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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 developinc 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	• 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	• 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.
Topic 3	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding
Topic 4	• 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 5	• Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q90-Q95):

NEW QUESTION # 90
Provider documentation states: "A patient is seen today with DM type 2, peripheral neuropathy with diabetic ulcer of the left great toe, hypertension, and BMI 43. O2 dependent, chronic respiratory failure due to COPD, stopped smoking 2 years ago - 84 packs per year smoking habit." Which of the following query opportunities will impact risk adjustment?

- A. Depth of diabetic ulcer
- B. Diabetes with complications
- C. Nicotine dependence
- D. Morbid obesity

Answer: A

Explanation:
In ambulatory CDI, "risk adjustment impact" means the clarification can change whether an HCC-relevant condition is captured accurately (or captured at all) based on ICD-10-CM reporting rules. Here, "DM2 with peripheral neuropathy with diabetic ulcer" already establishes diabetes with complications, so querying option B adds little-complications are already documented. "Nicotine dependence" is not supported because the patient stopped smoking two years ago; at most, this supports a history of nicotine dependence, which generally does not drive HCC risk scoring. "Morbid obesity" may be clinically relevant (BMI 43 supports it), but obesity typically does not produce meaningful CMS-HCC risk adjustment impact compared with other chronic categories. The diabetic ulcer does matter: correct reporting requires an additional L97.- code that depends on ulcer severity/depth (skin breakdown, fat layer exposed, necrosis of muscle/bone). Clarifying depth supports accurate ulcer severity coding and can affect HCC capture/validation for chronic ulcer burden.

NEW QUESTION # 91
Documentation states: "Patient with history of STEMI five weeks ago. Returning to office for follow-up. Problem list includes CAD, hypertension, heart failure, leukemia, malnutrition, and atrial fibrillation, all were relevant to the encounter. CBC and WBC reviewed

and referred to oncologist. Follow-up with dietitian to further evaluate nutritional status." Which of the following is the MOST impactful risk adjusted query opportunity?

- A. Type (diastolic, systolic, combined) and acuity of heart failure
- B. Differentiation of atrial fibrillation (paroxysmal, persistent, permanent)
- C. Status (remission, or relapse) and acuity of leukemia
- D. Severity of the malnutrition (mild, moderate, severe)

Answer: C

Explanation:
In outpatient risk adjustment, the highest-impact clarification is often the one that determines whether a condition is currently active (and therefore risk-adjustable) versus historical/resolved. "Leukemia" listed on the problem list, plus active review of CBC/WBC and referral to oncology, strongly suggests ongoing disease evaluation/management. ACDIS outpatient CDI principles emphasize querying to confirm whether the leukemia is active, in relapse, or in remission because that distinction can change code selection from an active malignancy to a history code, and history codes typically do not carry the same risk adjustment impact as an active HCC-bearing diagnosis. While heart failure type/acuity and malnutrition severity are also important for specificity and may affect risk capture, they generally represent refinement of already-established chronic conditions rather than a potential "on/off" determination of a major disease category. Likewise, atrial fibrillation subtype differentiation is clinically useful but usually does not materially change risk adjustment compared with confirming an active hematologic malignancy. Therefore, clarifying leukemia status/acuity is the most impactful risk-adjusted query opportunity.

NEW QUESTION # 92
What stage of pressure ulcer describes necrosis of soft tissue through the underlying muscle?

- A. 0
- B. 1
- C. 2
- D. 3

Answer: C

Explanation:
A Stage 4 pressure ulcer (pressure injury) is characterized by full-thickness tissue loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. The key phrase in the question-"necrosis of soft tissue through the underlying muscle"-signals a depth of injury that extends beyond the subcutaneous tissue and involves muscle, which is consistent with Stage 4. By comparison, Stage 2 involves partial-thickness skin loss with exposed dermis (no necrosis through deeper structures). Stage 3 involves full-thickness skin loss where adipose may be visible, but muscle, tendon, or bone are not exposed; undermining and tunneling may occur, yet the defining line is that it does not extend to muscle/bone involvement. "Stage 5" is not part of standard pressure ulcer staging used in coding and documentation. Outpatient CDI practice emphasizes documenting the exact stage, anatomic location, laterality when applicable, and whether the ulcer is healing or complicated (infection/osteomyelitis) because stage drives specificity, severity capture, and appropriate care planning documentation.

NEW QUESTION # 93
Which of the following is a leading query?

- A. "Your documentation states the patient drinks a 6-pack of beer nightly. Does this patient have alcohol dependence? Yes/No (circle one)"
- B. "The patient has a BMI of 42 per the nursing documentation. Does this patient have a medically relevant diagnosis to accompany the BMI? Please select one of the following options. A) morbid obesity, B) obesity, C) overweight, D) Other____, E) Clinically undetermined"
- C. "The documentation includes modifications for current Celexa dosages. Can you please identify the condition treated with this medication?"
- D. "The patient has a past medical history of RUL lung cancer. Should lung cancer be classified as: A) currently being treated, B) History of lung CA?"

Answer: A

Explanation:

A leading query is one that steers the provider toward a particular diagnosis or limits clinically appropriate choices in a way that can be perceived as prompting. Option D is leading because it presents a single, high-impact diagnosis ("alcohol dependence") and forces a binary yes/no response without offering reasonable alternative interpretations (e.g., alcohol use, alcohol abuse/harmful use, dependence in remission, or clinically undetermined) or an "other" option. In addition, it attempts to obtain a potentially new diagnosis based on one data point (quantity consumed) without a balanced set of diagnostic possibilities and supporting clinical indicators (tolerance, withdrawal, impairment, failed attempts to cut down, etc.). By contrast, A is open-ended and requests clarification of the treated condition; B provides two plausible classification choices (active vs history); and C offers multiple reasonable BMI-related diagnostic options plus "other" and "clinically undetermined," which supports compliant, non-leading clarification. Therefore, D best fits the definition of a leading query.

NEW QUESTION # 94

Upon retrospective review of a patient visit 2 weeks prior, a CDI specialist notes physician documentation stating the following: "Sick Sinus Syndrome in 2016 s/p pacemaker placement. Latest EKG shows normal paced rhythm." There are no codes noted for Sick Sinus Syndrome or the pacemaker. Which of the following is the BEST course of action for the CDI specialist?

- A. Educate the provider that a pacemaker status code as well as a Sick Sinus Syndrome code should be assigned.
- B. Ask the coder to re-bill based upon the documentation.
- C. Request the provider amend the codes to reflect the Sick Sinus Syndrome and pacemaker status.
- D. Capture code for pacemaker status only.

Answer: D

Explanation:
In outpatient CDI, diagnoses reported for an encounter must be supported as current and clinically relevant to that visit (evaluated, monitored, assessed, treated, or otherwise affecting care). The note documents a history of sick sinus syndrome with pacemaker placement in 2016 and indicates the current rhythm is paced. The most clearly reportable, present condition is the presence of a cardiac pacemaker, which is a status that can affect clinical decision-making (e.g., interpretation of rhythm findings, medication choices, procedures, and future cardiac evaluation) and is appropriate to code when documented. However, the documentation does not show that sick sinus syndrome itself was actively assessed or managed during this visit; it is referenced as a past condition leading to the device. Because outpatient coding does not assume an active diagnosis solely from historical mention, the best action is to capture the pacemaker status code only. Retrospective amendment requests or rebilling steps are not the first-line CDI action when the documentation does not support active management of the underlying arrhythmia.

NEW QUESTION # 95

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