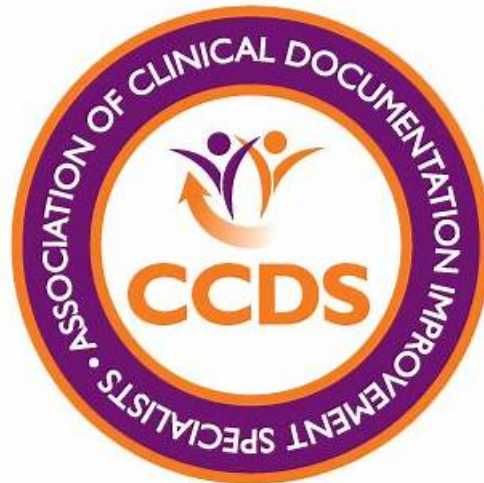


# ACDIS - CCDS-O - Certified Clinical Documentation Specialist-Outpatient Free Sample



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## ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"><li>• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding</li></ul>
Topic 2	<ul style="list-style-type: none"><li>• CDI Program Concepts: Department Metrics and Provider Education: Covers provider education development, CDI performance metrics including query rates, RAF progression, HCC capture, ACO</li><li>• MSSP impact, and physician documentation's effect on quality reporting.</li></ul>
Topic 3	<ul style="list-style-type: none"><li>• Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for</li></ul>

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## Quiz 2026 ACDIS CCDS-O: First-grade Certified Clinical Documentation Specialist-Outpatient Free Sample

It is known to us that the knowledge workers have been playing an increasingly important role all over the world, since we have to admit the fact that the CCDS-O certification means a great deal to a lot of the people, especially these who want to change the

present situation and get a better opportunity for development. If you also want to work your way up the ladder, preparing for the CCDS-O Exam will be the best and most suitable choice for you. If you are still hesitating whether you need to take the CCDS-O exam or not, you will lag behind other people.

## ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q33-Q38):

### NEW QUESTION # 33

A female patient who underwent total hip replacement 2 weeks ago is in for a follow-up visit with her PCP. The visit note states: "Patient complains of fatigue and lethargy. Hgb on discharge was 10.4gm/dL - now is 8.6 gm/dL. Will start FeSO<sub>4</sub> 325mg po daily with food. Repeat H/H in 2 weeks. She has return visit with Ortho then." Which of the following is the BEST course of action for the CDI specialist?

- A. Instruct the provider to add iron deficiency anemia to the problem list.
- B. Review the lab work referenced by the provider in the progress note for congruence.
- C. Query the provider for a diagnosis related to fatigue, decreased Hgb, and FeSO<sub>4</sub>.
- D. Add acute blood loss anemia to the diagnoses reported on the claim.

**Answer: C**

Explanation:

Outpatient CDI practice supports accurate, provider-validated diagnoses; CDI should not "diagnose," direct the provider to add a specific condition, or independently add diagnoses to the claim. Here, the documentation shows clinical indicators (fatigue/lethargy and hemoglobin drop from 10.4 to 8.6) and a treatment plan (oral iron and repeat H/H), but the provider has not stated a definitive diagnosis such as postoperative anemia, iron deficiency anemia, acute blood loss anemia, or anemia due to chronic disease. The best CDI action is to issue a compliant query that summarizes the relevant indicators and treatment and asks the provider to document the appropriate diagnosis and etiology, if clinically supported, and to link it to the plan of care. Option A is inappropriate because it leads the provider toward a specific diagnosis. Option D is noncompliant because coding must follow documented provider diagnoses. Option B may be a reasonable internal check, but it does not resolve the documentation gap.

### NEW QUESTION # 34

What diagnoses are included in code category N18, chronic kidney disease?

- A. AKI, ESRD, and dialysis
- B. CKD stage 3, CKD severe, and ESRD
- C. GFR, ATN, and unspecified kidney failure
- D. Dialysis, chronic uremia, and polycystic kidney disease

**Answer: B**

Explanation:

ICD-10-CM category N18 (Chronic kidney disease) is used to report CKD by stage, including stage-based descriptors and end stage renal disease (ESRD). Within N18, codes identify CKD stage 1 through stage 5, ESRD (stage 5D), and CKD unspecified. Outpatient CDI review focuses on ensuring providers document the stage (often supported by eGFR trends) because stage drives correct code selection and accurately reflects disease severity for risk, quality, and medical necessity. Options that include dialysis are not part of N18 itself; dialysis status and encounter codes are reported elsewhere (e.g., dialysis dependence/status codes), not as N18 category diagnoses. AKI (acute kidney injury) and ATN (acute tubular necrosis) are acute renal conditions and are coded outside N18. Likewise, polycystic kidney disease and "uremia" are separate diagnoses with their own code categories. Therefore, the set that correctly matches what N18 represents is CKD stage-based diagnoses such as CKD stage 3, more advanced/severe CKD stages, and ESRD.

### NEW QUESTION # 35

A prospective record review of a problem list states: "Upper respiratory infection (resolved), fractured right femoral head (resolved), metastatic melanoma (followed by oncology), hypertension, morbid obesity, and bipolar disorder." Which of the following query opportunities would provide the highest risk adjusted impact?

- A. Sequelae related to fracture femur
- B. Status of metastatic melanoma

- C. Body mass index
- D. Specificity of bipolar disorder

**Answer: B**

Explanation:

In ambulatory CDI risk adjustment, the largest RAF impact typically comes from ensuring accurate capture of high-weight, HCC-relevant chronic conditions—especially active malignancies with metastasis. "Metastatic melanoma (followed by oncology)" suggests an ongoing, clinically significant condition, but the wording could represent active metastatic disease, history of metastatic disease, remission, or no current evidence of disease. Because HCC models distinguish active metastatic cancer from history-only status, clarifying the current status (active/under treatment, recurrent, in remission, history) can materially change whether the condition qualifies for risk adjustment and how the patient's expected cost is benchmarked. By comparison, adding BMI (when morbid obesity is already documented) generally does not increase HCC capture, and fracture sequelae typically does not drive HCC risk scoring in the same way. Bipolar disorder may map to an HCC, but its relative impact is generally lower than metastatic cancer, making melanoma status the highest-value clarification.

### NEW QUESTION # 36

Clinic documentation states: "Follow-up for post-induction chemotherapy for metastatic uterine cancer." To BEST identify the conditions being monitored and treated, a CDI specialist should

- A. review the record for MRI results.
- **B. query for secondary sites.**
- C. evaluate diagnostic lab results.
- D. clarify the morphology of the tumor.

**Answer: B**

Explanation:

When documentation states "metastatic uterine cancer," the most important missing element for complete, accurate outpatient coding is where the cancer has metastasized (the secondary site[s]). In ambulatory CDI, identifying secondary sites best clarifies the full scope of disease being monitored and treated because metastatic disease coding relies on documenting both the primary malignancy and the specific metastatic location(s) (e.g., lung, liver, bone, peritoneum, lymph nodes). This supports correct severity representation, risk capture, treatment intent, and medical necessity for ongoing chemotherapy follow-up. While tumor morphology can be clinically relevant, it is usually established earlier in the diagnostic pathway and does not, by itself, define current metastatic burden. Likewise, reviewing labs or MRI results may provide supportive indicators, but they do not replace provider documentation of the confirmed metastatic sites being managed. A compliant query focused on secondary sites prompts the provider to document the current metastatic disease status (active, responding, progressing) and specific locations, which most directly identifies the conditions under treatment.

### NEW QUESTION # 37

Which of the following Medicare patients demonstrates the highest level of risk based on the above chart?

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

**Answer: B**

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

