CDIP Dumps

Certified Documentation Integrity Practitioner

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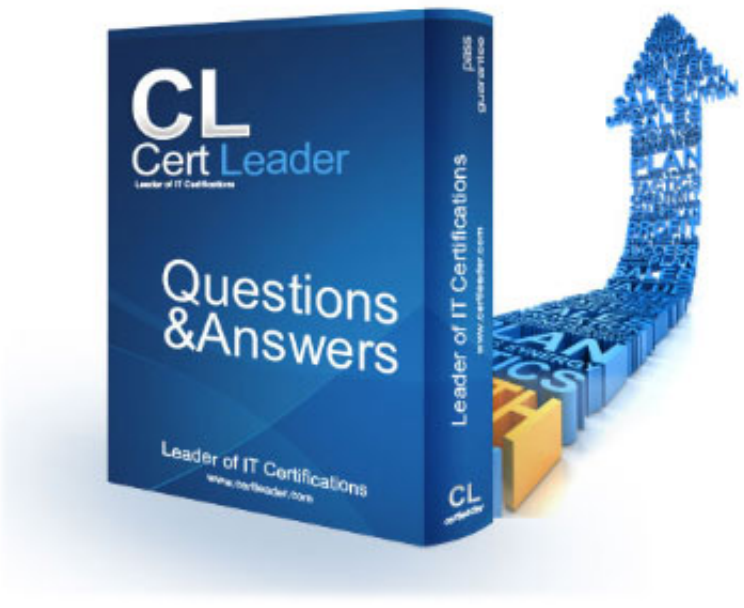

NEW QUESTION 1
A 90-year-old female patient was admitted to emergency room c/o nausea and vomiting x2 days. Vital signs: BP 130/72, P 86, R 22, T 99.8F, O2 sat 94% on room air. Patient has a history of cerebral vascular accident (CVA) and difficulty swallowing. CXR revealed right lower lobe infiltrate. Labs: WBC 12.0 with 71% segs. Physician documents patient with a history of CVA and difficulty swallowing. CXR revealed right lower lobe infiltrate, diagnosis: pneumonia. Aspiration precautions and IV Clindamycin ordered. Patient was discharged 3 days later with a diagnosis of pneumonia. Clarification is needed to determine which of the following is clinically indicated.

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

Answer: B

Explanation:
Aspiration pneumonia is a type of pneumonia that occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs, causing an infection or inflammation. Aspiration pneumonia is more likely to occur in people who have difficulty swallowing, such as those with a history of CVA2. In this case, the patient has a history of CVA and difficulty swallowing, and presents with nausea and vomiting, which are risk factors for aspiration. The CXR reveals a right lower lobe infiltrate, which is a common finding in aspiration pneumonia3. The physician documents pneumonia as the diagnosis, but does not specify the type or cause. Therefore, clarification is needed to determine if aspiration pneumonia is clinically indicated, as it would affect the coding and reimbursement of the case. Aspiration pneumonia is coded as ICD-10-CM code J69.x Pneumonitis due to solids and liquids, with a fourth digit required to specify the inhaled substance4.
References:
? CDI Week 2020 Q&A: CDI and key performance indicators1
? Mayo Clinic: Aspiration pneumonia2
? Medscape: Aspiration Pneumonia3
? ICD-10-CM Diagnosis Code J69.x: Pneumonitis due to solids and liquids4

NEW QUESTION 2
For inpatients with a discharge principal diagnosis of acute myocardial infarction, aspirin must be taken within 24 hours of arrival unless a contraindication to aspirin is
documented. How should this be documented in the health record?

A. The name of the medication (aspirin), the date and time it was last administered
B. The name of the medication (aspirin), the date, time and location where it was last administered
C. The name of the medication (aspirin) and the date it was last administered
D. The name of the medication (aspirin), the date and location where it was last administered

Answer: B

Explanation:
The name of the medication (aspirin), the date, time and location where it was last administered should be documented in the health record for inpatients with a discharge principal diagnosis of acute myocardial infarction, unless a contraindication to aspirin is documented. This is because aspirin is a core measure for acute myocardial infarction patients, and its administration within 24 hours of arrival is an indicator of quality of care and patient safety. The date, time and location are important to verify that the medication was given within the specified timeframe and to avoid duplication or omission of doses4 References: 1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 4: https://my.ahima.org/store/product?id=67077

NEW QUESTION 3
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 4
A 94-year-old female patient is admitted with altered mental status and inability to move the left side of her body. She is diagnosed with a cerebral vascular accident with left sided weakness. The patient is ambidextrous, but the physician does not specify the predominance of the affected side. The default code is

A. ambidextrous
B. non-dominant
C. preferred
D. dominant

Answer: B

Explanation:
According to the ICD-10-CM Official Guidelines for Coding and Reporting, when the affected side is not documented for a condition that is commonly associated with hemiplegia or hemiparesis, such as a cerebral vascular accident, the default code is the non-dominant side. The non-dominant side is usually the left side for right-handed individuals and the right side for left-handed individuals. However, if the patient is ambidextrous, the default code is still the non-dominant side, unless the provider indicates otherwise. Therefore, in this case, the default code for cerebral vascular accident with left sided weakness is I63.532 Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery1.
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? ICD-10 Code for Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery- I63.532- AAPC Coder1
? ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

NEW QUESTION 5
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 6
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:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA1

NEW QUESTION 7
A clinical documentation integrity (CDI) program that is compliant with regulations from the facility's payors results in

A. higher overall program cost
B. need for more CDI staff
C. less risk from audits
D. meeting external benchmarks

Answer: C

NEW QUESTION 8
A patient falls off a ladder and undergoes a right femur procedure. Three weeks later, the patient returns to the hospital for removal of the external fixation device. The ICD-10-CM 7th character code value should indicate

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

Answer: D

Explanation:
The ICD-10-CM 7th character code value should indicate aftercare for a patient who falls off a ladder and undergoes a right femur procedure, and then returns to the hospital for removal of the external fixation device. Aftercare codes are used to capture encounters for follow-up care after completed treatment of an injury or condition, such as removal of external fixation devices, casts, or pins. Aftercare codes are not used for subsequent encounters for complications or infections related to the injury or condition5 References: 1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 5: https://my.ahima.org/store/product?id=67077

NEW QUESTION 9
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 10
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 10
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 12
Which of the following may result in an incomplete health record deficiency being assigned to a provider?

A. A quality query
B. A retrospective query
C. A concurrent query
D. An outstanding query

Answer: D

Explanation:
An outstanding query may result in an incomplete health record deficiency being assigned to a provider, if the query is not answered or resolved before the discharge or final coding of the patient. An outstanding query is a query that has been generated by the clinical documentation integrity practitioner (CDIP) or the coder, but has not been acknowledged or addressed by the provider. An outstanding query may affect the accuracy and completeness of the health record, as well as the coding, reimbursement, quality measures, and compliance of the hospital. References: : https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf : https://my.ahima.org/store/product?id=67077

NEW QUESTION 16
Which of the following demonstrates the relative severity and complexity of patient treated in the hospital, and is used to evaluate the financial impact of a hospital's clinical documentation integrity (CDI) program?

A. Hospital acquired conditions
B. Program for evaluating payment patterns electronic report
C. Present on admission indicators
D. Adjusted case mix index

Answer: D

Explanation:
According to the AHIMA CDIP Exam Preparation Guide, the adjusted case mix index (CMI) is a measure that demonstrates the relative severity and complexity of patients treated in a hospital, and is used to evaluate the financial impact of a hospital??s clinical documentation integrity (CDI) program1. The adjusted CMI is calculated by multiplying the unadjusted CMI by a factor that accounts for the percentage of Medicare patients in the hospital2. The higher the adjusted CMI, the higher the expected reimbursement per patient, and the more effective the CDI program is assumed to be3. The other options are not correct because they do not measure the severity and complexity of patients or the financial impact of
CDI. Hospital acquired conditions (HACs) are conditions that are not present on admission and are considered preventable by CMS, and may result in reduced reimbursement or penalties4. The program for evaluating payment patterns electronic report (PEPPER) is a report that provides hospital-specific data on potential overpayments or underpayments for certain services or diagnoses, and helps identify areas of risk or opportunity for improvement. Present on admission (POA) indicators are codes that indicate whether a condition was present at the time of admission or acquired during the hospital stay, and affect the assignment of DRGs and HACs. References:
? CDIP Exam Preparation Guide - AHIMA
? Demystifying and communicating case-mix index - ACDIS
? What is Case Mix Index? | The Importance of CMI
? Hospital-Acquired Conditions (HACs) | CMS
? [PEPPER Resources]
? [Present on Admission Reporting Guidelines - CMS]

NEW QUESTION 19
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 21
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 24
Besides the physician advisor/champion, who should be included as a key stakeholder in the clinical documentation integrity (CDI) steering committee to promote CDI initiatives?

A. Manager of Surgical Services
B. Director of Informatics
C. Manager of HIM/Coding
D. Director of Risk Management

Answer: C

Explanation:
The manager of HIM/Coding should be included as a key stakeholder in the clinical documentation integrity (CDI) steering committee to promote CDI initiatives because they are responsible for overseeing the coding and billing processes, ensuring compliance with coding guidelines and regulations, and collaborating with the CDI team to resolve coding and documentation discrepancies. The manager of HIM/Coding can also provide feedback on the CDI program??s impact on coding quality, accuracy, productivity, and reimbursement. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2

NEW QUESTION 29
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 30
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 32
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 37
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 flair 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 39
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 40
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 43
A key physician approaches the director of the coding department about the new emphasis associated with clinical documentation integrity (CDI). The physician does not support the program and believes the initiative will encourage inappropriate billing.
How should the director respond to the concerns?

A. Develop an administrative panel to oversee CDI process
B. Refer the physician to the finance department to discuss required billing changes
C. Involve the physician advisor/champion in addressing the medical staff's concerns
D. Inform the physician that changes must be made

Answer: C

Explanation:
The director should involve the physician advisor/champion in addressing the medical staff??s concerns because the physician advisor/champion is a key member of the CDI team who can provide clinical expertise, education, and leadership to promote CDI among physicians. The physician advisor/champion can help to explain the goals and benefits of CDI, such as improving patient care quality, accuracy of documentation, and appropriate reimbursement. The physician advisor/champion can also address any misconceptions or fears that the physicians may have about CDI, such as encouraging inappropriate billing or increasing their workload. The physician advisor/champion can serve as a liaison between the CDI team and the medical staff, and foster a culture of collaboration and trust.
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 48
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 52
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 53
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 56
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 58
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 63
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 66
The clinical documentation integrity (CDI) manager is reviewing physician benchmarks and notices a low-severity level being measured against average length of

stay.
What should the CDI manager keep in mind when discussing this observation with physicians?

A. The indicator is a key factor of measurement for quality reports.
B. The query rate is too high while the agreement rate is low.
C. The query response rate directly correlates to quality reports.
D. The diagnosis with a higher degree of specificity has a lower severity of illness.

Answer: A

Explanation:
According to the AHIMA CDIP Exam Preparation Guide, one of the CDI metrics and statistics that CDI managers should track and interpret is the severity level measured against average length of stay (ALOS)1. This indicator reflects the complexity and acuity of the patient population and the quality of care provided by the hospital2. A low-severity level with a high ALOS may indicate under-documentation or under-coding of the patient??s condition, which may affect the hospital??s reimbursement, risk adjustment, and quality scores3. Therefore, the CDI manager should keep in mind that this indicator is a key factor of measurement for quality reports when discussing this observation with physicians, and educate them on the importance of documenting and coding accurately and completely to reflect the patient??s true severity of illness. The other options are not correct because they do not address the issue of severity level measured against ALOS, or they are not relevant to the CDI manager??s role or responsibility. References:
? CDIP Exam Preparation Guide - AHIMA
? Demystifying and communicating case-mix index - ACDIS
? Severity of Illness: What Is It? Why Is It Important? | HCPro

NEW QUESTION 68
A patient presented with shortness of breath, elevated B-type natriuretic peptide, and lower extremity edema to the emergency room. During the hospitalization, a cardiac echocardiogram was performed and revealed an ejection fraction of 55% with diastolic dysfunction. The patient's history includes hypertension (HTN), chronic kidney disease (CKD) (baseline glomerular filtration rate 40) and congestive heart failure (CHF).
The clinical documentation integrity practitioner (CDIP) has queried the physician to further clarify the patient's diagnosis. Which response provides the highest level of specificity?

A. Acute on chronic diastolic CHF with hypertensive renal disease, CKD 3
B. Acute on chronic systolic CHF with hypertensive renal disease, CKD 3
C. Acute diastolic CHF with HTN and CKD 3
D. Acute CHF with hypertensive renal disease, CKD 3

Answer: A

Explanation:
This response provides the highest level of specificity for the patient??s diagnosis because it includes the following elements:
? The type of heart failure: diastolic, which means the heart has difficulty relaxing and filling with blood during diastole, resulting in increased filling pressures and pulmonary congestion. Diastolic heart failure is also known as heart failure with preserved ejection fraction (HFpEF), which is defined as an ejection fraction of 50% or higher 2.
? The acuity of heart failure: acute on chronic, which means the patient has a history of chronic heart failure that has worsened acutely due to a precipitating factor, such as infection, ischemia, arrhythmia, or medication noncompliance. Acute on chronic heart failure is associated with higher mortality and morbidity than stable chronic heart failure 3.
? The associated conditions: hypertensive renal disease and CKD 3, which indicate that the patient has kidney damage and reduced kidney function due to high blood pressure. CKD 3 is the third stage of chronic kidney disease, which is characterized by a glomerular filtration rate of 30 to 59 mL per minute per 1.73 m2 4.
The other responses are less specific because they either omit or misrepresent some of these elements. For example, response B incorrectly states that the patient has systolic heart failure, which is contradicted by the echocardiogram result. Response C does not specify whether the heart failure is chronic or acute on chronic, which has implications for treatment and prognosis. Response D does not specify the type of heart failure, which affects the coding and classification of the condition.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 5 2: Heart Failure With Preserved Ejection Fraction (HFpEF) | American Heart Association 3: Acute-on-Chronic Heart Failure: A High-Risk Phenotype Needing Separate Attention 4: Chronic Kidney Disease (CKD) | National Kidney Foundation

NEW QUESTION 69
A patient presents to the emergency department for evaluation after suffering a head injury during a fall. A traumatic subdural hematoma is found on MRI, and the patient is taken directly to the operating room for evacuation. The neurosurgeon performs a burr hole procedure for evacuation of the subdural hematoma. The clot is removed successfully, and the patient is transferred to recovery in stable condition. Which is the correct current procedural terminology (CPT) code assignment for the procedure performed?

A. 61154 Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural
B. 61108 Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for evacuation and/or drainage of subdural hematoma
C. 61140 Burr hole(s) or trephine; with biopsy of brain or intracranial lesion
D. 61105 Twist drill hole subdural/ventricular puncture

Answer: A

Explanation:
According to the CPT code description, 61154 is the appropriate code for a burr hole procedure for evacuation of a subdural hematoma. A burr hole is a small hole made in the skull with a surgical drill to access the brain or its coverings2. A subdural hematoma is a collection of blood between the dura mater and the arachnoid mater, which are two of the three layers that cover the brain3. The evacuation of the hematoma involves removing the clot and relieving the pressure on the brain. The other codes are not applicable for this procedure because they describe different methods of access (twist drill hole) or different purposes (biopsy or puncture)4.
References:
? CDI Week 2020 Q&A: CDI and key performance indicators1
? Mayo Clinic: Burr hole2
? MedlinePlus: Subdural hematoma3
? CPT Code Book 20234

NEW QUESTION 74

The physician advisor/champion needs to provide ongoing education regarding coding and reimbursement regulations to the

A. clinical documentation integrity staff
B. organization senior administration staff
C. Health Information Management coding staff
D. organization's medical and surgical staff

Answer: D

Explanation:
The physician advisor/champion is a key role in the CDI program who serves as a liaison between the CDI staff and the organization??s medical and surgical staff. The physician advisor/champion needs to provide ongoing education regarding coding and reimbursement regulations to the organization??s medical and surgical staff to promote awareness, understanding, and compliance with CDI initiatives and goals.
References: AHIMA. ??CDIP Exam Preparation.?? AHIMA Press, Chicago, IL, 2017: 97-98.

NEW QUESTION 77
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 80
Yes/No queries may be used

A. when only the clinical indicators of a condition are present
B. to resolve conflicting documentation from multiple practitioners
C. when the diagnosis is not clearly documented in the health record
D. in any query format

Answer: B

NEW QUESTION 81
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 86
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 87
A clinical documentation integrity practitioner (CDIP) hired by an internal medicine clinic is creating policies governing written queries. What is an AHIMA best practice for these policies?

A. Queries are limited to non-leading questions
B. Non-responses to written queries are grounds for discipline
C. Primary care physicians must answer written queries
D. Queries for illegible chart notes are unnecessary

Answer: A

Explanation:
According to the AHIMA best practice for written queries, queries should be limited to non- leading questions that do not imply a specific answer or diagnosis, but rather ask for the provider??s opinion based on their clinical judgment and the evidence in the health record. Non-leading questions help to ensure that the query is compliant, objective, and respectful of the provider??s authority and autonomy. Leading questions, on the other hand, may introduce bias, influence the provider??s response, or compromise the integrity of the documentation and coding. For example, a non-leading query for a patient with chest pain would be: ??What is the etiology of the chest pain??? A leading query would be: ??Is the chest pain due to acute myocardial infarction???
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 89
Which of the following is nonessential to facilitate code capture when educating clinical staff on documentation practices associated with diabetes mellitus?

A. Type
B. Manifestation
C. Cause
D. Age

Answer: D

NEW QUESTION 91
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 94
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