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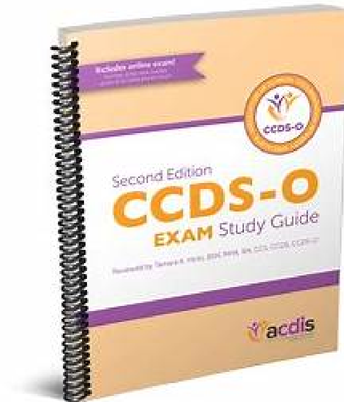

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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding
Topic 2	• Quality, Regulatory, and Health Initiatives: Covers population health, MSSP, ACO models, MACRA • MIPS, compliant query development, RADV audits, OIG compliance, problem list maintenance, and HIPAA requirements in outpatient CDI.
Topic 3	• 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 4	• 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 5	• CDI Program Concepts: Department Metrics and Provider Education: Covers provider education development, CDI performance metrics including query rates, RAF progression, HCC capture, ACO • MSSP impact, and physician documentation's effect on quality reporting.

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q26-Q31):

NEW QUESTION # 26
CMS-HCC risk adjustment methodology seeks to measure

- A. an individual's anticipated cost of care.
- B. physician cost of care provision.
- C. group beneficiary costs.
- D. a beneficiary's risk of mortality.

Answer: A

Explanation:
The CMS-HCC risk adjustment methodology is designed to estimate an individual beneficiary's expected healthcare resource use and cost relative to an average Medicare beneficiary. It does this by converting demographic factors (such as age/sex and certain eligibility variables) plus documented, coded chronic conditions into a Risk Adjustment Factor (RAF). That RAF is then used to forecast the likely cost of caring for that specific patient in the payment year and to adjust benchmarks/payments so plans and providers managing sicker patients are compared more fairly to those managing healthier patients. This is why outpatient CDI emphasizes accurate, specific documentation and annual recapture of active conditions that are monitored, evaluated, assessed/addressed, or treated-because those coded conditions drive the predicted cost profile. CMS-HCC is not a mortality prediction tool (eliminating B), nor is it intended to measure "group costs" as the primary target (C), even though aggregated risk scores can be used for population analytics. It also does not measure an individual physician's cost of care provision (D); it measures patient-level expected cost burden.

NEW QUESTION # 27
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. Chronic non-pressure ulcer; depression
- B. CKD 3; chronic non-pressure ulcer
- C. Depression; renal failure
- D. Renal failure; CKD 3

Answer: B

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 # 28
Which of the following encounters is billed as an outpatient encounter?

- A. Admission for COPD exacerbation with length of stay less than two midnights
- B. ED visit that leads to observation stay
- C. ED visit that leads to inpatient admission
- D. Ambulatory surgery encounter for scheduled sigmoid resection

Answer: B

Explanation:
Under Medicare billing rules applied in outpatient CDI education, observation services are outpatient (typically paid under Part B), even though the patient may stay in a hospital bed and receive ongoing monitoring and treatment. Therefore, an ED visit that converts to observation remains an outpatient encounter from a billing and documentation perspective, and the services are reported/paid as outpatient. By contrast, when an ED visit results in an inpatient admission, the encounter transitions to inpatient status, and many hospital ED services immediately preceding admission are commonly bundled/packaged with the inpatient stay rather than billed as a separate outpatient encounter. A scheduled sigmoid resection is generally a major procedure that is not typically performed as ambulatory/outpatient surgery in routine circumstances, so it is not the best outpatient choice here. Finally, "admission for COPD exacerbation with LOS less than two midnights" is ambiguous because "admission" implies inpatient, even though short stays may sometimes be observation/outpatient depending on medical necessity and the 2-midnight guidance. The clearest outpatient encounter is ED leading to observation.

NEW QUESTION # 29
Which of the following adds weight to the risk score over and above the CMS-HCC weights for individual conditions?

- A. Resource-based relative values
- B. Disease interactions
- C. Conversion factors
- D. Hierarchies

Answer: B

Explanation:
CMS-HCC risk adjustment assigns a baseline coefficient (weight) to each qualifying HCC condition, but certain combinations of conditions can increase predicted cost beyond what would be expected by simply adding the two individual weights. These added increments are captured through disease interaction factors, which apply when specific conditions coexist (for example, diabetes with certain severe complications, or other paired conditions defined by the model). In outpatient CDI, this is why documentation must clearly support both diagnoses-each must be clinically evaluated/managed and meet reporting rules-because accurately capturing the interacting conditions can legitimately increase the beneficiary's risk score. By contrast, hierarchies are designed to prevent double-counting within related condition families (the more severe manifestation typically supersedes a less severe one), which often limits-not adds-separate weights. Resource-based relative values and conversion factors belong to physician fee schedule payment methodology for services/procedures (RVUs and payment conversion), not HCC risk score calculation. Therefore, disease interactions are the correct concept that adds risk score weight beyond individual HCC coefficients.

NEW QUESTION # 30
In review of a clinic record, a CDI specialist notes the provider has directly copied and pasted a previous inpatient problem list into the current ambulatory visit note. Which of the following is the CDI specialist's BEST course of action?

- A. Assume the conditions are all relevant for this visit.
- B. Do not code conditions that were pasted from the problem list.

- C. Educate the provider regarding the concerns with copying and pasting this list.
- D. Query the provider for each of the conditions on the problem list.

Answer: C

Explanation:
Copy-and-paste of an inpatient problem list into an outpatient note creates significant documentation integrity risks: outdated diagnoses may be carried forward, resolved conditions may appear active, and the note may not clearly show which problems were actually evaluated or managed during the current encounter. Outpatient CDI best practice is not to assume relevance (eliminating D) and not to reflexively query every listed diagnosis (B), which can be burdensome, non-targeted, and may lead to "query fatigue." Likewise, blanket instruction to "not code" anything pasted (A) is not appropriate because some conditions may still be active and reportable if the provider documents assessment/management (e.g., monitoring, evaluation, addressing, or treatment). The most effective and sustainable action is provider education: explain why indiscriminate copy-forward threatens accuracy, compliance, medical necessity support, quality reporting, and risk adjustment validity; reinforce documenting current status and care provided for each active condition; and encourage updating the problem list and assessment to reflect what is truly addressed at the visit. Targeted queries can still be used when specific contradictions or high-impact ambiguities are identified.

NEW QUESTION # 31

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