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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• 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 2	• 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 3	• 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 4	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q89-Q94):

NEW QUESTION # 89
Documentation states: "Patient with history of STEMI five weeks ago. Returning to office for follow-up. Problem list includes CAD, hypertension, heart failure, leukemia, malnutrition, and atrial fibrillation, all were relevant to the encounter. CBC and WBC reviewed and referred to oncologist. Follow-up with dietitian to further evaluate nutritional status." Which of the following is the MOST impactful risk adjusted query opportunity?

- A. Severity of the malnutrition (mild, moderate, severe)
- B. Type (diastolic, systolic, combined) and acuity of heart failure
- C. Status (remission, or relapse) and acuity of leukemia
- D. Differentiation of atrial fibrillation (paroxysmal, persistent, permanent)

Answer: C

Explanation:
In outpatient risk adjustment, the highest-impact clarification is often the one that determines whether a condition is currently active (and therefore risk-adjustable) versus historical/resolved. "Leukemia" listed on the problem list, plus active review of CBC/WBC and referral to oncology, strongly suggests ongoing disease evaluation/management. ACDIS outpatient CDI principles emphasize querying to confirm whether the leukemia is active, in relapse, or in remission because that distinction can change code selection from an active malignancy to a history code, and history codes typically do not carry the same risk adjustment impact as an active HCC-bearing diagnosis. While heart failure type/acuity and malnutrition severity are also important for specificity and may affect risk capture, they generally represent refinement of already-established chronic conditions rather than a potential "on/off" determination of a major disease category. Likewise, atrial fibrillation subtype differentiation is clinically useful but usually does not materially change risk adjustment compared with confirming an active hematologic malignancy. Therefore, clarifying leukemia status/acuity is the most impactful risk-adjusted query opportunity.

NEW QUESTION # 90
Upon review of payer data, a decrease in RAF scores for the organization is noted. After reviewing internal metrics, a CDI specialist notes an increase in the volume of HCC queries across the organization, with accurate coding confirmed. Which of the following is the MOST plausible explanation for these findings?

- A. CDI specialist queries are validated and compliant
- B. The HCC model has not been updated within the organization
- C. CPT codes are not reflected in the reporting
- D. The payer is not receiving all diagnosis codes

Answer: D

Explanation:
When internal CDI metrics show increased HCC-related querying and coding accuracy is confirmed, you would typically expect payer RAF outputs to stabilize or improve-assuming the payer receives and processes the same diagnosis data. A payer-reported RAF decrease despite accurate internal capture most strongly suggests a break in the data flow between the organization and the payer. In outpatient risk adjustment, RAF depends on documented, supported diagnoses being correctly coded and then successfully transmitted on the encounter/claim to the payer's risk-adjustment ingestion process. If certain diagnoses are dropped (claim edits, interface mapping issues, encounter rejection, late submissions, or incomplete encounter files), the payer's dataset will under-represent HCCs and RAF will fall even though internal coding looks correct. CPT visibility (B) generally affects utilization/fee-for-service payment and analytics, not HCC-based RAF. Compliant queries (C) describe process quality but don't explain a payer-side RAF decline. A local "model not updated" (D) wouldn't reduce payer-calculated RAF if the payer is applying its own current model to received diagnoses.

NEW QUESTION # 91

Which of the following statements is true regarding RADV reviews?

- A. Diagnoses assigned by technicians are considered during RADV reviews.
- B. Diagnoses assigned by a diagnostic radiologist are considered during RADV reviews.
- C. Conditions reported must be documented in the final visit diagnoses or facesheet of the medical record.
- D. Acceptable physician authentication includes hand-written or electronic signatures.

Answer: D

Explanation:
RADV (Risk Adjustment Data Validation) is an audit process used to validate that risk-adjusting diagnoses submitted for payment are supported by compliant medical record documentation. A foundational requirement is that the record is properly authenticated by an acceptable provider-meaning the documentation must be attributable to the treating clinician through a valid signature. In compliant documentation standards emphasized in outpatient CDI education, acceptable authentication may be a traditional hand-written signature or an electronic signature/attestation that meets organizational and regulatory policy. Option B is not correct because diagnoses do not have to appear only on a facesheet or "final diagnosis" list; they may be supported within the body of the note (assessment/plan, problem-based charting, or other authenticated sections) as long as they are clearly documented and clinically supported. Options A and D are not reliably true statements in a general RADV context because RADV focuses on diagnoses supported by appropriate provider documentation and acceptable encounter record criteria; "technician-assigned" diagnoses are not acceptable, and radiology documentation alone may not meet all validation expectations depending on the program's rules and encounter context.

NEW QUESTION # 92
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. Hemiparesis following cerebral infarction affecting unspecified side
- B. Cerebral infarction, unspecified, hemiparesis affecting right dominant 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 # 93
A 75-year-old with a PMH of chronic foot ulcer, CKD, and depression is seen by his PCP for continued fatigue and decreased urination. Labs drawn on previous day are reviewed. Patient describes extreme fatigue and no motivation. Assessment and plan include: "CKD 3 with renal failure - refer to nephrologist. Chronic nonpressure foot ulcer - home care for wound assessment. Depression - Rx for SSRI." Which of the following are the validated diagnoses that risk adjust and qualify as CMS-HCCs?

- A. Depression; renal failure
- B. Chronic non-pressure ulcer; depression
- C. Renal failure; CKD 3
- D. CKD 3; chronic non-pressure ulcer

Answer: D

Explanation:
Under CMS-HCC methodology, risk adjustment is driven by ICD-10-CM diagnoses that map to HCC categories and are

supported as active conditions addressed at the encounter. CKD stage 3 is a classic HCC-qualifying chronic condition because it represents ongoing kidney disease severity and expected resource use, and in this note it is actively assessed with labs reviewed and a nephrology referral. A chronic non-pressure foot ulcer is also typically HCC-qualifying when documented as ongoing and requiring management, which is supported here by home care/wound assessment planning. In contrast, "depression" (without specification such as major depressive disorder severity/status) commonly does not qualify for HCC in the way major depressive/bipolar categories do, making it less reliable as a risk-adjusting diagnosis. Likewise, "renal failure" is nonspecific and potentially conflicting with CKD stage 3; CDI best practice would be to clarify acuity/severity (acute kidney injury vs CKD stage vs ESRD) rather than assume "renal failure" as an HCC driver. Therefore, the validated HCC-qualifying pair is CKD 3 and chronic non-pressure ulcer.

NEW QUESTION # 94

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