AHIMA

Exam Questions CDIP

Certified Documentation Integrity Practitioner

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

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

Answer: D

NEW QUESTION 2
Which of the following organizations should a clinical documentation integrity practitioner (CDIP) monitor?

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

Answer: C

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

NEW QUESTION 3
A pressure ulcer stage III is documented in the progress note. The clinical documentation integrity practitioner (CDIP) has queried the attending regarding the present on admission status of the pressure ulcer but has not received a response in an appropriate
time frame. What should the CDIP do next?

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

Answer: A

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

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

Diagnoses:
* 1. Primary osteoarthritis of right hip status post uncomplicated total hip replacement
* 2. Aspiration pneumonia due to choking on liquid episode
What is the correct diagnostic related group assignment?

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

Answer: B

Explanation:
The correct diagnostic related group (DRG) assignment for this case is 469 Major Joint Replacement or Reattachment of Lower Extremity with MCC. This is because the principal diagnosis is primary osteoarthritis of right hip status post uncomplicated total hip replacement, which belongs to the Major Diagnostic Category (MDC) 08 Diseases and Disorders of the Musculoskeletal System and Connective Tissue. The DRG 469 is assigned to cases with this MDC and a surgical procedure code for major joint replacement or reattachment of lower extremity. The secondary diagnosis of aspiration pneumonia due to choking on liquid episode qualifies as a major complication or comorbidity (MCC), which increases the relative weight and payment for the DRG. The MCC is determined by applying the Medicare Code Editor (MCE) software, which checks the validity and compatibility of the diagnosis codes and assigns them to different severity levels based on the CMS Severity-Diagnosis Related Group (MS-DRG) definitions manual 2.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: CMS MS-DRG Definitions Manual, Version 38.0, p. 8-9 4

NEW QUESTION 6
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 7
The BEST place for the provider to document a query response is which of the following?

A. The query form
B. The next progress note and the problem list
C. The next progress note and all subsequent notes including the discharge summary
D. An addendum to the history and physical

Answer: B

Explanation:
The best place for the provider to document a query response is the next progress note and the problem list because this ensures that the query response is timely, consistent, and integrated into the health record. According to the AHIMA/ACDIS query practice brief1, the provider should document the query response in the health record as soon as possible after receiving the query, preferably in the next progress note. The provider should also update the problem list to reflect any new or revised diagnoses resulting from the query response. This helps to maintain an accurate and comprehensive list of the patient??s current and chronic conditions, which can facilitate continuity of care, quality reporting, and reimbursement. Documenting the query response in an addendum to the history and physical or only on the query form is not sufficient, as it may not capture the current status of the patient or be easily accessible to other providers or coders.
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 8
A 94-year-old female patient is admitted with altered mental status and inability to move the left side of her body. She is diagnosed with a cerebral vascular accident with left sided weakness. The patient is ambidextrous, but the physician does not specify the predominance of the affected side. The default code is

A. ambidextrous
B. non-dominant
C. preferred
D. dominant

Answer: B

Explanation:
According to the ICD-10-CM Official Guidelines for Coding and Reporting, when the affected side is not documented for a condition that is commonly associated with hemiplegia or hemiparesis, such as a cerebral vascular accident, the default code is the non-dominant side. The non-dominant side is usually the left side for right-handed individuals and the right side for left-handed individuals. However, if the patient is ambidextrous, the default code is still the non-dominant side, unless the provider indicates otherwise. Therefore, in this case, the default code for cerebral vascular accident with left sided weakness is I63.532 Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery1.
References:

? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? ICD-10 Code for Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery- I63.532- AAPC Coder1
? ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

NEW QUESTION 9
Review the following query to determine if it is compliant:
Dr. Jones, this patient had a sodium level of 126 on admission and was started on a 0.9% saline IV. Can you indicate what condition is being treated?
Dehydration Hyponatremia Hypernatremia
Chronic kidney disease (indicate stage) Other (please specify)

A. Yes, query is compliant as it offers the minimum number of multiple-choice answers ..
B. No, query is noncompliant as it does not provide the option of "unable to determine".
C. No, query is noncompliant as one of the multiple-choice options is clinically irrelevant.
D. Yes, query is compliant as it provides clinical indicators and several options for response.

Answer: C

Explanation:
A query is noncompliant if it includes options that are not supported by the clinical indicators or the patient??s condition. In this case, hypernatremia is a condition of high sodium level, not low sodium level, and it is not consistent with the treatment of 0.9% saline IV. Therefore, it is a clinically irrelevant option that may confuse or mislead the provider. A compliant query should only include options that are reasonable and plausible based on the available documentation and evidence. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? AHIMA Practice Brief: Guidelines for Achieving a Compliant Query Practice3

NEW QUESTION 10
Which of the following individuals should the clinical documentation integrity (CDI) manager consult when developing query policy and procedures?

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

Answer: A

Explanation:
The clinical documentation integrity (CDI) manager should consult the Chief Medical Officer when developing query policy and procedures because the Chief Medical Officer is responsible for overseeing the quality and safety of patient care, ensuring compliance with regulatory and accreditation standards, and providing leadership and guidance to the medical staff. The Chief Medical Officer can help to establish the goals, scope, and authority of the CDI program, as well as to support the query process and promote provider education and engagement. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2

NEW QUESTION 10
Collaboration between the physician advisor/champion and the clinical documentation integrity practitioners (CDIPs) would likely include

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

Answer: C

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

NEW QUESTION 11
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 14
Which of these medical conditions would a clinical documentation integrity practitioner (CDIP) expect to be treated with Levophed?

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

Answer: A

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

NEW QUESTION 18
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 20
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 25
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 27
A modifier may be used in CPT and/or HCPCS codes to indicate

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

Answer: A

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

NEW QUESTION 29
A clinical documentation integrity practitioner (CDIP) has been successful in getting physicians to respond to queries. However, when the CDIP poses a query to a specific doctor, there is no response at all. The CDIP has tried face-to-face conversations, calling, emails, texts, but still gets no response. What is the next step the CDIP should take?

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

Answer: A

Explanation:
According to the Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA1, a query escalation policy should describe how to handle situations in which an answer is not received, an inappropriate answer or comment is provided, etc. The escalation policy should address when the issue is brought to the physician advisor, the department director, or administration with defined actions as to the responsibilities at each level. The policies should reflect a method of response that can realistically occur for the organization1. In this case, since the CDIP has tried multiple methods of communication
with the doctor but still gets no response, the CDIP should elevate the issue to the physician advisor/champion, who can facilitate communication and education with the doctor and ensure documentation integrity and compliance1. However, before escalating the issue, the CDIP should consult with the CDI supervisor to review the case and confirm that the query is appropriate, relevant, and compliant with the query guidelines1. This would ensure that the escalation is justified and not based on personal bias or preference. The other options are not advisable because they either involve skipping the escalation policy, reporting the doctor without proper review or feedback, holding a meeting without involving the physician advisor/champion, or giving up on querying altogether. References:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA1

NEW QUESTION 32
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

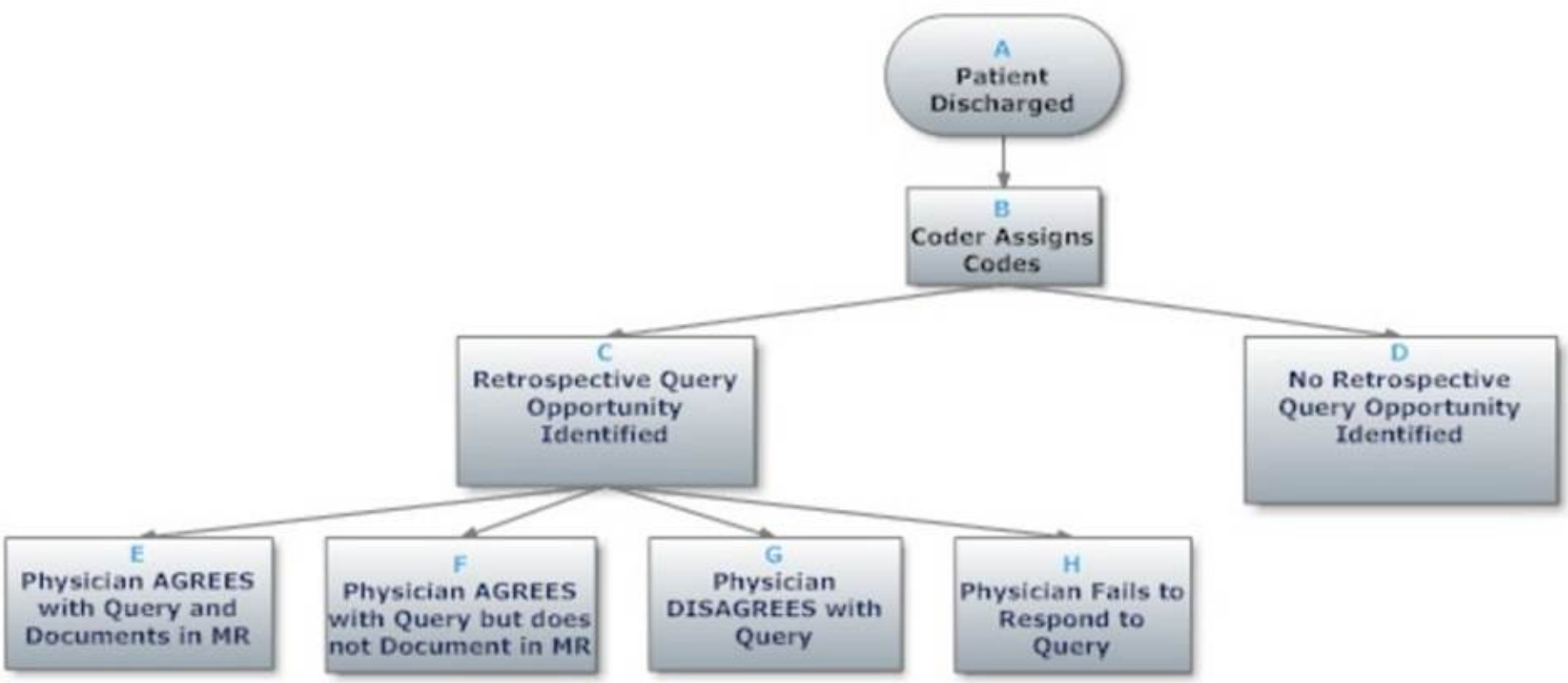
NEW QUESTION 35
Which of the following is MOST likely to trigger a second-level review?

A. A procedure code that increases reimbursement
B. A diagnosis that impacts a quality-of-care measure
C. An account coded before the discharge summary is available
D. A record with multiple major complicating conditions (MCCs)

Answer: D

Explanation:
According to the AHIMA CDIP Exam Preparation Guide, a second-level review is a process that involves a review of coded records by a designated person or team to ensure the accuracy and completeness of coding and documentation1. A second-level review may be triggered by various factors, such as high-risk or high-dollar accounts, coding quality indicators, payer requirements, or internal audit findings1. One of the factors that is most likely to trigger a second-level review is a record with multiple major complicating
conditions (MCCs)2. MCCs are diagnoses that significantly affect the severity of illness and resource utilization of a patient, and are assigned a higher relative weight in the DRG system3. A record with multiple MCCs may indicate a complex or unusual case that requires additional validation and verification of the coding and documentation. A record with multiple MCCs may also affect the reimbursement, risk adjustment, and quality scores of the hospital, and therefore may be subject to external scrutiny or audit4. The other options are not as likely to trigger a second-level review, as they are not as indicative of coding or documentation issues or risks. A procedure code that increases reimbursement may not necessarily require a second-level review, unless it is inconsistent with the documentation or the clinical indicators. A diagnosis that impacts a quality-of-care measure may be relevant for CDI purposes, but not necessarily for coding validation. An account coded before the discharge summary is available may be incomplete or inaccurate, but it may also be corrected or updated before final billing.
References:
? CDIP Exam Preparation Guide - AHIMA
? Building a Resilient CDI: Second Level Review
? Major Complications or Comorbidities (MCC) & Complications or Comorbidities (CC) | CMS
? Demystifying and communicating case-mix index - ACDIS

NEW QUESTION 36
Based on the flowchart below, at what point might the clinical documentation integrity practitioner (CDIP) enlist the help of the physician advisor/champion?



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

Answer: B

NEW QUESTION 41
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 43
A hospital noticed a 30% denial rate in Medicare claims due to lack of clinical documentation, placing the hospital at risk of multiple Medicare violations. What step should the clinical documentation integrity (CDI) manager take to help avoid future Medicare violations?
? Collaborate with physician advisor/champion and revenue cycle manager
? Instruct the billing department to write off claims with insufficient documentation
A. Assign pre-billing claim review duties to physicians
B. Prevent submission of claims for improper documentation

Answer: A

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

NEW QUESTION 44
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 46
An 80-year-old male is admitted as an inpatient to the ICU with shortness of breath, productive yellow sputum, and a temperature of 101.2. CXR reveals bilateral pleural effusion and LLL pneumonia. Labs reveal a BUN of 42 and a creatinine level of 1.500.
The patient is given Zithromax 500 mg. IV, NS IV, and Lasix 40 mg tabs 2x/day. The attending physician documents bilateral pleural effusion, LLL pneumonia, and kidney failure. Two days later, the renal consult documents AKI with acute tubular necrosis (ATN). The correct principal and secondary diagnoses are

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

Answer: C

Explanation:

According to the ICD-10-CM Official Guidelines for Coding and Reporting FY 2023, the principal diagnosis is defined as "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care"2. In this case, the patient was admitted with shortness of breath, productive yellow sputum, and a temperature of 101.2, which are signs and symptoms of pneumonia. The CXR confirmed the diagnosis of LLL pneumonia, which is a serious condition that requires inpatient care. Therefore, LLL pneumonia is the principal diagnosis.
The secondary diagnoses are defined as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay"2. In this case, the patient had bilateral pleural effusion and kidney failure at the time of admission, which are coexisting conditions that affect the treatment received and/or the length of stay. The renal consult documented AKI with ATN, which is a more specific diagnosis than kidney failure and reflects the severity and etiology of the condition. Therefore, AKI with ATN and bilateral pleural effusion are secondary diagnoses. References:
? CDI Week 2020 Q&A: CDI and key performance indicators1
? ICD-10-CM Official Guidelines for Coding and Reporting FY 20232

NEW QUESTION 47
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 51
Hospital-acquired condition pay provisions apply only to

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

Answer: A

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

NEW QUESTION 53
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 56
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 60
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 64
When benchmarking with outside organizations, the clinical documentation integrity practitioner (CDIP) must determine if the organization is benchmarking with which
of the following criteria?

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

Answer: B

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

NEW QUESTION 66
Whether or not queries should be kept as a permanent part of the medical record is decided by

A. physician preference
B. state law
C. federal law
D. organizational policy

Answer: D

Explanation:
According to the AHIMA/ACDIS Query Practice Brief, whether or not queries should be kept as a permanent part of the medical record is decided by the organizational policy of each facility1. There is no federal or state law that mandates the retention of queries in the medical record, although some external reviewers may request copies of queries to validate the query wording and compliance2. Physician preference is not a valid factor in determining the query

retention policy, as queries should be handled consistently across the organization3. Therefore, the correct answer is D. organizational policy. References:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA
? Q&A: Develop policies regarding query retention | ACDIS
? Q&A: Keep query retention policies consistent | ACDIS

NEW QUESTION 68
What type of query may NOT be used in circumstances where only clinical indicators of a condition are present, and the condition/diagnosis has not been documented in the health record?

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

Answer: D

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

NEW QUESTION 71
A clinical documentation integrity practitioner (CDIP) identified the need to correct a resident physician's note in a patient health record that wrongly identified the organism causing the patient's pneumonia. What is best practice for fixing this mistake according to AHIMA?

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

Answer: B

Explanation:
According to AHIMA, best practice for fixing a mistake in a patient health record is that errors are corrected by the clinician who authored the documentation1. The clinician who made the error should identify and correct the inaccurate information, and document the date, time, and reason for the correction1. The correction should also be made in a way that preserves the original content and does not obscure or delete it1. The other options are not correct according to AHIMA. Any physician caring for the patient cannot correct inaccurate record notes, as this may compromise the accountability and integrity of the documentation2. Amendments to record content do not need to be co-signed by the attending physician, unless required by organizational policy or state law3. Coders cannot rely on the laboratory results to confirm the patient??s diagnosis, as they should code based on the physician??s documentation and not on test results alone.
References:
? Making Corrections in the Electronic Health Record - AHIMA
? Auditing Copy and Paste - AHIMA
? Amendments, Corrections, and Deletions in Transcribed Reports Toolkit - AHIMA
? [Coding from Test Results | Journal Of AHIMA]

NEW QUESTION 72
When queries are part of the health record, which of the following physician privilege could be suspended if the provider receives too many deficiencies due to incomplete records for failure to respond to queries?

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

Answer: A

Explanation:
When queries are part of the health record, which is recommended by AHIMA and ACDIS, physicians are responsible for responding to queries in a timely manner and ensuring that their documentation is complete and accurate. If a provider receives too many deficiencies due to incomplete records for failure to respond to queries, their admitting privilege could be suspended by the medical staff committee as a disciplinary action.
References: AHIMA/ACDIS. ??Guidelines for Achieving a Compliant Query Practice (2019 Update).?? Journal of AHIMA 90, no. 2 (February 2019): 20-29.

NEW QUESTION 75
Educating physicians on severity of illness and risk of mortality is best accomplished by utilizing

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

Answer: C

Explanation:

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

NEW QUESTION 77
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 80
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 84
The clinical documentation integrity (CDI) metrics recently showed a drastic drop in the physician query rate. What might this indicate to the CDI manager?

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

Answer: C

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

NEW QUESTION 89
Given the following ICD-10-CM Alphabetical Index entry: Ectopic (pregnancy) 008.9
What is the meaning of the parenthesis?

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

Answer: B

NEW QUESTION 93
A patient receives a blood transfusion after a 400 ml blood loss during surgery. The clinical documentation integrity practitioner (CDIP) queries the physician for an associated diagnosis. The facility does not maintain queries as part of the permanent health record. What does the physician need to document for the CDIP to record the
query as answered and agreed?

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

Answer: B

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

NEW QUESTION 95
In order to best demonstrate the impact of clinical documentation on severity of illness and risk of mortality, which of the following examples is the most effective for physicians in a hospital?

A. The latest Medicare Provider and Analysis Review data
B. Emphasize the Medicare requirements for documentation
C. Examples from the hospital's actual cases
D. Explanations on how severity of illness and risk of mortality impact reimbursement

Answer: C

Explanation:
In order to best demonstrate the impact of clinical documentation on severity of illness and risk of mortality, examples from the hospital??s actual cases are the most effective for physicians in a hospital. Examples from the hospital??s actual cases can show how specific documentation elements, such as diagnoses, procedures, complications, comorbidities, and present on admission indicators, can affect the severity of illness and risk of mortality scores of the patients, as well as the hospital??s performance and reputation. Examples from
the hospital??s actual cases can also provide feedback and education to the physicians on how to improve their documentation practices and standards.
References: : https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf : https://my.ahima.org/store/product?id=67077

NEW QUESTION 96
An organization dealing with staffing shortages has adopted a policy requiring clinical documentation integrity practitioner (CDIP) to stop reviewing any record after a major complication or co-morbidity is found. What is the unintended consequence of this?

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

Answer: D

Explanation:
Severity of illness (SOI) and risk of mortality (ROM) are two metrics that measure the complexity and acuity of a patient??s condition, based on the number, nature, and interaction of complications and comorbidities (CCs) and major CCs (MCCs). SOI reflects the extent of physiologic decompensation or organ system loss of function, while ROM reflects the likelihood of dying. Both SOI and ROM are divided into four levels: minor, moderate, major, or extreme. These metrics are used to adjust payment rates, quality indicators, and performance measures for hospitals and other healthcare providers.
If a CDIP stops reviewing any record after a major CC is found, they may miss other CCs or MCCs that could affect the patient??s SOI and ROM levels. For example, a patient with pneumonia and sepsis would have a major CC (pneumonia) and an MCC (sepsis). If the CDIP stops reviewing the record after finding pneumonia, they would not capture sepsis, which would increase the patient??s SOI and ROM levels from major to extreme. This would result in underreporting the patient??s true complexity and acuity, and potentially lead to lower reimbursement, lower quality scores, and higher denial risk.
Therefore, the unintended consequence of this policy is a decrease in SOI and ROM levels for patients who have more than one CC or MCC.
References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? Q&A: Understanding SOI and ROM in the APR-DRG system
? 3M™ All Patient Refined Diagnosis Related Groups (APR DRGs)
? Severity of illness | definition of severity of illness by Medical dictionary
? Using Severity Adjustment Classification for Hospital Internal and External Comparisons

NEW QUESTION 101
A patient is admitted for pneumonia with a WBC of 20,000, respiratory rate 20, heart rate 85, and oral temperature 99.0??. On day 2, sputum cultures reveal positive results for pseudomonas bacteria. The most appropriate action is to

A. code pneumonia, unspecified
B. query the provider to see if pseudomonas sepsis is supported by the health record
C. query the provider to document the etiology of pneumonia
D. code pseudomonas pneumonia

Answer: C

Explanation:
The most appropriate action in this case is to query the provider to document the etiology of pneumonia, which is pseudomonas bacteria. This is because the etiology of pneumonia affects the coding and classification of the condition, as well as the severity of illness, risk
of mortality, and reimbursement. According to the ICD-10-CM Official Guidelines for Coding and Reporting, pneumonia should be coded by type whenever possible, and if the type of pneumonia is not documented, then the default code is J18.9, Pneumonia, unspecified organism 2. However, if the type of pneumonia is documented, then a more specific code can be assigned, such as J15.1, Pneumonia due to Pseudomonas 3. Therefore, querying the provider to document the etiology of pneumonia will improve the accuracy and completeness of the documentation and coding, and reflect the true clinical picture of the patient.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 139 4 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section I.C.9.a 3: ICD-10-CM Code J15.1 - Pneumonia due to Pseudomonas

NEW QUESTION 105
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 108
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 110
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 111
The clinical documentation integrity practitioner (CDIP) performed a verbal query and then later neglected following up with the provider. How should the CDIP avoid a compliance risk for this follow up failure according to AHIMA's Guidelines for Achieving a Compliant Query Practice?

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

Answer: D

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

NEW QUESTION 112
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 115
The best approach in resolving unanswered queries is to

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

Answer: B

Explanation:
facilities must develop an escalation policy for unanswered queries and address any medical staff concerns regarding queries1. If a query does not receive an appropriate professional response, the case should be referred for further review in accordance with the facility??s written escalation policy2. The escalation policy should address when the issue is brought to the physician advisor, the department director, or administration with defined actions as to the responsibilities at each level1. The policies should reflect a method of response that can realistically occur for the organization1. Therefore, reviewing the facility??s query policies and procedures is the best approach to ensure compliance and consistency in handling unanswered queries.
The other options are not advisable because they either involve skipping the escalation policy, notifying the physician advisor/champion without proper review or feedback, contacting the physician repeatedly without respecting their time or availability, or notifying the coding team without resolving the query issue.

NEW QUESTION 117
The clinical documentation integrity (CDI) manager has noted a query response rate of 60%. The CDI practitioner reports that physicians often respond verbally to the query. What can be done to improve this rate?

A. Have CDI manager teaming with coding supervisor to monitor physician responses
B. Require physicians to document responses in charts

C. Permit CDI practitioners to document physician responses in the charts
D. Allow physician to respond via e-mail

Answer: B

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

NEW QUESTION 122
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 124
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 125
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 127
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 131
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 134
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 139
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 141
Automated registration entries that generate erroneous patient identification—possibly leading to patient safety and quality of care issues, enabling fraudulent activity involving patient identity theft, or providing unjustified care for profit—is an example of a potential breach of:

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

Answer: B

Explanation:
Patient identification and demographic accuracy is the process of ensuring that the patient??s identity and personal information are correctly recorded and verified in the health record and other systems. A potential breach of this process could result in automated registration entries that generate erroneous patient identification, which could lead to patient safety and quality of care issues, enabling fraudulent activity involving patient identity theft, or providing unjustified care for profit2
Authorship integrity is the process of ensuring that the source and content of the health record are authentic, accurate, complete, and consistent. Documentation integrity is the process of ensuring that the health record reflects the patient??s clinical status, treatment, and outcomes. Auditing integrity is the process of ensuring that the health record is reviewed and monitored for compliance, quality, and improvement purposes2
1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 2: https://my.ahima.org/store/product?id=67077

NEW QUESTION 142
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 144
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 145
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 146
Proposed changes to the inpatient prospective payment system (IPPS) take effect on

A. October 1
B. January 1
C. July 1
D. April 1

Answer: A

Explanation:
Proposed changes to the inpatient prospective payment system (IPPS) take effect on October 1 of each fiscal year (FY), which begins on October 1 and ends on September 30 of the next calendar year. The IPPS final rule is usually issued by the Centers for Medicare & Medicaid Services (CMS) around August 1 of each year, and it updates the Medicare payment policies and rates for acute care hospitals and long-term care hospitals for the upcoming FY. The effective date of the final rule is October 1, unless otherwise specified by CMS 2.
References: 1: Inpatient Prospective Payment System (IPPS) 2023 Final Rule Summary of ?? 3 2: Acute Inpatient PPS | CMS 1

NEW QUESTION 147
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