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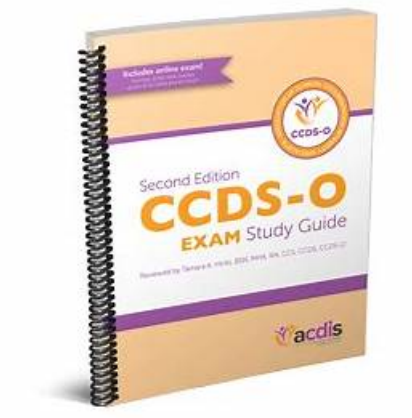

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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• and billing: Covers Official Coding Guidelines, OPPS reimbursement (APCs), and professional billing concepts including CPT E • M codes and Medicare Physician Fee Schedule documentation.
Topic 2	• 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.
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	• 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 5	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q67-Q72):

NEW QUESTION # 67
In review of a clinic record, a CDI specialist notes the provider has directly copied and pasted a previous inpatient problem list into the current ambulatory visit note. Which of the following is the CDI specialist's BEST course of action?

- A. Query the provider for each of the conditions on the problem list.
- B. Do not code conditions that were pasted from the problem list.
- C. Assume the conditions are all relevant for this visit.
- D. Educate the provider regarding the concerns with copying and pasting this list.

Answer: D

Explanation:
Copy-and-paste of an inpatient problem list into an outpatient note creates significant documentation integrity risks: outdated diagnoses may be carried forward, resolved conditions may appear active, and the note may not clearly show which problems were actually evaluated or managed during the current encounter. Outpatient CDI best practice is not to assume relevance (eliminating D) and not to reflexively query every listed diagnosis (B), which can be burdensome, non-targeted, and may lead to "query fatigue." Likewise, blanket instruction to "not code" anything pasted (A) is not appropriate because some conditions may still be active and reportable if the provider documents assessment/management (e.g., monitoring, evaluation, addressing, or treatment). The most effective and sustainable action is provider education: explain why indiscriminate copy-forward threatens accuracy, compliance, medical necessity support, quality reporting, and risk adjustment validity; reinforce documenting current status and care provided for each active condition; and encourage updating the problem list and assessment to reflect what is truly addressed at the visit. Targeted queries can still be used when specific contradictions or high-impact ambiguities are identified.

NEW QUESTION # 68
Which of the following lab values, when trended for greater than 3 months, indicates an objective measure of chronic kidney damage?

- A. Glucose >100 mg/dL
- B. BUN <12 mg/dL
- C. GFR <60 ml/min
- D. BNP >1000 pg/mL

Answer: C

Explanation:
Chronic kidney disease (CKD) is defined by evidence of kidney damage or reduced kidney function that persists for at least three months. An estimated glomerular filtration rate (eGFR/GFR) below 60 mL/min sustained over that timeframe is an objective indicator of chronically decreased renal function and supports CKD identification and staging in the outpatient record. This is why outpatient CDI programs frequently use trended eGFR as a clinical indicator to prompt documentation of CKD stage (e.g., stage 3a/3b, stage 4, etc.) when appropriate. BNP >1000 is more aligned with heart failure severity/volume status rather than kidney damage. BUN <12 is within/near normal and does not indicate renal impairment (elevated BUN may be seen with renal dysfunction

but is less specific and affected by hydration, diet, GI bleed). Glucose >100 is a screening indicator for impaired fasting glucose/prediabetes but does not, by itself, establish chronic kidney damage. Therefore, sustained GFR <60 is the best objective lab-based measure of chronic kidney damage over time.

NEW QUESTION # 69
A CDI specialist read the most recent AHA Coding Clinic that provided updated guidance related to a prior AHA Coding Clinic. The CDI specialist should

- A. utilize the updated Coding Clinic advice from published date forward.
- B. employ the updated Coding Clinic advice to relevant cases discharged last year.
- C. follow the initial Coding Clinic advice for remainder of the fiscal year.
- D. apply the initial Coding Clinic advice to relevant cases in that calendar year only.

Answer: A

Explanation:
AHA Coding Clinic guidance functions as an authoritative interpretive resource for correct ICD-10-CM/PCS code assignment when official guidelines or code descriptors need clarification. When Coding Clinic publishes an update that revises, clarifies, or supersedes earlier advice, outpatient CDI practice is to operationalize the newest guidance prospectively-meaning it should be applied going forward from the publication/effective timeframe of that update. This supports consistent, defensible coding and reduces compliance risk by aligning current reporting with the most current official interpretation. Applying the original advice for a calendar or fiscal year (choices A and B) is not how Coding Clinic updates are intended to be implemented; the governing principle is "most current advice controls" once released. Similarly, automatically applying updated guidance retroactively to cases from last year (choice D) is not routine CDI practice; retrospective rebilling or recoding is typically limited, policy-driven, and subject to payer rules, auditing constraints, and organizational compliance decisions. Therefore, the best action is to use the updated Coding Clinic guidance from the date it is published/implemented forward.

NEW QUESTION # 70
What is the goal of an MSSP program?

- A. Increase fee schedule payment
- B. Optimize risk score
- C. Share in savings
- D. Improve transitions of care

Answer: C

Explanation:
The Medicare Shared Savings Program (MSSP) is designed to move reimbursement away from pure volume-based payment and toward value by rewarding organizations that reduce the total cost of care for an assigned Medicare population while meeting defined quality performance requirements. In MSSP, eligible provider groups participate as Accountable Care Organizations (ACOs) and are compared against a financial benchmark. If the ACO's actual spending comes in below the benchmark and quality standards are achieved, the ACO can earn a portion of the savings-hence "shared savings." Outpatient CDI supports MSSP success by ensuring documentation accurately reflects patients' true disease burden (supporting appropriate risk adjustment for benchmarking), and that conditions addressed during visits are clearly documented as evaluated/managed to support reliable coding and quality measurement. While improving transitions of care may be a strategy that helps achieve savings and quality goals, it is not the core purpose of the program itself. Likewise, MSSP is not intended to increase fee schedule payments or simply optimize risk scores; the primary aim is participating in value-based care and sharing in savings when performance supports it.

NEW QUESTION # 71
CMS-HCC risk adjustment methodology seeks to measure

- A. an individual's anticipated cost of care.
- B. group beneficiary costs.
- C. a beneficiary's risk of mortality.
- D. physician cost of care provision.

Answer: A

Explanation:
The CMS-HCC risk adjustment methodology is designed to estimate an individual beneficiary's expected healthcare resource use and cost relative to an average Medicare beneficiary. It does this by converting demographic factors (such as age/sex and certain eligibility variables) plus documented, coded chronic conditions into a Risk Adjustment Factor (RAF). That RAF is then used to forecast the likely cost of caring for that specific patient in the payment year and to adjust benchmarks/payments so plans and providers managing sicker patients are compared more fairly to those managing healthier patients. This is why outpatient CDI emphasizes accurate, specific documentation and annual recapture of active conditions that are monitored, evaluated, assessed/addressed, or treated-because those coded conditions drive the predicted cost profile. CMS-HCC is not a mortality prediction tool (eliminating B), nor is it intended to measure "group costs" as the primary target (C), even though aggregated risk scores can be used for population analytics. It also does not measure an individual physician's cost of care provision (D); it measures patient-level expected cost burden.

NEW QUESTION # 72
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