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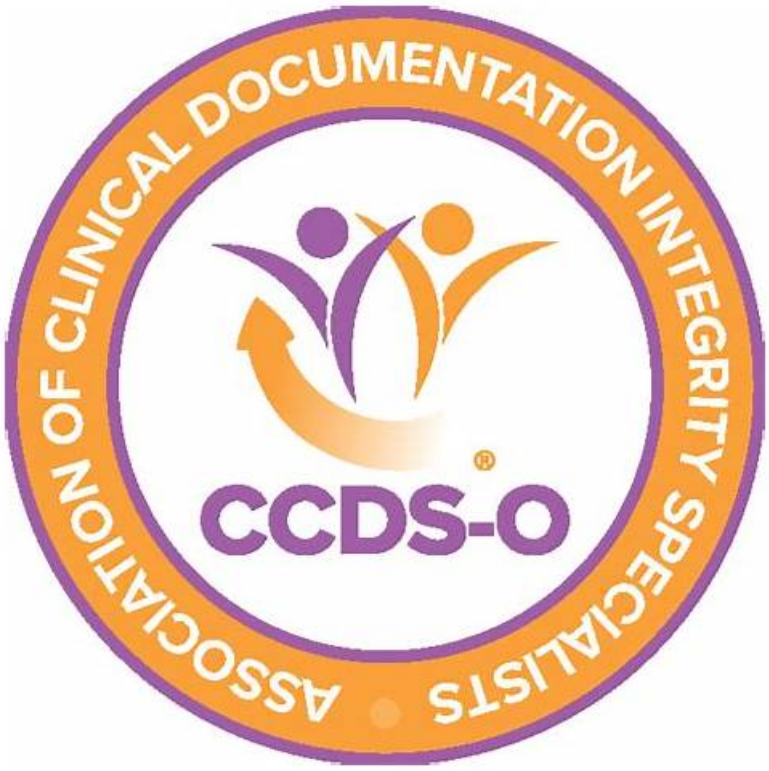

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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• Risk Adjustment Models and Impact of Documentation and Coding: Covers CMS-HCC model fundamentals, RAF scoring, Medicare Advantage payments, hierarchies, disease interactions, and compliant HCC reporting requirements.
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
Topic 4	• Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for
Topic 5	• 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.

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q48-Q53):

NEW QUESTION # 48
ICD-10-CM code assignment can be supported by documentation from someone other than the patient's provider in which of the following circumstances?

- A. Type of obesity
- B. Site of ostomy
- C. Stage of pressure ulcer
- D. Anatomic site of previous amputation

Answer: C

Explanation:
Outpatient ICD-10-CM guidance allows certain code elements to be based on documentation from clinicians other than the patient's diagnosing provider when those elements are considered objective, routinely assessed, and commonly documented by nursing or ancillary staff. A key example is pressure ulcer staging, which is frequently assessed and documented by wound care nurses and other qualified clinicians as part of routine skin/wound evaluation. Because the stage drives code specificity and is an observable clinical finding, coders may use non-provider documentation to assign the stage when it is clearly documented and not contradicted by the provider record. In contrast, items such as the type of obesity generally require provider diagnosis/clinical assessment rather than ancillary documentation alone. Similarly, while status conditions (like amputations or ostomies) may be observed, the coding guidelines do not broadly permit assigning these diagnoses solely from non-provider documentation without provider confirmation, unless the chart otherwise supports it. Therefore, among the choices, pressure ulcer stage is the appropriate circumstance where non-provider documentation can support ICD-10-CM assignment.

NEW QUESTION # 49
A patient is scheduled to see his PCP in 3 days. A CDI specialist notes that during the patient's last visit earlier this year, the problem list shows both DM 2 associated erectile dysfunction and DM 2 without complications. The last clinic note states that DM 2 with autonomic neuropathy was addressed. The CDI specialist should do which of the following FIRST?

- A. Remove DM 2 without complications from the problem list
- B. Query if the DM 2 is with or without complications
- C. Ask the patient if he still has DM 2 with autonomic neuropathy
- D. Query the provider for the link between erectile dysfunction and DM 2

Answer: B

Explanation:
The record contains conflicting documentation: the problem list includes both "type 2 diabetes without complications" and diabetes with complications (erectile dysfunction association), while the most recent clinic note indicates the provider addressed "DM2 with autonomic neuropathy," which is clearly a diabetic complication. In outpatient CDI, the first priority is to resolve internal inconsistency so coding accurately reflects the patient's current clinical status and what was evaluated/managed at the encounter. A query should therefore focus on whether the patient's diabetes is with complications (and which complications are active/being addressed) versus truly without complications, because "without complications" is generally not appropriate when neuropathy/other manifestations are present and being managed. CDI staff also should not unilaterally remove items from the provider-maintained problem list, and asking the patient is not a reliable documentation/coding source for establishing diagnoses. Once the provider

clarifies diabetes complication status, a follow-up clarification can address specific linkages (e.g., erectile dysfunction due to diabetes) if needed for correct code assignment

NEW QUESTION # 50
When compliantly querying providers, CDI specialists or HIM/coding professionals may

- A. identify which diagnoses are HCCs.
- B. omit clinical indicators in a query as this may be leading to the provider.
- C. offer diagnoses choices supported by documentation solely from previous encounters.
- D. offer a new diagnosis, that is supported by the clinical evidence, as an option in a multiple-choice query.

Answer: D

Explanation:
Compliant querying principles taught in outpatient CDI allow the CDI/coding professional to present a multiple-choice query that includes reasonable diagnostic options supported by the current encounter's clinical indicators. Including a "new" diagnosis as an option is acceptable when it is clinically supported by documented findings (signs/symptoms, test results, treatments, clinical course) and the query is written in a non-leading manner-typically with balanced options and an "other" and/or "unable to determine" choice. This approach helps the provider clarify the most accurate condition being evaluated or treated without steering toward a particular response. Option A is not compliant because relying solely on prior encounter documentation (without current relevance) risks coding historical conditions that are not addressed today. Option B is generally discouraged because calling out HCC status can be perceived as prompting for payment impact rather than clinical accuracy. Option D is incorrect because including relevant clinical indicators is essential; omitting them weakens the clinical basis and does not make a query less leading-rather, it makes it less defensible.

NEW QUESTION # 51
Which of the following section(s) of the Official Guidelines for Coding and Reporting are applicable to outpatient settings?

- A. Section I, Conventions, General Coding Guidelines, and Chapter Specific Guidelines
- B. Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services
- C. Section III, Reporting Additional Diagnoses; and Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services
- D. Section I, Conventions, General Coding Guidelines and Chapter Specific Guidelines; and Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services

Answer: D

Explanation:
In outpatient CDI and coding, the Official ICD-10-CM Guidelines that apply are the universal rules plus the outpatient-specific rules. Section I contains conventions, general coding guidelines, and chapter-specific guidance that govern code assignment in every setting (e.g., code structure, "use additional code," laterality, sequencing instructions, and condition-specific rules). Section IV is specifically written for outpatient services and drives core outpatient behaviors such as selecting the "first-listed" diagnosis based on the main reason for the encounter, reporting additional diagnoses that are evaluated/assessed/treated or impact care, and applying outpatient-only restrictions (for example, diagnoses documented as "rule out," "probable," or "suspected" generally are not coded in outpatient the way they may be for inpatient reporting). ACDIS outpatient CDI education emphasizes teaching providers to document clearly the reason for visit, the assessment/clinical relevance of each condition addressed, and the linkage between conditions and services rendered so Section I and Section IV rules can be applied accurately for compliant reimbursement and reporting.

NEW QUESTION # 52
PCP notes describe declining renal function with creatinine trending upward over the last 12 months. Nephrology consult ordered. Which of the following diagnostic tests could support a query to identify status of the patient's baseline renal function?

- A. BUN (Blood urea nitrogen)
- B. ACR (albumin to creatinine ratio)
- C. Creatinine
- D. eGFR (glomerular filtration rate)

Answer: D

Explanation:
To establish and query for a patient's baseline renal function in the outpatient setting, eGFR is the most direct and standardized measure because it estimates kidney filtration capacity using serum creatinine (and patient factors such as age/sex, and sometimes race depending on the equation used). Outpatient CDI concepts emphasize that chronic kidney disease staging is based primarily on eGFR categories (G1-G5) and persistence over time, making eGFR trends particularly useful for determining whether the patient has CKD, whether it is worsening, and what stage should be documented. Serum creatinine alone can suggest decline but does not translate cleanly to CKD stage without calculating eGFR and considering patient characteristics. BUN is influenced by hydration status, protein intake, bleeding, and catabolic states, so it is less reliable for baseline kidney function assessment. ACR is important for detecting albuminuria and refining CKD classification/risk stratification, but it complements eGFR rather than replacing it as the primary indicator of baseline filtration function.

NEW QUESTION # 53
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