Exam Questions CDIP

Certified Documentation Integrity Practitioner

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NEW QUESTION 1
For inpatients with a discharge principal diagnosis of acute myocardial infarction, aspirin must be taken within 24 hours of arrival unless a contraindication to aspirin is
documented. How should this be documented in the health record?

A. The name of the medication (aspirin), the date and time it was last administered
B. The name of the medication (aspirin), the date, time and location where it was last administered
C. The name of the medication (aspirin) and the date it was last administered
D. The name of the medication (aspirin), the date and location where it was last administered

Answer: B

Explanation:
The name of the medication (aspirin), the date, time and location where it was last administered should be documented in the health record for inpatients with a discharge principal diagnosis of acute myocardial infarction, unless a contraindication to aspirin is documented. This is because aspirin is a core measure for acute myocardial infarction patients, and its administration within 24 hours of arrival is an indicator of quality of care and patient safety. The date, time and location are important to verify that the medication was given within the specified timeframe and to avoid duplication or omission of doses4 References: 1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 4: https://my.ahima.org/store/product?id=67077

NEW QUESTION 2
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 3
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 4
A patient has a history of asthma and presents with complaints of fever, cough, general body aches, and lethargy. The patient's child was recently diagnosed with influenza. Wheezing is heard on exam. The physician documents the diagnosis as asthma exacerbation and orders nebulizer treatments of Albuterol and a 5-day course of oral Prednisone. The clinical documentation integrity practitioner (CDIP) is unsure which signs and symptoms are inherent to asthma. Which reference resource should be used to obtain this information?

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

Answer: C

Explanation:
The reference resource that should be used to obtain information about the signs and symptoms that are inherent to asthma is The Merck Manual. This is a comprehensive medical reference that covers various topics related to diseases, diagnosis, treatment, and prevention. The Merck Manual provides a detailed

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

NEW QUESTION 5
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 6
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 7
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 8
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 9
Patient is admitted with oliguria, pulmonary edema, and dehydration. Labs are remarkable for an elevated creatinine of 2.4, with a baseline of 1.1. Patient was hydrated for 48 hours with drop in creatinine. What would the appropriate action be?

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

Answer: B

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

NEW QUESTION 10
An increase in claim denials has prompted a clinical documentation integrity (CDI) manager to engage the CDI physician advisor/champion in an effort to avoid future denials. How does this strategy impact the goal?

A. The CDI manager will exclusively provide education.
B. Physicians will learn documentation integrity practices from peers.
C. Physicians can manage the documentation integrity process.
D. Clinicians will not require documentation integrity education.

Answer: B

Explanation:
Engaging the CDI physician advisor/champion in an effort to avoid future denials is a strategy that impacts the goal of improving documentation integrity by leveraging the influence and expertise of a physician leader who can educate, mentor, and advocate for other physicians on documentation best practices. The CDI physician advisor/champion can act as a liaison between the CDI team and the medical staff, provide feedback and guidance on complex or challenging cases, resolve conflicts or discrepancies in documentation, and promote a culture of collaboration and quality improvement. Physicians are more likely to learn and adopt documentation integrity practices from their peers who understand their clinical perspective and challenges, rather than from non-physician CDI staff or managers.
* A. The CDI manager will exclusively provide education. This is incorrect because engaging the CDI physician advisor/champion implies that the CDI manager will not be the sole source of education, but rather will partner with the physician leader to deliver effective and tailored education to the medical staff.
* C. Physicians can manage the documentation integrity process. This is incorrect because engaging the CDI physician advisor/champion does not mean that physicians will take over the responsibility of managing the documentation integrity process, which involves multiple stakeholders, such as CDI specialists, coders, quality analysts, and auditors. Rather, physicians will be more involved and supportive of the documentation integrity process as a result of the education and mentorship provided by the CDI physician advisor/champion.
* D. Clinicians will not require documentation integrity education. This is incorrect because engaging the CDI physician advisor/champion does not eliminate the need for documentation integrity education for clinicians, but rather enhances and facilitates it by using a peer-to-peer approach that can increase awareness, engagement, and compliance among physicians.
References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? Q&A: Defining roles for physician advisor/champion | ACDIS
? Q&A: The Role of the Physician Advisor in CDI | ACDIS
? The Role of a Physician Advisor - UASI Solutions
? PA/NP in Physician Champion / Advisor Role — ACDIS Forums

NEW QUESTION 10
Which of the following indicates a noncompliant multiple-choice query? One that does NOT

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

Answer: A

Explanation:
A noncompliant multiple-choice query is one that does not include at least four options because it may limit the provider??s choice and suggest a preferred answer. A compliant multiple-choice query should include at least four options that are clinically significant, reasonable, and plausible based on the clinical indicators and documentation in the health record. The options should also be listed in alphabetical order to avoid any bias or preference. A compliant multiple-choice query should also allow the provider to add their own response if none of the options are appropriate, and include the option of ??unable to determine?? if the provider cannot make a definitive diagnosis based on the available information. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? Guidelines for Achieving a Compliant Query Practice (2019 Update)3

NEW QUESTION 12
A query should be generated when documentation contains a

A. postoperative hospital-acquired condition
B. principal diagnosis without an MCC
C. diagnosis without clinical validation
D. problem list with symptoms related to the chief complaint

Answer: C

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

NEW QUESTION 15
Which of the following may result in an incomplete health record deficiency being assigned to a provider?

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

Answer: D

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

NEW QUESTION 16
Which of the following demonstrates the relative severity and complexity of patient treated in the hospital, and is used to evaluate the financial impact of a hospital's clinical documentation integrity (CDI) program?

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

Answer: D

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

NEW QUESTION 19
The clinical documentation integrity (CDI) manager reviewed all payer refined-diagnosis related groups (APR-DRG) benchmarking data and has identified potential opportunities for improvement. The manager hopes to develop a work plan to target severity of illness (SOI)/risk of mortality (ROM) by service line and providers. How can the manager gain more information about this situation?

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

Answer: D

Explanation:
APR-DRGs are a patient classification system that assigns each inpatient stay to one of more than 300 base APR-DRGs, and then further stratifies each base APR-DRG into four levels of severity of illness (SOI) and risk of mortality (ROM), based on the number, nature, and interaction of complications and comorbidities (CCs) and major CCs (MCCs). SOI reflects the extent of physiologic decompensation or organ system loss of function, while ROM reflects the likelihood of dying. Both SOI and ROM are used to adjust payment rates, quality indicators, and performance measures for hospitals and other healthcare providers. The CDI manager can gain more information about the potential opportunities for improvement by auditing focused APR-DRGs that have a high impact on SOI/ROM levels, such as those that have a large variation in relative weights across the four severity levels, or those that have a high frequency or volume of cases. The audit can help identify the documentation gaps, inconsistencies, or inaccuracies that may affect the assignment of SOI/ROM levels, such as missing, vague, or conflicting diagnoses, procedures, or clinical indicators. The audit can also help evaluate the CDI team??s performance in terms of query rate, response rate, agreement rate,

and accuracy rate. Based on the audit findings, the CDI manager can develop an education plan for both the CDI team and the physicians to address the specific documentation improvement areas and provide feedback and guidance on best practices.
* A. Audit cases for missed diagnosis by the CDI practitioner to target in the education plan. This is not the best way to gain more information about the situation, because it may not capture all the factors that affect SOI/ROM levels, such as procedures, clinical indicators, or interactions among diagnoses. It may also focus only on the CDI practitioner??s performance, without considering the physician??s role in documentation quality and completeness.
* B. Audit focused cases by physicians that have a higher SOI/ROM for education plan. This is not a valid way to gain more information about the situation, because it may not identify the documentation improvement opportunities for cases that have a lower SOI/ROM than expected, based on their clinical complexity and acuity. It may also create a perception of bias or favoritism among physicians, if only some are selected for audit and education.
* C. Audit cases that have high SOI/ROM assigned by coders for education and follow-up. This is not a reliable way to gain more information about the situation, because it may not reflect the true SOI/ROM levels of the cases, if there are errors or discrepancies in coding or grouping. It may also overlook the documentation improvement opportunities for cases that have low SOI/ROM assigned by coders, despite having high clinical complexity and acuity.
References:
? CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530
? 3M™ All Patient Refined Diagnosis Related Groups (APR DRGs) | 3M United States
? Q&A: Understanding SOI and ROM in the APR-DRG system | ACDIS
? Use SOI/ROM scores to enhance CDI program effectiveness | ACDIS

NEW QUESTION 20
The correct coding for insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is

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

Answer: A

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

NEW QUESTION 22
Which entity has the following regulation?
A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but
prior to surgery or a procedure requiring anesthesia services.

A. Centers for Medicare & Medicaid Services
B. Office for Civil Rights
C. Office of the National Coordinator for Health Information Technology
D. Office of Inspector General

Answer: A

Explanation:
The entity that has the following regulation is the Centers for Medicare & Medicaid Services (CMS), which is the federal agency that oversees the Medicare and Medicaid programs and sets the Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) for health care organizations that participate in these programs. The regulation that requires a medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, is part of the CoPs for Hospitals, which are located in 42 CFR ?? 482.24. This regulation was revised in 2007 to align with the Joint Commission??s standard and to provide more flexibility and consistency for hospitals and practitioners. (CDIP Exam Preparation Guide)
References:
? CDIP Exam Content Outline1
? CDIP Exam Preparation Guide2
? 42 CFR ?? 482.243

NEW QUESTION 23
A clinical documentation integrity practitioner (CDIP) generates a concurrent query and continues to follow retrospectively; however, the coder releases the bill before the query is answered. The CDIP wonders if it is appropriate to re-bill the account if the physician answers the query after the bill has dropped. Which policy should the hospital follow to avoid a compliance risk?

A. A rebilling is permissible when queries are answered after the initial bill.
B. A post-bill query rarely occurs as a result of an audit or other internal monitor.
C. A second bill should not be submitted when the first bill was incomplete.
D. A post bill query is not appropriate when an error is found after an audit.

Answer: A

Explanation:
A rebilling is permissible when queries are answered after the initial bill, as long as the hospital follows the appropriate guidelines and procedures for rebilling, such as submitting a corrected claim within the timely filing limit, notifying the payer of the reason for rebilling, and documenting the query process and outcome in the health record. Rebilling may be necessary to ensure accurate coding and reporting of the patient??s condition and treatment, as well as appropriate reimbursement and quality measures. [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 24
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 26
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 29
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 32
A hospital administrator has hired a clinical documentation integrity (CDI) firm to improve its revenue objectives. The physicians object to this action. How should the firm collaborate with physicians to overcome their objections?

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

Answer: D

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

NEW QUESTION 37
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 41
When there is a discrepancy between the clinical documentation integrity practitioner's (CDIP's) working DRG and the coder's final DRG, which of the following is considered a fundamental element that must be in place for a successful resolution?

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

Answer: B

Explanation:
According to the AHIMA/ACDIS Query Practice Brief, one of the fundamental elements that must be in place for a successful DRG discrepancy resolution is a

collaborative and respectful interaction between the coder and the CDIP1. The coder and the CDIP should communicate effectively and timely to identify and resolve any DRG mismatches, using evidence-based guidelines, coding conventions, and query standards1. The coder and the CDIP should also share their knowledge and expertise with each other, and seek clarification from the provider or the physician advisor/champion when necessary1. The other options are not considered fundamental elements for DRG discrepancy resolution, although they may be helpful or supportive in some situations. References:
? Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA

NEW QUESTION 43
The most beneficial step to identify post-discharge query opportunities that affect severity of illness, risk of mortality and case weight is to

A. look for documented conditions that have well supported accompanying clinical criteria
B. determine if only the treatment is documented and there is no diagnosis documented
C. watch for reportable conditions or conditions that are unambiguous or otherwise complete
D. identify normal diagnostic test results that may indicate a possible addition of a secondary diagnosis

Answer: B

NEW QUESTION 47
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 50
Which of the following criteria for clinical documentation means the content of the record is trustworthy, safe, and yielding the same result when repeated?

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

Answer: C

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

NEW QUESTION 53
Which physician would best benefit from additional education for unanswered queries?

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

A. D
B. A
C. D
D. B
E. D
F. C
G. D
H. D

Answer: D

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

NEW QUESTION 56
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 59
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 64
What is the term used when a patient is entered in the Master Patient Index (MPI) multiple times, in different ways, resulting in multiple medical record numbers?

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

Answer: D

Explanation:
The term used when a patient is entered in the MPI multiple times, in different ways, resulting in multiple medical record numbers is overlap. An overlap occurs when a person has more than one medical record number within an integrated delivery network or enterprise, and may cause problems such as incomplete or inaccurate patient information, duplicate testing or treatment, billing errors, or patient safety issues. An overlap may be caused by data entry errors, system conversions, mergers or acquisitions, or lack of standardization. Regular audits of the MPI database must be done to identify and resolve any overlaps and ensure data quality and integrity.
References:
? CDIP® Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam- content-outline.pdf)
? Master patient index - Clinfowiki1

NEW QUESTION 69
A hospital clinical documentation integrity (CDI) director suspects physicians are over-using electronic copy and paste in patient records, a practice that increases the risk of fraudulent insurance billings. A documentation integrity project may be needed. What is the first step the CDI director should take?

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

Answer: D

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

NEW QUESTION 71
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 74
The clinical documentation integrity practitioner (CDIP) is reviewing tracking data and has noted physician responses are not captured in the medical chart. What can be done to improve this process?

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

Answer: C

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

NEW QUESTION 75
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 78
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 80
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 84
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 86
An 88-year-old male is admitted with a fever, cough, and leukocytosis. The physician documents admit for probable sepsis due to urinary tract infection (UTI). Antibiotics are started. Three days later, the blood and urine cultures are negative, the patient has been afebrile since admission, and the white blood count is returning to normal. What documentation clarification is needed to support accurate coding of the record?

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

Answer: B

Explanation:
According to the Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA1, clinical validation is a process by which documentation is evaluated to ensure that the medical record demonstrates enough clinical support for all documented diagnoses as mandated by the False Claims Act. If there is a lack of clinical support for sepsis or UTI within the documentation, a clinical validation query should be sent. Query choices should list sepsis or UTI as ruled out

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

NEW QUESTION 89
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 93
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 98
Which of the following is an appropriate first step to address physicians with low query response rates?

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

Answer: A

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

NEW QUESTION 99
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 102
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