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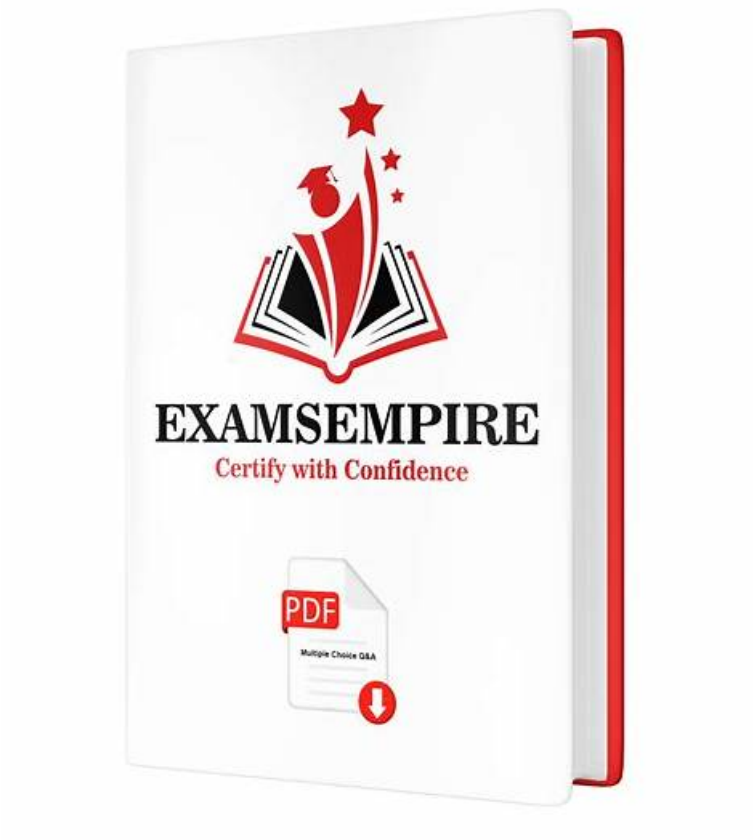

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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• 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 2	• Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for
Topic 3	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding
Topic 4	• 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 5	• 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 6	• 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.

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q19-Q24):

NEW QUESTION # 19
A patient presents with pulmonary rales, pulmonary edema found on chest x-ray, and bilateral ankle edema. Which of the following conditions will the provider MOST likely evaluate further?

- A. Pleural effusion
- B. Pulmonary hypertension
- C. Pneumonia
- D. Heart failure

Answer: D

Explanation:
Pulmonary rales (crackles), radiographic pulmonary edema, and peripheral (ankle) edema together strongly suggest a systemic volume overload state, most classically due to heart failure. In ambulatory CDI chart review, these findings function as clinical indicators that drive the provider's diagnostic reasoning and typically prompt further evaluation of heart failure type and status (e.g., acute vs chronic, systolic vs diastolic, preserved vs reduced EF), along with assessment of severity and potential decompensation. Providers commonly correlate these indicators with additional data such as weight gain trends, BNP, echocardiogram findings, medication adherence (diuretics), and signs of congestion to determine whether the patient is experiencing a heart failure exacerbation requiring treatment adjustments. While pleural effusion may coexist and pneumonia can cause rales, the presence of pulmonary edema on chest x-ray plus bilateral ankle edema points more directly to a cardiac/volume etiology than an isolated infectious process. Pulmonary hypertension may contribute to dyspnea and edema but does not most directly explain pulmonary edema on imaging in the same way. Therefore, heart failure is the most likely condition to be evaluated further.

NEW QUESTION # 20
When reviewing physician metrics, a CDI specialist notes upward trends in the use of unspecified diagnoses. Which of the following diagnoses provides the BEST opportunity to positively influence the providers' RAF score in the CMS-HCC model?

- A. Kaposi's sarcoma, unspecified
- B. Arthropathic psoriasis, unspecified
- C. Angina pectoris, unspecified
- D. Cystic fibrosis, unspecified

Answer: C

Explanation:

In CMS-HCC risk adjustment, RAF impact comes from reporting qualifying chronic diseases (HCCs), not from nonspecific symptom-only documentation. "Angina pectoris, unspecified" is frequently a symptom-level statement and, by itself, often does not carry the same risk-adjustment weight as documenting and coding the underlying ischemic heart disease responsible for the angina (for example, coronary artery disease/atherosclerotic heart disease with angina). Ambulatory CDI practice emphasizes that when providers document only "angina," coders may be limited to a symptom code, which can under-represent the patient's true disease burden in the HCC model. This makes angina an excellent target for provider education: clarify whether the angina is due to CAD, whether CAD is present and being managed, and whether there are related manifestations (e.g., unstable angina, prior MI history, status post CABG/stent) that support more complete, clinically accurate reporting. By improving documentation linkage from symptom (angina) to the definitive chronic condition (CAD with angina), the provider can more reliably capture an HCC-relevant diagnosis and positively influence RAF accuracy.

NEW QUESTION # 21
Which of the following health record elements impacts HHS-HCC risk scores?

- A. Ethnicity
- B. Discharge status
- C. CPT codes
- D. Gender

Answer: D

Explanation:
The HHS-HCC risk adjustment model (used for ACA Marketplace plans) calculates a member's risk score using a combination of demographic factors and diagnosis codes that map to HHS-HCCs. Among the listed health record elements, gender is a core demographic variable used in the model's coefficients because expected healthcare utilization and cost patterns differ by age/sex groupings. In outpatient CDI terms, this is why accurate demographic data capture (including sex) matters alongside complete and specific condition reporting. CPT codes do not drive HHS-HCC risk scores; the model relies on diagnosis reporting (ICD-10-CM) rather than procedure codes for risk category assignment. Discharge status is an encounter/billing element relevant to certain facility payment and quality measures, but it is not a standard HHS-HCC risk score input. Ethnicity is not used as a direct risk adjustment variable in the HHS-HCC model for score calculation. Therefore, gender is the correct element that impacts HHS-HCC risk scores.

NEW QUESTION # 22
CMS-HCCs are used to

- A. determine capitation payments to insurers that administer Medicare Advantage health plans.
- B. distribute reimbursement to providers based on quality of care.
- C. adjust capitation payments to physicians, excluding advanced practice providers.
- D. reimburse physicians based on the principal diagnosis.

Answer: A

Explanation:
The CMS-HCC model is a risk adjustment methodology used primarily to set capitated payments for Medicare Advantage (MA) organizations based on the expected cost of caring for their enrolled beneficiaries. Under this approach, CMS calculates a Risk Adjustment Factor (RAF) for each member using demographic variables (such as age/sex and certain entitlement factors) plus disease burden captured from ICD-10-CM diagnoses that map to Hierarchical Condition Categories (HCCs). The resulting RAF increases or decreases the plan's payment to better match predicted healthcare needs-higher RAF for sicker, more complex patients and lower RAF for healthier patients. ACDIS outpatient CDI education emphasizes that the purpose is not physician reimbursement based on a "principal diagnosis" (an inpatient concept) and not payment distribution tied directly to quality performance (that aligns more with MIPS/VBP frameworks). It also does not adjust capitation payments specifically "to physicians," nor does it exclude advanced practice providers in the way described. The correct use is to determine MA plan capitation payments through risk-adjusted member-level projections.

NEW QUESTION # 23
Clinic visit documentation describes patient complaints of increased shortness of breath, following recent inpatient admission for pneumonia. Diagnoses include COPD - GOLD stage 3. Increase home O2 to 3 liters. Home health follow-up to begin home nebulizers, and Solu-Medrol ordered. Which of the following is the MOST significant query opportunity?

- A. Specificity of the organism causing the pneumonia
- B. Acuity of the COPD
- C. Oxygen dependence
- D. Presence of chronic respiratory failure

Answer: D

Explanation:
The documentation shows a patient with advanced COPD (GOLD stage 3) who now requires an increase in home oxygen to 3 liters, along with escalation of respiratory therapies (home nebulizers and systemic steroids). In outpatient CDI, an increased or ongoing home oxygen requirement is a strong clinical indicator that the provider may be managing chronic respiratory failure (or chronic hypoxemic respiratory failure), which is more clinically meaningful than simply documenting oxygen use as a status. "Oxygen dependence" is a status code and does not fully describe the underlying physiologic impairment driving the need for oxygen; chronic respiratory failure captures the severity and ongoing nature of the condition and better reflects risk, complexity, and medical necessity for durable oxygen therapy. Querying for pneumonia organism specificity is not as relevant in a follow-up visit unless pneumonia is still being actively treated and the organism is known. Querying COPD acuity (e.g., exacerbation) may be appropriate, but the most significant clarification prompted by increased home O2 is whether chronic respiratory failure is present and being managed.

NEW QUESTION # 24
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