AHIMA

Exam Questions CDIP

Certified Documentation Integrity Practitioner

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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
Tracking denials within the clinical documentation integrity program is important to

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

Answer: C

Explanation:
Tracking denials within the clinical documentation integrity program is important to identify documentation improvement opportunities and educate as necessary because it helps to analyze the root causes of denials, improve the quality and specificity of clinical documentation, and reduce the risk of future denials. Denials can also provide feedback on the effectiveness of the CDI program and the areas that need more attention or intervention. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2

NEW QUESTION 3
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 4
Which of the following is the definition of an Excludes 2 note in ICD-10-CM?

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

Answer: B

Explanation:
An Excludes 2 note in ICD-10-CM indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together to completely describe the condition. For example, under code R05 Cough, there is an Excludes 2 note for whooping cough (A37.-). This means that a patient can have both a cough and whooping cough at the same time, and both codes can be used together to capture the full clinical picture.
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? ICD-10-CM Features | Diagnosis Coding: Using the ICD-10-CM1

NEW QUESTION 5
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 6
A 75-year-old, diabetic patient with a history of osteoporosis, being treated with Fosamax, who sustained a femur fracture after falling down three stairs. The provider's documentation indicates to admit the patient for a traumatic femur fracture and an orthopedics consult is pending. The clinical documentation integrity practitioner (CDIP) decides to query for a possible link between osteoporosis and the femur fracture. Which of the following is the most compliant query based on the most recent AHIMA/ACDIS query practice brief?

A. Patient admitted for a femur fracture with a history of osteoporosis being treated with Fosama
B. In your medical opinion, is this fracture consistent with an osteoporotic pathological fracture?
C. Patient admitted for a femur fracture with a history of osteoporosis being treated with Fosama
D. Please clarify the cause of the femur fracture in your next note and/or the discharge summary.
E. Patient admitted for a femur fracture with a history of osteoporosis being treated with Fosama
F. Could diabetes be a contributing factor in the femur fracture?
G. Patient admitted for a femur fracture with a history of osteoporosis being treated with Fosama
H. Please document "femur fracture due to osteoporosis" in your next progress note to demonstrate a link between the two diagnoses.

Answer: A

Explanation:
This query option is the most compliant based on the most recent AHIMA/ACDIS query practice brief because it meets the following criteria:
? It is based on clinical indicators in the health record that support a reasonable and logical connection between the conditions (femur fracture and osteoporosis).
? It is non-leading and non-suggestive, as it does not imply a specific answer or diagnosis, but rather asks for the provider??s opinion based on their clinical judgment.
? It is concise and clear, as it uses simple and direct language that avoids ambiguity or confusion.
? It is relevant and specific, as it addresses a clinical issue that has an impact on patient care, quality reporting, and/or reimbursement.
? It is consistent with clinical documentation integrity (CDI) standards and guidelines, as it follows the AHIMA/ACDIS query practice brief recommendations for query format, content, delivery, and documentation.
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)
? Guidelines for Achieving a Compliant Query Practice—2022 Update (https://acdis.org/resources/guidelines-achieving-compliant-query-practice%E2%80%942022-update)

NEW QUESTION 7
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 8
Which of the following may make physicians lose respect for clinical documentation integrity (CDI) efforts and disengage?

A. Inconsistent clinically relevant queries
B. CDI practitioners sending multiple queries to hospitalist physicians
C. The physician advisor/champion's interventions with noncompliant physicians
D. Providing many lectures, newsletters, tip sheets, and pocket cards for physician education

Answer: A

Explanation:
Inconsistent clinically relevant queries may make physicians lose respect for CDI efforts and disengage because they may perceive them as irrelevant, redundant, or contradictory. Clinically relevant queries are those that affect the quality of care, patient safety, severity of illness, risk of mortality, or reimbursement. Inconsistent queries may result from lack of standardization, conflicting guidelines, poor communication, or lack of clinical validation. To avoid inconsistency, CDI practitioners should follow best practices such as using evidence- based criteria, adhering to query policies and procedures, collaborating with coding and quality staff, and seeking feedback from physicians and physician advisors 2. References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 136 3 2: Proactive CDI: Tackling the Problem of Physician Engagement 4

NEW QUESTION 9

A query should include

A. information from previous encounters
B. the impact on quality
C. the impact of reimbursement
D. relevant clinical indicators

Answer: D

Explanation:
A query should include 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. Information from previous encounters, the impact on quality, and the impact of reimbursement are not appropriate to include in a query, as they may introduce bias, lead the provider, or imply a desired response.

NEW QUESTION 10
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 10
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 12
Patient is admitted with oliguria, pulmonary edema, and dehydration. Labs are remarkable for an elevated creatinine of 2.4, with a baseline of 1.1. Patient was hydrated for 48 hours with drop in creatinine. What would the appropriate action be?

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

Answer: B

Explanation:
The appropriate action in this case is to query the physician to see if acute renal failure is clinically supported. This is because the patient has signs and symptoms of acute renal failure, such as oliguria, pulmonary edema, and elevated creatinine, but the diagnosis is not documented in the medical record. Acute renal failure is a clinical syndrome characterized by a rapid decline in kidney function and accumulation of metabolic waste products. It can be caused by various factors, such as dehydration, hypovolemia, sepsis, nephrotoxins, or obstruction. Acute renal failure can be classified according to the RIFLE criteria (Risk, Injury, Failure, Loss, End-stage kidney disease) or the AKIN criteria (Acute Kidney Injury Network), which are based on changes in serum creatinine and urine output 23. A query to the physician is needed to confirm or rule out the diagnosis of acute renal failure, specify the etiology and severity of the condition, and document any associated complications or comorbidities. A query to the physician will also improve the accuracy and completeness of the documentation and coding, and reflect the true clinical picture and resource utilization of the patient.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: Acute Kidney Injury: Diagnosis and Management | AAFP 3: AKIN Classification for Acute Kidney Injury (AKI) - MDCalc

NEW QUESTION 14
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 18
A modifier may be used in CPT and/or HCPCS codes to indicate

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

Answer: A

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

NEW QUESTION 22
When there are comparative contrasting diagnoses supported by clinical criteria, the correct action is to

A. code the first condition listed
B. query for clarification
C. not code either diagnosis
D. code both diagnoses

Answer: D

Explanation:
When there are comparative contrasting diagnoses supported by clinical criteria, the correct action is to code both diagnoses, as long as they are not mutually exclusive. Comparative contrasting diagnoses are those that are considered as possible alternatives or differentials for the patient??s condition, such as pneumonia versus bronchitis, or appendicitis versus diverticulitis. Coding both diagnoses will capture the clinical uncertainty and complexity of the case, and will allow for accurate reporting and
reimbursement. References: : https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf : https://my.ahima.org/store/product?id=67077

NEW QUESTION 23
The clinical documentation integrity (CDI) manager reviewed all payer refined-diagnosis related groups (APR-DRG) benchmarking data and has identified potential opportunities for improvement. The manager hopes to develop a work plan to target severity of illness (SOI)/risk of mortality (ROM) by service line and providers. How can the manager gain more information about this situation?

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

Answer: D

Explanation:
APR-DRGs are a patient classification system that assigns each inpatient stay to one of more than 300 base APR-DRGs, and then further stratifies each base APR-DRG into four levels of severity of illness (SOI) and risk of mortality (ROM), based on the number, nature, and interaction of complications and comorbidities (CCs) and major CCs (MCCs). SOI reflects the extent of physiologic decompensation or organ system loss of function, while ROM reflects the likelihood of dying. Both SOI and ROM are used to adjust payment rates, quality indicators, and performance measures for hospitals and other healthcare providers. The CDI manager can gain more information about the potential opportunities for improvement by auditing focused APR-DRGs that have a high impact on SOI/ROM levels, such as those that have a large variation in relative weights across the four severity levels, or those that have a high frequency or volume of cases. The audit can help identify the documentation gaps, inconsistencies, or inaccuracies that may affect the assignment of SOI/ROM levels, such as missing, vague, or conflicting diagnoses, procedures, or clinical indicators. The audit can also help evaluate the CDI team??s performance in terms of query rate, response rate, agreement rate, and accuracy rate. Based on the audit findings, the CDI manager can develop an education plan for both the CDI team and the physicians to address the specific documentation improvement areas and provide feedback and guidance on best practices.
* A. Audit cases for missed diagnosis by the CDI practitioner to target in the education plan. This is not the best way to gain more information about the situation, because it may not capture all the factors that affect SOI/ROM levels, such as procedures, clinical indicators, or interactions among diagnoses. It may also focus only on the CDI practitioner??s performance, without considering the physician??s role in documentation quality and completeness.
* B. Audit focused cases by physicians that have a higher SOI/ROM for education plan. This is not a valid way to gain more information about the situation, because it may not identify the documentation improvement opportunities for cases that have a lower SOI/ROM than expected, based on their clinical complexity and acuity. It may also create a perception of bias or favoritism among physicians, if only some are selected for audit and education.
* C. Audit cases that have high SOI/ROM assigned by coders for education and follow-up. This is not a reliable way to gain more information about the situation, because it may not reflect the true SOI/ROM levels of the cases, if there are errors or discrepancies in coding or grouping. It may also overlook the documentation improvement opportunities for cases that have low SOI/ROM assigned by coders, despite having high clinical complexity and acuity.
References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? 3M™ All Patient Refined Diagnosis Related Groups (APR DRGs) | 3M United States
? Q&A: Understanding SOI and ROM in the APR-DRG system | ACDIS
? Use SOI/ROM scores to enhance CDI program effectiveness | ACDIS

NEW QUESTION 26
The key component of the auditing and monitoring process to ensure provider query response is to

A. audit individual providers to indicate improvement in health record documentation
B. have a process in place for ongoing education and training of the staff involved in conducting provider queries
C. make sure that the language in the query is not leading or otherwise inappropriate
D. review queries retrospectively to ensure that they are completed according to documented Policies and procedures

Answer: D

NEW QUESTION 31
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 35
A 77-year-old male with chronic obstructive pulmonary disease (COPD) is admitted as an inpatient with severe shortness of breath. The patient is placed on oxygen at 2 liters per minute via nasal cannula. History reveals that the patient is on oxygen nightly at home. CXR is unremarkable. The most compliant query is

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

Answer: C

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

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

NEW QUESTION 39
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 43
A 100-year-old female presents to the emergency department with altered mental state and a 3-day history of productive cough, shortness of breath, and fever after a witnessed aspiration 3 days ago. The patient lives in custodial care at a nearby skilled nursing facility. Patient was treated with Augmentin at the facility without improvement. Exam is notable for Tc 38.9, blood pressure 142/78, respiratory rate 28, pulse 91. There is accessory muscle use with breathing. Patient is moaning and disoriented but otherwise the neurologic exam is nonfocal.
Labs notable for sodium 126, creatinine 0.5. white blood count 17.5, hemoglobin 13, platelet 200. venous blood gas 7.44/32/45/-3
Chest x-ray shows bilateral lower lobe infiltrates and dense right lower lobe consolidation. Patient is placed on bilevel positive airway pressure and given vancomycin, pip/tazo, levofloxacin.
Discharge Diagnosis: health care associated pneumonia (HCAP), respiratory distress, altered mental status, low sodium
Which list of diagnoses require a post-discharge query that will result in a more specific principal diagnosis with the highest level of severity of illness and risk of mortality?

A. Sepsis with acute hypoxemic respiratory failure, hyponatremia, pneumonia
B. Coma, stroke, HCAP, hypernatremia
C. Aspiration pneumonia, hyponatremia, septic encephalopathy, and sepsis with acute hypoxemic respiratory failure
D. Severe sepsis, hypernatremia, delirium, pneumonia

Answer: C

Explanation:
A post-discharge query is needed to obtain a more specific principal diagnosis with the highest level of severity of illness (SOI) and risk of mortality (ROM) for this patient. The discharge diagnosis of health care associated pneumonia (HCAP) is not specific enough to capture the etiology, site, and severity of the pneumonia. Based on the clinical indicators in the case scenario, such as the history of aspiration, the chest x-ray findings, the elevated white blood count, the fever, and the antibiotic treatment, a more specific diagnosis of aspiration pneumonia would be appropriate. Aspiration pneumonia is a type of pneumonia that occurs when foreign material, such as food or vomit, is inhaled into the lungs, causing inflammation and infection. Aspiration pneumonia has a higher SOI and ROM than HCAP because it is associated with more complications and poorer outcomes 1.
Additionally, the discharge diagnosis of altered mental status is vague and does not reflect the underlying cause or severity of the condition. Based on the clinical indicators in the case scenario, such as the fever, the low sodium level, the moaning and disorientation, and the venous blood gas results, a more specific diagnosis of septic encephalopathy would be appropriate. Septic encephalopathy is a type of delirium that occurs when sepsis affects the brain function, causing confusion, agitation, or reduced consciousness. Septic encephalopathy has a higher SOI and ROM than altered mental status because it indicates a systemic inflammatory response and multi-organ dysfunction 2.
Furthermore, the discharge diagnosis of respiratory distress is also vague and does not reflect the underlying cause or severity of the condition. Based on the clinical indicators in the case scenario, such as the shortness of breath, the accessory muscle use, the respiratory rate, and the bilevel positive airway pressure treatment, a more specific diagnosis of acute hypoxemic respiratory failure would be appropriate. Acute hypoxemic respiratory failure is a type of respiratory failure that occurs when there is insufficient oxygen exchange in the lungs, causing low oxygen levels in the blood. Acute hypoxemic respiratory failure has a higher SOI and ROM than respiratory distress because it indicates a life-threatening condition that requires mechanical ventilation or oxygen therapy 3. Finally, based on the clinical indicators in the case scenario, such as the fever, the elevated white blood count, and the antibiotic treatment, a diagnosis of sepsis should also be included in the query. Sepsis is a serious complication of infection that occurs when the body??s immune system overreacts to an infection and causes widespread inflammation and organ damage. Sepsis has a high SOI and ROM because it can lead to septic shock or death if not treated promptly 4.
Therefore, a post-discharge query should ask the provider to confirm or rule out aspiration pneumonia, hyponatremia (low sodium level), septic encephalopathy, and sepsis with acute hypoxemic respiratory failure as possible diagnoses for this patient. These diagnoses would result in a more specific principal diagnosis with the highest level of SOI and ROM for this patient.
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? Aspiration Pneumonia - an overview | ScienceDirect Topics1
? Septic Encephalopathy - an overview | ScienceDirect Topics2
? Acute Hypoxemic Respiratory Failure - an overview | ScienceDirect Topics3
? Sepsis - Symptoms and causes - Mayo Clinic4

NEW QUESTION 47

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 50
The correct coding for heart failure with preserved ejection fraction is

A. 150.32 Chronic diastolic (congestive) heart failure
B. I50.20 Unspecified systolic (congestive) heart failure
C. I50.9 Heart failure, unspecified
D. I50.30 Unspecified diastolic (congestive) heart failure

Answer: D

Explanation:
According to the ICD-10-CM Official Guidelines for Coding and Reporting FY 2023, heart failure with preserved ejection fraction (HFpEF) is also known as diastolic heart failure or heart failure with normal ejection fraction1. The code category for diastolic heart failure is I50.3-, which includes unspecified diastolic (congestive) heart failure (I50.30), acute diastolic (congestive) heart failure (I50.31), chronic diastolic (congestive) heart failure (I50.32), and acute on chronic diastolic (congestive) heart failure (I50.33)1. If the documentation does not specify the acuity of the diastolic heart failure, the default code is I50.301. Therefore, the correct coding for heart failure with preserved ejection fraction is I50.30.
References:
? ICD-10-CM Official Guidelines for Coding and Reporting FY 20231

NEW QUESTION 52
The clinical documentation integrity (CDI) manager is meeting with a steering committee to discuss the adoption of a new CDI program. The plan is to use case mix index (CMI) as a metric of CDI performance. How will this metric be measured?

A. Over time with a focus on high relative weight (RW) procedures that impact these procedures on overall CMI
B. Over time with a focus on particular documentation improvement areas in addition to the overall CMI
C. Month-to-month and focus on patient volumes to determine the raise the overall CMI
D. Month-to-month to show CMI variability as a barometer of a specific month

Answer: B

Explanation:
CMI is a metric that reflects the diversity, complexity, and severity of the patients treated at a healthcare facility, such as a hospital. CMI is used by CMS to determine hospital reimbursement rates for Medicare and Medicaid beneficiaries. CMI is calculated by adding up the relative MS-DRG weight for each discharge, and dividing that by the total number of Medicare and Medicaid discharges in a given month and year. Higher CMI values indicate that a hospital has treated a greater number of complex, resource-intensive patients, and the hospital may be reimbursed at a higher rate for those cases.
However, CMI is not the best measure of CDI performance, because it is influenced by many factors beyond CDI efforts, such as patient population, coding accuracy, documentation specificity, patient comorbidities, high volumes of highly weighted DRGs, and annual updates to relative MS-DRG weights. Therefore, measuring CMI over time with a focus on particular documentation improvement areas in addition to the overall CMI can provide a more comprehensive and meaningful assessment of CDI performance. For example, CDI programs can track CMI changes for specific DRGs, clinical conditions, or service lines that are targeted for documentation improvement initiatives. This can help identify the impact of CDI interventions on documentation quality, accuracy, and completeness.
* A. Over time with a focus on high relative weight (RW) procedures that impact these procedures on overall CMI. This is not the best way to measure CMI as a metric of CDI performance, because it may not reflect the true complexity and severity of the patients treated at the facility. Focusing only on high RW procedures may overlook other documentation improvement opportunities for lower RW procedures or medical cases that may also affect patient outcomes, quality indicators, and reimbursement.
* C. Month-to-month and focus on patient volumes to determine the raise the overall CMI. This is not a valid way to measure CMI as a metric of CDI performance, because patient volumes do not directly affect CMI. CMI is calculated by dividing the total relative weights by the total number of discharges, so increasing patient volumes will not necessarily raise the overall CMI unless the relative weights also increase.
* D. Month-to-month to show CMI variability as a barometer of a specific month. This is not a reliable way to measure CMI as a metric of CDI performance, because month-to-month variations in CMI may be due to random fluctuations or seasonal effects that are not related to CDI efforts. Measuring CMI over a longer period of time can provide a more stable and accurate picture of CDI performance.
References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? Case Mix Index (CMI) | Definitive Healthcare
? Q&A: Understanding case mix index | ACDIS

NEW QUESTION 57

Hospital-acquired condition pay provisions apply only to

A. inpatient prospective payment system hospitals
B. critical access hospitals
C. long-term acute care hospitals
D. inpatient psychiatric hospitals

Answer: A

Explanation:
Hospital-acquired condition pay provisions apply only to inpatient prospective payment system hospitals because they are subject to the CMS policy that reduces payments for cases with conditions that were not present on admission. This policy is intended to encourage hospitals to improve the quality of care and prevent avoidable complications. Other types of hospitals, such as critical access hospitals, long-term acute care hospitals, and inpatient psychiatric hospitals, are not affected by this policy and are paid based on different methodologies. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? Hospital-Acquired Conditions (Present on Admission Indicator): Hospital ??3

NEW QUESTION 61
Which of the following committees should determine the chain of comnfand that will be used to manage physicians who are either unresponsive or uncooperative with the clinical documentation integrity (CDI) program?

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

Answer: A

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

NEW QUESTION 63
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 67
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 70

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 74
When benchmarking with outside organizations, the clinical documentation integrity practitioner (CDIP) must determine if the organization is benchmarking with which
of the following criteria?

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

Answer: B

Explanation:
When benchmarking with outside organizations, the clinical documentation integrity practitioner (CDIP) must determine if the organization is benchmarking with hospitals that are its peers because peer hospitals have similar characteristics such as size, location, teaching status, case mix index, and payer mix. Benchmarking with peer hospitals allows for a more accurate and meaningful comparison of performance indicators and outcomes. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2

NEW QUESTION 77
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 79
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 82
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 87
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 91
Educating physicians on severity of illness and risk of mortality is best accomplished by utilizing

A. the case mix index
B. physician report cards
C. case studies
D. the DRG Expert

Answer: C

Explanation:
Educating physicians on severity of illness and risk of mortality is best accomplished by using case studies that demonstrate how documentation affects these indicators and how they impact patient care, quality outcomes, and reimbursement.
References: AHIMA. ??CDIP Exam Preparation.?? AHIMA Press, Chicago, IL, 2017: 97-98.

NEW QUESTION 95
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 100

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

A. That the blood loss was not clinically significant
B. The associated diagnosis and the clinical rationale in the progress notes
C. A cause-and-effect relationship between anemia and the underlying cause
D. The associated diagnosis directly on the query form

Answer: B

Explanation:
The physician needs to document the associated diagnosis and the clinical rationale in the progress notes for the CDIP to record the query as answered and agreed because this is the best way to ensure that the health record reflects the patient??s condition and treatment accurately and completely. The associated diagnosis is the condition that caused or contributed to the blood loss and the need for transfusion, such as acute blood loss anemia, hemorrhage, or trauma. The clinical rationale is the explanation of how the diagnosis is supported by the clinical indicators, such as laboratory values, vital signs, symptoms, or procedures. Documenting the associated diagnosis and the clinical rationale in the progress notes also helps to avoid any confusion or inconsistency with other parts of the health record, such as the discharge summary or the coding. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? Guidelines for Achieving a Compliant Query Practice (2019 Update)3

NEW QUESTION 103
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 106
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 109
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 112
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 113
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 114
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 116
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 120
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 122
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 127
AHIMA suggests which of the following for an organization to consider as physician response rate and agreement rate?

A. 80%/40%
B. 80%/80%
C. 75%/75%
D. 70%/50%

Answer: B

Explanation:
AHIMA suggests that an organization should consider a physician response rate of 80% and an agreement rate of 80% as benchmarks for CDI program performance. These rates indicate the level of physician engagement and documentation accuracy in relation to CDI queries.
References: AHIMA. ??Guidelines for Achieving a Compliant Query Practice (2019 Update).?? Journal of AHIMA 90, no. 2 (February 2019): 20-29.

NEW QUESTION 128
What policies should query professionals follow?

A. AHIMA's policies related to querying
B. All healthcare entity's policies are the same
C. Their healthcare entity's internal policies related to querying
D. CMS's policies related to querying

Answer: C

Explanation:
Query professionals should follow their healthcare entity??s internal policies related to querying, as they may vary depending on the organization??s size, structure, scope, and goals. The internal policies should be based on industry best practices and standards, such as those provided by AHIMA and ACDIS, as well as applicable laws and regulations, such as those from CMS and OIG. However, AHIMA??s and CMS??s policies are not binding for all healthcare entities, and they may not address all the specific situations and challenges that query professionals may encounter. Therefore, query professionals should be familiar with their own healthcare entity??s policies and procedures for querying, such as the query format, content, timing, delivery method, escalation process, retention, and audit. The other options are incorrect because they do not reflect the diversity and complexity of query policies across different healthcare entities.

NEW QUESTION 132
A clinical documentation integrity practitioner (CDIP) is reviewing an outpatient surgical chart. The patient underwent a laparoscopic appendectomy for acute gangrenous appendicitis. Which coding reference should be used for coding advice on correct assignment of the procedure code for proper ambulatory payment classification (APC) reimbursement?

A. The Merck Manual
B. AHA Coding Clinic for ICD-10-CM/PCS
C. O AMA CPT Assistant
D. O ICD-10-CM/PCS Codebook

Answer: C

Explanation:
The coding reference that should be used for coding advice on correct assignment of the procedure code for proper ambulatory payment classification (APC) reimbursement is the AMA CPT Assistant. The CPT Assistant is the official source of guidance from the American Medical Association (AMA) on the proper use and interpretation of the Current Procedural Terminology (CPT) codes, which are used to report outpatient and professional services. The CPT Assistant provides clinical scenarios, frequently asked questions, coding tips, and updates on CPT coding changes. The CPT codes are used to determine the APC reimbursement for outpatient services under the Medicare Outpatient Prospective Payment System (OPPS). (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? AMA CPT Assistant3
? Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

NEW QUESTION 135
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