AHIMA CDIP Exam Questions: Reduce Your Chances Of Failure

CDIP Practice Exam 1

Assign code(s) for the following diagnosis: Congestive heart failure due to hypertension.

I10 Essential (primary) hypertension

I11.9 Hypertensive heart disease without heart failure

I11.0 Hypertensive heart disease with heart failure

I50.9 Heart failure, unspecified

I50.1 Left ventricular failure

I50.20 Unspecified systolic (congestive) heart failure

I50.21 Acute systolic (congestive) heart failure

I50.22 Chronic systolic (congestive) heart failure

I50.23 Acute on chronic systolic (congestive) heart failure

a. I10, I50.9

b. I11.0

c. I50.23, I10

d. I11.0, I50.9 - correct answer d Heart conditions are assigned a combination code when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code to identify the type of heart failure in those patients with heart failure (ICD-10-CM Official Guidelines for Coding and Reporting 2016b, 41).

Assign the best answer to complete the following sentence. The CPT codes for treatment of fractures:

a. Use the terminology "manipulation" rather than "reduction" of fracture

b. Include internal fixation in all codes

c. Do not include application of cast

d. Do not differentiate between open and closed treatment; CPT only specifies the site of the fracture - correct answer a Manipulation refers to the attempted reduction or restoration of a dislocated joint or fracture (Smith 2015, 84)

In CPT, if a patient has two lacerations of the arm that are repaired with simple closures, the coder would assign:

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AHIMA Certified Documentation Integrity Practitioner Sample Questions (Q31-Q36):

NEW QUESTION # 31
The BEST place for the provider to document a query response is which of the following?

- A. The query form
- B. The next progress note and the problem list
- C. The next progress note and all subsequent notes including the discharge summary
- D. An addendum to the history and physical

Answer: B

Explanation:
Explanation
The best place for the provider to document a query response is the next progress note and the problem list because this ensures that the query response is timely, consistent, and integrated into the health record. According to the AHIMA/ACDIS query practice brief1, the provider should document the query response in the health record as soon as possible after receiving the query, preferably in the next progress note.
The provider should also update the problem list to reflect any new or revised diagnoses resulting from the query response. This helps to maintain an accurate and comprehensive list of the patient's current and chronic conditions, which can facilitate continuity of care, quality reporting, and reimbursement. Documenting the query response in an addendum to the history and physical or only on the query form is not sufficient, as it may not capture the current status of the patient or be easily accessible to other providers or coders.
References:
CDIP Exam Content Outline (https://www.ahima.org/media/1z0x0x1a/cdip-exam-content-outline.pdf) Guidelines for Achieving a Compliant Query Practice-2022 Update1

NEW QUESTION # 32
When writing a compliant query, best practice is to

- A. use the term "possible" to describe a condition or diagnosis when uncertain if the diagnosis is present
- B. direct the physician to a specific diagnosis
- C. use a yes/no query format for specificity of a diagnosis
- D. include all relevant clinical indicators

Answer: D

Explanation:
Explanation
One of the best practices for writing a compliant query is to include all relevant clinical indicators from the health record that support the need for clarification and the query options. Clinical indicators are objective and measurable signs, symptoms, laboratory results, diagnostic test results, medications, treatments, and other documented findings that are related to a specific diagnosis or condition. Including clinical indicators helps to provide the rationale for the query, avoid leading or suggesting a desired response, and ensure that the query is based on evidence and not assumptions. The other options are not best practices for writing a compliant query. Directing the physician to a specific diagnosis is leading and noncompliant. Using the term "possible" to describe a condition or diagnosis when uncertain if the diagnosis is present is vague and imprecise. Using a yes/no query format for specificity of a diagnosis is discouraged, as it limits the provider's choices and may not capture the true clinical picture.

NEW QUESTION # 33
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. Milestones
- B. Productivity standards
- C. Review schedule
- D. Mission

Answer: D

Explanation:
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

NEW QUESTION # 34
A patient has a history of asthma and presents with complaints of fever, cough, general body aches, and lethargy. The patient's child was recently diagnosed with influenza. Wheezing is heard on exam. The physician documents the diagnosis as asthma exacerbation and orders nebulizer treatments of Albuterol and a 5-day course of oral Prednisone. The clinical documentation integrity practitioner (CDIP) is unsure which signs and symptoms are inherent to asthma. Which reference resource should be used to obtain this information?

- A. Physician's Desk Reference
- B. AMA CPT Assistant
- C. The Merck Manual
- D. Medical Dictionary

Answer: C

Explanation:
Explanation
The reference resource that should be used to obtain information about the signs and symptoms that are inherent to asthma is The Merck Manual. This is a comprehensive medical reference that covers various topics related to diseases, diagnosis, treatment, and prevention. The Merck Manual provides a detailed description of asthma, including its causes, risk factors, pathophysiology, clinical features, diagnosis, management, and complications. According to The Merck Manual, the signs and symptoms that are inherent to asthma are wheezing, coughing, chest tightness, and dyspnea (shortness of breath) 2. These symptoms are caused by the reversible bronchoconstriction and inflammation of the airways that characterize asthma. The Merck Manual also explains how these symptoms can be triggered or exacerbated by various factors, such as allergens, infections, exercise, cold air, stress, or medications 2.
References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 3 2: Asthma - Pulmonary Disorders - Merck Manuals Professional Edition 4

NEW QUESTION # 35
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. Examples from the hospital's actual cases
- B. Emphasize the Medicare requirements for documentation
- C. The latest Medicare Provider and Analysis Review data
- D. Explanations on how severity of illness and risk of mortality impact reimbursement

Answer: A

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 # 36

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