

CERTIFIED DOCUMENTATION INTEGRITY PRACTITIONER (CDIP) 1 PRACTICE EXAM (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. What term describes the interactive process of sharing experiences about clinical documentation in training?**
 - A. Asking
 - B. Training
 - C. Mastering
 - D. Coaching
- 2. What condition is classified as significant when coding for a patient with CHF and exacerbation of symptoms?**
 - A. Preventative measure
 - B. Additional diagnosis
 - C. Main concern
 - D. Non-essential diagnosis
- 3. 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
- 4. According to coding guidelines, which conditions would be classified as secondary diagnoses in a patient with CHF and COPD?**
 - A. CHF, pneumonia
 - B. Pneumonia, COPD
 - C. CHF, COPD
 - D. COPD
- 5. Which of the following is a form of severe protein malnutrition affecting children during periods of famine?**
 - A. Protein-calorie malnutrition
 - B. Severe malnutrition
 - C. Vitamin A deficient malnutrition
 - D. Kwashiorkor

- 6. What should a coder do if they are uncertain about the validity of a diagnosis noted in the medical record?**
- A. Document it as is
 - B. Query the attending physician
 - C. Leave it undocumented
 - D. Independently diagnose
- 7. In determining the working DRG, what is the primary focus of the CDS review?**
- A. Cost analysis
 - B. Patient treatment plan
 - C. Severity of illness
 - D. Clinical documentation quality
- 8. When coding for hospital-acquired conditions, what is key to ensuring payment accuracy?**
- A. Ensuring audits are regularly performed
 - B. Validating condition prior to admission
 - C. Documenting any and all conditions
 - D. Focusing only on principal diagnosis
- 9. What is a key role of the physician advisor in CDI?**
- A. To manage coders directly
 - B. To ensure compliance with coding
 - C. To review patient discharge summaries
 - D. To lead medication management discussions
- 10. During a CDI review, which scenario best indicates an appropriate query?**
- A. A query that suggests a specific diagnosis
 - B. A query regarding a missing laboratory result
 - C. A query asking for clarification on a documented complication
 - D. A general query with no specifics

Answers

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

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Explanations

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1. What term describes the interactive process of sharing experiences about clinical documentation in training?

- A. Asking
- B. Training
- C. Mastering
- D. Coaching**

The correct term for the interactive process of sharing experiences about clinical documentation in training is "Coaching." Coaching involves not only imparting knowledge but also facilitating discussions, providing feedback, and encouraging the application of skills. It emphasizes a two-way exchange where both the coach and the participants actively engage in dialogue to enhance understanding and improve practices related to clinical documentation. In the context of clinical documentation, coaching also includes the practical application of best practices, scenario-based learning, and real-time support as learners navigate complex documentation requirements. This approach fosters a deeper understanding of the nuances in documentation and helps practitioners develop their skills in a supportive environment. Other terms, such as training and mastering, imply a more formalized or one-directional transfer of knowledge, while asking suggests a more passive process of inquiry without the dynamic interaction inherent in effective coaching. Thus, coaching is the most appropriate term for this collaborative and experiential learning process.

2. What condition is classified as significant when coding for a patient with CHF and exacerbation of symptoms?

- A. Preventative measure
- B. Additional diagnosis**
- C. Main concern
- D. Non-essential diagnosis

In the context of coding for a patient with Congestive Heart Failure (CHF) and exacerbation of symptoms, the condition that is classified as significant is recognized as an additional diagnosis. In medical coding, additional diagnoses are those that are pertinent to the patient's current condition and are necessary for a comprehensive understanding of their health status. In this case, the exacerbation of CHF symptoms directly impacts the patient's treatment and care plan, hence it must be documented as an additional diagnosis to accurately reflect the complexity of the patient's condition. This classification is essential for several reasons, including appropriate billing, ensuring the complete clinical picture is represented, and guiding treatment decisions. By coding for the additional diagnosis of exacerbated symptoms, healthcare providers can demonstrate the severity of the patient's condition, which may influence their management and resource allocation during treatment. Correctly coding this information plays a vital role in healthcare documentation and can impact quality measures and care continuity. The other provided choices do not capture this significant relationship between the primary condition (CHF) and its exacerbated state, thereby failing to represent the nuances of the patient's health adequately.

3. 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.

4. According to coding guidelines, which conditions would be classified as secondary diagnoses in a patient with CHF and COPD?

A. CHF, pneumonia

B. Pneumonia, COPD

C. CHF, COPD

D. COPD

In the context of coding guidelines, a secondary diagnosis refers to any condition that coexists with the primary diagnosis but is not the primary reason for the patient's admission or encounter. For a patient diagnosed with congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD), CHF is typically considered the primary diagnosis, especially if it was the main reason for the hospitalization or treatment. In this scenario, both pneumonia and COPD could be considered for classification as secondary diagnoses. However, the focus is on identifying all relevant conditions present during that patient encounter. Since CHF is the primary diagnosis here, and COPD is another significant chronic condition that may complicate the patient's health status, it qualifies as a secondary diagnosis. This classification aligns with coding guidelines aimed at accurately depicting the complexity of a patient's conditions. The presence of these diagnoses helps ensure that healthcare providers receive appropriate reimbursement and that the patient's full clinical picture is represented, which informs better care decisions. Hence, in the scenario presented, both CHF (as the primary diagnosis) and COPD (as a significant chronic condition contributing to the overall health status) are classified as appropriate diagnoses for documentation.

5. Which of the following is a form of severe protein malnutrition affecting children during periods of famine?

- A. Protein-calorie malnutrition
- B. Severe malnutrition
- C. Vitamin A deficient malnutrition

D. Kwashiorkor

Kwashiorkor is recognized as a severe form of protein malnutrition that particularly affects children, especially during times of famine or when there is inadequate protein intake despite sufficient calorie consumption. This condition is characterized by a range of symptoms, including edema (swelling), irritability, an enlarged liver, and skin changes. The primary cause of Kwashiorkor is a deficiency in protein, which is critical for the development and maintenance of body tissues, immune function, and overall growth. During famine, children may receive enough calories from carbohydrates, but if their diet lacks sufficient protein, they are at risk for developing this condition. The physiological effects of Kwashiorkor highlight the importance of balanced nutrient intake, particularly protein, for children's health and development. Other forms of malnutrition, like protein-calorie malnutrition, encompass broader categories that may not focus solely on the absence of protein as seen in Kwashiorkor. Vitamin A deficient malnutrition specifically relates to the lack of vitamin A, and severe malnutrition may describe a range of nutritional deficiencies without pinpointing the critical role of protein. Thus, while the terms might overlap in the context of malnutrition, Kwashiorkor distinctly addresses severe protein deficiency, making it the correct choice in this case

6. What should a coder do if they are uncertain about the validity of a diagnosis noted in the medical record?

- A. Document it as is
- B. Query the attending physician**
- C. Leave it undocumented
- D. Independently diagnose

When a coder is uncertain about the validity of a diagnosis noted in the medical record, the best course of action is to query the attending physician. This approach ensures that the coder receives clarification directly from the source of the information—the physician who has comprehensive knowledge of the patient's condition. By reaching out to the attending physician, the coder can obtain accurate and specific information that may not be fully captured in the medical record. This step is crucial in maintaining the integrity and accuracy of the clinical documentation, which impacts coding, billing, and the overall quality of care. In the context of medical coding and documentation practices, querying the physician aligns with standards for ethical coding as it ensures that the diagnoses reported are substantiated and reflective of the patient's actual health status. Accurate coding not only supports reimbursement but also enhances data quality for healthcare analytics and research.

7. In determining the working DRG, what is the primary focus of the CDS review?

- A. Cost analysis
- B. Patient treatment plan
- C. Severity of illness**
- D. Clinical documentation quality

In determining the working Diagnosis-Related Group (DRG), the primary focus of the Clinical Documentation Specialist (CDS) review is the severity of illness. This focus is crucial because the severity of illness influences the classification of the DRG, which subsequently affects hospital reimbursement rates. A clear understanding of the patient's severity helps ensure that the appropriate DRG is assigned, reflecting the complexity of the patient's condition and the resources utilized during treatment. When the severity of illness is accurately documented, it allows for a more precise representation of the patient's health status and the medical necessity of the services provided. This also supports better clinical outcomes, as healthcare providers can tailor their interventions based on a clear understanding of the patient's condition. Other aspects, like cost analysis, patient treatment plans, and clinical documentation quality, are important in the broader context of healthcare delivery and reimbursement but do not take precedence in determining the working DRG. While cost analysis may give insight into financial implications, patient treatment plans reflect healthcare strategies, and clinical documentation quality pertains to the overall integrity of medical records. However, the immediate objective related to DRG assignment is primarily centered around the severity of illness.

8. When coding for hospital-acquired conditions, what is key to ensuring payment accuracy?

- A. Ensuring audits are regularly performed
- B. Validating condition prior to admission**
- C. Documenting any and all conditions
- D. Focusing only on principal diagnosis

When coding for hospital-acquired conditions, validating a condition prior to admission is crucial for ensuring payment accuracy. This step is essential because it helps to distinguish between conditions that were present upon admission and those that developed during the patient's hospital stay. Proper validation ensures that the healthcare provider accurately captures the patient's clinical picture, which directly influences reimbursement and compliance with regulatory standards. By confirming whether a condition existed prior to admission, healthcare professionals can appropriately allocate resources and follow correct coding practices, thereby minimizing the risk of denials or incorrect payment adjustments. Additionally, understanding whether a condition was acquired during the hospital stay helps organizations manage risk effectively and enhances the overall quality of care. This process is vital as it impacts both financial outcomes and quality measures within healthcare systems.

9. What is a key role of the physician advisor in CDI?

- A. To manage coders directly
- B. To ensure compliance with coding**
- C. To review patient discharge summaries
- D. To lead medication management discussions

The role of the physician advisor in Clinical Documentation Improvement (CDI) primarily revolves around ensuring compliance with coding standards and guidelines. This responsibility is crucial because accurate coding directly impacts the hospital's reimbursement, quality reporting, and overall financial health. By engaging with the clinical team, the physician advisor helps to clarify documentation requirements, improve the accuracy of coded data, and promote adherence to coding regulations, all of which contribute to the integrity of the health information system. The physician advisor provides education and support to other physicians regarding how their documentation influences coding and reimbursement, fostering awareness and better practices throughout the healthcare facility. Their expertise is vital in aligning clinical documentation with the nuances of coding conventions, thus enhancing compliance and minimizing the risk of audits or denials from payers. This function of driving compliance with coding is integral to the successful implementation of a CDI program.

10. During a CDI review, which scenario best indicates an appropriate query?

- A. A query that suggests a specific diagnosis
- B. A query regarding a missing laboratory result
- C. A query asking for clarification on a documented complication**
- D. A general query with no specifics

A query asking for clarification on a documented complication is the appropriate choice because it serves a vital role in the clinical documentation improvement process. This type of query seeks to clarify existing documentation, ensuring that the medical record accurately reflects the patient's condition and the severity of their illness. It can lead to a more precise understanding of the patient's health status, which is essential for quality patient care, proper coding, and accurate reimbursement. Clarifying documented complications is particularly important since it helps to establish the medical necessity of additional treatment or resources and influences risk adjustment and outcome measures. This improves the integrity of the data used for reporting and analytics, making it a key focus in the CDI process. In contrast, suggestions for specific diagnoses, inquiries about missing laboratory results, and general queries tend not to directly address the nuances of existing documentation. They may not contribute as effectively to clarifying the patient's clinical picture or improving the overall accuracy of the medical record. Therefore, focusing on clarity and specificity in existing documentation, as seen in the correct scenario, is paramount for effective CDI practices.

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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