AHIMA

Exam Questions CDIP

Certified Documentation Integrity Practitioner

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

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

Answer: D

Explanation:
It is appropriate to code the pneumonia in this scenario because the condition is still present and being treated at the time of admission to the long-term care facility. According to the ICD-10-CM Official Guidelines for Coding and Reporting, a diagnosis is reportable if it is documented as ??present on admission?? or ??active?? by the provider, or if it requires or affects patient care treatment or management 2. In this case, the pneumonia is still active and requires IV antibiotics and a repeat x-ray, which indicates that it affects the patient care treatment and management. Therefore, the pneumonia should be coded as J18.9, Pneumonia, unspecified organism, which is the default code for pneumonia when no causal organism is identified 3. In addition, the code Z79.2, Long term (current) use of antibiotics, should be coded to indicate that the patient is receiving long term antibiotic therapy as part of the treatment plan 4.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 138 5 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section I.B.14 3: ICD-10-CM Code J18.9 - Pneumonia, unspecified organism 4: ICD-10-CM Code Z79.2 - Long term (current) use of antibiotics

NEW QUESTION 4
An otherwise healthy male was admitted to undergo a total hip replacement as treatment for ongoing primary osteoarthritis of the right hip. During the post-operative period, the patient choked on liquids which resulted in aspiration pneumonia as shown on chest x-ray. Intravenous antibiotics were administered, and the pneumonia was monitored for improvement with two additional chest x-rays. The patient was discharged to home in stable condition on post-operative day 5. Final Diagnoses:
* 1. Primary osteoarthritis of right hip status post uncomplicated total hip replacement
* 2. Aspiration pneumonia due to choking on liquid episode
What is the correct diagnostic related group assignment?

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

Answer: B

Explanation:
The correct diagnostic related group (DRG) assignment for this case is 469 Major Joint Replacement or Reattachment of Lower Extremity with MCC. This is because the principal diagnosis is primary osteoarthritis of right hip status post uncomplicated total hip replacement, which belongs to the Major Diagnostic Category (MDC) 08 Diseases and Disorders of the Musculoskeletal System and Connective Tissue. The DRG 469 is assigned to cases with this MDC and a

surgical procedure code for major joint replacement or reattachment of lower extremity. The secondary diagnosis of aspiration pneumonia due to choking on liquid episode qualifies as a major complication or comorbidity (MCC), which increases the relative weight and payment for the DRG. The MCC is determined by applying the Medicare Code Editor (MCE) software, which checks the validity and compatibility of the diagnosis codes and assigns them to different severity levels based on the CMS Severity-Diagnosis Related Group (MS-DRG) definitions manual 2.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: CMS MS-DRG Definitions Manual, Version 38.0, p. 8-9 4

NEW QUESTION 5
Which of the following is the definition of an Excludes 2 note in ICD-10-CM?

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

Answer: B

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

NEW QUESTION 6
A patient has a history of asthma and presents with complaints of fever, cough, general body aches, and lethargy. The patient's child was recently diagnosed with influenza. Wheezing is heard on exam. The physician documents the diagnosis as asthma exacerbation and orders nebulizer treatments of Albuterol and a 5-day course of oral Prednisone. The clinical documentation integrity practitioner (CDIP) is unsure which signs and symptoms are inherent to asthma. Which reference resource should be used to obtain this information?

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

Answer: C

Explanation:
The reference resource that should be used to obtain information about the signs and symptoms that are inherent to asthma is The Merck Manual. This is a comprehensive medical reference that covers various topics related to diseases, diagnosis, treatment, and prevention. The Merck Manual provides a detailed description of asthma, including its causes, risk factors, pathophysiology, clinical features, diagnosis, management, and complications. According to The Merck Manual, the signs and symptoms that are inherent to asthma are wheezing, coughing, chest tightness, and dyspnea (shortness of breath) 2. These symptoms are caused by the reversible bronchoconstriction and inflammation of the airways that characterize asthma. The Merck Manual also explains how these symptoms can be triggered or exacerbated by various factors, such as allergens, infections, exercise, cold air, stress, or medications 2.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: Asthma - Pulmonary Disorders - Merck Manuals Professional Edition 4

NEW QUESTION 7
A 50-year-old with a history of stage II lung cancer is brought to the emergency department with severe dyspnea. The patient underwent the last round of chemotherapy 3 days ago. Vital signs reveal a temperature of 98.4, a heart rate of 98, a respiratory rate of 28, and a blood pressure of 124/82. O2 saturation on room air is 92%. The patient is 5'5"and weighs 98 lbs. The registered dietitian notes the patient is malnourished with BMI of 19. Chest x-ray reveals a large pleural effusion in the right lung.
Thoracentesis is performed and 1000 cc serosanguinous fluid is removed. The admitting diagnosis is large right lung pleural effusion related to lung cancer stage II, documented multiple times. What post discharge query opportunity should be sent to the physician that will affect severity of illness (SOI)/risk of mortality (ROM)?

A. Query for protein calorie malnutrition
B. Query for malignant pleural effusion
C. Query for a diagnosis associated with the dietician's finding of malnutrition
D. Query if the malignant pleural effusion is the reason for admission

Answer: B

Explanation:
According to the AHIMA CDIP Exam Preparation Guide, a query is a communication tool or process used to clarify documentation in the health record for documentation integrity and accurate code assignment1. A query should be clear, concise, and consistent, and should include relevant clinical indicators that support the query1. A query should also provide multiple choice answer options that are supported by clinical indicators and include a non- leading query statement2. In this case, the patient has a large right lung pleural effusion related to lung cancer stage II, which is documented multiple times. However, the documentation does not specify whether the pleural effusion is malignant or not. A malignant pleural effusion is a condition where cancer cells spread to the pleural space and cause fluid accumulation3. A malignant pleural effusion is a major complication or comorbidity (MCC) that affects the severity of illness (SOI) and risk of mortality (ROM) of the patient, as well as the reimbursement and quality scores of the hospital4. Therefore, a post discharge query opportunity should be sent to the physician to clarify whether the pleural effusion is malignant or not, based on the clinical indicators such as chest x-ray, thoracentesis, and fluid analysis. The query should provide answer options such as malignant pleural effusion, non-malignant pleural effusion, unable to determine, or other. The other options are not correct because they either do not affect the SOI/ROM of the patient (A and C), or they do not address the specificity of the diagnosis (D). References:
? CDIP Exam Preparation Guide - AHIMA
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA
? Malignant Pleural Effusion: Symptoms, Causes, Diagnosis & Treatment
? Q&A: Coding for malignant pleural effusions | ACDIS

NEW QUESTION 8
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 9
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 10
A clinical documentation integrity (CDI) program that is compliant with regulations from the facility's payors results in

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

Answer: C

NEW QUESTION 10
Identify the error in the following query:
This patient's echocardiogram showed an ejection fraction of 25%. The chest x-ray showed congestive heart failure (CHF). The patient was prescribed Lasix and an angiotensin- converting enzyme inhibitor (ACEI). Is this patient's CHF systolic?

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

Answer: D

Explanation:
A leading query is one that suggests a specific diagnosis, condition, or treatment to the provider, or implies that a certain response is desired or expected. A

leading query can compromise the integrity and accuracy of the documentation and the coded data, and may also raise compliance and ethical issues. A query should be non-leading, meaning that it presents the facts from the health record without bias or influence, and allows the provider to use their clinical judgment to determine the appropriate response.

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

? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? Guidelines for Achieving a Compliant Query Practice—2022 Update | ACDIS
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA
? The Provider Query Toolkit: A Guide to Compliant Practices

NEW QUESTION 13
A patient falls off a ladder and undergoes a right femur procedure. Three weeks later, the patient returns to the hospital for removal of the external fixation device. The ICD-10-CM 7th character code value should indicate

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

Answer: D

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

NEW QUESTION 17
A modifier may be used in CPT and/or HCPCS codes to indicate

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

Answer: A

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

NEW QUESTION 18
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 23
A query should be generated when documentation contains a

A. postoperative hospital-acquired condition
B. principal diagnosis without an MCC

C. diagnosis without clinical validation
D. problem list with symptoms related to the chief complaint

Answer: C

Explanation:
A query should be generated when documentation contains a diagnosis without clinical validation, meaning that there is no evidence in the health record to support the diagnosis or that the diagnosis is inconsistent with other clinical indicators. A diagnosis without clinical validation may affect the accuracy and completeness of coding, quality measures, reimbursement, and patient care.
References: AHIMA/ACDIS. ??Guidelines for Achieving a Compliant Query Practice (2019 Update).?? Journal of AHIMA 90, no. 2 (February 2019): 20-29.

NEW QUESTION 25
Which of the following demonstrates the relative severity and complexity of patient treated in the hospital, and is used to evaluate the financial impact of a hospital's clinical documentation integrity (CDI) program?

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

Answer: D

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

NEW QUESTION 26
Which of the following is used to measure the impact of a clinical documentation integrity (CDI) program on Centers for Medicare and Medicaid Services quality performance?

A. Risk of mortality
B. Case mix index
C. Severity of illness
D. Outcome measures

Answer: D

Explanation:
Outcome measures are indicators of the quality of care provided by a healthcare organization, such as mortality rates, readmission rates, hospital-acquired conditions, patient safety indicators, and patient satisfaction scores. These measures are used by CMS to evaluate and compare the performance of hospitals and other providers under various pay-for-performance programs, such as value-based purchasing, hospital readmissions reduction program, hospital-acquired condition reduction program, and hospital inpatient quality reporting program. A CDI program can influence these outcome measures by ensuring that the clinical documentation accurately reflects the severity of illness, risk of mortality, and complexity of care of the patients. This can help to improve the risk adjustment and case mix index of the organization, as well as to identify and prevent potential quality issues.
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 29
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 34
The clinical documentation integrity (CDI) manager reviewed all payer refined-diagnosis related groups (APR-DRG) benchmarking data and has identified potential opportunities for improvement. The manager hopes to develop a work plan to target severity of illness (SOI)/risk of mortality (ROM) by service line and providers. How can the manager gain more information about this situation?

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

Answer: D

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

NEW QUESTION 38
The key component of the auditing and monitoring process to ensure provider query response is to

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

Answer: D

NEW QUESTION 39
The correct coding for insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is

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

Answer: A

Explanation:
According to the ICD-10-PCS Reference Manual 2023, the insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is coded as follows1:
? The first character 0 indicates the Medical and Surgical section.
? The second character 5 indicates the Extracorporeal or Systemic Assistance and Performance root operation, which is defined as "Putting in or on a device that completely takes over a body function by extracorporeal means"1.
? The third character H indicates the Central Vein body system, which includes the internal jugular vein1.
? The fourth character M indicates the Infusion Device device value, which is defined as "A device that is inserted into a body part to deliver fluids or other substances to a body part or into the circulation"1.
? The fifth character 3 indicates the Right Internal Jugular Vein body part value, which is the specific site of the procedure1.
? The sixth character 3 indicates the Percutaneous approach, which is defined as "Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach and visualize the site of the procedure"1.
? The seventh character Z indicates No Qualifier, which means there is no additional information necessary to complete the code1.
Therefore, the correct coding for insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is 05HM33Z.
References:
? ICD-10-PCS Reference Manual 20231

NEW QUESTION 41
A 77-year-old male with chronic obstructive pulmonary disease (COPD) is admitted as an inpatient with severe shortness of breath. The patient is placed on oxygen at 2 liters per minute via nasal cannula. History reveals that the patient is on oxygen nightly at home. CXR is unremarkable. The most compliant query is

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

Answer: C

Explanation:
According to the AHIMA/ACDIS Query Practice Brief, a compliant query should provide multiple choice answer options that are supported by clinical indicators and include a non- leading query statement1. Option C meets these criteria, as it provides a list of possible diagnoses that are relevant to the patient??s condition and asks the provider to indicate which one they are treating. Option C also does not imply or suggest a preferred answer or outcome, and allows the provider to choose unable to determine or other if none of the listed options apply. Option A is not compliant, as it does not provide any answer options and implies that the provider should order more tests to capture a higher severity of illness. Option B is not compliant, as it provides only one answer option and suggests that the provider should document it based on the clinical indicators. Option D is not compliant, as it provides only one answer option and implies that the provider should document it based on the indications. References:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

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

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

Answer: C

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

NEW QUESTION 46
A hospital noticed a 30% denial rate in Medicare claims due to lack of clinical documentation, placing the hospital at risk of multiple Medicare violations. What step should the clinical documentation integrity (CDI) manager take to help avoid future Medicare violations?
? Collaborate with physician advisor/champion and revenue cycle manager
? Instruct the billing department to write off claims with insufficient documentation

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

Answer: A

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

NEW QUESTION 50
An 86-year-old female is brought to the emergency department by her daughter. The patient complains of feeling tired, weak and excessive sleeping. The patient's daughter comments that patient's mental condition has not been the same. Lab results are unremarkable except for a sodium level of 119, a BUN of 22, and a creatinine of 1.35. The patient receives normal saline IV infusing at 100 cc/hr. The admitting diagnosis is weakness, altered mental status and dehydration. Which of the following queries is presented in an ethical manner thus avoiding potential fraud and/or compliance issues?

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

Answer: D

NEW QUESTION 53
Hospital policy states that physician responses to queries should be no longer than timely payer filing requirements. A physician responds to a query after the final bill has been submitted. How should administration respond in this situation?

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

Answer: B

Explanation:
Administration should respond to this situation by reviewing the record to determine any potential data integrity impact and/or rebilling implications. According to the AHIMA Practice Brief on Managing an Effective Query Process, post-bill queries are generally initiated as a result of an audit or other internal monitor, and healthcare entities can develop a policy regarding whether they will generate post-bill queries and the timeframe following claims generation that queries may be initiated. The practice brief also states that healthcare entities should consider the following three concepts in the development of a post-bill (including query) policy: applying normal course of business guidelines, using payer-specific rules on rebilling timeframes, and determining reliability of query response over time 2. Therefore, administration should review the record to see if the physician??s response to the query affects the quality of care, patient safety, severity of illness, risk of mortality, or reimbursement, and if so, whether it is appropriate and feasible to rebill the account based on the payer??s rules and the normal course of business guidelines. Administration should also evaluate the reasons for the physician??s delayed response and provide feedback and education to prevent future occurrences.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: AHIMA Practice Brief: Managing an Effective Query Process 4

NEW QUESTION 58
A patient's progress note states "The patient has chronic systolic heart failure". After reviewing clinical indicators suggestive of an exacerbation of systolic heart failure, the clinical documentation integrity practitioner (CDIP) queries the physician to clarify the current acuity of the diagnosis. Which subsequent documentation in the health record suggests the provider did not understand the query?

A. The patient has chronic systolic heart failure.
B. The patient has acute on chronic systolic heart failure.
C. The patient did have an exacerbation of heart failure.
D. The patient has decompensated systolic heart failure.

Answer: A

Explanation:
According to the AHIMA CDIP Exam Preparation Guide, a query is a communication tool or process used to clarify documentation in the health record for documentation integrity and accurate code assignment1. A query should be clear, concise, and consistent, and should include relevant clinical indicators that support the query1. A query should also provide multiple choice answer options that are supported by clinical indicators and include a non- leading query statement2. In this case, the CDIP queried the physician to clarify the current acuity of the diagnosis of chronic systolic heart failure, based on clinical indicators suggestive of an exacerbation of systolic heart failure. The subsequent documentation in the health record that suggests the provider did not understand the query is A. The patient has chronic systolic heart failure. This documentation does not address the query or provide any additional information about the patient??s condition. It simply repeats the same diagnosis that was already documented in the progress note. This documentation does not reflect the patient??s true severity of illness, risk of mortality, or reimbursement3. The other options are not correct because they do provide some information about the current acuity of the diagnosis of chronic systolic heart failure, such as acute on chronic, exacerbation, or decompensation. These terms indicate a higher level of severity and complexity than chronic alone. References:
? CDIP Exam Preparation Guide - AHIMA
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA
? Severity of Illness: What Is It? Why Is It Important? | HCPro
? [Q&A: Acute on chronic versus decompensated heart failure | ACDIS]

NEW QUESTION 62
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 65
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 68
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 73
Hospital-acquired condition pay provisions apply only to

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

Answer: A

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

NEW QUESTION 75
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 77
A 50-year-old male patient was admitted with complaint of 3-day history of shortness of breath. Vital signs: BP 165/90, P 90, T 99.9.F, O2 sat 95% on room air. Patient has history of asthma, chronic obstructive pulmonary disease (COPD), and hypertension (HTN). His medicines are Albuterol and Norvasc. CXR showed chronic lung disease and left lower lobe infiltrate. Labs: WBC 9.5 with 65% segs. Physician documented that patient has asthma flair and admitted with decompensated COPD, ordered IV steroids, O2 at 2L/min via nasal cannula, Albuterol inhalers 4x per day, and Clindamycin. Patient improved and was discharged 3 days later. Which action would have the highest impact on the patient's severity of illness (SOI) and risk of mortality (ROM)?

A. Query the physician to clarify if CXR result means patient has pneumonia.
B. Query the physician to clarify for type of COPD such as severe asthma.
C. Query the physician to clarify for clinical significance of the CXR results.
D. Query the physician to clarify if patient has acute COPD exacerbation.

Answer: A

NEW QUESTION 78
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 CDIP1. 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 standards1. 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 necessary1. 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 81
Which of the following is a clinical documentation integrity (CDI) financial impact measure?

A. Severity of illness
B. Hierarchical condition category

C. Case mix index
D. Release of information

Answer: C

Explanation:
Case mix index (CMI) is a measure of the average severity and resource consumption of a group of patients, such as those in a hospital or a diagnosis-related group (DRG). CMI reflects the financial impact of CDI by showing how documentation improvement can affect the DRG assignment and reimbursement. A higher CMI indicates more complex and costly cases, while a lower CMI indicates less complex and costly cases. CDI programs can monitor the changes in CMI over time to evaluate their effectiveness and return on investment. (Understanding CDI Metrics2)
References:
? CDI Week 2020 Q&A: CDI and key performance indicators1
? Understanding CDI Metrics2

NEW QUESTION 82
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 23.
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 85
A patient was admitted due to possible pneumonia. Chest x-ray was positive for infiltrate.
The physician's documentation indicates that the patient continues to smoke cigarettes despite recommendations to quit. Patient also has a long-term history of chronic obstructive pulmonary disease (COPD) due to smoking. IV antibiotic was given for pneumonia along with oral Prednisone and Albuterol for COPD.
Discharge diagnoses:
* 1. Pneumonia
* 2. COPD
* 3. Current smoker
What is the correct diagnostic related group assignment?

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

Answer: A

Explanation:
According to the ICD-10-CM/PCS MS-DRG Definitions Manual, DRG 190 is assigned for patients with a principal diagnosis of chronic obstructive pulmonary disease (COPD) and a major complication or comorbidity (MCC)1. Pneumonia is considered an MCC for this DRG2. Therefore, the patient in this case meets the criteria for DRG 190. The other options are incorrect because they do not match the principal diagnosis or the MCC of the patient. References:
? ICD-10-CM/PCS MS-DRG Definitions Manual
? ICD-10-CM/PCS MS-DRG v38.0 Definitions Manual - MDC 4: Diseases and Disorders of the Respiratory System

NEW QUESTION 86
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 88
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 93
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 94
Which of the following criteria for clinical documentation means the content of the record is trustworthy, safe, and yielding the same result when repeated?

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

Answer: C

Explanation:
According to AHIMA, clinical documentation is at the core of every patient encounter and it must be meaningful to accurately reflect the patient??s disease burden and scope of services provided. In order to be meaningful, the documentation must be clear, consistent, complete, precise, reliable, timely, and legible1. Reliability is one of the criteria for clinical documentation that means the content of the record is trustworthy, safe, and yielding the same result when repeated1. Reliability ensures that the documentation is consistent with the clinical evidence and reasoning, and that it can be verified by other sources or methods. Reliability also implies that the documentation is free from errors, omissions, contradictions, or ambiguities that could compromise its validity or usefulness1. References:
? Clinical Documentation Integrity Education & Training | AHIMA1

NEW QUESTION 97
Which physician would best benefit from additional education for unanswered queries?

Physician	Number of Queries	Agree	Disagree	No Response
Dr. A	31	25	5	1
Dr. B	32	28	2	2
Dr. C	18	2	16	0
Dr. D	10	0	1	9

A. D
B. A
C. D
D. B

E. D
F. C
G. D
H. D

Answer: D

Explanation:
According to the Documentation Integrity Practitioner (CDIP®) study guide, the physician with the highest number of unanswered queries would benefit from additional education. In this case, Dr. D has the highest number of unanswered queries with 9. Unanswered queries may indicate a lack of understanding, engagement, or compliance with the query process, which may affect the quality and accuracy of clinical documentation and coding1. Therefore, Dr. D would best benefit from additional education for unanswered queries, such as the importance of timely and appropriate query responses, the impact of queries on severity of illness, risk of mortality, and reimbursement, and the best practices for a compliant query practice2. References:
? Q&A: What to do with unanswered queries | ACDIS
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

NEW QUESTION 100
Educating physicians on severity of illness and risk of mortality is best accomplished by utilizing

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

Answer: C

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

NEW QUESTION 102
Given the following ICD-10-CM Alphabetical Index entry: Ectopic (pregnancy) 008.9
What is the meaning of the parenthesis?

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

Answer: B

NEW QUESTION 103
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 106
Several physicians at a local hospital are having difficulty providing adequate documentation on patients admitted with a diagnosis of pneumonia with or without clinical indications of gram-negative pneumonia. Subsequently, clinical documentation integrity practitioners (CDIPs) are altering health records. Which policy and procedure
should be developed to ensure compliant practice?

A. Professional ethical standards
B. Accreditation standards
C. Performance standards
D. Quality improvement standards

Answer: A

Explanation:
A policy and procedure that should be developed to ensure compliant practice for CDIPs who are altering health records is professional ethical standards. Professional ethical standards are the principles and values that guide the conduct and decision-making of CDIPs in their role of ensuring the accuracy, completeness, and integrity of clinical documentation and coded data. According to the AHIMA Standards of Ethical Coding1 and the ACDIS Code of Ethics2, CDIPs should not alter health records without the consent or direction of the provider, as this may compromise the quality and validity of the documentation and coding, and may violate legal and regulatory requirements. CDIPs should also respect the confidentiality and security of health records, and report any unethical or fraudulent practices to the appropriate authority.
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? AHIMA Standards of Ethical Coding1
? ACDIS Code of Ethics2

NEW QUESTION 111
A hospital is conducting a documentation integrity project for the purpose of reducing indiscriminate use of electronic copy and paste of patient information in records
by physicians. Which data should be used to quantify the extent of the problem?

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

Answer: D

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

NEW QUESTION 112
The clinical documentation integrity practitioner (CDIP) performed a verbal query and then later neglected following up with the provider. How should the CDIP avoid a compliance risk for this follow up failure according to AHIMA's Guidelines for Achieving a Compliant Query Practice?

A. Complete the documentation immediately after the provider's response
B. Complete the documentation at the end of the day when entering cases reviewed
C. Complete the documentation when there is a provider agreement
D. Complete the documentation at the time of discussion or immediately following

Answer: D

Explanation:
According to AHIMA??s Guidelines for Achieving a Compliant Query Practice, the clinical documentation integrity practitioner (CDIP) should complete the documentation at the time of discussion or immediately following to avoid a compliance risk for this follow up failure. This is because verbal queries are considered part of the health record and must be documented in a timely and accurate manner to reflect the provider??s response and any changes in documentation or coding. Completing the documentation later or only when there is an agreement may result in errors, omissions, inconsistencies, or delays that may affect the quality and integrity of the health record and the query process. (AHIMA Guidelines for Achieving a Compliant Query Practice1)
References:
? AHIMA Guidelines for Achieving a Compliant Query Practice1

NEW QUESTION 113
The best approach in resolving unanswered queries is to

A. notify the physician advisor/champion that the physician has not responded to the query
B. review the facility's query policies and procedures
C. contact the physician repeatedly until he/she responds to the query
D. notify the coding team of the physician's unanswered query

Answer: B

Explanation:
facilities must develop an escalation policy for unanswered queries and address any medical staff concerns regarding queries1. If a query does not receive an appropriate professional response, the case should be referred for further review in accordance with the facility??s written escalation policy2. 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 level1. The policies should reflect a method of response that can realistically occur for the organization1. Therefore, reviewing the facility??s query policies and

procedures is the best approach to ensure compliance and consistency in handling unanswered queries.
The other options are not advisable because they either involve skipping the escalation policy, notifying the physician advisor/champion without proper review or feedback, contacting the physician repeatedly without respecting their time or availability, or notifying the coding team without resolving the query issue.

NEW QUESTION 117
A patient presented with shortness of breath, elevated B-type natriuretic peptide, and lower extremity edema to the emergency room. During the hospitalization, a cardiac echocardiogram was performed and revealed an ejection fraction of 55% with diastolic dysfunction. The patient's history includes hypertension (HTN), chronic kidney disease (CKD) (baseline glomerular filtration rate 40) and congestive heart failure (CHF).
The clinical documentation integrity practitioner (CDIP) has queried the physician to further clarify the patient's diagnosis. Which response provides the highest level of specificity?

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

Answer: A

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

NEW QUESTION 120
The clinical documentation integrity practitioner (CDIP) is reviewing tracking data and has noted physician responses are not captured in the medical chart. What can be done to improve this process?

A. Update medical records with unsigned physician responses
B. Allow physician responses via e-mail
C. Provide education to physicians on query process
D. Require the CDIP to call physicians to follow up

Answer: C

Explanation:
According to the AHIMA/ACDIS Query Practice Brief, one of the best practices for a compliant query process is to provide ongoing education to physicians on the importance of documentation integrity, the query process, and the impact of documentation on quality measures, reimbursement, and compliance1. Education can help physicians understand the rationale and expectations for responding to queries, as well as the benefits of accurate and complete documentation for patient care and data quality. Education can also address any barriers or challenges that physicians may face in responding to queries, such as time constraints, technology issues, or workflow preferences1. References:
? AHIMA/ACDIS Query Practice Brief – Updated 12/2022
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

NEW QUESTION 123
A patient presents to the emergency department for evaluation after suffering a head injury during a fall. A traumatic subdural hematoma is found on MRI, and the patient is taken directly to the operating room for evacuation. The neurosurgeon performs a burr hole procedure for evacuation of the subdural hematoma. The clot is removed successfully, and the patient is transferred to recovery in stable condition. Which is the correct current procedural terminology (CPT) code assignment for the procedure performed?

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

Answer: A

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

NEW QUESTION 124

The clinical documentation integrity (CDI) manager has noted a query response rate of 60%. The CDI practitioner reports that physicians often respond verbally to the query. What can be done to improve this rate?

A. Have CDI manager teaming with coding supervisor to monitor physician responses
B. Require physicians to document responses in charts
C. Permit CDI practitioners to document physician responses in the charts
D. Allow physician to respond via e-mail

Answer: B

Explanation:
According to the AHIMA/ACDIS Query Practice Brief, one of the best practices for a compliant query process is to require physicians to document their responses to queries in the health record1. This ensures that the documentation is consistent, accurate, and complete, and that the query and response are part of the permanent record. Verbal responses are not acceptable, as they do not provide a clear audit trail and may lead to errors or discrepancies in coding and billing1. Therefore, the CDI manager should educate the physicians on the importance of documenting their responses in the charts and monitor their compliance. The other options are not recommended, as they may compromise the integrity of the documentation or violate the query guidelines1. References:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

NEW QUESTION 129

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

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

Answer: D

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

NEW QUESTION 134

Reviewing and analyzing physician query content on a regular basis

A. helps to calculate query response rate
B. aids in discussion between physician and reviewer
C. assists in identifying gaps in skills and knowledge
D. facilitates physician data collection

Answer: C

Explanation:
Reviewing and analyzing physician query content on a regular basis assists in identifying gaps in skills and knowledge of the clinical documentation integrity practitioners (CDIPs) and the providers. By evaluating the quality, accuracy, appropriateness, and effectiveness of the queries, the CDIPs can identify areas of improvement, education, and feedback for themselves and the providers. Reviewing and analyzing physician query content can also help to ensure compliance with industry standards and best practices, as well as to monitor query outcomes and trends2 References: 1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 2: https://my.ahima.org/store/product?id=67077

NEW QUESTION 135

A 56-year-old male patient complains of feeling fatigued, has nausea & vomiting, swelling in both legs. Patient has history of chronic kidney disease (CKD) stage III, coronary artery disease (CAD) & hypertension (HTN). He is on Lisinopril. Vital signs: BP 160/80, P 84, R 20, T 100.0F. Labs: WBC 11.5 with 76% segs, GFR 45. CXR showed slight left lower lobe haziness. Patient was admitted for acute kidney injury (AKI) with acute tubular necrosis (ATN). He was scheduled for hemodialysis 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 138
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 141
A patient is admitted for chronic obstructive pulmonary disease (COPD) exacerbation. The patient is on 3L of home oxygen and is treated during admission with 3L of oxygen. The most appropriate action is to

A. query the provider to see if acute on chronic respiratory failure is supported by the health record
B. query the provider to see if chronic respiratory failure is supported by the health record
C. code the diagnoses of COPD exacerbation and chronic respiratory failure
D. query the provider to see if respiratory insufficiency is supported by the health record

Answer: A

Explanation:
According to the AHIMA/ACDIS Query Practice Brief, one of the scenarios that warrants a query is when there is clinical evidence of a higher degree of specificity or severity[1]. In this case, the patient??s COPD exacerbation and oxygen therapy may indicate a higher level of respiratory impairment than chronic respiratory failure alone. Therefore, a query to the provider to see if acute on chronic respiratory failure is supported by the health record is appropriate and compliant. Acute on chronic respiratory failure is a more specific and severe diagnosis that may affect the patient??s severity of illness, risk of mortality, and reimbursement[2]. The other options are not correct because they either assume a diagnosis without querying the provider, or query for a less specific or severe diagnosis than what the clinical indicators suggest. References:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA
? Q&A: Respiratory failure in a drug overdose | ACDIS

NEW QUESTION 143
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 Update[1]

NEW QUESTION 146
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[2]
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[2]
1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 2: https://my.ahima.org/store/product?id=67077

NEW QUESTION 147
What policies should query professionals follow?

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

Answer: C

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

NEW QUESTION 150
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