

## CDIP Dumps

### Certified Documentation Integrity Practitioner

<https://www.certleader.com/CDIP-dumps.html>



**NEW QUESTION 1**

Which of the following organizations should a clinical documentation integrity practitioner (CDIP) monitor?

- A. Office of Inspector General (OIG), Accreditation Commission for Healthcare (ACHC), Recovery Auditors (RAs)
- B. Program for Evaluating Payment Patterns Electronic Report (PEPPER), Recovery Auditors (RAs), Center for Improvement in Healthcare (CIHQ)
- C. Recovery Auditors (RAs), Program for Evaluating Payment Patterns Electronic Report (PEPPER), Office of Inspector General (OIG)
- D. Center for Improvement in Healthcare (CIHQ), Accreditation Commission for Healthcare (ACHC), Recovery Auditors (RAs)

**Answer:** C

**Explanation:**

The organizations that a clinical documentation integrity practitioner (CDIP) should monitor are Recovery Auditors (RAs), Program for Evaluating Payment Patterns Electronic Report (PEPPER), and Office of Inspector General (OIG). These organizations are involved in auditing, reviewing, and investigating the accuracy, completeness, and compliance of clinical documentation, coding, billing, and reimbursement practices of hospitals and other healthcare providers. The CDIP should monitor these organizations to stay updated on their policies, guidelines, findings, recommendations, and actions that may affect the CDI program and the hospital's performance and reputation. [3][3] References: 1: [https://www.ahima.org/media/owmhxbv1/cdip\\_contentoutline\\_2023\\_final.pdf](https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf) [3][3]: <https://my.ahima.org/store/product?id=67077>

**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**

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 4**

Which of the following individuals should the clinical documentation integrity (CDI) manager consult when developing query policy and procedures?

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

**Answer:** A

**Explanation:**

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

References:

? CDIP Exam Content Outline1

? CDIP Exam Preparation Guide2

**NEW QUESTION 5**

Collaboration between the physician advisor/champion and the clinical documentation integrity practitioners (CDIPs) would likely include

- A. performing data analysis
- B. developing query forms
- C. educating physicians
- D. querying physicians

**Answer:** C

**Explanation:**

Collaboration between the physician advisor/champion and the clinical documentation integrity practitioners (CDIPs) would likely include educating physicians on the importance and impact of clinical documentation on coding, reimbursement, quality measures, compliance, and patient care. The physician advisor/champion can act as a liaison between the CDIPs and the medical staff, provide feedback and guidance on query development and resolution, and facilitate peer-to-peer education sessions on documentation best practices and standards6 References: 1: [https://www.ahima.org/media/owmhxbv1/cdip\\_contentoutline\\_2023\\_final.pdf](https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf) 6: <https://my.ahima.org/store/product?id=67077>

**NEW QUESTION 6**

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 7**

Creating policies and procedures for the query process will help eliminate

- A. confusion
- B. risk
- C. indecision
- D. duplication

**Answer:** A

**Explanation:**

Creating policies and procedures for the query process will help eliminate confusion among CDI staff, providers, coders, and other stakeholders regarding the purpose, scope, format, and expectations of the query process. Policies and procedures should be based on industry standards and best practices, and should be reviewed and updated regularly. References: AHIMA/ACDIS. ??Guidelines for Achieving a Compliant Query Practice (2019 Update).?? Journal of AHIMA 90, no. 2 (February 2019): 20-29.

**NEW QUESTION 8**

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

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

**Answer:** B

**Explanation:**

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

[https://www.ahima.org/media/owmhxbv1/cdip\\_contentoutline\\_2023\\_final.pdf](https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf) 4: <https://my.ahima.org/store/product?id=67077>

**NEW QUESTION 9**

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

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

**Answer:** B

**Explanation:**

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

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: Acute Kidney Injury: Diagnosis and Management | AAFP 3: AKIN Classification for Acute Kidney Injury (AKI) - MDCalc

**NEW QUESTION 10**

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

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

**Answer: A**

**Explanation:**

A noncompliant multiple-choice query is one that does not include at least four options because it may limit the provider's choice and suggest a preferred answer. A compliant multiple-choice query should include at least four options that are clinically significant, reasonable, and plausible based on the clinical indicators and documentation in the health record. The options should also be listed in alphabetical order to avoid any bias or preference. A compliant multiple-choice query should also allow the provider to add their own response if none of the options are appropriate, and include the option of "unable to determine" if the provider cannot make a definitive diagnosis based on the available information. (CDIP Exam Preparation Guide)

References:

? CDIP Exam Content Outline1

? CDIP Exam Preparation Guide2

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

**NEW QUESTION 10**

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 14**

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

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

**Answer: A**

**Explanation:**

Malnutrition is a diagnosis that is most likely to trigger a second level review because it affects the severity of illness (SOI) and risk of mortality (ROM) of the patient, as well as the reimbursement and quality measures of the hospital. Malnutrition also requires clinical validation and clear documentation of its etiology, type, degree, and duration2 References: 1:

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

**NEW QUESTION 15**

A clinical documentation integrity practitioner (CDIP) has been successful in getting physicians to respond to queries. However, when the CDIP poses a query to a specific doctor, there is no response at all. The CDIP has tried face-to-face conversations, calling, emails, texts, but still gets no response. What is the next step the CDIP should take?

- A. Elevate the issue to the physician advisor/champion after the CDI supervisor has reviewed the case and deemed the query appropriate
- B. Report the doctor to the Vice President of Medical Affairs so the doctor understands the importance of clinical documentation
- C. Hold a meeting with the CDI director and the doctor to find out why the doctor is not responding to the queries
- D. Warn the other CDIPs that the doctor is a non-responder and to forego querying

**Answer: A**

**Explanation:**



According to the Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA<sup>1</sup>, 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 organization<sup>1</sup>. In this case, since the CDIP has tried multiple methods of communication with the doctor but still gets no response, the CDIP should elevate the issue to the physician advisor/champion, who can facilitate communication and education with the doctor and ensure documentation integrity and compliance<sup>1</sup>. However, before escalating the issue, the CDIP should consult with the CDI supervisor to review the case and confirm that the query is appropriate, relevant, and compliant with the query guidelines<sup>1</sup>. This would ensure that the escalation is justified and not based on personal bias or preference. The other options are not advisable because they either involve skipping the escalation policy, reporting the doctor without proper review or feedback, holding a meeting without involving the physician advisor/champion, or giving up on querying altogether. References:  
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA<sup>1</sup>

**NEW QUESTION 20**

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

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

**Answer:** C

**Explanation:**

According to the AHIMA/ACDIS Query Practice Brief, a compliant query should provide multiple choice answer options that are supported by clinical indicators and include a non-leading query statement<sup>1</sup>. Option C meets these criteria, as it provides a list of possible diagnoses that are relevant to the patient's condition and asks the provider to indicate which one they are treating. Option C also does not imply or suggest a preferred answer or outcome, and allows the provider to choose unable to determine or other if none of the listed options apply. Option A is not compliant, as it does not provide any answer options and implies that the provider should order more tests to capture a higher severity of illness. Option B is not compliant, as it provides only one answer option and suggests that the provider should document it based on the clinical indicators. Option D is not compliant, as it provides only one answer option and implies that the provider should document it based on the indications. References:

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

**NEW QUESTION 21**

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 Outline<sup>1</sup>

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

? 42 CFR ?? 482.24<sup>3</sup>

**NEW QUESTION 24**

The correct coding for heart failure with preserved ejection fraction is

- A. I50.32 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 fraction<sup>1</sup>. 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)<sup>1</sup>. If the documentation does not specify the acuity of the diastolic heart failure, the default code is I50.30<sup>1</sup>. 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 2023<sup>1</sup>

**NEW QUESTION 26**

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 28**

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

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

**Answer:** C

**Explanation:**

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

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 4

**NEW QUESTION 30**

When there is a discrepancy between the clinical documentation integrity practitioner's (CDIP's) working DRG and the coder's final DRG, which of the following is considered a fundamental element that must be in place for a successful resolution?

- A. Physician and CDIP interaction
- B. Coder and CDIP interaction
- C. Executive oversight
- D. Physician advisor/champion involvement

**Answer:** B

**Explanation:**

According to the AHIMA/ACDIS Query Practice Brief, one of the fundamental elements that must be in place for a successful DRG discrepancy resolution is a collaborative and respectful interaction between the coder and the CDIP<sup>1</sup>. The coder and the CDIP should communicate effectively and timely to identify and resolve any DRG mismatches, using evidence-based guidelines, coding conventions, and query standards<sup>1</sup>. The coder and the CDIP should also share their knowledge and expertise with each other, and seek clarification from the provider or the physician advisor/champion when necessary<sup>1</sup>. The other options are not considered fundamental elements for DRG discrepancy resolution, although they may be helpful or supportive in some situations. References: ? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

**NEW QUESTION 31**

A clinical documentation integrity practitioner (CDIP) is developing a plan to promote the CDI program throughout a major hospital. It is proving challenging to find support. What is a primary step for the CDIP?

- A. Determine primary interests and needs as requested
- B. Determine primary interests of an individual or department
- C. Teach coding classes to the new physicians as needed
- D. Teach nursing staff about documentation integrity

**Answer:** B

**Explanation:**

A primary step for the CDIP to promote the CDI program throughout a major hospital is to determine the primary interests of an individual or department that could benefit from or support the CDI program. This is because different stakeholders may have different motivations, expectations, and challenges related to CDI, and the CDIP should tailor the communication and education strategies accordingly. For example, physicians may be interested in how CDI can improve their quality metrics, reimbursement, and patient outcomes; coders may be interested in how CDI can reduce coding errors, denials, and queries; and executives may be interested in how CDI can enhance revenue integrity, compliance, and reputation. By identifying the primary interests of each individual or department, the CDIP can demonstrate the value and relevance of the CDI program, address any barriers or concerns, and foster collaboration and engagement<sup>23</sup>.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: How to Promote Your Clinical Documentation Improvement Program 3: How to Market Your Clinical Documentation Improvement Program

**NEW QUESTION 32**

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 33**

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 34**

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

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

**Answer:** A

**Explanation:**

When queries are part of the health record, which is recommended by AHIMA and ACDIS, physicians are responsible for responding to queries in a timely manner and ensuring that their documentation is complete and accurate. If a provider receives too many deficiencies due to incomplete records for failure to respond to queries, their admitting privilege could be suspended by the medical staff committee as a disciplinary action.

References: AHIMA/ACDIS. ??Guidelines for Achieving a Compliant Query Practice (2019 Update).?? Journal of AHIMA 90, no. 2 (February 2019): 20-29.

**NEW QUESTION 38**

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 43**

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 44**

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 45**

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 47**

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 49**

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

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



**Answer:** D

**Explanation:**

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

References:

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

? Master patient index - Clinfowiki1

**NEW QUESTION 52**

A query should be generated when the documentation is

- A. legible
- B. consistent
- C. complete
- D. conflicting

**Answer:** D

**Explanation:**

A query should be generated when the documentation is conflicting, meaning that there is contradictory or inconsistent information in the medical record that may affect the accuracy of coding, quality reporting, or reimbursement. For example, if the documentation in the progress notes differs from the documentation in the discharge summary, or if different providers document different diagnoses or procedures for the same patient, a query may be needed to resolve the discrepancy and obtain clarification from the source of the documentation. A query should not be generated when the documentation is legible, consistent, or complete, as these are desirable characteristics of documentation that do not require further clarification or verification.

References:

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

? Accurate Documentation is Essential – Knowing When to Query your Providers1

**NEW QUESTION 56**

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 57**

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 58

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 62

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

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

**Answer: A**

#### Explanation:

According to the AHIMA best practice for written queries, queries should be limited to non- leading questions that do not imply a specific answer or diagnosis, but rather ask for the provider's opinion based on their clinical judgment and the evidence in the health record. Non-leading questions help to ensure that the query is compliant, objective, and respectful of the provider's authority and autonomy. Leading questions, on the other hand, may introduce bias, influence the provider's response, or compromise the integrity of the documentation and coding. For example, a non-leading query for a patient with chest pain would be:

??What is the etiology of the chest pain??? A leading query would be: ??Is the chest pain due to acute myocardial infarction??

References:

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

? Guidelines for Achieving a Compliant Query Practice—2022 Update1

#### NEW QUESTION 66

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 68

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 72**

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 75**

Which of the following is an appropriate first step to address physicians with low query response rates?

- A. An educational session between the clinical documentation integrity practitioner (CDIP) and physician
- B. The medical staff review the physician's noncompliance to consider sanctions
- C. The physician receives a suspension until query responses are improved
- D. A meeting between the physician advisor/champion and the noncompliant physician

**Answer:** A

**Explanation:**

An appropriate first step to address physicians with low query response rates is an educational session between the clinical documentation integrity practitioner (CDIP) and physician because it provides an opportunity to explain the purpose and benefits of the query process, to identify and address any barriers or challenges to responding, and to offer feedback and guidance on how to improve query response rates. An educational session can also help to build rapport and trust between the CDIP and the physician, and to demonstrate respect and professionalism. (CDIP Exam Preparation Guide) References:

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

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

? Understanding CDI Metrics<sup>3</sup>

**NEW QUESTION 80**

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