

Certified Documentation Integrity Practitioner (CDIP) 1 Practice Exam (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. What is the denial rate for DRG 637 if there are 5 total denials out of 20?**
 - A. 0 percent**
 - B. 25 percent**
 - C. 50 percent**
 - D. 100 percent**

- 2. What is the principal role of the clinical documentation specialist in a healthcare facility?**
 - A. To conduct patient admissions**
 - B. To ensure quality documentation practices**
 - C. To perform surgical procedures**
 - D. To manage patient discharges**

- 3. What should be the approach of the HIM department towards a billing abstract narrative that is too lengthy and inconsistent with facility reporting?**
 - A. Shorten the narrative**
 - B. Change the narrative to what is acceptable at the facility**
 - C. Never change the narrative on the billing abstract**
 - D. Utilize abbreviations**

- 4. What is the first significant challenge in establishing a CDI program?**
 - A. Persuade administration to support the CDI program**
 - B. Find qualified staff for the program**
 - C. Engage medical staff**
 - D. Show quarterly return on investment**

- 5. Which best describes an appropriate action for a clinical documentation specialist before coding?**
 - A. Complete final coding without verification**
 - B. Ensure consultation with medical providers when necessary**
 - C. Always code based on assumption**
 - D. Query process should not involve documentation review**

- 6. Which organization has CMS engaged to assist in record reviews of certain DRGs and documentation concerns?**
- A. QIO**
 - B. PEPPER**
 - C. ONC**
 - D. Q-Net**
- 7. Which modifiers were introduced to provide greater specificity in lieu of modifier 59?**
- A. XA, XB, XC, XD**
 - B. CC44, CC45, CC46, CC47**
 - C. XE, XS, XP, XU**
 - D. 44, 45, 45, 47**
- 8. What type of complication would be documented as present only after admission?**
- A. Acute appendicitis**
 - B. Chronic headache**
 - C. Postoperative complication**
 - D. Open fracture**
- 9. What should a query policy include regarding the physician's role?**
- A. How to optimize revenue**
 - B. The physician's responsibility in responding to queries**
 - C. Number of queries to ask**
 - D. DRGs to target for revenue impact**
- 10. A patient with a history of Alzheimer's is showing signs of possible medication underdosing. What behavior supports this assumption?**
- A. Overdosing**
 - B. Underdosing**
 - C. A drug interaction**
 - D. Advancing Alzheimer's**

Answers

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

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Explanations

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1. What is the denial rate for DRG 637 if there are 5 total denials out of 20?

- A. 0 percent**
- B. 25 percent**
- C. 50 percent**
- D. 100 percent**

To determine the denial rate for DRG 637, you need to use the formula for calculating the denial rate, which is the number of denials divided by the total claims, then multiply by 100 to convert it into a percentage. In this case, there are 5 denials out of a total of 20 claims. When you perform the calculation: $(5 \text{ denials} / 20 \text{ total claims}) \times 100 = 25$ percent. This indicates that 25 percent of the claims for DRG 637 were denied. Thus, the denial rate being 25 percent accurately reflects the proportion of denied claims to the total claims submitted for that DRG. This calculation is essential for understanding the performance of claims processing and identifying potential issues in documentation or billing practices.

2. What is the principal role of the clinical documentation specialist in a healthcare facility?

- A. To conduct patient admissions**
- B. To ensure quality documentation practices**
- C. To perform surgical procedures**
- D. To manage patient discharges**

The principal role of the clinical documentation specialist in a healthcare facility is to ensure quality documentation practices. This involves reviewing and auditing medical records to make sure that they accurately reflect the patient's condition and the services provided. The specialist plays a crucial part in maintaining the integrity and accuracy of clinical documentation, which is essential for patient care, billing processes, and compliance with regulatory standards. By promoting best practices in documentation, the specialist helps to ensure that healthcare providers capture all relevant patient information, thus supporting appropriate coding and reimbursement, and ultimately improving the overall quality and safety of patient care. This focus on quality documentation is vital because poor documentation can lead to misunderstandings regarding patient treatment, financial discrepancies, and potential compliance issues.

3. What should be the approach of the HIM department towards a billing abstract narrative that is too lengthy and inconsistent with facility reporting?

- A. Shorten the narrative**
- B. Change the narrative to what is acceptable at the facility**
- C. Never change the narrative on the billing abstract**
- D. Utilize abbreviations**

The appropriate approach for the HIM department regarding a billing abstract narrative that is too lengthy and inconsistent with facility reporting is to maintain the integrity of the original narrative without alteration. Healthcare records are essential legal documents, and any modifications can potentially compromise their accuracy and reliability. Preserving the original content ensures that all pertinent information, decisions, and clinical outcomes remain intact, which is crucial for proper billing, compliance, and quality reporting. Maintaining the narrative in its original form upholds the ethical responsibilities associated with medical documentation, which includes ensuring that the documentation reflects the true and complete account of the patient's care and treatment. Discrepancies or alterations could result in billing inaccuracies or compliance issues, affecting both the healthcare facility's operations and patient care continuity. In contrast, shortening the narrative, changing it to fit facility standards, or using abbreviations could lead to a loss of critical details and create potential misunderstandings about the patient's care, leading to downstream consequences in patient safety and compliance audits. Hence, preserving the original narrative is critical in ensuring that the documentation adheres to high standards of integrity and reliability in healthcare records.

4. What is the first significant challenge in establishing a CDI program?

- A. Persuade administration to support the CDI program**
- B. Find qualified staff for the program**
- C. Engage medical staff**
- D. Show quarterly return on investment**

The first significant challenge in establishing a Clinical Documentation Improvement (CDI) program is persuading administration to support the initiative. Administrative backing is crucial as it provides the necessary resources, funding, and strategic alignment for the CDI program. Without this support, it becomes extremely difficult to implement the program effectively, attract qualified staff, and secure the engagement of medical staff, all of which are essential components for a successful CDI initiative. When the administration understands the value of a CDI program and commits to it, they can facilitate the necessary changes within the institution, advocate for the program's importance, and help create a culture that prioritizes accurate documentation. This foundational step sets the stage for subsequent challenges, such as recruiting qualified staff and engaging medical staff, to be addressed more easily with strong administrative support.

5. Which best describes an appropriate action for a clinical documentation specialist before coding?

A. Complete final coding without verification

B. Ensure consultation with medical providers when necessary

C. Always code based on assumption

D. Query process should not involve documentation review

The best action for a clinical documentation specialist before coding is to ensure consultation with medical providers when necessary. This step is crucial because clinical documentation specialists play a key role in ensuring that the medical records accurately reflect the patient's clinical picture and support coding decisions. When there are uncertainties or ambiguities in the documentation, it is vital to communicate with healthcare providers to clarify those elements. Engaging in consultation with medical providers can help to ensure that any missing information is obtained and any discrepancies are resolved. This can enhance the integrity of the documentation and its compliance with coding requirements, ensuring accuracy in the coding process and upholding the quality of healthcare reporting. Addressing documentation issues through provider queries not only aids in confirming the clinical picture but also supports compliance with regulations and standards in medical coding practices. By prioritizing direct communication with the healthcare team, clinical documentation specialists contribute to producing reliable and precise coding outcomes.

6. Which organization has CMS engaged to assist in record reviews of certain DRGs and documentation concerns?

A. QIO

B. PEPPER

C. ONC

D. Q-Net

The correct answer is the Quality Improvement Organization (QIO). QIOs are federally contracted organizations that work to improve healthcare quality and ensure that Medicare beneficiaries receive proper services. They assist in record reviews to address documentation concerns and improve compliance with quality standards related to Diagnosis-Related Groups (DRGs). This role is particularly significant in monitoring and evaluating healthcare services provided to Medicare patients, ensuring that documentation meets the necessary requirements. In contrast, PEPPER, or the Program for Evaluating Payment Patterns Electronic Reports, primarily focuses on providing hospitals with data that highlights outlier diagnosis and treatment patterns but does not engage directly in record reviews. The Office of the National Coordinator (ONC) for Health Information Technology is responsible for coordinating health information technology efforts rather than reviewing medical records or documentation concerns in the context of DRGs. Q-Net is related to the QualityNet initiative aimed at quality reporting and improvement activities but does not directly participate in the review process as the QIO does. Thus, the QIO's role in facilitating record reviews makes it the most appropriate choice.

7. Which modifiers were introduced to provide greater specificity in lieu of modifier 59?

- A. XA, XB, XC, XD
- B. CC44, CC45, CC46, CC47
- C. XE, XS, XP, XU**
- D. 44, 45, 45, 47

The introduction of modifiers XA, XB, XC, XD, XE, XS, XP, and XU serves to enhance specificity in medical coding practices, particularly as they relate to the use of modifier 59. Modifier 59 was often used to indicate that a procedure or service was distinct or independent from others performed on the same day. However, its broad application sometimes led to ambiguity. Modifiers XE, XS, XP, and XU were specifically designed to provide more detailed distinctions between services. For example, XE indicates a service that is separate because it occurs in a different encounter, while XS denotes a service that is separate because it is a distinct procedural service. XP identifies a service that is performed by a different provider, and XU signifies an “unusual” non-overlapping service. This level of granularity allows coders to convey more specific information regarding the circumstances under which the services were performed, which aids in better clarity and accuracy in billing and documentation. The other choices provided either include modifiers that do not pertain to the specificity provided in lieu of modifier 59 or include incorrect combinations or codes that do not relate to the proper categorization of services. Therefore, the correct answer showcases the new modifiers aimed at enhancing clarity in coding practices.

8. What type of complication would be documented as present only after admission?

- A. Acute appendicitis
- B. Chronic headache
- C. Postoperative complication**
- D. Open fracture

The correct answer is that a postoperative complication is documented as present only after admission. This type of complication arises as a direct result of a surgical procedure and typically manifests after the patient has been admitted for the surgery. It emphasizes the importance of recognizing and documenting complications that can develop due to the operative interventions. In terms of context, understanding the timing of when complications arise helps healthcare providers in managing patient care and refining treatment plans. Conditions like acute appendicitis or an open fracture are often present prior to admission; they are not considered postoperative complications. Similarly, chronic headache is a long-standing issue that pre-exists the current hospitalization and, therefore, does not fit the criteria of being documented as a complication that arises exclusively after admission. Prioritizing documentation of postoperative complications is crucial for accurate medical records, quality improvement, and ensuring comprehensive patient follow-up.

9. What should a query policy include regarding the physician's role?

- A. How to optimize revenue**
- B. The physician's responsibility in responding to queries**
- C. Number of queries to ask**
- D. DRGs to target for revenue impact**

Including the physician's responsibility in responding to queries is a critical component of a query policy. This aspect highlights the importance of collaboration between the documentation and coding teams and the physicians. When physicians understand their role in responding to queries, it promotes timely and accurate documentation, which is essential for coding processes, compliance, and high-quality patient care. Clearly defining the physician's responsibilities ensures they acknowledge the necessity of addressing queries promptly and providing the information needed to enhance the medical record. This collaboration ultimately supports better clinical outcomes and compliance with regulations, as accurate and complete documentation is fundamental for appropriate reimbursement and quality reporting. Considering the other options, while optimizing revenue, the number of queries to ask, and targeting specific Diagnosis-Related Groups (DRGs) are important topics in the broader context of coding and revenue cycle management, these details do not specifically address the essential role physicians play in the query process. Therefore, focusing on the physician's responsibilities within the query policy is most relevant for ensuring clarity and effectiveness in documentation practices.

10. A patient with a history of Alzheimer's is showing signs of possible medication underdosing. What behavior supports this assumption?

- A. Overdosing**
- B. Underdosing**
- C. A drug interaction**
- D. Advancing Alzheimer's**

When considering the signs of possible medication underdosing in a patient with a history of Alzheimer's, the behavior that most directly supports this assumption is the indication of undosing. Patients with Alzheimer's may struggle to manage their medications effectively due to cognitive decline, leading to missed doses or lower-than-prescribed dosages. This could manifest as symptoms returning or worsening, as the medication intended to aid in managing their condition isn't being taken properly. Other behaviors, such as overdosing or drug interactions, would present differently and are not supporting signs of underdosing. For example, overdosing would typically lead to symptoms of toxicity rather than indicate a lack of effective medication. Similarly, drug interactions could be a concern, but they usually complicate treatment rather than indicate underdosing. The consideration of advancing Alzheimer's, while relevant to the patient's overall condition, does not in itself provide evidence of underdosing, as that reflects a broader disease progression rather than specific medication adherence or dosing issues. In summary, the assumption of medication underdosing is strongly supported by the observation of symptoms indicative of insufficient medication levels, reflecting the challenges faced by patients in managing their treatment due to the cognitive impairments associated with Alzheimer's disease.

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://cdip1.examzify.com>

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

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