

# CDIP Domain 4: CDI Metrics and Statistics 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.

# 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!**

## Questions

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- 1. Policies for Queries include which items?**
  - A. Only when to query, but not who should generate**
  - B. When to Query, Who should Generate the query, types of queries, who should answer, etc.**
  - C. Only the format of responses**
  - D. Billing timelines**
  
- 2. Severity of Illness (SOI) in CDI metrics refers to which concept?**
  - A. A measure of the patient's age and comorbidity burden**
  - B. A measure of the level of illness severity used with ROM to assess risk**
  - C. Severity of Illness defines how sick a patient is and is used with ROM to assess risk**
  - D. A chart type used in reporting**
  
- 3. Which CDI metrics are linked to patient safety or quality improvement?**
  - A. Documentation of patient satisfaction scores.**
  - B. Documentation of pressure ulcers, sepsis, pneumonia, etc., affecting risk-adjusted quality scores.**
  - C. Number of charts audited per month regardless of outcomes.**
  - D. Length of stay averages only.**
  
- 4. Explain the difference between POA data quality issues and documentation quality issues.**
  - A. POA issues concern incorrect flags; documentation quality concerns missing or unclear documentation regardless of POA**
  - B. POA issues are about physician experience; documentation quality is about coding accuracy**
  - C. POA issues only occur in private hospitals; documentation quality only in academic centers**
  - D. POA issues are the same as documentation quality issues**

- 5. Explain the difference between internal and external benchmarking for CDI metrics.**
- A. Internal benchmarking compares against peer institutions or national norms.**
  - B. External benchmarking compares facilities or units within the same organization.**
  - C. Internal benchmarking compares patient satisfaction across hospitals.**
  - D. Internal benchmarking compares facilities or units within the same organization; external benchmarking compares against peer institutions or national norms.**
- 6. Which data visualization helps monitor process stability and identify shifts in CDI measures over time?**
- A. Pareto charts**
  - B. Scatter plots**
  - C. Control charts**
  - D. Bar charts**
- 7. Which statement about Medical Necessity Reviews is true?**
- A. They are performed by a licensed medical professional and require specific criteria sets.**
  - B. They are performed by a licensed medical professional and do not require specific criteria sets.**
  - C. They are always done by non-clinical staff.**
  - D. They are not used for chronic conditions.**
- 8. Which statement is true about confidence intervals?**
- A. They guarantee the true parameter is within the interval for every sample.**
  - B. They are fixed once computed.**
  - C. They provide a range that would contain the true parameter with a specified probability over many samples.**
  - D. They replace hypothesis testing.**

- 9. What is another name for the manual review of the health record that is also called Complex Review?**
- A. CERT audit**
  - B. Medical Record Review**
  - C. SMRC review**
  - D. ZPIC investigation**
- 10. After a CDI intervention, which method best determines DRG assignment appropriateness?**
- A. Reconcile clinical documentation with coding rules; review POA, CC/MCC presence, and observer reliability.**
  - B. Compare DRG to national average.**
  - C. Only check POA status.**
  - D. Audit physician performance.**

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## Answers

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

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## **Explanations**

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## 1. Policies for Queries include which items?

- A. Only when to query, but not who should generate
- B. When to Query, Who should Generate the query, types of queries, who should answer, etc.**
- C. Only the format of responses
- D. Billing timelines

Policies for queries govern the entire lifecycle of a query, ensuring consistency, accountability, and timely responses. The best answer reflects that a comprehensive policy includes when to issue a query, who should generate it, the different types of queries that can be issued, and who should respond. This broad scope matters because focusing on just one aspect, like when to query, leaves other essential pieces undefined and can lead to delays or miscommunication. Similarly, restricting to the format of responses misses how the process starts and who is responsible, and bringing in billing timelines introduces financial considerations that aren't central to how queries are governed within the workflow.

## 2. Severity of Illness (SOI) in CDI metrics refers to which concept?

- A. A measure of the patient's age and comorbidity burden
- B. A measure of the level of illness severity used with ROM to assess risk
- C. Severity of Illness defines how sick a patient is and is used with ROM to assess risk**
- D. A chart type used in reporting

Severity of Illness measures how sick a patient is and is used with Risk of Mortality to assess risk. In CDI metrics, SOI comes from a standardized system and places patients into categories of illness severity, which, when paired with ROM, allows meaningful risk adjustment and comparison across different patient populations. This makes the description that SOI defines how sick a patient is and is used with ROM to assess risk the most accurate. The other ideas miss the core purpose: age and comorbidity burden describe a separate concept, and a chart type is not related to SOI.

**3. Which CDI metrics are linked to patient safety or quality improvement?**

- A. Documentation of patient satisfaction scores.**
- B. Documentation of pressure ulcers, sepsis, pneumonia, etc., affecting risk-adjusted quality scores.**
- C. Number of charts audited per month regardless of outcomes.**
- D. Length of stay averages only.**

CDI metrics tied to patient safety or quality improvement focus on accurately documenting conditions that affect a patient's risk-adjusted outcomes. Documenting issues like pressure ulcers, sepsis, and pneumonia is essential because these conditions are used to adjust quality measures and safety indicators in risk-adjusted scores. When such conditions are captured correctly, they reflect the patient's true severity and help hospitals assess and improve safety and care quality, while also ensuring appropriate benchmarking and reimbursement considerations. Other options miss this direct link to safety and quality. Documenting patient satisfaction scores relates to patient experience rather than safety outcomes. Tracking the number of charts audited per month is a process measure, not a safety/quality outcome. Focusing on length of stay averages alone doesn't directly tie into risk-adjusted quality or safety reporting.

**4. Explain the difference between POA data quality issues and documentation quality issues.**

- A. POA issues concern incorrect flags; documentation quality concerns missing or unclear documentation regardless of POA**
- B. POA issues are about physician experience; documentation quality is about coding accuracy**
- C. POA issues only occur in private hospitals; documentation quality only in academic centers**
- D. POA issues are the same as documentation quality issues**

POA data quality issues focus on the accuracy of the Present On Admission indicators attached to each diagnosis—whether a condition was present when the patient arrived or developed later. Errors happen when a flag is incorrect, misclassifying a condition as POA or not POA, which can skew risk adjustment and reporting. Documentation quality issues concern how well the chart describes the patient's conditions and procedures—whether the documentation is complete, clear, and specific enough to support correct coding. This is about missing or vague notes, ambiguity, or unclear onset timing, regardless of what the POA flag says. So, the best option captures that POA problems are about incorrect POA flags, while documentation quality problems are about missing or unclear documentation. The other statements mix concepts (such as linking POA to physician experience or hospital type) or claim they're the same, which aren't accurate.

5. Explain the difference between internal and external benchmarking for CDI metrics.
- A. Internal benchmarking compares against peer institutions or national norms.
  - B. External benchmarking compares facilities or units within the same organization.
  - C. Internal benchmarking compares patient satisfaction across hospitals.
  - D. Internal benchmarking compares facilities or units within the same organization; external benchmarking compares against peer institutions or national norms.**

Benchmarking CDI metrics looks at how your organization performs compared with a standard or with others to spot gaps and drive improvement. The main distinction is where the comparison happens. Internal benchmarking compares facilities or units within the same organization, highlighting how performance varies inside the organization and where to focus improvement efforts. External benchmarking compares your performance to outside benchmarks like peer institutions or national norms, providing context on how you stack up against others and what best practices you might adopt. The correct idea is that internal benchmarking is within the same organization, while external benchmarking is against peer institutions or national norms. The other options mix up these definitions or apply them to unrelated concepts, such as comparing internal metrics to external peers or using internal benchmarks for cross-hospital comparisons. In CDI metrics, internal benchmarking helps identify internal variations to target improvements, while external benchmarking offers external context and aspirational goals.

6. Which data visualization helps monitor process stability and identify shifts in CDI measures over time?
- A. Pareto charts
  - B. Scatter plots
  - C. Control charts**
  - D. Bar charts

Control charts are used to monitor process stability by plotting data in chronological order and comparing it to a central tendency with upper and lower control limits. They reveal whether variation is random or if there are shifts or trends that point to assignable causes. When data stay within control limits and show only random fluctuation, the process is considered in control; when a point crosses a limit or a nonrandom pattern emerges, it signals a potential shift needing investigation. In CDI metrics, this lets you watch measures like coding accuracy or query turnaround over time and detect when performance changes, so you can explore underlying factors and take action. Pareto charts highlight the most frequent categories, not time-based stability; scatter plots show relationships between two variables; bar charts compare values across categories—none are designed to track a metric's stability over time.

**7. Which statement about Medical Necessity Reviews is true?**

- A. They are performed by a licensed medical professional and require specific criteria sets.
- B. They are performed by a licensed medical professional and do not require specific criteria sets.**
- C. They are always done by non-clinical staff.
- D. They are not used for chronic conditions.

Medical necessity reviews rely on clinical judgment to decide whether a proposed service is appropriate for a patient. A licensed medical professional examines the patient's medical history, current condition, and the standard of care to determine if the service is justified. While guidelines and payer policies can inform the decision, there isn't a single universal set of criteria that must be applied in every case. The reviewer weighs the individual patient context and available evidence, rather than rigidly following a fixed checklist. This is why the statement that these reviews are performed by a licensed medical professional and do not require specific criteria sets is the best fit. It emphasizes professional clinical evaluation rather than a mandatory, universal criteria framework.

**8. Which statement is true about confidence intervals?**

- A. They guarantee the true parameter is within the interval for every sample.
- B. They are fixed once computed.
- C. They provide a range that would contain the true parameter with a specified probability over many samples.**
- D. They replace hypothesis testing.

The main idea here is how a confidence interval reflects uncertainty about a population parameter. A confidence interval is built from sample data to estimate a range where the true parameter would lie if we repeated the study many times with the same method. The best statement says that the interval would contain the true parameter with a specified probability over many samples. In other words, if we could repeat the whole process lots of times and construct an interval each time at a chosen confidence level (say 95%), about 95% of those intervals would include the true parameter. This describes the long-run performance of the method, not guarantees for any single obtained interval. Why the others don't fit: for any given sample, the true parameter doesn't have to be inside the single interval we computed; it can be outside due to sampling variation. The interval we get from one sample is a fixed outcome for that data, but the process that generates intervals is random across repeated samples, so saying they are fixed once computed misrepresents that variability. Finally, confidence intervals and hypothesis testing address different questions: a CI provides a range of plausible parameter values, while hypothesis testing evaluates evidence against a specific null hypothesis; they're related but do not replace one another.

**9. What is another name for the manual review of the health record that is also called Complex Review?**

- A. CERT audit
- B. Medical Record Review**
- C. SMRC review
- D. ZPIC investigation

Manual review of the health record is the process where a clinician examiner goes through the chart to verify that the documentation, coding, and requested services are accurate and medically necessary. When reviewers encounter more complex cases requiring deeper clinical interpretation, this is called Complex Review. The term that best describes this hands-on, record-by-record examination is Medical Record Review, which is the standard label for the manual review of charts used to confirm proper coding and billing. The other options refer to different CMS activities: CERT audits are used to estimate improper payments and involve records as part of a wider program, ZPIC investigations are enforcement actions for fraud and abuse, and SMRC review is not a commonly used term for this process.

**10. After a CDI intervention, which method best determines DRG assignment appropriateness?**

- A. Reconcile clinical documentation with coding rules; review POA, CC/MCC presence, and observer reliability.**
- B. Compare DRG to national average.
- C. Only check POA status.
- D. Audit physician performance.

The essential idea is validating DRG assignment by aligning what's documented with how it's coded, and checking the factors that drive DRG grouping. Reconcile clinical documentation with coding rules so every diagnosis and procedure is coded according to ICD-10-CM/PCS and payer guidelines. Review the presence or absence of POA to distinguish complications that should affect DRG from conditions that are present on admission. Assess CCs and MCCs because these designations often change DRG weight and final grouping. Ensuring observer reliability makes sure the audit conclusions are consistent and defensible rather than dependent on a single reviewer's judgment. Together, this approach directly confirms that the DRG assigned reflects the actual documented clinical scenario. Benchmarking DRG against a national average provides a broad context but doesn't verify a specific case's DRG. Checking POA alone misses the impact of CCs/MCCs and coding rules. Auditing physician performance is valuable for overall quality but doesn't directly validate the accuracy of DRG assignment through documentation and coding.

## 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](mailto:hello@examzify.com).**

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

**<https://cdipdom4cdimetricsstats.examzify.com>**

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

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