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CDIP - Certified Documentation Integrity Practitioner Practice Tests 2025 | DumpsMaterials

NEW QUESTION 60

Collaboration between the physician advisor/champion and the clinical documentation integrity practitioners (CDIPs) would likely include
* performing data analysis
* developing query forms
* educating physicians
* querying physicians
Explanation

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

https://my.ahima.org/store/product?id=67077

NEW QUESTION 61

Which of the following is nonessential to facilitate code capture when educating clinical staff on documentation practices associated with diabetes mellitus?
* Type
* Manifestation
* Cause
* Age

NEW QUESTION 62

A hospital noticed a 30% denial rate in Medicare claims due to lack of clinical documentation, placing the hospital at risk of multiple Medicare violations. What step should the clinical documentation integrity (CDI) manager take to help avoid future Medicare violations?

Collaborate with physician advisor/champion and revenue cycle manager

Instruct the billing department to write off claims with insufficient documentation
* Assign pre-billing claim review duties to physicians
* Prevent submission of claims for improper documentation
Explanation

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

https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf :

https://my.ahima.org/store/product?id=67077

NEW QUESTION 63

A hospital administrator wants to initiate a clinical documentation integrity (CDI) program and has developed a steering committee to identify performance metrics. The CDI manager expects to use a case mix index as one of the metrics. Which other metric will need to be measured?
* Comparison of risk of mortality with diagnostic related group capture rates
* Assessment of APR-DRGs with capture of CC or MCC
* Comparison of severity of illness with the CC capture rates
* Assessment of CC/MCC capture rates

Explanation

A CC/MCC capture rate is a metric that measures the percentage of cases that have at least one complication or comorbidity (CC) or major complication or comorbidity (MCC) coded in the medical record. This metric is important for a CDI program because CCs and MCCs affect the severity of illness, risk of mortality, and reimbursement of the cases under the Medicare Severity-Diagnosis Related Group (MS-DRG) system. A higher CC/MCC capture rate indicates a more accurate and complete documentation of the patient’s condition and the resources used to treat them. A CDI program can use this metric to monitor the effectiveness of its queries, education, and feedback to the providers and coders. A CDI program can also compare its CC/MCC capture rate with national or regional benchmarks to identify areas of improvement or best practices 2.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: The Natural History of CDI Programs: A Metric-Based Model 4

NEW QUESTION 64

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?
* Physician and CDIP interaction
* Coder and CDIP interaction
* Executive oversight
* Physician advisor/champion involvement

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 65

Which of the following is the definition of an Excludes 2 note in ICD-10-CM?
* Neither of the codes can be assigned
* Two codes can be used together to completely describe the condition
* Only one code can be assigned to completely describe the condition
* This is not a convention found in ICD-10-CM
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 66

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?
* Audit cases for missed diagnosis by the CDI practitioner to target in the education plan
* Audit focused cases by physicians that have a higher SOI/ROM for education plan
* Audit cases that have high SOI/ROM assigned by coders for education and follow-up
* Audit focused APR-DRGs and develop education plan for CDI team and physicians
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 67

A 27-year-old male patient presents to the emergency room with crampy, right lower quadrant abdominal pain, a low-grade fever (101° Fahrenheit) and vomiting. The patient also has a history of type I diabetes mellitus. A complete blood count reveals mild leukocytosis (13,000/microliter). Abdominal ultrasound is ordered, and the patient is admitted for laparoscopic surgery. The patient is given an injection of neutral protamine Hagedorn insulin, in order to normalize the blood sugar level prior to surgery. Upon discharge, the attending physician documents “right lower quadrant abdominal pain due to possible acute appendicitis or probable Meckel diverticulitis”.

What is the proper sequencing of the principal and secondary diagnoses?
* Right lower quadrant abdominal pain, acute appendicitis, Meckel diverticulitis, fever, vomiting, leukocytosis
* Right lower quadrant abdominal pain, fever, vomiting, leukocytosis
* Acute appendicitis, Meckel diverticulitis, type I diabetes mellitus
* Acute appendicitis, right lower quadrant abdominal pain, type I diabetes mellitus

Explanation

The proper sequencing of the principal and secondary diagnoses in this case is as follows:

Principal diagnosis: Acute appendicitis. This is the condition, after study, that occasioned the admission to the hospital, according to the ICD-10-CM Official Guidelines for Coding and Reporting. The patient was admitted for laparoscopic surgery, which is a definitive treatment for acute appendicitis. The physician documented “possible acute appendicitis or probable Meckel diverticulitis” as the cause of the right lower quadrant abdominal pain. According to the AHA’s Coding Clinic, Fourth Quarter 2016, pp.

147-148, when a physician documents two diagnoses connected by “or”, coders should query the physician for clarification if possible. However, if a query is not possible or not answered, coders should assign codes for both conditions, unless one of them has been ruled out or confirmed by further testing or treatment. In this case, there is no indication that either acute appendicitis or Meckel diverticulitis has been ruled out or confirmed by further testing or treatment. Therefore, both conditions

should be coded and reported. However, only one of them can be the principal diagnosis. Since acute appendicitis is more commonly associated with laparoscopic surgery than Meckel diverticulitis, and since it has a higher relative weight than Meckel diverticulitis under the MS-DRG system, it is reasonable to select acute appendicitis as the principal diagnosis 23.

Secondary diagnosis: Right lower quadrant abdominal pain. This is a sign or symptom that is associated with the principal diagnosis and requires clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. The patient presented with right lower quadrant abdominal pain as a manifestation of acute appendicitis or Meckel diverticulitis. The pain required clinical evaluation by abdominal ultrasound and therapeutic treatment by laparoscopic surgery. Therefore, it should be coded and reported as a secondary diagnosis 4.

Secondary diagnosis: Type I diabetes mellitus. This is a chronic condition that affects the patient’s care in terms of requiring diagnostic or therapeutic services or affecting patient outcomes or resource utilization. The patient has a history of type I diabetes mellitus and received an injection of neutral protamine Hagedorn insulin to normalize the blood sugar level prior to surgery. Therefore, it should be coded and reported as a secondary diagnosis 4.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section II.A 3: AHA Coding Clinic for ICD-10-CM and ICD-10-PCS, Fourth Quarter 2016 4: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section III.C : AHIMA CDIP Exam Prep, Fourth Edition https://my.ahima.org/store/product?id=67077

NEW QUESTION 68

Which of the following is a clinical documentation element supporting a transbronchial biopsy?
* Length of procedure
* Pathology report documenting alveolar tissue
* Hemoptysis
* Pathology report documenting bronchial tissue
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 69

Which of the following organizations should a clinical documentation integrity practitioner (CDIP) monitor?
* Office of Inspector General (OIG), Accreditation Commission for Healthcare (ACHC), Recovery Auditors (RAs)
* Program for Evaluating Payment Patterns Electronic Report (PEPPER), Recovery Auditors (RAs), Center for Improvement in Healthcare (CIHQ)
* Recovery Auditors (RAs), Program for Evaluating Payment Patterns Electronic Report (PEPPER), Office of Inspector General (OIG)
* Center for Improvement in Healthcare (CIHQ), Accreditation Commission for Healthcare (ACHC), Recovery Auditors (RAs)
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 70

Which of the following committees should determine the chain of comnfand that will be used to manage physicians who are either unresponsive or uncooperative with the clinical documentation integrity (CDI) program?
* Oversight
* Communications
* Operations
* Compliance

Explanation

The oversight committee is responsible for establishing the policies, procedures, and guidelines for the CDI program, as well as monitoring its performance and outcomes. The oversight committee should include representatives from senior leadership, medical staff, coding, quality, compliance, and other relevant stakeholders. The oversight committee should determine the chain of command that will be used to manage physicians who are either unresponsive or uncooperative with the CDI program, as well as the consequences for non-compliance. The other committees are not directly involved in setting the chain of command or the disciplinary actions for the CDI program. The communications committee is responsible for facilitating the information flow and feedback among the CDI staff, providers, coders, and other departments. The operations committee is responsible for managing the day-to-day activities and functions of the CDI staff, such as staffing, training, productivity, and workflow. The compliance committee is responsible for ensuring that the CDI program adheres to the ethical and legal standards and regulations, such as query compliance, documentation integrity, and privacy and security.

NEW QUESTION 71

The clinical documentation integrity (CDI) metrics recently showed a drastic drop in the physician query rate.

What might this indicate to the CDI manager?
* The program is successful because documentation has improved
* The loss of a large volume of patients has impacted workflow
* CDI staff need education on identifying query opportunities
* The decrease in hospital census has caused a lack of query opportunities

Explanation

A drastic drop in the physician query rate might indicate to the CDI manager that the CDI staff need education on identifying query opportunities. The physician query rate is a metric that measures the percentage of records that have at least one query sent by the CDI staff to clarify or improve the documentation. A high query rate may reflect a high level of documentation quality issues or a high level of CDI staff vigilance and expertise. A low query rate may reflect a low level of documentation quality issues or a low level of CDI staff awareness and competence 2. Therefore, a drastic drop in the query rate could suggest that the CDI staff are missing some query opportunities or are not following the query policies and procedures. The CDI manager should investigate the reasons for the drop and provide education and feedback to the CDI staff on how to identify and address query opportunities effectively and compliantly 3.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: Understanding CDI Metrics – AHIMA 2 3: The Natural History of CDI Programs: A Metric-Based Model 5

NEW QUESTION 72

Automated registration entries that generate erroneous patient identification-possibly leading to patient safety and quality of care issues, enabling fraudulent activity involving patient identity theft, or providing unjustified care for profit-is an example of a potential breach of:
* Authorship integrity
* Patient identification and demographic accuracy
* Documentation integrity
* Auditing integrity

Explanation

Patient identification and demographic accuracy is the process of ensuring that the patient’s identity and personal information are correctly recorded and verified in the health record and other systems. A potential breach of this process could result in automated registration entries that generate erroneous patient identification, which could lead to patient safety and quality of care issues, enabling fraudulent activity involving patient identity theft, or providing unjustified care for profit2 Authorship integrity is the process of ensuring that the source and content of the health record are authentic, accurate, complete, and consistent. Documentation integrity is the process of ensuring that the health record reflects the patient’s clinical status, treatment, and outcomes. Auditing integrity is the process of ensuring that the health record is reviewed and monitored for compliance, quality, and improvement purposes2

1: https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 2:

https://my.ahima.org/store/product?id=67077

NEW QUESTION 73

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?
* Stage IV pressure ulcer
* Stage III pressure ulcer
* Unstageable pressure ulcer
* Undetermined stage pressure ulcer

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 74

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?
* The name of the medication (aspirin), the date and time it was last administered
* The name of the medication (aspirin), the date, time and location where it was last administered
* The name of the medication (aspirin) and the date it was last administered
* The name of the medication (aspirin), the date and location where it was last administered

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 75

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 Insertion of infusion device into right internal jugular vein, percutaneous approach
* 02H633Z Insertion of infusion device into right atrium, percutaneous approach
* 05HP33Z Insertion of infusion device into right external jugular vein, percutaneous approach
* 02HV33Z Insertion of infusion device into superior vena cava, percutaneous approach

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 76

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

Explanation

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

NEW QUESTION 77

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?
* Hospital acquired conditions
* Program for evaluating payment patterns electronic report
* Present on admission indicators
* Adjusted case mix index

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 78

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?
* Update medical records with unsigned physician responses
* Allow physician responses via e-mail
* Provide education to physicians on query process
* Require the CDIP to call physicians to follow up

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 79

Which of the following should be examined when developing documentation integrity projects?

* Query rates from coding staff
* CC and MCC capture rates
* Coding productivity statistics
* Physician satisfaction surveys

Explanation

The factor that should be examined when developing documentation integrity projects is CC and MCC capture rates. CC stands for complication or comorbidity, and MCC stands for major complication or comorbidity.

These are secondary diagnoses that affect the severity of illness (SOI) and risk of mortality (ROM) of the patient, as well as the reimbursement and quality measures of the hospital. CC and MCC capture rates measure how well the clinical documentation reflects the presence and impact of these conditions on the patient’s care. Examining CC and MCC capture rates can help to identify documentation improvement opportunities, goals, strategies, and outcomes4 References: 1:

https://www.ahima.org/media/owmhxbv1/cdip_contentoutline_2023_final.pdf 4:

https://my.ahima.org/store/product?id=67077

NEW QUESTION 80

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?

* Determine primary interests and needs as requested
* Determine primary interests of an individual or department
* Teach coding classes to the new physicians as needed
* Teach nursing staff about documentation integrity

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 81

The ultimate purpose of clinical documentation integrity (CDI) expansion and growth is to

* provide community education to healthcare consumers
* create synergy between clinical education and CDI principles
* show a direct relationship between clinical documentation and quality patient care
* promote CDI functions so that physicians view the CDI staff as value-added service

Explanation

The ultimate purpose of clinical documentation integrity (CDI) expansion and growth is to show a direct relationship between

clinical documentation and quality patient care. According to the web search results, CDI programs aim to improve the quality and efficiency of clinical documentation by ensuring that it is accurate, complete, and consistent. This in turn leads to better health care data, which is vital for capturing the appropriate indicators used for health care facility and provider profiling, reimbursement, risk adjustment, and quality scores12. CDI programs also focus on patient safety, by identifying and resolving any documentation omissions, discrepancies, or adverse events that may affect the patient’s outcome or care3. Therefore, CDI programs demonstrate how clinical documentation can impact the quality of patient care and the performance of health care organizations.

NEW QUESTION 82

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

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