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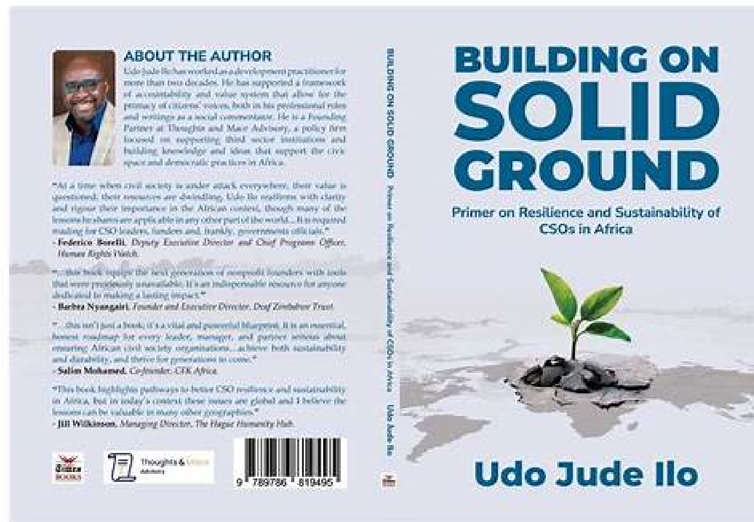


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## ACDIS CCDS-O Exam Syllabus Topics:

| Topic | Details |
|---|---|
| Topic 1 | • CDI Program Concepts: Department Metrics and Provider Education: Covers provider education development, CDI performance metrics including query rates, RAF progression, HCC capture, ACO<br>• MSSP impact, and physician documentation's effect on quality reporting. |
| 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 |
| Topic 4 | • Quality, Regulatory, and Health Initiatives: Covers population health, MSSP, ACO models, MACRA<br>• MIPS, compliant query development, RADV audits, OIG compliance, problem list maintenance, and HIPAA requirements in outpatient CDI. |
| Topic 5 | • and billing: Covers Official Coding Guidelines, OPPS reimbursement (APCs), and professional billing concepts including CPT E<br>• M codes and Medicare Physician Fee Schedule documentation. |

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## ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q61-Q66):

**NEW QUESTION # 61**
Which diagnosis and treatment plan may generate a query?

- A. Severe major depressive disorder and immunotherapy
- B. Prostate carcinoma and luteinizing hormone-releasing hormone
- C. Malnutrition and parenteral nutrition
- D. Atrial fibrillation and amiodarone

**Answer: A**

Explanation:
Outpatient CDI queries are most commonly triggered when there is a disconnect between the documented diagnosis and the documented treatment plan, suggesting that the clinician may be managing an additional condition that is not clearly stated, or that the diagnosis is inaccurately documented. Options A and B reflect typical, clinically aligned management: luteinizing hormone-releasing hormone therapy is a standard treatment pathway for prostate carcinoma, and amiodarone is a recognized antiarrhythmic used in atrial fibrillation management in appropriate circumstances. Option C can also be clinically consistent because parenteral nutrition is often used when malnutrition is present and the patient cannot meet nutritional needs enterally. Option D is the outlier: "immunotherapy" is not a standard treatment for severe major depressive disorder and more commonly aligns with oncology or certain immune-mediated diseases. This mismatch would appropriately prompt a query to clarify the actual condition being treated (e.g., an active malignancy) or to confirm whether "immunotherapy" refers to something else (such as allergy immunotherapy) and whether depression is the correct, visit-relevant diagnosis being addressed.

**NEW QUESTION # 62**
Which of the following conclusions can be drawn from the impact of a CDI program on Clinic A using the table below?

- A. Consistently captured a higher RAF percentage each month in 2023 than in 2022.
- B. Providers are more engaged in 2023 than in 2022.
- C. Treated a more complex population than any of the other clinics in 2023.
- D. Served a sicker population in 2023 than in 2022.

**Answer: A**

Explanation:
The only conclusion that is directly supported by the table is that Clinic A's percent RAF captured is higher in every month of 2023 compared with the corresponding month in 2022. The monthly values rise year-over-year (e.g., January 21% vs 17%, February 33% vs 25%, and continuing through December 84% vs 76%), showing a consistent improvement pattern across the entire calendar year. In outpatient CDI and risk adjustment work, "RAF capture" is commonly used as a performance indicator reflecting how completely documented and coded risk-adjusting conditions (e.g., HCC-supported diagnoses) are being captured within the measurement period. However, the table does not prove why the improvement occurred. It cannot confirm provider engagement (A) without workflow/participation data, cannot compare to other clinics (B) because no other clinic data are shown, and cannot establish that the population was sicker (C) because RAF capture measures documentation/coding completeness relative to opportunity, not inherent patient acuity. Therefore, D is the verified conclusion.

**NEW QUESTION # 63**
If a patient is being seen for follow-up and the documentation indicates that the patient was admitted to the hospital 28 days ago with an acute cerebral infarction with remaining right-sided weakness, which of the following diagnoses would be MOST appropriate?

- A. Other sequelae of cerebral infarction
- B. Hemiparesis following cerebral infarction affecting unspecified side
- C. Cerebral infarction, unspecified, hemiparesis affecting right dominant side
- D. Hemiparesis following cerebral infarction affecting right dominant side

**Answer: D**

Explanation:
In the outpatient follow-up setting, when the acute stroke event has occurred in the recent past and the patient is now being evaluated for residual deficits, documentation and coding should focus on the sequelae (late effects) rather than re-coding the acute infarction itself-unless the provider clearly states the stroke is still in the acute phase and being actively treated as such. ACDIS outpatient CDI principles stress selecting the diagnosis that best reflects the reason for today's encounter and the condition being assessed/managed. Here, the ongoing clinical issue driving follow-up care is the persistent neurologic deficit (right-sided weakness/hemiparesis) after the cerebral infarction. Option C is the most specific and clinically accurate because it captures (1) the relationship to the prior cerebral infarction ("following cerebral infarction") and (2) laterality and dominance ("right dominant side"), which improves code specificity and reflects functional impact. Option A incorrectly keeps the focus on an unspecified cerebral infarction rather than the residual deficit, and option D is too nonspecific compared with a clearly described hemiparesis.

**NEW QUESTION # 64**
Which of the following is a provider benefit of a prospective query?

- A. Instructs the provider to the best diagnosis to use
- B. Addresses the query topic during the actual patient encounter
- C. Guarantees risk adjusted diagnosis capture
- D. Defines the purpose of the encounter

**Answer: B**

Explanation:
A prospective query is initiated early enough (before or during the visit workflow) so the provider can evaluate, assess, and document the condition in real time while the patient is present. This is a major provider benefit because it supports better clinical accuracy and completeness: the clinician can ask targeted questions, perform relevant exam elements, review results, and determine whether the condition is present, active, being monitored, or ruled out-then document the final clinical impression and plan. From an ACDIS outpatient CDI perspective, prospective querying improves efficiency and reduces retrospective "chart-chasing," late addenda, and documentation gaps that occur when clarification is requested after the encounter is closed. Importantly, prospective queries must remain non-leading and cannot direct the provider to a particular diagnosis (eliminating option A). They also cannot "guarantee" risk-adjusted capture because the diagnosis must be clinically supported and addressed (eliminating option B). Defining the purpose of the encounter is driven by the clinical reason for visit, not by CDI (eliminating option D).

**NEW QUESTION # 65**
CMS-HCCs are used to

- A. distribute reimbursement to providers based on quality of care.
- B. adjust capitation payments to physicians, excluding advanced practice providers.
- C. reimburse physicians based on the principal diagnosis.
- D. determine capitation payments to insurers that administer Medicare Advantage health plans.

**Answer: D**

Explanation:
The CMS-HCC model is a risk adjustment methodology used primarily to set capitated payments for Medicare Advantage (MA) organizations based on the expected cost of caring for their enrolled beneficiaries. Under this approach, CMS calculates a Risk Adjustment Factor (RAF) for each member using demographic variables (such as age/sex and certain entitlement factors) plus disease burden captured from ICD-10-CM diagnoses that map to Hierarchical Condition Categories (HCCs). The resulting RAF increases or decreases the plan's payment to better match predicted healthcare needs-higher RAF for sicker, more complex patients and lower RAF for healthier patients. ACDIS outpatient CDI education emphasizes that the purpose is not physician reimbursement based on a "principal diagnosis" (an inpatient concept) and not payment distribution tied directly to quality performance (that aligns more with MIPS/VBP frameworks). It also does not adjust capitation payments specifically "to physicians," nor does it exclude advanced practice providers in the way described. The correct use is to determine MA plan capitation payments through risk-

adjusted member-level projections.

**NEW QUESTION # 66**

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