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Q&A

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Exam : CCDS-O

Title : Certified Clinical
Documentation Specialist-
Outpatient (CCDS-O)

Version : DEMO

1. Which of the following categories of MIPS is MOST impacted by CDI provider education around specificity with diagnoses and documentation?

- A. Quality and cost
- B. Cost and improvement activity
- C. Improvement activity and promoting interoperability
- D. Quality and promoting interoperability

Answer: A

Explanation:

CDI education focused on diagnosis specificity and complete, clinically supported documentation most directly influences the Quality and Cost performance categories. In the Quality category, many measures depend on correct identification of eligible patient populations (denominators), exclusions, and risk adjustment. When providers document conditions precisely (e.g., specific heart failure type, diabetes complications, CKD stage), it improves the accuracy of coded data that underpins measure calculations and risk stratification. In the Cost category, CMS uses claims-based methodologies that compare observed versus expected costs; accurate diagnosis capture affects patient complexity and risk adjustment, which can materially change expected cost targets and episode attribution. ACDIS outpatient CDI principles emphasize that incomplete or vague documentation can make patients appear less complex than they are, potentially worsening both quality comparisons and cost benchmarks. By contrast, Promoting Interoperability is driven primarily by EHR use and electronic processes, and Improvement Activities reflect practice transformation/engagement rather than diagnosis specificity. Therefore, Quality and Cost are the MIPS categories most impacted by CDI education on specificity.

2. Which of the following concepts BEST reflects how risk adjustment is related to cost efficiency metrics?

- A. It is directly calculated from provider E&M levels.
- B. It is applied to resource utilization measures.
- C. It is related to physician time spent with patient.
- D. It is supported by interventions and procedures.

Answer: B

Explanation:

Risk adjustment is used to make cost and efficiency comparisons fair by accounting for differences in patient severity and expected resource needs. In outpatient CDI, accurate documentation and coding of chronic and acute conditions (especially risk-adjusting diagnoses such as HCC-relevant conditions) directly influence the risk profile assigned to a patient population. That risk profile is then applied when evaluating utilization and cost measures—such as total cost of care, inpatient admissions, ED use, and other resource consumption—so that providers or groups caring for more complex patients are not inappropriately labeled as inefficient simply because their patients require more services. This aligns with option B: risk adjustment is applied to resource utilization measures.

Option A is incorrect because E&M levels are a professional billing construct and are not the basis for risk score calculation.

Option C is incorrect because physician time may affect E&M selection under certain rules, but it is not the mechanism for risk adjustment in cost efficiency analytics.

Option D is incorrect because procedures/interventions describe services rendered, not the adjustment methodology itself.

3. A prospective record review of a problem list states: “Upper respiratory infection (resolved), fractured right femoral head (resolved), metastatic melanoma (followed by oncology), hypertension, morbid obesity, and bipolar disorder.”

Which of the following query opportunities would provide the highest risk adjusted impact?

- A. Body mass index
- B. Sequelae related to fracture femur
- C. Specificity of bipolar disorder
- D. Status of metastatic melanoma

Answer: D

Explanation:

In ambulatory CDI risk adjustment, the largest RAF impact typically comes from ensuring accurate capture of high-weight, HCC-relevant chronic conditions—especially active malignancies with metastasis. “Metastatic melanoma (followed by oncology)” suggests an ongoing, clinically significant condition, but the wording could represent active metastatic disease, history of metastatic disease, remission, or no current evidence of disease. Because HCC models distinguish active metastatic cancer from history-only status, clarifying the current status (active/under treatment, recurrent, in remission, history) can materially change whether the condition qualifies for risk adjustment and how the patient’s expected cost is benchmarked. By comparison, adding BMI (when morbid obesity is already documented) generally does not increase HCC capture, and fracture sequelae typically does not drive HCC risk scoring in the same way. Bipolar disorder may map to an HCC, but its relative impact is generally lower than metastatic cancer, making melanoma status the highest-value clarification.

4. A patient is seen at the clinic for a fever, and the provider documents possible Zika virus. A CDI specialist reviews the record and notes that a positive serology test indicates the Zika virus.

Which of the following should the CDI specialist do NEXT?

- A. Code the Zika virus as the reason for the visit.
- B. Query the provider to code the result of the serology test.
- C. Query the provider to confirm the diagnosis of Zika.
- D. Code the fever as the first-listed diagnosis and Zika virus as secondary.

Answer: C

Explanation:

In the outpatient setting, diagnoses documented as uncertain (e.g., “possible,” “probable,” “suspected,” “rule out”) are generally not coded as confirmed conditions; instead, coding is based on confirmed diagnoses or, when not confirmed, the presenting signs/symptoms. Here, the provider documented only “possible Zika,” which is not a confirmed diagnosis for outpatient reporting. Even though the CDI specialist sees a positive serology result, lab data alone does not replace provider diagnostic confirmation in the assessment/plan. The appropriate next step is to query the provider to confirm whether Zika is the established diagnosis based on the positive test (and whether it is clinically addressed during the encounter). If confirmed, Zika can be coded appropriately and sequenced based on the reason for the visit; if not confirmed or still under evaluation, the symptom (fever) remains first-listed.

Option B is incorrect because coders do not “code the result” of a serology test as a diagnosis; they code the condition the test supports once clinically confirmed.

5. Which of the following adds weight to the risk score over and above the CMS-HCC weights for individual conditions?

- A. Hierarchies
- B. Disease interactions
- C. Resource-based relative values
- D. Conversion factors

Answer: B

Explanation:

In the CMS-HCC risk adjustment methodology, each qualifying condition maps to an HCC with an associated coefficient (weight). However, CMS also recognizes that certain combinations of conditions can drive costs and complexity more than the simple sum of individual HCC weights. To account for this, the model includes disease interaction terms—additional coefficients applied when specific conditions coexist in the same beneficiary (for example, selected interactions involving diabetes and particular complications, or other defined pairings). This is why outpatient CDI focuses not only on capturing each chronic condition accurately, but also ensuring both conditions are clearly documented as assessed/managed and meet reporting requirements, because capturing both can legitimately trigger interaction weights. By contrast, hierarchies primarily prevent double-counting within related disease groups by allowing the most severe manifestation to “trump” a less severe one; this generally controls/limits weight rather than adding extra. Resource-based relative values and conversion factors are physician fee schedule payment components (RVUs and payment calculation), not HCC risk scoring elements. Therefore, disease interactions are the correct answer.