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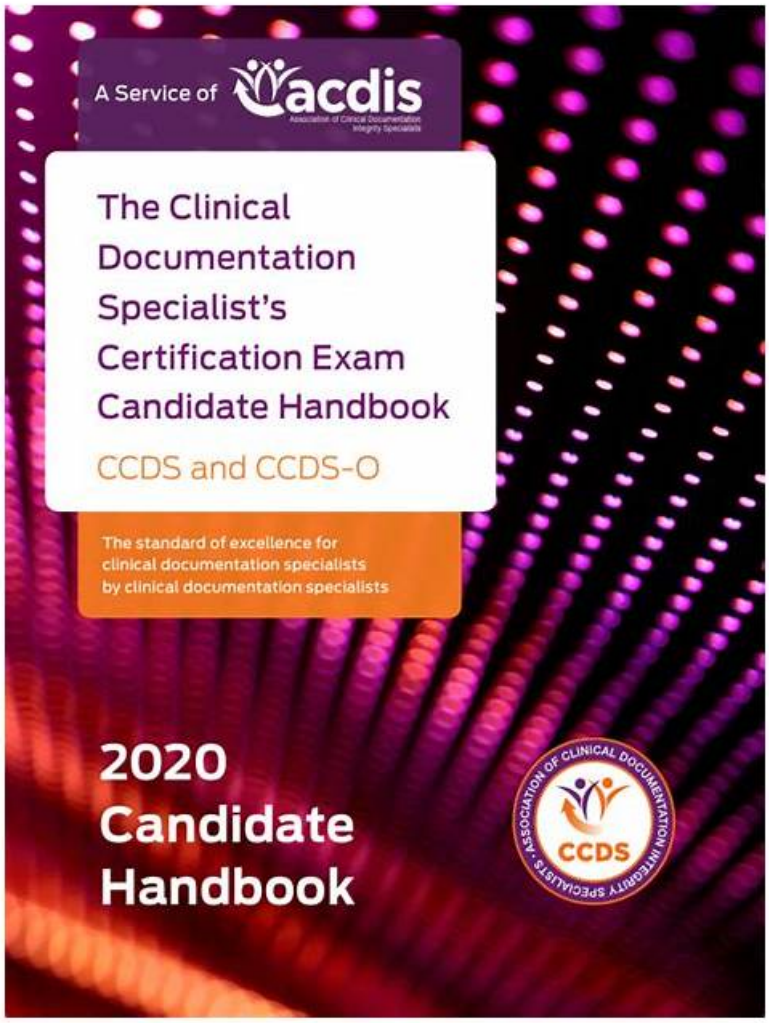

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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• 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 2	• Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for

Topic 3	• 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 (Q81-Q86):

NEW QUESTION # 81
Which of the following therapies is MOST likely to be recommended?

- A. Ensure for morbid obesity
- B. Xarelto for hematemesis
- C. Tamoxifen for chronic congestive heart failure
- D. Metoprolol for atrial fibrillation

Answer: D

Explanation:
Metoprolol is a beta-blocker commonly used in atrial fibrillation to achieve ventricular rate control, reduce symptoms (palpitations, dyspnea), and improve hemodynamic stability, especially when the rhythm is persistent or recurrent. From an outpatient CDI chart-review perspective, therapy-to-diagnosis consistency is a key clinical indicator that supports clarifying the condition being treated and ensuring it is documented as assessed/managed at the encounter. The other options are clinically mismatched: "Ensure" is a nutritional supplement typically used for inadequate intake or weight loss and would not be recommended for morbid obesity; rivaroxaban (Xarelto) is an anticoagulant and would be inappropriate in the setting of hematemesis (active GI bleeding) where anticoagulation generally increases risk and would typically be held or reassessed; tamoxifen is an endocrine therapy for hormone receptor-positive breast cancer risk/treatment and is not a standard therapy for chronic congestive heart failure. Therefore, metoprolol for atrial fibrillation is the most appropriate and likely recommendation among the choices.

NEW QUESTION # 82
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 with complications, COPD, alcohol dependence
- C. DM Type 2 without complications, HTN, alcohol abuse
- D. DM Type 2 without complications, HTN, alcohol dependence

Answer: D

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 # 83
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. Do not code conditions that were pasted from the problem list.
- B. Assume the conditions are all relevant for this visit.
- C. Educate the provider regarding the concerns with copying and pasting this list.
- D. Query the provider for each of the conditions on the problem list.

Answer: C

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 # 84
CMS-HCC risk adjustment methodology seeks to measure

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

Answer: B

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 # 85
A 62-year-old female with history of HTN, CAD, chronic cough and obesity is seen by her PCP. Which of the following treatment plans may result in a query?

- A. Order placed for hemoglobin A1c (HbA1c)
- B. Prescription written for the ACE inhibitor captopril

- C. Diagnostic chest x-ray
- D. A visit with a nutrition specialist

Answer: A

Explanation:
In outpatient CDI practice, a common reason to query is a mismatch between what is being evaluated/treated and what is explicitly documented as an active condition for the encounter. A diagnostic chest x-ray aligns with the already-documented symptom (chronic cough), and a nutrition specialist referral aligns with an established diagnosis (obesity); neither inherently suggests an undocumented condition. Prescribing captopril aligns with documented HTN management, so it generally would not create documentation ambiguity requiring clarification (even though ACE inhibitors can be associated with cough, the plan alone does not establish a new reportable diagnosis). In contrast, ordering an HbA1c often signals assessment for diabetes, impaired glucose regulation, or monitoring of known diabetes. Because diabetes is not listed in the history provided, the HbA1c order may prompt the CDI specialist to query whether the provider is evaluating a suspected or existing glycemic disorder, whether there is a diagnosis such as prediabetes/diabetes being addressed, and to ensure the record clearly supports the medical necessity and any reportable condition.

NEW QUESTION # 86
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