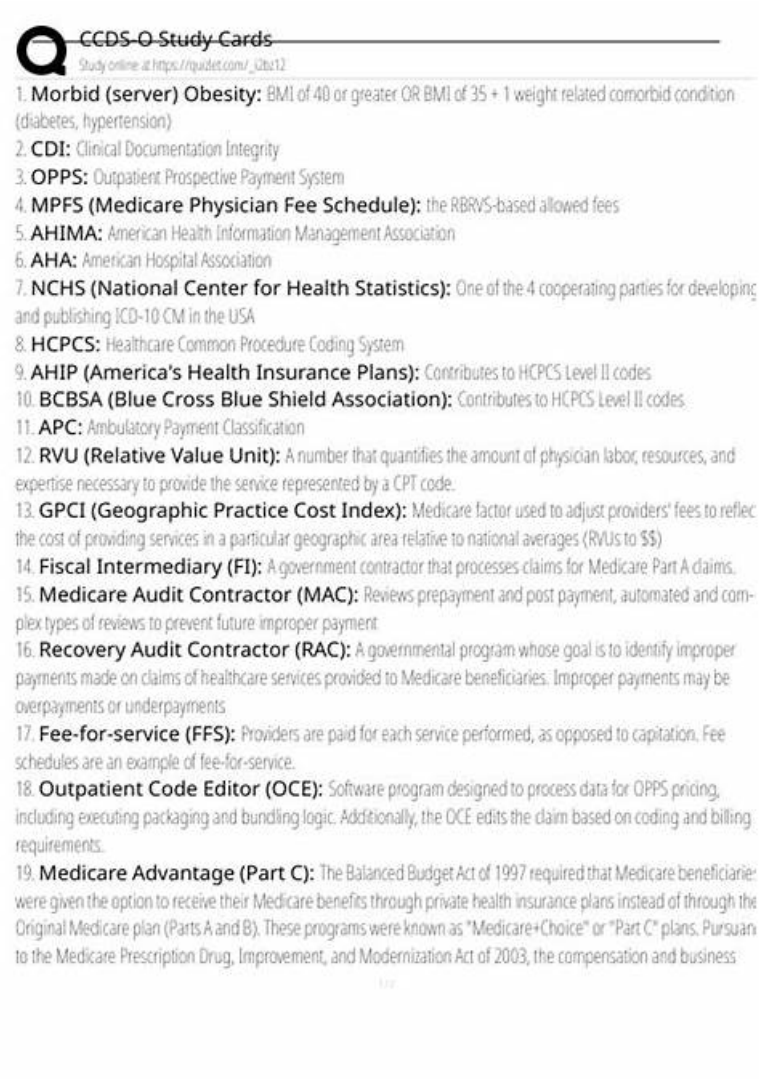
CCDS-O Guide Covers 100% Composite Exams


CCDS-O Study Cards

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1. **Morbid (server) Obesity:** BMI of 40 or greater OR BMI of 35 + 1 weight related comorbid condition (diabetes, hypertension)
2. **CDI:** Clinical Documentation Integrity
3. **OPPS:** Outpatient Prospective Payment System
4. **MPFS (Medicare Physician Fee Schedule):** the RBRVS-based allowed fees
5. **AHIMA:** American Health Information Management Association
6. **AHA:** American Hospital Association
7. **NCHS (National Center for Health Statistics):** One of the 4 cooperating parties for developing and publishing ICD-10 CM in the USA
8. **HCPCS:** Healthcare Common Procedure Coding System
9. **AHIP (America's Health Insurance Plans):** Contributes to HCPCS Level II codes
10. **BCBSA (Blue Cross Blue Shield Association):** Contributes to HCPCS Level II codes
11. **APC:** Ambulatory Payment Classification
12. **RVU (Relative Value Unit):** A number that quantifies the amount of physician labor, resources, and expertise necessary to provide the service represented by a CPT code.
13. **GPCI (Geographic Practice Cost Index):** Medicare factor used to adjust providers' fees to reflec the cost of providing services in a particular geographic area relative to national averages (RVUs to $$)
14. **Fiscal Intermediary (FI):** A government contractor that processes claims for Medicare Part A claims.
15. **Medicare Audit Contractor (MAC):** Reviews prepayment and post payment, automated and complex types of reviews to prevent future improper payment
16. **Recovery Audit Contractor (RAC):** A governmental program whose goal is to identify improper payments made on claims of healthcare services provided to Medicare beneficiaries. Improper payments may be overpayments or underpayments
17. **Fee-for-service (FFS):** Providers are paid for each service performed, as opposed to capitation. Fee schedules are an example of fee-for-service.
18. **Outpatient Code Editor (OCE):** Software program designed to process data for OPPS pricing, including executing packaging and bundling logic. Additionally, the OCE edits the claim based on coding and billing requirements.
19. **Medicare Advantage (Part C):** The Balanced Budget Act of 1997 required that Medicare beneficiarie were given the option to receive their Medicare benefits through private health insurance plans instead of through the Original Medicare plan (Parts A and B). These programs were known as "Medicare+Choice" or "Part C" plans. Pursuan to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the compensation and business

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You have to get the ACDIS CCDS-O certification that can keep your job safe and give you a rise in the competition. Success in the CCDS-O exam improves your rank at your workplace. The Certified Clinical Documentation Specialist-Outpatient (CCDS-O) certification exam helps to upgrade your skills and learn new technologies and applications which you can use in your live projects. If you are worried about how to prepare for the CCDS-O Certification Exam, just download BraindumpsIT real CCDS-O Dumps PDF and study well to crack it. Using the CCDS-O exam questions of BraindumpsIT is the easiest way to pass the Certified Clinical Documentation Specialist-Outpatient (CCDS-O) test.

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	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding

Topic 3	• and billing: Covers Official Coding Guidelines, OPPS reimbursement (APCs), and professional billing concepts including CPT E • M codes and Medicare Physician Fee Schedule documentation.

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q41-Q46):

NEW QUESTION # 41
Which of the following conclusions can be drawn from the impact of a CDI program on Clinic A using the table below?

- A. Treated a more complex population than any of the other clinics in 2023.
- B. Served a sicker population in 2023 than in 2022.
- C. Consistently captured a higher RAF percentage each month in 2023 than in 2022.
- D. Providers are more engaged in 2023 than in 2022.

Answer: C

Explanation:
The only conclusion that is directly supported by the table is that Clinic A's percent RAF captured is higher in every month of 2023 compared with the corresponding month in 2022. The monthly values rise year-over-year (e.g., January 21% vs 17%, February 33% vs 25%, and continuing through December 84% vs 76%), showing a consistent improvement pattern across the entire calendar year. In outpatient CDI and risk adjustment work, "RAF capture" is commonly used as a performance indicator reflecting how completely documented and coded risk-adjusting conditions (e.g., HCC-supported diagnoses) are being captured within the measurement period. However, the table does not prove why the improvement occurred. It cannot confirm provider engagement (A) without workflow/participation data, cannot compare to other clinics (B) because no other clinic data are shown, and cannot establish that the population was sicker (C) because RAF capture measures documentation/coding completeness relative to opportunity, not inherent patient acuity. Therefore, D is the verified conclusion.

NEW QUESTION # 42
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 be calculated based upon HCC 18 and HCC 23 because they were both documented and coded in the same calendar year.
- B. The risk score will be calculated based upon HCC 23 because it was captured first.
- C. The risk score will not be impacted by the presence of HCC 18 or HCC 23 because they are not currently being treated.
- D. The risk score will be calculated based upon HCC 18 because it has the highest weight in the hierarchy HCC 23.

Answer: D

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 # 43
A patient is scheduled to see his PCP in 3 days. A CDI specialist notes that during the patient's last visit earlier this year, the problem list shows both DM 2 associated erectile dysfunction and DM 2 without complications. The last clinic note states that DM 2 with autonomic neuropathy was addressed. The CDI specialist should do which of the following FIRST?

- A. Query the provider for the link between erectile dysfunction and DM 2
- B. Ask the patient if he still has DM 2 with autonomic neuropathy
- C. Remove DM 2 without complications from the problem list
- D. Query if the DM 2 is with or without complications

Answer: D

Explanation:
The record contains conflicting documentation: the problem list includes both "type 2 diabetes without complications" and diabetes with complications (erectile dysfunction association), while the most recent clinic note indicates the provider addressed "DM2 with autonomic neuropathy," which is clearly a diabetic complication. In outpatient CDI, the first priority is to resolve internal inconsistency so coding accurately reflects the patient's current clinical status and what was evaluated/managed at the encounter. A query should therefore focus on whether the patient's diabetes is with complications (and which complications are active/being addressed) versus truly without complications, because "without complications" is generally not appropriate when neuropathy/other manifestations are present and being managed. CDI staff also should not unilaterally remove items from the provider-maintained problem list, and asking the patient is not a reliable documentation/coding source for establishing diagnoses. Once the provider clarifies diabetes complication status, a follow-up clarification can address specific linkages (e.g., erectile dysfunction due to diabetes) if needed for correct code assignment

NEW QUESTION # 44
Provider documentation states: "A 72-year-old patient with an active history of colon cancer, status post bowel resection, receiving chemotherapy. Newly diagnosed lung metastasis. Presents with UTI and elevated creatinine. Labs demonstrate a hemoglobin of 7.9, WBC of 2,500, and platelet count of 20,000." Which of the following is the query opportunity that supports a disease interaction that impacts the risk adjustment?

- A. Colon cancer and lung metastasis
- B. Colon cancer and chemotherapy
- C. Acute tubular necrosis and UTI
- D. Chemotherapy induced pancytopenia

Answer: D

Explanation:
In outpatient risk adjustment, "disease interactions" refer to model coefficients that are triggered when certain clinically related conditions co-exist, reflecting higher expected resource use than either condition alone. In this case, the record already supports active malignancy care (colon cancer on chemotherapy) with newly documented metastasis, and the lab pattern (anemia, leukopenia, and severe thrombocytopenia) strongly suggests pancytopenia. The highest-yield query opportunity is to clarify whether the cytopenias represent chemotherapy-induced pancytopenia (or another specified etiology) because a confirmed, well-specified hematologic complication in the context of active cancer treatment is the type of combination that commonly drives interaction effects in risk models (cancer plus significant systemic complication/manifestation). Options A and B describe clinical context but do not, by themselves, establish an interaction-ready, separately reportable complication. Option C is unrelated to the presented lab-driven severity signal. Querying and documenting chemotherapy-induced pancytopenia supports accurate capture of severity and the interaction impact.

NEW QUESTION # 45
A patient returns to a PCP for follow-up care related to a UTI. The provider documents "stage 3 CKD" as determined by a single eGFR of 52 mL/min. Which of the following actions should the CDI specialist take?

- A. Add diagnosis of CKD stage 3 to claim, as it is reportable.
- B. Delete CKD diagnosis from claim as it was not treated during this encounter.
- C. Query for stage 4 CKD.
- D. Review CKD staging criteria with provider.

Answer: D

Explanation:
The CDI specialist should review CKD staging criteria with the provider because assigning CKD based on a single eGFR value can be clinically unreliable and may lead to inaccurate documentation and coding. Outpatient CDI guidance emphasizes that documentation must reflect a condition that is clinically valid, supported by the record, and accurately described, especially for chronic diseases. CKD is generally established by evidence of decreased kidney function or kidney damage that is persistent, not a one-time lab that could be affected by hydration status, acute illness, medications, or transient physiologic changes. While an eGFR of 52 falls within the numeric range commonly associated with stage 3a, the key CDI issue is the foundation for diagnosing chronic disease, not simply whether the number is "reportable." Option A inappropriately directs CDI to add diagnoses to claims; CDI supports providers and coding, but does not independently "add" conditions. Option C is incorrect because chronic conditions may be coded when addressed/impact care, not only when actively treated. Option D is unsupported because eGFR 52 does not suggest stage 4.

NEW QUESTION # 46
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