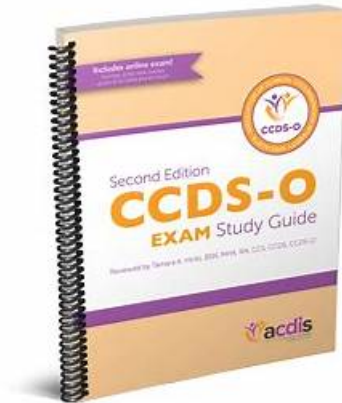


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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> • and billing: Covers Official Coding Guidelines, OPSS reimbursement (APCs), and professional billing concepts including CPT E • M codes and Medicare Physician Fee Schedule documentation.
Topic 2	<ul style="list-style-type: none"> • Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for
Topic 3	<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 4	<ul style="list-style-type: none"> • Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding
Topic 5	<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 6	<ul style="list-style-type: none"> • 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.

ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q113-Q118):

NEW QUESTION # 113

E/M services must meet specific medical necessity criteria as defined by

- A. American Medical Association and American Hospital Association.
- **B. National Coverage Determinations and Local Coverage Determinations.**
- C. National Medical Specialty Societies.
- D. American Health Information Management Association.

Answer: B

Explanation:

For outpatient Evaluation and Management (E/M) services, "medical necessity" is ultimately judged against Medicare coverage policy, which is established through National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). NCDs set nationwide rules for when specific services are considered reasonable and necessary, while LCDs are developed by Medicare Administrative Contractors to define coverage expectations within their jurisdictions, including indications, frequency limits, required documentation elements, and diagnosis-to-service relationships. Outpatient CDI and coding education emphasizes that correct E/M code selection and documentation must support not only the level of service (MDM/time) but also why the service was needed based on the patient's condition and the payer's coverage criteria. Specialty society recommendations and AMA/AHA guidance can inform clinical practice and coding conventions, but they do not define Medicare coverage requirements. Likewise, AHIMA provides professional guidance but does not set payer medical necessity policy. Therefore, the most accurate source defining medical necessity criteria for billing compliance is NCDs and LCDs.

NEW QUESTION # 114

Which of the following is designed to reduce claims denials and appeals by providing one-on-one feedback to the provider to increase accuracy in specific areas?

- A. Comprehensive Error Rate Testing
- **B. Target Probe and Educate**
- C. OIG Work Plan

- D. Recovery Audit Contractor

Answer: B

Explanation:

Targeted Probe and Educate (TPE) is an education-focused review initiative intended to improve billing accuracy and reduce future denials by combining targeted claim review with direct provider/supplier feedback. In outpatient CDI terms, TPE aligns with a "fix-forward" approach: auditors identify specific error patterns (often documentation, medical necessity, coding, or coverage rule issues), then provide one-on-one education so the provider can correct processes and documentation habits. This is distinct from Recovery Audit Contractors (RACs), which primarily identify and recoup improper payments, often after the fact, and are not structured as an individualized education cycle. The OIG Work Plan identifies oversight priorities and areas of potential fraud/waste/abuse; it does not deliver provider-level coaching to reduce denials. CERT measures Medicare improper payment rates through sampling and can drive policy/education broadly, but it is not designed as individualized, iterative provider education. Because TPE is specifically built around targeted review plus direct education to prevent repeat errors and reduce appeals, it is the best answer.

NEW QUESTION # 115

A patient is evaluated in the clinic. Documentation states: "HIV positive, gravida 1 at 24 weeks." Which of the following conditions will be coded and in which sequence based on the documentation?

- A. Asymptomatic HIV, pregnancy
- **B. Pregnancy with asymptomatic HIV**
- C. HIV disease, pregnancy
- D. Pregnancy with HIV disease

Answer: B

Explanation:

In outpatient coding, selection and sequencing must follow ICD-10-CM Official Guidelines, including obstetric chapter rules. When HIV is documented in a pregnant patient, the pregnancy complication code is sequenced first because the pregnancy status frames the encounter and drives the obstetric complication coding structure. The phrase "HIV positive" (without documentation of HIV-related illness or "HIV disease") is treated as asymptomatic HIV infection status, which aligns with the status concept rather than active HIV disease. Therefore, the correct approach is to code pregnancy complicated by asymptomatic HIV first (obstetric complication category), followed by the HIV status code to fully describe the condition affecting the pregnancy. Options that place "pregnancy" second do not follow obstetric sequencing conventions, and options that assume "HIV disease" overstep the documentation because "HIV positive" alone does not confirm symptomatic HIV disease. Outpatient CDI best practice would be to query if the provider intends HIV disease versus asymptomatic status, but based strictly on the given statement, pregnancy with asymptomatic HIV is most appropriate.

NEW QUESTION # 116

Which of the following actions should be taken when the documentation states: "Hemiparesis, history of CVA, and intracranial trauma?"

- A. Report hemiparesis, history of CVA, and history of trauma.
- B. Report hemiparesis as sequelae of CVA.
- **C. Query to clarify the etiology of the hemiparesis.**
- D. Assign the code for hemiparesis.

Answer: C

Explanation:

This documentation presents a key outpatient CDI problem: hemiparesis is present, but two potential causal conditions are referenced—history of CVA and intracranial trauma—without clear linkage. In ICD-10-CM, correct reporting of hemiparesis often depends on identifying whether it is a late effect (sequela) of a prior stroke, a residual from traumatic brain injury, or due to another neurologic condition. Coding hemiparesis automatically as a CVA sequela (option A) would be assumptive and potentially inaccurate, because the clinician has not documented the relationship. Likewise, simply coding hemiparesis alone (option D) may miss important etiologic specificity, and coding both histories without clarifying the cause (option B) still leaves the main clinical ambiguity unresolved. Outpatient CDI best practice is to issue a non-leading query requesting provider clarification of the etiology/source of the hemiparesis (e.g., due to prior CVA, due to prior intracranial trauma, both, or other/undetermined). This

supports accurate diagnosis reporting, appropriate sequencing, and defensible risk/quality representation.

NEW QUESTION # 117

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

- A. "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?"
- B. "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."
- C. "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?"
- D. "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."

Answer: D

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 # 118

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