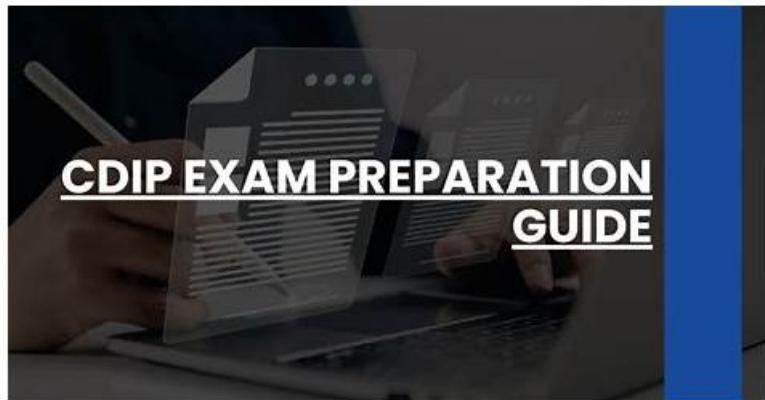


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AHIMA Certified Documentation Integrity Practitioner Sample Questions (Q81-Q86):

NEW QUESTION # 81

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 diagnosis with a higher degree of specificity has a lower severity of illness.
- B. The query rate is too high while the agreement rate is low.
- **C. The indicator is a key factor of measurement for quality reports.**
- D. The query response rate directly correlates to quality reports.

Answer: C

Explanation:

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

NEW QUESTION # 82

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

Answer: C

Explanation:

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/ownhxbv1/cdip_contentoutline_2023_final.pdf[3][3]:

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

NEW QUESTION # 83

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

Answer: A

Explanation:

Explanation

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

manual 2.

References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: CMS MS-DRG Definitions Manual, Version 38.0, p. 8-9 4

NEW QUESTION # 84

Reviewing and analyzing physician query content on a regular basis

- A. facilitates physician data collection
- B. aids in discussion between physician and reviewer
- C. helps to calculate query response rate
- D. assists in identifying gaps in skills and knowledge

Answer: D

Explanation:

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/ownhxhv1/cdip_contentoutline_2023_final.pdf 2:

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

NEW QUESTION # 85

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

Answer: B

Explanation:

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 # 86

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