# Exam Questions CDIP

Certified Documentation Integrity Practitioner

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

**NEW QUESTION 1**
The facility has received a clinical validation denial for sepsis. The denial states sepsis is not a clinically valid diagnosis because it does not meet Sepsis-3 criteria. The facility has a policy stating it uses Sepsis-2 criteria. What is the BEST next step?

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

**Answer:** D

**NEW QUESTION 2**
A 90-year-old female patient was admitted to emergency room c/o nausea and vomiting x2 days. Vital signs: BP 130/72, P 86, R 22, T 99.8F, O2 sat 94% on room air. Patient has a history of cerebral vascular accident (CVA) and difficulty swallowing. CXR revealed right lower lobe infiltrate. Labs: WBC 12.0 with 71% segs. Physician documents patient with a history of CVA and difficulty swallowing. CXR revealed right lower lobe infiltrate, diagnosis: pneumonia. Aspiration precautions and IV Clindamycin ordered. Patient was discharged 3 days later with a diagnosis of pneumonia. Clarification is needed to determine which of the following is clinically indicated.

A. Simple pneumonia
B. Aspiration pneumonia
C. Pneumonia, a sequela of CVA
D. Complex pneumonia

**Answer:** B

**Explanation:**
Aspiration pneumonia is a type of pneumonia that occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs, causing an infection or inflammation. Aspiration pneumonia is more likely to occur in people who have difficulty swallowing, such as those with a history of CVA2. In this case, the patient has a history of CVA and difficulty swallowing, and presents with nausea and vomiting, which are risk factors for aspiration. The CXR reveals a right lower lobe infiltrate, which is a common finding in aspiration pneumonia3. The physician documents pneumonia as the diagnosis, but does not specify the type or cause. Therefore, clarification is needed to determine if aspiration pneumonia is clinically indicated, as it would affect the coding and reimbursement of the case. Aspiration pneumonia is coded as ICD-10-CM code J69.x Pneumonitis due to solids and liquids, with a fourth digit required to specify the inhaled substance4.
References:
? CDI Week 2020 Q&A: CDI and key performance indicators1
? Mayo Clinic: Aspiration pneumonia2
? Medscape: Aspiration Pneumonia3
? ICD-10-CM Diagnosis Code J69.x: Pneumonitis due to solids and liquids4

**NEW QUESTION 3**
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 4**
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 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 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 7**
Which of the following may make physicians lose respect for clinical documentation integrity (CDI) efforts and disengage?

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

**Answer:** A

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

**NEW QUESTION 8**
Which factors are important to include when refocusing the primary vision of a clinical documentation integrity (CDI) program?

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

**Answer:** B

**Explanation:**

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

**NEW QUESTION 9**
A clinical documentation integrity practitioner (CDIP) is looking for clarity on whether a diagnosis has been "ruled in" or "ruled out". Which type of query is the best option?

A. Yes/No
B. None
C. Open-ended
D. Multiple-choice

**Answer:** C

**Explanation:**
An open-ended query is a type of query that allows the provider to respond with free text, rather than choosing from a list of options or answering yes or no. An open-ended query is appropriate when the CDIP is looking for clarity on whether a diagnosis has been ??ruled in?? or ??ruled out??, because it allows the provider to document the final diagnosis or impression based on the clinical evidence and reasoning. An open-ended query also avoids leading or suggesting a specific diagnosis to the provider, which could compromise the integrity and validity of the documentation. (Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA1)
References:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA1

**NEW QUESTION 10**
A query should include

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

**Answer:** D

**Explanation:**
A query should include relevant clinical indicators from the health record that support the need for clarification and the query options. Clinical indicators are objective and measurable signs, symptoms, laboratory results, diagnostic test results, medications, treatments, and other documented findings that are related to a specific diagnosis or condition. Information from previous encounters, the impact on quality, and the impact of reimbursement are not appropriate to include in a query, as they may introduce bias, lead the provider, or imply a desired response.

**NEW QUESTION 10**
A patient is admitted due to pneumonia. On day 1, a sputum culture is positive for psuedomonas bacteria. If the physician is queried and agrees that the patient has pseudomonas pneumonia, this specificity would

A. meet medical necessity
B. increase relative weight
C. not increase relative weight
D. not meet medical necessity

**Answer:** B

**Explanation:**
The specificity of pseudomonas pneumonia would increase the relative weight of the diagnosis-related group (DRG) for the patient??s admission, which would affect the reimbursement for the hospital. Relative weight is a factor that reflects the average cost and resource use of a DRG compared to the average cost and resource use of all DRGs. The higher the relative weight, the higher the payment for the hospital. Pseudomonas pneumonia is classified as a major complication or comorbidity (MCC) in ICD-10-CM, which means that it significantly increases the severity of illness and risk of mortality of the patient. MCCs increase the relative weight of a DRG by assigning it to a higher-paying subclass within the same base DRG. For example, according to the CMS FY 2022 Inpatient Prospective Payment System Final Rule1, the relative weight for DRG 193 (Simple pneumonia and pleurisy with MCC) is 1.4819, while the relative weight for DRG 195 (Simple pneumonia and pleurisy without MCC) is 0.7579. Therefore, if the patient is admitted due to pneumonia and has pseudomonas pneumonia as an MCC, the hospital would receive a higher payment than if the patient does not have an MCC.
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? CMS FY 2022 Inpatient Prospective Payment System Final Rule1

**NEW QUESTION 14**
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 17**
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 21**
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 24**
Patient is admitted with oliguria, pulmonary edema, and dehydration. Labs are remarkable for an elevated creatinine of 2.4, with a baseline of 1.1. Patient was hydrated for 48 hours with drop in creatinine. What would the appropriate action be?

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

**Answer:** B

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

**NEW QUESTION 28**
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 30**
Which of the following may result in an incomplete health record deficiency being assigned to a provider?

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

**Answer:** D

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

**NEW QUESTION 34**
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 39**
What type of laboratory test is a creatinine test?

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

**Answer:** A

**NEW QUESTION 44**
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 47**
Which of the following diagnosis is MOST likely to trigger a second level review?

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

**Answer:** A

**Explanation:**
Malnutrition is a diagnosis that is most likely to trigger a second level review because it affects the severity of illness (SOI) and risk of mortality (ROM) of the patient, as well as the reimbursement and quality measures of the hospital. Malnutrition also requires clinical validation and clear documentation of its etiology, type, degree, and duration2 References: 1:
https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 2: https://my.ahima.org/store/product?id=67077

**NEW QUESTION 49**
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 52**
Combination codes are used to classify two diagnoses, a diagnosis with a manifestation, or a diagnosis

A. that is an integral part of a disease process
B. with an associated complication
C. with an associated procedure
D. with a sequelae or late effect

**Answer:** B

**Explanation:**
Combination codes are used to classify two diagnoses, a diagnosis with a manifestation, or a diagnosis with an associated complication. A complication is a condition that arises during the hospital stay that prolongs the length of stay by at least one day in approximately 75 percent of cases1. Complications may affect payment and severity of illness and risk of mortality classifications. Examples of combination codes that include a diagnosis with an associated complication are:
? I50.23 Acute on chronic systolic (congestive) heart failure
? K57.21 Diverticulitis of large intestine with perforation and abscess with bleeding
? O34.211 Maternal care for incompetent cervix with cerclage, first trimester A diagnosis that is an integral part of a disease process is not a valid option for combination codes, because it does not represent a separate or additional condition that needs to be coded. For example, chest pain is an integral part of acute myocardial infarction and does not require a separate code.
A diagnosis with an associated procedure is not a valid option for combination codes, because procedures are coded separately from diagnoses using ICD-10-PCS codes. For example, appendicitis with appendectomy is not a combination code, but rather two codes: one for the diagnosis (K35.80 Acute appendicitis without perforation or gangrene) and one for the procedure (0DTJ4ZZ Resection of appendix, percutaneous endoscopic approach). A diagnosis with a sequelae or late effect is not a valid option for combination codes, because sequelae or late effects are coded separately from the original condition using the appropriate code from category B90-B94 Sequelae of infectious and parasitic diseases or category I69 Sequelae of cerebrovascular disease, followed by the code for the specific condition2. For example, hemiplegia following cerebral infarction is not a combination code, but rather two codes: one for the sequelae (I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side) and one for the original condition (I63.9 Cerebral infarction, unspecified).
References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? ICD-10-CM Official Guidelines for Coding and Reporting FY 2022
? Identifying ICD-10 Combination Codes - Outsource Strategies International

**NEW QUESTION 54**
Besides the physician advisor/champion, who should be included as a key stakeholder in the clinical documentation integrity (CDI) steering committee to promote CDI initiatives?

A. Manager of Surgical Services
B. Director of Informatics
C. Manager of HIM/Coding
D. Director of Risk Management

**Answer:** C

**Explanation:**
The manager of HIM/Coding should be included as a key stakeholder in the clinical documentation integrity (CDI) steering committee to promote CDI initiatives because they are responsible for overseeing the coding and billing processes, ensuring compliance with coding guidelines and regulations, and collaborating with the CDI team to resolve coding and documentation discrepancies. The manager of HIM/Coding can also provide feedback on the CDI program??s impact on coding quality, accuracy, productivity, and reimbursement. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2

**NEW QUESTION 56**
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 58**
Which of the following is an example of a hospital-acquired condition when not present on admission?

A. Iatrogenic pneumothorax with lung biopsy
B. Iatrogenic pneumothorax with venous catheterization
C. Pressure ulcer stage II
D. Pressure ulcer stage III

**Answer:** D

**Explanation:**
A hospital-acquired condition (HAC) is an undesirable situation or condition that affects a patient and that arose during a stay in a hospital or medical facility. CMS has identified 14 categories of HACs for which it will not pay the higher DRG rate if the condition was not present on admission (POA). One of these categories is stage III and IV pressure ulcers. A pressure ulcer is damage to the skin and underlying tissue caused by prolonged pressure on the skin. Stage III pressure ulcers involve full-thickness skin loss with damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents as a deep crater with or without undermining of adjacent tissue.
* A. Iatrogenic pneumothorax with lung biopsy is not a HAC, because it is not included in the CMS HAC list. Iatrogenic pneumothorax is a HAC only when it occurs with venous catheterization.
* B. Iatrogenic pneumothorax with venous catheterization is a HAC, but it may be present on admission if the venous catheterization was performed before the admission to the hospital.
* C. Pressure ulcer stage II is not a HAC, because only stage III and IV pressure ulcers are included in the CMS HAC list. Stage II pressure ulcers involve partial-thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? Hospital Acquired Conditions | CMS
? ICD-10 HAC List | CMS
? Bedsores (pressure ulcers) - Symptoms and causes - Mayo Clinic

**NEW QUESTION 60**
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 65**
The correct coding for heart failure with preserved ejection fraction is

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

**Answer:** D

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

**NEW QUESTION 69**
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 71**
A clinical documentation integrity practitioner (CDIP) in an acute care hospital was asked to create new query templates for ICD-10 based on AHIMA and ACDIS guidelines. What should the multiple-choice query format include?

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

**Answer:** D

**NEW QUESTION 74**
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 78**
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 80**
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 85**
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 88**
While reviewing a chart, a clinical documentation integrity practitioner (CDIP) needs to access the general rules for the ICD-10-CM Includes Notes and Excludes Notes 1 and 2. Which coding reference should be used?

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

**Answer:** C

**Explanation:**
The coding reference that should be used to access the general rules for the ICD-10-CM Includes Notes and Excludes Notes 1 and 2 is the ICD-10-CM Official Guidelines for Coding and Reporting. This document provides the conventions and instructions for the proper use of the ICD-10-CM classification system, including the definitions and examples of the Includes Notes and Excludes Notes 1 and 2. The document is updated annually by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), and is available online at 2. The other coding references listed are not specific to ICD-10-CM or do not contain the general rules for the Includes Notes and Excludes Notes 1 and 2.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 4

**NEW QUESTION 92**
A hospital administrator has hired a clinical documentation integrity (CDI) firm to improve its revenue objectives. The physicians object to this action. How should the firm collaborate with physicians to overcome their objections?

A. Create a vision statement that outlines the project objectives
B. Communicate the benefits of the CDI firm about the project
C. Hire a consultant to communicate the benefits to the physicians
D. Identify an influential physician advisor/champion to promote support

**Answer:** D

**Explanation:**
A physician advisor/champion is a physician leader who supports and advocates for the CDI program and its objectives. A physician advisor/champion can help overcome the objections of other physicians by providing education, feedback, guidance, and mentorship on documentation best practices and their impact on revenue, quality, and patient care. A physician advisor/champion can also act as a liaison between the CDI firm and the medical staff, resolve conflicts or discrepancies in documentation, and foster a culture of collaboration and improvement. Physicians are more likely to trust and engage with their peers who understand their clinical perspective and challenges, rather than an external CDI firm that may be perceived as intrusive or disruptive.
* A. Create a vision statement that outlines the project objectives. This is not sufficient to collaborate with physicians and overcome their objections. A vision statement is a general statement that describes the desired outcome of the project, but it does not address the specific concerns or questions that physicians may have about the CDI firm??s role, methods, or benefits.
* B. Communicate the benefits of the CDI firm about the project. This is not enough to collaborate with physicians and overcome their objections. Communicating the benefits of the CDI firm may be informative, but it may not be persuasive or credible if it comes from the CDI firm itself, without any endorsement or support from a physician leader within the organization.
* C. Hire a consultant to communicate the benefits to the physicians. This is not a good way to collaborate with physicians and overcome their objections. Hiring a consultant may add another layer of complexity and cost to the project, and it may not improve the trust or relationship between the CDI firm and the physicians. A consultant may also lack the clinical expertise or authority to influence the physicians?? behavior or attitude. References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? Q&A: Defining roles for physician advisor/champion | ACDIS
? Q&A: The Role of the Physician Advisor in CDI | ACDIS
? The Role of a Physician Advisor - UASI Solutions
? PA/NP in Physician Champion / Advisor Role — ACDIS Forums

**NEW QUESTION 96**
A patient presents to the emergency room with acute shortness of breath. The patient has a history of lung cancer that has been treated previously with radiation and chemotherapy. The patient is intubated and placed on mechanical ventilation. A chest x-ray is remarkable for a pleural effusion. A thoracentesis is performed, and the cytology results show malignant cells. Diagnoses on discharge: Acute respiratory failure due to recurrence of small cell carcinoma and malignant pleural effusion. Which coding reference takes precedence for assigning the ICD-10-CM/PCS codes?

A. Conventions and instructions of the classification for ICD-10-CM/PCS
B. AMA CPT Assistant
C. AHA Coding Clinic for ICD-10-CM/PCS
D. ICD-10-CM Official Guidelines for Coding and Reporting

**Answer:** A

**Explanation:**
According to the CDIP® Exam Content Outline, one of the tasks of a clinical documentation integrity practitioner (CDIP) is to apply coding conventions, guidelines, and definitions for ICD-10-CM/PCS. Coding conventions are the general rules for the use of the classification system, such as the use of abbreviations, punctuation, symbols, and sequencing instructions. Coding guidelines are the official rules for selecting and reporting codes based on the documentation in the health record. Coding definitions are the explanations of the terms and concepts used in the classification system. The conventions and instructions of the classification for ICD-10-CM/PCS take precedence over any other coding reference because they are the primary source of coding rules and standards. The other coding references, such as AMA CPT Assistant, AHA Coding Clinic for ICD-10-CM/PCS, and ICD- 10-CM Official Guidelines for Coding and Reporting, are secondary sources that provide additional guidance, clarification, or interpretation of the coding conventions and instructions.
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 100**
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 103**
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 106**
Which of the following falls under the False Claims Act?

A. Missing charges
B. Unbundling services
C. Missing modifiers
D. Missing diagnosis codes

**Answer:** B

**Explanation:**
Unbundling services falls under the False Claims Act because it is a form of coding fraud that involves billing separately for components of a related group of procedures or tests that should be billed as a single code. For example, if a provider performs a comprehensive metabolic panel, which is a blood test that measures several components of the blood, such as glucose, electrolytes, and liver enzymes, and bills for each component individually instead of using the single code for the panel, that is unbundling. Unbundling services can result in overpayment by the government and can violate the False Claims Act, which prohibits submitting false or fraudulent claims for payment to the government, including the Medicare and Medicaid programs. Violators of the False Claims Act can face civil penalties of up to three times the amount of the false claim plus an additional $11,000 per claim 23. References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: Coding Fraud | VSG 5 3: False Claims Act | OIG 2

**NEW QUESTION 110**
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 114**
A patient was admitted for high fever and pain in umbilical region. During the second day of the hospital stay, the patient stood up to use the restroom and fell on the floor, resulting in a broken chin bone. A physician noted the fall on the second day in progress note. Which further clarification should be done regarding present on admission (POA) indicator of fall?

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

**Answer:** B

**Explanation:**
A query should be generated to ask the physician for the POA indicator of the fall because the documentation is unclear whether the fall was present at the time of inpatient admission or not. The POA indicator is used to identify conditions that are present or not present at the time of admission, and has payment implications for certain hospital-acquired conditions (HACs). According to CMS, a fall resulting in trauma is one of the HACs that will not be paid at a higher rate if it is not present on admission. Therefore, it is important to clarify the POA indicator of the fall to ensure accurate coding and reimbursement. A query should be non-leading, concise, clear, relevant, and consistent with CDI standards and guidelines.
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? Coding | CMS1
? Present on Admission Indicators - Novitas Solutions2

**NEW QUESTION 119**
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 121**
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 123**
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 127**
Which of the following should an organization consider when developing a query retention policy and procedure?

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

**Answer:** A

**Explanation:**
One of the factors that an organization should consider when developing a query retention policy and procedure is if the query is considered part of the health record or not. According to the AHIMA/ACDIS query practice brief1, a query is considered part of the health record if
it meets any of the following criteria:
? It is used to clarify documentation that affects code assignment or other data elements
? It is used to support clinical validation of a diagnosis or procedure
? It is used to support medical necessity or quality indicators
? It is used to communicate clinical information between providers If a query is part of the health record, it should be retained according to the organization??s health record retention policy and procedure, which should comply with federal, state, and local laws and regulations. The query retention policy and procedure should also address issues such as:
? The format and location of the query (e.g., paper, electronic, hybrid)
? The security and confidentiality of the query
? The accessibility and availability of the query
? The ownership and custodianship of the query
? The legal implications and evidentiary value of the query
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? Guidelines for Achieving a Compliant Query Practice—2022 Update1

**NEW QUESTION 129**
The clinical documentation integrity (CDI) team in a hospital is initiating a project to change the unacceptable documentation behaviors of some physicians. What strategy should be part of a project aimed at improving these behaviors?

A. Expand use of coding queries by CDI team
B. Add a physician advisor/champion to the CDI team
C. Encourage physician-nurse cooperation
D. Alter the physician documentation requirements

**Answer:** B

**Explanation:**
A strategy that should be part of a project aimed at improving the unacceptable documentation behaviors of some physicians is to add a physician advisor/champion to the CDI team. A physician advisor/champion is a physician leader who supports and advocates for the CDI program, educates and mentors other physicians on documentation best practices, resolves conflicts and barriers, and provides feedback and recognition to physicians who improve their documentation. A physician advisor/champion can help change the documentation behaviors of some physicians by using peer influence, credibility, and authority to motivate them to comply with the CDI program goals and standards. A physician advisor/champion can also help bridge the gap between the CDI team and the physicians, and foster a culture of collaboration and quality improvement 23.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 136 4 2: The Role of Physician Advisors in Clinical Documentation Improvement Programs 5 3:

Physician Advisor: The
Key to Clinical Documentation Improvement Success

**NEW QUESTION 134**
Which of the following clinical documentation integrity (CDI) dashboard metrics is frequently used to help evaluate the credibility of CDI practitioner queries and the success of the CDI program?

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

**Answer:** D

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

**NEW QUESTION 137**
When are concurrent queries initiated?

A. After the health record has been coded
B. After discharge of the patient
C. While the patient is hospitalized
D. Before patient is admitted

**Answer:** C

**NEW QUESTION 139**
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 141**
A query should be generated when the documentation is

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

**Answer:** D

**Explanation:**
A query should be generated when the documentation is conflicting, meaning that there is contradictory or inconsistent information in the medical record that may affect the accuracy of coding, quality reporting, or reimbursement. For example, if the documentation in the progress notes differs from the documentation in the discharge summary, or if different providers document different diagnoses or procedures for the same patient, a query may be needed to resolve the discrepancy and obtain clarification from the source of the documentation. A query should not be generated when the documentation is legible, consistent, or complete, as these are desirable characteristics of documentation that do not require further clarification or verification.
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? Accurate Documentation is Essential – Knowing When to Query your Providers1

**NEW QUESTION 143**

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 148**
A hospital clinical documentation integrity (CDI) director suspects physicians are over-using electronic copy and paste in patient records, a practice that increases the risk of fraudulent insurance billings. A documentation integrity project may be needed. What is the first step the CDI director should take?

A. Recommend the physicians to be involved in the project
B. Bring together a team of physicians and informatics specialists
C. Alert senior leadership to the record documentation problem
D. Gather data on the incidence of inaccurate record documentation

**Answer:** D

**Explanation:**
The first step the CDI director should take is to gather data on the incidence of inaccurate record documentation because it is important to establish the baseline and scope of the problem, as well as to identify the potential causes and consequences of over-using electronic copy and paste. Data collection can help to measure the frequency, severity, and impact of documentation errors, such as inconsistencies, redundancies, contradictions, or omissions. Data collection can also help to determine the best methods and tools for conducting the documentation integrity project, such as audits, surveys, interviews, or software applications. (CDIP Exam Preparation Guide1)
References:
? CDIP Exam Content Outline2
? CDIP Exam Preparation Guide1

**NEW QUESTION 150**
When a change in departmental workflow is necessary, the first step is to

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

**Answer:** D

**Explanation:**
The first step in changing a departmental workflow is to assess the current workflow and identify the problems or inefficiencies that need to be addressed. This will help to define the gaps and solutions, set realistic timelines, and re-engineer the process.
References: AHIMA. ??CDIP Exam Preparation.?? AHIMA Press, Chicago, IL, 2017: 125- 126.

**NEW QUESTION 151**
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 156**
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 159**
A physician documented the specific site of the malignancy in the medical record documentation; however, the coder is unable to locate a specific entry in the ICD-10-CM Alphabetical Index to match the specified diagnosis. Which abbreviation used in the Alphabetical Index will assist the coder in assigning the appropriate diagnosis code for the specified condition?

A. DRG
B. OCE
C. NOS
D. NEC

**Answer:** D

**Explanation:**
The abbreviation NEC stands for ??not elsewhere classified?? and is used in the ICD-10-CM Alphabetical Index when a specific code is not available for a condition. The coder should use the NEC notation to locate the closest existing code that matches the documented diagnosis. For example, if the physician documented a malignant neoplasm of the left upper eyelid, but the Alphabetical Index only has an entry for malignant neoplasm of eyelid NEC, then the coder should use the code C44.10 (Unspecified malignant neoplasm of unspecified eyelid, including canthus) and assign a seventh character to specify laterality. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? ICD-10-CM Official Guidelines for Coding and Reporting FY 20213

**NEW QUESTION 162**
A 56-year-old male patient complains of feeling fatigued, has nausea & vomiting, swelling in both legs. Patient has history of chronic kidney disease (CKD) stage III, coronary artery disease (CAD) & hypertension (HTN). He is on Lisinopril. Vital signs: BP 160/80, P 84, R 20, T 100.OF. Labs: WBC 11.5 with 76% segs, GFR 45. CXR showed slight left lower lobe haziness. Patient was admitted for acute kidney injury (AKI) with acute tubular necrosis (ATN). He was scheduled for hemodialysis thenext day. Two days after admission patient started coughing, fever of 101.8F, CXR showed left lower lobe infiltrate, possible pneumonia. Attending physician documented that patient has pneumonia and ordered Rocephin IV. How should the clinical documentation integrity practitioner (CDIP) interact with the physician to clarify whether or not the pneumonia is a hospital-acquired condition (HAC)?

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

**Answer:** D

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

**NEW QUESTION 167**
The third quarter target concurrent physician query response rate for each physician in a hospital gastroenterology department was 80%. Nine physicians met or

exceeded this metric; however, two physicians had third quarter concurrent physician query response rates of 19% and 64%. What is the best course of action for the clinical documentation integrity (CDI) physician advisor/champion?

A. Schedule a group meeting with all physicians
B. Schedule individual meetings with each physician
C. Schedule individual meetings with each low-performing physician
D. Schedule a meeting with the chair of the gastroenterology department

**Answer:** C

**Explanation:**
According to the ACDIS Practice Brief, a query escalation policy should describe how to handle situations in which an answer is not received, an inappropriate answer or comment is provided, etc. The escalation policy should address when the issue is brought to the physician advisor, the department director, or administration with defined actions as to the responsibilities at each level. The policies should reflect a method of response that can realistically occur for the organization1. In this case, since two physicians have significantly lower query response rates than the target, the CDI physician advisor/champion should schedule individual meetings with each low-performing physician to provide feedback, education, and support. A group meeting with all physicians may not be effective or efficient, as it may not address the specific barriers or challenges faced by the low-performing physicians. A meeting with the chair of the gastroenterology department may be helpful, but it may not be sufficient to resolve the issue without direct communication with the low-performing physicians.
References:
? CDI Week 2020 Q&A: CDI and key performance indicators1

**NEW QUESTION 168**
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 severity1. 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 reimbursement2. 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 173**
A 70-year-old severely malnourished nursing home patient is admitted for a pressure ulcer covered by eschar on the right hip. The provider is queried to clarify the stage of the pressure ulcer. Because the wound has not been debrided, the provider responds "unable to determine". How will the stage of this pressure ulcer be coded?

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

**Answer:** C

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

**NEW QUESTION 175**
A patient was admitted with complaints of confusion, weakness, and slurred speech. A CT of the head and MRI were performed and resulted in normal findings. Daily aspirin was administered and a speech therapy evaluation was conducted. The final diagnosis on discharge was transient ischemic attack, and cerebrovascular disease
was ruled out. What is the correct diagnostic related group assignment?

A. 093 Other Disorders of Nervous System without CC/MCC
B. 948 Signs and Symptoms without MCC
C. 069 Transient Ischemia
D. 066 Intracranial Hemorrhage or Cerebral Infarction without CC/MCC

**Answer:** C

**Explanation:**
Transient ischemic attack (TIA) is a neurological event with the signs and symptoms of a stroke, but which go away within a short period of time. TIA is assigned to DRG 069, which is a medical DRG. Cerebrovascular disease was ruled out, so it cannot be coded as a secondary diagnosis. The other options are incorrect because they do not reflect the principal diagnosis of TIA.

**NEW QUESTION 178**
A clinical documentation integrity practitioner (CDIP) hired by an internal medicine clinic is creating policies governing written queries. What is an AHIMA best practice for these policies?

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

**Answer:** A

**Explanation:**
According to the AHIMA best practice for written queries, queries should be limited to non- leading questions that do not imply a specific answer or diagnosis, but rather ask for the provider??s opinion based on their clinical judgment and the evidence in the health record. Non-leading questions help to ensure that the query is compliant, objective, and respectful of the provider??s authority and autonomy. Leading questions, on the other hand, may introduce bias, influence the provider??s response, or compromise the integrity of the documentation and coding. For example, a non-leading query for a patient with chest pain would be: ??What is the etiology of the chest pain??? A leading query would be: ??Is the chest pain due to acute myocardial infarction???
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? Guidelines for Achieving a Compliant Query Practice—2022 Update1

**NEW QUESTION 181**
Which of the following is nonessential to facilitate code capture when educating clinical staff on documentation practices associated with diabetes mellitus?

A. Type
B. Manifestation
C. Cause
D. Age

**Answer:** D

**NEW QUESTION 185**
AHIMA suggests which of the following for an organization to consider as physician response rate and agreement rate?

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

**Answer:** B

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

**NEW QUESTION 190**
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 191**
Which of the following is an appropriate first step to address physicians with low query response rates?

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

**Answer:**

A

**Explanation:**
An appropriate first step to address physicians with low query response rates is an educational session between the clinical documentation integrity practitioner (CDIP) and physician because it provides an opportunity to explain the purpose and benefits of the query process, to identify and address any barriers or challenges to responding, and to offer feedback and guidance on how to improve query response rates. An educational session can also help to build rapport and trust between the CDIP and the physician, and to demonstrate respect and professionalism. (CDIP Exam Preparation Guide) References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? Understanding CDI Metrics3

**NEW QUESTION 196**
A clinical documentation integrity practitioner (CDIP) is reviewing an outpatient surgical chart. The patient underwent a laparoscopic appendectomy for acute gangrenous appendicitis. Which coding reference should be used for coding advice on correct assignment of the procedure code for proper ambulatory payment classification (APC) reimbursement?

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

**Answer:** C

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

**NEW QUESTION 201**
.....

# THANKS FOR TRYING THE DEMO OF OUR PRODUCT

Visit Our Site to Purchase the Full Set of Actual CDIP Exam Questions With Answers.

We Also Provide Practice Exam Software That Simulates Real Exam Environment And Has Many Self-Assessment Features. Order the CDIP Product From:

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

## Money Back Guarantee

### CDIP Practice Exam Features:

* CDIP Questions and Answers Updated Frequently

* CDIP Practice Questions Verified by Expert Senior Certified Staff

* CDIP Most Realistic Questions that Guarantee you a Pass on Your FirstTry

* CDIP Practice Test Questions in Multiple Choice Formats and Updatesfor 1 Year