Exam Questions CDIP

Certified Documentation Integrity Practitioner

https://www.2passeasy.com/dumps/CDIP/

NEW QUESTION 1
The facility has received a clinical validation denial for sepsis. The denial states sepsis is not a clinically valid diagnosis because it does not meet Sepsis-3 criteria. The facility has a policy stating it uses Sepsis-2 criteria. What is the BEST next step?

A. Remove sepsis from all claims where the diagnosis is not supported by sepsis 3 criteria.
B. Appeal the denial because all payors must use the hospital's sepsis criteria when reviewing their claims.
C. Query physicians when Sepsis-3 criteria is not met so they can provide additional documentation to support the diagnosis.
D. Have the contracting department work with payors to obtain agreement on how sepsis will be clinically validated.

Answer: D

NEW QUESTION 2
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 3
A pressure ulcer stage III is documented in the progress note. The clinical documentation integrity practitioner (CDIP) has queried the attending regarding the present on admission status of the pressure ulcer but has not received a response in an appropriate
time frame. What should the CDIP do next?

A. Escalate issue to medical staff leadership
B. Query wound care nurse
C. Escalate issue to hospital administration
D. Query surgical consultant

Answer: A

Explanation:
According to the AHIMA-ACDIS Practice Brief, 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 attending physician has not responded to the query in an appropriate time frame, the CDIP should escalate the issue to the medical staff leadership, such as the chief medical officer, the department chair, or the physician advisor, who can facilitate communication and education with the attending physician and ensure documentation integrity and compliance1.
References:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA1

NEW QUESTION 4
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 5
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 6
An otherwise healthy male was admitted to undergo a total hip replacement as treatment for ongoing primary osteoarthritis of the right hip. During the post-operative period, the patient choked on liquids which resulted in aspiration pneumonia as shown on chest x-ray. Intravenous antibiotics were administered, and the pneumonia was monitored for improvement with two additional chest x-rays. The patient was discharged to home in stable condition on post-operative day 5. Final Diagnoses:
* 1. Primary osteoarthritis of right hip status post uncomplicated total hip replacement
* 2. Aspiration pneumonia due to choking on liquid episode
What is the correct diagnostic related group assignment?

A. 179 Respiratory Infections and Inflammations without CC/MCC
B. 469 Major Joint Replacement or Reattachment of Lower Extremity with MCC
C. 470 Major Joint Replacement or Reattachment of Lower Extremity without MCC
D. 553 Bone Diseases and Arthropathies with MCC

Answer: B

Explanation:
The correct diagnostic related group (DRG) assignment for this case is 469 Major Joint Replacement or Reattachment of Lower Extremity with MCC. This is because the principal diagnosis is primary osteoarthritis of right hip status post uncomplicated total hip replacement, which belongs to the Major Diagnostic Category (MDC) 08 Diseases and Disorders of the Musculoskeletal System and Connective Tissue. The DRG 469 is assigned to cases with this MDC and a surgical procedure code for major joint replacement or reattachment of lower extremity. The secondary diagnosis of aspiration pneumonia due to choking on liquid episode qualifies as a major complication or comorbidity (MCC), which increases the relative weight and payment for the DRG. The MCC is determined by applying the Medicare Code Editor (MCE) software, which checks the validity and compatibility of the diagnosis codes and assigns them to different severity levels based on the CMS Severity-Diagnosis Related Group (MS-DRG) definitions manual 2.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: CMS MS-DRG Definitions Manual, Version 38.0, p. 8-9 4

NEW QUESTION 7
The BEST place for the provider to document a query response is which of the following?

A. The query form
B. The next progress note and the problem list
C. The next progress note and all subsequent notes including the discharge summary
D. An addendum to the history and physical

Answer: B

Explanation:
The best place for the provider to document a query response is the next progress note and the problem list because this ensures that the query response is timely, consistent, and integrated into the health record. According to the AHIMA/ACDIS query practice brief1, the provider should document the query response in the health record as soon as possible after receiving the query, preferably in the next progress note. The provider should also update the problem list to reflect any new or revised diagnoses resulting from the query response. This helps to maintain an accurate and comprehensive list of the patient??s current and chronic conditions, which can facilitate continuity of care, quality reporting, and reimbursement. Documenting the query response in an addendum to the history and physical or only on the query form is not sufficient, as it may not capture the current status of the patient or be easily accessible to other providers or coders.
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 8
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 9
Which of the following individuals should the clinical documentation integrity (CDI) manager consult when developing query policy and procedures?

A. Chief Medical Officer
B. Compliance Officer
C. CDI practitioner
D. Chief Financial Officer

Answer: A

Explanation:
The clinical documentation integrity (CDI) manager should consult the Chief Medical Officer when developing query policy and procedures because the Chief Medical Officer is responsible for overseeing the quality and safety of patient care, ensuring compliance with regulatory and accreditation standards, and providing leadership and guidance to the medical staff. The Chief Medical Officer can help to establish the goals, scope, and authority of the CDI program, as well as to support the query process and promote provider education and engagement. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2

NEW QUESTION 10
A noncompliant query includes querying the provider regarding

A. acute blood loss anemia due to low hemoglobin treated with iron supplements
B. sepsis that was present on admission because sepsis was only documented in the discharge summary
C. gram-negative pneumonia on every pneumonia case, regardless of documented clinical indicators
D. morbid obesity due to BMI of 40.9 documented on the history and physical

Answer: C

Explanation:
A noncompliant query includes querying the provider regarding gram-negative pneumonia on every pneumonia case, regardless of documented clinical indicators because it may lead to over-specification of a diagnosis that is not supported by the health record. A compliant query should be based on the clinical evidence and documentation in the record, and should not suggest or imply a diagnosis that is not clinically relevant or plausible. A query should also not be driven by reimbursement or coding factors, but by the need to improve the quality and accuracy of documentation. (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 10
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 15
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 16
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 20
Which of these medical conditions would a clinical documentation integrity practitioner (CDIP) expect to be treated with Levophed?

A. Septic shock
B. Acute respiratory failure
C. Multiple sclerosis
D. Acute kidney failure

Answer: A

Explanation:
Levophed is a brand name of norepinephrine, a medication that is similar to adrenaline and acts as a vasopressor, meaning that it constricts blood vessels and increases blood pressure. Levophed is indicated to raise blood pressure in adult patients with severe, acute hypotension (low blood pressure) that can occur with certain medical conditions or surgical procedures1. One of these conditions is septic shock, which is a life-threatening complication of sepsis, a systemic inflammatory response to infection. Septic shock is characterized by persistent hypotension despite adequate fluid resuscitation, along with signs of organ dysfunction and tissue hypoperfusion. Levophed is used as a first-line vasopressor agent in septic shock to restore adequate perfusion pressure and tissue oxygenation.
Acute respiratory failure, multiple sclerosis, and acute kidney failure are not indications for Levophed treatment. Acute respiratory failure is a condition in which the lungs cannot provide enough oxygen to the blood or remove enough carbon dioxide from the blood. It can be caused by various lung diseases, injuries, or infections. The treatment of acute respiratory failure depends on the underlying cause and the severity of the condition, but it may include oxygen therapy, mechanical ventilation, medications to treat infections or inflammation, or other supportive measures. Multiple sclerosis is a chronic autoimmune disease that affects the central nervous system, causing inflammation, demyelination, and axonal damage. The symptoms of multiple sclerosis vary depending on the location and extent of the nerve damage, but they may include vision problems, numbness, weakness, fatigue, cognitive impairment, or pain. The treatment of multiple sclerosis aims to reduce the frequency and severity of relapses, slow the progression of disability, and manage the symptoms. It may include immunomodulatory drugs, corticosteroids, symptomatic medications, physical therapy, or other interventions. Acute kidney failure is a condition in which the kidneys suddenly lose their ability to filter waste products and fluids from the blood. It can be caused by various factors that impair the blood flow to the kidneys, damage the kidney tissue, or block the urine output. The symptoms of acute kidney failure may include decreased urine output, fluid retention, nausea, confusion, or shortness of breath. The treatment of acute kidney failure depends on the underlying cause and the severity of the condition, but it may include fluid management, electrolyte replacement, dialysis, medications to treat infections or inflammation, or other supportive measures. References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN:
9781584268530
? Levophed Uses, Side Effects & Warnings - Drugs.com
? Levophed (Norepinephrine Bitartrate): Uses, Dosage ?? - RxList
? Levarterenol, Levophed (norepinephrine) dosing ?? - Medscape
? [Septic Shock: Practice Essentials ?? - Medscape Reference]
? [Surviving Sepsis Campaign: International Guidelines for ?? - PubMed]
? [Acute respiratory failure: MedlinePlus Medical Encyclopedia]
? [Multiple sclerosis - Symptoms and causes - Mayo Clinic]
? [Acute kidney failure - Symptoms and causes - Mayo Clinic]

NEW QUESTION 21
A patient is admitted due to pneumonia. On day 1, a sputum culture is positive for psuedomonas bacteria. If the physician is queried and agrees that the patient has pseudomonas pneumonia, this specificity would

A. meet medical necessity
B. increase relative weight
C. not increase relative weight
D. not meet medical necessity

Answer: B

Explanation:
The specificity of pseudomonas pneumonia would increase the relative weight of the diagnosis-related group (DRG) for the patient??s admission, which would affect the reimbursement for the hospital. Relative weight is a factor that reflects the average cost and resource use of a DRG compared to the average cost and resource use of all DRGs. The higher the relative weight, the higher the payment for the hospital. Pseudomonas pneumonia is classified as a major complication or comorbidity (MCC) in ICD-10-CM, which means that it significantly increases the severity of illness and risk of mortality of the patient. MCCs increase the relative weight of a DRG by assigning it to a higher-paying subclass within the same base DRG. For example, according to the CMS FY 2022 Inpatient Prospective Payment System Final Rule1, the relative weight for DRG 193 (Simple pneumonia and pleurisy with MCC) is 1.4819, while the relative weight for DRG 195 (Simple pneumonia and pleurisy without MCC) is 0.7579. Therefore, if the patient is admitted due to pneumonia and has pseudomonas pneumonia as an MCC, the hospital would receive a higher payment than if the patient does not have an MCC.
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? CMS FY 2022 Inpatient Prospective Payment System Final Rule1

NEW QUESTION 22
Which of the following should be examined when developing documentation integrity projects?

A. Query rates from coding staff
B. CC and MCC capture rates
C. Coding productivity statistics
D. Physician satisfaction surveys

Answer: B

Explanation:
The factor that should be examined when developing documentation integrity projects is CC and MCC capture rates. CC stands for complication or comorbidity, and MCC stands for major complication or comorbidity. These are secondary diagnoses that affect the severity of illness (SOI) and risk of mortality (ROM) of the patient, as well as the reimbursement and quality measures of the hospital. CC and MCC capture rates measure how well the clinical documentation reflects the presence and impact of these conditions on the patient??s care. Examining CC and MCC capture rates can help to identify documentation improvement opportunities, goals, strategies, and outcomes4 References: 1:
https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 4: https://my.ahima.org/store/product?id=67077

NEW QUESTION 23
Which of the following indicates a noncompliant multiple-choice query? One that does NOT

A. include at least four options
B. allow the provider to add their own response
C. list options in alphabetical order
D. include the option of "unable to determine"

Answer: A

Explanation:
A noncompliant multiple-choice query is one that does not include at least four options because it may limit the provider??s choice and suggest a preferred answer. A compliant multiple-choice query should include at least four options that are clinically significant, reasonable, and plausible based on the clinical indicators and documentation in the health record. The options should also be listed in alphabetical order to avoid any bias or preference. A compliant multiple-choice query should also allow the provider to add their own response if none of the options are appropriate, and include the option of ??unable to determine?? if the provider cannot make a definitive diagnosis based on the available information. (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 25
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 28
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 31
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 AHIIMA/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 32
Which of the following diagnosis is MOST likely to trigger a second level review?

A. Malnutrition
B. Pneumonia
C. Heart failure
D. Acute kidney injury

Answer: A

Explanation:
Malnutrition is a diagnosis that is most likely to trigger a second level review because it affects the severity of illness (SOI) and risk of mortality (ROM) of the patient, as well as the reimbursement and quality measures of the hospital. Malnutrition also requires clinical validation and clear documentation of its etiology, type, degree, and duration2 References: 1:
https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 2: https://my.ahima.org/store/product?id=67077

NEW QUESTION 37
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 38
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 42
Which of the following is an example of a hospital-acquired condition when not present on admission?

A. Iatrogenic pneumothorax with lung biopsy
B. Iatrogenic pneumothorax with venous catheterization
C. Pressure ulcer stage II
D. Pressure ulcer stage III

Answer: D

Explanation:
A hospital-acquired condition (HAC) is an undesirable situation or condition that affects a patient and that arose during a stay in a hospital or medical facility. CMS has identified 14 categories of HACs for which it will not pay the higher DRG rate if the condition was not present on admission (POA). One of these categories is stage III and IV pressure ulcers. A pressure ulcer is damage to the skin and underlying tissue caused by prolonged pressure on the skin. Stage III pressure ulcers involve full-thickness skin loss with damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents as a deep crater with or without undermining of adjacent tissue.
* A. Iatrogenic pneumothorax with lung biopsy is not a HAC, because it is not included in the CMS HAC list. Iatrogenic pneumothorax is a HAC only when it occurs with venous catheterization.
* B. Iatrogenic pneumothorax with venous catheterization is a HAC, but it may be present on admission if the venous catheterization was performed before the admission to the hospital.
* C. Pressure ulcer stage II is not a HAC, because only stage III and IV pressure ulcers are included in the CMS HAC list. Stage II pressure ulcers involve partial-thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? Hospital Acquired Conditions | CMS
? ICD-10 HAC List | CMS
? Bedsores (pressure ulcers) - Symptoms and causes - Mayo Clinic

NEW QUESTION 46
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 51
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 53
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 56
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 59
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 62
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 67
While reviewing a chart, a clinical documentation integrity practitioner (CDIP) needs to access the general rules for the ICD-10-CM Includes Notes and Excludes Notes 1 and 2. Which coding reference should be used?

A. Faye Brown's Coding Handbook
B. AMA CPT Assistant
C. ICD-10-CM Official Guidelines for Coding and Reporting
D. AHA Coding Clinic for ICD-10-CM

Answer: C

Explanation:
The coding reference that should be used to access the general rules for the ICD-10-CM Includes Notes and Excludes Notes 1 and 2 is the ICD-10-CM Official Guidelines for Coding and Reporting. This document provides the conventions and instructions for the proper use of the ICD-10-CM classification system, including the definitions and examples of the Includes Notes and Excludes Notes 1 and 2. The document is updated annually by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), and is available online at 2. The other coding references listed are not specific to ICD-10-CM or do not contain the general rules for the Includes Notes and Excludes Notes 1 and 2.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 4

NEW QUESTION 70
Which of the following is considered a hospital-acquired condition if not present on admission?

A. Air leak
B. Diabetes with hypoglycemia
C. Stage I and II pressure ulcers
D. Blood incompatibility

Answer: D

Explanation:
Blood incompatibility is considered a hospital-acquired condition if not present on admission, according to the CMS Hospital-Acquired Conditions (HAC) Reduction Program. This program reduces payments to hospitals that have high rates of certain conditions that are acquired during the hospital stay and could have been prevented by following evidence-based guidelines. Blood incompatibility is one of the 14 HAC categories that are included in the program, and it refers to a patient receiving a blood transfusion with incompatible blood type or Rh factor, which can cause serious adverse reactions such as hemolysis, anemia, renal failure, or death 23. Blood incompatibility is a preventable
condition that can be avoided by proper blood typing and cross-matching before transfusion, and by following strict protocols and procedures for blood handling and administration 4.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 5 2: Hospital-Acquired Conditions | CMS 1 3: Hospital Acquired Conditions (HACs) - New York State Department of Health 3 4: Transfusion Reactions - Hematology and Oncology - Merck Manuals Professional Edition 6

NEW QUESTION 71
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 76
Which of the following is a clinical documentation integrity (CDI) financial impact measure?

A. Severity of illness
B. Hierarchical condition category
C. Case mix index
D. Release of information

Answer: C

Explanation:
Case mix index (CMI) is a measure of the average severity and resource consumption of a group of patients, such as those in a hospital or a diagnosis-related group (DRG). CMI reflects the financial impact of CDI by showing how documentation improvement can affect the DRG assignment and reimbursement. A higher CMI indicates more complex and costly cases, while a lower CMI indicates less complex and costly cases. CDI programs can monitor the changes in CMI over time to evaluate their effectiveness and return on investment. (Understanding CDI Metrics2)
References:
? CDI Week 2020 Q&A: CDI and key performance indicators1
? Understanding CDI Metrics2

NEW QUESTION 78
Which of the following falls under the False Claims Act?

A. Missing charges
B. Unbundling services
C. Missing modifiers
D. Missing diagnosis codes

Answer: B

Explanation:
Unbundling services falls under the False Claims Act because it is a form of coding fraud that involves billing separately for components of a related group of procedures or tests that should be billed as a single code. For example, if a provider performs a comprehensive metabolic panel, which is a blood test that measures several components of the blood, such as glucose, electrolytes, and liver enzymes, and bills for each component individually instead of using the single code for the panel, that is unbundling. Unbundling services can result in overpayment by the government and can violate the False Claims Act, which prohibits submitting false or fraudulent claims for payment to the government, including the Medicare and Medicaid programs. Violators of the False Claims Act can face civil penalties of up to three times the amount of the false claim plus an additional $11,000 per claim 23. References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: Coding Fraud | VSG 5 3: False Claims Act | OIG 2

NEW QUESTION 79
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 81
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 85

A clinical documentation integrity practitioner (CDIP) must determine the present on admission (POA) status of a stage IV sacral decubitus ulcer documented in the discharge summary. What is the first step that should be taken?

A. Look for wound care documentation
B. Read the nursing admission notes
C. Query the attending provider
D. Review the history and physical

Answer: D

Explanation:
The first step that a clinical documentation integrity practitioner (CDIP) should take to determine the present on admission (POA) status of a stage IV sacral decubitus ulcer documented in the discharge summary is to review the history and physical (H&P) because it is the initial source of information about the patient??s condition at the time of admission. The H&P should include a comprehensive physical examination that covers all body systems, including the skin. If the H&P documents the presence of a stage IV sacral decubitus ulcer, then the POA status is ??yes??. If the H&P does not mention the ulcer, then the CDIP should look for other sources of documentation, such as wound care notes, nursing notes, or progress notes, to see if the ulcer was identified or treated during the hospital stay. If there is no clear evidence of when the ulcer developed, then the CDIP should query the attending provider to clarify the POA status. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? Present on Admission Reporting Guidelines3

NEW QUESTION 86
Which member of the clinical documentation integrity (CDI) team can help provide peer-to- peer level of education on the importance of accurate documentation and
query responses?

A. Chief Financial Officer
B. Physician advisor/champion
C. CDI practitioner
D. CDI manager

Answer: B

Explanation:
The member of the clinical documentation integrity (CDI) team who can help provide peer-
to-peer level of education on the importance of accurate documentation and query responses is the physician advisor/champion. The physician advisor/champion is a physician who supports and advocates for the CDI program and its goals, and who can communicate effectively with other physicians about the clinical and financial implications of documentation quality and accuracy. The physician advisor/champion can also serve as a liaison between the CDI team and the medical staff, and help to resolve any issues or conflicts that may arise from the query process. The physician advisor/champion can also provide feedback and guidance to the CDI team on clinical matters and documentation standards. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2

NEW QUESTION 91
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 95
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 97
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 99
When queries are part of the health record, which of the following physician privilege could be suspended if the provider receives too many deficiencies due to incomplete records for failure to respond to queries?

A. Admitting
B. Consulting
C. Surgical
D. Credentialing

Answer: A

Explanation:
When queries are part of the health record, which is recommended by AHIMA and ACDIS, physicians are responsible for responding to queries in a timely manner and ensuring that their documentation is complete and accurate. If a provider receives too many deficiencies due to incomplete records for failure to respond to queries, their admitting privilege could be suspended by the medical staff committee as a disciplinary action.
References: AHIMA/ACDIS. ??Guidelines for Achieving a Compliant Query Practice (2019 Update).?? Journal of AHIMA 90, no. 2 (February 2019): 20-29.

NEW QUESTION 104
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 107
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 110
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 improvement 23.
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 114
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 competence 2. 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 compliantly 3.
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 115
Which of the following clinical documentation integrity (CDI) dashboard metrics is frequently used to help evaluate the credibility of CDI practitioner queries and the success of the CDI program?

A. CDI agreement rate
B. CDI query rate
C. Provider response rate
D. Provider agreement rate

Answer: D

Explanation:

The provider agreement rate is the percentage of queries that result in a change in the documentation or coding that is consistent with the query. It is a measure of the accuracy and appropriateness of the queries, as well as the provider??s acceptance of the CDI program??s recommendations. A high provider agreement rate indicates that the CDI practitioners are asking relevant and compliant queries that improve the quality and specificity of the documentation. The other options are not directly related to the credibility of the queries or the success of the CDI program. The CDI agreement rate is the percentage of queries that agree with the coder??s final DRG assignment. The CDI query rate is the percentage of records that generate a query from the CDI practitioner. The provider response rate is the percentage of queries that receive a response from the provider.

NEW QUESTION 117
A patient is admitted for pneumonia with a WBC of 20,000, respiratory rate 20, heart rate 85, and oral temperature 99.0??. On day 2, sputum cultures reveal positive results for pseudomonas bacteria. The most appropriate action is to

A. code pneumonia, unspecified
B. query the provider to see if pseudomonas sepsis is supported by the health record
C. query the provider to document the etiology of pneumonia
D. code pseudomonas pneumonia

Answer: C

Explanation:
The most appropriate action in this case is to query the provider to document the etiology of pneumonia, which is pseudomonas bacteria. This is because the etiology of pneumonia affects the coding and classification of the condition, as well as the severity of illness, risk
of mortality, and reimbursement. According to the ICD-10-CM Official Guidelines for Coding and Reporting, pneumonia should be coded by type whenever possible, and if the type of pneumonia is not documented, then the default code is J18.9, Pneumonia, unspecified organism 2. However, if the type of pneumonia is documented, then a more specific code can be assigned, such as J15.1, Pneumonia due to Pseudomonas 3. Therefore, querying the provider to document the etiology of pneumonia will improve the accuracy and completeness of the documentation and coding, and reflect the true clinical picture of the patient.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 139 4 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section I.C.9.a 3: ICD-10-CM Code J15.1 - Pneumonia due to Pseudomonas

NEW QUESTION 118
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 123
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 124
What is the term used when a patient is entered in the Master Patient Index (MPI) multiple times, in different ways, resulting in multiple medical record numbers?

A. Replica
B. Clone
C. Facsimile
D. Overlap

Answer: D

Explanation:
The term used when a patient is entered in the MPI multiple times, in different ways, resulting in multiple medical record numbers is overlap. An overlap occurs when a person has more than one medical record number within an integrated delivery network or enterprise, and may cause problems such as incomplete or inaccurate patient information, duplicate testing or treatment, billing errors, or patient safety issues. An overlap may be caused by data entry errors, system conversions, mergers or acquisitions, or lack of standardization. Regular audits of the MPI database must be done to identify and resolve any overlaps and ensure data quality and integrity.

References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? Master patient index - Clinfowiki1

NEW QUESTION 129
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 134
A patient presents to the emergency room with complaint of cough with thick yellow/greenish sputum, and generalized pain. Admitting vital signs are noted below and sputum culture performed. The patient is admitted with septicemia due to pneumonia and has received 2L of normal saline and piperacillin/ tazobactam. After all results were reviewed, on day 2, the hospitalist continued to document septicemia due to pneumonia.
White blood count BC 18,000 Temperature 101.5
Heart rate 110
Respiratory rate 24
Blood pressure 95/67
Sputum culture (+) klebsiella pneumoniae
Which diagnosis implies that a query was sent and answered?

A. Sepsis with respiratory failure due to pneumonia
B. Sepsis with pneumonia due to klebsiella pneumoniae
C. Septicemia due to klebsiella pneumoniae
D. Severe sepsis with pneumonia due to klebsiella pneumoniae

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 presents with signs and symptoms of sepsis, such as fever, tachycardia, tachypnea, hypotension, and elevated white blood count. The patient also has a positive sputum culture for klebsiella pneumoniae, which is the likely source of infection. However, the hospitalist continues to document septicemia due to pneumonia, which is a vague and outdated term that does not reflect the patient??s true severity of illness, risk of mortality, or reimbursement3. Therefore, a query to the hospitalist to clarify the diagnosis of sepsis and its etiology is appropriate and compliant. The diagnosis that implies that a query was sent and answered is B. Sepsis with pneumonia due to klebsiella pneumoniae. This diagnosis is more specific and accurate than septicemia due to pneumonia, as it indicates the type of infection (sepsis), the site of infection (pneumonia), and the causal organism (klebsiella pneumoniae). This diagnosis also affects the assignment of DRGs and quality scores. The other options are not correct because they either do not provide enough specificity ©, or they introduce additional diagnoses that are not supported by the clinical indicators (A and D). References:
? CDIP Exam Preparation Guide - AHIMA
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA
? Q&A: Three query opportunities related to sepsis infections | ACDIS
? [Q&A: Clinical validation of sepsis and clinical criteria | ACDIS]

NEW QUESTION 136
A hospital is conducting a documentation integrity project for the purpose of reducing indiscriminate use of electronic copy and paste of patient information in records
by physicians. Which data should be used to quantify the extent of the problem?

A. Percent of insurance billings denied due to lack of record documentation
B. Number of coder queries regarding inconsistent physician record documentation
C. Results of a survey of physicians that asks about documentation practices
D. Incidence of redundancies in physician notes in a sample of hospital admissions

Answer: D

Explanation:
According to the AHIMA CDIP Exam Preparation Guide, a documentation integrity project is a systematic process of identifying, analyzing, and improving the quality and accuracy of clinical documentation in the health record1. A documentation integrity project may have various purposes, such as enhancing patient safety, improving coding and reimbursement, or complying with regulatory standards1. One of the common issues that may affect the quality and accuracy of clinical documentation is the indiscriminate use of electronic copy and paste of patient information in records by physicians2. Copy and paste is a function that allows physicians to duplicate existing text in the record and paste it in a new destination, which may save time and effort, but also may introduce errors, inconsistencies, or redundancies in the documentation2. Therefore, to quantify the extent of the problem of copy and paste, the data that should be used is the incidence of redundancies in physician notes in a sample of hospital admissions. Redundancies are repeated or unnecessary information that may clutter the record and impair its readability and reliability3. By measuring the frequency and types of redundancies in physician notes, the hospital can assess the impact of

copy and paste on the documentation quality and identify areas for improvement. The other options are not correct because they do not directly measure the problem of copy and paste. The percent of insurance billings denied due to lack of record documentation may reflect other issues besides copy and paste, such as incomplete or inaccurate documentation, coding errors, or payer policies4. The number of coder queries regarding inconsistent physician record documentation may indicate the presence of copy and paste, but it may also depend on other factors such as coder knowledge, query guidelines, or query response rate. The results of a survey of physicians that asks about documentation practices may provide some insight into the perceptions and attitudes of physicians regarding copy and paste, but it may not reflect the actual extent or impact of the problem on the documentation quality. References:
? CDIP Exam Preparation Guide - AHIMA
? Auditing Copy and Paste - AHIMA
? Copy/Paste: Prevalence, Problems, and Best Practices - AHIMA
? Documentation Denials: How to Avoid Them - AAPC
? [Q&A: Querying for clinical validation | ACDIS]

NEW QUESTION 139
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 140
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 145
The clinical documentation integrity practitioner (CDIP) is reviewing tracking data and has noted physician responses are not captured in the medical chart. What can be done to improve this process?

A. Update medical records with unsigned physician responses
B. Allow physician responses via e-mail
C. Provide education to physicians on query process
D. Require the CDIP to call physicians to follow up

Answer: C

Explanation:
According to the AHIMA/ACDIS Query Practice Brief, one of the best practices for a compliant query process is to provide ongoing education to physicians on the importance of documentation integrity, the query process, and the impact of documentation on quality measures, reimbursement, and compliance1. Education can help physicians understand the rationale and expectations for responding to queries, as well as the benefits of accurate and complete documentation for patient care and data quality. Education can also address any barriers or challenges that physicians may face in responding to queries, such as time constraints, technology issues, or workflow preferences1. References:
? AHIMA/ACDIS Query Practice Brief – Updated 12/2022
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

NEW QUESTION 150
Reviewing and analyzing physician query content on a regular basis

A. helps to calculate query response rate
B. aids in discussion between physician and reviewer
C. assists in identifying gaps in skills and knowledge
D. facilitates physician data collection

Answer: C

Explanation:

Reviewing and analyzing physician query content on a regular basis assists in identifying gaps in skills and knowledge of the clinical documentation integrity practitioners (CDIPs) and the providers. By evaluating the quality, accuracy, appropriateness, and effectiveness of the queries, the CDIPs can identify areas of improvement, education, and feedback for themselves and the providers. Reviewing and analyzing physician query content can also help to ensure compliance with industry standards and best practices, as well as to monitor query outcomes and trends2 References: 1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 2: https://my.ahima.org/store/product?id=67077

NEW QUESTION 154
The third quarter target concurrent physician query response rate for each physician in a hospital gastroenterology department was 80%. Nine physicians met or exceeded this metric; however, two physicians had third quarter concurrent physician query response rates of 19% and 64%. What is the best course of action for the clinical documentation integrity (CDI) physician advisor/champion?

A. Schedule a group meeting with all physicians
B. Schedule individual meetings with each physician
C. Schedule individual meetings with each low-performing physician
D. Schedule a meeting with the chair of the gastroenterology department

Answer: C

Explanation:
According to the ACDIS Practice Brief, 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 two physicians have significantly lower query response rates than the target, the CDI physician advisor/champion should schedule individual meetings with each low-performing physician to provide feedback, education, and support. A group meeting with all physicians may not be effective or efficient, as it may not address the specific barriers or challenges faced by the low-performing physicians. A meeting with the chair of the gastroenterology department may be helpful, but it may not be sufficient to resolve the issue without direct communication with the low-performing physicians.
References:
? CDI Week 2020 Q&A: CDI and key performance indicators1

NEW QUESTION 159
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 163
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 167
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 169
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