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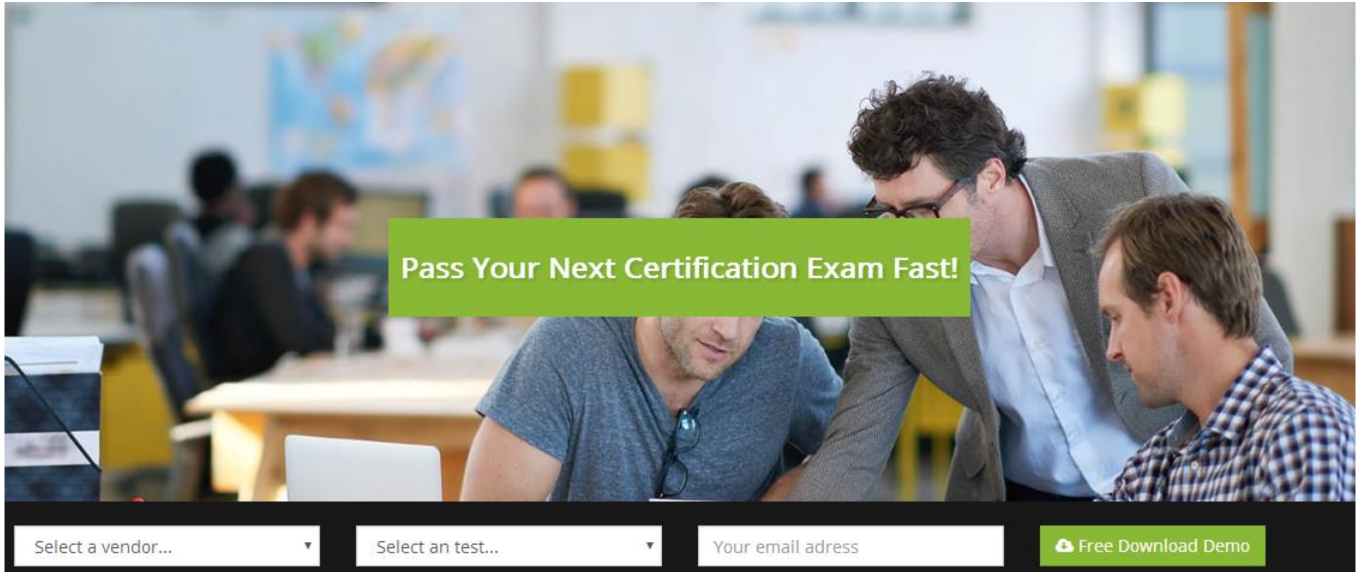

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Exam : **CDIP**

Title : Certified Documentation Integrity Practitioner

Vendor : AHIMA

Version : DEMO

NO.1 Which of the following criteria for clinical documentation means the content of the record is trustworthy, safe, and yielding the same result when repeated?

A. Legible

B. Complete

C. Reliable

D. Precise

Answer: C

Explanation

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

References:

Clinical Documentation Integrity Education & Training | AHIMA1

NO.2 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

NO.3 The clinical documentation integrity (CDI) manager is reviewing physician benchmarks and notices a low-severity level being measured against average length of stay.

What should the CDI manager keep in mind when discussing this observation with physicians?

A. The indicator is a key factor of measurement for quality reports.
B. The query rate is too high while the agreement rate is low.
C. The query response rate directly correlates to quality reports.
D. The diagnosis with a higher degree of specificity has a lower severity of illness.
Answer: A
Explanation
According to the AHIMA CDIP Exam Preparation Guide, one of the CDI metrics and statistics that CDI managers should track and interpret is the severity level measured against average length of stay (ALOS)1. This indicator reflects the complexity and acuity of the patient population and the quality of care provided by the hospital2. A low-severity level with a high ALOS may indicate under-documentation or under-coding of the patient's condition, which may affect the hospital's reimbursement, risk adjustment, and quality scores3. Therefore, the CDI manager should keep in mind that this indicator is a key factor of measurement for quality reports when discussing this observation with physicians, and educate them on the importance of documenting and coding accurately and completely to reflect the patient's true severity of illness. The other options are not correct because they do not address the issue of severity level measured against ALOS, or they are not relevant to the CDI manager's role or responsibility. References:
CDIP Exam Preparation Guide - AHIMA
Demystifying and communicating case-mix index - ACDIS
Severity of Illness: What Is It? Why Is It Important? | HCPro

NO.4 Which of the following is a clinical documentation integrity (CDI) financial impact measure?
A. Severity of illness
B. Hierarchical condition category
C. Case mix index
D. Release of information
Answer: C
Explanation
Case mix index (CMI) is a measure of the average severity and resource consumption of a group of patients, such as those in a hospital or a diagnosis-related group (DRG). CMI reflects the financial impact of CDI by showing how documentation improvement can affect the DRG assignment and reimbursement. A higher CMI indicates more complex and costly cases, while a lower CMI indicates less complex and costly cases. CDI programs can monitor the changes in CMI over time to evaluate their effectiveness and return on investment. (Understanding CDI Metrics2) References:
CDI Week 2020 Q&A: CDI and key performance indicators1
Understanding CDI Metrics2

NO.5 A hospital is conducting a documentation integrity project for the purpose of reducing indiscriminate use of electronic copy and paste of patient information in records by physicians. Which data should be used to quantify the extent of the problem?
A. Percent of insurance billings denied due to lack of record documentation
B. Number of coder queries regarding inconsistent physician record documentation
C. Results of a survey of physicians that asks about documentation practices
D. Incidence of redundancies in physician notes in a sample of hospital admissions
Answer: D

Explanation
According to the AHIMA CDIP Exam Preparation Guide, a documentation integrity project is a systematic process of identifying, analyzing, and improving the quality and accuracy of clinical documentation in the health record1. A documentation integrity project may have various purposes, such as enhancing patient safety, improving coding and reimbursement, or complying with regulatory standards1. One of the common issues that may affect the quality and accuracy of clinical documentation is the indiscriminate use of electronic copy and paste of patient information in records by physicians2. Copy and paste is a function that allows physicians to duplicate existing text in the record and paste it in a new destination, which may save time and effort, but also may introduce errors, inconsistencies, or redundancies in the documentation2. Therefore, to quantify the extent of the problem of copy and paste, the data that should be used is the incidence of redundancies in physician notes in a sample of hospital admissions. Redundancies are repeated or unnecessary information that may clutter the record and impair its readability and reliability3. By measuring the frequency and types of redundancies in physician notes, the hospital can assess the impact of copy and paste on the documentation quality and identify areas for improvement. The other options are not correct because they do not directly measure the problem of copy and paste. The percent of insurance billings denied due to lack of record documentation may reflect other issues besides copy and paste, such as incomplete or inaccurate documentation, coding errors, or payer policies4. The number of coder queries regarding inconsistent physician record documentation may indicate the presence of copy and paste, but it may also depend on other factors such as coder knowledge, query guidelines, or query response rate. The results of a survey of physicians that asks about documentation practices may provide some insight into the perceptions and attitudes of physicians regarding copy and paste, but it may not reflect the actual extent or impact of the problem on the documentation quality.
CDIP Exam Preparation Guide - AHIMA
Auditing Copy and Paste - AHIMA
Copy/Paste: Prevalence, Problems, and Best Practices - AHIMA
Documentation Denials: How to Avoid Them - AAPC
[Q&A: Querying for clinical validation | ACDIS]

NO.6 A 45-year-old female is admitted after sustaining a femur fracture. Orthopedics is consulted and performs an open reduction internal fixation (ORIF) of the femur without complication. Nursing documents the patient has a body mass index of 42 kg/m2. The clinical documentation integrity practitioner (CDIP) determines a query is needed to capture a diagnosis associated with the body mass index so it can be reported. Which of the following is the MOST compliant query based on the most recent AHIIMA/ACDIS query practice brief?

A. Nursing documents the BMI is 42 kg/m2. In order to capture a co-morbid condition (CC) to increase reimbursement, please add 'morbid obesity with BMI 42 kg/m2' to your next progress note.

B. Nursing documents the BMI is 42 kg/m2. To increase the severity of illness and risk of mortality, please add 'morbid obesity with BMI 42 kg/m2' to your next progress note.

C. Nursing documents the BMI is 42 kg/m2. Can you please clarify if the patient's morbid obesity was present on admission and add the diagnosis to future progress notes?

D. Nursing documents the BMI is 42 kg/m2. Please consider if any of the following diagnoses should be added to the health record to support this finding: morbid obesity; obesity; other diagnosis (please state)

Answer: D
Explanation
This is the most compliant query based on the most recent AHIMA/ACDIS query practice brief because it is non-leading, non-suggestive, and provides multiple options for the physician to choose from. It also does not imply any financial or quality implications for adding a diagnosis associated with the BMI.
References: AHIMA/ACDIS. "Guidelines for Achieving a Compliant Query Practice (2019 Update)." Journal of AHIMA 90, no. 2 (February 2019): 20-29.

NO.7 Which of the following should be shared to ensure a clear sense of what clinical documentation integrity (CDI) is and the CDI practitioner's role within the organization?
A. Productivity standards
B. Review schedule
C. Milestones
D. Mission
Answer: D
Explanation
Sharing the mission of the CDI program should be done to ensure a clear sense of what CDI is and the CDI practitioner's role within the organization. The mission statement defines the purpose, goals, and values of the CDI program, and how it aligns with the organization's vision and strategy. The mission statement also communicates the benefits and expectations of the CDI program to various stakeholders, such as providers, executives, coders, quality staff, and patients. The mission statement can help establish the credibility, professionalism, and identity of the CDI practitioners, and guide their daily activities and decisions 2.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: Mission CDI: Guiding goals, values, and principles 1

NO.8 An 88-year-old male is admitted with a fever, cough, and leukocytosis. The physician documents admit for probable sepsis due to urinary tract infection (UTI). Antibiotics are started. Three days later, the blood and urine cultures are negative, the patient has been afebrile since admission, and the white blood count is returning to normal. What documentation clarification is needed to support accurate coding of the record?
A. Send a clinical validation query for only the diagnosis of sepsis.
B. Send a clinical validation query for both the diagnoses of sepsis and UTI.
C. A clinical validation query is not required for either diagnosis.
D. Send a clinical validation query for only the diagnosis of UTI.
Answer: B
Explanation
According to the Guidelines for Achieving a Compliant Query Practice (2019 Update) - AHIMA1, clinical validation is a process by which documentation is evaluated to ensure that the medical record demonstrates enough clinical support for all documented diagnoses as mandated by the False Claims Act. If there is a lack of clinical support for sepsis or UTI within the documentation, a clinical validation query should be sent.
Query choices should list sepsis or UTI as ruled out versus ruled in (because the physician is documenting sepsis or UTI), but the query choice should also ask the provider to provide additional

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

NO.9 A patient presents to the emergency room with acute shortness of breath. The patient has a history of lung cancer that has been treated previously with radiation and chemotherapy. The patient is intubated and placed on mechanical ventilation. A chest x-ray is remarkable for a pleural effusion. A thoracentesis is performed, and the cytology results show malignant cells. Diagnoses on discharge: Acute respiratory failure due to recurrence of small cell carcinoma and malignant pleural effusion. Which coding reference takes precedence for assigning the ICD-10-CM/PCS codes?

A. Conventions and instructions of the classification for ICD-10-CM/PCS

B. AMA CPT Assistant

C. AHA Coding Clinic for ICD-10-CM/PCS

D. ICD-10-CM Official Guidelines for Coding and Reporting

Answer: A

Explanation
According to the CDIP Exam Content Outline, one of the tasks of a clinical documentation integrity practitioner (CDIP) is to apply coding conventions, guidelines, and definitions for ICD-10-CM/PCS. Coding conventions are the general rules for the use of the classification system, such as the use of abbreviations, punctuation, symbols, and sequencing instructions. Coding guidelines are the official rules for selecting and reporting codes based on the documentation in the health record. Coding definitions are the explanations of the terms and concepts used in the classification system. The conventions and instructions of the classification for ICD-10-CM/PCS take precedence over any other coding reference because they are the primary source of coding rules and standards. The other coding references, such as AMA CPT Assistant, AHA Coding Clinic for ICD-10-CM/PCS, and ICD-10-CM Official Guidelines for Coding and Reporting, are secondary sources that provide additional guidance, clarification, or interpretation of the coding conventions and instructions.
References:
CDIP Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam-content-outline.pdf) ICD-10-CM Features | Diagnosis Coding: Using the ICD-10-CM1

NO.10 Which physician would best benefit from additional education for unanswered queries?

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

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

NO.11 A patient is admitted due to pneumonia. On day 1, a sputum culture is positive for psuedomonas bacteria. If the physician is queried and agrees that the patient has pseudomonas pneumonia, this specificity would
A. meet medical necessity
B. increase relative weight
C. not increase relative weight
D. not meet medical necessity
Answer: B
Explanation
The specificity of pseudomonas pneumonia would increase the relative weight of the diagnosis-related group (DRG) for the patient's admission, which would affect the reimbursement for the hospital. Relative weight is a factor that reflects the average cost and resource use of a DRG compared to the average cost and resource use of all DRGs. The higher the relative weight, the higher the payment for the hospital. Pseudomonas pneumonia is classified as a major complication or comorbidity (MCC) in ICD-10-CM, which means that it significantly increases the severity of illness and risk of mortality of the patient. MCCs increase the relative weight of a DRG by assigning it to a higher-paying subclass within the same base DRG. For example, according to the CMS FY 2022 Inpatient Prospective Payment System Final Rule1, the relative weight for DRG 193 (Simple pneumonia and pleurisy with MCC) is 1.4819, while the relative weight for DRG 195 (Simple pneumonia and pleurisy without MCC) is 0.7579. Therefore, if the patient is admitted due to pneumonia and has pseudomonas pneumonia as an MCC, the hospital would receive a higher payment than if the patient does not have an MCC.
References:

CDIP Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam-content-outline.pdf) CMS FY 2022 Inpatient Prospective Payment System Final Rule1

NO.12 The correct coding for insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is

A. 05HM33Z Insertion of infusion device into right internal jugular vein, percutaneous approach

B. 02H633Z Insertion of infusion device into right atrium, percutaneous approach

C. 05HP33Z Insertion of infusion device into right external jugular vein, percutaneous approach

D. 02HV33Z Insertion of infusion device into superior vena cava, percutaneous approach

Answer: A

Explanation

According to the ICD-10-PCS Reference Manual 2023, the insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is coded as follows1:

The first character 0 indicates the Medical and Surgical section.

The second character 5 indicates the Extracorporeal or Systemic Assistance and Performance root operation, which is defined as "Putting in or on a device that completely takes over a body function by extracorporeal means"1.

The third character H indicates the Central Vein body system, which includes the internal jugular vein1.

The fourth character M indicates the Infusion Device device value, which is defined as "A device that is inserted into a body part to deliver fluids or other substances to a body part or into the circulation"1.

The fifth character 3 indicates the Right Internal Jugular Vein body part value, which is the specific site of the procedure1.

The sixth character 3 indicates the Percutaneous approach, which is defined as "Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach and visualize the site of the procedure"1.

The seventh character Z indicates No Qualifier, which means there is no additional information necessary to complete the code1.

Therefore, the correct coding for insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is 05HM33Z.

References:

ICD-10-PCS Reference Manual 20231

NO.13 A 56-year-old male patient complains of feeling fatigued, has nausea & vomiting, swelling in both legs.

Patient has history of chronic kidney disease (CKD) stage III,

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

A. Dr. Adair, in your clinical opinion, do you think that the patient's acute kidney injury with ATN

exacerbated the patient's pneumonia?

B. No need to query the physician because even if the pneumonia is considered a HAC and cannot be used as an MCC, ATN is also an MCC.

C. No need to interact with the physician because it is obvious the pneumonia developed after admission, therefore, not present on admission.

D. Dr. Adair, please indicate if the patient's pneumonia was present on admission (POA) based on the initial chest x-ray?

Answer: D

Explanation

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

CDIP Exam Content Outline

CDIP Exam Preparation Guide

Present on Admission Reporting Guidelines

NO.14 Which of the following individuals is the first line of escalation for an unanswered query?

A. CDI Manager

B. CDI Steering Committee

C. Medical Director

D. HIM/Coding Manager

Answer: A

Explanation

The first line of escalation for an unanswered query is the CDI Manager because they are responsible for overseeing the CDI program and ensuring compliance with query policies and procedures. The CDI Manager can monitor the query response rates, identify the providers who are not responding, and communicate with them to address any issues or barriers. The CDI Manager can also provide education and feedback to the providers on the importance and benefits of timely query responses. If the CDI Manager is unable to resolve the problem, then they can escalate it to the next level, such as the Medical Director or the CDI Steering Committee. (CDIP Exam Preparation Guide) References:

CDIP Exam Content Outline1

CDIP Exam Preparation Guide2

Q&A: Establishing an escalation policy for inappropriate queries3