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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q15-Q20):

NEW QUESTION # 15
Which of the following diabetic complications requires the assignment of a combination code plus the code for the specific complication?

- A. Osteomyelitis
- B. Nephropathy
- C. Dermatitis
- D. Retinopathy

Answer: A

Explanation:
In ICD-10-CM diabetes coding (as reinforced in outpatient CDI education), some diabetes manifestations are fully captured by a single diabetes "combination" code, while others require a diabetes complication code plus an additional code to identify the specific manifestation. Diabetic nephropathy and many forms of diabetic retinopathy are commonly represented by diabetes combination codes that already describe the manifestation with built-in specificity options (e.g., diabetes with nephropathy; diabetes with retinopathy with/without macular edema and severity). Osteomyelitis, however, is typically captured using a diabetes code such as "diabetes with other specified complication" (e.g., E11.69) to establish the linkage to diabetes and an additional code from the osteomyelitis category (e.g., M86.-) to specify the site, acuity, and type of osteomyelitis. From a chart review standpoint, CDI often queries to confirm the causal relationship ("due to diabetes") and to ensure the osteomyelitis details (site, acute vs chronic) are documented so both codes can be assigned accurately and compliantly.

NEW QUESTION # 16
A CDI specialist is following up on a query while the provider is seeing patients in the clinic. The BEST action that will support a quick and compliant response to the query is to

- A. discuss in a private room with the door closed.
- B. leave a sticky note on the chart of the next patient.
- C. wait to speak with the provider during the next scheduled meeting.
- D. catch the provider in the hallway between patients.

Answer: A

Explanation:
Outpatient CDI follow-up must balance responsiveness with confidentiality and professional standards. The most compliant approach is to communicate query-related information in a setting that protects protected health information and minimizes the risk of incidental disclosure. Discussing the query in a private room with the door closed supports timely clarification while maintaining privacy, avoiding conversations that could be overheard by patients, visitors, or staff who are not involved in the patient's care. Catching the provider in the hallway is faster but increases privacy risk because clinical details can be overheard, and it may also distract the provider in a high-traffic environment. Leaving a sticky note on the next patient's chart is inappropriate because it can be seen by others, may be misplaced, and can create compliance and medico-legal concerns (including mixing patients or leaving PHI unsecured). Waiting for the next scheduled meeting may be compliant but does not support a quick response, potentially delaying coding completion and data integrity. Therefore, a private discussion is both the quickest and most compliant option.

NEW QUESTION # 17
In February, a patient is diagnosed with prostate cancer, which is classified as HCC 23. In October, the patient is diagnosed with prostate cancer with bone metastases, which is classified as HCC 18. Which of the following is true about the patient's risk score?

- A. The risk score will not be impacted by the presence of HCC 18 or HCC 23 because they are not currently being treated.
- B. The risk score will be calculated based upon HCC 18 because it has the highest weight in the hierarchy HCC 23.
- C. The risk score will be calculated based upon HCC 23 because it was captured first.
- D. The risk score will be calculated based upon HCC 18 and HCC 23 because they were both documented and coded in the same calendar year.

Answer: B

Explanation:
In the CMS-HCC model, many related conditions are organized into hierarchies so that only the most severe manifestation within a disease family contributes to the RAF. This prevents double counting when multiple codes describe progressive severity of the same underlying condition. Cancer categories are a common example: a diagnosis reflecting metastatic disease represents substantially higher expected resource utilization than a diagnosis of localized/primary malignancy. In this scenario, the February prostate cancer maps to a lower-severity HCC (HCC 23), while the October documentation of prostate cancer with bone metastases maps to a higher-severity HCC (HCC 18). When both are captured within the applicable period, the hierarchy logic retains the higher-

weighted metastatic category and suppresses the lower category. The timing of which was coded first does not control the hierarchy outcome, and both HCCs are not counted together when they fall within the same hierarchical grouping. Therefore, the patient's risk score calculation reflects HCC 18 rather than HCC 23.

NEW QUESTION # 18
Documentation from which of the following facility settings contributes to the CMS-HCC risk score?

- A. Renal dialysis center
- B. Hospital ambulatory clinic
- C. Hospice care
- D. Freestanding ambulatory surgical center

Answer: B

Explanation:
Under CMS-HCC risk adjustment (commonly applied to Medicare Advantage), qualifying diagnoses must come from acceptable encounter/claim sources and eligible provider types. Hospital-based outpatient services (including a hospital ambulatory clinic) are among the standard, acceptable settings where diagnoses documented, coded, and submitted on qualifying encounters may be used for risk adjustment-assuming they are supported, assessed/managed, and submitted per program requirements. In contrast, certain facility claim types do not typically contribute to CMS-HCC capture in the same way. Hospice care is generally treated as a carve-out/unique payment environment and is not relied upon as a routine source of risk-adjusting diagnosis capture for the member's ongoing RAF. Renal dialysis centers (ESRD facilities) likewise operate under specialized payment constructs and are not the typical outpatient setting used to drive CMS-HCC diagnosis capture for risk adjustment in standard CDI workflows. Freestanding ambulatory surgical centers also frequently fall outside the usual risk-adjustment-eligible encounter sources emphasized in outpatient CDI programs. Therefore, the hospital ambulatory clinic is the correct setting among these choices.

NEW QUESTION # 19
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. Type of obesity
- B. Anatomic site of previous amputation
- C. Stage of pressure ulcer
- D. Site of ostomy

Answer: C

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 # 20
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