CDIP$^{Q\&As}$

Certified Documentation Integrity Practitioner

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QUESTION 1

When writing a compliant query, best practice is to

A. direct the physician to a specific diagnosis

B. include all relevant clinical indicators

C. use the term "possible" to describe a condition or diagnosis when uncertain if the diagnosis is present

D. use a yes/no query format for specificity of a diagnosis

Correct Answer: B

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.

QUESTION 2

A 56-year-old male patient complains of feeling fatigued, has nausea and vomiting, swelling in both legs. Patient has history of chronic kidney disease (CKD) stage III, coronary artery disease (CAD) and hypertension (HTN). He is on Lisinopril. Vital signs: BP 160/80, P 84, R 20, T 100.OF. Labs: WBC 11.5 with 76% segs, GFR 45. CXR showed slight left lower lobe haziness. Patient was admitted for acute kidney injury (AKI) with acute tubular necrosis (ATN). He was scheduled for hemodialysis the next day. Two days after admission patient started coughing, fever of 101.8F, CXR showed left lower lobe infiltrate, possible pneumonia. Attending physician documented that patient has pneumonia and ordered Rocephin

IV.

How should the clinical documentation integrity practitioner (CDIP) interact with the physician to clarify whether or not the pneumonia is a hospital-acquired condition (HAC)?

A.

Dr. Adair, in your clinical opinion, do you think that the patient\\'s acute kidney injury with ATN exacerbated the patient\\'s pneumonia?

B.

No need to query the physician because even if the pneumonia is considered a HAC and cannot be used as an MCC, ATN is also an MCC.

C.

No need to interact with the physician because it is obvious the pneumonia developed after admission, therefore, not present on admission.

D.

Dr. Adair, please indicate if the patient\\'s pneumonia was present on admission (POA) based on the initial chest x-ray?

Correct Answer: D

The clinical documentation integrity practitioner (CDIP) should interact with the physician to clarify whether or not the pneumonia is a hospital-acquired condition (HAC) by asking the physician to indicate if the pneumonia was present on admission (POA) based on the initial chest x-ray. This is because the POA status of a condition affects its coding, reporting, and reimbursement, and it is the responsibility of the physician to document the POA status of all diagnoses. The CDIP should not assume that the pneumonia developed after admission based on the timing of symptoms or treatment, as this may not reflect the true clinical picture. The CDIP should also not ask the physician about the causal relationship between the acute kidney injury and the pneumonia, as this is not relevant to the POA status. The CDIP should also not avoid querying the physician based on the presence of another MCC, as this may compromise the accuracy and completeness of documentation. (CDIP Exam Preparation Guide) References: CDIP ontent Outline CDIP Exam Preparation Guide Present on Admission Reporting Guidelines

QUESTION 3

A 27-year-old male patient presents to the emergency room with crampy, right lower quadrant abdominal pain, a low-grade fever (101?Fahrenheit) and vomiting. The patient also has a history of type I diabetes mellitus. A complete blood count reveals mild leukocytosis (13,000/microliter). Abdominal ultrasound is ordered, and the patient is admitted for laparoscopic surgery. The patient is given an injection of neutral protamine Hagedorn insulin, in order to normalize the blood sugar level prior to surgery. Upon discharge, the attending physician documents "right lower quadrant abdominal pain due to possible acute appendicitis or probable Meckel diverticulitis".

What is the proper sequencing of the principal and secondary diagnoses?

A. Right lower quadrant abdominal pain, acute appendicitis, Meckel diverticulitis, fever, vomiting, leukocytosis

B. Right lower quadrant abdominal pain, fever, vomiting, leukocytosis

C. Acute appendicitis, Meckel diverticulitis, type I diabetes mellitus

D. Acute appendicitis, right lower quadrant abdominal pain, type I diabetes mellitus

Correct Answer: D

The proper sequencing of the principal and secondary diagnoses in this case is as follows: Principal diagnosis: Acute appendicitis. This is the condition, after study, that occasioned the admission to the hospital, according to the ICD-10-CM Official Guidelines for Coding and Reporting. The patient was admitted for laparoscopic surgery, which is a definitive treatment for acute appendicitis. The physician documented "possible acute appendicitis or probable Meckel diverticulitis" as the cause of the right lower quadrant abdominal pain. According to the AHA\\'s Coding Clinic, Fourth Quarter 2016, pp. 147-148, when a physician documents two diagnoses connected by "or", coders should query the physician for clarification if possible. However, if a query is not possible or not answered, coders should assign codes for both conditions, unless one of them has been ruled out or confirmed by further testing or treatment. In this case, there is no indication that either acute appendicitis or Meckel diverticulitis has been ruled out or confirmed by further testing or treatment. Therefore, both conditions should be coded and reported. However, only one of them can be the principal diagnosis. Since acute appendicitis is more commonly associated with laparoscopic surgery than Meckel diverticulitis, and since it has a higher relative weight than Meckel diverticulitis under the MS-DRG system, it is reasonable to select acute appendicitis as the principal diagnosis 23. Secondary diagnosis: Right lower quadrant abdominal pain. This is a sign or symptom that is associated with the principal diagnosis and requires clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. The patient presented with right lower quadrant abdominal pain as a manifestation of acute appendicitis or Meckel diverticulitis. The pain required clinical evaluation by abdominal ultrasound and therapeutic treatment by

laparoscopic surgery. Therefore, it should be coded and reported as a secondary diagnosis 4. Secondary diagnosis: Type I diabetes mellitus. This is a chronic condition that affects the patient\\'s care in terms of requiring diagnostic or therapeutic services or affecting patient outcomes or resource utilization. The patient has a history of type I diabetes mellitus and received an injection of neutral protamine Hagedorn insulin to normalize the blood sugar level prior to surgery. Therefore, it should be coded and reported as a secondary diagnosis 4. References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 2: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section II.A 3: AHA Coding Clinic for ICD- 10-CM and ICD-10-PCS, Fourth Quarter 2016 4: ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, Section III.C : AHIMA CDIP Exam Prep, Fourth Edition
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QUESTION 4

Patient is admitted with oliguria, pulmonary edema, and dehydration. Labs are remarkable for an elevated creatinine of 2.4, with a baseline of 1.1. Patient was hydrated for 48 hours with drop in creatinine. What would the appropriate action be?

A. No query is needed because the patient was dehydrated

B. Query the physician to see if acute renal failure is clinically supported

C. Query the physician to see if acute renal failure with tubular necrosis is supported

D. Code acute renal failure since symptoms are there and documented

Correct Answer: B

The appropriate action in this case is to query the physician to see if acute renal failure is clinically supported. This is because the patient has signs and symptoms of acute renal failure, such as oliguria, pulmonary edema, and elevated creatinine, but the diagnosis is not documented in the medical record. Acute renal failure is a clinical syndrome characterized by a rapid decline in kidney function and accumulation of metabolic waste products. It can be caused by various factors, such as dehydration, hypovolemia, sepsis, nephrotoxins, or obstruction. Acute renal failure can be classified according to the RIFLE criteria (Risk, Injury, Failure, Loss, End-stage kidney disease) or the AKIN criteria (Acute Kidney Injury Network), which are based on changes in serum creatinine and urine output 23. A query to the physician is needed to confirm or rule out the diagnosis of acute renal failure, specify the etiology and severity of the condition, and document any associated complications or comorbidities. A query to the physician will also improve the accuracy and completeness of the documentation and coding, and reflect the true clinical picture and resource utilization of the patient. References: 1: AHIMA CDIP Exam Prep, Fourth Edition, p. 133 4 2: Acute Kidney Injury: Diagnosis and Management | AAFP 3: AKIN Classification for Acute Kidney Injury (AKI) - MDCalc

QUESTION 5

Collaboration between the physician advisor/champion and the clinical documentation integrity practitioners (CDIPs) would likely include

A. performing data analysis

B. developing query forms

C. educating physicians

D. querying physicians

Correct Answer: C

Collaboration between the physician advisor/champion and the clinical documentation integrity practitioners (CDIPs) would likely include educating physicians on the importance and impact of clinical documentation on coding, reimbursement,

quality measures, compliance, and patient care. The physician advisor/champion can act as a liaison between the CDIPs and the medical staff, provide feedback and guidance on query development and resolution, and facilitate peer-to-peer

education sessions on documentation best practices and standards6 References: 1:

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