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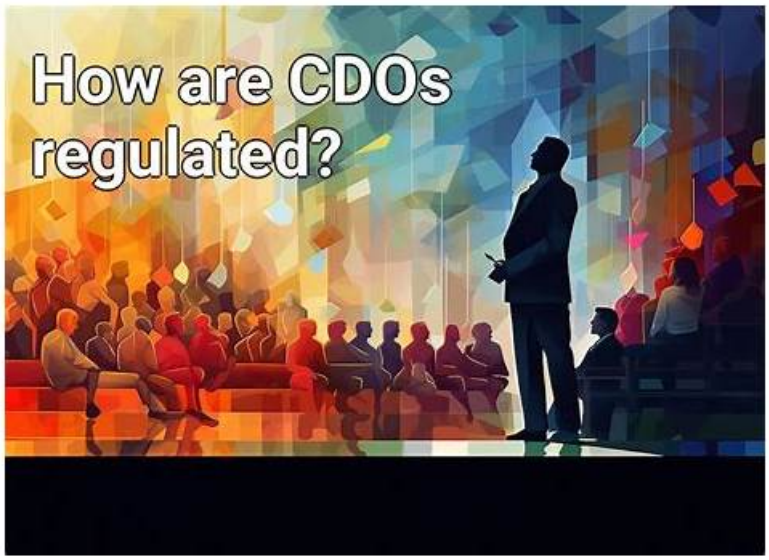

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ACDIS CCDS-O Exam Syllabus Topics:

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	• 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	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding
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.

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q40-Q45):

NEW QUESTION # 40
A patient is evaluated in the primary care clinic for chest pain, slight shortness of breath, and mild nausea. Documentation includes an ECG and chest x-ray to rule out MI. Which of the following diagnoses are reportable?

- A. Rule out MI, shortness of breath, and nausea
- B. Angina pectoris, unspecified, shortness of breath, and nausea
- C. Other chest pain, shortness of breath, and nausea
- D. Acute MI, chest pain, shortness of breath, and nausea

Answer: C

Explanation:
In the outpatient/ambulatory setting, ICD-10-CM reporting rules applied in CDI education distinguish clearly between confirmed diagnoses and "uncertain" or "rule out" conditions. Terms such as "rule out," "suspected," or "probable" generally are not coded as established diagnoses in the outpatient record because the encounter is often for evaluation and testing rather than definitive confirmation. Instead, coders report the patient's presenting signs and symptoms when a definitive condition has not been documented as confirmed by the provider. Here, the clinician ordered diagnostic testing (ECG and chest x-ray) specifically to rule out myocardial infarction (MI), but no final diagnosis of MI or angina is documented in the scenario. Therefore, "rule out MI" is not reportable, and neither is acute MI or angina unless explicitly diagnosed. The reportable conditions are the symptoms that drove the visit and required evaluation: chest pain (captured as "other chest pain" in the options), shortness of breath, and nausea.

NEW QUESTION # 41
Upon review of payer data, a decrease in RAF scores for the organization is noted. After reviewing internal metrics, a CDI specialist notes an increase in the volume of HCC queries across the organization, with accurate coding confirmed. Which of the following is the MOST plausible explanation for these findings?

- A. The HCC model has not been updated within the organization
- B. The payer is not receiving all diagnosis codes
- C. CPT codes are not reflected in the reporting
- D. CDI specialist queries are validated and compliant

Answer: B

Explanation:
When internal CDI metrics show increased HCC-related querying and coding accuracy is confirmed, you would typically expect payer RAF outputs to stabilize or improve-assuming the payer receives and processes the same diagnosis data. A payer-reported RAF decrease despite accurate internal capture most strongly suggests a break in the data flow between the organization and the payer. In outpatient risk adjustment, RAF depends on documented, supported diagnoses being correctly coded and then successfully transmitted on the encounter/claim to the payer's risk-adjustment ingestion process. If certain diagnoses are dropped (claim edits, interface mapping issues, encounter rejection, late submissions, or incomplete encounter files), the payer's dataset will under-represent HCCs and RAF will fall even though internal coding looks correct. CPT visibility (B) generally affects utilization/fee-for-service payment and analytics, not HCC-based RAF. Compliant queries (C) describe process quality but don't explain a payer-side RAF decline. A local "model not updated" (D) wouldn't reduce payer-calculated RAF if the payer is applying its own current model to received diagnoses.

NEW QUESTION # 42
When should the assignment of a not elsewhere classified (NEC)/other specified code be reported?

- A. When two codes may be required to fully describe a condition
- B. When two conditions cannot occur together
- C. When the information in the medical record is insufficient to assign a more specific code
- D. When the information in the medical record provides detail for when a specific code does not exist

Answer: D

Explanation:
In outpatient CDI and ICD-10-CM coding guidance emphasized in ACDIS education, "NEC" (Not Elsewhere Classified) aligns with the "other specified" options in the code set and is used when the provider's documentation is clinically specific, but the classification system does not offer a unique code for that exact specificity. In other words, the record contains enough detail to describe a distinct type, cause, manifestation, or clinical variation of a condition, yet there is no more precise code available, so the "other specified" category appropriately captures that documented specificity. This is the opposite of "unspecified" (often associated with "NOS"), which is selected when the documentation is not detailed enough to choose a more specific code option. From a chart review perspective, NEC/other specified supports accurate reporting because it reflects that the clinician did document additional detail, and the coder is not defaulting to unspecified due to missing documentation-rather, the code set itself limits further granularity.

NEW QUESTION # 43
Which statement is MOST accurate about the problem list?

- A. More diagnoses on the problem list assist the provider in caring for the patient.
- B. Problem list diagnoses should be removed after one year.
- C. A well-maintained problem list is vital in the continuity of patient care.
- D. A CDI specialist should update the problem list to provide continuity of care.

Answer: C

Explanation:
A well-maintained problem list supports continuity of care by giving the care team an accurate, up-to-date clinical "snapshot" of active and relevant historical conditions that affect ongoing management, decision-making, and risk assessment. Outpatient CDI education emphasizes that the problem list should be curated-conditions should be current, clinically meaningful, and appropriately resolved or clarified (e.g., active vs history, controlled vs uncontrolled). Option A is incorrect because diagnoses are not removed based on an arbitrary time threshold; they are updated based on clinical status (resolved, inactive, erroneous, or no longer relevant). Option C is inaccurate because simply adding more diagnoses can introduce noise and increase the risk of outdated or incorrect conditions being propagated ("problem list bloat"), which can harm patient safety and lead to inaccurate coding. Option D is inaccurate because CDI professionals typically do not independently update the problem list; rather, they support providers through compliant queries, education, and process improvements so the treating provider validates and maintains the record. Therefore, B best reflects outpatient documentation best practice.

NEW QUESTION # 44
Which of the following tools or processes is MOST appropriate to share with providers and administrators during a department meeting when demonstrating documentation and coding patterns?

- A. PDSA cycle
- B. Donabedian Model
- C. Spaghetti diagram
- D. Bar graph

Answer: D

Explanation:
When the goal is to demonstrate documentation and coding patterns to a mixed audience of providers and administrators, the most effective tool is one that clearly displays comparisons and trends in an easily interpretable way. A bar graph is ideal because it can quickly show differences in rates or volumes-such as unspecified diagnosis utilization, HCC capture rates, query response/agree rates, denial categories, or condition specificity-across providers, clinics, or time periods. This supports outpatient CDI education by making variation visible and actionable while keeping the discussion focused on documentation behaviors and opportunities for improvement. A spaghetti diagram is used for mapping physical workflow movement and inefficiencies, not coding patterns. The PDSA cycle is a structured improvement method for testing changes, but it is not primarily a visualization tool for presenting pattern data. The Donabedian model (structure-process-outcome) is a quality framework that helps organize improvement thinking, but it doesn't display coding/documentation pattern performance as directly as a bar graph.

NEW QUESTION # 45
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