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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	• 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	• 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 3	• Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q32-Q37):

NEW QUESTION # 32
Documentation from which of the following facility settings contributes to the CMS-HCC risk score?

- A. Hospital ambulatory clinic
- B. Hospice care
- C. Renal dialysis center
- D. Freestanding ambulatory surgical center

Answer: A

Explanation:
Under CMS-HCC risk adjustment (commonly applied to Medicare Advantage), qualifying diagnoses must come from acceptable encounter/claim sources and eligible provider types. Hospital-based outpatient services (including a hospital ambulatory clinic) are among the standard, acceptable settings where diagnoses documented, coded, and submitted on qualifying encounters may be used for risk adjustment-assuming they are supported, assessed/managed, and submitted per program requirements. In contrast, certain facility claim types do not typically contribute to CMS-HCC capture in the same way. Hospice care is generally treated as a carve-out/unique payment environment and is not relied upon as a routine source of risk-adjusting diagnosis capture for the member's ongoing RAF. Renal dialysis centers (ESRD facilities) likewise operate under specialized payment constructs and are not the typical outpatient setting used to drive CMS-HCC diagnosis capture for risk adjustment in standard CDI workflows. Freestanding ambulatory surgical centers also frequently fall outside the usual risk-adjustment-eligible encounter sources emphasized in outpatient CDI programs. Therefore, the hospital ambulatory clinic is the correct setting among these choices.

NEW QUESTION # 33
Which entity is tasked by CMS to process both Part A and Part B beneficiary claims?

- A. Risk adjustment validation contractors
- B. Recovery audit contractors
- C. Medicare administrative contractors
- D. Zone program integrity contractors

Answer: C

Explanation:
CMS assigns Medicare Administrative Contractors (MACs) to administer Medicare fee-for-service operations at the jurisdictional

level, including processing and paying both Part A and Part B claims. In outpatient CDI terms, MACs are central because they apply Medicare coverage rules, edit logic, and payment policies that determine whether documentation supports medical necessity and correct coding for submitted claims. This includes adjudicating hospital outpatient (Part B) services and facility-based Part A services, handling provider enrollment functions, issuing Local Coverage Determinations (as applicable through their medical review processes), and responding to claim inquiries and appeals routing. By contrast, Recovery Audit Contractors (RACs) focus on identifying and recovering improper payments (post-payment auditing). Risk Adjustment Data Validation (RADV) contractors validate diagnosis data submitted for risk-adjusted programs (primarily Medicare Advantage), not routine FFS claim processing. Zone Program Integrity Contractors (ZPICs) (and their successors in some contexts) focus on program integrity and fraud/waste/abuse investigations rather than standard claim adjudication. Therefore, the entity responsible for processing Part A and Part B beneficiary claims is the MAC.

NEW QUESTION # 34
A female patient presents for her yearly wellness check-up. Her vital signs are within normal limits with the exception of dyspnea. Her weight is 165 lbs, up 10 lbs from her previous clinic visit 2 weeks prior. Problem list includes diagnoses of obesity, COPD, heart failure, and diabetes without complications. The patient's A1c noted 9.2 up from 7.2 from previous year wellness exam. Based on the clinical indicators, which of the following medications should be evaluated and addressed during this clinic visit?

- A. Wellbutrin and Allegra
- B. Megace and ferrous sulfate
- C. Metformin and methotrexate
- D. NovoLog and Lasix

Answer: D

Explanation:
In ambulatory CDI chart review, clinical indicators should align with assessment and management captured in the note (problem relevance and MEAT-style support: monitor, evaluate, assess/address, treat). This visit has two strong indicators that warrant medication evaluation. First, dyspnea plus a rapid 10-lb weight increase over two weeks is a classic signal of possible fluid overload in a patient with heart failure, making a loop diuretic such as Lasix clinically relevant to assess (effectiveness, adherence, dose changes, exacerbation risk, and whether HF is stable vs decompensated). Second, the A1c has worsened significantly (9.2 from 7.2), indicating inadequate glycemic control that should prompt review and adjustment of diabetes therapy; insulin such as NovoLog is directly tied to diabetes treatment escalation or optimization. The other medication pairs do not logically match the documented problems and indicators (e.g., appetite stimulant/anemia therapy, immunosuppressant, antidepressant/antihistamine). Therefore, NovoLog and Lasix best reflect what should be evaluated and addressed

NEW QUESTION # 35
The majority of E/M services are based on which of the following criteria?

- A. New/established, site of service, and time
- B. New/established, level of service, and age of patient
- C. New/established, site of service, and level of service
- D. New/established, physician specialty, and level of service

Answer: C

Explanation:
In outpatient CDI and coding education, selecting the correct E/M code starts with identifying the encounter category (e.g., office/outpatient vs inpatient/observation vs ED) and whether the patient is new or established, because these define the applicable CPT code range. Next, the level of service is selected within that range based on the documentation supporting the required elements for that code family. For most E/M services, "site of service" (place/setting) and "new vs established" are foundational code-selection drivers, while "level" is determined by the record's support for the applicable leveling methodology (commonly medical decision making and, when allowed/appropriate, time). Time can be a valid leveling method for many office/outpatient E/M visits, but it is not universally the basis for the majority of E/M services across all categories; it is an alternative pathway when documentation supports it. Physician specialty and patient age do not define the majority of E/M code selection. Therefore, the best overall statement is new/established status + site of service + level of service.

NEW QUESTION # 36

Symbicort is used to treat which of the following conditions?

- A. Diabetic neuropathy
- B. Congestive heart failure
- C. Degenerative osteoarthritis
- D. Persistent asthma

Answer: D

Explanation:
Symbicort is an inhaled combination medication containing an inhaled corticosteroid (ICS) and a long-acting beta-agonist (LABA). In outpatient chart review, this medication class is most strongly associated with chronic airway inflammatory diseases requiring controller therapy-especially persistent asthma (and also maintenance therapy for COPD, though COPD is not an option here). For CDI purposes, medication-to-diagnosis linkage can act as a clinical indicator supporting clarification when the visit note lists respiratory symptoms but does not clearly document the chronic condition being treated or its acuity/status. Symbicort is not used to treat musculoskeletal degenerative disease (osteoarthritis), peripheral nerve pain from diabetes (diabetic neuropathy), or cardiac pump failure (congestive heart failure). When Symbicort appears on the active med list, outpatient CDI commonly checks that the provider's documentation appropriately reflects asthma classification (intermittent vs persistent), current control, exacerbation status if applicable, and that the condition is being monitored/assessed/treated during the encounter to support reportability and accurate coding.

NEW QUESTION # 37
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