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ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	• and billing: Covers Official Coding Guidelines, OPPS reimbursement (APCs), and professional billing concepts including CPT E • M codes and Medicare Physician Fee Schedule documentation.
Topic 2	• Healthcare regulations, reimbursement, and documentation requirements related to the Official Guidelines for
Topic 3	• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding
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.
Topic 5	• 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.

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ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q73-Q78):

NEW QUESTION # 73
A patient presents to the clinic for follow up of type 2 diabetes. The patient is also noted to have peripheral neuropathy. The patient has COPD and is found to have no recent exacerbations. The patient also has a history of depression, reported as stable. Which of the following CMS-HCCs will be captured for this visit?
HCC 17: Diabetes with Acute Complications
HCC 18: Diabetes with Chronic Complications
HCC 19: Diabetes without Complications
HCC 58: Major Depressive, Bipolar and Paranoid Disorders
HCC 111: Chronic Obstructive Pulmonary Disease

- A. HCC 17 and HCC 58
- B. HCC 18 and HCC 111
- C. HCC 19, HCC 58, and HCC 111
- D. HCC 18, HCC 19, and HCC 111

Answer: B

Explanation:
In the CMS-HCC model, diabetes categories are hierarchical, meaning you capture the highest supported diabetes HCC for the year, not multiple diabetes HCCs simultaneously. Type 2 diabetes with peripheral neuropathy represents a chronic diabetic complication, so it maps to HCC 18 (Diabetes with Chronic Complications) rather than HCC 19 (without complications) or HCC 17 (acute complications). COPD is documented as present and clinically relevant (even without an exacerbation) and therefore maps to HCC 111 (Chronic Obstructive Pulmonary Disease) when it is assessed/managed as part of the visit. "History of depression, stable" does not necessarily meet the threshold for HCC 58, which is reserved for specific serious psychiatric diagnoses (e.g., major depressive disorder, bipolar disorder, paranoid disorders). A general "depression" history, especially if not specified as major depressive disorder and not actively addressed, often will not support HCC 58 capture. Therefore, the visit captures HCC 18 and HCC 111 only.

NEW QUESTION # 74
Which of the following contributes to the risk adjustment score under the CMS-HCC model?

- A. Enrollment eligibility status and reported conditions
- B. Income status and disability status
- C. Cost of care provided and hospital readmissions
- D. Health status and previous risk score

Answer: A

Explanation:
Under the CMS-HCC risk adjustment methodology, the RAF is calculated primarily from two categories of inputs: (1) demographic/enrollment eligibility factors and (2) diagnosis codes that map to HCCs based on documented, reportable conditions. Eligibility status matters because Medicare models differentiate beneficiaries by factors such as aged versus disabled status and other enrollment characteristics that affect expected cost. The second major driver is the set of valid, supported ICD-10-CM codes reported for the beneficiary during the data collection period; only certain chronic, clinically significant conditions map to HCCs, and they must be documented as active and applicable to the encounter and coded correctly. In ambulatory CDI, this is why accurate

condition capture, specificity, and linkage (e.g., cause/manifestation relationships) are emphasized-because reported conditions directly affect the patient's risk profile and the expected cost benchmark. By contrast, income status is not a standard CMS-HCC input, "previous risk score" is not itself an input variable, and utilization outcomes like cost of care or readmissions are not used to compute RAF (they may be evaluated separately in quality/cost programs).

NEW QUESTION # 75
A CDI specialist read the most recent AHA Coding Clinic that provided updated guidance related to a prior AHA Coding Clinic. The CDI specialist should

- A. follow the initial Coding Clinic advice for remainder of the fiscal year.
- B. utilize the updated Coding Clinic advice from published date forward.
- C. employ the updated Coding Clinic advice to relevant cases discharged last year.
- D. apply the initial Coding Clinic advice to relevant cases in that calendar year only.

Answer: B

Explanation:
AHA Coding Clinic guidance functions as an authoritative interpretive resource for correct ICD-10-CM/PCS code assignment when official guidelines or code descriptors need clarification. When Coding Clinic publishes an update that revises, clarifies, or supersedes earlier advice, outpatient CDI practice is to operationalize the newest guidance prospectively-meaning it should be applied going forward from the publication/effective timeframe of that update. This supports consistent, defensible coding and reduces compliance risk by aligning current reporting with the most current official interpretation. Applying the original advice for a calendar or fiscal year (choices A and B) is not how Coding Clinic updates are intended to be implemented; the governing principle is "most current advice controls" once released. Similarly, automatically applying updated guidance retroactively to cases from last year (choice D) is not routine CDI practice; retrospective rebilling or recoding is typically limited, policy-driven, and subject to payer rules, auditing constraints, and organizational compliance decisions. Therefore, the best action is to use the updated Coding Clinic guidance from the date it is published/implemented forward.

NEW QUESTION # 76
An elderly patient with a PMH of CHF, DM type 1, arthritis, and HTN is seen in the clinic for a follow-up appointment after a recent hospitalization. After an evaluation of the patient's current health status, the provider documents the following: "HFrEF: lungs clear, no edema, continue meds. DM: no changes to insulin pump. Arthritis: asymptomatic joint destruction. HTN: BP stable. Continue meds." Which of the following is the clarification opportunity in the above scenario?

- A. A link between the DM and arthritis
- B. The insulin status
- C. A link between HTN and heart failure
- D. The type and severity of heart failure

Answer: C

Explanation:
This encounter documents both hypertension and heart failure management, creating a key outpatient documentation/coding clarification opportunity: whether the heart failure is related to hypertension (hypertensive heart disease with heart failure). Outpatient CDI principles emphasize capturing the true clinical relationships that affect code assignment, risk adjustment, and longitudinal disease management. When HTN and HF coexist, coding may require combination coding and correct sequencing, plus an additional heart failure code to describe the specific HF type. Provider documentation that explicitly links (or explicitly rules out) a causal relationship supports compliant selection of the most accurate diagnosis codes and reduces ambiguity during chart review. The other options are weaker: the provider already documents HFrEF (type), and while added severity detail can help, the scenario's primary clarification "opportunity" is the HTN-HF relationship. DM type 1 inherently involves insulin, so "insulin status" is not the key outpatient clarification point here, and there is no typical direct linkage between DM and arthritis supported by the note.

NEW QUESTION # 77
Which of the following is a form of a cardiac condition that may be treated with a beta-blocker?

- A. Coronary artery disease
- B. Sinus bradycardia

- C. Cardiomyopathy
- D. Third degree heart block

Answer: A

Explanation:
Beta-blockers are commonly used in the management of coronary artery disease (CAD) because they lower heart rate, decrease myocardial contractility, and reduce oxygen demand-key goals in treating stable angina and in secondary prevention after myocardial infarction. In outpatient chart review, ACDIS-focused clinical documentation education emphasizes linking the medication to the condition being managed (e.g., "CAD with angina-on metoprolol for symptom control" or "history of MI-on beta-blocker for secondary prevention") to support accurate diagnosis reporting and demonstrate ongoing assessment and treatment. By contrast, third-degree (complete) heart block and sinus bradycardia are conditions where beta-blockers are typically avoided or used only with extreme caution because they can worsen conduction delay and slow the heart rate further. Cardiomyopathy can sometimes be treated with certain evidence-based beta-blockers when the clinical context is systolic heart failure, but the option most broadly and reliably associated with beta-blocker treatment in standard outpatient practice and documentation is CAD.

NEW QUESTION # 78
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