Exam ACDIS CCDS-O Material | Hot CCDS-O Spot Questions

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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• 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	• 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	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding

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Hot ACDIS CCDS-O Spot Questions - Exam CCDS-O Cram Review

Our Certified Clinical Documentation Specialist-Outpatient (CCDS-O) practice exam simulator mirrors the Certified Clinical Documentation Specialist-Outpatient (CCDS-O) exam experience, so you know what to anticipate on Certified Clinical Documentation Specialist-Outpatient (CCDS-O) certification exam day. Our Certified Clinical Documentation Specialist-Outpatient (CCDS-O) practice test software features various question styles and levels, so you can customize your ACDIS CCDS-O exam questions preparation to meet your needs.

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

NEW QUESTION # 46
A patient is evaluated in the primary care clinic for chest pain, slight shortness of breath, and mild nausea. Documentation includes an ECG and chest x-ray to rule out MI. Which of the following diagnoses are reportable?

- A. Angina pectoris, unspecified, shortness of breath, and nausea
- B. Rule out MI, shortness of breath, and nausea
- C. Other chest pain, shortness of breath, and nausea
- D. Acute MI, chest pain, shortness of breath, and nausea

Answer: C

Explanation:
In the outpatient/ambulatory setting, ICD-10-CM reporting rules applied in CDI education distinguish clearly between confirmed diagnoses and "uncertain" or "rule out" conditions. Terms such as "rule out," "suspected," or "probable" generally are not coded as established diagnoses in the outpatient record because the encounter is often for evaluation and testing rather than definitive confirmation. Instead, coders report the patient's presenting signs and symptoms when a definitive condition has not been documented as confirmed by the provider. Here, the clinician ordered diagnostic testing (ECG and chest x-ray) specifically to rule out myocardial infarction (MI), but no final diagnosis of MI or angina is documented in the scenario. Therefore, "rule out MI" is not reportable, and neither is acute MI or angina unless explicitly diagnosed. The reportable conditions are the symptoms that drove the visit and required evaluation: chest pain (captured as "other chest pain" in the options), shortness of breath, and nausea.

NEW QUESTION # 47
A patient is seen at the clinic for a fever, and the provider documents possible Zika virus. A CDI specialist reviews the record and notes that a positive serology test indicates the Zika virus. Which of the following should the CDI specialist do NEXT?

- A. Code the fever as the first-listed diagnosis and Zika virus as secondary.
- B. Query the provider to confirm the diagnosis of Zika.
- C. Query the provider to code the result of the serology test.
- D. Code the Zika virus as the reason for the visit.

Answer: B

Explanation:
In the outpatient setting, diagnoses documented as uncertain (e.g., "possible," "probable," "suspected," "rule out") are generally not coded as confirmed conditions; instead, coding is based on confirmed diagnoses or, when not confirmed, the presenting signs/symptoms. Here, the provider documented only "possible Zika," which is not a confirmed diagnosis for outpatient reporting. Even though the CDI specialist sees a positive serology result, lab data alone does not replace provider diagnostic confirmation in the assessment/plan. The appropriate next step is to query the provider to confirm whether Zika is the established diagnosis based on the positive test (and whether it is clinically addressed during the encounter). If confirmed, Zika can be coded appropriately and sequenced based on the reason for the visit; if not confirmed or still under evaluation, the symptom (fever) remains first-listed. Option B is incorrect because coders do not "code the result" of a serology test as a diagnosis; they code the condition the test supports once clinically confirmed.

NEW QUESTION # 48
Which of the following payment models enables Medicare to forecast costs for Medicare Advantage members for the coming year?

- A. Hierarchical Condition Categories
- B. Relative Value Scale
- C. Ambulatory Payment Classification
- D. Geographic Practice Cost Indexes

Answer: A

Explanation:
Medicare Advantage (MA) payments are risk adjusted so CMS can predict expected healthcare costs for each enrollee in the upcoming payment year. The model used for this forecasting is the CMS-HCC (Hierarchical Condition Category) risk adjustment methodology. It converts demographic factors (such as age/sex and eligibility status) plus documented, coded diagnoses (ICD-10-CM codes that map to HCCs) into a Risk Adjustment Factor (RAF). CMS then uses the RAF to adjust capitation payments to MA plans to reflect the member's anticipated resource needs. This is why outpatient CDI places heavy emphasis on accurate, specific

capture and annual "recapture" of active chronic conditions that are monitored, evaluated, assessed/addressed, or treated during the encounter-because the prior year's valid HCCs drive the next year's predicted cost and payment. By contrast, APCs relate to OPPS facility outpatient payment, RVUs/RBRVS relate to physician fee schedule valuation, and GPCIs adjust payment geographically; none of those are the MA risk forecasting model.

NEW QUESTION # 49
PCP notes describe the presence of atrial fibrillation for 10 days. Atenolol, sotalol and rivaroxaban are ordered. Possible ablation is discussed. Identify the type of atrial fibrillation described in this clinical scenario.

- A. Permanent
- B. Chronic
- C. Persistent
- D. Paroxysmal

Answer: C

Explanation:
Atrial fibrillation (AF) type is determined largely by episode duration and whether the rhythm self-terminates. In outpatient CDI education, paroxysmal AF is intermittent and typically terminates spontaneously, commonly within 7 days (often within 48 hours). Persistent AF is sustained and lasts more than 7 days, or requires active intervention (e.g., cardioversion) to restore sinus rhythm. This scenario documents AF "for 10 days," which exceeds the 7-day threshold and therefore best fits persistent AF. The management also aligns with a sustained arrhythmia strategy: rate control (atenolol), rhythm control/antiarrhythmic therapy (sotalol), stroke prevention anticoagulation (rivaroxaban), and discussion of catheter ablation, which is often considered for symptomatic or recurrent/persistent AF. "Chronic" is a nonspecific descriptor and not the preferred current classification term, and permanent AF implies a decision has been made not to pursue rhythm control (accepting AF long-term), which is not supported here because rhythm-control options are being considered.

NEW QUESTION # 50
In which of the following ways does payment determination (risk score calculation) differ between HHS-HCCs and CMS-HCCs?

- A. HHS-HCCs use the current year's demographics/diagnoses to predict the current year's spending.
- B. HHS-HCCs use current ICD-10-CM and CPT codes to predict the current year's spending.
- C. HHS-HCCs use the previous year's ICD-10-CM and CPT codes to predict the next year's spending.
- D. HHS-HCCs use the previous year's demographics/diagnoses to predict the next year's spending.

Answer: A

Explanation:
A key ambulatory CDI distinction between the two major risk models is timing. The HHS-HCC model (used for ACA Marketplace risk adjustment) is commonly described as a concurrent model: it uses the enrollee's demographics and diagnoses from the same benefit year to reflect morbidity and support that year's risk transfer/payment balancing. In contrast, the CMS-HCC model (commonly applied in Medicare Advantage) is prospective: conditions documented and coded in the prior data collection year are used to predict expected cost for the following payment year. From an outpatient CDI perspective, this timing difference affects operational priorities. For CMS-HCC, accurate annual capture and recapture of active chronic conditions is essential because last year's documented conditions drive next year's risk score and revenue. For HHS-HCC, complete documentation and coding during the current year impacts the current year's risk measurement. Options referencing CPT codes are not correct for the core HCC risk score calculation, which is driven by demographics and ICD diagnosis reporting mapped to HCC categories.

NEW QUESTION # 51
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