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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q122-Q127):

NEW QUESTION # 122
Which of the following is a leading query?

- A. "The patient has a BMI of 42 per the nursing documentation. Does this patient have a medically relevant diagnosis to

accompany the BMI? Please select one of the following options. A) morbid obesity, B) obesity, C) overweight, D) Other____, E) Clinically undetermined"

- B. "The documentation includes modifications for current Celexa dosages. Can you please identify the condition treated with this medication?"
- C. "Your documentation states the patient drinks a 6-pack of beer nightly. Does this patient have alcohol dependence? Yes/No (circle one)"
- D. "The patient has a past medical history of RUL lung cancer. Should lung cancer be classified as: A) currently being treated, B) History of lung CA?"

Answer: C

Explanation:
A leading query is one that steers the provider toward a particular diagnosis or limits clinically appropriate choices in a way that can be perceived as prompting. Option D is leading because it presents a single, high-impact diagnosis ("alcohol dependence") and forces a binary yes/no response without offering reasonable alternative interpretations (e.g., alcohol use, alcohol abuse/harmful use, dependence in remission, or clinically undetermined) or an "other" option. In addition, it attempts to obtain a potentially new diagnosis based on one data point (quantity consumed) without a balanced set of diagnostic possibilities and supporting clinical indicators (tolerance, withdrawal, impairment, failed attempts to cut down, etc.). By contrast, A is open-ended and requests clarification of the treated condition; B provides two plausible classification choices (active vs history); and C offers multiple reasonable BMI-related diagnostic options plus "other" and "clinically undetermined," which supports compliant, non-leading clarification. Therefore, D best fits the definition of a leading query.

NEW QUESTION # 123
Which of the following coding guidelines is MOST important for a provider to understand when selecting diagnosis codes for an office visit as opposed to an inpatient stay?

- A. Documentation of uncertain diagnoses may not be assigned ICD-10-CM codes.
- B. Chronic conditions only have to be coded once a year even if relevant to multiple encounters.
- C. Documentation is only required for the main reason of the office visit.
- D. First-listed diagnosis and principal diagnosis are synonymous terms.

Answer: A

Explanation:
A core outpatient guideline difference is how to handle uncertainty in diagnoses. In the inpatient setting, facilities may code diagnoses documented as "probable," "suspected," "likely," or "rule out" at discharge if they meet inpatient reporting rules. In outpatient/office settings, however, uncertain conditions generally are not coded as established diagnoses because the encounter is often focused on evaluation rather than confirmed final diagnoses. Instead, outpatient coding relies on confirmed conditions and/or signs and symptoms when a definitive diagnosis has not been made. This is why outpatient CDI education emphasizes precise provider language: if the clinician is still evaluating, they should document the symptom/abnormal finding and the assessment plan; if the condition is confirmed, they should state it clearly and link it to evaluation/management performed. Options A, B, and D are incorrect because chronic conditions may need to be reported whenever they are assessed/managed, "first-listed" is an outpatient concept distinct from inpatient "principal," and documentation should support all clinically relevant conditions addressed, not only the chief complaint.

NEW QUESTION # 124
Which of the following Medicare patients demonstrates the highest level of risk based on the above chart?

- A. 94-year-old female, living in skilled nursing facility, history includes diabetes type 2, peripheral neuropathy, morbid obesity, and depression
- B. 64-year-old female, living at home, disabled due to chronic pain, history includes diabetes type 2, peripheral neuropathy, obesity, and depression
- C. 65-year-old female, living at home, history includes diabetes type 2, obesity, and depression
- D. 72-year-old female, living in skilled nursing facility, history includes diabetes type 2, peripheral neuropathy, morbid obesity, and depression

Answer: D

Explanation:

The Relative Factors table shown is a demographic/eligibility-driven component of risk scoring for female beneficiaries, separating patients by setting/status (community vs institutional) and age band. "Institutional" beneficiaries carry higher expected cost because they typically require more resources and support than community patients. In the chart, the institutional relative factor for females age 70-74 is higher than the community factors shown for similar ages and higher than the 90-94 institutional factor displayed. Among the answer choices, option C is the only patient who matches an institutional setting (skilled nursing facility) in the 70-74 age band (72 years). Option D is also institutional, but the table's 90-94 institutional value is lower than the 70-74 institutional value in this specific chart. Options A and B are community patients, whose relative factors are lower than the institutional values shown. While the listed diagnoses are clinically important and may affect HCC-based risk, the question asks "based on the above chart," so the highest risk is determined by the chart's demographic/setting factor-making the 72-year-old institutional patient the highest.

NEW QUESTION # 125
A patient presents to the PCP's office with LLE edema and pain for 3 days. The problem list indicates morbid obesity and a history of DVT. Vital signs are T 37.9, P 76, R 12, BP 142/88, BMI 46. Documentation states: "Patient presents with LLE edema, increased pain, and hx of DVT. Sedentary lifestyle and contraindications to anticoagulation therapy. LLE warm to touch, 3+ edema from ankle to knee. Pedal pulses 2+ on L and 3+ on R." Doppler exam indicates DVT. The PCP should be queried for which of the following diagnoses?

- A. Hypercoagulability and morbid obesity
- B. Morbid obesity and status of the DVT
- C. Hypercoagulability and hypertensive urgency
- D. Hypertensive urgency and status of the DVT

Answer: B

Explanation:
The documented indicators strongly support two clarification needs that affect accurate outpatient reporting. First, morbid obesity is supported by an objective BMI of 46, and outpatient CDI practice emphasizes ensuring obesity class is clearly documented as a diagnosis (not only implied by BMI) and that it is clinically relevant to care planning and risk (e.g., contributes to thrombotic risk, impacts treatment options). Second, the Doppler "indicates DVT," but the record also notes a history of DVT, creating ambiguity about status-is this an acute new/recurrent DVT, a chronic/residual thrombosis, or a prior condition now re-identified? Clarifying acuity/status is essential because it changes code selection and clinical severity representation and supports medical necessity for management decisions, especially given "contraindications to anticoagulation." Hypertensive urgency is not supported (BP 142/88 without crisis features), and "hypercoagulability" is not established by the provided indicators. Therefore, querying for morbid obesity and DVT status is most appropriate.

NEW QUESTION # 126
Which of the following best differentiates inpatient from outpatient coding guidelines?

- A. Inpatient guidelines emphasize diagnosis sequencing and MS-DRGs
- B. Outpatient guidelines focus on principal diagnoses
- C. Outpatient coding ignores encounter diagnoses
- D. Both use the same guidelines with no differences

Answer: A

Explanation:
A key distinction is that inpatient coding is tightly linked to MS-DRG assignment and inpatient-specific sequencing rules, including selection of the principal diagnosis using the "after study" standard and capture of secondary diagnoses that qualify as complications/comorbidities (CC/MCC) when they meet reporting criteria. This makes diagnosis sequencing and documentation of severity/acuity central to inpatient reimbursement and quality measurement. Outpatient coding does not use MS-DRGs; instead, it typically uses "first-listed" diagnosis concepts for the encounter and assigns ICD-10-CM based on conditions addressed that day, with procedure payment often driven by CPT/HCPCS and, in hospital outpatient departments, packaging/OPPS logic. Therefore, statement A is incorrect (principal diagnosis is not the outpatient focus), C is incorrect (there are meaningful differences), and D is incorrect because outpatient coding absolutely depends on encounter diagnoses being documented and supported. Outpatient CDI education stresses documenting the reason for visit, linking symptoms to confirmed conditions when known, and showing MEAT for chronic conditions so outpatient coding is accurate and defensible.

NEW QUESTION # 127
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In this chapter we frequently use the term expression, To control CCDS-O the traffic from the ringo and curly_bill routers, this example uses policy routing and route maps on the tombstone router.

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