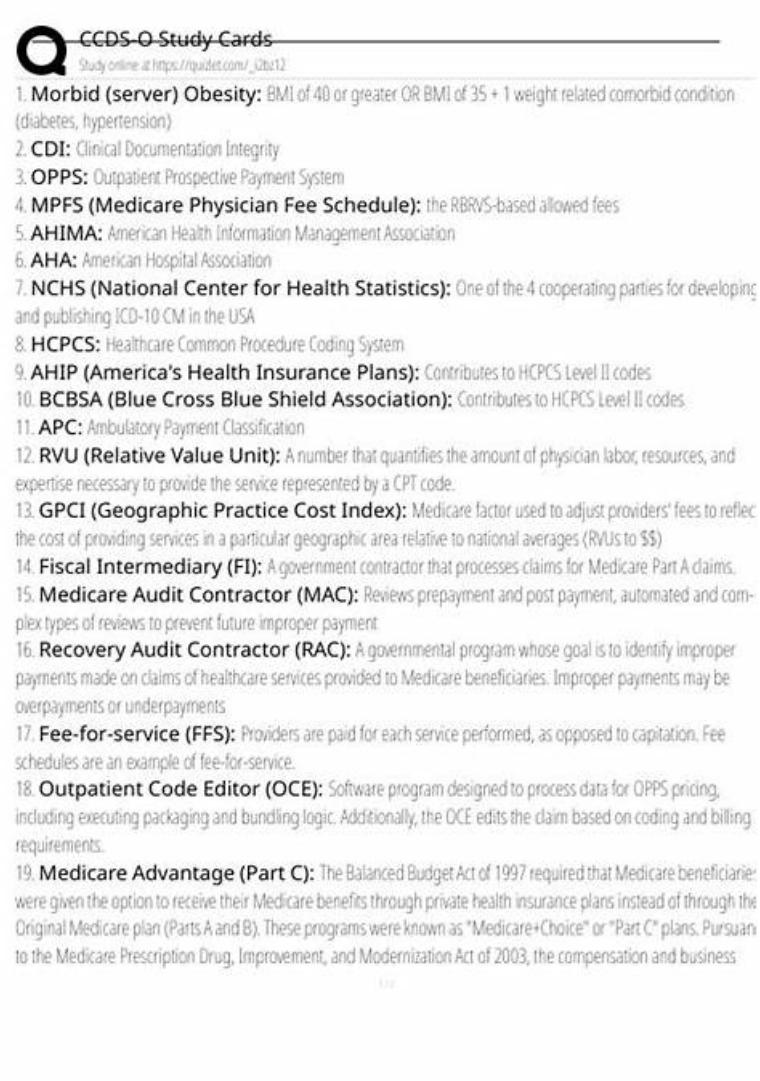
Actual ACDIS CCDS-O Exam Questions



CCDS-O Study Cards

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1. **Morbid (server) Obesity:** BMI of 40 or greater OR BMI of 35 + 1 weight related comorbid condition (diabetes, hypertension)
2. **CDI:** Clinical Documentation Integrity
3. **OPPS:** Outpatient Prospective Payment System
4. **MPFS (Medicare Physician Fee Schedule):** the RBRVS-based allowed fees
5. **AHIMA:** American Health Information Management Association
6. **AHA:** American Hospital Association
7. **NCHS (National Center for Health Statistics):** One of the 4 cooperating parties for developing and publishing ICD-10 CM in the USA
8. **HCPCS:** Healthcare Common Procedure Coding System
9. **AHIP (America's Health Insurance Plans):** Contributes to HCPCS Level II codes
10. **BCBSA (Blue Cross Blue Shield Association):** Contributes to HCPCS Level II codes
11. **APC:** Ambulatory Payment Classification
12. **RVU (Relative Value Unit):** A number that quantifies the amount of physician labor, resources, and expertise necessary to provide the service represented by a CPT code.
13. **GPCI (Geographic Practice Cost Index):** Medicare factor used to adjust providers' fees to reflec the cost of providing services in a particular geographic area relative to national averages (RVUs to $$)
14. **Fiscal Intermediary (FI):** A government contractor that processes claims for Medicare Part A claims.
15. **Medicare Audit Contractor (MAC):** Reviews prepayment and post payment, automated and complex types of reviews to prevent future improper payment
16. **Recovery Audit Contractor (RAC):** A governmental program whose goal is to identify improper payments made on claims of healthcare services provided to Medicare beneficiaries. Improper payments may be overpayments or underpayments
17. **Fee-for-service (FFS):** Providers are paid for each service performed, as opposed to capitation. Fee schedules are an example of fee-for-service.
18. **Outpatient Code Editor (OCE):** Software program designed to process data for OPPS pricing, including executing packaging and bundling logic. Additionally, the OCE edits the claim based on coding and billing requirements.
19. **Medicare Advantage (Part C):** The Balanced Budget Act of 1997 required that Medicare beneficiarie were given the option to receive their Medicare benefits through private health insurance plans instead of through the Original Medicare plan (Parts A and B). These programs were known as "Medicare+Choice" or "Part C" plans. Pursuan to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the compensation and business

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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• Diseases and Disease Processes and Application to the Clinical Chart Review: Covers clinical indicators across all ICD-10-CM chapters, applied to chart reviews, with recognition of medications, diagnostic tests, and abbreviations as documentation clarification triggers.
Topic 2	• and billing: Covers Official Coding Guidelines, OPPS reimbursement (APCs), and professional billing concepts including CPT E • M codes and Medicare Physician Fee Schedule documentation.
Topic 3	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q98-Q103):

NEW QUESTION # 98
PCP notes describe the presence of atrial fibrillation for 10 days. Atenolol, sotalol and rivaroxaban are ordered. Possible ablation is discussed. Identify the type of atrial fibrillation described in this clinical scenario.

- A. Paroxysmal
- B. Permanent
- C. Chronic
- D. Persistent

Answer: D

Explanation:
Atrial fibrillation (AF) type is determined largely by episode duration and whether the rhythm self-terminates. In outpatient CDI education, paroxysmal AF is intermittent and typically terminates spontaneously, commonly within 7 days (often within 48 hours). Persistent AF is sustained and lasts more than 7 days, or requires active intervention (e.g., cardioversion) to restore sinus rhythm. This scenario documents AF "for 10 days," which exceeds the 7-day threshold and therefore best fits persistent AF. The management also aligns with a sustained arrhythmia strategy: rate control (atenolol), rhythm control/antiarrhythmic therapy (sotalol), stroke prevention anticoagulation (rivaroxaban), and discussion of catheter ablation, which is often considered for symptomatic or recurrent/persistent AF. "Chronic" is a nonspecific descriptor and not the preferred current classification term, and permanent AF implies a decision has been made not to pursue rhythm control (accepting AF long-term), which is not supported here because rhythm-control options are being considered.

NEW QUESTION # 99
Which of the following BEST represents performance metrics important to an outpatient CDI program?

- A. HCC capture rate, unspecified code utilization rate, and query response rate
- B. Medicare Case Mix Index, aggregate RAF scores, and clinical denial rate
- C. Severity of illness, HCC capture rate, and Medicare Case Mix Index
- D. Number of secondary diagnoses per claim, aggregate RAF score, and quality indicators

Answer: A

Explanation:
Outpatient CDI performance is best measured by metrics that reflect ambulatory documentation quality, risk-adjustment accuracy, and provider engagement. HCC capture rate is central because outpatient CDI frequently supports risk adjustment (e.g., CMS-HCC/HHS-HCC) and aims to ensure chronic conditions are accurately documented, linked, and reported when they are actively managed. Unspecified code utilization rate is a practical quality metric for provider education because high unspecified use often signals missed clinical specificity (severity, laterality, acuity, manifestations, staging) that can reduce coding accuracy, obscure patient complexity, and weaken data used for benchmarking and quality reporting. Query response rate is also a core operational KPI: it reflects provider participation, workflow effectiveness, and the CDI team's ability to obtain timely clarifications that support compliant coding and complete clinical representation. In contrast, Medicare CMI and severity of illness are predominantly inpatient-focused constructs and are not the primary yardsticks for outpatient CDI program success. While aggregate RAF and quality indicators matter, the best "program performance" set is the one directly tied to outpatient CDI levers: HCC capture, specificity/unspecified reduction, and query responsiveness.

NEW QUESTION # 100
Which of the following contributes to the risk adjustment score under the CMS-HCC model?

- A. Health status and previous risk score
- B. Income status and disability status
- C. Cost of care provided and hospital readmissions
- D. Enrollment eligibility status and reported conditions

Answer: D

Explanation:
Under the CMS-HCC risk adjustment methodology, the RAF is calculated primarily from two categories of inputs: (1) demographic/enrollment eligibility factors and (2) diagnosis codes that map to HCCs based on documented, reportable conditions. Eligibility status matters because Medicare models differentiate beneficiaries by factors such as aged versus disabled status and other enrollment characteristics that affect expected cost. The second major driver is the set of valid, supported ICD-10-CM codes reported for the beneficiary during the data collection period; only certain chronic, clinically significant conditions map to HCCs, and they must be documented as active and applicable to the encounter and coded correctly. In ambulatory CDI, this is why accurate condition capture, specificity, and linkage (e.g., cause/manifestation relationships) are emphasized-because reported conditions directly affect the patient's risk profile and the expected cost benchmark. By contrast, income status is not a standard CMS-HCC input, "previous risk score" is not itself an input variable, and utilization outcomes like cost of care or readmissions are not used to compute RAF (they may be evaluated separately in quality/cost programs).

NEW QUESTION # 101
Which component of the OPPS assigns payment rates based on procedure grouping?

- A. DRGs
- B. APCs
- C. Physician Fee Schedule
- D. CPT codes

Answer: B

Explanation:
Under the Medicare Outpatient Prospective Payment System (OPPS), hospital outpatient services are paid based on Ambulatory Payment Classifications (APCs). APCs are the mechanism that groups clinically similar services and procedures-typically identified through CPT/HCPCS reporting-into payment categories with established relative resource costs. CPT codes identify what service was performed, but CPT itself is not the OPPS payment grouping methodology; OPPS takes the coded line items and maps many of them into APC groupings (with packaging rules, status indicators, and modifier impacts) to determine the payment rate. DRGs are used for inpatient prospective payment and do not apply to OPPS outpatient claims in the same way. The Physician Fee Schedule applies to professional services (physician/clinician billing) rather than the hospital facility component paid under OPPS. From an outpatient CDI lens, accurate, specific documentation supports correct CPT/HCPCS selection, modifier use, units, and medical necessity linkages-ensuring services map to the correct APC and are not inappropriately bundled, denied, or downcoded during review. This protects payment accuracy and compliance by aligning the clinical story with the reported outpatient services.

NEW QUESTION # 102
Provider documentation states: "A 72-year-old patient with an active history of colon cancer, status post bowel resection, receiving chemotherapy. Newly diagnosed lung metastasis. Presents with UTI and elevated creatinine. Labs demonstrate a hemoglobin of 7.9, WBC of 2,500, and platelet count of 20,000." Which of the following is the query opportunity that supports a disease interaction that impacts the risk adjustment?

- A. Colon cancer and chemotherapy
- B. Acute tubular necrosis and UTI
- C. Chemotherapy induced pancytopenia
- D. Colon cancer and lung metastasis

Answer: C

Explanation:
In outpatient risk adjustment, "disease interactions" refer to model coefficients that are triggered when certain clinically related

conditions co-exist, reflecting higher expected resource use than either condition alone. In this case, the record already supports active malignancy care (colon cancer on chemotherapy) with newly documented metastasis, and the lab pattern (anemia, leukopenia, and severe thrombocytopenia) strongly suggests pancytopenia. The highest-yield query opportunity is to clarify whether the cytopenias represent chemotherapy-induced pancytopenia (or another specified etiology) because a confirmed, well-specified hematologic complication in the context of active cancer treatment is the type of combination that commonly drives interaction effects in risk models (cancer plus significant systemic complication/manifestation). Options A and B describe clinical context but do not, by themselves, establish an interaction-ready, separately reportable complication. Option C is unrelated to the presented lab-driven severity signal. Querying and documenting chemotherapy-induced pancytopenia supports accurate capture of severity and the interaction impact.

NEW QUESTION # 103

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