Exam Questions CDIP

Certified Documentation Integrity Practitioner

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

NEW QUESTION 1
A pressure ulcer stage III is documented in the progress note. The clinical documentation integrity practitioner (CDIP) has queried the attending regarding the present on admission status of the pressure ulcer but has not received a response in an appropriate
time frame. What should the CDIP do next?

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

Answer: A

Explanation:
According to the AHIMA-ACDIS Practice Brief, a query escalation policy should describe how to handle situations in which an answer is not received, an inappropriate answer or comment is provided, etc. The escalation policy should address when the issue is brought to the physician advisor, the department director, or administration with defined actions as to the responsibilities at each level. The policies should reflect a method of response that can realistically occur for the organization1. In this case, since the attending physician has not responded to the query in an appropriate time frame, the CDIP should escalate the issue to the medical staff leadership, such as the chief medical officer, the department chair, or the physician advisor, who can facilitate communication and education with the attending physician and ensure documentation integrity and compliance1.
References:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA1

NEW QUESTION 2
Tracking denials within the clinical documentation integrity program is important to

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

Answer: C

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

NEW QUESTION 3
Which of the following can be evidence of physician-hospital alignment?

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

Answer: A

Explanation:
A high physician agreement rate can be evidence of physician-hospital alignment because it indicates that the physicians are supportive of the clinical documentation integrity (CDI) program and its goals, and that they are willing to provide accurate and complete documentation in response to CDI queries. A high physician agreement rate also reflects a positive relationship and communication between the CDI team and the physicians, as well as a mutual understanding of the benefits of CDI for patient care, quality reporting, and reimbursement. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2

NEW QUESTION 4
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
Which of these medical conditions would a clinical documentation integrity practitioner (CDIP) expect to be treated with Levophed?

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

Answer: A

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

NEW QUESTION 6
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 7
Which of the following may result in an incomplete health record deficiency being assigned to a provider?

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

Answer: D

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

NEW QUESTION 8
A 45-year-old female is admitted after sustaining a femur fracture. Orthopedics is consulted and performs an open reduction internal fixation (ORIF) of the femur without complication. Nursing documents the patient has a body mass index of 42 kg/m2.
The clinical documentation integrity practitioner (CDIP) determines a query is needed to capture a diagnosis associated with the body mass index so it can be reported. Which of the following is the MOST compliant query based on the most recent AHIIMA/ACDIS query practice brief?

A. Nursing documents the BMI is 42 kg/m2. In order to capture a co-morbid condition (CC) to increase reimbursement, please add 'morbid obesity with BMI 42 kg/m2' to your next progress note.
B. Nursing documents the BMI is 42 kg/m2. To increase the severity of illness and risk of mortality, please add 'morbid obesity with BMI 42 kg/m2' to your next progress note.
C. Nursing documents the BMI is 42 kg/m2. Can you please clarify if the patient's morbid obesity was present on admission and add the diagnosis to future progress notes?
D. Nursing documents the BMI is 42 kg/m2. Please consider if any of the following diagnoses should be added to the health record to support this finding: morbid obesity; obesity; other diagnosis (please state)

Answer: D

Explanation:
This is the most compliant query based on the most recent AHIMA/ACDIS query practice brief because it is non-leading, non-suggestive, and provides multiple options for the physician to choose from. It also does not imply any financial or quality implications for adding a diagnosis associated with the BMI.
References: AHIMA/ACDIS. ??Guidelines for Achieving a Compliant Query Practice (2019 Update).?? Journal of AHIMA 90, no. 2 (February 2019): 20-29.

NEW QUESTION 9
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 10
The correct coding for heart failure with preserved ejection fraction is

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

Answer: D

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

NEW QUESTION 10
An 80-year-old male is admitted as an inpatient to the ICU with shortness of breath, productive yellow sputum, and a temperature of 101.2. CXR reveals bilateral pleural effusion and LLL pneumonia. Labs reveal a BUN of 42 and a creatinine level of 1.500.
The patient is given Zithromax 500 mg. IV, NS IV, and Lasix 40 mg tabs 2x/day. The attending physician documents bilateral pleural effusion, LLL pneumonia, and kidney failure. Two days later, the renal consult documents AKI with acute tubular necrosis (ATN). The correct principal and secondary diagnoses are

A. PDx: AKI with ATNSDx: LLL pneumonia, bilateral pleural effusion
B. PDx: LLL pneumoniaSDx: Bilateral pleural effusion, kidney failure
C. PDx: LLL pneumoniaSDx: AKI with ATN, bilateral pleural effusion
D. PDx: Bilateral pleural effusion SDx: LLL pneumonia, kidney failure

Answer: C

Explanation:
According to the ICD-10-CM Official Guidelines for Coding and Reporting FY 2023, the principal diagnosis is defined as "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care"2. In this case, the patient was admitted with shortness of breath, productive yellow sputum, and a temperature of 101.2, which are signs and symptoms of pneumonia. The CXR confirmed the diagnosis of LLL pneumonia, which is a serious condition that requires inpatient care. Therefore, LLL pneumonia is the principal diagnosis.
The secondary diagnoses are defined as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay"2. In this case, the patient had bilateral pleural effusion and kidney failure at the time of admission, which are coexisting conditions that

affect the treatment received and/or the length of stay. The renal consult documented AKI with ATN, which is a more specific diagnosis than kidney failure and reflects the severity and etiology of the condition. Therefore, AKI with ATN and bilateral pleural effusion are secondary diagnoses. References:
? CDI Week 2020 Q&A: CDI and key performance indicators1
? ICD-10-CM Official Guidelines for Coding and Reporting FY 20232

NEW QUESTION 12
The clinical documentation integrity (CDI) manager is meeting with a steering committee to discuss the adoption of a new CDI program. The plan is to use case mix index (CMI) as a metric of CDI performance. How will this metric be measured?

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

Answer: B

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

NEW QUESTION 15
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 16
After one year, the clinical documentation integrity (CDI) program has become stagnant, and the manager plans to reinvigorate the program to better reflect the CDI efforts in the organization. What can the manager do to ensure program success?

A. Expand the CDI program to larger areas in outpatient clinics
B. Prioritize to focus on efforts with the largest return on investment
C. Identify key metrics to develop program measures for coders
D. Establish a CDI steering committee to build a strong foundation

Answer: D

Explanation:
A CDI steering committee is a group of interdisciplinary leaders who oversee and guide the CDI program??s objectives, outcomes, and metrics. The committee should include representatives from finance, clinical, coding, quality, and other areas that are impacted by CDI. The committee should meet regularly to review the CDI program??s performance, identify opportunities for improvement, and provide support and education to the CDI staff and providers. A CDI steering committee can help reinvigorate a stagnant CDI program by ensuring that it aligns with the organization??s vision and mission, addresses the current challenges and needs, and fosters collaboration and communication among stakeholders. The other options are not necessarily effective ways to reinvigorate a CDI program. Expanding the CDI program to larger areas in outpatient clinics may not be feasible or appropriate without a clear strategy and plan. Prioritizing to focus on efforts with the largest return on investment may not reflect the true value and quality of the CDI program. Identifying key metrics to develop program measures for coders may not capture the full scope and impact of the CDI program.

NEW QUESTION 17
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 21
When benchmarking with outside organizations, the clinical documentation integrity practitioner (CDIP) must determine if the organization is benchmarking with which
of the following criteria?

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

Answer: B

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

NEW QUESTION 22
What type of query may NOT be used in circumstances where only clinical indicators of a condition are present, and the condition/diagnosis has not been documented in the health record?

A. Multiple-choice
B. Open-ended
C. Verbal
D. Yes/No

Answer: D

Explanation:
A yes/no query may not be used in circumstances where only clinical indicators of a condition are present, and the condition/diagnosis has not been documented in the health record because it may lead to leading or suggesting a diagnosis that is not supported by the provider??s documentation. A yes/no query should only be used when there is clear and consistent documentation of a condition/diagnosis in the health record, and the query is seeking confirmation or denial of a specific fact or detail related to that condition/diagnosis. A multiple-choice, open-ended, or verbal query may be more appropriate to allow the provider to choose from a list of possible diagnoses, provide additional information, or explain the clinical reasoning behind the documentation. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? AHIMA Practice Brief: Guidelines for Achieving a Compliant Query Practice3

NEW QUESTION 25
A clinical documentation integrity practitioner (CDIP) must determine the present on admission (POA) status of a stage IV sacral decubitus ulcer documented in the discharge summary. What is the first step that should be taken?

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

Answer: D

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

NEW QUESTION 26

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 31
The clinical documentation integrity (CDI) metrics recently showed a drastic drop in the physician query rate. What might this indicate to the CDI manager?

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

Answer: C

Explanation:
A drastic drop in the physician query rate might indicate to the CDI manager that the CDI staff need education on identifying query opportunities. The physician query rate is a metric that measures the percentage of records that have at least one query sent by the CDI staff to clarify or improve the documentation. A high query rate may reflect a high level of documentation quality issues or a high level of CDI staff vigilance and expertise. A low query rate may reflect a low level of documentation quality issues or a low level of CDI staff awareness and competence 2. Therefore, a drastic drop in the query rate could suggest that the CDI staff are missing some query opportunities or are not following the query policies and procedures. The CDI manager should investigate the reasons for the drop and provide education and feedback to the CDI staff on how to identify and address query opportunities effectively and compliantly 3.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: Understanding CDI
Metrics - AHIMA 2 3: The Natural History of CDI Programs: A Metric-Based Model 5

NEW QUESTION 35
A patient receives a blood transfusion after a 400 ml blood loss during surgery. The clinical documentation integrity practitioner (CDIP) queries the physician for an associated diagnosis. The facility does not maintain queries as part of the permanent health record. What does the physician need to document for the CDIP to record the
query as answered and agreed?

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

Answer: B

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

NEW QUESTION 40
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 41
A hospital is conducting a documentation integrity project for the purpose of reducing indiscriminate use of electronic copy and paste of patient information in records

by physicians. Which data should be used to quantify the extent of the problem?

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

Answer: D

Explanation:
According to the AHIMA CDIP Exam Preparation Guide, a documentation integrity project is a systematic process of identifying, analyzing, and improving the quality and accuracy of clinical documentation in the health record1. A documentation integrity project may have various purposes, such as enhancing patient safety, improving coding and reimbursement, or complying with regulatory standards1. One of the common issues that may affect the quality and accuracy of clinical documentation is the indiscriminate use of electronic copy and paste of patient information in records by physicians2. Copy and paste is a function that allows physicians to duplicate existing text in the record and paste it in a new destination, which may save time and effort, but also may introduce errors, inconsistencies, or redundancies in the documentation2. Therefore, to quantify the extent of the problem of copy and paste, the data that should be used is the incidence of redundancies in physician notes in a sample of hospital admissions. Redundancies are repeated or unnecessary information that may clutter the record and impair its readability and reliability3. By measuring the frequency and types of redundancies in physician notes, the hospital can assess the impact of copy and paste on the documentation quality and identify areas for improvement. The other options are not correct because they do not directly measure the problem of copy and paste. The percent of insurance billings denied due to lack of record documentation may reflect other issues besides copy and paste, such as incomplete or inaccurate documentation, coding errors, or payer policies4. The number of coder queries regarding inconsistent physician record documentation may indicate the presence of copy and paste, but it may also depend on other factors such as coder knowledge, query guidelines, or query response rate. The results of a survey of physicians that asks about documentation practices may provide some insight into the perceptions and attitudes of physicians regarding copy and paste, but it may not reflect the actual extent or impact of the problem on the documentation quality. References:
? CDIP Exam Preparation Guide - AHIMA
? Auditing Copy and Paste - AHIMA
? Copy/Paste: Prevalence, Problems, and Best Practices - AHIMA
? Documentation Denials: How to Avoid Them - AAPC
? [Q&A: Querying for clinical validation | ACDIS]

NEW QUESTION 44
The clinical documentation integrity (CDI) manager is reviewing physician benchmarks and notices a low-severity level being measured against average length of stay.
What should the CDI manager keep in mind when discussing this observation with physicians?

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

Answer: A

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

NEW QUESTION 47
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 50
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.OF. 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 thenext 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 52
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 57
A 70-year-old severely malnourished nursing home patient is admitted for a pressure ulcer covered by eschar on the right hip. The provider is queried to clarify the stage of the pressure ulcer. Because the wound has not been debrided, the provider responds "unable to determine". How will the stage of this pressure ulcer be coded?

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

Answer: C

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

NEW QUESTION 62
An 88-year-old male is admitted with a fever, cough, and leukocytosis. The physician documents admit for probable sepsis due to urinary tract infection (UTI). Antibiotics are started. Three days later, the blood and urine cultures are negative, the patient has been afebrile since admission, and the white blood count is returning to normal. What documentation clarification is needed to support accurate coding of the record?

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

Answer: B

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

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

NEW QUESTION 66

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