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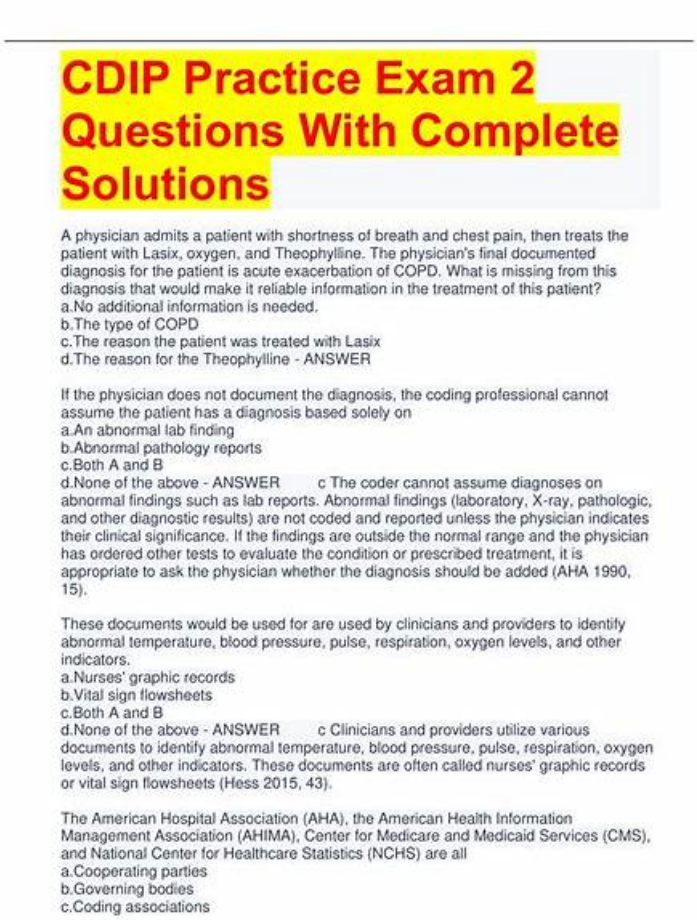

CDIP Practice Exam 2 Questions With Complete Solutions

A physician admits a patient with shortness of breath and chest pain, then treats the patient with Lasix, oxygen, and Theophylline. The physician's final documented diagnosis for the patient is acute exacerbation of COPD. What is missing from this diagnosis that would make it reliable information in the treatment of this patient?
a.No additional information is needed.
b.The type of COPD
c.The reason the patient was treated with Lasix
d.The reason for the Theophylline - ANSWER

If the physician does not document the diagnosis, the coding professional cannot assume the patient has a diagnosis based solely on
a.An abnormal lab finding
b.Abnormal pathology reports
c.Both A and B
d.None of the above - ANSWER c The coder cannot assume diagnoses on abnormal findings such as lab reports. Abnormal findings (laboratory, X-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the diagnosis should be added (AHA 1990, 15).

These documents would be used for are used by clinicians and providers to identify abnormal temperature, blood pressure, pulse, respiration, oxygen levels, and other indicators.
a.Nurses' graphic records
b.Vital sign flowsheets
c.Both A and B
d.None of the above - ANSWER c Clinicians and providers utilize various documents to identify abnormal temperature, blood pressure, pulse, respiration, oxygen levels, and other indicators. These documents are often called nurses' graphic records or vital sign flowsheets (Hess 2015, 43).

The American Hospital Association (AHA), the American Health Information Management Association (AHIMA), Center for Medicare and Medicaid Services (CMS), and National Center for Healthcare Statistics (NCHS) are all
a.Cooperating parties
b.Governing bodies
c.Coding associations

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AHIMA Certified Documentation Integrity Practitioner Sample Questions (Q21-Q26):

NEW QUESTION # 21
The physician advisor/champion needs to provide ongoing education regarding coding and reimbursement regulations to the

- A. Health Information Management coding staff
- B. organization senior administration staff
- C. clinical documentation integrity staff
- D. organization's medical and surgical staff

Answer: D

Explanation:
Explanation
The physician advisor/champion is a key role in the CDI program who serves as a liaison between the CDI staff and the organization's medical and surgical staff. The physician advisor/champion needs to provide ongoing education regarding coding and reimbursement regulations to the organization's medical and surgical staff to promote awareness, understanding, and compliance with CDI initiatives and goals.
References: AHIMA. "CDIP Exam Preparation." AHIMA Press, Chicago, IL, 2017: 97-98.

NEW QUESTION # 22
A patient is admitted for pneumonia with a WBC of 20,000, respiratory rate 20, heart rate 85, and oral temperature 99.0°. On day 2, sputum cultures reveal positive results for pseudomonas bacteria. The most appropriate action is to

- A. code pseudomonas pneumonia
- B. query the provider to see if pseudomonas sepsis is supported by the health record
- C. query the provider to document the etiology of pneumonia
- D. code pneumonia, unspecified

Answer: C

Explanation:
Explanation
The most appropriate action in this case is to query the provider to document the etiology of pneumonia, which is pseudomonas bacteria. This is because the etiology of pneumonia affects the coding and classification of the condition, as well as the severity of illness, risk of mortality, and reimbursement. According to the ICD-10-CM Official Guidelines for Coding and Reporting, pneumonia should be coded by type whenever possible, and if the type of pneumonia is not documented, then the default code is J18.9, Pneumonia, unspecified organism 2. However, if the type of pneumonia is documented, then a more specific code can be assigned, such as J15.1, Pneumonia due to Pseudomonas 3. Therefore, querying the provider to document the etiology of pneumonia will improve the accuracy and completeness of the documentation and coding, and reflect the true clinical picture of the patient.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 139 4 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section I.C.9.a 3: ICD-10-CM Code J15.1 - Pneumonia due to Pseudomonas

NEW QUESTION # 23
The clinical documentation integrity (CDI) team in a hospital is initiating a project to change the unacceptable documentation behaviors of some physicians. What strategy should be part of a project aimed at improving these behaviors?

- A. Encourage physician-nurse cooperation
- B. Add a physician advisor/champion to the CDI team
- C. Alter the physician documentation requirements
- D. Expand use of coding queries by CDI team

Answer: B

Explanation:
Explanation
A strategy that should be part of a project aimed at improving the unacceptable documentation behaviors of some physicians is to

add a physician advisor/champion to the CDI team. A physician advisor/champion is a physician leader who supports and advocates for the CDI program, educates and mentors other physicians on documentation best practices, resolves conflicts and barriers, and provides feedback and recognition to physicians who improve their documentation. A physician advisor/champion can help change the documentation behaviors of some physicians by using peer influence, credibility, and authority to motivate them to comply with the CDI program goals and standards. A physician advisor/champion can also help bridge the gap between the CDI team and the physicians, and foster a culture of collaboration and quality improvement 23.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 136 4 2: The Role of Physician Advisors in Clinical Documentation Improvement Programs 5 3: Physician Advisor: The Key to Clinical Documentation Improvement Success

NEW QUESTION # 24
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. Examples from the hospital's actual cases
- C. Explanations on how severity of illness and risk of mortality impact reimbursement
- D. Emphasize the Medicare requirements for documentation

Answer: B

Explanation:
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 # 25
Which of the following is the definition of an Excludes 2 note in ICD-10-CM?

- A. This is not a convention found in ICD-10-CM
- B. Neither of the codes can be assigned
- C. Only one code can be assigned to completely describe the condition
- D. Two codes can be used together to completely describe the condition

Answer: D

Explanation:
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 # 26
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