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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• 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 2	• 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 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
Topic 5	• 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.

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q75-Q80):

NEW QUESTION # 75
Which performance metric is MOST appropriate for an outpatient program to share with providers?

- A. HCC per member per month payments
- B. APC payment rates
- C. RAF scores
- D. Major complication comorbidity (MCC) rates

Answer: C

Explanation:
Outpatient CDI programs should share provider-facing metrics that are clinically meaningful, aligned with ambulatory documentation goals, and unlikely to be perceived as payment-driven prompting. RAF scores are an appropriate metric because they reflect how well the documented and coded condition burden represents the patient panel's complexity in risk adjustment models. Discussing RAF supports education around accurate diagnosis capture, specificity, and annual recapture of active chronic conditions that are monitored, evaluated, assessed/addressed, or treated. In contrast, APC payment rates are facility OPPS payment constructs and typically are not actionable for individual ambulatory provider documentation improvement. HCC per member per month payments is explicitly financial and can create compliance risk by tying documentation discussions directly to payment, which outpatient CDI guidance warns against in provider messaging. MCC rates are primarily an inpatient DRG severity concept and are not the most relevant outpatient performance measure. Therefore, RAF scores best balance provider relevance, program goals, and compliant education focus.

NEW QUESTION # 76
A patient returns to a PCP for follow-up care related to a UTI. The provider documents "stage 3 CKD" as determined by a single eGFR of 52 mL/min. Which of the following actions should the CDI specialist take?

- A. Query for stage 4 CKD.
- B. Review CKD staging criteria with provider.
- C. Delete CKD diagnosis from claim as it was not treated during this encounter.
- D. Add diagnosis of CKD stage 3 to claim, as it is reportable.

Answer: B

Explanation:
The CDI specialist should review CKD staging criteria with the provider because assigning CKD based on a single eGFR value can be clinically unreliable and may lead to inaccurate documentation and coding. Outpatient CDI guidance emphasizes that documentation must reflect a condition that is clinically valid, supported by the record, and accurately described, especially for chronic diseases. CKD is generally established by evidence of decreased kidney function or kidney damage that is persistent, not a one-time lab that could be affected by hydration status, acute illness, medications, or transient physiologic changes. While an eGFR

of 52 falls within the numeric range commonly associated with stage 3a, the key CDI issue is the foundation for diagnosing chronic disease, not simply whether the number is "reportable." Option A inappropriately directs CDI to add diagnoses to claims; CDI supports providers and coding, but does not independently "add" conditions. Option C is incorrect because chronic conditions may be coded when addressed/impact care, not only when actively treated. Option D is unsupported because eGFR 52 does not suggest stage 4.

NEW QUESTION # 77
A female patient who underwent total hip replacement 2 weeks ago is in for a follow-up visit with her PCP. The visit note states: "Patient complains of fatigue and lethargy. Hgb on discharge was 10.4gm/dL - now is 8.6 gm/dL. Will start FeSO4 325mg po daily with food. Repeat H/H in 2 weeks. She has return visit with Ortho then." Which of the following is the BEST course of action for the CDI specialist?

- A. Add acute blood loss anemia to the diagnoses reported on the claim.
- B. Instruct the provider to add iron deficiency anemia to the problem list.
- C. Query the provider for a diagnosis related to fatigue, decreased Hgb, and FeSO4.
- D. Review the lab work referenced by the provider in the progress note for congruence.

Answer: C

Explanation:
Outpatient CDI practice supports accurate, provider-validated diagnoses; CDI should not "diagnose," direct the provider to add a specific condition, or independently add diagnoses to the claim. Here, the documentation shows clinical indicators (fatigue/lethargy and hemoglobin drop from 10.4 to 8.6) and a treatment plan (oral iron and repeat H/H), but the provider has not stated a definitive diagnosis such as postoperative anemia, iron deficiency anemia, acute blood loss anemia, or anemia due to chronic disease. The best CDI action is to issue a compliant query that summarizes the relevant indicators and treatment and asks the provider to document the appropriate diagnosis and etiology, if clinically supported, and to link it to the plan of care. Option A is inappropriate because it leads the provider toward a specific diagnosis. Option D is noncompliant because coding must follow documented provider diagnoses. Option B may be a reasonable internal check, but it does not resolve the documentation gap.

NEW QUESTION # 78
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. HIV disease, pregnancy
- C. Pregnancy with asymptomatic HIV
- D. Pregnancy with HIV disease

Answer: C

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 # 79
Which of the following physician performance metrics BEST illustrates provider engagement with outpatient CDI specialist?

- A. Physician RAF scores and RAF capture rates
- B. Problem list updates and RAF capture rates

- C. Physician MIPS scores and query response rates
- D. Query response rates and problem list updates

Answer: D

Explanation:
Provider engagement in an outpatient CDI program is best reflected by measures that show the provider is actively interacting with CDI processes and improving documentation behaviors in real time. Query response rates directly indicate whether the provider is reading and responding to CDI clarifications promptly and consistently, which is a fundamental engagement behavior and a key operational driver of documentation accuracy. Problem list updates further demonstrate sustained engagement because they reflect the provider's willingness to maintain an accurate, current list of active conditions (adding validated diagnoses, removing resolved problems, and updating specificity such as stage, severity, or laterality). Together, these two metrics show both immediate participation (responding to queries) and longer-term adoption of documentation best practices (maintaining the problem list). In contrast, RAF scores and RAF capture rates are influenced by patient complexity, payer mix, and coding capture processes, and may improve even without meaningful provider participation. MIPS scores reflect broader quality program performance and are not specific to CDI-provider interaction. Therefore, query responsiveness plus problem list maintenance most directly measures engagement with outpatient CDI.

NEW QUESTION # 80
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