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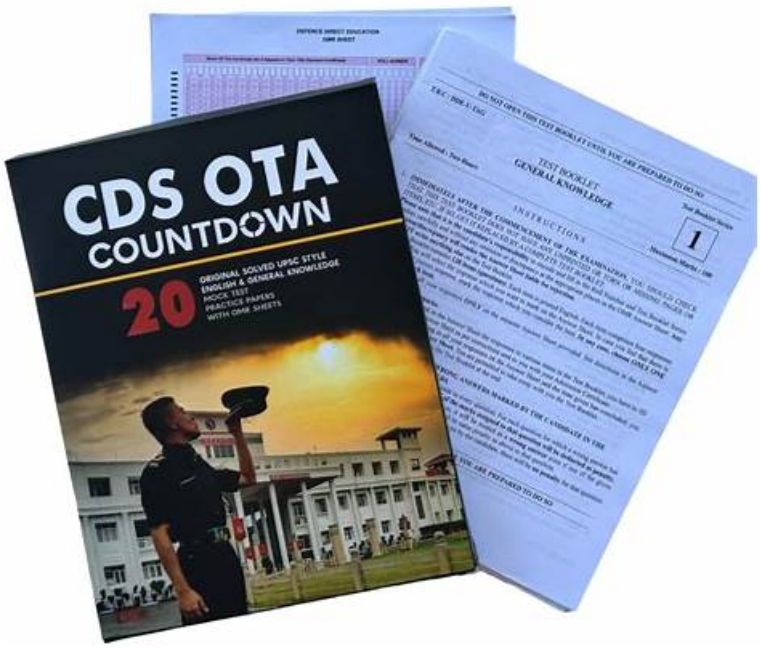

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ACDIS CCDS-O Exam Syllabus Topics:

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	• 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 3	• 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 4	• Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for
Topic 5	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding
Topic 6	• 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.

ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q82-Q87):

NEW QUESTION # 82
Which statement is MOST accurate about the problem list?

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

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 # 83
ICD-10-CM code assignment can be supported by documentation from someone other than the patient's provider in which of the following circumstances?

- A. Site of ostomy
- B. Anatomic site of previous amputation
- C. Type of obesity
- D. Stage of pressure ulcer

Answer: D

Explanation:
Outpatient ICD-10-CM guidance allows certain code elements to be based on documentation from clinicians other than the patient's diagnosing provider when those elements are considered objective, routinely assessed, and commonly documented by nursing or ancillary staff. A key example is pressure ulcer staging, which is frequently assessed and documented by wound care nurses and

other qualified clinicians as part of routine skin/wound evaluation. Because the stage drives code specificity and is an observable clinical finding, coders may use non-provider documentation to assign the stage when it is clearly documented and not contradicted by the provider record. In contrast, items such as the type of obesity generally require provider diagnosis/clinical assessment rather than ancillary documentation alone. Similarly, while status conditions (like amputations or ostomies) may be observed, the coding guidelines do not broadly permit assigning these diagnoses solely from non-provider documentation without provider confirmation, unless the chart otherwise supports it. Therefore, among the choices, pressure ulcer stage is the appropriate circumstance where non-provider documentation can support ICD-10-CM assignment.

NEW QUESTION # 84
A patient presents for a right inguinal herniorrhaphy in ambulatory surgery and is placed in observation status postoperatively. Provider documentation states: "Observation related to the post procedural urinary retention likely related to benign prostatic hyperplasia or adverse reaction to anesthesia." From this documentation, which of the following is the first-listed diagnosis?

- A. Right inguinal hernia
- B. Benign prostatic hyperplasia
- C. Urinary retention
- D. Adverse reaction to anesthetic

Answer: C

Explanation:
For outpatient/observation encounters, the first-listed diagnosis is the condition chiefly responsible for the services provided during that encounter. In this scenario, the patient's ambulatory surgery (herniorrhaphy) has already occurred, and the reason the patient is now in observation is explicitly documented as "post procedural urinary retention." That makes urinary retention the condition driving the extended monitoring, evaluation, and management in observation status. Benign prostatic hyperplasia and an adverse reaction to anesthesia are documented only as possible etiologies ("likely related to...or..."), and outpatient guidelines do not support coding uncertain diagnoses expressed as "likely" or as alternative possibilities without definitive confirmation. Therefore, those potential causes would not replace the confirmed problem that necessitated observation. The hernia was the reason for the procedure, but it is not the reason for the postoperative observation services described. Outpatient CDI practice reinforces documenting the clinical reason for observation and clearly distinguishing confirmed postoperative complications from suspected causes to support correct first-listed selection.

NEW QUESTION # 85
What is the goal of an MSSP program?

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

Answer: D

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 # 86
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. Hypertensive urgency and status of the DVT
- B. Hypercoagulability and hypertensive urgency
- C. Hypercoagulability and morbid obesity
- D. Morbid obesity and status of the DVT

Answer: D

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 # 87
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