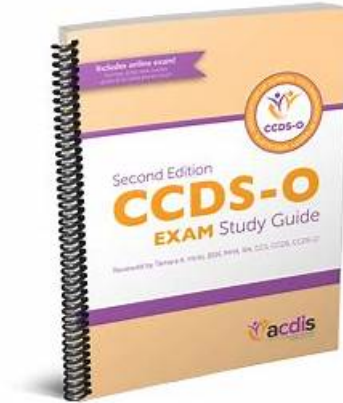


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If you want to pass a high percentage of the ACDIS CCDS-O Exam, you should consider studying for the actual exam. These practice tests are designed to help you prepare for the exam and ensure you know the syllabus content. It will also help you improve your time management skills, as these tests are designed like an actual exam. Moreover, they will help you learn to answer all questions in the time allowed.

ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
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Topic 1	<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 2	<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.
Topic 3	<ul style="list-style-type: none"> • Coding and Reporting, the Outpatient Prospective Payment System (OPSS), and provider coding
Topic 4	<ul style="list-style-type: none"> • 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.

ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q115-Q120):

NEW QUESTION # 115

Which of the following statements is true regarding RADV reviews?

- A. Conditions reported must be documented in the final visit diagnoses or facesheet of the medical record.
- **B. Acceptable physician authentication includes hand-written or electronic signatures.**
- C. Diagnoses assigned by a diagnostic radiologist are considered during RADV reviews.
- D. Diagnoses assigned by technicians are considered during RADV reviews.

Answer: B

Explanation:

RADV (Risk Adjustment Data Validation) is an audit process used to validate that risk-adjusting diagnoses submitted for payment are supported by compliant medical record documentation. A foundational requirement is that the record is properly authenticated by an acceptable provider—meaning the documentation must be attributable to the treating clinician through a valid signature. In compliant documentation standards emphasized in outpatient CDI education, acceptable authentication may be a traditional hand-written signature or an electronic signature/attestation that meets organizational and regulatory policy. Option B is not correct because diagnoses do not have to appear only on a facesheet or "final diagnosis" list; they may be supported within the body of the note (assessment/plan, problem-based charting, or other authenticated sections) as long as they are clearly documented and clinically supported. Options A and D are not reliably true statements in a general RADV context because RADV focuses on diagnoses supported by appropriate provider documentation and acceptable encounter record criteria; "technician-assigned" diagnoses are not acceptable, and radiology documentation alone may not meet all validation expectations depending on the program's rules and encounter context.

NEW QUESTION # 116

Which of the following BEST describes a Stage 3 pressure ulcer?

- A. Abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
- **B. Full thickness skin loss involving damage or necrosis of subcutaneous tissue**
- C. Necrosis of soft tissues through to underlying muscle, tendon, or bone
- D. Pre-ulcer skin changes limited to persistent focal edema

Answer: B

Explanation:

Stage 3 pressure ulcers are defined by full-thickness skin loss where the injury extends through the dermis and involves damage or necrosis of subcutaneous tissue. Clinically, the ulcer may present as a deep crater and can include undermining or tunneling, but the key boundary is that bone, tendon, and muscle are not exposed. That deeper involvement (exposed muscle/tendon/bone) is characteristic of Stage 4, making option C incorrect. Option D describes partial-thickness loss, which aligns with Stage 2 (epidermis/dermis involvement such as abrasion or blister). Option A reflects early skin changes that correspond more closely to Stage 1 (intact skin with non-blanchable erythema and possible localized edema/induration). In outpatient CDI chart review,

accurately distinguishing Stage 3 from Stage 2 and Stage 4 is essential because staging drives severity capture, care planning (wound care interventions, debridement considerations), and quality reporting. Documentation should clearly support "full thickness," the tissue layers involved, and the absence of exposed bone/tendon/muscle.

NEW QUESTION # 117

In which of the following situations would a yes/no query format be considered compliant?

- A. Resolving conflicting documentation from multiple providers
- B. Clarifying acuity of disease process
- C. Obtaining a specification of a contributing organism to an infection
- D. Obtaining a new (previously undocumented) diagnosis

Answer: A

Explanation:

A yes/no query format is considered compliant when it is used to resolve a clear documentation conflict and the provider is being asked to confirm which statement accurately reflects the patient's condition for that encounter. In these situations, the intent is not to introduce a new diagnosis or steer the provider toward a particular coded outcome, but to reconcile inconsistent information already present in the record (e.g., one clinician documents a condition and another documents the opposite, or different notes describe different statuses). A focused yes/no confirmation can be appropriate because the clinical question is essentially binary: which interpretation is correct. By contrast, obtaining a new diagnosis generally requires an open-ended or multiple-choice format with balanced options (including "unable to determine") and strong encounter-specific indicators to avoid leading. Likewise, organism specification and acuity clarification often involve more than two clinically valid possibilities (different organisms, acute vs chronic vs acute-on-chronic, etc.), making yes/no overly restrictive and potentially leading. Therefore, resolving conflicting documentation is the best fit for a compliant yes/no query.

NEW QUESTION # 118

When evaluating a CDI specialist's performance, which of the following expectations is held to the same standard for both inpatient and outpatient initiatives?

- A. Review productivity
- B. Query opportunities
- C. Revenue impact
- D. Query compliance

Answer: D

Explanation:

Across both inpatient and outpatient CDI, the single expectation that must remain consistent is query compliance. While productivity targets, the types of query opportunities, and the way "impact" is measured can differ significantly by setting (e.g., DRG/CC-MCC focus in inpatient vs. HCC capture, specificity, and MEAT support in outpatient), the compliance framework for querying does not change. A compliant query must be clinically supported, non-leading, clearly written, and must allow the provider to independently determine the most accurate documentation based on the record. It should include relevant clinical indicators, present reasonable options (including "other"/"unable to determine" when appropriate), and avoid language that appears to request diagnoses for payment purposes. These principles protect documentation integrity, support defensible coding, and reduce audit risk regardless of whether the encounter is hospital-based or ambulatory. By contrast, "review productivity" and "revenue impact" vary widely by program design and setting, and "query opportunities" differ because inpatient vs. outpatient have different reportability rules and documentation drivers. Therefore, query compliance is the metric held to the same standard in both environments.

NEW QUESTION # 119

CMS-HCCs are used to

- A. determine capitation payments to insurers that administer Medicare Advantage health plans.
- B. distribute reimbursement to providers based on quality of care.
- C. reimburse physicians based on the principal diagnosis.
- D. adjust capitation payments to physicians, excluding advanced practice providers.

Answer: A

Explanation:

The CMS-HCC model is a risk adjustment methodology used primarily to set capitated payments for Medicare Advantage (MA) organizations based on the expected cost of caring for their enrolled beneficiaries. Under this approach, CMS calculates a Risk Adjustment Factor (RAF) for each member using demographic variables (such as age/sex and certain entitlement factors) plus disease burden captured from ICD-10-CM diagnoses that map to Hierarchical Condition Categories (HCCs). The resulting RAF increases or decreases the plan's payment to better match predicted healthcare needs—higher RAF for sicker, more complex patients and lower RAF for healthier patients. ACDIS outpatient CDI education emphasizes that the purpose is not physician reimbursement based on a "principal diagnosis" (an inpatient concept) and not payment distribution tied directly to quality performance (that aligns more with MIPS/VBP frameworks). It also does not adjust capitation payments specifically "to physicians," nor does it exclude advanced practice providers in the way described. The correct use is to determine MA plan capitation payments through risk-adjusted member-level projections.

NEW QUESTION # 120

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