the explanations of the terms and concepts used in the classification system. The conventions and instructions of the classification for ICD-10-CM/PCS take precedence over any other coding reference because they are the primary source of coding rules and standards. The other coding references, such as AMA CPT Assistant, AHA Coding Clinic for ICD-10-CM/PCS, and ICD- 10-CM Official Guidelines for Coding and Reporting, are secondary sources that provide additional guidance, clarification, or interpretation of the coding conventions and instructions.

References:

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

? ICD-10-CM Features | Diagnosis Coding: Using the ICD-10-CM1

NEW QUESTION 62

A clinical documentation integrity practitioner (CDIP) is developing a plan to promote the CDI program throughout a major hospital. It is proving challenging to find support. What is a primary step for the CDIP?

- A. Determine primary interests and needs as requested
- B. Determine primary interests of an individual or department
- C. Teach coding classes to the new physicians as needed
- D. Teach nursing staff about documentation integrity

Answer: B

Explanation:

A primary step for the CDIP to promote the CDI program throughout a major hospital is to determine the primary interests of an individual or department that could benefit from or support the CDI program. This is because different stakeholders may have different motivations, expectations, and challenges related to CDI, and the CDIP should tailor the communication and education strategies accordingly. For example, physicians may be interested in how CDI can improve their quality metrics, reimbursement, and patient outcomes; coders may be interested in how CDI can reduce coding errors, denials, and queries; and executives may be interested in how CDI can enhance revenue integrity, compliance, and reputation. By identifying the primary interests of each individual or department, the CDIP can demonstrate the value and relevance of the CDI program, address any barriers or concerns, and foster collaboration and engagement 23.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: How to Promote Your Clinical Documentation Improvement Program 3: How to Market Your Clinical

Documentation Improvement Program

NEW QUESTION 64

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 66

When benchmarking with outside organizations, the clinical documentation integrity practitioner (CDIP) must determine if the organization is benchmarking with which of the following criteria?

- A. Hospital within its region
- B. Hospitals that are its peers
- C. Hospital within its county
- D. Hospital within its state

Answer: B

Explanation:

When benchmarking with outside organizations, the clinical documentation integrity practitioner (CDIP) must determine if the organization is benchmarking with hospitals that are its peers because peer hospitals have similar characteristics such as size, location, teaching status, case mix index, and payer mix.

Benchmarking with peer hospitals allows for a more accurate and meaningful comparison of performance indicators and outcomes. (CDIP Exam Preparation Guide)

References:

? CDIP Exam Content Outline1

? CDIP Exam Preparation Guide2

NEW QUESTION 68

Whether or not queries should be kept as a permanent part of the medical record is decided by

- A. physician preference
- B. state law
- C. federal law
- D. organizational policy

Answer: D

Explanation:

According to the AHIMA/ACDIS Query Practice Brief, whether or not queries should be kept as a permanent part of the medical record is decided by the organizational policy of each facility¹. There is no federal or state law that mandates the retention of queries in the medical record, although some external reviewers may request copies of queries to validate the query wording and compliance². Physician preference is not a valid factor in determining the query retention policy, as queries should be handled consistently across the organization³. Therefore, the correct answer is D. organizational policy. References:

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

? Q&A: Develop policies regarding query retention | ACDIS

? Q&A: Keep query retention policies consistent | ACDIS

NEW QUESTION 73

Which physician would best benefit from additional education for unanswered queries?

Physician	Number of Queries	Agree	Disagree	No Response
Dr. A	31	25	5	1
Dr. B	32	28	2	2
Dr. C	18	2	16	0
Dr. D	10	0	1	9

- A. D
- B. A
- C. D
- D. B
- E. D
- F. C
- G. D
- H. D

Answer: D

Explanation:

According to the Documentation Integrity Practitioner (CDIP®) study guide, the physician with the highest number of unanswered queries would benefit from additional education. In this case, Dr. D has the highest number of unanswered queries with 9. Unanswered queries may indicate a lack of understanding, engagement, or compliance with the query process, which may affect the quality and accuracy of clinical documentation and coding¹. Therefore, Dr. D would best benefit from additional education for unanswered queries, such as the importance of timely and appropriate query responses, the impact of queries on severity of illness, risk of mortality, and reimbursement, and the best practices for a compliant query practice². References:

? Q&A: What to do with unanswered queries | ACDIS

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

NEW QUESTION 75

The ultimate purpose of clinical documentation integrity (CDI) expansion and growth is to

- A. provide community education to healthcare consumers
- B. create synergy between clinical education and CDI principles
- C. show a direct relationship between clinical documentation and quality patient care
- D. promote CDI functions so that physicians view the CDI staff as value-added service

Answer: C

Explanation:

The ultimate purpose of clinical documentation integrity (CDI) expansion and growth is to show a direct relationship between clinical documentation and quality patient care. According to the web search results, CDI programs aim to improve the quality and efficiency of clinical documentation by ensuring that it is accurate, complete, and consistent. This in turn leads to better health care data, which is vital for capturing the appropriate indicators used for health care facility and provider profiling, reimbursement, risk adjustment, and quality scores¹². CDI programs also focus on patient safety, by identifying and resolving any documentation omissions, discrepancies, or adverse events that may affect the patient's outcome or care³. Therefore, CDI programs demonstrate how clinical documentation can impact the quality of patient care and the performance of health care organizations.

NEW QUESTION 77

Which of the following should an organization consider when developing a query retention policy and procedure?

- A. If the query is considered part of the health record
- B. How the query will be formatted
- C. Who should be queried
- D. What the escalation process will be

Answer: A

Explanation:

One of the factors that an organization should consider when developing a query retention policy and procedure is if the query is considered part of the health record or not. According to the AHIMA/ACDIS query practice brief¹, a query is considered part of the health record if it meets any of the following criteria:

- ? It is used to clarify documentation that affects code assignment or other data elements
 - ? It is used to support clinical validation of a diagnosis or procedure
 - ? It is used to support medical necessity or quality indicators
 - ? It is used to communicate clinical information between providers
- If a query is part of the health record, it should be retained according to the organization's health record retention policy and procedure, which should comply with federal, state, and local laws and regulations. The query retention policy and procedure should also address issues such as:
- ? The format and location of the query (e.g., paper, electronic, hybrid)
 - ? The security and confidentiality of the query
 - ? The accessibility and availability of the query
 - ? The ownership and custodianship of the query
 - ? The legal implications and evidentiary value of the query

References:

- ? CDIP® Exam Content Outline (<https://www.ahima.org/media/1z0x0x1a/cdip-exam-content-outline.pdf>)
- ? Guidelines for Achieving a Compliant Query Practice—2022 Update¹

NEW QUESTION 78

The clinical documentation integrity (CDI) team in a hospital is initiating a project to change the unacceptable documentation behaviors of some physicians. What strategy should be part of a project aimed at improving these behaviors?

- A. Expand use of coding queries by CDI team
- B. Add a physician advisor/champion to the CDI team
- C. Encourage physician-nurse cooperation
- D. Alter the physician documentation requirements

Answer: B

Explanation:

A strategy that should be part of a project aimed at improving the unacceptable documentation behaviors of some physicians is to add a physician advisor/champion to the CDI team. A physician advisor/champion is a physician leader who supports and advocates for the CDI program, educates and mentors other physicians on documentation best practices, resolves conflicts and barriers, and provides feedback and recognition to physicians who improve their documentation. A physician advisor/champion can help change the documentation behaviors of some physicians by using peer influence, credibility, and authority to motivate them to comply with the CDI program goals and standards. A physician advisor/champion can also help bridge the gap between the CDI team and the physicians, and foster a culture of collaboration and quality improvement²³.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 136 4 2: The Role of Physician Advisors in Clinical Documentation Improvement Programs 5 3:

Physician Advisor: The

Key to Clinical Documentation Improvement Success

NEW QUESTION 79

The clinical documentation integrity (CDI) metrics recently showed a drastic drop in the physician query rate. What might this indicate to the CDI manager?

- A. The program is successful because documentation has improved
- B. The loss of a large volume of patients has impacted workflow
- C. CDI staff need education on identifying query opportunities
- D. The decrease in hospital census has caused a lack of query opportunities

Answer: C

Explanation:

A drastic drop in the physician query rate might indicate to the CDI manager that the CDI staff need education on identifying query opportunities. The physician query rate is a metric that measures the percentage of records that have at least one query sent by the CDI staff to clarify or improve the documentation. A high query rate may reflect a high level of documentation quality issues or a high level of CDI staff vigilance and expertise. A low query rate may reflect a low level of documentation quality issues or a low level of CDI staff awareness and competence². Therefore, a drastic drop in the query rate could suggest that the CDI staff are missing some query opportunities or are not following the query policies and procedures. The CDI manager should investigate the reasons for the drop and provide education and feedback to the CDI staff on how to identify and address query opportunities effectively and compliantly³.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: Understanding CDI

Metrics - AHIMA 2 3: The Natural History of CDI Programs: A Metric-Based Model 5

NEW QUESTION 80

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 82

A patient receives a blood transfusion after a 400 ml blood loss during surgery. The clinical documentation integrity practitioner (CDIP) queries the physician for an associated diagnosis. The facility does not maintain queries as part of the permanent health record. What does the physician need to document for the CDIP to record the

query as answered and agreed?

- A. That the blood loss was not clinically significant

- B. The associated diagnosis and the clinical rationale in the progress notes
- C. A cause-and-effect relationship between anemia and the underlying cause
- D. The associated diagnosis directly on the query form

Answer: B

Explanation:

The physician needs to document the associated diagnosis and the clinical rationale in the progress notes for the CDIP to record the query as answered and agreed because this is the best way to ensure that the health record reflects the patient's condition and treatment accurately and completely. The associated diagnosis is the condition that caused or contributed to the blood loss and the need for transfusion, such as acute blood loss anemia, hemorrhage, or trauma. The clinical rationale is the explanation of how the diagnosis is supported by the clinical indicators, such as laboratory values, vital signs, symptoms, or procedures. Documenting the associated diagnosis and the clinical rationale in the progress notes also helps to avoid any confusion or inconsistency with other parts of the health record, such as the discharge summary or the coding. (CDIP Exam Preparation Guide)

References:

- ? CDIP Exam Content Outline¹
- ? CDIP Exam Preparation Guide²
- ? Guidelines for Achieving a Compliant Query Practice (2019 Update)³

NEW QUESTION 84

The provider was queried because the patient met clinical criteria for acute hypoxic respiratory failure. The response to the query was different than what was expected by the clinical documentation integrity practitioner (CDIP). What should the CDIP do?

- A. Record the query response as disagreed
- B. Have a different CDIP query the provider
- C. Revise the query and send it back to the provider
- D. Implement the department's escalation process

Answer: D

Explanation:

If the provider's response to the query is different than what was expected by the CDIP, the CDIP should implement the department's escalation process to ensure the validity and accuracy of the documentation and the coded data. The escalation process is a standardized procedure that involves a manager, committee, or other supervisory position to review and assess the query and the response, and to determine the appropriate next steps. The escalation process may include contacting the provider for clarification, education, or feedback; consulting with a physician advisor/champion or a coding auditor; or reporting the issue to a higher authority or regulatory body. The escalation process should be documented and communicated clearly and respectfully to all parties involved.

* A. Record the query response as disagreed. This is not a sufficient action to take if the provider's response to the query is different than what was expected by the CDIP. Recording the query response as disagreed may indicate a lack of agreement or consensus between the CDIP and the provider, but it does not address the underlying issue of documentation validity or accuracy. It may also create a negative impression or relationship between the CDIP and the provider.

* B. Have a different CDI query the provider. This is not an appropriate action to take if the provider's response to the query is different than what was expected by the CDIP. Having a different CDI query the provider may create confusion, inconsistency, or redundancy in the query process. It may also undermine the credibility or authority of the original CDI who queried the provider.

* C. Revise the query and send it back to the provider. This is not a recommended action to take if the provider's response to the query is different than what was expected by the CDIP. Revising the query and sending it back to the provider may imply that the CDI is dissatisfied or disagreeing with the provider's response, which may be perceived as disrespectful or confrontational. It may also suggest that the CDI is trying to influence or coerce the provider to change their response, which may compromise the integrity and compliance of the query process.

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 86

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 89

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 92

When a change in departmental workflow is necessary, the first step is to

- A. define the gaps and solutions
- B. set realistic timelines
- C. re-engineer the process
- D. assess the current workflow

Answer: D

Explanation:

The first step in changing a departmental workflow is to assess the current workflow and identify the problems or inefficiencies that need to be addressed. This will help to define the gaps and solutions, set realistic timelines, and re-engineer the process.

References: AHIMA. ??CDIP Exam Preparation.?? AHIMA Press, Chicago, IL, 2017: 125- 126.

NEW QUESTION 97

A 56-year-old male patient complains of feeling fatigued, has nausea & vomiting, swelling in both legs. Patient has history of chronic kidney disease (CKD) stage III, coronary artery disease (CAD) & hypertension (HTN). He is on Lisinopril. Vital signs: BP 160/80, P 84, R 20, T 100.0F. Labs: WBC 11.5 with 76% segs, GFR 45. CXR showed slight left lower lobe haziness. Patient was admitted for acute kidney injury (AKI) with acute tubular necrosis (ATN). He was scheduled for hemodialysis the next day. Two days after admission patient started coughing, fever of 101.8F, CXR showed left lower lobe infiltrate, possible pneumonia. Attending physician documented that patient has pneumonia and ordered Rocephin IV. How should the clinical documentation integrity practitioner (CDIP) interact with the physician to clarify whether or not the pneumonia is a hospital-acquired condition (HAC)?

- A. D
- B. Adair, in your clinical opinion, do you think that the patient's acute kidney injury with ATN exacerbated the patient's pneumonia?
- C. No need to query the physician because even if the pneumonia is considered a HAC and cannot be used as an MCC, ATN is also an MCC.
- D. No need to interact with the physician because it is obvious the pneumonia developed after admission, therefore, not present on admission.
- E. D
- F. Adair, please indicate if the patient's pneumonia was present on admission (POA) based on the initial chest x-ray?

Answer: D

Explanation:

The clinical documentation integrity practitioner (CDIP) should interact with the physician to clarify whether or not the pneumonia is a hospital-acquired condition (HAC) by asking the physician to indicate if the pneumonia was present on admission (POA) based on the initial chest x-ray. This is because the POA status of a condition affects its coding, reporting, and reimbursement, and it is the responsibility of the physician to document the POA status of all diagnoses. The CDIP should not assume that the pneumonia developed after admission based on the timing of symptoms or treatment, as this may not reflect the true clinical picture. The CDIP should also not ask the physician about the causal relationship between the acute kidney injury and the pneumonia, as this is not relevant to the POA status. The CDIP should also not avoid querying the physician based on the presence of another MCC, as this may compromise the accuracy and completeness of documentation. (CDIP Exam Preparation Guide)

References:

- ? CDIP Exam Content Outline
- ? CDIP Exam Preparation Guide
- ? Present on Admission Reporting Guidelines

NEW QUESTION 99

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 103

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 104

A 70-year-old severely malnourished nursing home patient is admitted for a pressure ulcer covered by eschar on the right hip. The provider is queried to clarify the stage of the pressure ulcer. Because the wound has not been debrided, the provider responds "unable to determine". How will the stage of this pressure ulcer be coded?

- A. Stage IV pressure ulcer
- B. Stage III pressure ulcer
- C. Unstageable pressure ulcer
- D. Undetermined stage pressure ulcer

Answer: C

Explanation:

A pressure ulcer covered by eschar on the right hip is coded as an unstageable pressure ulcer, according to the ICD-10-CM Official Guidelines for Coding and Reporting. The guidelines state that ??Pressure-induced deep tissue damage is defined as a pressure injury that is unstageable due to coverage of the wound bed by slough and/or eschar?? 2. Eschar is a thick, dry, black necrotic tissue that obscures the depth of tissue loss and prevents accurate staging of the pressure ulcer 3. Therefore, the provider's response of ??unable to determine?? the stage of the pressure ulcer is consistent with the definition of unstageable pressure ulcer. The code for unstageable pressure ulcer of right hip is L89.210 4. References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 139 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section I.C.12.b.4 3: Pressure Ulcer/Injury Coding Pocket Guide - Centers for Medicare & Medicaid Services 2 4: ICD-10-CM Code L89.210 - Pressure ulcer of right hip, unstageable : AHIMA CDIP Exam Prep, Fourth Edition : ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 : ICD-10-CM Code L89.210 - Pressure ulcer of right hip, unstageable : AHIMA CDIP Exam Prep, Fourth Edition : ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 : ICD-10-CM Code L89.210 - Pressure ulcer of right hip, unstageable : AHIMA CDIP Exam Prep, Fourth Edition <https://my.ahima.org/store/product?id=67077> : ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 <https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf> : ICD-10-CM Code L89.210 - Pressure ulcer of right hip, unstageable <https://www.icd10data.com/ICD10CM/Codes/L00-L99/L80-L99/L89/L89.210>

NEW QUESTION 108

An 88-year-old male is admitted with a fever, cough, and leukocytosis. The physician documents admit for probable sepsis due to urinary tract infection (UTI). Antibiotics are started. Three days later, the blood and urine cultures are negative, the patient has been afebrile since admission, and the white blood count is returning to normal. What documentation clarification is needed to support accurate coding of the record?

- A. Send a clinical validation query for only the diagnosis of sepsis.
- B. Send a clinical validation query for both the diagnoses of sepsis and UTI.
- C. A clinical validation query is not required for either diagnosis.
- D. Send a clinical validation query for only the diagnosis of UTI.

Answer: B

Explanation:

According to the Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA¹, clinical validation is a process by which documentation is evaluated to ensure that the medical record demonstrates enough clinical support for all documented diagnoses as mandated by the False Claims Act. If there is a lack of clinical support for sepsis or UTI within the documentation, a clinical validation query should be sent. Query choices should list sepsis or UTI as ruled out versus ruled in (because the physician is documenting sepsis or UTI), but the query choice should also ask the provider to provide additional clinical support within the medical record. Additional query choices that are supported by clinical indicators listed on the query should also be listed as appropriate¹. In this case, the patient was admitted with a fever, cough, and leukocytosis, which are signs and symptoms of sepsis or UTI. However, three days later, the blood and urine cultures are negative, the patient has been afebrile since admission, and the white blood count is returning to normal, which are indicators that sepsis or UTI may not be present or resolved. Therefore, there is a discrepancy between the documented diagnoses of sepsis and UTI and the clinical evidence in the record. A clinical validation query should be sent to clarify if sepsis and UTI are still valid diagnoses or if they have been ruled out after study. The query should also request additional documentation of any other clinical indicators that support the diagnosis of sepsis or UTI, such as vital signs, physical exam findings, inflammatory markers, imaging results, etc¹.

References:

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

NEW QUESTION 111

Automated registration entries that generate erroneous patient identification—possibly leading to patient safety and quality of care issues, enabling fraudulent activity involving patient identity theft, or providing unjustified care for profit—is an example of a potential breach of:

- A. Authorship integrity
- B. Patient identification and demographic accuracy
- C. Documentation integrity
- D. Auditing integrity

Answer: B

Explanation:

Patient identification and demographic accuracy is the process of ensuring that the patient's identity and personal information are correctly recorded and verified in the health record and other systems. A potential breach of this process could result in automated registration entries that generate erroneous patient identification, which could lead to patient safety and quality of care issues, enabling fraudulent activity involving patient identity theft, or providing unjustified care for profit2

Authorship integrity is the process of ensuring that the source and content of the health record are authentic, accurate, complete, and consistent. Documentation integrity is the process of ensuring that the health record reflects the patient's clinical status, treatment, and outcomes. Auditing integrity is the process of ensuring that the health record is reviewed and monitored for compliance, quality, and improvement purposes2

1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 2: <https://my.ahima.org/store/product?id=67077>

NEW QUESTION 114

Which of the following is an appropriate first step to address physicians with low query response rates?

- A. An educational session between the clinical documentation integrity practitioner (CDIP) and physician
- B. The medical staff review the physician's noncompliance to consider sanctions
- C. The physician receives a suspension until query responses are improved
- D. A meeting between the physician advisor/champion and the noncompliant physician

Answer: A

Explanation:

An appropriate first step to address physicians with low query response rates is an educational session between the clinical documentation integrity practitioner (CDIP) and physician because it provides an opportunity to explain the purpose and benefits of the query process, to identify and address any barriers or challenges to responding, and to offer feedback and guidance on how to improve query response rates. An educational session can also help to build rapport and trust between the CDIP and the physician, and to demonstrate respect and professionalism. (CDIP Exam Preparation Guide) References:

? CDIP Exam Content Outline1

? CDIP Exam Preparation Guide2

? Understanding CDI Metrics3

NEW QUESTION 115

Proposed changes to the inpatient prospective payment system (IPPS) take effect on

- A. October 1
- B. January 1
- C. July 1
- D. April 1

Answer: A

Explanation:

Proposed changes to the inpatient prospective payment system (IPPS) take effect on October 1 of each fiscal year (FY), which begins on October 1 and ends on September 30 of the next calendar year. The IPPS final rule is usually issued by the Centers for Medicare & Medicaid Services (CMS) around August 1 of each year, and it updates the Medicare payment policies and rates for acute care hospitals and long-term care hospitals for the upcoming FY. The effective date of the final rule is October 1, unless otherwise specified by CMS 2.

References: 1: Inpatient Prospective Payment System (IPPS) 2023 Final Rule Summary of ?? 3 2: Acute Inpatient PPS | CMS 1

NEW QUESTION 118

.....

Relate Links

100% Pass Your CDIP Exam with Exambible Prep Materials

<https://www.exambible.com/CDIP-exam/>

Contact us

We are proud of our high-quality customer service, which serves you around the clock 24/7.

Viste - <https://www.exambible.com/>