

## Exam Questions CDIP

Certified Documentation Integrity Practitioner

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



#### NEW QUESTION 1

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

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

**Answer:** D

#### NEW QUESTION 2

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

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

**Answer:** A

#### Explanation:

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

References:

? CDIP Exam Content Outline<sup>1</sup>

? CDIP Exam Preparation Guide<sup>2</sup>

#### NEW QUESTION 3

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

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

**Answer:** D

#### Explanation:

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

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

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

#### NEW QUESTION 4

An otherwise healthy male was admitted to undergo a total hip replacement as treatment for ongoing primary osteoarthritis of the right hip. During the post-operative period, the patient choked on liquids which resulted in aspiration pneumonia as shown on chest x-ray. Intravenous antibiotics were administered, and the pneumonia was monitored for improvement with two additional chest x-rays. The patient was discharged to home in stable condition on post-operative day 5. Final Diagnoses:

\* 1. Primary osteoarthritis of right hip status post uncomplicated total hip replacement

\* 2. Aspiration pneumonia due to choking on liquid episode

What is the correct diagnostic related group assignment?

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

**Answer:** B

#### Explanation:

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

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: CMS MS-DRG Definitions Manual, Version 38.0, p. 8-9 4

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

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

**Answer: C**

**Explanation:**

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

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

**NEW QUESTION 7**

A noncompliant query includes querying the provider regarding

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

**Answer: C**

**Explanation:**

A noncompliant query includes querying the provider regarding gram-negative pneumonia on every pneumonia case, regardless of documented clinical indicators because it may lead to over-specification of a diagnosis that is not supported by the health record. A compliant query should be based on the clinical evidence and documentation in the record, and should not suggest or imply a diagnosis that is not clinically relevant or plausible. A query should also not be driven by reimbursement or coding factors, but by the need to improve the quality and accuracy of documentation. (CDIP Exam Preparation Guide) References:

? CDIP Exam Content Outline1

? CDIP Exam Preparation Guide2

? Guidelines for Achieving a Compliant Query Practice (2019 Update)3

**NEW QUESTION 8**

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 Fosamax
- 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 Fosamax
- 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 Fosamax
- 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 Fosamax
- 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 9**

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 standards<sup>6</sup> References: 1: [https://www.ahima.org/media/owmhxbv1/cdip\\_contentoutline\\_2023\\_final.pdf](https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf)  
6: <https://my.ahima.org/store/product?id=67077>

**NEW QUESTION 10**

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<sup>2</sup>. References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 136 3 2: Proactive CDI: Tackling the Problem of Physician Engagement<sup>4</sup>

**NEW QUESTION 10**

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

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

**Answer: B**

**Explanation:**

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

**NEW QUESTION 14**

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 16

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 18

Which of these medical conditions would a clinical documentation integrity practitioner (CDIP) expect to be treated with Levophed?

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

**Answer: A**

#### Explanation:

Levophed is a brand name of norepinephrine, a medication that is similar to adrenaline and acts as a vasopressor, meaning that it constricts blood vessels and increases blood pressure. Levophed is indicated to raise blood pressure in adult patients with severe, acute hypotension (low blood pressure) that can occur with certain medical conditions or surgical procedures<sup>1</sup>. One of these conditions is septic shock, which is a life-threatening complication of sepsis, a systemic inflammatory response to infection. Septic shock is characterized by persistent hypotension despite adequate fluid resuscitation, along with signs of organ dysfunction and tissue hypoperfusion. Levophed is used as a first-line vasopressor agent in septic shock to restore adequate perfusion pressure and tissue oxygenation.

Acute respiratory failure, multiple sclerosis, and acute kidney failure are not indications for Levophed treatment. Acute respiratory failure is a condition in which the lungs cannot provide enough oxygen to the blood or remove enough carbon dioxide from the blood. It can be caused by various lung diseases, injuries, or infections. The treatment of acute respiratory failure depends on the underlying cause and the severity of the condition, but it may include oxygen therapy, mechanical ventilation, medications to treat infections or inflammation, or other supportive measures. Multiple sclerosis is a chronic autoimmune disease that affects the central nervous system, causing inflammation, demyelination, and axonal damage. The symptoms of multiple sclerosis vary depending on the location and extent of the nerve damage, but they may include vision problems, numbness, weakness, fatigue, cognitive impairment, or pain. The treatment of multiple sclerosis aims to reduce the frequency and severity of relapses, slow the progression of disability, and manage the symptoms. It may include immunomodulatory drugs, corticosteroids, symptomatic medications, physical therapy, or other interventions. Acute kidney failure is a condition in which the kidneys suddenly lose their ability to filter waste products and fluids from the blood. It can be caused by various factors that impair the blood flow to the kidneys, damage the kidney tissue, or block the urine output. The symptoms of acute kidney failure may include decreased urine output, fluid retention, nausea, confusion, or shortness of breath. The treatment of acute kidney failure depends on the underlying cause and the severity of the condition, but it may include fluid management, electrolyte replacement, dialysis, medications to treat infections or inflammation, or other supportive measures. References:

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

9781584268530

? Levophed Uses, Side Effects & Warnings - Drugs.com

? Levophed (Norepinephrine Bitartrate): Uses, Dosage ?? - RxList

? Levarterenol, Levophed (norepinephrine) dosing ?? - Medscape

? [Septic Shock: Practice Essentials ?? - Medscape Reference]

? [Surviving Sepsis Campaign: International Guidelines for ?? - PubMed]

? [Acute respiratory failure: MedlinePlus Medical Encyclopedia]

? [Multiple sclerosis - Symptoms and causes - Mayo Clinic]

? [Acute kidney failure - Symptoms and causes - Mayo Clinic]

#### NEW QUESTION 19

A patient is admitted due to pneumonia. On day 1, a sputum culture is positive for pseudomonas 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 Rule<sup>1</sup>, 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 Rule<sup>1</sup>

#### NEW QUESTION 22

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 24

Identify the error in the following query:

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

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

**Answer: D**

#### Explanation:

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

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

References:

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

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

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

? The Provider Query Toolkit: A Guide to Compliant Practices

#### NEW QUESTION 27

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 condition<sup>5</sup>

References: 1: [https://www.ahima.org/media/owmhxbv1/cdip\\_contentoutline\\_2023\\_final.pdf](https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf) 5:

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

#### NEW QUESTION 30

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

### NEW QUESTION 33

What type of laboratory test is a creatinine test?

- A. Chemistry
- B. Microbiology
- C. Hematology
- D. Serology

**Answer:** A

### NEW QUESTION 36

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

### NEW QUESTION 39

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

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

**Answer:** A

#### Explanation:

Malnutrition is a diagnosis that is most likely to trigger a second level review because it affects the severity of illness (SOI) and risk of mortality (ROM) of the patient, as well as the reimbursement and quality measures of the hospital. Malnutrition also requires clinical validation and clear documentation of its etiology, type, degree, and duration<sup>2</sup> References: 1: [https://www.ahima.org/media/owmhxbv1/cdip\\_contentoutline\\_2023\\_final.pdf](https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf) 2: <https://my.ahima.org/store/product?id=67077>

### NEW QUESTION 42

The correct coding for insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is

- A. 05HM33Z Insertion of infusion device into right internal jugular vein, percutaneous approach
- B. 02H633Z Insertion of infusion device into right atrium, percutaneous approach
- C. 05HP33Z Insertion of infusion device into right external jugular vein, percutaneous approach
- D. 02HV33Z Insertion of infusion device into superior vena cava, percutaneous approach

**Answer:** A

#### Explanation:

According to the ICD-10-PCS Reference Manual 2023, the insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is coded as follows<sup>1</sup>:

? The first character 0 indicates the Medical and Surgical section.

? The second character 5 indicates the Extracorporeal or Systemic Assistance and Performance root operation, which is defined as "Putting in or on a device that completely takes over a body function by extracorporeal means"<sup>1</sup>.

? The third character H indicates the Central Vein body system, which includes the internal jugular vein<sup>1</sup>.

? The fourth character M indicates the Infusion Device device value, which is defined as "A device that is inserted into a body part to deliver fluids or other substances to a body part or into the circulation"<sup>1</sup>.

? The fifth character 3 indicates the Right Internal Jugular Vein body part value, which is the specific site of the procedure<sup>1</sup>.

? The sixth character 3 indicates the Percutaneous approach, which is defined as "Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach and visualize the site of the procedure"<sup>1</sup>.

? The seventh character Z indicates No Qualifier, which means there is no additional information necessary to complete the code<sup>1</sup>.

Therefore, the correct coding for insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is 05HM33Z.

References:

? ICD-10-PCS Reference Manual 2023<sup>1</sup>

### NEW QUESTION 44

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 46**

Which entity has the following regulation?

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

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

**Answer:** A

**Explanation:**

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

References:

? CDIP Exam Content Outline1

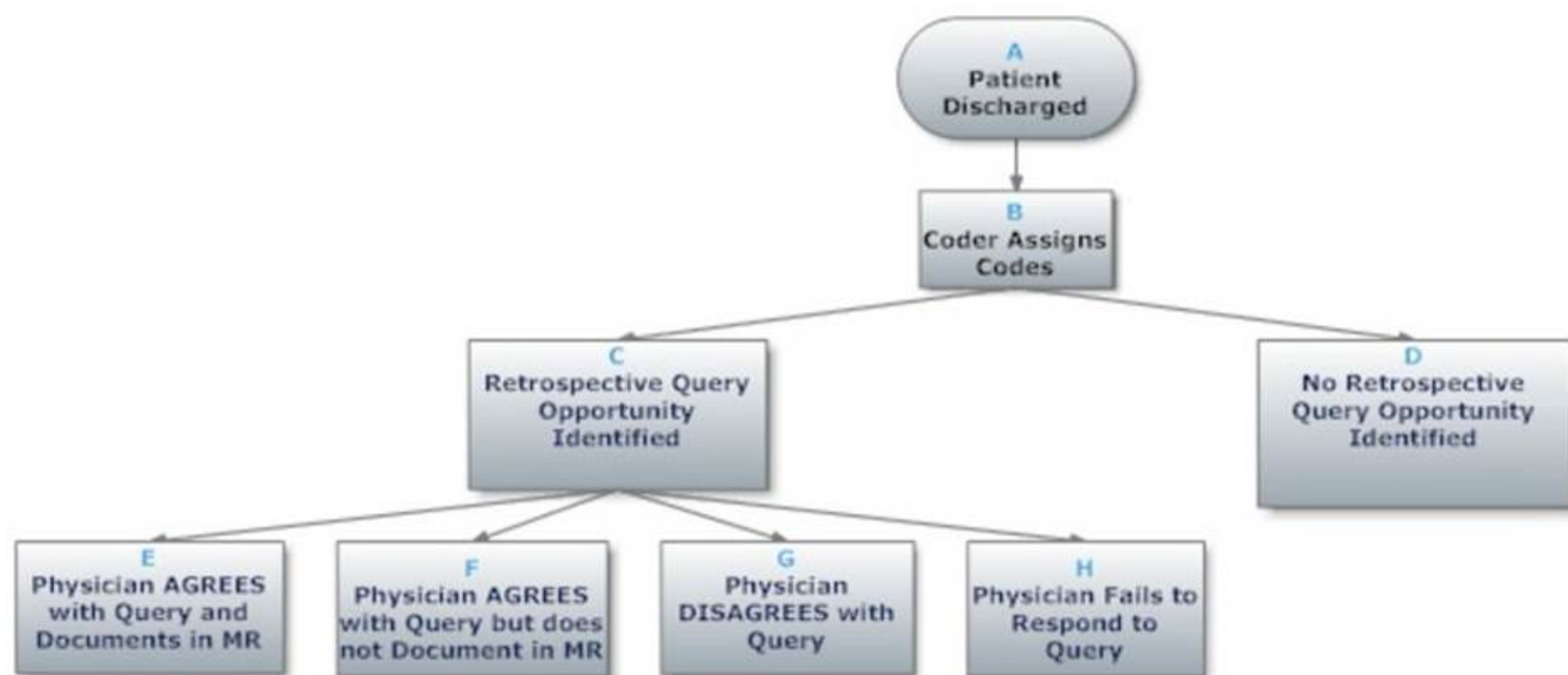
? CDIP Exam Preparation Guide2

? 42 CFR ?? 482.243

**NEW QUESTION 47**

Based on the flowchart below, at what point might the clinical documentation integrity practitioner (CDIP) enlist the help of the physician advisor/champion?





- A. D - No retrospective query opportunity identified  
B. H - Physician fails to respond to query  
C. C - Retrospective query opportunity identified  
D. E - Physician agrees with query and documents in MR

**Answer:** B

#### NEW QUESTION 49

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

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

**Answer:** A

#### Explanation:

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

References:

- ? CDIP Exam Content Outline<sup>1</sup>  
? CDIP Exam Preparation Guide<sup>2</sup>  
? Q&A: Establishing an escalation policy for inappropriate queries<sup>3</sup>

#### NEW QUESTION 52

A hospital noticed a 30% denial rate in Medicare claims due to lack of clinical documentation, placing the hospital at risk of multiple Medicare violations. What step should the clinical documentation integrity (CDI) manager take to help avoid future Medicare violations?

- ? Collaborate with physician advisor/champion and revenue cycle manager  
? Instruct the billing department to write off claims with insufficient documentation

- A. Assign pre-billing claim review duties to physicians  
B. Prevent submission of claims for improper documentation

**Answer:** A

#### Explanation:

The step that the clinical documentation integrity (CDI) manager should take to help avoid future Medicare violations is to collaborate with physician advisor/champion and revenue cycle manager. The physician advisor/champion can help with educating and engaging the physicians on the importance and impact of clinical documentation on coding, reimbursement, quality measures, compliance, and patient care. The revenue cycle manager can help with analyzing and monitoring the denial trends and patterns, identifying and resolving the root causes of denials, implementing corrective actions and preventive measures, and ensuring timely and accurate claim submission and appeal processes. References: : [https://www.ahima.org/media/owmhxbv1/cdip\\_contentoutline\\_2023\\_final.pdf](https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf) : <https://my.ahima.org/store/product?id=67077>

#### NEW QUESTION 54

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

- A. A rebilling is permissible when queries are answered after the initial bill.

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

**Answer:** A

**Explanation:**

A rebilling is permissible when queries are answered after the initial bill, as long as the hospital follows the appropriate guidelines and procedures for rebilling, such as submitting a corrected claim within the timely filing limit, notifying the payer of the reason for rebilling, and documenting the query process and outcome in the health record. Rebilling may be necessary to ensure accurate coding and reporting of the patient's condition and treatment, as well as appropriate reimbursement and quality measures. [3][3] References: 1: [https://www.ahima.org/media/owmhxbv1/cdip\\_contentoutline\\_2023\\_final.pdf](https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf) [3][3]: <https://my.ahima.org/store/product?id=67077>

**NEW QUESTION 58**

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

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

**Answer:** D

**NEW QUESTION 59**

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

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

**Answer:** B

**Explanation:**

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

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

**NEW QUESTION 61**

A clinical documentation integrity practitioner (CDIP) in an acute care hospital was asked to create new query templates for ICD-10 based on AHIMA and ACDIS guidelines. What should the multiple-choice query format include?

- A. Clinically insignificant options
- B. Impact on reimbursement
- C. Clinically unsupported diagnosis
- D. Clinically significant options

**Answer:** D

**NEW QUESTION 63**

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

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

**Answer:** D

**Explanation:**

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

decisions 2.

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

#### NEW QUESTION 64

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 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 69

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 70

The most beneficial step to identify post-discharge query opportunities that affect severity of illness, risk of mortality and case weight is to

- A. look for documented conditions that have well supported accompanying clinical criteria
- B. determine if only the treatment is documented and there is no diagnosis documented
- C. watch for reportable conditions or conditions that are unambiguous or otherwise complete
- D. identify normal diagnostic test results that may indicate a possible addition of a secondary diagnosis

**Answer:** B

#### NEW QUESTION 74

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

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

Discharge diagnoses:

\* 1. Pneumonia

\* 2. COPD

\* 3. Current smoker

What is the correct diagnostic related group assignment?

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

**Answer:** A

**Explanation:**

According to the ICD-10-CM/PCS MS-DRG Definitions Manual, DRG 190 is assigned for patients with a principal diagnosis of chronic obstructive pulmonary disease (COPD) and a major complication or comorbidity (MCC)<sup>1</sup>. Pneumonia is considered an MCC for this DRG<sup>2</sup>. Therefore, the patient in this case meets the criteria for DRG 190. The other options are incorrect because they do not match the principal diagnosis or the MCC of the patient. References:

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

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

**NEW QUESTION 75**

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 Outline<sup>1</sup>

? CDIP Exam Preparation Guide<sup>2</sup>

**NEW QUESTION 77**

A patient was admitted for high fever and pain in umbilical region. During the second day of the hospital stay, the patient stood up to use the restroom and fell on the floor, resulting in a broken chin bone. A physician noted the fall on the second day in progress note. Which further clarification should be done regarding present on admission (POA) indicator of fall?

- A. No query is needed
- B. Query physician for POA
- C. Bring this case up in weekly Health Information Management meetings for further action
- D. Take the case to physician advisor/champion to discuss further action

**Answer:** B

**Explanation:**

A query should be generated to ask the physician for the POA indicator of the fall because the documentation is unclear whether the fall was present at the time of inpatient admission or not. The POA indicator is used to identify conditions that are present or not present at the time of admission, and has payment implications for certain hospital-acquired conditions (HACs). According to CMS, a fall resulting in trauma is one of the HACs that will not be paid at a higher rate if it is not present on admission. Therefore, it is important to clarify the POA indicator of the fall to ensure accurate coding and reimbursement. A query should be non-leading, concise, clear, relevant, and consistent with CDI standards and guidelines.

References:

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

? Coding | CMS<sup>1</sup>

? Present on Admission Indicators - Novitas Solutions<sup>2</sup>

**NEW QUESTION 81**

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

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

**Answer:** B

**Explanation:**

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



References:

? CDIP Exam Content Outline<sup>1</sup>

? CDIP Exam Preparation Guide<sup>2</sup>

#### NEW QUESTION 82

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 83

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

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

**Answer:** B

#### Explanation:

According to AHIMA, best practice for fixing a mistake in a patient health record is that errors are corrected by the clinician who authored the documentation<sup>1</sup>. The clinician who made the error should identify and correct the inaccurate information, and document the date, time, and reason for the correction<sup>1</sup>. The correction should also be made in a way that preserves the original content and does not obscure or delete it<sup>1</sup>. The other options are not correct according to AHIMA. Any physician caring for the patient cannot correct inaccurate record notes, as this may compromise the accountability and integrity of the documentation<sup>2</sup>.

Amendments to record content do not need to be co-signed by the attending physician, unless required by organizational policy or state law<sup>3</sup>. Coders cannot rely on the laboratory results to confirm the patient's diagnosis, as they should code based on the physician's documentation and not on test results alone.

References:

? Making Corrections in the Electronic Health Record - AHIMA

? Auditing Copy and Paste - AHIMA

? Amendments, Corrections, and Deletions in Transcribed Reports Toolkit - AHIMA

? [Coding from Test Results | Journal Of AHIMA]

#### NEW QUESTION 86

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

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

**Answer:** C

#### Explanation:

According to AHIMA, clinical documentation is at the core of every patient encounter and it must be meaningful to accurately reflect the patient's disease burden and scope of services provided. In order to be meaningful, the documentation must be clear, consistent, complete, precise, reliable, timely, and legible<sup>1</sup>. Reliability is one of the criteria for clinical documentation that means the content of the record is trustworthy, safe, and yielding the same result when repeated<sup>1</sup>. Reliability ensures that the documentation is consistent with the clinical evidence and reasoning, and that it can be verified by other sources or methods. Reliability also implies that the documentation is free from errors, omissions, contradictions, or ambiguities that could compromise its validity or usefulness<sup>1</sup>. References:

? Clinical Documentation Integrity Education & Training | AHIMA<sup>1</sup>

#### NEW QUESTION 88

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 90

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

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

**Answer: A**

#### Explanation:

One of the factors that an organization should consider when developing a query retention policy and procedure is if the query is considered part of the health record or not. According to the AHIMA/ACDIS query practice brief<sup>1</sup>, a query is considered part of the health record if it meets any of the following criteria:

? It is used to clarify documentation that affects code assignment or other data elements

? It is used to support clinical validation of a diagnosis or procedure

? It is used to support medical necessity or quality indicators

? It is used to communicate clinical information between providers If a query is part of the health record, it should be retained according to the organization??s health record retention policy and procedure, which should comply with federal, state, and local laws and regulations. The query retention policy and procedure should also address issues such as:

? The format and location of the query (e.g., paper, electronic, hybrid)

? The security and confidentiality of the query

? The accessibility and availability of the query

? The ownership and custodianship of the query

? The legal implications and evidentiary value of the query

References:

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

? Guidelines for Achieving a Compliant Query Practice—2022 Update<sup>1</sup>

#### NEW QUESTION 92

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 <sup>23</sup>.

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 97

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

What is the meaning of the parenthesis?

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

**Answer: B**

#### NEW QUESTION 102

Which of the following clinical documentation integrity (CDI) dashboard metrics is frequently used to help evaluate the credibility of CDI practitioner queries and the success of the CDI program?

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

**Answer: D**

#### Explanation:

The provider agreement rate is the percentage of queries that result in a change in the documentation or coding that is consistent with the query. It is a measure of

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

#### NEW QUESTION 106

An organization dealing with staffing shortages has adopted a policy requiring clinical documentation integrity practitioner (CDIP) to stop reviewing any record after a major complication or co-morbidity is found. What is the unintended consequence of this?

- A. Increase in case mix index
- B. Reduced risk of clinical denials
- C. Increased number of records reviewed by each CDIP
- D. Decrease in severity of illness and risk of mortality

**Answer:** D

#### Explanation:

Severity of illness (SOI) and risk of mortality (ROM) are two metrics that measure the complexity and acuity of a patient's condition, 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 divided into four levels: minor, moderate, major, or extreme. These metrics are used to adjust payment rates, quality indicators, and performance measures for hospitals and other healthcare providers.

If a CDIP stops reviewing any record after a major CC is found, they may miss other CCs or MCCs that could affect the patient's SOI and ROM levels. For example, a patient with pneumonia and sepsis would have a major CC (pneumonia) and an MCC (sepsis). If the CDIP stops reviewing the record after finding pneumonia, they would not capture sepsis, which would increase the patient's SOI and ROM levels from major to extreme. This would result in underreporting the patient's true complexity and acuity, and potentially lead to lower reimbursement, lower quality scores, and higher denial risk.

Therefore, the unintended consequence of this policy is a decrease in SOI and ROM levels for patients who have more than one CC or MCC.

References:

- ? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
- ? Q&A: Understanding SOI and ROM in the APR-DRG system
- ? 3M™ All Patient Refined Diagnosis Related Groups (APR DRGs)
- ? Severity of illness | definition of severity of illness by Medical dictionary
- ? Using Severity Adjustment Classification for Hospital Internal and External Comparisons

#### NEW QUESTION 111

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 112

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 Coding<sup>1</sup> and the ACDIS Code of Ethics<sup>2</sup>, 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 Coding<sup>1</sup>
- ? ACDIS Code of Ethics<sup>2</sup>

#### NEW QUESTION 116

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 Providers<sup>1</sup>

**NEW QUESTION 119**

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 assignment<sup>1</sup>. A query should be clear, concise, and consistent, and should include relevant clinical indicators that support the query<sup>1</sup>. A query should also provide multiple choice answer options that are supported by clinical indicators and include a non-leading query statement<sup>2</sup>. 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 reimbursement<sup>3</sup>. 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 124**

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 record<sup>1</sup>. A documentation integrity project may have various purposes, such as enhancing patient safety, improving coding and reimbursement, or complying with regulatory standards<sup>1</sup>. 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 physicians<sup>2</sup>. 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 documentation<sup>2</sup>. 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 reliability<sup>3</sup>. 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 policies<sup>4</sup>. 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 127**

A 27-year-old male patient presents to the emergency room with crampy, right lower quadrant abdominal pain, a low-grade fever (101°F Fahrenheit) and vomiting.



The patient also has a history of type I diabetes mellitus. A complete blood count reveals mild leukocytosis (13,000/microliter). Abdominal ultrasound is ordered, and the patient is admitted for laparoscopic surgery. The patient is given an injection of neutral protamine Hagedorn insulin, in order to normalize the blood sugar level prior to surgery. Upon discharge, the attending physician documents "right lower quadrant abdominal pain due to possible acute appendicitis or probable Meckel diverticulitis".

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

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

**Answer: D**

**Explanation:**

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

? Principal diagnosis: Acute appendicitis. This is the condition, after study, that occasioned the admission to the hospital, according to the ICD-10-CM Official Guidelines for Coding and Reporting. The patient was admitted for laparoscopic surgery, which is a definitive treatment for acute appendicitis. The physician documented ??possible acute appendicitis or probable Meckel diverticulitis?? as the cause of the right lower quadrant abdominal pain. According to the AHA??s Coding Clinic, Fourth Quarter 2016, pp. 147-148, when a physician documents two diagnoses connected by ??or??, coders should query the physician for clarification if possible. However, if a query is not possible or not answered, coders should assign codes for both conditions, unless one of them has been ruled out or confirmed by further testing or treatment. In this case, there is no indication that either acute appendicitis or Meckel diverticulitis has been ruled out or confirmed by further testing or treatment. Therefore, both conditions should be coded and reported. However, only one of them can be the principal diagnosis. Since acute appendicitis is more commonly associated with laparoscopic surgery than Meckel diverticulitis, and since it has a higher relative weight than Meckel diverticulitis under the MS-DRG system, it is reasonable to select acute appendicitis as the principal diagnosis 23.

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

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

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

**NEW QUESTION 131**

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

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

**Answer: D**

**Explanation:**

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

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

**NEW QUESTION 134**

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 compliance<sup>1</sup>. 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 preferences<sup>1</sup>. References:

? AHIMA/ACDIS Query Practice Brief – Updated 12/2022

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

**NEW QUESTION 139**

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 coverings<sup>2</sup>. 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 brain<sup>3</sup>. 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)<sup>4</sup>.

References:

? CDI Week 2020 Q&A: CDI and key performance indicators<sup>1</sup>

? Mayo Clinic: Burr hole<sup>2</sup>

? MedlinePlus: Subdural hematoma<sup>3</sup>

? CPT Code Book 2023<sup>4</sup>

**NEW QUESTION 144**

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

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

**Answer:** D

**Explanation:**

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

References:

? CDIP Exam Content Outline

? CDIP Exam Preparation Guide

? Present on Admission Reporting Guidelines

**NEW QUESTION 146**

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 147**

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

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

**Answer:** B

**Explanation:**

According to the Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA<sup>1</sup>, clinical validation is a process by which documentation is evaluated to ensure that the medical record demonstrates enough clinical support for all documented diagnoses as mandated by the False Claims Act. If there is a lack of clinical support for sepsis or UTI within the documentation, a clinical validation query should be sent. Query choices should list sepsis or UTI as ruled out versus ruled in (because the physician is documenting sepsis or UTI), but the query choice should also ask the provider to provide additional clinical support within the medical record. Additional query choices that are supported by clinical indicators listed on the query should also be listed as appropriate<sup>1</sup>.

In this case, the patient was admitted with a fever, cough, and leukocytosis, which are signs and symptoms of sepsis or UTI. However, three days later, the blood and urine cultures are negative, the patient has been afebrile since admission, and the white blood count is returning to normal, which are indicators that sepsis or UTI may not be present or resolved. Therefore, there is a discrepancy between the documented diagnoses of sepsis and UTI and the clinical evidence in the record. A clinical validation query should be sent to clarify if sepsis and UTI are still valid diagnoses or if they have been ruled out after study. The query should also request additional documentation of any other clinical indicators that support the diagnosis of sepsis or UTI, such as vital signs, physical exam findings, inflammatory markers, imaging results, etc<sup>1</sup>.

References:

? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA<sup>1</sup>

#### NEW QUESTION 152

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

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

**Answer: B**

#### Explanation:

Patient identification and demographic accuracy is the process of ensuring that the patient's identity and personal information are correctly recorded and verified in the health record and other systems. A potential breach of this process could result in automated registration entries that generate erroneous patient identification, which could lead to patient safety and quality of care issues, enabling fraudulent activity involving patient identity theft, or providing unjustified care for profit<sup>2</sup>

Authorship integrity is the process of ensuring that the source and content of the health record are authentic, accurate, complete, and consistent. Documentation integrity is the process of ensuring that the health record reflects the patient's clinical status, treatment, and outcomes. Auditing integrity is the process of ensuring that the health record is reviewed and monitored for compliance, quality, and improvement purposes<sup>2</sup>

1: [https://www.ahima.org/media/owmhxbv1/cdip\\_contentoutline\\_2023\\_final.pdf](https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf) 2: <https://my.ahima.org/store/product?id=67077>

#### NEW QUESTION 154

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 156

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 161

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 Outline<sup>1</sup>

? CDIP Exam Preparation Guide<sup>2</sup>

? AMA CPT Assistant<sup>3</sup>

? Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

#### NEW QUESTION 165

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