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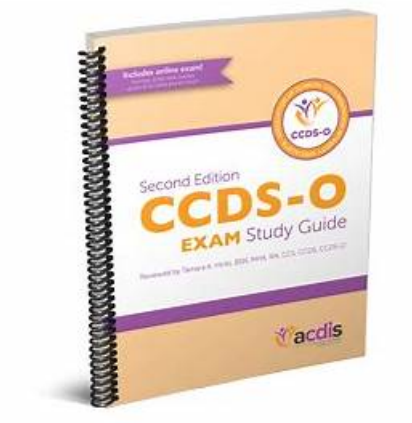

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q42-Q47):

NEW QUESTION # 42
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. Status (remission, or relapse) and acuity of leukemia
- C. Differentiation of atrial fibrillation (paroxysmal, persistent, permanent)
- D. Severity of the malnutrition (mild, moderate, severe)

Answer: B

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 # 43
A patient is scheduled to see his PCP in 3 days. A CDI specialist notes that during the patient's last visit earlier this year, the problem list shows both DM 2 associated erectile dysfunction and DM 2 without complications. The last clinic note states that DM 2 with autonomic neuropathy was addressed. The CDI specialist should do which of the following FIRST?

- A. Query the provider for the link between erectile dysfunction and DM 2
- B. Remove DM 2 without complications from the problem list
- C. Query if the DM 2 is with or without complications
- D. Ask the patient if he still has DM 2 with autonomic neuropathy

Answer: C

Explanation:
The record contains conflicting documentation: the problem list includes both "type 2 diabetes without complications" and diabetes with complications (erectile dysfunction association), while the most recent clinic note indicates the provider addressed "DM2 with autonomic neuropathy," which is clearly a diabetic complication. In outpatient CDI, the first priority is to resolve internal inconsistency so coding accurately reflects the patient's current clinical status and what was evaluated/managed at the encounter. A query should therefore focus on whether the patient's diabetes is with complications (and which complications are active/being addressed) versus truly without complications, because "without complications" is generally not appropriate when neuropathy/other manifestations are present and being managed. CDI staff also should not unilaterally remove items from the provider-maintained problem list, and asking the patient is not a reliable documentation/coding source for establishing diagnoses. Once the provider clarifies diabetes complication status, a follow-up clarification can address specific linkages (e.g., erectile dysfunction due to diabetes) if needed for correct code assignment

NEW QUESTION # 44
An African American male enrolled in Medicaid has not been taking his blood pressure medication. Which of the following factors impacts this beneficiary's risk score?

- A. Medicaid status and gender
- B. Medicaid status and race
- C. Patient noncompliance and age
- D. ICD-10-CM codes and race

Answer: A

Explanation:
Medicaid risk adjustment models generally calculate risk using two major categories of inputs: demographics and diagnosis data. Demographic factors commonly include gender and indicators tied to Medicaid status/eligibility (for example, eligibility category, dual status, disability-related eligibility, or other program qualifiers depending on the state/model). These demographic elements adjust expected cost and are foundational to the risk score even before considering diagnoses. By contrast, race is not a standard input for calculating Medicaid risk scores in typical risk adjustment methodologies, so options that include race are not supported. Likewise, "patient noncompliance" is primarily a clinical and quality-of-care issue and may affect treatment outcomes, but it is not itself a standard risk-score driver unless it is documented as a reportable, supported diagnosis that the specific model recognizes (and most models don't directly risk-adjust for nonadherence codes). Therefore, among the options given, Medicaid status and gender are the most clearly valid factors that impact the beneficiary's risk score.

NEW QUESTION # 45
A provider has been determined to be a high-cost provider after a total claims cost analysis. The provider's patient panel has an overall low HCC average score. Which of the following is the MOST likely explanation regarding the low HCC average score?

- A. The provider is failing to capture all relevant diagnoses
- B. The provider has a less complex patient population
- C. The provider cares for patients of a higher acuity
- D. The provider is not reporting unspecified diagnoses

Answer: A

Explanation:
In the CMS-HCC risk adjustment framework, the HCC average score reflects the coded burden of illness for the provider's attributed panel, driven by documented, reportable conditions that map to HCCs and qualifying demographic factors. If a provider appears "high cost" based on total claims but the panel's average HCC score is low, the most common CDI interpretation is documentation/coding under-capture: the clinical complexity driving utilization is not being fully documented and coded to HCC-relevant diagnoses. This creates a mismatch-actual resource use is high, but the recorded risk profile is artificially low-leading to unfavorable benchmarking because costs are compared against an expected spend that is too low for the true acuity. Option A would typically raise HCC scores, not lower them. Option C could explain both low HCC and low cost; it conflicts with the high-cost finding. Option D misunderstands HCC mechanics: "unspecified" does not reliably increase HCC capture and often reduces coding specificity/validity rather than improving risk adjustment. Therefore, incomplete capture of relevant diagnoses is the most likely driver.

NEW QUESTION # 46
Which of the following conclusions can be drawn from the impact of a CDI program on Clinic A using the table below?

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

Answer: D

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 # 47
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