



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

When writing a compliant query, best practice is to

- A. direct the physician to a specific diagnosis
- B. include all relevant clinical indicators
- C. use the term "possible" to describe a condition or diagnosis when uncertain if the diagnosis is present
- D. use a yes/no query format for specificity of a diagnosis

Answer: B

Explanation:

One of the best practices for writing a compliant query is to include all relevant clinical indicators from the health record that support the need for clarification and the query options. Clinical indicators are objective and measurable signs, symptoms, laboratory results, diagnostic test results, medications, treatments, and other documented findings that are related to a specific diagnosis or condition. Including clinical indicators helps to provide the rationale for the query, avoid leading or suggesting a desired response, and ensure that the query is based on evidence and not assumptions. The other options are not best practices for writing a compliant query. Directing the physician to a specific diagnosis is leading and noncompliant. Using the term "possible" to describe a condition or diagnosis when uncertain if the diagnosis is present is vague and imprecise. Using a yes/no query format for specificity of a diagnosis is discouraged, as it limits the provider's choices and may not capture the true clinical picture.

NEW QUESTION 4

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

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

Answer: B

Explanation:

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

- ? CDI Week 2020 Q&A: CDI and key performance indicators¹
- ? Mayo Clinic: Aspiration pneumonia²
- ? Medscape: Aspiration Pneumonia³
- ? ICD-10-CM Diagnosis Code J69.x: Pneumonitis due to solids and liquids⁴

NEW QUESTION 5

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 6

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 management². 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 identified³. 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 plan⁴. 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 7

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 manual².

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 8

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 9

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 10

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 medications².

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: Asthma - Pulmonary Disorders - Merck Manuals Professional Edition 4

NEW QUESTION 10

A noncompliant query includes querying the provider regarding

- A. acute blood loss anemia due to low hemoglobin treated with iron supplements
- B. sepsis that was present on admission because sepsis was only documented in the discharge summary
- C. gram-negative pneumonia on every pneumonia case, regardless of documented clinical indicators
- D. morbid obesity due to BMI of 40.9 documented on the history and physical

Answer: C

Explanation:

A noncompliant query includes querying the provider regarding gram-negative pneumonia on every pneumonia case, regardless of documented clinical indicators because it may lead to over-specification of a diagnosis that is not supported by the health record. A compliant query should be based on the clinical evidence and documentation in the record, and should not suggest or imply a diagnosis that is not clinically relevant or plausible. A query should also not be driven by reimbursement or coding factors, but by the need to improve the quality and accuracy of documentation. (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 15

A 50-year-old with a history of stage II lung cancer is brought to the emergency department with severe dyspnea. The patient underwent the last round of chemotherapy 3 days ago. Vital signs reveal a temperature of 98.4, a heart rate of 98, a respiratory rate of 28, and a blood pressure of 124/82. O₂ saturation on room air is 92%. The patient is 5'5" and weighs 98 lbs. The registered dietitian notes the patient is malnourished with BMI of 19. Chest x-ray reveals a large pleural effusion in the right lung.

Thoracentesis is performed and 1000 cc serosanguinous fluid is removed. The admitting diagnosis is large right lung pleural effusion related to lung cancer stage II, documented multiple times. What post discharge query opportunity should be sent to the physician that will affect severity of illness (SOI)/risk of mortality (ROM)?

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

Answer: B

Explanation:

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

? CDIP Exam Preparation Guide - AHIMA

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

? Malignant Pleural Effusion: Symptoms, Causes, Diagnosis & Treatment

? Q&A: Coding for malignant pleural effusions | ACDIS

NEW QUESTION 19

A 75-year-old, diabetic patient with a history of osteoporosis, being treated with Fosamax, who sustained a femur fracture after falling down three stairs. The provider's documentation indicates to admit the patient for a traumatic femur fracture and an orthopedics consult is pending. The clinical documentation integrity practitioner (CDIP) decides to query for a possible link between osteoporosis and the femur fracture. Which of the following is the most compliant query based on the most recent AHIMA/ACDIS query practice brief?

- A. Patient admitted for a femur fracture with a history of osteoporosis being treated with Fosamax
- B. In your medical opinion, is this fracture consistent with an osteoporotic pathological fracture?
- C. Patient admitted for a femur fracture with a history of osteoporosis being treated with Fosamax
- D. Please clarify the cause of the femur fracture in your next note and/or the discharge summary.
- E. Patient admitted for a femur fracture with a history of osteoporosis being treated with Fosamax
- F. Could diabetes be a contributing factor in the femur fracture?
- G. Patient admitted for a femur fracture with a history of osteoporosis being treated with Fosamax
- H. Please document "femur fracture due to osteoporosis" in your next progress note to demonstrate a link between the two diagnoses.

Answer: A

Explanation:

This query option is the most compliant based on the most recent AHIMA/ACDIS query practice brief because it meets the following criteria:

? It is based on clinical indicators in the health record that support a reasonable and logical connection between the conditions (femur fracture and osteoporosis).

? It is non-leading and non-suggestive, as it does not imply a specific answer or diagnosis, but rather asks for the provider's opinion based on their clinical judgment.

? It is concise and clear, as it uses simple and direct language that avoids ambiguity or confusion.

? It is relevant and specific, as it addresses a clinical issue that has an impact on patient care, quality reporting, and/or reimbursement.

? It is consistent with clinical documentation integrity (CDI) standards and guidelines, as it follows the AHIMA/ACDIS query practice brief recommendations for query format, content, delivery, and documentation.

References:

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

? CDIP® Exam Preparation Guide (<https://my.ahima.org/store/product?id=67077>)

? Guidelines for Achieving a Compliant Query Practice—2022 Update (<https://acdis.org/resources/guidelines-achieving-compliant-query-practice%E2%80%942022-update>)

NEW QUESTION 20

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

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

Answer: B

Explanation:

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

NEW QUESTION 23

A query should include

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

Answer: D

Explanation:

A query should include relevant clinical indicators from the health record that support the need for clarification and the query options. Clinical indicators are objective and measurable signs, symptoms, laboratory results, diagnostic test results, medications, treatments, and other documented findings that are related to a

specific diagnosis or condition. Information from previous encounters, the impact on quality, and the impact of reimbursement are not appropriate to include in a query, as they may introduce bias, lead the provider, or imply a desired response.

NEW QUESTION 25

Creating policies and procedures for the query process will help eliminate

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

Answer: A

Explanation:

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

NEW QUESTION 29

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 33

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 35

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 40

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 42

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 47

What type of laboratory test is a creatinine test?

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

Answer: A

NEW QUESTION 52

When there are comparative contrasting diagnoses supported by clinical criteria, the correct action is to

- A. code the first condition listed
- B. query for clarification
- C. not code either diagnosis
- D. code both diagnoses

Answer: D

Explanation:

When there are comparative contrasting diagnoses supported by clinical criteria, the correct action is to code both diagnoses, as long as they are not mutually exclusive. Comparative contrasting diagnoses are those that are considered as possible alternatives or differentials for the patient's condition, such as pneumonia versus bronchitis, or appendicitis versus diverticulitis. Coding both diagnoses will capture the clinical uncertainty and complexity of the case, and will allow for accurate reporting and

reimbursement. References: : https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf : <https://my.ahima.org/store/product?id=67077>

NEW QUESTION 54

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 55

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 56

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

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

Answer: B

Explanation:

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

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: AHIMA Practice Brief: Managing an Effective Query Process 4

NEW QUESTION 57

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

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

Answer: D

NEW QUESTION 59

Which of the following should be shared to ensure a clear sense of what clinical documentation integrity (CDI) is and the CDI practitioner's role within the organization?

- A. Productivity standards
- B. Review schedule
- C. Milestones
- D. Mission

Answer: D

Explanation:

Sharing the mission of the CDI program should be done to ensure a clear sense of what CDI is and the CDI practitioner's role within the organization. The mission statement defines the purpose, goals, and values of the CDI program, and how it aligns with the organization's vision and strategy. The mission statement also communicates the benefits and expectations of the CDI program to various stakeholders, such as providers, executives, coders, quality staff, and patients. The mission statement can help establish the credibility, professionalism, and identity of the CDI practitioners, and guide their daily activities and decisions.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: Mission CDI: Guiding goals, values, and principles 1

NEW QUESTION 63

After one year, the clinical documentation integrity (CDI) program has become stagnant, and the manager plans to reinvigorate the program to better reflect the CDI efforts in the organization. What can the manager do to ensure program success?

- A. Expand the CDI program to larger areas in outpatient clinics
- B. Prioritize to focus on efforts with the largest return on investment
- C. Identify key metrics to develop program measures for coders
- D. Establish a CDI steering committee to build a strong foundation

Answer: D

Explanation:

A CDI steering committee is a group of interdisciplinary leaders who oversee and guide the CDI program's objectives, outcomes, and metrics. The committee should include representatives from finance, clinical, coding, quality, and other areas that are impacted by CDI. The committee should meet regularly to review the CDI program's performance, identify opportunities for improvement, and provide support and education to the CDI staff and providers. A CDI steering committee can help reinvigorate a stagnant CDI program by ensuring that it aligns with the organization's vision and mission, addresses the current challenges and needs, and fosters collaboration and communication among stakeholders. The other options are not necessarily effective ways to reinvigorate a CDI program. Expanding the CDI program to larger areas in outpatient clinics may not be feasible or appropriate without a clear strategy and plan. Prioritizing to focus on efforts with the largest return on investment may not reflect the true value and quality of the CDI program. Identifying key metrics to develop program measures for coders may not capture the full scope and impact of the CDI program.

NEW QUESTION 64

Which of the following is considered a hospital-acquired condition if not present on admission?

- A. Air leak
- B. Diabetes with hypoglycemia
- C. Stage I and II pressure ulcers
- D. Blood incompatibility

Answer: D

Explanation:

Blood incompatibility is considered a hospital-acquired condition if not present on admission, according to the CMS Hospital-Acquired Conditions (HAC) Reduction Program. This program reduces payments to hospitals that have high rates of certain conditions that are acquired during the hospital stay and could have been prevented by following evidence-based guidelines. Blood incompatibility is one of the 14 HAC categories that are included in the program, and it refers to a patient receiving a blood transfusion with incompatible blood type or Rh factor, which can cause serious adverse reactions such as hemolysis, anemia, renal failure, or death. Blood incompatibility is a preventable condition that can be avoided by proper blood typing and cross-matching before transfusion, and by following strict protocols and procedures for blood handling and administration.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 5 2: Hospital-Acquired Conditions | CMS 1 3: Hospital Acquired Conditions (HACs) - New York State Department of Health 3 4: Transfusion Reactions - Hematology and Oncology - Merck Manuals Professional Edition 6

NEW QUESTION 69

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

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

D. Teach nursing staff about documentation integrity

Answer: B

Explanation:

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

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

Documentation Improvement Program

NEW QUESTION 74

A patient was admitted due to possible pneumonia. Chest x-ray was positive for infiltrate.

The physician's documentation indicates that the patient continues to smoke cigarettes despite recommendations to quit. Patient also has a long-term history of chronic obstructive pulmonary disease (COPD) due to smoking. IV antibiotic was given for pneumonia along with oral Prednisone and Albuterol for COPD.

Discharge diagnoses:

- * 1. Pneumonia
- * 2. COPD
- * 3. Current smoker

What is the correct diagnostic related group assignment?

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

Answer: A

Explanation:

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

? ICD-10-CM/PCS MS-DRG Definitions Manual

? ICD-10-CM/PCS MS-DRG v38.0 Definitions Manual - MDC 4: Diseases and Disorders of the Respiratory System

NEW QUESTION 78

Which member of the clinical documentation integrity (CDI) team can help provide peer-to- peer level of education on the importance of accurate documentation and query responses?

- A. Chief Financial Officer
- B. Physician advisor/champion
- C. CDI practitioner
- D. CDI manager

Answer: B

Explanation:

The member of the clinical documentation integrity (CDI) team who can help provide peer-to-peer level of education on the importance of accurate documentation and query responses is the physician advisor/champion. The physician advisor/champion is a physician who supports and advocates for the CDI program and its goals, and who can communicate effectively with other physicians about the clinical and financial implications of documentation quality and accuracy. The physician advisor/champion can also serve as a liaison between the CDI team and the medical staff, and help to resolve any issues or conflicts that may arise from the query process. The physician advisor/champion can also provide feedback and guidance to the CDI team on clinical matters and documentation standards. (CDIP Exam Preparation Guide)

References:

? CDIP Exam Content Outline1

? CDIP Exam Preparation Guide2

NEW QUESTION 80

A key physician approaches the director of the coding department about the new emphasis associated with clinical documentation integrity (CDI). The physician does not support the program and believes the initiative will encourage inappropriate billing.

How should the director respond to the concerns?

- A. Develop an administrative panel to oversee CDI process
- B. Refer the physician to the finance department to discuss required billing changes
- C. Involve the physician advisor/champion in addressing the medical staff's concerns
- D. Inform the physician that changes must be made

Answer: C

Explanation:

The director should involve the physician advisor/champion in addressing the medical staff's concerns because the physician advisor/champion is a key member of the CDI team who can provide clinical expertise, education, and leadership to promote CDI among physicians. The physician advisor/champion can help to explain the goals and benefits of CDI, such as improving patient care quality, accuracy of documentation, and appropriate reimbursement. The physician advisor/champion can also address any misconceptions or fears that the physicians may have about CDI, such as encouraging inappropriate billing or increasing their workload. The physician advisor/champion can serve as a liaison between the CDI team and the medical staff, and foster a culture of collaboration and trust.

References:

- ? CDIP® Exam Content Outline (<https://www.ahima.org/media/1z0x0x1a/cdip-exam-content-outline.pdf>)
- ? CDIP® Exam Preparation Guide (<https://my.ahima.org/store/product?id=67077>)

NEW QUESTION 82

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 83

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 86

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 89

The provider was queried because the patient met clinical criteria for acute hypoxic respiratory failure. The response to the query was different than what was expected by the clinical documentation integrity practitioner (CDIP). What should the CDIP do?

- A. Record the query response as disagreed
- B. Have a different CDIP query the provider
- C. Revise the query and send it back to the provider
- D. Implement the department's escalation process

Answer: D

Explanation:

If the provider??s response to the query is different than what was expected by the CDIP, the CDIP should implement the department??s escalation process to ensure the validity and accuracy of the documentation and the coded data. The escalation process is a standardized procedure that involves a manager, committee, or other supervisory position to review and assess the query and the response, and to determine the appropriate next steps. The escalation process may include contacting the provider for clarification, education, or feedback; consulting with a physician advisor/champion or a coding auditor; or reporting the issue to a higher authority or regulatory body. The escalation process should be documented and communicated clearly and respectfully to all parties involved.

* A. Record the query response as disagreed. This is not a sufficient action to take if the provider??s response to the query is different than what was expected by the CDIP. Recording the query response as disagreed may indicate a lack of agreement or consensus between the CDIP and the provider, but it does not address

the underlying issue of documentation validity or accuracy. It may also create a negative impression or relationship between the CDIP and the provider.

* B. Have a different CDI query the provider. This is not an appropriate action to take if the provider's response to the query is different than what was expected by the CDIP. Having a different CDI query the provider may create confusion, inconsistency, or redundancy in the query process. It may also undermine the credibility or authority of the original CDI who queried the provider.

* C. Revise the query and send it back to the provider. This is not a recommended action to take if the provider's response to the query is different than what was expected by the CDIP. Revising the query and sending it back to the provider may imply that the CDI is dissatisfied or disagreeing with the provider's response, which may be perceived as disrespectful or confrontational. It may also suggest that the CDI is trying to influence or coerce the provider to change their response, which may compromise the integrity and compliance of the query process.

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 92

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 94

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 99

Which of the following is a clinical documentation element supporting a transbronchial biopsy?

- A. Length of procedure
- B. Pathology report documenting alveolar tissue
- C. Hemoptysis
- D. Pathology report documenting bronchial tissue

Answer: B

Explanation:

A transbronchial biopsy is a procedure that involves obtaining tissue samples from the alveoli (air sacs) of the lungs through a bronchoscope. A pathology report documenting alveolar tissue is a clinical documentation element that supports a transbronchial biopsy, as it confirms the source and nature of the tissue sample.

References: AHIMA. ??CDIP Exam Preparation.?? AHIMA Press, Chicago, IL, 2017: 55-56.

NEW QUESTION 102

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 107

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 112

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