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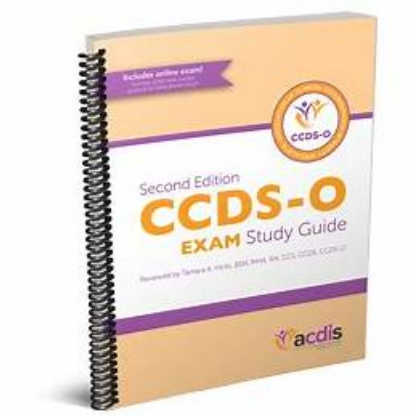

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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• Risk Adjustment Models and Impact of Documentation and Coding: Covers CMS-HCC model fundamentals, RAF scoring, Medicare Advantage payments, hierarchies, disease interactions, and compliant HCC reporting requirements.
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	• Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for
Topic 4	• 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 5	• 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 6	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q104-Q109):

NEW QUESTION # 104
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. 65-year-old female, living at home, history includes diabetes type 2, obesity, and depression
- C. 64-year-old female, living at home, disabled due to chronic pain, history includes diabetes type 2, peripheral neuropathy, 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 # 105
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. Assume the conditions are all relevant for this visit.
- B. Educate the provider regarding the concerns with copying and pasting this list.
- C. Do not code conditions that were pasted from the problem list.
- D. Query the provider for each of the conditions on the problem list.

Answer: B

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 # 106
Which diagnosis and treatment plan may generate a query?

- A. Malnutrition and parenteral nutrition
- B. Atrial fibrillation and amiodarone
- C. Prostate carcinoma and luteinizing hormone-releasing hormone
- D. Severe major depressive disorder and immunotherapy

Answer: D

Explanation:
Outpatient CDI queries are most commonly triggered when there is a disconnect between the documented diagnosis and the documented treatment plan, suggesting that the clinician may be managing an additional condition that is not clearly stated, or that the diagnosis is inaccurately documented. Options A and B reflect typical, clinically aligned management: luteinizing hormone-releasing hormone therapy is a standard treatment pathway for prostate carcinoma, and amiodarone is a recognized antiarrhythmic used in atrial fibrillation management in appropriate circumstances. Option C can also be clinically consistent because parenteral nutrition is often used when malnutrition is present and the patient cannot meet nutritional needs enterally. Option D is the outlier: "immunotherapy" is not a standard treatment for severe major depressive disorder and more commonly aligns with oncology or certain immune-mediated diseases. This mismatch would appropriately prompt a query to clarify the actual condition being treated (e.g., an active malignancy) or to confirm whether "immunotherapy" refers to something else (such as allergy immunotherapy) and whether depression is the correct, visit-relevant diagnosis being addressed.

NEW QUESTION # 107
A patient receives treatment for diabetes during a primary care visit. He has a glucose level of 240 and A1C of 7.9. The patient is prescribed Gabapentin 100mg TID. Which of the following should the CDI specialist query for?

- A. Diabetes with ketoacidosis
- B. Diabetes with chronic kidney disease
- C. Diabetes with peripheral neuropathy
- D. Diabetes with macular degeneration

Answer: C

Explanation:
In outpatient CDI chart review, a key skill is recognizing when medications and treatment plans suggest a specific diabetic complication that is not explicitly documented. Gabapentin is commonly prescribed for neuropathic pain, and in a diabetic patient it is frequently used to treat diabetic peripheral neuropathy symptoms (burning, tingling, numbness, shooting pain). ACDIS outpatient CDI guidance supports querying when there are strong clinical indicators that a more specific, clinically relevant diagnosis may be present and is being treated at the encounter, because diabetes codes require complication specificity when supported (e.g., "diabetes with neuropathy" rather than unspecified diabetes). The elevated glucose and A1C confirm ongoing diabetes management but do not, by themselves, indicate CKD, macular degeneration, or ketoacidosis. Ketoacidosis would require documentation of acute metabolic decompensation and supporting clinical/lab findings, which are not provided here. Therefore, the most appropriate clarification is whether the patient has diabetic peripheral neuropathy (and whether it is painful neuropathy) being managed with gabapentin, so the provider can document the condition clearly and accurately.

NEW QUESTION # 108
If a patient is being seen for follow-up and the documentation indicates that the patient was admitted to the hospital 28 days ago with an acute cerebral infarction with remaining right-sided weakness, which of the following diagnoses would be MOST appropriate?

- A. Cerebral infarction, unspecified, hemiparesis affecting right dominant side
- B. Hemiparesis following cerebral infarction affecting unspecified side
- C. Other sequelae of cerebral infarction

- D. Hemiparesis following cerebral infarction affecting right dominant side

Answer: D

Explanation:
In the outpatient follow-up setting, when the acute stroke event has occurred in the recent past and the patient is now being evaluated for residual deficits, documentation and coding should focus on the sequelae (late effects) rather than re-coding the acute infarction itself-unless the provider clearly states the stroke is still in the acute phase and being actively treated as such. ACDIS outpatient CDI principles stress selecting the diagnosis that best reflects the reason for today's encounter and the condition being assessed/managed. Here, the ongoing clinical issue driving follow-up care is the persistent neurologic deficit (right-sided weakness/hemiparesis) after the cerebral infarction. Option C is the most specific and clinically accurate because it captures (1) the relationship to the prior cerebral infarction ("following cerebral infarction") and (2) laterality and dominance ("right dominant side"), which improves code specificity and reflects functional impact. Option A incorrectly keeps the focus on an unspecified cerebral infarction rather than the residual deficit, and option D is too nonspecific compared with a clearly described hemiparesis.

NEW QUESTION # 109
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