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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • 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 3	<ul style="list-style-type: none"> • Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding
Topic 4	<ul style="list-style-type: none"> • and billing: Covers Official Coding Guidelines, OPPS reimbursement (APCs), and professional billing concepts including CPT E • M codes and Medicare Physician Fee Schedule documentation.

ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q46-Q51):

NEW QUESTION # 46

Which of the following is a strategy that is often used by ACOs to improve their performance in the Readmission Reduction program?

- A. Educate providers about the importance of capturing chronic conditions in documentation.
- B. Work with IT to increase the unspecified code choices in pick lists in the EHR.
- C. Encourage providers to avoid reporting chronic conditions on subsequent admissions.
- D. Flag qualifying patients upon arrival to ED to be placed in observation status vs. admission.

Answer: A

Explanation:

ACOs commonly focus on strengthening documentation and coding of clinically relevant chronic conditions because many quality and utilization comparisons—including readmission-related performance assessments—are influenced by patient complexity and risk adjustment. When chronic diseases and their specificity (e.g., stage, severity, manifestations) are under-documented, attributed patients can appear "healthier" on paper than they truly are, which can worsen an organization's apparent readmission performance when outcomes are compared to an expected benchmark. Provider education that reinforces documenting active conditions that are monitored, evaluated, assessed/addressed, or treated helps ensure an accurate picture of acuity and comorbidity burden. This improves the integrity of risk adjustment inputs and supports fairer benchmarking, while also strengthening medical necessity and continuity-of-care communication across settings. The other choices represent either noncompliant behavior (avoiding condition reporting), poor documentation practice (promoting unspecified codes), or operational maneuvering that may be perceived as gaming rather than a sustainable quality strategy. Therefore, educating providers to capture chronic conditions accurately is the best and most commonly used improvement approach.

NEW QUESTION # 47

A 75-year-old with a PMH of chronic foot ulcer, CKD, and depression is seen by his PCP for continued fatigue and decreased urination. Labs drawn on previous day are reviewed. Patient describes extreme fatigue and no motivation. Assessment and plan include: "CKD 3 with renal failure - refer to nephrologist. Chronic nonpressure foot ulcer - home care for wound assessment. Depression - Rx for SSRI." Which of the following are the validated diagnoses that risk adjust and qualify as CMS-HCCs?

- A. Depression; renal failure
- B. Chronic non-pressure ulcer; depression
- C. CKD 3; chronic non-pressure ulcer
- D. Renal failure; CKD 3

Answer: C

Explanation:

Under CMS-HCC methodology, risk adjustment is driven by ICD-10-CM diagnoses that map to HCC categories and are supported as active conditions addressed at the encounter. CKD stage 3 is a classic HCC-qualifying chronic condition because it represents ongoing kidney disease severity and expected resource use, and in this note it is actively assessed with labs reviewed and a nephrology referral. A chronic non-pressure foot ulcer is also typically HCC-qualifying when documented as ongoing and requiring management, which is supported here by home care/wound assessment planning. In contrast, "depression" (without specification such as major depressive disorder severity/status) commonly does not qualify for HCC in the way major depressive/bipolar categories do, making it less reliable as a risk-adjusting diagnosis. Likewise, "renal failure" is nonspecific and potentially conflicting

with CKD stage 3; CDI best practice would be to clarify acuity/severity (acute kidney injury vs CKD stage vs ESRD) rather than assume "renal failure" as an HCC driver. Therefore, the validated HCC-qualifying pair is CKD 3 and chronic non-pressure ulcer.

NEW QUESTION # 48

Which of the following contributes to the risk adjustment score under the CMS-HCC model?

- A. Cost of care provided and hospital readmissions
- B. Health status and previous risk score
- C. Income status and disability status
- 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 # 49

Which of the following illustrates an example of a compliant, prospective query?

- A. "Dr.: Your patient has a past medical history of CHF noted in her problem list. A review of her medication list shows Lasix 20 mg QD. Please review this diagnosis for pertinence and relevance during her upcoming visit and specify the type and acuity of the CHF if the diagnosis is still being addressed."
- B. "Dr.: Your patient has chronic diastolic heart failure documented in her problem list. Can you please add this diagnosis to your progress note from her office visit?"
- C. "Dr.: Your patient was here for her Annual Wellness Visit. A review of her medication list shows a new order for Lasix 20mg QD. A review of your progress note from that visit notes 2+ pitting edema bilaterally and that the patient complains of shortness of breath at night requiring her to sleep on 2 pillows. Please add CHF to the problem list if this is the diagnosis you are treating with the Lasix."
- D. "Dr.: Your patient was ordered an echocardiogram at her last visit. Can you please document that the CHF was addressed as the basis for the study?"

Answer: A

Explanation:

A compliant prospective query is initiated before the next encounter so the provider can clarify documentation during the upcoming visit, using clinically relevant indicators without directing a specific diagnosis. Option A does this appropriately: it references an existing CHF history and a supportive medication (Lasix), then asks the provider to confirm whether CHF is pertinent at the next visit and, if so, to specify type and acuity. This supports accurate outpatient reporting because heart failure coding requires specificity (systolic/diastolic/combined; acute/chronic/acute on chronic) and should reflect what is actually evaluated/managed at the encounter. Option B is retrospective and attempts to justify a prior test. Option C is leading because it asks the provider to "add" a diagnosis to a past note rather than clarify current clinical status. Option D is also retrospective and uses "please add CHF," which is leading and can be perceived as prompting. Therefore, A best demonstrates a compliant prospective query.

NEW QUESTION # 50

An African American male enrolled in Medicaid has not been taking his blood pressure medication. Which of the following factors impacts this beneficiary's risk score?

- A. Medicaid status and gender

- B. ICD-10-CM codes and race
- C. Medicaid status and race
- D. Patient noncompliance and age

Answer: A

Explanation:

Medicaid risk adjustment models generally calculate risk using two major categories of inputs: demographics and diagnosis data. Demographic factors commonly include gender and indicators tied to Medicaid status/eligibility (for example, eligibility category, dual status, disability-related eligibility, or other program qualifiers depending on the state/model). These demographic elements adjust expected cost and are foundational to the risk score even before considering diagnoses. By contrast, race is not a standard input for calculating Medicaid risk scores in typical risk adjustment methodologies, so options that include race are not supported. Likewise, "patient noncompliance" is primarily a clinical and quality-of-care issue and may affect treatment outcomes, but it is not itself a standard risk-score driver unless it is documented as a reportable, supported diagnosis that the specific model recognizes (and most models don't directly risk-adjust for nonadherence codes). Therefore, among the options given, Medicaid status and gender are the most clearly valid factors that impact the beneficiary's risk score.

NEW QUESTION # 51

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