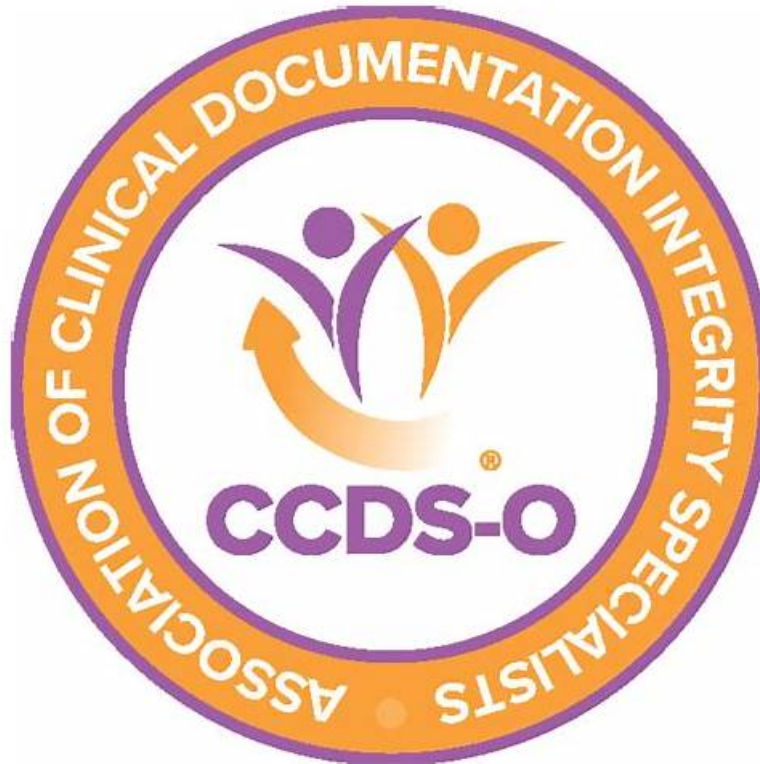


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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• and billing: Covers Official Coding Guidelines, OPSS reimbursement (APCs), and professional billing concepts including CPT E• M codes and Medicare Physician Fee Schedule documentation.
Topic 3	<ul style="list-style-type: none">• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q126-Q131):

NEW QUESTION # 126

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

Answer: C

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 # 127

Which of the following section(s) of the Official Guidelines for Coding and Reporting are applicable to outpatient settings?

- A. Section I, Conventions, General Coding Guidelines, and Chapter Specific Guidelines
- **B. Section I, Conventions, General Coding Guidelines and Chapter Specific Guidelines; and Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services**
- C. Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services
- D. Section III, Reporting Additional Diagnoses; and Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services

Answer: B

Explanation:

In outpatient CDI and coding, the Official ICD-10-CM Guidelines that apply are the universal rules plus the outpatient-specific rules. Section I contains conventions, general coding guidelines, and chapter-specific guidance that govern code assignment in every setting (e.g., code structure, "use additional code," laterality, sequencing instructions, and condition-specific rules). Section IV is specifically written for outpatient services and drives core outpatient behaviors such as selecting the "first-listed" diagnosis based on the main reason for the encounter, reporting additional diagnoses that are evaluated/assessed/treated or impact care, and applying outpatient-only restrictions (for example, diagnoses documented as "rule out," "probable," or "suspected" generally are not coded in outpatient the way they may be for inpatient reporting). ACDIS outpatient CDI education emphasizes teaching providers to document clearly the reason for visit, the assessment/clinical relevance of each condition addressed, and the linkage between conditions and services rendered so Section I and Section IV rules can be applied accurately for compliant reimbursement and reporting.

NEW QUESTION # 128

The primary purpose of the RADV program is to

- A. support accuracy of Evaluation and Management billing.
- **B. ensure risk-adjusted payment integrity and accuracy.**
- C. identify over-payments rendered to individual physicians.

- D. verify medical necessity of care provided.

Answer: B

Explanation:

RADV (Risk Adjustment Data Validation) is a CMS audit program used in Medicare Advantage to confirm that diagnoses submitted for risk adjustment are supported by medical record documentation and meet reporting requirements. Its central aim is payment integrity—ensuring that risk-adjusted capitation payments to Medicare Advantage organizations are accurate based on valid, documented conditions. In outpatient CDI practice, RADV risk underscores why documentation must clearly support each reported diagnosis (e.g., condition evaluated/assessed/treated, clinically relevant, and properly documented by an eligible provider), because unsupported diagnoses can lead to payment recoupment and compliance exposure. RADV is not designed to assess medical necessity of the services provided (that is typically addressed through utilization review and other payer audits), nor is it focused on identifying overpayments to individual physicians (it targets plan-level risk adjustment payments). It also is separate from E/M leveling accuracy, which is governed by CPT/E/M guidelines and distinct audit processes. Therefore, the best definition of RADV's primary purpose is ensuring the integrity and accuracy of risk-adjusted payments.

NEW QUESTION # 129

Which of the following physician performance metrics BEST illustrates provider engagement with outpatient CDI specialist?

- A. Problem list updates and RAF capture rates
- **B. Query response rates and problem list updates**
- C. Physician RAF scores and RAF capture rates
- D. Physician MIPS scores and query response rates

Answer: B

Explanation:

Provider engagement in an outpatient CDI program is best reflected by measures that show the provider is actively interacting with CDI processes and improving documentation behaviors in real time. Query response rates directly indicate whether the provider is reading and responding to CDI clarifications promptly and consistently, which is a fundamental engagement behavior and a key operational driver of documentation accuracy. Problem list updates further demonstrate sustained engagement because they reflect the provider's willingness to maintain an accurate, current list of active conditions (adding validated diagnoses, removing resolved problems, and updating specificity such as stage, severity, or laterality). Together, these two metrics show both immediate participation (responding to queries) and longer-term adoption of documentation best practices (maintaining the problem list). In contrast, RAF scores and RAF capture rates are influenced by patient complexity, payer mix, and coding capture processes, and may improve even without meaningful provider participation. MIPS scores reflect broader quality program performance and are not specific to CDI-provider interaction. Therefore, query responsiveness plus problem list maintenance most directly measures engagement with outpatient CDI.

NEW QUESTION # 130

In the outpatient setting, which of the following guidelines depicts the reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided?

- A. Differential diagnoses
- B. Principal diagnosis
- **C. First-listed diagnosis**
- D. Co-existing diagnoses

Answer: C

Explanation:

In outpatient and physician-office reporting, the diagnosis that best describes the main reason for the visit is reported as the first-listed diagnosis. Outpatient coding guidance emphasizes that the "principal diagnosis" concept is primarily an inpatient construct (the condition established after study to be chiefly responsible for admission). In ambulatory encounters, patients are often seen for evaluation, management, follow-up, or symptom assessment, so the coding framework uses first-listed to identify the condition, problem, or symptom chiefly responsible for the services provided during that encounter. Co-existing conditions may also be reported when they are addressed or affect care (e.g., monitored, evaluated, assessed/managed, or treated), but they do not replace the requirement to sequence the primary reason for the visit first. Differential diagnoses are not used as the "reason chiefly responsible" in outpatient coding unless a confirmed diagnosis is established; if uncertainty remains, symptoms may be reported

instead. Therefore, "first-listed diagnosis" is the correct term for the outpatient setting.

NEW QUESTION # 131

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