EXAMS 4 SUCCESS

ACDIS

CCDS-O

Questions & Answers

Certified Clinical Documentation Specialist-Outpatient

(Demo Version - Limited Content)

Question: 1

Which of the following is the major difference between MIPS and APMs?

A. MIPS participation is required by eligible providers (non-participation results in a financial penalty), and APM participation is voluntary.

B. APM participation is required by eligible providers (non-participation results in a financial penalty), and MIPS participation is voluntary.

C. MIPS and APM participation is voluntary by eligible providers.

D. MIPS and APM participation is required of eligible providers.

Answer: A

Explanation:

MIPS (Merit-based Incentive Payment System) is the default Medicare Quality Payment Program pathway for most eligible clinicians who are not sufficiently participating in an Advanced APM. In practice, if a clinician is MIPS-eligible and does not meet reporting requirements (or performs poorly), Medicare applies a negative payment adjustment—so "non-participation" effectively carries financial risk. APMs (Alternative Payment Models), especially Advanced APMs, are not automatically required for all clinicians; they are model-based arrangements (often tied to specific payers, contracts, patient populations, and risk/quality terms) that clinicians typically enter through organizational participation decisions. A key operational difference emphasized in outpatient CDI education is that MIPS performance hinges on accurate, complete documentation supporting quality measures and resource use across a broad clinician population, whereas APM participation depends on being in a qualifying model and meeting its participation/threshold rules. Therefore, MIPS functions as the required/default track with potential penalties, while APM participation is elective and model-dependent.

Question: 2

review]

A 76-year-old patient presents for a wellness visit. The patient's vitals are BP 120/80, T 98.7, R 19,

and there are no abnormal findings in the exam. The patient has COPD, home oxygen, anemia, hypertension, diabetes, fatigue, and weakness. The patient's medications are called into the pharmacy and home health resource of choice. Which of the following is the BEST query option?

A. Acute blood loss anemia

B. Peripheral neuropathy

C. Chronic respiratory failure

D. CKD

Answer: C

Explanation:

The best query is chronic respiratory failure because home oxygen is a strong clinical indicator that often reflects an underlying chronic hypoxemic condition beyond uncomplicated COPD. Outpatient CDI guidance stresses that queries should be driven by present clinical indicators in the note and should seek clarification that impacts accurate diagnosis capture and ongoing care. Here, the provider documents COPD plus home oxygen and is arranging continued services (medication management and home health), which supports asking whether the patient has a reportable condition such as chronic respiratory failure with hypoxia (or COPD with chronic hypoxemia) and whether it is being monitored/managed. The other options lack support: acute blood loss anemia has no bleeding, hemodynamic instability, or acute findings; peripheral neuropathy is not assessed or described despite diabetes; and CKD has no labs, staging, history, or assessment. A compliant query would be non-leading and include the indicator (home O_2) and request the most accurate diagnosis and specificity/status.

Question: 3

A patient with a PMH of DM, GERD, and HTN is seen in the clinic with complaints of stuffy nose, fever, and feeling tired for the past four days. The patient's medication list includes SSI, Prilosec, and Diovan. The provider documented: "Congestion, fever, malaise, DM, GERD, HTN. Continue OTC medications for congestion and fever. Rest. Return to the clinic in one week if symptoms persist." Which of the following ICD-10-CM guidelines BEST applies to how this scenario should be coded?

A. Selection of first-listed condition

B. Codes that describe symptoms and signs

C. Uncertain diagnoses

D. Encounters for general medical examination with abnormal finding

Answer: B

Explanation:

In the outpatient setting, when the provider does not document a definitive diagnosis for the acute complaint (e.g., influenza, sinusitis, URI), ICD-10-CM guidance directs coders to report the signs and symptoms that are documented and addressed. Here, the clinician documents congestion, fever, and malaise and provides treatment instructions for those symptoms (OTC meds, rest, follow-up). That makes the symptom codes the most appropriate representation of the reason for the encounter. Outpatient CDI principles further emphasize that chronic conditions like DM, GERD, and HTN should only be coded when the documentation shows they were evaluated, monitored, assessed/managed, or treated during the visit (e.g., status, control, medication adjustment, related testing, counseling). In this note, the plan targets only the acute symptoms and does not demonstrate active management of the chronic conditions beyond listing history/medications. Therefore, the guideline most directly applicable to correct coding of the encounter is codes that describe symptoms and signs.

Question: 4

review]

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. Review CKD staging criteria with provider.

C. Delete CKD diagnosis from claim as it was not treated during this encounter.

D. Query for stage 4 CKD.

Answer: B

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.

Question: 5

The table below provides data indicating the use of Major Depressive Disorder (MDD) diagnosis code assignment for years 1 and 2 of an ambulatory CDI program. Based on the data and if the HCC value assigned to MDD was 0.299, which of the following should be inferred?

A. The number of patients increased with an equal increase in use of MDD specified and a decrease in MDD, unspecified, not impacting future cost benchmarking.

B. The number of patients increased with an increase in use of MDD specified and a decrease in MDD, unspecified, impacting future cost benchmarking.

C. The number of patients increased with the difference between MDD specified and MDD, unspecified insignificant, not impacting future cost benchmarking.

D. The number of patients increased with an increase in use of MDD specified and an increase in MDD, unspecified, impacting future cost benchmarking.

Answer: B

Explanation:

Year 2 shows a higher total volume of MDD diagnoses (185,090 vs. 155,501), but the key CDI signal is the shift in coding specificity: “MDD, specified” increases substantially (118,516 vs. 76,318), while “MDD, unspecified” decreases (66,574 vs. 79,193). In outpatient CDI terms, this pattern is consistent with improved documentation quality and code capture—providers are describing the condition with greater clinical detail (episode type, severity, remission status, recurrence, etc.), allowing assignment of more specific ICD codes. When an HCC value (0.299) is associated with MDD, improved capture of qualifying, specific MDD codes supports more accurate risk adjustment. That increases the accuracy of projected resource need and affects future cost benchmarking (and potentially quality/utilization comparisons) because the population’s documented burden of illness is better represented. Therefore, the appropriate inference is increased patients plus increased “specified” use and decreased “unspecified,” with an impact on future benchmarking.

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