

CERTIFIED DOCUMENTATION IMPROVEMENT (CDI) PRACTICE TEST (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE**

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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. Which condition is associated with gastroesophageal reflux disease that may exacerbate asthma?**
 - A. Chronic obstructive pulmonary disease (COPD)
 - B. Asthma
 - C. Gastroenteritis
 - D. Allergic rhinitis
- 2. In cases of dehydration, which element should the CDI specialist especially consider?**
 - A. If it was caused by a recent surgery
 - B. If it is a direct result of the chronic kidney disease
 - C. If the patient has been physically active
 - D. If the dehydration is reversible
- 3. What does a CDI specialist do when conflicting information is present in documentation?**
 - A. Query the physician for clarification
 - B. Assume the most common diagnosis
 - C. Code the most specific diagnosis available
 - D. Document the conflict without further action
- 4. In terms of documentation improvement, why is the stage of acute kidney injury important?**
 - A. It impacts patient treatment schedules
 - B. It is crucial for accurate coding
 - C. It affects hospital discharge procedures
 - D. It relates to patient education needs
- 5. What condition results from impairments in the nervous system function?**
 - A. Neurological Deficits
 - B. Chronic Kidney Disease
 - C. Vomiting
 - D. Diabetic Ketoacidosis

- 6. What condition should be coded following a diagnosis of "right-sided hemiparesis"?**
- A. Right-sided stroke
 - B. Hemiplegia
 - C. Hemiparesis as a sequela of stroke
 - D. Weakness of right side
- 7. What are the possible types associated with the classification of DKA?**
- A. Stable, Acute, and Chronic
 - B. Mild, Moderate, or Severe
 - C. Primary, Secondary, and Tertiary
 - D. Complicated and Uncomplicated
- 8. What should a physician specify to impact coding and patient management?**
- A. The patient's lifestyle choices
 - B. The degree of weakness in the patient
 - C. The number of medications taken
 - D. Patient's family history of diseases
- 9. What is a compliant query format for documentation?**
- A. It should include unnecessary details to support the query
 - B. It should provide clinical evidence without options for diagnosis
 - C. It should offer clear options, including 'other' or 'unable to determine'
 - D. It should avoid providing information about the patient's condition
- 10. What is the first step when faced with an unclear asthma diagnosis?**
- A. Assume the Worst Case
 - B. Document It and Move On
 - C. Query for Clarification
 - D. Ask the Patient

Answers

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

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Explanations

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1. Which condition is associated with gastroesophageal reflux disease that may exacerbate asthma?

- A. Chronic obstructive pulmonary disease (COPD)
- B. Asthma**
- C. Gastroenteritis
- D. Allergic rhinitis

Gastroesophageal reflux disease (GERD) can trigger or worsen symptoms in individuals with asthma. This occurs because the stomach acid in the esophagus can lead to increased airway reactivity and inflammation when aspirated or refluxed into the airways. In patients who already suffer from asthma, the irritation caused by acid can lead to exacerbated asthma symptoms such as increased wheezing, coughing, and respiratory distress. Asthma is a chronic inflammatory condition of the airways, and GERD is often seen as a comorbidity in asthmatic patients. The relationship between these two conditions is important for healthcare providers to recognize, as managing GERD effectively can lead to improved asthma control. The other conditions listed do not have a direct relationship with exacerbating asthma symptoms as GERD does. For instance, COPD is a separate chronic condition related to airflow limitation and has different underlying mechanisms compared to asthma. Gastroenteritis primarily involves the gastrointestinal system and does not typically impact asthma. Allergic rhinitis, while it can coexist with asthma and contribute to overall respiratory issues, does not have the same direct impact as GERD on asthma exacerbations. Therefore, asthma is the correct association in the context of GERD and its complications.

2. In cases of dehydration, which element should the CDI specialist especially consider?

- A. If it was caused by a recent surgery
- B. If it is a direct result of the chronic kidney disease**
- C. If the patient has been physically active
- D. If the dehydration is reversible

In cases of dehydration, special consideration should be given to whether it is a direct result of chronic kidney disease. Chronic kidney disease is known to affect the body's ability to regulate fluid and electrolyte balance. Patients with this condition may have diminished kidney function, which can impair their ability to concentrate urine, leading to an increased risk of dehydration. Understanding the underlying causes of dehydration is critical for a CDI specialist, as it informs the clinical documentation and coding that reflect the patient's health condition accurately. If dehydration stems from chronic kidney disease, it may also indicate a more severe situation requiring specific management strategies and interventions. The focus on chronic kidney disease highlights its significant role in dehydration complications and necessitates thorough documentation and understanding of its impacts on patient care. This ensures that the patient's condition is accurately portrayed in medical records, affecting treatment and reimbursement.

3. What does a CDI specialist do when conflicting information is present in documentation?

- A. Query the physician for clarification**
- B. Assume the most common diagnosis
- C. Code the most specific diagnosis available
- D. Document the conflict without further action

When a CDI specialist encounters conflicting information in documentation, the appropriate action is to query the physician for clarification. This approach is crucial because it not only ensures the accuracy of the patient's medical record but also promotes clear communication between healthcare providers. By seeking clarification, the CDI specialist can obtain the most accurate and comprehensive understanding of the patient's condition, which directly impacts clinical decisions and coding practices. Clarifying discrepancies prevents misunderstandings that could lead to improper coding, which can affect reimbursement, quality metrics, and ultimately patient care. Involving the physician in resolving these conflicts helps maintain the integrity of the documentation and supports compliance with regulatory standards. The other options do not uphold the standards of accuracy and effective communication that are essential in medical documentation. Assuming the most common diagnosis lacks clinical basis and can lead to erroneous coding and potential compliance issues. Coding the most specific diagnosis available without resolving the conflict may lead to inaccuracies that could compromise patient safety and financial integrity. Merely documenting the conflict without taking action does not resolve the issue and risks maintaining an inaccurate representation of the patient's health status.

4. In terms of documentation improvement, why is the stage of acute kidney injury important?

- A. It impacts patient treatment schedules
- B. It is crucial for accurate coding**
- C. It affects hospital discharge procedures
- D. It relates to patient education needs

The stage of acute kidney injury (AKI) is essential for accurate coding because it directly influences how a patient's condition is classified within the healthcare system. Correctly identifying the stage of AKI ensures that healthcare providers use the appropriate International Classification of Diseases (ICD) codes for billing and clinical reporting. The codes not only determine the reimbursement rates for the services provided but also affect the quality metrics reported by healthcare organizations. Accurate coding facilitates proper communication about the severity of the patient's condition and helps in the collection of data for research and treatment outcomes. In contrast, while the impact on patient treatment schedules, hospital discharge procedures, and patient education may be relevant considerations in patient care, they do not specifically address the significance of documentation improvement as it relates to coding accuracy, which is primarily focused on how conditions are classified and billed in the healthcare system. Understanding the coding implications of AKI stages is critical because it ensures that healthcare facilities receive appropriate reimbursements and can reflect the patient's true clinical picture in their records.

5. What condition results from impairments in the nervous system function?

A. Neurological Deficits

B. Chronic Kidney Disease

C. Vomiting

D. Diabetic Ketoacidosis

The condition characterized by impairments in nervous system function is neurological deficits. These deficits can manifest in various ways, including issues with movement, sensation, cognition, and other functions that the nervous system regulates. Neurological deficits arise from a variety of factors, such as injury, disease, or congenital conditions affecting the brain, spinal cord, or nerves, leading to compromised function. In contrast, chronic kidney disease is specifically related to the kidneys' inability to filter waste effectively, while vomiting is a symptom that can be caused by numerous conditions affecting the gastrointestinal tract or other systems. Diabetic ketoacidosis is a serious complication of diabetes that occurs when the body begins to break down fat at an excessive rate, resulting in a buildup of acids called ketones, which does not directly relate to nervous system impairment. Thus, the connection of neurological deficits to the nervous system highlights its significance as the correct choice.

6. What condition should be coded following a diagnosis of "right-sided hemiparesis"?

A. Right-sided stroke

B. Hemiplegia

C. Hemiparesis as a sequela of stroke

D. Weakness of right side

The most appropriate coding choice following a diagnosis of "right-sided hemiparesis" is to select "hemiparesis as a sequela of stroke." This option correctly links the hemiparesis to a prior event, such as a stroke, which is often the underlying cause of such motor deficits. In coding, it's essential to accurately represent the relationship between a condition and its cause or context, especially when documenting conditions that arise as a consequence of other diagnoses. When coding hemiparesis, it's critical to specify whether it is an acute condition or a residual effect (or sequela) of a stroke, which helps in understanding the patient's current health status and the long-term implications of their condition. The other options do not convey this necessary detail: "right-sided stroke" describes the cause rather than the effect, "hemiplegia" indicates a more severe condition than hemiparesis, and "weakness of right side" is vague and not specific enough for precise coding. Thus, coding the hemiparesis as a direct result of the stroke accurately reflects the patient's conditions and follows best practices in documentation improvement.

7. What are the possible types associated with the classification of DKA?

- A. Stable, Acute, and Chronic
- B. Mild, Moderate, or Severe**
- C. Primary, Secondary, and Tertiary
- D. Complicated and Uncomplicated

The classification of Diabetic Ketoacidosis (DKA) is primarily based on the severity of the condition, which includes the distinctions of Mild, Moderate, or Severe. This categorization is crucial because it helps healthcare providers determine the appropriate level of intervention and management strategies needed for patients experiencing DKA. Each level of severity is typically assessed based on clinical and laboratory findings, including blood glucose levels, ketone bodies, and the degree of acidosis. Mild DKA may present with a lower level of acidosis and can often be managed with outpatient care, while Moderate and Severe DKA indicate increasingly critical conditions requiring more intensive medical intervention, potentially including hospitalization and monitoring for complications. Therefore, using this classification helps ensure that patients receive the right level of care based on their specific condition and needs at the time of treatment.

8. What should a physician specify to impact coding and patient management?

- A. The patient's lifestyle choices
- B. The degree of weakness in the patient**
- C. The number of medications taken
- D. Patient's family history of diseases

The degree of weakness in the patient is crucial for accurate coding and effective patient management. When physicians specify the level of weakness, it provides a clear understanding of the patient's condition, which directly influences the coding process. This specification allows coders to determine the appropriate diagnosis codes related to the patient's functional status and severity of illness, which are essential for reimbursement and care planning. Additionally, the degree of weakness can guide treatment decisions and facilitate communication among healthcare providers about the patient's needs. For example, a documented level of weakness can justify the need for specific therapies, home care, or interventions that enhance patient outcomes. While other factors like lifestyle choices, medication adherence, and family history are important in patient care and can influence treatment plans, they do not directly impact coding in the same way that the specifics of the patient's current condition do. Thus, focusing on the degree of weakness is key in aligning clinical documentation with the coding requirements and ensuring holistic patient management.

9. What is a compliant query format for documentation?

- A. It should include unnecessary details to support the query
- B. It should provide clinical evidence without options for diagnosis
- C. It should offer clear options, including 'other' or 'unable to determine'**
- D. It should avoid providing information about the patient's condition

A compliant query format for documentation emphasizes clarity and comprehensiveness while allowing for flexibility in clinical interpretation. Including clear options, such as 'other' or 'unable to determine,' enables the healthcare provider to respond based on their clinical judgment and the specifics of the patient's situation. This approach not only encourages accurate documentation but also ensures that all potential diagnoses are considered, fostering an environment of thorough clinical assessment. Providing options helps eliminate ambiguity, guiding the respondent to provide a well-considered diagnosis based on clinical evidence. This format supports compliance with regulatory guidelines and improves overall communication among healthcare professionals, ultimately enhancing the quality of patient care and documentation accuracy. In contrast, providing unnecessary details or omitting information would detract from the clarity and focus of the query. It is essential for queries to be straightforward and relevant to ensure that they serve their intended purpose effectively.

10. What is the first step when faced with an unclear asthma diagnosis?

- A. Assume the Worst Case
- B. Document It and Move On
- C. Query for Clarification**
- D. Ask the Patient

The first step when faced with an unclear asthma diagnosis is to query for clarification. This is crucial because the accuracy of documentation and coding depends on precise and clear diagnosis statements from healthcare providers. If the initial diagnosis is ambiguous, it's essential to seek further information to ensure that the patient's health record reflects their true condition. Querying allows healthcare professionals to ask specific questions regarding the patient's symptoms, history, and other relevant details that can lead to a more accurate diagnosis. This approach not only contributes to improved patient care by ensuring that appropriate treatment is provided but also guards against potential issues such as incorrect coding for reimbursement purposes. Clarifying the diagnosis before proceeding with documentation or coding helps maintain the integrity of the medical records and supports quality care initiatives.

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:

<https://docimprovement.examzify.com>

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

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