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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q33-Q38):

NEW QUESTION # 33
Provider documentation states: "Patient is here for follow-up for multiple chronic conditions, including COPD, HTN, DM, and

alcohol abuse. She admits to drinking more than she has in the past, starting in the early morning and consumes at least a pint a day. Her BP today is elevated at 165/89. Discussed medications and diet. As she continues to be dependent on alcohol, several treatment options were offered. She stated she would think about it." Which of the following groups of diagnoses is supported by the clinical indicators described?

- A. DM Type 2 with complications, COPD, HTN, alcohol use
- B. DM Type 2 without complications, HTN, alcohol abuse
- C. DM Type 2 without complications, HTN, alcohol dependence
- D. DM Type 2 with complications, COPD, alcohol dependence

Answer: C

Explanation:
The clinical indicators strongly support alcohol dependence, not merely alcohol "use" or "abuse." The patient reports heavy, compulsive intake (early-morning drinking and at least a pint daily), and the provider explicitly documents that she "continues to be dependent on alcohol" and discusses treatment options-this aligns with a dependence-level disorder being addressed. Hypertension is also supported because the BP is elevated (165/89) and the provider documents management activity (medications and diet counseling), meeting encounter relevance/reportability expectations. Diabetes is listed among chronic conditions, but the scenario provides no indicators of complications (no neuropathy, CKD, ulcers, retinopathy, etc.), so the supported choice is DM type 2 without complications rather than "with complications." Although COPD is listed in the "including" statement, no COPD-specific assessment/monitoring/treatment is described in the indicators provided, so the best-supported grouped option focuses on the conditions with clear supporting indicators and management in the note: DM2 without complications, HTN, and alcohol dependence.

NEW QUESTION # 34
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. Review CKD staging criteria with provider.
- B. Add diagnosis of CKD stage 3 to claim, as it is reportable.
- C. Query for stage 4 CKD.
- D. Delete CKD diagnosis from claim as it was not treated during this encounter.

Answer: A

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 # 35
Which of the following is the MOST compliant provider query?

- A. "According to a visit last year, this patient has a history of alcohol use; quit two years ago; previously drank 6-9 beers daily, 10-12 beers on weekend. Patient now attends AA meetings. Is the patient's alcohol use now in remission?"
- B. "Noted that the patient has skin that is 'warm and dry with no rashes or lesions'; however, nursing documentation describes a 'stage 3 sacral pressure ulcer' requiring wet-to-dry dressing changes. Please add the pressure ulcer to your ED assessment note if appropriate."
- C. "Noted that this patient is being referred for a colonoscopy. She has no documented GI symptoms and has a family history of colon cancer. When this patient is seen, please clarify whether this is a screening colonoscopy or diagnostic colonoscopy."
- D. "The patient has a past medical history of CAD, HF, and COPD. Please document these conditions during the encounter today if they are still being treated."

Answer: C

Explanation:
The most compliant query is the one that is clinically supported, non-leading, and focused on clarifying documentation for correct reporting and medical necessity-without directing the provider to "add" diagnoses or document conditions for payment purposes. Option A presents relevant clinical context (no GI symptoms; family history) and asks the provider to clarify whether the planned colonoscopy is screening or diagnostic, which is a legitimate documentation clarification affecting correct code selection and coverage rules. It does not imply a desired answer and does not instruct the provider to document additional diagnoses. Option B is problematic because it instructs the provider to "document these conditions" if treated, which can be perceived as prompting and is not tied to encounter-specific indicators. Option C is based primarily on historical information and asks a yes/no about remission, which can be leading and may not reflect current-visit evaluation. Option D effectively asks the provider to add a diagnosis based on nursing documentation, which risks leading language and requires provider confirmation and assessment. Therefore, A is most compliant.

NEW QUESTION # 36
Provider documentation states: "A 72-year-old patient with an active history of colon cancer, status post bowel resection, receiving chemotherapy. Newly diagnosed lung metastasis. Presents with UTI and elevated creatinine. Labs demonstrate a hemoglobin of 7.9, WBC of 2,500, and platelet count of 20,000." Which of the following is the query opportunity that supports a disease interaction that impacts the risk adjustment?

- A. Colon cancer and chemotherapy
- B. Chemotherapy induced pancytopenia
- C. Colon cancer and lung metastasis
- D. Acute tubular necrosis and UTI

Answer: B

Explanation:
In outpatient risk adjustment, "disease interactions" refer to model coefficients that are triggered when certain clinically related conditions co-exist, reflecting higher expected resource use than either condition alone. In this case, the record already supports active malignancy care (colon cancer on chemotherapy) with newly documented metastasis, and the lab pattern (anemia, leukopenia, and severe thrombocytopenia) strongly suggests pancytopenia. The highest-yield query opportunity is to clarify whether the cytopenias represent chemotherapy-induced pancytopenia (or another specified etiology) because a confirmed, well-specified hematologic complication in the context of active cancer treatment is the type of combination that commonly drives interaction effects in risk models (cancer plus significant systemic complication/manifestation). Options A and B describe clinical context but do not, by themselves, establish an interaction-ready, separately reportable complication. Option C is unrelated to the presented lab-driven severity signal. Querying and documenting chemotherapy-induced pancytopenia supports accurate capture of severity and the interaction impact.

NEW QUESTION # 37
A patient presents to the office complaining of lower abdominal pain and burning urination. Urinalysis indicates WBC >10, positive nitrites, and leuk esterase. Documentation identifies pain, urinary frequency, and fever likely UTI. Cultures are pending for E-Coli. The patient is started on antipyretics and Levaquin. Which of the following conditions can be reported?

- A. UTI
- B. Abdominal pain, fever, and pyuria
- C. Abdominal pain, fever, and urinary frequency
- D. E-Coli, UTI, and fever

Answer: C

Explanation:
In the outpatient setting, uncertain diagnoses described with terms such as "likely," "probable," "suspected," or "rule out" generally are not reported as established conditions for coding purposes. Instead, the encounter is coded to the confirmed signs and symptoms documented and evaluated at that visit. Here, the provider's assessment is "likely UTI," with urine culture results still pending, so a definitive UTI diagnosis is not yet confirmed within the scenario. Likewise, the organism (E. coli) cannot be coded because it is only suspected and not confirmed until culture results are finalized. Outpatient CDI emphasizes aligning reportable diagnoses to what is clearly supported as present and addressed during the visit. The note explicitly identifies pain, urinary frequency, and fever-symptoms that drove evaluation and treatment (antipyretics and antibiotic initiation). Between the answer choices,

"abdominal pain, fever, and urinary frequency" best represents the reportable conditions based on documented, evaluated symptoms without coding an uncertain infection diagnosis or an unconfirmed causative organism.

NEW QUESTION # 38
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