CDIP Domain 3: Research & Education Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- **Practice answering questions under realistic conditions,**
- **Improve accuracy and speed,**
- **Review explanations to strengthen weak areas, and**
- **Approach the exam with greater confidence.**

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. **When a discharge diagnosis of septicemia is not documented by the physician, but laboratory tests and treatment align with septicemia, how should the physician be requested to document this condition?**
    - **A. An addendum to the chart should be written.**
    - **B. Document septicemia in the discharge summary.**
    - **C. Rewrite the history and physical.**
    - **D. Code septicemia based on lab results.**

2. **Severe sepsis includes the signs and symptoms of sepsis plus what?**
    - **A. Multi-organ dysfunction**
    - **B. Renal failure**
    - **C. Pneumonia**
    - **D. Hypotension only**

3. **In the pneumonia case, which organism was identified as the causative agent?**
    - **A. Klebsiella pneumoniae**
    - **B. Streptococcus pneumoniae**
    - **C. Pseudomonas aeruginosa**
    - **D. Staphylococcus aureus**

4. **A patient presents with acute chest pain and a 12-lead ECG showing ST elevation. What type of myocardial infarction is this commonly referred to?**
    - **A. NSTEMI**
    - **B. STEMI**
    - **C. Type 2 MI**
    - **D. Q-wave MI**

5. **In the case of the patient with a traumatic GI bleed, what symptom persisted at discharge affecting mobility status?**
    - **A. Full mobility**
    - **B. No feeling or mobility in the lower extremities**
    - **C. Normal sensation in feet**
    - **D. Improved motor function in legs**

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6. In this case of heart failure, which biomarker was elevated to support the diagnosis?

A. BNP

B. Troponin

C. CK-MB

D. D-dimer

7. A physician query should be used to clarify documentation that affects which aspect?

A. Diagnostic ambiguities impacting code assignment

B. Billing dates only

C. Nurse notes only

D. Equipment used

8. According to CMS guidelines, which document should be completed no more than 30 days before or 24 hours after admission?

A. History and Physical

B. Operative Report

C. Discharge Summary

D. Progress Note

9. A physician query is sometimes called a clarification, clinical clarification, or documentation clarification. What is another term used for a query?

A. Documentation alert

B. Clinical decision support

C. Audit reminder

D. Coding guidance

10. For a patient with traumatic brain injury and no responses, what action should the CDI professional take?

A. Query the provider if coma should be reported and review Glasgow coma score

B. Document coma in the record automatically

C. Ignore the coma status until discharge

D. Wait for neurological assessment at discharge

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Answers

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1. A
2. A
3. A
4. B
5. B
6. A
7. A
8. A
9. A
10. A

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Explanations

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1. When a discharge diagnosis of septicemia is not documented by the physician, but laboratory tests and treatment align with septicemia, how should the physician be requested to document this condition?

A. An addendum to the chart should be written.

B. Document septicemia in the discharge summary.

C. Rewrite the history and physical.

D. Code septicemia based on lab results.

The key idea is that coding relies on a diagnosis that the physician has documented. When there's strong clinical evidence—lab results and treatment—that septicemia is present or highly likely, the chart should explicitly reflect that diagnosis, and the way to do this is to have the physician add an addendum to the chart. An addendum allows the physician to document septicemia after reviewing the evidence without altering the original note inappropriately, and it creates an auditable, accurate record that supports coding. This approach keeps the medical record truthful and complete. If you coded septicemia based only on labs or treatment, you'd be labeling a diagnosis that isn't officially documented by the clinician, which isn't appropriate. Rewriting the history and physical isn't the proper route, and simply including septicemia in the discharge summary without the physician's documented confirmation can lead to inaccuracies. So the correct step is requesting an addendum to document the condition as recognized by the physician.

2. Severe sepsis includes the signs and symptoms of sepsis plus what?

A. Multi-organ dysfunction

B. Renal failure

C. Pneumonia

D. Hypotension only

Severe sepsis means sepsis with organ dysfunction, indicating that the septic process has affected multiple body systems beyond the initial infection. The best choice reflects this broader impact—multi-organ dysfunction signals that more than one organ is failing, which is what makes sepsis become severe. Renal failure is an example of organ dysfunction, but naming just one organ doesn't capture the widespread systemic impact that defines severe sepsis. Pneumonia describes where the infection started, not the severity of the septic response. Hypotension can occur with sepsis, but it isn't by itself sufficient to define severe sepsis; some patients exhibit organ dysfunction without low blood pressure.

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3. In the pneumonia case, which organism was identified as the causative agent?

A. Klebsiella pneumoniae

B. Streptococcus pneumoniae

C. Pseudomonas aeruginosa

D. Staphylococcus aureus

The key idea is linking the clinical context with microbiology clues to identify the culprit. Klebsiella pneumoniae is an encapsulated Gram-negative rod that classically causes lobar pneumonia in older adults and in individuals with risk factors such as alcohol use or aspiration. Its thick capsule makes the bacteria particularly virulent, and it often yields mucoid, glossy colonies on culture. In the lab, sputum Gram stain would typically show Gram-negative bacilli that ferment lactose, which helps distinguish Klebella from other pathogens. Clinically, this organism is also associated with thick, sometimes blood-tinged sputum, though not always. By contrast, Streptococcus pneumoniae is the most common cause of community-acquired pneumonia and is a Gram-positive diplococcus; Pseudomonas is more typical in hospital-acquired cases or those with chronic lung disease like cystic fibrosis, and Staphylococcus aureus is often linked to post-viral pneumonia and can form abscesses. The combination of the patient's risk factors and the microbiology profile pointing to encapsulated Gram-negative rods supports Klebsiella pneumoniae as the causative agent.

4. A patient presents with acute chest pain and a 12-lead ECG showing ST elevation. What type of myocardial infarction is this commonly referred to?

A. NSTEMI

B. STEMI

C. Type 2 MI

D. Q-wave MI

ST-segment elevation on a 12-lead ECG during acute chest pain points to a STEMI, an ST-elevation myocardial infarction. The ST elevation reflects transmural, full-thickness myocardial ischemia from an acute coronary artery occlusion, making this the urgent diagnosis that needs immediate reperfusion therapy. In contrast, NSTEMI usually shows ST-segment depression or T-wave inversion and represents subendocardial ischemia; Type 2 MI arises from a supply-demand mismatch rather than a primary plaque rupture; and a Q-wave infarction indicates an older, evolved infarct with developed Q waves rather than the current acute ST elevation.

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5. In the case of the patient with a traumatic GI bleed, what symptom persisted at discharge affecting mobility status?

A. Full mobility

B. No feeling or mobility in the lower extremities

C. Normal sensation in feet

D. Improved motor function in legs

Mobility status at discharge hinges on motor and sensory function in the legs. If a patient has no feeling or movement in the lower extremities, they cannot ambulate, making mobility severely limited and requiring rehabilitation and assistive support. That persistent deficit directly affects mobility, so it best fits the scenario. The other options describe preserved or improved function (full mobility, normal sensation, improved motor function), which would not indicate a persistent mobility-impairing symptom.

6. In this case of heart failure, which biomarker was elevated to support the diagnosis?

A. BNP

B. Troponin

C. CK-MB

D. D-dimer

BNP is released by the heart's ventricles in response to increased wall tension from volume and pressure overload, which is a hallmark of heart failure. When the ventricles are stretched by excess filling pressures, they secrete B-type natriuretic peptide to help reduce that burden by promoting sodium and water loss and by causing vasodilation to lower preload and afterload. Because of this, BNP levels rise as heart failure worsens or becomes more hemodynamically significant, making it a useful biomarker to support the diagnosis and gauge severity in patients with suspected congestive heart failure. In contrast, troponin and CK-MM are markers of myocardial injury like a heart attack, and D-dimer indicates clot formation and breakdown, not heart failure. So the elevated BNP best fits the scenario of heart failure.

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7. A physician query should be used to clarify documentation that affects which aspect?

A. Diagnostic ambiguities impacting code assignment

B. Billing dates only

C. Nurse notes only

D. Equipment used

Physician queries are used to extract precise clinical facts from the chart when the documented diagnoses aren't clear enough to support the codes that will be billed. If the chart states something ambiguous like "suspected pneumonia" or "rule out infection," the coding team cannot finalize the correct diagnosis codes until the physician confirms the final diagnosis and notes whether related conditions are present or absent. This clarification directly affects which ICD-10-CM codes are assigned, which in turn influences reimbursement and reporting. That's why the best answer centers on diagnostic ambiguities that impact code assignment. While billing dates, nurse notes, or equipment might appear in a chart, they don't routinely drive the need for a physician query in the same way that unclear diagnoses do; the main purpose is to resolve uncertainties in the diagnoses so the codes reflect the patient's actual condition and care.

8. According to CMS guidelines, which document should be completed no more than 30 days before or 24 hours after admission?

A. History and Physical

B. Operative Report

C. Discharge Summary

D. Progress Note

The document that must be completed within that time frame is the History and Physical. This initial assessment captures the patient's history, physical findings, current medications, allergies, and the overall plan for care. Having it documented within 30 days before admission or within 24 hours after admission ensures the treating team has up-to-date information to make safe decisions, assess anesthesia risk, plan procedures, and coordinate treatment from the outset of the hospital stay. Other documents serve different purposes and are tied to later stages of care. An operative report is generated after a surgical procedure to describe what was done and findings. A discharge summary is prepared at the end of a stay to summarize the hospitalization and follow-up instructions. A progress note is written throughout the stay to document ongoing observations and responses to treatment. None of these have the same timing requirement tied to admission as the History and Physical.

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9. A physician query is sometimes called a clarification, clinical clarification, or documentation clarification. What is another term used for a query?

A. Documentation alert

B. Clinical decision support

C. Audit reminder

D. Coding guidance

Documentation alert is the term used for a physician query in some workflows. A physician query asks the provider to add or specify documentation to support the coded diagnosis or procedure. In many documentation systems, the prompt that triggers this clarification is called a documentation alert, drawing attention to documentation gaps that affect coding. This differs from clinical decision support, which provides guidance to clinicians but isn't a direct request for clarification in the medical record; an audit reminder is merely a reminder during an audit; coding guidance refers to rules for coding, not a direct request for physician input.

10. For a patient with traumatic brain injury and no responses, what action should the CDI professional take?

A. Query the provider if coma should be reported and review Glasgow coma score

B. Document coma in the record automatically

C. Ignore the coma status until discharge

D. Wait for neurological assessment at discharge

When a patient with traumatic brain injury has no responses, the priority is to verify the exact neurological status with the treating clinician and capture a clear, standardized assessment like the Glasgow Coma Scale. The CDI professional should reach out to the provider to confirm whether coma should be documented and to obtain the GCS score, if available. This ensures the chart accurately reflects the patient's level of consciousness and severity of injury, which directly affects coding, reporting, and prognosis. Automatically documenting coma without clinician input risks misrepresenting the bedside assessment. Waiting until discharge or delaying clarification ignores the current status and can lead to coding and documentation errors, as well as missed opportunities for accurate severity classification and care planning.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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