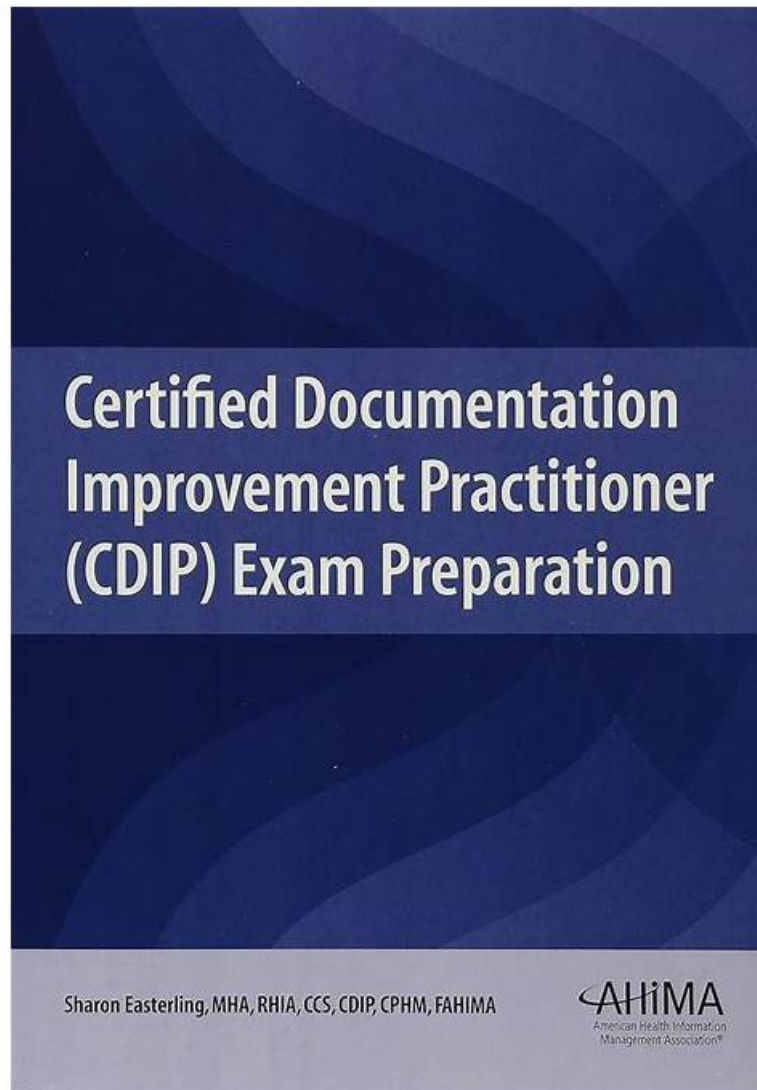


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AHIMA Certified Documentation Integrity Practitioner Sample Questions (Q73-Q78):

NEW QUESTION # 73

A hospital clinical documentation integrity (CDI) director suspects physicians are over-using electronic copy and paste in patient records, a practice that increases the risk of fraudulent insurance billings. A documentation integrity project may be needed. What is the first step the CDI director should take?

- A. Recommend the physicians to be involved in the project
- **B. Gather data on the incidence of inaccurate record documentation**
- C. Alert senior leadership to the record documentation problem
- D. Bring together a team of physicians and informatics specialists

Answer: B

Explanation:

Explanation

The first step the CDI director should take is to gather data on the incidence of inaccurate record documentation because it is important to establish the baseline and scope of the problem, as well as to identify the potential causes and consequences of over-using electronic copy and paste. Data collection can help to measure the frequency, severity, and impact of documentation errors, such as inconsistencies, redundancies, contradictions, or omissions. Data collection can also help to determine the best methods and tools for conducting the documentation integrity project, such as audits, surveys, interviews, or software applications. (CDIP Exam Preparation Guide1) References:

CDIP Exam Content Outline2

CDIP Exam Preparation Guide1

NEW QUESTION # 74

A patient presents to the emergency department for evaluation after suffering a head injury during a fall. A traumatic subdural hematoma is found on MRI, and the patient is taken directly to the operating room for evacuation. The neurosurgeon performs a burr hole procedure for evacuation of the subdural hematoma. The clot is removed successfully, and the patient is transferred to recovery in stable condition. Which is the correct current procedural terminology (CPT) code assignment for the procedure performed?

- A. 61140 Burr hole(s) or trephine; with biopsy of brain or intracranial lesion
- B. 61105 Twist drill hole subdural/ventricular puncture
- C. 61108 Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for evacuation and/or drainage of subdural hematoma
- **D. 61154 Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural**

Answer: D

Explanation:

Explanation

According to the CPT code description, 61154 is the appropriate code for a burr hole procedure for evacuation of a subdural hematoma. A burr hole is a small hole made in the skull with a surgical drill to access the brain or its coverings2. A subdural hematoma is a collection of blood between the dura mater and the arachnoid mater, which are two of the three layers that cover the brain3. The evacuation of the hematoma involves removing the clot and relieving the pressure on the brain. The other codes are not applicable for this procedure because they describe different methods of access (twist drill hole) or different purposes (biopsy or puncture)4.

References:

CDI Week 2020 Q&A: CDI and key performance indicators1

Mayo Clinic: Burr hole2

MedlinePlus: Subdural hematoma3

CPT Code Book 20234

NEW QUESTION # 75

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 # 76

Combination codes are used to classify two diagnoses, a diagnosis with a manifestation, or a diagnosis

- **A. with an associated complication**
- B. with an associated procedure
- C. that is an integral part of a disease process
- D. with a sequelae or late effect

Answer: A

Explanation:

Explanation

Combination codes are used to classify two diagnoses, a diagnosis with a manifestation, or a diagnosis with an associated complication. A complication is a condition that arises during the hospital stay that prolongs the length of stay by at least one day in approximately 75 percent of cases¹. Complications may affect payment and severity of illness and risk of mortality classifications. Examples of combination codes that include a diagnosis with an associated complication are:

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

K57.21 Diverticulitis of large intestine with perforation and abscess with bleeding O34.211 Maternal care for incompetent cervix with cerclage, first trimester A diagnosis that is an integral part of a disease process is not a valid option for combination codes, because it does not represent a separate or additional condition that needs to be coded. For example, chest pain is an integral part of acute myocardial infarction and does not require a separate code.

A diagnosis with an associated procedure is not a valid option for combination codes, because procedures are coded separately from diagnoses using ICD-10-PCS codes. For example, appendicitis with appendectomy is not a combination code, but rather two codes: one for the diagnosis (K35.80 Acute appendicitis without perforation or gangrene) and one for the procedure (0DTJ4ZZ Resection of appendix, percutaneous endoscopic approach).

A diagnosis with a sequelae or late effect is not a valid option for combination codes, because sequelae or late effects are coded separately from the original condition using the appropriate code from category B90-B94 Sequelae of infectious and parasitic diseases or category I69 Sequelae of cerebrovascular disease, followed by the code for the specific condition². For example, hemiplegia following cerebral infarction is not a combination code, but rather two codes: one for the sequelae (I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side) and one for the original condition (I63.9 Cerebral infarction, unspecified).

References:

CDIP Exam Preparation Guide, 2021 Edition. AHIMA Press. ISBN: 9781584268530 ICD-10-CM Official Guidelines for Coding and Reporting FY 2022 Identifying ICD-10 Combination Codes - Outsource Strategies International

NEW QUESTION # 77

Which of the following is MOST likely to trigger a second-level review?

- A. A diagnosis that impacts a quality-of-care measure

- B. A procedure code that increases reimbursement
- **C. A record with multiple major complicating conditions (MCCs)**
- D. An account coded before the discharge summary is available

Answer: C

Explanation:

Explanation

According to the AHIMA CDIP Exam Preparation Guide, a second-level review is a process that involves a review of coded records by a designated person or team to ensure the accuracy and completeness of coding and documentation¹. A second-level review may be triggered by various factors, such as high-risk or high-dollar accounts, coding quality indicators, payer requirements, or internal audit findings¹. One of the factors that is most likely to trigger a second-level review is a record with multiple major complicating conditions (MCCs)². MCCs are diagnoses that significantly affect the severity of illness and resource utilization of a patient, and are assigned a higher relative weight in the DRG system³. A record with multiple MCCs may indicate a complex or unusual case that requires additional validation and verification of the coding and documentation. A record with multiple MCCs may also affect the reimbursement, risk adjustment, and quality scores of the hospital, and therefore may be subject to external scrutiny or audit⁴. The other options are not as likely to trigger a second-level review, as they are not as indicative of coding or documentation issues or risks. A procedure code that increases reimbursement may not necessarily require a second-level review, unless it is inconsistent with the documentation or the clinical indicators. A diagnosis that impacts a quality-of-care measure may be relevant for CDI purposes, but not necessarily for coding validation.

An account coded before the discharge summary is available may be incomplete or inaccurate, but it may also be corrected or updated before final billing.

CDIP Exam Preparation Guide - AHIMA

Building a Resilient CDI: Second Level Review

Major Complications or Comorbidities (MCC) & Complications or Comorbidities (CC) | CMS Demystifying and communicating case-mix index - ACDIS

NEW QUESTION # 78

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