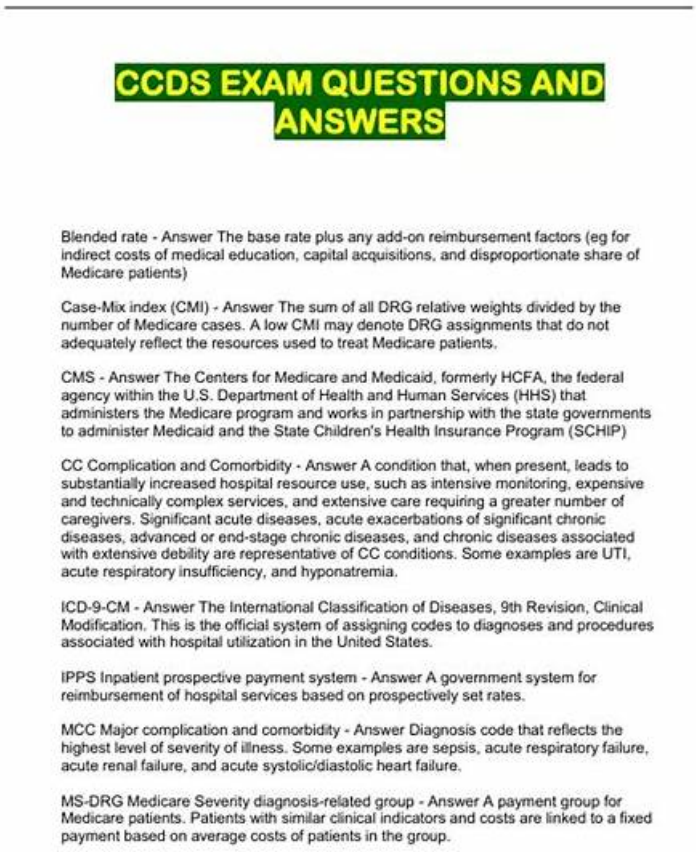
CCDS-O Questions of the Highest Quality - Unlock Your Success



CCDS EXAM QUESTIONS AND ANSWERS

Blended rate - Answer The base rate plus any add-on reimbursement factors (eg for indirect costs of medical education, capital acquisitions, and disproportionate share of Medicare patients)

Case-Mix index (CMI) - Answer The sum of all DRG relative weights divided by the number of Medicare cases. A low CMI may denote DRG assignments that do not adequately reflect the resources used to treat Medicare patients.

CMS - Answer The Centers for Medicare and Medicaid, formerly HCFA, the federal agency within the U.S. Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with the state governments to administer Medicaid and the State Children's Health Insurance Program (SCHIP)

CC Complication and Comorbidity - Answer A condition that, when present, leads to substantially increased hospital resource use, such as intensive monitoring, expensive and technically complex services, and extensive care requiring a greater number of caregivers. Significant acute diseases, acute exacerbations of significant chronic diseases, advanced or end-stage chronic diseases, and chronic diseases associated with extensive debility are representative of CC conditions. Some examples are UTI, acute respiratory insufficiency, and hyponatremia.

ICD-9-CM - Answer The International Classification of Diseases, 9th Revision, Clinical Modification. This is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States.

IPPS Inpatient prospective payment system - Answer A government system for reimbursement of hospital services based on prospectively set rates.

MCC Major complication and comorbidity - Answer Diagnosis code that reflects the highest level of severity of illness. Some examples are sepsis, acute respiratory failure, acute renal failure, and acute systolic/diastolic heart failure.

MS-DRG Medicare Severity diagnosis-related group - Answer A payment group for Medicare patients. Patients with similar clinical indicators and costs are linked to a fixed payment based on average costs of patients in the group.

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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• 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 2	• 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 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	• 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.

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q87-Q92):

NEW QUESTION # 87
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. Review CKD staging criteria with provider.
- B. Delete CKD diagnosis from claim as it was not treated during this encounter.
- C. Query for stage 4 CKD.
- D. Add diagnosis of CKD stage 3 to claim, as it is reportable.

Answer: A

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 # 88
A provider has been determined to be a high-cost provider after a total claims cost analysis. The provider's patient panel has an overall low HCC average score. Which of the following is the MOST likely explanation regarding the low HCC average score?

- A. The provider is failing to capture all relevant diagnoses
- B. The provider has a less complex patient population
- C. The provider is not reporting unspecified diagnoses
- D. The provider cares for patients of a higher acuity

Answer: A

Explanation:

In the CMS-HCC risk adjustment framework, the HCC average score reflects the coded burden of illness for the provider's attributed panel, driven by documented, reportable conditions that map to HCCs and qualifying demographic factors. If a provider appears "high cost" based on total claims but the panel's average HCC score is low, the most common CDI interpretation is documentation/coding under-capture: the clinical complexity driving utilization is not being fully documented and coded to HCC-relevant diagnoses. This creates a mismatch-actual resource use is high, but the recorded risk profile is artificially low-leading to unfavorable benchmarking because costs are compared against an expected spend that is too low for the true acuity. Option A would typically raise HCC scores, not lower them. Option C could explain both low HCC and low cost; it conflicts with the high-cost finding. Option D misunderstands HCC mechanics: "unspecified" does not reliably increase HCC capture and often reduces coding specificity/validity rather than improving risk adjustment. Therefore, incomplete capture of relevant diagnoses is the most likely driver.

NEW QUESTION # 89
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. Acuity of the COPD
- B. Presence of chronic respiratory failure
- C. Specificity of the organism causing the pneumonia
- D. Oxygen dependence

Answer: B

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 # 90
The majority of E/M services are based on which of the following criteria?

- A. New/established, level of service, and age of patient
- B. New/established, site of service, and level of service
- C. New/established, site of service, and time
- D. New/established, physician specialty, and level of service

Answer: B

Explanation:
In outpatient CDI and coding education, selecting the correct E/M code starts with identifying the encounter category (e.g., office/outpatient vs inpatient/observation vs ED) and whether the patient is new or established, because these define the applicable CPT code range. Next, the level of service is selected within that range based on the documentation supporting the required elements for that code family. For most E/M services, "site of service" (place/setting) and "new vs established" are foundational code-selection drivers, while "level" is determined by the record's support for the applicable leveling methodology (commonly medical decision making and, when allowed/appropriate, time). Time can be a valid leveling method for many office/outpatient E/M visits, but it is not universally the basis for the majority of E/M services across all categories; it is an alternative pathway when documentation supports it. Physician specialty and patient age do not define the majority of E/M code selection. Therefore, the best overall statement is new/established status + site of service + level of service.

NEW QUESTION # 91

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

Answer: C

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 # 92
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