

# Certified Documentation Integrity Practitioner (CDIP) Domain 2 Practice Exam (Sample)

## Study Guide



**Everything you need from our exam experts!**

**Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.**

**ALL RIGHTS RESERVED.**

**No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.**

**Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.**

**SAMPLE**

# Table of Contents

<b>Copyright</b> .....	<b>1</b>
<b>Table of Contents</b> .....	<b>2</b>
<b>Introduction</b> .....	<b>3</b>
<b>How to Use This Guide</b> .....	<b>4</b>
<b>Questions</b> .....	<b>5</b>
<b>Answers</b> .....	<b>9</b>
<b>Explanations</b> .....	<b>11</b>
<b>Next Steps</b> .....	<b>17</b>

SAMPLE

# 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

SAMPLE

- 1. How is a patient's management documented if they require at least 20 minutes of clinical staff time monthly?**
  - A. Patient management requirements**
  - B. Chronic care management services**
  - C. Regular patient check-ins**
  - D. Ongoing care evaluations**
  
- 2. What is the primary focus of documentation integrity?**
  - A. Recording patient emotions**
  - B. Ensuring accuracy in clinical records**
  - C. Reducing administrative workload**
  - D. Completing forms for billing only**
  
- 3. Why is interdisciplinary collaboration important in documentation integrity?**
  - A. It leads to a competitive workplace**
  - B. It ensures comprehensive understanding and communication of patient care**
  - C. It minimizes the amount of documentation required**
  - D. It reduces the complexity of paperwork for individual staff members**
  
- 4. When should a query for anemia due to blood loss be considered?**
  - A. Inappropriate**
  - B. Appropriate**
  - C. Always inappropriate**
  - D. Only in chronic cases**
  
- 5. What is an important consideration for a CDI specialist when dealing with documentation that shows conflicting diagnoses?**
  - A. Always code based on the specialist's input.**
  - B. Ensure to clarify with the attending physician to resolve conflicts.**
  - C. Disregard the conflicting information.**
  - D. Submit queries for all discrepancies without question.**

- 6. What should a query in clinical documentation improvement be based on?**
- A. Well-defined documentation practices**
  - B. Personal experiences of the healthcare provider**
  - C. Ambiguous or unclear documentation that requires clarification**
  - D. Standardized templates for documentation**
- 7. What term describes the rerouting of contents in a tubular body part to an abnormal route?**
- A. Division**
  - B. Alteration**
  - C. Change**
  - D. Bypass**
- 8. When assessing a patient for admission, what criterion is met if they exhibit persistent fever and require inpatient surgery within 24 hours?**
- A. The patient does not meet both severity of illness and intensity of service criteria**
  - B. The patient does meet both severity of illness and intensity of service criteria**
  - C. The patient meets intensity of service criteria but not severity of illness criteria**
  - D. The patient meets severity of illness criteria but not intensity of service criteria**
- 9. How do clinical indicators aid in documentation improvement?**
- A. By providing subjective opinions on patient care**
  - B. By offering measurable data to identify areas needing improvement**
  - C. By standardizing the language used in documentation**
  - D. By enforcing stricter regulations on documentation practices**

**10. For a patient with acute congestive heart failure and atrial fibrillation, which condition should be coded as principal?**

- A. The condition documented as causing the admission**
- B. EITHER diagnosis**
- C. Neither**
- D. Coding rules state query should be performed**

**SAMPLE**

## Answers

SAMPLE

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

SAMPLE

## **Explanations**

SAMPLE

**1. How is a patient's management documented if they require at least 20 minutes of clinical staff time monthly?**

- A. Patient management requirements**
- B. Chronic care management services**
- C. Regular patient check-ins**
- D. Ongoing care evaluations**

The correct choice highlights the importance of chronic care management services in documenting a patient's management when it requires at least 20 minutes of clinical staff time monthly. Chronic care management is specifically designed for patients with multiple chronic conditions that necessitate a consistent level of care and coordination by healthcare providers. This documentation is vital as it ensures that the services provided to the patient are recorded accurately, allowing for appropriate reimbursement and continuity of care. This type of management includes a range of activities such as medication management, coordination of healthcare services, and assisting patients in managing their conditions effectively. By focusing on the time commitment of at least 20 minutes each month, chronic care management services ensure that patients receive the necessary attention for their ongoing health issues, which aids in achieving better health outcomes and reducing hospital readmissions. Other options do not adequately capture the regulatory and billing frameworks that apply to scenarios requiring consistent clinical staff involvement. While regular patient check-ins and ongoing care evaluations have relevance in patient management, they lack the structured guidelines and billing implications associated with chronic care management, which is specifically designed to address the complexities of managing chronic conditions systematically.

**2. What is the primary focus of documentation integrity?**

- A. Recording patient emotions**
- B. Ensuring accuracy in clinical records**
- C. Reducing administrative workload**
- D. Completing forms for billing only**

The primary focus of documentation integrity is ensuring accuracy in clinical records. This is critical because the integrity of documentation directly affects patient care, reimbursement, and compliance with regulations. Accurate clinical records are essential for reflecting the true patient condition, supporting clinical decisions, and providing a foundation for quality improvement initiatives. When documentation is precise and trustworthy, it enhances communication among healthcare providers and leads to better patient outcomes. In contrast, while recording patient emotions can be a component of clinical assessments, it does not represent the overall goal of documentation integrity. Reducing administrative workload is a beneficial outcome of efficient documentation processes but is not the primary focus. Completing forms for billing only is too narrow a view, as documentation integrity encompasses much more than just billing; it includes all aspects of patient care represented in clinical records.

### 3. Why is interdisciplinary collaboration important in documentation integrity?

- A. It leads to a competitive workplace
- B. It ensures comprehensive understanding and communication of patient care**
- C. It minimizes the amount of documentation required
- D. It reduces the complexity of paperwork for individual staff members

Interdisciplinary collaboration is crucial in documentation integrity because it fosters a comprehensive understanding and effective communication regarding patient care among various healthcare professionals. When different disciplines, such as nursing, medicine, pharmacy, and social work, collaborate, they bring diverse perspectives and expertise that contribute to more thorough and accurate documentation. This collective approach ensures that all relevant patient information is captured, leading to better-informed medical decisions and improved patient outcomes. By engaging in collaboration, team members can clarify roles, share insights about patient conditions, and establish consistent documentation practices that reflect the full scope of care provided. This comprehensive understanding not only enhances the quality of the information recorded but also supports compliance with regulatory standards and promotes continuity of care. As a result, interdisciplinary collaboration is a key element in achieving documentation integrity and ensuring that patient records are complete, accurate, and truly representative of the care delivered.

### 4. When should a query for anemia due to blood loss be considered?

- A. Inappropriate
- B. Appropriate**
- C. Always inappropriate
- D. Only in chronic cases

A query for anemia due to blood loss should be considered appropriate in situations where clinical indicators suggest that blood loss may be a contributing factor to the patient's anemia. In the realm of clinical documentation, it is vital to capture accurately the underlying causes of conditions, as this directly impacts patient care, treatment plans, and reimbursement policies. When healthcare providers identify signs of anemia, such as low hemoglobin or hematocrit levels, and there is clinical evidence or suspicion of blood loss (whether acute or chronic), it's essential to query for this specific etiology. The rationale behind this practice is rooted in the concept of thoroughness and precision in medical documentation, ensuring that the patient's clinical picture is fully represented. This encompasses considering various causes for anemia, including but not limited to nutritional deficits, bone marrow problems, and, importantly, blood loss. This practice aligns with guidelines that emphasize clear documentation and inquiry when a patient's condition can be traced to specific physiological events or diseases. Therefore, the response that categorizes the query as appropriate reflects an understanding of the importance of accurate clinical documentation in supporting comprehensive care and facilitating better health outcomes.

**5. What is an important consideration for a CDI specialist when dealing with documentation that shows conflicting diagnoses?**

**A. Always code based on the specialist's input.**

**B. Ensure to clarify with the attending physician to resolve conflicts.**

**C. Disregard the conflicting information.**

**D. Submit queries for all discrepancies without question.**

When dealing with documentation that shows conflicting diagnoses, it is crucial for a CDI specialist to ensure clarification with the attending physician to resolve any conflicts. This approach enables the specialist to gather the physician's insights and understand their clinical reasoning, ensuring that the documentation accurately reflects the patient's condition and supports appropriate coding. The need for clarification is particularly important because coding relies heavily on the consistency and clarity of medical documentation. Conflicting diagnoses can lead to incorrect coding and affect compliance, reimbursement, and quality reporting. Engaging the attending physician fosters collaboration, aids in the development of a comprehensive understanding of the patient's health status, and enhances the integrity of the documentation. In addition, it encourages a teamwork approach within the healthcare setting, which can ultimately lead to better patient care and more accurate data capture. By resolving conflicts through direct communication, the CDI specialist minimizes the risk of errors that may arise from incorrect interpretations of conflicting information.

**6. What should a query in clinical documentation improvement be based on?**

**A. Well-defined documentation practices**

**B. Personal experiences of the healthcare provider**

**C. Ambiguous or unclear documentation that requires clarification**

**D. Standardized templates for documentation**

A query in clinical documentation improvement should be based on ambiguous or unclear documentation that requires clarification. The primary goal of querying is to ensure the accuracy and completeness of clinical documentation, which directly impacts patient care, coding accuracy, and reimbursement. When documentation is not clear or fails to capture the necessary details about a patient's condition or the care provided, it can lead to misunderstandings and inaccuracies that affect clinical outcomes and financial performance. By focusing on areas where documentation lacks clarity, healthcare providers can seek additional information that enriches the record and ensures that it truly reflects the patient's clinical status. This approach helps to improve the overall quality of documentation. Additionally, establishing clarity is essential for compliance with regulations and standards in healthcare. In contrast, while well-defined documentation practices and standardized templates contribute to clear documentation, they are not the basis for querying; instead, they serve as tools to promote good documentation habits. Personal experiences of healthcare providers may inform their practice but do not provide the objective basis needed for a query, which should focus on specific instances of unclear documentation rather than subjective interpretations.

**7. What term describes the rerouting of contents in a tubular body part to an abnormal route?**

- A. Division**
- B. Alteration**
- C. Change**
- D. Bypass**

The term that describes the rerouting of contents in a tubular body part to an abnormal route is "bypass." In medical terminology, a bypass typically refers to a surgical procedure or process in which the normal route of a bodily fluid or material is redirected away from a blockage or dysfunctional area. This can occur in various anatomical systems, such as the gastrointestinal tract or cardiovascular system, to restore function or relieve obstruction. Bypassing is often employed in treatment scenarios where it is necessary to circumvent a pathological condition, enabling proper flow or function that would otherwise be compromised. This understanding is crucial in the context of documentation integrity, as accurate terminology is essential for effective communication and appropriate coding in medical records.

**8. When assessing a patient for admission, what criterion is met if they exhibit persistent fever and require inpatient surgery within 24 hours?**

- A. The patient does not meet both severity of illness and intensity of service criteria**
- B. The patient does meet both severity of illness and intensity of service criteria**
- C. The patient meets intensity of service criteria but not severity of illness criteria**
- D. The patient meets severity of illness criteria but not intensity of service criteria**

When a patient exhibits persistent fever and requires inpatient surgery within a 24-hour timeframe, it indicates a significant clinical situation that requires close monitoring and intervention. This scenario fulfills both the severity of illness and intensity of service criteria. The severity of illness criterion is met due to the patient's acute condition, which suggests that they are experiencing significant health issues that necessitate immediate attention, such as a potential infection or other serious health concerns that could deteriorate without timely intervention. Furthermore, the intensity of service criterion is satisfied because the requirement for inpatient surgery within 24 hours indicates that the patient needs a higher level of care, including operating room resources, anesthesia, and postoperative monitoring typically provided in a hospital setting. This requires a comprehensive and intensive healthcare response that exceeds what would be available in less acute or outpatient settings. As a result, the patient qualifies for both criteria, making this option the correct choice in the context of their clinical assessment for admission.

**9. How do clinical indicators aid in documentation improvement?**

- A. By providing subjective opinions on patient care**
- B. By offering measurable data to identify areas needing improvement**
- C. By standardizing the language used in documentation**
- D. By enforcing stricter regulations on documentation practices**

Clinical indicators play a crucial role in documentation improvement by offering measurable data to identify areas that require enhancement. These indicators are quantifiable metrics derived from patient care data, reflecting aspects such as treatment outcomes, adherence to clinical guidelines, and overall patient safety. When healthcare organizations analyze these indicators, they can pinpoint areas where documentation may be lacking or where processes could be optimized to promote better patient care. For example, if a clinical indicator reveals a high rate of hospital readmissions for a particular condition, this might suggest that the documentation around discharge planning and patient education needs to be strengthened. By focusing on these measurable aspects, healthcare organizations can implement targeted initiatives aimed at improving both documentation practices and patient outcomes. This data-driven approach leads to a more systematic and effective process for enhancing the quality of clinical documentation.

**10. For a patient with acute congestive heart failure and atrial fibrillation, which condition should be coded as principal?**

- A. The condition documented as causing the admission**
- B. EITHER diagnosis**
- C. Neither**
- D. Coding rules state query should be performed**

The principal diagnosis is defined as the condition that, after study, is determined to be the primary reason for the patient's admission to a healthcare facility. In cases involving acute congestive heart failure alongside atrial fibrillation, the condition that directly necessitated the patient's hospital admission is typically considered first. Acute congestive heart failure is often the primary concern that leads to hospitalization due to its acute nature and the immediate need for treatment to stabilize the patient. While atrial fibrillation may be a significant clinical issue as well, it is often associated as a secondary condition, particularly if it was not the impetus for admission. Therefore, the correct approach is to code acute congestive heart failure as the principal diagnosis because it represents the acute, life-threatening condition that required urgent intervention and care. This perspective aligns with standard coding guidelines wherein the underlying condition that prompts the need for hospitalization takes precedence in determining the principal diagnosis.

## 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://cdipdomain2.examzify.com>**

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

SAMPLE