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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	<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 2	<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.
Topic 3	<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 4	<ul style="list-style-type: none">• 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.

ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q16-Q21):

NEW QUESTION # 16

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. Request the provider amend the codes to reflect the Sick Sinus Syndrome and pacemaker status.
- C. Ask the coder to re-bill based upon the documentation.
- 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 # 17

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 # 18

A CDI specialist reviews the record of a patient with a history of CHF and DM Type 2 who was seen in the clinic earlier that day for possible bronchitis, fever, congestion, dyspnea, and cough. A chest x-ray indicated LLL infiltrate, and a nebulizer treatment was administered while in the office. Levofloxacin and albuterol were prescribed. Which of the following is MOST appropriate to query?

- **A. Presence of pneumonia**
- B. Diabetic complications
- C. Specificity of heart failure
- D. Acuity of bronchitis

Answer: A

Explanation:

The documented clinical picture and treatment plan better align with pneumonia than uncomplicated bronchitis, creating a clear documentation/coding consistency opportunity. A LLL infiltrate on chest x-ray is a classic clinical indicator for pneumonia, and prescribing levofloxacin supports treatment of a likely bacterial lower respiratory infection rather than routine viral bronchitis. The patient also has fever, dyspnea, cough, and required an in-office nebulizer treatment, all of which can accompany pneumonia and increase clinical significance. In outpatient CDI practice, the most appropriate query is the one that clarifies the provider's definitive diagnosis when objective findings and management suggest a more specific condition than what is stated (e.g., "possible bronchitis"). Querying for diabetic complications or heart failure specificity is not as directly supported by the encounter's indicators and treatment actions provided, and "acuity of bronchitis" is secondary if the true condition is pneumonia. Clarifying whether pneumonia is present ensures accurate reporting, medical necessity support, and appropriate risk/quality capture.

NEW QUESTION # 19

A 67-year-old male patient has been seen by a PCP multiple times this year. Diagnoses reported are diabetes with nephropathy with an HCC weight of 0.166; diabetes with retinopathy with an HCC weight of 0.166; atrial fibrillation with an HCC weight of 0.299, and a demographic risk factor weight of 0.332. Which of the following is this patient's final RAF score for these diagnoses?

- A. 1.418
- B. 0.932
- C. 0.678
- **D. 0.797**

Answer: D

Explanation:

The patient's RAF is calculated by adding the applicable HCC weights plus the demographic factor, but only after applying the HCC model's hierarchy rules. In outpatient risk adjustment education (as emphasized in ACDIS-based training), certain condition groups are hierarchical—meaning multiple related diagnoses in the same hierarchy do not "stack." Instead, only the highest-ranked HCC in that disease group contributes to the RAF. Here, "diabetes with nephropathy" and "diabetes with retinopathy" both carry the same HCC weight (0.166) and fall within the diabetes complication hierarchy, so they do not add together; only one 0.166 value is

counted. Atrial fibrillation contributes separately (0.299), and the demographic risk factor contributes (0.332). Therefore, the final RAF is $0.166 + 0.299 + 0.332 = 0.797$. This illustrates why outpatient CDI focuses on documenting all clinically supported conditions for care accuracy, while understanding that some related diagnoses won't increase RAF beyond the highest applicable HCC in that hierarchy.

NEW QUESTION # 20

Which of the following descriptors is classified as an uncertain diagnosis?

- A. Treating a streptococcal pneumonia with antibiotic
- **B. Concern for streptococcal pneumonia**
- C. Broad spectrum antibiotic prescribed for streptococcal pneumonia
- D. Evidence of streptococcal pneumonia

Answer: B

Explanation:

In outpatient CDI and coding guidance, an "uncertain diagnosis" is identified by wording that indicates the provider has not confirmed the condition (e.g., possible, probable, suspected, rule out, question of, concern for). These terms reflect diagnostic consideration rather than an established diagnosis. Option A uses the phrase "concern for," which is a classic uncertainty qualifier and signals the provider is considering streptococcal pneumonia but has not definitively diagnosed it. In contrast, options B and D describe active treatment "for streptococcal pneumonia," which implies the provider is managing the condition as a working diagnosis; however, in outpatient coding, treatment alone does not automatically make a diagnosis confirmed if the documentation still reflects uncertainty- CDI would look for explicit provider confirmation. Option C ("evidence of") generally suggests supportive findings and is commonly interpreted as stronger than "concern for," though CDI would still assess whether the provider has clearly stated a confirmed diagnosis in the assessment/plan. Therefore, the clearest uncertain descriptor is "concern for."

NEW QUESTION # 21

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