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Topic Break Down

Topic	No. of Questions
Topic 1, Clinical Documentation Integrity	73
Topic 2, Leadership	27
Topic 3, Coding and Healthcare Reimbursement Methodologies	28
Topic 4, Quality and Compliance	27
Total	155

QUESTION NO: 1

The best approach in resolving unanswered queries is to

- A. notify the physician advisor/champion that the physician has not responded to the query
- B. review the facility's query policies and procedures
- C. contact the physician repeatedly until he/she responds to the query
- D. notify the coding team of the physician's unanswered query

ANSWER: B

Explanation:

Reviewing the facility's query policies and procedures is the appropriate first approach because unanswered queries must be handled through a consistent, organization-approved escalation process rather than through an ad hoc response. A well-defined policy establishes the expected timeframe for provider response, appropriate follow-up steps, documentation requirements, and the roles of individuals who may become involved when a query remains unresolved, such as a physician advisor, department leadership, or administration. Applying the established process supports equitable treatment of providers, respects provider workflow, and helps preserve the integrity of the clinical documentation improvement process. It also ensures that the organization addresses outstanding documentation clarification needs in a manner aligned with its governance structure and compliance expectations. AHIMA's practice guidance emphasizes that organizations should have policies for query escalation and follow-up, including procedures for queries that do not receive a response. Consulting the local policy enables the CDI professional to take the next appropriate action at the correct escalation level and within the facility's defined timelines. See AHIMA's [Guidelines for Achieving a Compliant Query Practice](#) and AHIMA's [Clinical Documentation Integrity resources](#).

QUESTION NO: 2

A dietitian documents severe protein-calorie malnutrition after assessing significant weight loss, severe muscle wasting, and poor oral intake. The attending provider documents only weight loss and poor appetite. What is the most appropriate action?

- A. Code severe protein-calorie malnutrition from the dietitian's assessment
- B. Query the provider to clarify whether malnutrition is clinically supported
- C. Code weight loss because it is the only condition documented by the provider
- D. Wait until discharge to determine whether the dietitian's diagnosis can be coded

ANSWER: B

Explanation:

Query the provider to clarify whether malnutrition is clinically supported is correct. Dietitian documentation and nutrition assessments provide important clinical indicators, but the provider is responsible for establishing and documenting the diagnosis of malnutrition for code assignment.

The query should include relevant findings such as the weight-loss history, muscle wasting, intake, nutrition assessment, and treatment plan. It should ask the provider to identify the clinically supported diagnosis and severity, if applicable, while allowing an alternative response or a determination that malnutrition is not present. Coding severe malnutrition from the dietitian's documentation alone would not be appropriate.

QUESTION NO: 3

A resident returns to the long-term care facility following hospital care for pneumonia. The physician's orders and progress note state "Continue IV antibiotics for

pneumonia - 3 more days, after which time the resident is to have a repeat x-ray to determine status of the pneumonia". Is it appropriate to code the pneumonia in this

scenario?

- A. Yes J18.8, Pneumonia, other specified organism
- B. No, since the patient needed a repeat x-ray, the condition does not clarify as a diagnosis
- C. Yes, J18.9, Pneumonia, unspecified organism, should be coded until the condition is resolved
- D. Yes, J18.9, Pneumonia, unspecified organism, Z79.2 should be coded along with long term antibiotics

ANSWER: C

Explanation:

Yes, J18.9, Pneumonia, unspecified organism, should be coded until the condition is resolved. The provider has explicitly documented pneumonia, and the documentation shows that it remains an active condition on the resident's return to the long-term care facility. Specifically, treatment continues with IV antibiotics for three additional days, and a follow-up chest x-ray is planned to assess the pneumonia's status. These actions demonstrate that the diagnosis is currently affecting the resident's care, treatment plan, and clinical monitoring rather than merely representing resolved historical illness.

When a provider documents pneumonia without identifying a causal organism, ICD-10-CM code J18.9, Pneumonia, unspecified organism, is the appropriate code. The diagnosis remains reportable while it is active and requires management. In the long-term care setting, active diagnoses are those that have a direct relationship to the resident's current status, care, or services. Ongoing antimicrobial therapy and planned diagnostic reassessment support continued reporting of pneumonia until the provider documents that it has resolved or is no longer active. This approach is consistent with the ICD-10-CM outpatient coding principle to report documented conditions that require or affect care, treatment, or management. See the [ICD-10-CM Official Guidelines for Coding and Reporting](#) and CMS's [ICD-10-CM code resources](#).

QUESTION NO: 4

A patient receives a blood transfusion after a 400 ml blood loss during surgery. The clinical documentation integrity practitioner (CDIP) queries the physician for an

associated diagnosis. The facility does not maintain queries as part of the permanent health record. What does the physician need to document for the CDIP to record the

query as answered and agreed?

- A. That the blood loss was not clinically significant
- B. The associated diagnosis and the clinical rationale in the progress notes
- C. A cause-and-effect relationship between anemia and the underlying cause
- D. The associated diagnosis directly on the query form

ANSWER: B

Explanation:

The associated diagnosis and the clinical rationale in the progress notes is correct because the query itself will not be retained as part of this facility's permanent health record. To make the response available for coding, quality reporting, and future clinical use, the physician must place the substantive clarification in the legal health record. In this situation, the documentation should identify the diagnosis that explains the clinical significance of the blood loss and transfusion, when clinically supported, and describe the relevant rationale or supporting clinical context. This creates a clear, provider-authenticated record of the condition and its relationship to the care delivered rather than relying on an external CDI communication tool. A CDI practitioner may then record the query as answered and agreed because the requested clarification is represented in the physician's progress documentation. This practice supports a complete and accurate health record while preserving the physician's responsibility for diagnostic statements. Federal hospital requirements likewise require medical records to contain information sufficient to identify, support, and justify the patient's diagnosis and treatment.

QUESTION NO: 5

After one year, the clinical documentation integrity (CDI) program has become stagnant, and the manager plans to reinvigorate the program to better reflect the CDI

efforts in the organization. What can the manager do to ensure program success?

- A. Expand the CDI program to larger areas in outpatient clinics
- B. Prioritize to focus on efforts with the largest return on investment
- C. Identify key metrics to develop program measures for coders
- D. Establish a CDI steering committee to build a strong foundation

ANSWER: D

Explanation:

Establish a CDI steering committee to build a strong foundation is correct because a mature, sustainable CDI program requires formal interdisciplinary governance. A steering committee brings together leaders and stakeholders from areas affected by documentation integrity, commonly including health information management/coding, clinical leadership, quality, case management, finance/revenue cycle, compliance, and information technology as appropriate. This structure enables the organization to set a shared vision, align CDI priorities with enterprise goals, review meaningful performance data, remove operational barriers, and make decisions about resources and program scope. For a program that has become stagnant, regular steering-committee oversight provides a mechanism to reassess the program charter, define actionable goals, monitor outcomes, and maintain provider and leadership engagement. AHIMA describes CDI as a process that improves the quality and integrity of health record documentation through collaboration among healthcare professionals; effective governance supports that collaboration across the organization. The committee should use established reporting and a regular meeting cadence to evaluate whether CDI activities continue to support accurate, complete documentation and organizational quality initiatives. AHIMA resources on CDI practice and governance are available through the [AHIMA CDIP certification page](#) and the [Journal of AHIMA](#).

QUESTION NO: 6

A 94-year-old female patient is admitted with altered mental status and inability to move the left side of her body. She is diagnosed with a cerebral vascular accident with left sided weakness. The patient is ambidextrous, but the physician does not specify the

predominance of the affected side. The default code is

- A. ambidextrous
- B. non-dominant
- C. preferred
- D. dominant

ANSWER: D

Explanation:

dominant is correct. ICD-10-CM code selection for conditions involving hemiplegia, hemiparesis, or similar deficits may require identification of whether the affected side is dominant or nondominant. When the record identifies the affected side but does not document its dominance, the ICD-10-CM Official Guidelines provide a default convention. Specifically, for an ambidextrous patient, the default is the dominant side. Therefore, the documentation integrity professional or coder should apply the dominant-side code choice when no provider clarification establishes a different dominance status. This convention

supports consistent code assignment where the clinical documentation contains laterality but lacks the additional dominance detail required by the classification. It does not establish a clinical fact about the patient's functional preference; rather, it is the coding default expressly supplied by the ICD-10-CM guidelines for this documentation scenario. The relevant guidance appears in the ICD-10-CM conventions addressing dominance and is applicable when the classification does not otherwise provide a default. See the [ICD-10-CM Official Guidelines for Coding and Reporting](#) and the [CMS ICD-10-CM resources](#).

QUESTION NO: 7

A patient with chronic obstructive pulmonary disease uses 2 L of oxygen at home. During the admission, the patient remains on 2 L of oxygen with oxygen saturation of 96%, no documented respiratory distress, and no escalation of respiratory support. The attending provider documents acute respiratory failure. What is the most appropriate action for the clinical documentation integrity practitioner (CDIP)?

- A. Accept acute respiratory failure because it was documented by the attending provider
- B. Send a clinical validation query regarding acute respiratory failure
- C. Query the provider for acute on chronic respiratory failure
- D. Remove acute respiratory failure from the record before coding

ANSWER: B

Explanation:

Send a clinical validation query regarding acute respiratory failure is correct. A documented diagnosis should be clinically supported by the health record. In this case, the available information describes oxygen use at the patient's baseline level without documented evidence of acute respiratory compromise or increased respiratory support. The CDIP should not independently remove the diagnosis or assume that the diagnosis is valid solely because it was documented.

A compliant clinical validation query should summarize the relevant clinical indicators and allow the provider to clarify whether acute respiratory failure was present, another condition was present, or the condition was ruled out. Querying for acute on chronic respiratory failure would be inappropriate because the record does not establish an acute change from the patient's baseline respiratory status.

QUESTION NO: 8

The key component of the auditing and monitoring process to ensure provider query response is to

- A. audit individual providers to indicate improvement in health record documentation
- B. have a process in place for ongoing education and training of the staff involved in conducting provider queries
- C. make sure that the language in the query is not leading or otherwise inappropriate
- D. review queries retrospectively to ensure that they are completed according to documented Policies and procedures

ANSWER: D

Explanation:

Review queries retrospectively to ensure that they are completed according to documented Policies and procedures is correct because retrospective auditing provides an objective way to verify that the organization's query workflow is being followed consistently after queries are issued. A compliant query process must define expectations for query initiation, tracking, provider response, escalation, follow-up, and closure. Reviewing completed queries against those established policies and procedures allows the CDI or HIM team to measure whether responses are being obtained and processed in the required manner, identify workflow gaps or recurring barriers, and use findings to improve the process. This monitoring also creates evidence that the organization actively oversees its query practice rather than relying solely on informal follow-up. AHIMA's guidance emphasizes that organizations should maintain a formal, compliant query process with policies and procedures, including quality-monitoring activities that support appropriate query practices and documentation

integrity. Retrospective review is therefore a core operational control for confirming that queries have been handled and completed in alignment with the organization's approved standards. See AHIMA's [Guidelines for Achieving a Compliant Query Practice](#) and its [policy and practice resources](#).

QUESTION NO: 9

The clinical documentation integrity practitioner (CDIP) performed a verbal query and then later neglected following up with the provider. How should the CDIP avoid a

compliance risk for this follow up failure according to AHIMA's Guidelines for Achieving a Compliant Query Practice?

- A. Complete the documentation immediately after the provider's response
- B. Complete the documentation at the end of the day when entering cases reviewed
- C. Complete the documentation when there is a provider agreement
- D. Complete the documentation at the time of discussion or immediately following

ANSWER: D

Explanation:

Complete the documentation at the time of discussion or immediately following is correct because AHIMA's compliant query guidance treats verbal queries as a process that requires timely, clear, and auditable documentation. When a CDIP discusses a query verbally with a provider, documenting the interaction at the time it occurs—or immediately afterward—creates a reliable record of the clinical clarification sought, the provider's response, and any resulting documentation action. This prompt documentation supports continuity between the query, the provider's decision, and the health record, while reducing the risk that details will be forgotten, misstated, or omitted during later case-entry work. It also supports an organization's ability to monitor query activity and demonstrate that its query process is compliant, non-leading, and appropriately integrated into the record workflow. AHIMA emphasizes that organizations should have policies addressing verbal queries and their documentation, including timely recording of the query and response. The timing described directly addresses the risk created when a practitioner fails to follow up after a verbal discussion. See AHIMA's [Guidelines for Achieving a Compliant Query Practice: 2022 Update](#) and the related [AHIMA policy resources](#).

QUESTION NO: 10

The correct coding for insertion of a dialysis catheter into the right internal jugular vein with the tip ending in the cavoatrial junction is

- A. 05HM33Z Insertion of infusion device into right internal jugular vein, percutaneous approach
- B. 02H633Z Insertion of infusion device into right atrium, percutaneous approach
- C. 05HP33Z Insertion of infusion device into right external jugular vein, percutaneous approach
- D. 02HV33Z Insertion of infusion device into superior vena cava, percutaneous approach

ANSWER: A

Explanation:

05HM33Z Insertion of infusion device into right internal jugular vein, percutaneous approach correctly represents placement of a dialysis catheter through the right internal jugular vein. In the ICD-10-PCS Medical and Surgical section, the root operation is *Insertion*, because a nonbiological appliance is being put in a body part for monitoring, assisting, performing, or preventing a physiological function. The applicable body system is Upper Veins, and the body-part value identifies the right internal jugular vein, which is the documented vascular access site. The device value for this catheter is an infusion device, and the percutaneous approach is appropriate when the catheter is introduced through a needle puncture or small skin incision rather than by an open incision. The cavoatrial-junction tip location confirms central venous placement and the intended function of the catheter but does not change the documented right internal jugular vein insertion-site body-

part value. Code assignment should be supported by the operative or procedural documentation, including the access vein, approach, and device placed. The ICD-10-PCS tables and official coding guidelines are published by CMS at [CMS ICD-10-PCS](#) and [Official ICD-10-PCS Coding Guidelines](#).

QUESTION NO: 11

Besides the physician advisor/champion, who should be included as a key stakeholder in the clinical documentation integrity (CDI) steering committee to promote CDI

initiatives?

- A. Manager of Surgical Services
- B. Director of Informatics
- C. Manager of HIM/Coding
- D. Director of Risk Management

ANSWER: C

Explanation:

Manager of HIM/Coding is the appropriate key stakeholder because CDI and coding are interdependent functions. CDI specialists work to ensure that the health record clearly, consistently, and completely reflects the patient's clinical condition and care, while the HIM/coding function translates final provider documentation into compliant coded data. Including the HIM/Coding manager on the steering committee creates a formal connection between CDI operations, coding quality, reimbursement processes, clinical data integrity, and organizational compliance.

This leader can identify documentation patterns that affect code assignment, communicate coding-guideline changes and audit findings, help establish query and escalation practices, and monitor whether CDI efforts improve the accuracy and completeness of coded data. The HIM/Coding manager also brings insight into coding workflow, productivity, denial trends, and the effect of documentation improvement initiatives on reporting and revenue-cycle performance. Those responsibilities make this role especially valuable in setting program goals, reviewing performance measures, and aligning CDI priorities with organizational data-governance needs.

AHIMA identifies documentation integrity as a collaborative practice involving accurate health information and coded data, competencies central to the CDIP credential. See AHIMA's [CDIP certification information](#) and its [professional resources](#).

QUESTION NO: 12

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 pneumonia, unspecified
- 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 pseudomonas pneumonia

ANSWER: C

Explanation:

"query the provider to document the etiology of pneumonia" is the most appropriate action because the positive sputum culture is clinical evidence that may clarify the organism responsible for the patient's documented pneumonia, but it does not by itself establish the provider's diagnosis of pneumonia due to Pseudomonas. The provider must integrate the culture result

with the patient's clinical presentation, assessment, and treatment to determine whether *Pseudomonas* is the cause of the pneumonia, represents colonization, or has another clinical significance. A nonleading, clinically supported query gives the provider the opportunity to document that conclusion clearly.

If the provider confirms *Pseudomonas* as the etiology, the record supports assignment of the more specific diagnosis, Pneumonia due to *Pseudomonas* (J15.1), rather than an unspecified-organism pneumonia code. Specific provider documentation improves the accuracy and completeness of the health record and ensures that coded data reflect the condition evaluated and managed during the admission. The ICD-10-CM Official Guidelines require code assignment to be based on the provider's diagnostic statement, with additional code specificity applied when supported by documentation. See the [ICD-10-CM Official Guidelines for Coding and Reporting](#) and the [CMS ICD-10-CM code resources](#).

QUESTION NO: 13

A 45-year-old female is admitted after sustaining a femur fracture. Orthopedics is consulted and performs an open reduction internal fixation (ORIF) of the femur

without complication. Nursing documents the patient has a body mass index of 42 kg/m². The clinical documentation integrity practitioner (CDIP) determines a query is

needed to capture a diagnosis associated with the body mass index so it can be reported. Which of the following is the MOST compliant query based on the most recent

AHIMA/ACDIS query practice brief?

- A. Please add obesity due to a BMI of 42 kg/m² to your next progress note.
- B. Can you document morbid obesity in the progress note?
- C. Does this patient have obesity based on the nursing notes?
- D. Based on the documented BMI of 42 kg/m², please clarify the diagnosis associated with this finding: obesity; morbid obesity; other diagnosis (please state).

ANSWER: D

Explanation:

"Based on the documented BMI of 42 kg/m², please clarify the diagnosis associated with this finding: obesity; morbid obesity; other diagnosis (please state)" is the most compliant query because it is based on a documented clinical indicator and asks the responsible provider to establish the clinically relevant diagnosis. A BMI value is a finding, not itself a provider diagnosis; the query appropriately seeks clarification of the condition represented by that finding so the health record accurately reflects the patient's condition. The query is non-leading because it presents clinically reasonable choices rather than directing the provider to document a particular diagnosis. It also provides an open-ended "other diagnosis" response, preserving the provider's independent clinical judgment. In practice, a compliant multiple-choice query should include the relevant clinical indicators, reasonable options supported by the record, and an opportunity for the provider to document another diagnosis or indicate that no diagnosis is clinically supported. These elements help ensure that the final documentation is complete and accurate without influencing the provider's decision. The AHIMA/ACDIS guidance describes queries as clarification tools that must be non-leading and supported by clinical evidence. See the [AHIMA/ACDIS Guidelines for Achieving a Compliant Query Practice](#) and [CMS ICD-10-CM resources](#).

QUESTION NO: 14

A patient presents to the emergency room with acute shortness of breath. The patient has a history of lung cancer that has been treated previously with radiation and

chemotherapy. The patient is intubated and placed on mechanical ventilation. A chest x-ray is remarkable for a pleural effusion. A thoracentesis is performed, and the

cytology results show malignant cells. Diagnoses on discharge: Acute respiratory failure due to recurrence of small cell carcinoma and malignant pleural effusion. Which

coding reference takes precedence for assigning the ICD-10-CM/PCS codes?

- A. Conventions and instructions of the classification for ICD-10-CM/PCS
- B. AMA CPT Assistant
- C. AHA Coding Clinic for ICD-10-CM/PCS
- D. ICD-10-CM Official Guidelines for Coding and Reporting

ANSWER: A

Explanation:

Conventions and instructions of the classification for ICD-10-CM/PCS take precedence because they are part of the code sets themselves and establish the mandatory rules for code assignment, code specificity, sequencing, and the interpretation of instructional notes. The ICD-10-CM Official Guidelines for Coding and Reporting explicitly state that adherence to the official conventions, general coding guidelines, and chapter-specific guidelines is required, and that the conventions and instructions within the classification take precedence over the guidelines. In practice, this means the coder must first follow applicable Tabular List instructions, such as inclusion terms, excludes notes, code-first notes, use-additional-code notes, and other sequencing directions, when assigning diagnosis codes. The same principle applies to ICD-10-PCS, whose tables, definitions, and instructional conventions govern inpatient procedure-code construction. These classification-level directions are authoritative because they directly control how the code set is applied to the documented clinical facts, including the recurrent malignancy, malignant pleural effusion, and acute respiratory failure in this case. Official guidance can supplement code assignment, but it cannot override an explicit convention or instruction in ICD-10-CM/PCS. See the [ICD-10-CM Official Guidelines for Coding and Reporting](#) and CMS's [ICD-10-PCS code-set resources](#).

QUESTION NO: 15

A patient is admitted for chronic obstructive pulmonary disease (COPD) exacerbation. The patient is on 3L of home oxygen and is treated during admission with 3L of

oxygen. The most appropriate action is to

- A. query the provider to see if acute on chronic respiratory failure is supported by the health record
- B. query the provider to see if chronic respiratory failure is supported by the health record
- C. code the diagnoses of COPD exacerbation and chronic respiratory failure
- D. query the provider to see if respiratory insufficiency is supported by the health record

ANSWER: B

Explanation:

query the provider to see if chronic respiratory failure is supported by the health record is the appropriate action. Long-term home oxygen use is a clinical indicator that may be consistent with chronic respiratory failure, but oxygen use alone does not establish or permit coding of that diagnosis. When the record contains clinical indicators suggesting a reportable condition that has not been documented, a nonleading provider query may be used to clarify whether the condition is clinically present and evaluated, monitored, or treated. Here, the patient's baseline use of 3 L of oxygen at home and continued use of the same flow rate during the admission supports clarification of possible chronic respiratory failure. The provider remains responsible for determining whether chronic respiratory failure is clinically supported and for documenting the final diagnosis. This approach follows compliant query principles: queries should be based on relevant clinical evidence, seek clarification rather than direct a particular response, and accurately reflect the patient's condition. The ICD-10-CM Official Guidelines also require coding to be based on provider documentation, with clarification obtained when documentation is incomplete or unclear. See the [AHIMA query practice resources](#) and the [ICD-10-CM Official Guidelines for Coding and Reporting](#).