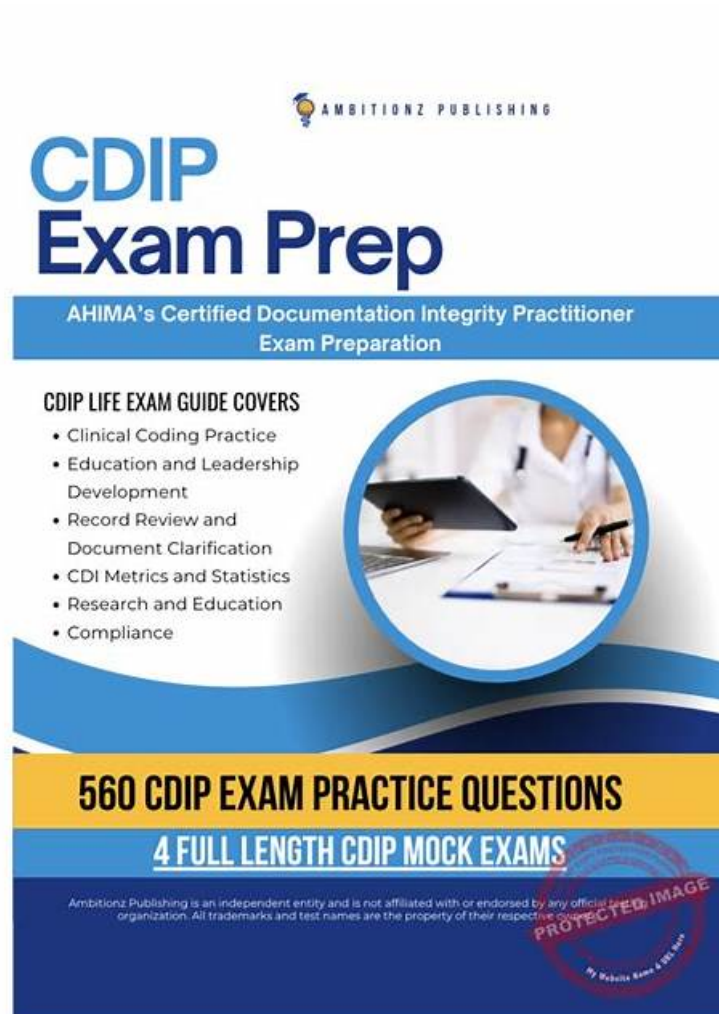


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AHIMA Certified Documentation Integrity Practitioner Sample Questions (Q75-Q80):

NEW QUESTION # 75

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

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

Answer: A

Explanation:

Explanation

The term used when a patient is entered in the MPI multiple times, in different ways, resulting in multiple medical record numbers is overlap. An overlap occurs when a person has more than one medical record number within an integrated delivery network or enterprise, and may cause problems such as incomplete or inaccurate patient information, duplicate testing or treatment, billing errors, or patient safety issues. An overlap may be caused by data entry errors, system conversions, mergers or acquisitions, or lack of standardization. Regular audits of the MPI database must be done to identify and resolve any overlaps and ensure data quality and integrity.

References:

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

NEW QUESTION # 76

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. Diagnostic related groups and revenue cycle
- C. Benchmarks and case mix index
- D. **Value and mission statements**

Answer: D

Explanation:

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 # 77

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

Answer: D

Explanation:

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 # 78

Based on the flowchart below, at what point might the clinical documentation integrity practitioner (CDIP) enlist the help of the physician advisor/champion?

- A. D - No retrospective query opportunity identified
- **B. H - Physician fails to respond to query**
- C. C - Retrospective query opportunity identified
- D. E - Physician agrees with query and documents in MR

Answer: B

NEW QUESTION # 79

Identify the error in the following query:

This patient's echocardiogram showed an ejection fraction of 25%. The chest x-ray showed congestive heart failure (CHF). The patient was prescribed Lasix and an angiotensin-converting enzyme inhibitor (ACEI). Is this patient's CHF systolic?

- A. The query is unclear.
- **B. The query is leading.**
- C. The query contains irrelevant information.
- D. The query does not contain clinical indicators.

Answer: B

Explanation:

Explanation

A leading query is one that suggests a specific diagnosis, condition, or treatment to the provider, or implies that a certain response is desired or expected. A leading query can compromise the integrity and accuracy of the documentation and the coded data, and may

also raise compliance and ethical issues. A query should be non-leading, meaning that it presents the facts from the health record without bias or influence, and allows the provider to use their clinical judgment to determine the appropriate response. The query in the question is leading because it implies that the patient's CHF is systolic by asking a yes/no question that only offers one option. A non-leading query would ask an open-ended question that offers multiple options, such as "What type of CHF does this patient have?" or "Please specify the type of CHF: systolic, diastolic, or combined."

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 # 80

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