

ACDIS.CCDS-O.v2026-06-02.q56

Exam Code:	CCDS-O
Exam Name:	Certified Clinical Documentation Specialist-Outpatient
Certification Provider:	ACDIS
Free Question Number:	56
Version:	v2026-06-02
# of views:	130
# of Questions views:	560
https://www.freepdfdumps.com/ACDIS.CCDS-O.v2026-06-02.q56.html	

NEW QUESTION: 1

A 62-year-old female with history of HTN, CAD, chronic cough and obesity is seen by her PCP. Which of the following treatment plans may result in a query?

- A. Diagnostic chest x-ray
- B. A visit with a nutrition specialist
- C. Order placed for hemoglobin A1c (HbA1c)
- D. Prescription written for the ACE inhibitor captopril

Answer: C (LEAVE A REPLY)

In outpatient CDI practice, a common reason to query is a mismatch between what is being evaluated/treated and what is explicitly documented as an active condition for the encounter. A diagnostic chest x-ray aligns with the already-documented symptom (chronic cough), and a nutrition specialist referral aligns with an established diagnosis (obesity); neither inherently suggests an undocumented condition. Prescribing captopril aligns with documented HTN management, so it generally would not create documentation ambiguity requiring clarification (even though ACE inhibitors can be associated with cough, the plan alone does not establish a new reportable diagnosis). In contrast, ordering an HbA1c often signals assessment for diabetes, impaired glucose regulation, or monitoring of known diabetes. Because diabetes is not listed in the history provided, the HbA1c order may prompt the CDI specialist to query whether the provider is evaluating a suspected or existing glycemic disorder, whether there is a diagnosis such as prediabetes/diabetes being addressed, and to ensure the record clearly supports the medical necessity and any reportable condition.

NEW QUESTION: 2

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 19, HCC 58, and HCC 111

B. HCC 18 and HCC 111

C. HCC 17 and HCC 58

D. HCC 18, HCC 19, and HCC 111

Answer: B (LEAVE A REPLY)

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: 3

In the outpatient setting, which of the following guidelines depicts the reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided?

A. Differential diagnoses

B. Co-existing diagnoses

C. Principal diagnosis

D. First-listed diagnosis

Answer: D (LEAVE A REPLY)

In outpatient and physician-office reporting, the diagnosis that best describes the main reason for the visit is reported as the first-listed diagnosis. Outpatient coding guidance emphasizes that the "principal diagnosis" concept is primarily an inpatient construct (the condition established after study to be chiefly responsible for admission). In ambulatory encounters, patients are often seen for evaluation, management, follow-up, or symptom assessment, so the coding framework uses first-listed to identify the condition, problem, or symptom chiefly responsible for the services provided during that encounter. Co-existing

conditions may also be reported when they are addressed or affect care (e.g., monitored, evaluated, assessed/managed, or treated), but they do not replace the requirement to sequence the primary reason for the visit first. Differential diagnoses are not used as the "reason chiefly responsible" in outpatient coding unless a confirmed diagnosis is established; if uncertainty remains, symptoms may be reported instead. Therefore, "first-listed diagnosis" is the correct term for the outpatient setting.

NEW QUESTION: 4

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: ([SHOW ANSWER](#))

CMS-HCC risk adjustment assigns a baseline coefficient (weight) to each qualifying HCC condition, but certain combinations of conditions can increase predicted cost beyond what would be expected by simply adding the two individual weights. These added increments are captured through disease interaction factors, which apply when specific conditions coexist (for example, diabetes with certain severe complications, or other paired conditions defined by the model). In outpatient CDI, this is why documentation must clearly support both diagnoses-each must be clinically evaluated/managed and meet reporting rules-because accurately capturing the interacting conditions can legitimately increase the beneficiary's risk score. By contrast, hierarchies are designed to prevent double-counting within related condition families (the more severe manifestation typically supersedes a less severe one), which often limits-not adds-separate weights. Resource-based relative values and conversion factors belong to physician fee schedule payment methodology for services/procedures (RVUs and payment conversion), not HCC risk score calculation. Therefore, disease interactions are the correct concept that adds risk score weight beyond individual HCC coefficients.

NEW QUESTION: 5

A record review conducted prior to a primary care appointment indicates a patient has been followed for history of colon cancer. The patient is 18 months s/p bowel resection and is under treatment for LLE DVT, which required monitoring of INR - on Coumadin. The problem list also includes obesity, obstructive sleep apnea (OSA), COPD, and hypertension. Which of the following is the query opportunity?

- A.** Status of ostomy
- B.** Status of the sleep apnea
- C.** Status of the COPD
- D.** Status of colon cancer

Answer: D (LEAVE A REPLY)

In outpatient CDI, a prime query opportunity is any diagnosis with unclear "status" that materially affects coding, risk adjustment, surveillance, and care planning. "History of colon cancer" paired with "18 months s/p bowel resection" creates ambiguity: the provider must clarify whether the malignancy is still active (current disease, recurrence, metastasis, ongoing treatment) versus no longer present (history of malignancy, in remission, disease-free status, post-treatment surveillance only). This distinction changes code selection substantially and prevents inappropriate reporting of an active cancer when the encounter is actually follow-up after curative treatment. By contrast, ostomy status is not documented as present, and OSA/COPD "status" may be clinically useful but is not inherently ambiguous from the prompt in the same way (they are listed as chronic problems without a conflicting timeline event). ACDIS outpatient CDI practice prioritizes clarifying cancer status because it impacts longitudinal documentation integrity, accurate problem list management, and compliant diagnosis reporting at each visit.

NEW QUESTION: 6

Symbicort is used to treat which of the following conditions?

- A. Degenerative osteoarthritis
- B. Persistent asthma
- C. Diabetic neuropathy
- D. Congestive heart failure

Answer: B (LEAVE A REPLY)

Symbicort is an inhaled combination medication containing an inhaled corticosteroid (ICS) and a long-acting beta-agonist (LABA). In outpatient chart review, this medication class is most strongly associated with chronic airway inflammatory diseases requiring controller therapy-especially persistent asthma (and also maintenance therapy for COPD, though COPD is not an option here). For CDI purposes, medication-to-diagnosis linkage can act as a clinical indicator supporting clarification when the visit note lists respiratory symptoms but does not clearly document the chronic condition being treated or its acuity/status. Symbicort is not used to treat musculoskeletal degenerative disease (osteoarthritis), peripheral nerve pain from diabetes (diabetic neuropathy), or cardiac pump failure (congestive heart failure). When Symbicort appears on the active med list, outpatient CDI commonly checks that the provider's documentation appropriately reflects asthma classification (intermittent vs persistent), current control, exacerbation status if applicable, and that the condition is being monitored/assessed/treated during the encounter to support reportability and accurate coding.

NEW QUESTION: 7

Which of the following conditions or findings supports a diagnosis of diabetes?

- A. 2-hour blood sugar level of 90 during oral glucose tolerance test
- B. Hemoglobin A1c (HbA1c) level of 7.0%

C. Hypoglycemia

D. Fasting glucose of 100

Answer: B (LEAVE A REPLY)

In outpatient clinical documentation and chart review, diabetes can be supported by recognized diagnostic thresholds. An HbA1c value reflects average blood glucose over approximately the prior 2-3 months and is commonly used to diagnose and monitor diabetes. An HbA1c $\geq 6.5\%$ (when confirmed per clinical practice standards and interpreted in the appropriate clinical context) supports a diagnosis of diabetes; therefore an HbA1c of 7.0% clearly meets the threshold and supports diabetes. By comparison, a 2-hour OGTT value of 90 mg/dL is normal and does not support diabetes (diabetes is typically supported when the 2-hour value is ≥ 200 mg/dL). Hypoglycemia is low blood glucose and is not diagnostic of diabetes; it may occur in diabetics due to treatment but can also occur in non-diabetics for many reasons. A fasting glucose of 100 mg/dL is at most borderline/prediabetes range and does not meet diagnostic criteria for diabetes (diabetes is supported at ≥ 126 mg/dL).

NEW QUESTION: 8

What is the goal of an MSSP program?

A. Optimize risk score

B. Share in savings

C. Improve transitions of care

D. Increase fee schedule payment

Answer: (SHOW ANSWER)

The Medicare Shared Savings Program (MSSP) is designed to move reimbursement away from pure volume-based payment and toward value by rewarding organizations that reduce the total cost of care for an assigned Medicare population while meeting defined quality performance requirements. In MSSP, eligible provider groups participate as Accountable Care Organizations (ACOs) and are compared against a financial benchmark. If the ACO's actual spending comes in below the benchmark and quality standards are achieved, the ACO can earn a portion of the savings-hence "shared savings." Outpatient CDI supports MSSP success by ensuring documentation accurately reflects patients' true disease burden (supporting appropriate risk adjustment for benchmarking), and that conditions addressed during visits are clearly documented as evaluated/managed to support reliable coding and quality measurement. While improving transitions of care may be a strategy that helps achieve savings and quality goals, it is not the core purpose of the program itself. Likewise, MSSP is not intended to increase fee schedule payments or simply optimize risk scores; the primary aim is participating in value-based care and sharing in savings when performance supports it.

NEW QUESTION: 9

A patient reports recent weight loss of 10 pounds in the last two months, decreased appetite, and no energy or desire to eat. She describes an inability to concentrate and complete simple tasks, likely due to ongoing insomnia. Documentation includes a PHQ-9 score of 11, and the patient is currently on paroxetine for depression. Which of the following is a query opportunity to obtain more specificity?

- A. Major depressive occurrence
- B. Major depressive event
- C. Major depressive disorder
- D. Major depressive reaction

Answer: C (LEAVE A REPLY)

In outpatient CDI, a strong specificity opportunity is to clarify the exact diagnostic term that best matches clinical indicators and supports correct ICD-10-CM reporting. The patient has multiple depressive symptoms (weight loss, poor appetite, low energy, impaired concentration), is already treated with an antidepressant (paroxetine), and has a PHQ-9 score of 11, consistent with at least moderate depressive symptom burden that warrants diagnostic clarity. Among the options, only Major Depressive Disorder (MDD) is a recognized clinical diagnosis category with structured ICD-10-CM options that require further specificity (e.g., single vs recurrent episode, severity-mild/moderate/severe, psychotic features, and remission status). The other choices ("occurrence," "event," "reaction") are nonspecific, nonstandard phrases that do not reliably map to accurate ICD-10-CM diagnostic reporting and do not help improve documentation precision. A compliant query would ask the provider to specify whether the patient has MDD and, if so, document the episode type/severity and relationship to insomnia if clinically relevant, ensuring the record reflects what is being evaluated and treated during the encounter.

NEW QUESTION: 10

Which performance metric is MOST appropriate for an outpatient program to share with providers?

- A. APC payment rates
- B. RAF scores
- C. HCC per member per month payments
- D. Major complication comorbidity (MCC) rates

Answer: B (LEAVE A REPLY)

Outpatient CDI programs should share provider-facing metrics that are clinically meaningful, aligned with ambulatory documentation goals, and unlikely to be perceived as payment-driven prompting. RAF scores are an appropriate metric because they reflect how well the documented and coded condition burden represents the patient panel's complexity in risk adjustment models. Discussing RAF supports education around accurate diagnosis capture, specificity, and annual recapture of active chronic conditions that are monitored, evaluated, assessed/addressed, or treated. In contrast, APC payment rates are facility OPPS payment constructs and typically are not actionable for individual ambulatory

provider documentation improvement. HCC per member per month payments is explicitly financial and can create compliance risk by tying documentation discussions directly to payment, which outpatient CDI guidance warns against in provider messaging. MCC rates are primarily an inpatient DRG severity concept and are not the most relevant outpatient performance measure. Therefore, RAF scores best balance provider relevance, program goals, and compliant education focus.

NEW QUESTION: 11

Provider documentation states: "A patient is seen today with DM type 2, peripheral neuropathy with diabetic ulcer of the left great toe, hypertension, and BMI 43. O2 dependent, chronic respiratory failure due to COPD, stopped smoking 2 years ago - 84 packs per year smoking habit." Which of the following query opportunities will impact risk adjustment?

- A.** Nicotine dependence
- B.** Diabetes with complications
- C.** Morbid obesity
- D.** Depth of diabetic ulcer

Answer: D (LEAVE A REPLY)

In ambulatory CDI, "risk adjustment impact" means the clarification can change whether an HCC-relevant condition is captured accurately (or captured at all) based on ICD-10-CM reporting rules. Here, "DM2 with peripheral neuropathy with diabetic ulcer" already establishes diabetes with complications, so querying option B adds little-complications are already documented. "Nicotine dependence" is not supported because the patient stopped smoking two years ago; at most, this supports a history of nicotine dependence, which generally does not drive HCC risk scoring. "Morbid obesity" may be clinically relevant (BMI 43 supports it), but obesity typically does not produce meaningful CMS-HCC risk adjustment impact compared with other chronic categories. The diabetic ulcer does matter: correct reporting requires an additional L97.- code that depends on ulcer severity/depth (skin breakdown, fat layer exposed, necrosis of muscle/bone). Clarifying depth supports accurate ulcer severity coding and can affect HCC capture/validation for chronic ulcer burden.

NEW QUESTION: 12

Clinic documentation states: "Follow-up for post-induction chemotherapy for metastatic uterine cancer." To BEST identify the conditions being monitored and treated, a CDI specialist should

- A.** clarify the morphology of the tumor.
- B.** evaluate diagnostic lab results.
- C.** review the record for MRI results.
- D.** query for secondary sites.

Answer: D (LEAVE A REPLY)

When documentation states "metastatic uterine cancer," the most important missing element for complete, accurate outpatient coding is where the cancer has metastasized (the secondary site[s]). In ambulatory CDI, identifying secondary sites best clarifies the full scope of disease being monitored and treated because metastatic disease coding relies on documenting both the primary malignancy and the specific metastatic location(s) (e.g., lung, liver, bone, peritoneum, lymph nodes). This supports correct severity representation, risk capture, treatment intent, and medical necessity for ongoing chemotherapy follow-up. While tumor morphology can be clinically relevant, it is usually established earlier in the diagnostic pathway and does not, by itself, define current metastatic burden. Likewise, reviewing labs or MRI results may provide supportive indicators, but they do not replace provider documentation of the confirmed metastatic sites being managed. A compliant query focused on secondary sites prompts the provider to document the current metastatic disease status (active, responding, progressing) and specific locations, which most directly identifies the conditions under treatment.

NEW QUESTION: 13

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

Answer: (SHOW ANSWER)

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: 14

Which of the following is designed to reduce claims denials and appeals by providing one-on-one feedback to the provider to increase accuracy in specific areas?

- A. Recovery Audit Contractor
- B. Target Probe and Educate
- C. OIG Work Plan
- D. Comprehensive Error Rate Testing

Answer: (SHOW ANSWER)

Targeted Probe and Educate (TPE) is an education-focused review initiative intended to improve billing accuracy and reduce future denials by combining targeted claim review with direct provider/supplier feedback. In outpatient CDI terms, TPE aligns with a "fix-forward" approach: auditors identify specific error patterns (often documentation, medical necessity, coding, or coverage rule issues), then provide one-on-one education so the provider can correct processes and documentation habits. This is distinct from Recovery Audit Contractors (RACs), which primarily identify and recoup improper payments, often after the fact, and are not structured as an individualized education cycle. The OIG Work Plan identifies oversight priorities and areas of potential fraud/waste/abuse; it does not deliver provider-level coaching to reduce denials. CERT measures Medicare improper payment rates through sampling and can drive policy/education broadly, but it is not designed as individualized, iterative provider education. Because TPE is specifically built around targeted review plus direct education to prevent repeat errors and reduce appeals, it is the best answer.

NEW QUESTION: 15

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

Answer: (SHOW ANSWER)

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: 16

The primary purpose of clinical documentation improvement (CDI) is to:

- A. Increase hospital reimbursement
- B. Ensure accurate and complete documentation reflecting patient severity and care provided
- C. Simplify the physician's workflow
- D. Reduce coding workload

Answer: (SHOW ANSWER)

In outpatient CDI, the foundational aim is documentation integrity-making sure the medical record clearly and consistently tells the clinical story: why the patient is being seen, what conditions are evaluated/managed, the current severity and associated risks, what was done (assessment and treatment), and how this supports medical necessity and accurate code assignment. While reimbursement can be affected, it is an outcome-not the purpose. ACDIS-aligned CDI education emphasizes completeness and specificity so the record reflects true acuity and complexity (e.g., chronic conditions with current status, complicating comorbidities, medication management, and risk/decision-making). This improves downstream quality reporting, risk adjustment accuracy, continuity of care, and compliance because coders must code what is documented, not what is presumed. Strong CDI reduces denials and audit exposure by ensuring diagnoses are clinically supported (MEAT-monitor, evaluate, assess/address, treat) and linked to the encounter's work. In short, CDI exists to ensure the record accurately represents the patient's condition and the care delivered, enabling correct coding, quality measurement, and appropriate payment.

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NEW QUESTION: 17

A patient is evaluated in the clinic. Documentation states: "HIV positive, gravida 1 at 24 weeks." Which of the following conditions will be coded and in which sequence based on the documentation?

- A. HIV disease, pregnancy
- B. Pregnancy with HIV disease
- C. Asymptomatic HIV, pregnancy
- D. Pregnancy with asymptomatic HIV

Answer: D (LEAVE A REPLY)

In outpatient coding, selection and sequencing must follow ICD-10-CM Official Guidelines, including obstetric chapter rules. When HIV is documented in a pregnant patient, the pregnancy complication code is sequenced first because the pregnancy status frames the encounter and drives the obstetric complication coding structure. The phrase "HIV positive" (without documentation of HIV-related illness or "HIV disease") is treated as asymptomatic HIV infection status, which aligns with the status concept rather than active HIV disease. Therefore, the correct approach is to code pregnancy complicated by asymptomatic HIV first (obstetric complication category), followed by the HIV status code to fully describe the condition affecting the pregnancy. Options that place "pregnancy" second do not follow obstetric sequencing conventions, and options that assume "HIV disease" overstep the documentation because "HIV positive" alone does not confirm symptomatic HIV disease. Outpatient CDI best practice would be to query if the provider intends HIV disease versus asymptomatic status, but based strictly on the given statement, pregnancy with asymptomatic HIV is most appropriate.

NEW QUESTION: 18

Provider documentation states: "Patient is here for follow-up for multiple chronic conditions, including COPD, HTN, DM, and alcohol abuse. She admits to drinking more than she has in the past, starting in the early morning and consumes at least a pint a day. Her BP today is elevated at 165/89. Discussed medications and diet. As she continues to be dependent on alcohol, several treatment options were offered. She stated she would think about it." Which of the following groups of diagnoses is supported by the clinical indicators described?

- A. DM Type 2 without complications, HTN, alcohol abuse
- B. DM Type 2 with complications, COPD, HTN, alcohol use
- C. DM Type 2 without complications, HTN, alcohol dependence
- D. DM Type 2 with complications, COPD, alcohol dependence

Answer: (SHOW ANSWER)

The clinical indicators strongly support alcohol dependence, not merely alcohol "use" or "abuse." The patient reports heavy, compulsive intake (early-morning drinking and at least a pint daily), and the provider explicitly documents that she "continues to be dependent on alcohol" and discusses treatment options-this aligns with a dependence-level disorder being addressed. Hypertension is also supported because the BP is elevated (165/89) and

the provider documents management activity (medications and diet counseling), meeting encounter relevance/reportability expectations. Diabetes is listed among chronic conditions, but the scenario provides no indicators of complications (no neuropathy, CKD, ulcers, retinopathy, etc.), so the supported choice is DM type 2 without complications rather than "with complications." Although COPD is listed in the "including" statement, no COPD-specific assessment/monitoring/treatment is described in the indicators provided, so the best-supported grouped option focuses on the conditions with clear supporting indicators and management in the note: DM2 without complications, HTN, and alcohol dependence.

NEW QUESTION: 19

Calculate the expected yearly cost for this patient based on the RAF score.

- A. \$486.40
- B. \$12,672.00
- C. \$17,011.20
- D. \$5,836.80

Answer: [\(SHOW ANSWER\)](#)

In outpatient risk adjustment (commonly Medicare Advantage), the patient's predicted cost is derived from the Risk Adjustment Factor (RAF), which is the sum of component risk contributions. Here, the RAF is calculated by adding the HCC diagnoses score (0.166), disease interactions (0.112), and demographic score (0.330). That total equals 0.608. The PMPM (per-member-per-month) baseline cost is \$800. To estimate the patient's expected monthly cost, multiply PMPM by RAF: $\$800 \times 0.608 = \486.40 per month. The question asks for the expected yearly cost, so convert PMPM to annual: $\$486.40 \times 12 = \$5,836.80$. ACDIS outpatient CDI teaching emphasizes that accurate documentation and compliant coding directly affect RAF through captured HCCs and interactions (when supported), which in turn drives expected resource needs and plan payment. Missing or unsupported diagnoses can understate RAF; vague documentation can prevent valid HCC capture.

NEW QUESTION: 20

ICD-10-CM code assignment can be supported by documentation from someone other than the patient's provider in which of the following circumstances?

- A. Anatomic site of previous amputation
- B. Type of obesity
- C. Stage of pressure ulcer
- D. Site of ostomy

Answer: [C \(LEAVE A REPLY\)](#)

Outpatient ICD-10-CM guidance allows certain code elements to be based on documentation from clinicians other than the patient's diagnosing provider when those elements are considered objective, routinely assessed, and commonly documented by nursing or ancillary staff. A key example is pressure ulcer staging, which is frequently

assessed and documented by wound care nurses and other qualified clinicians as part of routine skin/wound evaluation. Because the stage drives code specificity and is an observable clinical finding, coders may use non-provider documentation to assign the stage when it is clearly documented and not contradicted by the provider record. In contrast, items such as the type of obesity generally require provider diagnosis/clinical assessment rather than ancillary documentation alone. Similarly, while status conditions (like amputations or ostomies) may be observed, the coding guidelines do not broadly permit assigning these diagnoses solely from non-provider documentation without provider confirmation, unless the chart otherwise supports it. Therefore, among the choices, pressure ulcer stage is the appropriate circumstance where non-provider documentation can support ICD-10-CM assignment.

NEW QUESTION: 21

When evaluating a CDI specialist's performance, which of the following expectations is held to the same standard for both inpatient and outpatient initiatives?

- A.** Review productivity
- B.** Query opportunities
- C.** Revenue impact
- D.** Query compliance

Answer: D (LEAVE A REPLY)

Across both inpatient and outpatient CDI, the single expectation that must remain consistent is query compliance. While productivity targets, the types of query opportunities, and the way "impact" is measured can differ significantly by setting (e.g., DRG/CC-MCC focus in inpatient vs. HCC capture, specificity, and MEAT support in outpatient), the compliance framework for querying does not change. A compliant query must be clinically supported, non-leading, clearly written, and must allow the provider to independently determine the most accurate documentation based on the record. It should include relevant clinical indicators, present reasonable options (including "other"/"unable to determine" when appropriate), and avoid language that appears to request diagnoses for payment purposes. These principles protect documentation integrity, support defensible coding, and reduce audit risk regardless of whether the encounter is hospital-based or ambulatory. By contrast, "review productivity" and "revenue impact" vary widely by program design and setting, and "query opportunities" differ because inpatient vs. outpatient have different reportability rules and documentation drivers. Therefore, query compliance is the metric held to the same standard in both environments.

NEW QUESTION: 22

Which of the following is a strategy that is often used by ACOs to improve their performance in the Readmission Reduction program?

- A.** Encourage providers to avoid reporting chronic conditions on subsequent admissions.

- B.** Educate providers about the importance of capturing chronic conditions in documentation.
- C.** Work with IT to increase the unspecified code choices in pick lists in the EHR.
- D.** Flag qualifying patients upon arrival to ED to be placed in observation status vs. admission.

Answer: ([SHOW ANSWER](#))

ACOs commonly focus on strengthening documentation and coding of clinically relevant chronic conditions because many quality and utilization comparisons-including readmission-related performance assessments-are influenced by patient complexity and risk adjustment. When chronic diseases and their specificity (e.g., stage, severity, manifestations) are under-documented, attributed patients can appear "healthier" on paper than they truly are, which can worsen an organization's apparent readmission performance when outcomes are compared to an expected benchmark. Provider education that reinforces documenting active conditions that are monitored, evaluated, assessed/addressed, or treated helps ensure an accurate picture of acuity and comorbidity burden. This improves the integrity of risk adjustment inputs and supports fairer benchmarking, while also strengthening medical necessity and continuity-of-care communication across settings. The other choices represent either noncompliant behavior (avoiding condition reporting), poor documentation practice (promoting unspecified codes), or operational maneuvering that may be perceived as gaming rather than a sustainable quality strategy. Therefore, educating providers to capture chronic conditions accurately is the best and most commonly used improvement approach.

NEW QUESTION: 23

A CDI specialist has created the following query:

"Dear Dr., Based on the following clinical indicators: history of CVA and physical therapy ordered to address left sided weakness, please confirm a diagnosis of hemiplegia." What feedback should be given to the CDI specialist regarding the query?

- A.** Hemiplegia can be coded without the provider clarification.
- B.** The query leads the physician to one diagnosis, making it non-compliant.
- C.** Clinical indicators do not support the query.
- D.** The query does not include results from the most recent MRI.

Answer: **B** ([LEAVE A REPLY](#))

This query is non-compliant because it is leading: it asks the provider to "confirm a diagnosis of hemiplegia," presenting only one targeted outcome rather than requesting clarification in a neutral, clinically appropriate way. ACDIS-aligned outpatient query practice requires queries to be compliant, non-leading, and supported by clinical indicators, typically offering multiple reasonable options (or an open-ended format) and allowing the provider to document the most accurate clinical impression. In this scenario, "history of CVA," "left-sided weakness," and "physical therapy ordered" could reflect several possibilities-such as hemiparesis, residual weakness, post-stroke deficits, deconditioning,

or other neurologic impairment-so the query should ask the provider to clarify the nature and diagnosis of the deficit (and laterality), not to confirm a single diagnosis. Option A is incorrect because coding cannot assume hemiplegia without provider documentation. Option C is not the best feedback because indicators can justify clarification. Option D is unnecessary; MRI results are not required for a compliant outpatient query.

NEW QUESTION: 24

What stage of pressure ulcer describes necrosis of soft tissue through the underlying muscle?

- A. 2**
- B. 3**
- C. 4**
- D. 5**

Answer: ([SHOW ANSWER](#))

A Stage 4 pressure ulcer (pressure injury) is characterized by full-thickness tissue loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. The key phrase in the question-"necrosis of soft tissue through the underlying muscle"-signals a depth of injury that extends beyond the subcutaneous tissue and involves muscle, which is consistent with Stage 4. By comparison, Stage 2 involves partial-thickness skin loss with exposed dermis (no necrosis through deeper structures). Stage 3 involves full-thickness skin loss where adipose may be visible, but muscle, tendon, or bone are not exposed; undermining and tunneling may occur, yet the defining line is that it does not extend to muscle/bone involvement. "Stage 5" is not part of standard pressure ulcer staging used in coding and documentation. Outpatient CDI practice emphasizes documenting the exact stage, anatomic location, laterality when applicable, and whether the ulcer is healing or complicated (infection/osteomyelitis) because stage drives specificity, severity capture, and appropriate care planning documentation.

NEW QUESTION: 25

In which of the following ways does payment determination (risk score calculation) differ between HHS-HCCs and CMS-HCCs?

- A. HHS-HCCs use the current year's demographics/diagnoses to predict the current year's spending.**
- B. HHS-HCCs use the previous year's demographics/diagnoses to predict the next year's spending.**
- C. HHS-HCCs use current ICD-10-CM and CPT codes to predict the current year's spending.**
- D. HHS-HCCs use the previous year's ICD-10-CM and CPT codes to predict the next year's spending.**

Answer: ([SHOW ANSWER](#))

A key ambulatory CDI distinction between the two major risk models is timing. The HHS-HCC model (used for ACA Marketplace risk adjustment) is commonly described as a concurrent model: it uses the enrollee's demographics and diagnoses from the same benefit year to reflect morbidity and support that year's risk transfer/payment balancing. In contrast, the CMS-HCC model (commonly applied in Medicare Advantage) is prospective: conditions documented and coded in the prior data collection year are used to predict expected cost for the following payment year. From an outpatient CDI perspective, this timing difference affects operational priorities. For CMS-HCC, accurate annual capture and recapture of active chronic conditions is essential because last year's documented conditions drive next year's risk score and revenue. For HHS-HCC, complete documentation and coding during the current year impacts the current year's risk measurement. Options referencing CPT codes are not correct for the core HCC risk score calculation, which is driven by demographics and ICD diagnosis reporting mapped to HCC categories.

NEW QUESTION: 26

In review of a clinic record, a CDI specialist notes the provider has directly copied and pasted a previous inpatient problem list into the current ambulatory visit note. Which of the following is the CDI specialist's BEST course of action?

- A.** Do not code conditions that were pasted from the problem list.
- B.** Query the provider for each of the conditions on the problem list.
- C.** Educate the provider regarding the concerns with copying and pasting this list.
- D.** Assume the conditions are all relevant for this visit.

Answer: (SHOW ANSWER)

Copy-and-paste of an inpatient problem list into an outpatient note creates significant documentation integrity risks: outdated diagnoses may be carried forward, resolved conditions may appear active, and the note may not clearly show which problems were actually evaluated or managed during the current encounter. Outpatient CDI best practice is not to assume relevance (eliminating D) and not to reflexively query every listed diagnosis (B), which can be burdensome, non-targeted, and may lead to "query fatigue." Likewise, blanket instruction to "not code" anything pasted (A) is not appropriate because some conditions may still be active and reportable if the provider documents assessment/management (e.g., monitoring, evaluation, addressing, or treatment). The most effective and sustainable action is provider education: explain why indiscriminate copy-forward threatens accuracy, compliance, medical necessity support, quality reporting, and risk adjustment validity; reinforce documenting current status and care provided for each active condition; and encourage updating the problem list and assessment to reflect what is truly addressed at the visit. Targeted queries can still be used when specific contradictions or high-impact ambiguities are identified.

NEW QUESTION: 27

Which of the following is the MOST compliant provider query?

A. "Noted that this patient is being referred for a colonoscopy. She has no documented GI symptoms and has a family history of colon cancer. When this patient is seen, please clarify whether this is a screening colonoscopy or diagnostic colonoscopy."

B. "The patient has a past medical history of CAD, HF, and COPD. Please document these conditions during the encounter today if they are still being treated."

C. "According to a visit last year, this patient has a history of alcohol use; quit two years ago; previously drank 6-9 beers daily, 10-12 beers on weekend. Patient now attends AA meetings. Is the patient's alcohol use now in remission?"

D. "Noted that the patient has skin that is 'warm and dry with no rashes or lesions'; however, nursing documentation describes a 'stage 3 sacral pressure ulcer' requiring wet-to-dry dressing changes. Please add the pressure ulcer to your ED assessment note if appropriate."

Answer: A (LEAVE A REPLY)

The most compliant query is the one that is clinically supported, non-leading, and focused on clarifying documentation for correct reporting and medical necessity-without directing the provider to "add" diagnoses or document conditions for payment purposes. Option A presents relevant clinical context (no GI symptoms; family history) and asks the provider to clarify whether the planned colonoscopy is screening or diagnostic, which is a legitimate documentation clarification affecting correct code selection and coverage rules. It does not imply a desired answer and does not instruct the provider to document additional diagnoses. Option B is problematic because it instructs the provider to "document these conditions" if treated, which can be perceived as prompting and is not tied to encounter-specific indicators. Option C is based primarily on historical information and asks a yes/no about remission, which can be leading and may not reflect current-visit evaluation. Option D effectively asks the provider to add a diagnosis based on nursing documentation, which risks leading language and requires provider confirmation and assessment. Therefore, A is most compliant.

NEW QUESTION: 28

Which of the following BEST defines a risk score under the CMS-HCC model?

A. Beneficiary's demographics and social determinants

B. Beneficiary and family demographics

C. Beneficiary's individual demographic and health status

D. Beneficiary's health status and risk of mortality

Answer: C (LEAVE A REPLY)

Under the CMS-HCC model, a beneficiary's risk score (RAF) is intended to represent the expected cost of caring for that individual relative to an average beneficiary. The score is calculated using two primary inputs: (1) the beneficiary's demographic factors (such as age, sex, Medicaid status/dual eligibility, disability status, and original reason for Medicare entitlement, depending on the model segment), and (2) the beneficiary's documented

disease burden captured through ICD-10-CM codes that map to Hierarchical Condition Categories (HCCs). Those HCCs reflect the person's health status and severity, with hierarchy rules preventing "stacking" of related conditions and with certain interaction terms in some model versions. Social determinants are not generally described as the defining basis of the traditional CMS-HCC RAF in CDI education, and "family demographics" are not used. The model is not a mortality predictor; it is a cost/risk prediction tool for payment adjustment. Therefore, the best definition is the beneficiary's individual demographic and health status.

NEW QUESTION: 29

Which of the following BEST describes a Stage 3 pressure ulcer?

- A.** Pre-ulcer skin changes limited to persistent focal edema
- B.** Full thickness skin loss involving damage or necrosis of subcutaneous tissue
- C.** Necrosis of soft tissues through to underlying muscle, tendon, or bone
- D.** Abrasion, blister, partial thickness skin loss involving epidermis and/or dermis

Answer: B (LEAVE A REPLY)

Stage 3 pressure ulcers are defined by full-thickness skin loss where the injury extends through the dermis and involves damage or necrosis of subcutaneous tissue. Clinically, the ulcer may present as a deep crater and can include undermining or tunneling, but the key boundary is that bone, tendon, and muscle are not exposed. That deeper involvement (exposed muscle/tendon/bone) is characteristic of Stage 4, making option C incorrect. Option D describes partial-thickness loss, which aligns with Stage 2 (epidermis/dermis involvement such as abrasion or blister). Option A reflects early skin changes that correspond more closely to Stage 1 (intact skin with non-blanchable erythema and possible localized edema/induration). In outpatient CDI chart review, accurately distinguishing Stage 3 from Stage 2 and Stage 4 is essential because staging drives severity capture, care planning (wound care interventions, debridement considerations), and quality reporting. Documentation should clearly support "full thickness," the tissue layers involved, and the absence of exposed bone/tendon/muscle.

NEW QUESTION: 30

Which statement is MOST accurate about the problem list?

- A.** Problem list diagnoses should be removed after one year.
- B.** A well-maintained problem list is vital in the continuity of patient care.
- C.** More diagnoses on the problem list assist the provider in caring for the patient.
- D.** A CDI specialist should update the problem list to provide continuity of care.

Answer: (SHOW ANSWER)

A well-maintained problem list supports continuity of care by giving the care team an accurate, up-to-date clinical "snapshot" of active and relevant historical conditions that affect ongoing management, decision-making, and risk assessment. Outpatient CDI education emphasizes that the problem list should be curated-conditions should be

current, clinically meaningful, and appropriately resolved or clarified (e.g., active vs history, controlled vs uncontrolled). Option A is incorrect because diagnoses are not removed based on an arbitrary time threshold; they are updated based on clinical status (resolved, inactive, erroneous, or no longer relevant). Option C is inaccurate because simply adding more diagnoses can introduce noise and increase the risk of outdated or incorrect conditions being propagated ("problem list bloat"), which can harm patient safety and lead to inaccurate coding. Option D is inaccurate because CDI professionals typically do not independently update the problem list; rather, they support providers through compliant queries, education, and process improvements so the treating provider validates and maintains the record. Therefore, B best reflects outpatient documentation best practice.

NEW QUESTION: 31

Which of the following physician performance metrics BEST illustrates provider engagement with outpatient CDI specialist?

- A. Query response rates and problem list updates
- B. Problem list updates and RAF capture rates
- C. Physician MIPS scores and query response rates
- D. Physician RAF scores and RAF capture rates

Answer: A (LEAVE A REPLY)

Provider engagement in an outpatient CDI program is best reflected by measures that show the provider is actively interacting with CDI processes and improving documentation behaviors in real time. Query response rates directly indicate whether the provider is reading and responding to CDI clarifications promptly and consistently, which is a fundamental engagement behavior and a key operational driver of documentation accuracy. Problem list updates further demonstrate sustained engagement because they reflect the provider's willingness to maintain an accurate, current list of active conditions (adding validated diagnoses, removing resolved problems, and updating specificity such as stage, severity, or laterality). Together, these two metrics show both immediate participation (responding to queries) and longer-term adoption of documentation best practices (maintaining the problem list). In contrast, RAF scores and RAF capture rates are influenced by patient complexity, payer mix, and coding capture processes, and may improve even without meaningful provider participation. MIPS scores reflect broader quality program performance and are not specific to CDI-provider interaction. Therefore, query responsiveness plus problem list maintenance most directly measures engagement with outpatient CDI.

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NEW QUESTION: 32

A CDI specialist is following up on a query while the provider is seeing patients in the clinic. The BEST action that will support a quick and compliant response to the query is to

- A.** wait to speak with the provider during the next scheduled meeting.
- B.** catch the provider in the hallway between patients.
- C.** discuss in a private room with the door closed.
- D.** leave a sticky note on the chart of the next patient.

Answer: (SHOW ANSWER)

Outpatient CDI follow-up must balance responsiveness with confidentiality and professional standards. The most compliant approach is to communicate query-related information in a setting that protects protected health information and minimizes the risk of incidental disclosure. Discussing the query in a private room with the door closed supports timely clarification while maintaining privacy, avoiding conversations that could be overheard by patients, visitors, or staff who are not involved in the patient's care. Catching the provider in the hallway is faster but increases privacy risk because clinical details can be overheard, and it may also distract the provider in a high-traffic environment. Leaving a sticky note on the next patient's chart is inappropriate because it can be seen by others, may be misplaced, and can create compliance and medico-legal concerns (including mixing patients or leaving PHI unsecured). Waiting for the next scheduled meeting may be compliant but does not support a quick response, potentially delaying coding completion and data integrity. Therefore, a private discussion is both the quickest and most compliant option.

NEW QUESTION: 33

An established patient is defined as one who has received professional services from the same or another physician or qualified healthcare professional from the exact same specialty and sub-specialty and belongs to the same group practice, within the past how many years?

- A.** 1
- B.** 2
- C.** 3
- D.** 4

Answer: (SHOW ANSWER)

For outpatient E/M reporting, "new vs. established patient" status is determined using a lookback period based on prior professional services. An established patient is one who has received face-to-face (or other qualifying professional) services from the same physician or another physician/qualified healthcare professional of the same specialty and

subspecialty in the same group practice within the previous three years. This definition is critical for compliant coding because it drives which E/M code family is available (new patient codes vs established patient codes), and it affects relative valuation, documentation expectations, and audit risk. Outpatient CDI education emphasizes helping providers document the medical necessity and complexity of the visit regardless of patient status, but also ensuring correct administrative classification so coders select the correct code set. The three-year window prevents inappropriate use of new patient codes when the patient has an ongoing clinical relationship with the practice/specialty, supporting accurate reimbursement and consistent reporting.

NEW QUESTION: 34

A patient presents with pulmonary rales, pulmonary edema found on chest x-ray, and bilateral ankle edema. Which of the following conditions will the provider MOST likely evaluate further?

- A.** Pleural effusion
- B.** Heart failure
- C.** Pneumonia
- D.** Pulmonary hypertension

Answer: B (LEAVE A REPLY)

Pulmonary rales (crackles), radiographic pulmonary edema, and peripheral (ankle) edema together strongly suggest a systemic volume overload state, most classically due to heart failure. In ambulatory CDI chart review, these findings function as clinical indicators that drive the provider's diagnostic reasoning and typically prompt further evaluation of heart failure type and status (e.g., acute vs chronic, systolic vs diastolic, preserved vs reduced EF), along with assessment of severity and potential decompensation. Providers commonly correlate these indicators with additional data such as weight gain trends, BNP, echocardiogram findings, medication adherence (diuretics), and signs of congestion to determine whether the patient is experiencing a heart failure exacerbation requiring treatment adjustments. While pleural effusion may coexist and pneumonia can cause rales, the presence of pulmonary edema on chest x-ray plus bilateral ankle edema points more directly to a cardiac/volume etiology than an isolated infectious process. Pulmonary hypertension may contribute to dyspnea and edema but does not most directly explain pulmonary edema on imaging in the same way. Therefore, heart failure is the most likely condition to be evaluated further.

NEW QUESTION: 35

A CDI specialist identifies an opportunity to clarify a patient's BMI. The CDI specialist leaves a query within the medical record for the ancillary support team to address during the patient's visit. Which of the following BEST describes this type of query?

- A.** Retrospective
- B.** Concurrent

C. Prospective

D. Prebill

Answer: (SHOW ANSWER)

This scenario describes a query placed before the patient is seen, with the intent that the issue be addressed during the upcoming visit. In outpatient CDI practice, that is the defining feature of a prospective query: it is initiated ahead of the encounter so the provider and/or clinic team can capture needed specificity in real time (here, clarifying BMI-related documentation to support an obesity diagnosis when clinically appropriate). By contrast, a concurrent query is typically issued while the encounter is actively occurring or immediately as documentation is being created and reviewed in near-real time. A retrospective query occurs after the visit is completed, usually during post-encounter review, when opportunities are identified after documentation is finalized. "Prebill" refers to a workflow timing concept tied to billing hold/review before claim submission, not the clinical timing of when the patient will be seen. Because the query is placed in advance specifically to be addressed during the scheduled visit, prospective is the best classification.

NEW QUESTION: 36

Which of the following payment models enables Medicare to forecast costs for Medicare Advantage members for the coming year?

A. Ambulatory Payment Classification

B. Relative Value Scale

C. Geographic Practice Cost Indexes

D. Hierarchical Condition Categories

Answer: D (LEAVE A REPLY)

Medicare Advantage (MA) payments are risk adjusted so CMS can predict expected healthcare costs for each enrollee in the upcoming payment year. The model used for this forecasting is the CMS-HCC (Hierarchical Condition Category) risk adjustment methodology. It converts demographic factors (such as age/sex and eligibility status) plus documented, coded diagnoses (ICD-10-CM codes that map to HCCs) into a Risk Adjustment Factor (RAF). CMS then uses the RAF to adjust capitation payments to MA plans to reflect the member's anticipated resource needs. This is why outpatient CDI places heavy emphasis on accurate, specific capture and annual "recapture" of active chronic conditions that are monitored, evaluated, assessed/addressed, or treated during the encounter-because the prior year's valid HCCs drive the next year's predicted cost and payment. By contrast, APCs relate to OPPS facility outpatient payment, RVUs/RBRVS relate to physician fee schedule valuation, and GPCIs adjust payment geographically; none of those are the MA risk forecasting model.

NEW QUESTION: 37

How does accurate documentation impact APC assignment in outpatient services?

A. It has no effect

- B.** It delays reimbursement
- C.** It ensures appropriate APC assignment, impacting reimbursement
- D.** It reduces coding accuracy

Answer: C ([LEAVE A REPLY](#))

In hospital outpatient settings paid under OPPS, Ambulatory Payment Classifications (APCs) are influenced by the coded services and, in many workflows, the clinical documentation that supports correct CPT/HCPCS selection, units, modifiers, and when applicable-medical necessity linkages to diagnoses. Accurate documentation ensures that the record supports what was actually performed (e.g., complexity, laterality, supplies, drug administration details, observation criteria, or separately payable procedures) and that coding can correctly apply bundling/packaging rules without losing legitimately reportable services. While APCs are primarily procedure-driven, documentation remains decisive because incomplete or ambiguous notes lead to downcoding, missed charges, incorrect status indicators, or denials during medical review. From an outpatient CDI standpoint, the goal is to ensure the clinical story supports codeable services and their necessity: clear indications, findings, assessment/plan, and any required elements (time, start/stop, dose/route for medications, device details, etc.). This supports appropriate APC grouping and reimbursement integrity, reducing rework, denials, and compliance risk.

NEW QUESTION: 38

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.** Specificity of the organism causing the pneumonia
- B.** Acuity of the COPD
- C.** Presence of chronic respiratory failure
- D.** Oxygen dependence

Answer: ([SHOW ANSWER](#))

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: 39

Which of the following is covered under the Outpatient Prospective Payment System (OPPS)? (Select all that apply)

- A.** Community mental health centers
- B.** Indian health services
- C.** Physical therapy treatment
- D.** Clinical diagnostic lab services

Answer: A ([LEAVE A REPLY](#))

Under Medicare, OPPS is the payment system used primarily for hospital outpatient department (HOPD) services paid under APCs, and it also applies to a limited set of non-hospital entities for specific covered services. Community Mental Health Centers (CMHCs) are included under OPPS for certain outpatient mental health services, most notably partial hospitalization-type services that are paid using OPPS methodology, which is why CMHCs are considered "covered under OPPS" in many outpatient CDI education materials. In contrast, clinical diagnostic laboratory services are generally excluded from OPPS and paid under the Clinical Laboratory Fee Schedule (with separate billing and payment rules). Indian Health Services follow different statutory and payment structures and are not paid broadly under OPPS in the same way as HOPDs/CMHC OPPS services. Physical therapy reimbursement is typically governed by therapy-specific rules and fee schedule methodologies rather than being a standard OPPS-covered category in this context. Therefore, among the listed options, CMHCs are the correct OPPS-covered selection.

NEW QUESTION: 40

A patient presents to the clinic with indwelling Foley catheter, symptoms of fatigue, and low back pain with BPH. Labs reveal WBC 20, and the urine culture is positive for E. coli. Prescription antibiotics are ordered for a UTI. Which of the following is the BEST query opportunity?

- A.** Etiology of BPH
- B.** UTI related to catheter
- C.** Etiology of low back pain
- D.** Leukocytosis

Answer: ([SHOW ANSWER](#))

The strongest CDI query opportunity is clarifying whether the UTI is catheter-associated. The patient has an indwelling Foley catheter, significant leukocytosis (WBC 20), a positive urine culture for E. coli, and is being treated with antibiotics for UTI-these indicators raise a clear question about the etiology of infection and whether it is related to the urinary catheter. In outpatient CDI practice, linking the infection to a device (when clinically

supported) improves documentation accuracy, supports correct code assignment, and has important quality and compliance implications because catheter-associated UTIs are captured differently than uncomplicated UTIs. By comparison, querying the "etiology of BPH" is not supported as an immediate gap (BPH is already stated), and the "etiology of low back pain" is less directly tied to the documented treatment focus (UTI management). "Leukocytosis" is a lab finding that is already objectively supported and often represents a symptom/abnormal result rather than the principal clarification needed. Therefore, confirming whether the UTI is related to the Foley catheter is the best, most clinically anchored query.

NEW QUESTION: 41

A patient presents for a right inguinal herniorrhaphy in ambulatory surgery and is placed in observation status postoperatively. Provider documentation states: "Observation related to the post procedural urinary retention likely related to benign prostatic hyperplasia or adverse reaction to anesthesia." From this documentation, which of the following is the first-listed diagnosis?

- A.** Urinary retention
- B.** Benign prostatic hyperplasia
- C.** Adverse reaction to anesthetic
- D.** Right inguinal hernia

Answer: A (LEAVE A REPLY)

For outpatient/observation encounters, the first-listed diagnosis is the condition chiefly responsible for the services provided during that encounter. In this scenario, the patient's ambulatory surgery (herniorrhaphy) has already occurred, and the reason the patient is now in observation is explicitly documented as "post procedural urinary retention." That makes urinary retention the condition driving the extended monitoring, evaluation, and management in observation status. Benign prostatic hyperplasia and an adverse reaction to anesthesia are documented only as possible etiologies ("likely related to...or..."), and outpatient guidelines do not support coding uncertain diagnoses expressed as "likely" or as alternative possibilities without definitive confirmation. Therefore, those potential causes would not replace the confirmed problem that necessitated observation. The hernia was the reason for the procedure, but it is not the reason for the postoperative observation services described. Outpatient CDI practice reinforces documenting the clinical reason for observation and clearly distinguishing confirmed postoperative complications from suspected causes to support correct first-listed selection.

NEW QUESTION: 42

A patient was recently admitted to the hospital for emphysema, end stage COPD, and heart failure. The patient was discharged on home oxygen. In preparation for the patient's upcoming PCP visit, the MOST important query opportunity for a CDI specialist is which of the following?

- A. Type of the heart failure
- B. Current status of emphysema
- C. Clarify indication for home oxygen
- D. Oxygen dependence

Answer: C (LEAVE A REPLY)

Home oxygen is a strong clinical indicator, but by itself it does not tell why the patient requires it. Outpatient CDI best practice prioritizes clarifying the clinical indication because it drives accurate, compliant diagnosis reporting and supports medical necessity and severity of illness. "Oxygen dependence" (a status concept) may be appropriate, but it is secondary and often incomplete without the underlying condition-such as chronic hypoxic respiratory failure, chronic respiratory failure with hypercapnia, or persistent hypoxemia related to end-stage COPD/emphysema. Clarifying the indication also helps ensure the provider documents objective support (e.g., qualifying O2 sats, ABG findings, exertional vs resting hypoxemia) and ties it to assessment/plan at the PCP visit. While specifying heart failure type (A) is valuable, and emphysema "status" (B) may be less actionable because emphysema is typically chronic and encompassed within COPD management, the oxygen requirement is the most immediate cue of higher acuity and a frequent documentation gap. Therefore, clarifying the indication for home oxygen is the highest-value query opportunity.

NEW QUESTION: 43

For outpatient/provider services, the primary sources of coding authority include the ICD-10-CM Official Guidelines for Coding and Reporting, AHA's Coding Clinic for ICD-10-CM/PCS, as well as which of the following?

- A. AHA's Coding Clinic for HCPCS and AMA's CPT Assistant
- B. AHA's Coding Clinic for HCPCS and ICD-10-PCS Official Guidelines for Coding and Reporting
- C. ICD-10-PCS Official Guidelines for Coding and Reporting and DRG Expert
- D. AHA's Coding Clinic for HCPCS, ICD-10-PCS Official Guidelines for Coding and Reporting, and DRG Expert

Answer: A (LEAVE A REPLY)

Outpatient/provider coding relies on two major code sets: ICD-10-CM for diagnoses and CPT/HCPCS for professional services, procedures, and supplies. Because of that, outpatient coding authority is anchored not only in the ICD-10-CM Official Guidelines and AHA Coding Clinic guidance for diagnosis reporting, but also in the authoritative guidance that clarifies CPT/HCPCS reporting. ACDIS outpatient CDI education stresses that CDI specialists must understand both sides: the diagnosis coding rules (ICD-10-CM) and the procedural/service reporting rules (CPT/HCPCS) that drive much of outpatient reimbursement. AMA's CPT Assistant is a key interpretive authority for CPT coding guidance, while AHA's Coding Clinic for HCPCS provides clarification on HCPCS Level II reporting. The other options focus on ICD-10-PCS guidelines and DRG tools, which are primarily inpatient facility concepts (PCS is inpatient procedure coding; DRGs are inpatient

payment groupers). Therefore, the correct supplemental outpatient authority pair is AHA's Coding Clinic for HCPCS and AMA's CPT Assistant.

NEW QUESTION: 44

Which of the following is true of the RAF metric?

- A.** It predicts how much the individual provider will be reimbursed for the concurrent practice year.
- B.** It is based only on demographic factors such as Medicaid status, gender, or aged/disabled.
- C.** It is a relative measure of the probable costs to meet the healthcare needs of the individual beneficiary.
- D.** It is used to calculate each primary care office visit reimbursement based on documentation of chronic conditions.

Answer: C (LEAVE A REPLY)

RAF (Risk Adjustment Factor) is a population risk stratification metric used in risk adjustment models to estimate expected healthcare resource utilization for an individual beneficiary relative to an average patient. In outpatient CDI, RAF is driven by a combination of demographic elements (such as age/sex and eligibility/status factors) and critically-documented, coded conditions that map to risk categories (e.g., HCCs). The intent is not to "predict the provider's reimbursement" for the current year in a direct, visit-by-visit sense; rather, RAF contributes to actuarial projections of expected cost and supports payment benchmarking and budget setting in value-based arrangements (e.g., Medicare Advantage and certain shared savings models). RAF is also not based only on demographics (eliminating option B) and it does not determine reimbursement for each individual office visit (eliminating option D). ACDIS outpatient CDI emphasizes that accurate, specific documentation and coding of active, clinically supported conditions improves the accuracy of RAF, which in turn better aligns projected costs and comparisons across attributed populations.

NEW QUESTION: 45

Which of the following conditions is commonly treated with the medication sertraline?

- A.** Schizophrenia
- B.** Asthma
- C.** Depression
- D.** Heart failure

Answer: (SHOW ANSWER)

Sertraline is a selective serotonin reuptake inhibitor (SSRI) most commonly used to treat depressive disorders and several anxiety-related conditions. In outpatient chart review, recognizing medication-condition relationships supports accurate problem list maintenance and compliant diagnosis reporting, but the diagnosis must still be clearly documented as assessed/managed at the encounter. Depression is the best match because SSRIs like

sertraline are first-line pharmacologic therapy for major depressive disorder and are frequently continued long-term with monitoring for symptom control, side effects, and functional status. Schizophrenia is primarily treated with antipsychotic medications; sertraline may be used only as an adjunct if a comorbid depressive or anxiety disorder is present, so it is not the common primary treatment. Asthma management centers on bronchodilators and inhaled corticosteroids, not SSRIs. Heart failure therapy involves guideline-directed cardiac medications (e.g., beta-blockers, ACE inhibitors/ARNI, diuretics), and sertraline is not a standard heart failure treatment. Outpatient CDI education emphasizes documenting the specific mental health diagnosis, current status (stable/worsening), and treatment plan to support coding.

NEW QUESTION: 46

Which of the following contributes to the risk adjustment score under the CMS-HCC model?

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

Answer: (SHOW ANSWER)

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).

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NEW QUESTION: 47

Which of the following are appropriate clinical indicators to support a query related to alcohol dependency in remission?

- A. The patient has history of cirrhosis of the liver and elevated liver enzymes.
- B. The patient has history of excessive alcohol use and attends AA meetings.
- C. The patient admits to occasional social drinking and recreational drug use.
- D. The patient presents with nausea, vomiting, and distended abdomen.

Answer: B (LEAVE A REPLY)

To support a query for alcohol dependence in remission, outpatient CDI practice looks for indicators that reflect a documented history of dependence plus evidence the patient is actively maintaining sobriety or being followed for recovery status. Attendance at AA meetings together with a documented history of excessive alcohol use is a strong, direct indicator of recovery efforts and ongoing monitoring of a prior substance use disorder. This combination supports clarifying whether the provider intends to diagnose alcohol dependence in remission (versus current dependence, use without dependence, or no current disorder). By contrast, cirrhosis and elevated liver enzymes (option A) can be caused by many etiologies and do not, by themselves, establish dependence or remission status. Nausea, vomiting, and abdominal distention (option D) are nonspecific and may suggest acute illness or liver disease but are not specific to remission. Occasional social drinking with recreational drug use (option C) suggests current substance use and would not support "in remission" without additional documentation. Therefore, option B best supports a remission-related query.

NEW QUESTION: 48

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

Answer: C (LEAVE A REPLY)

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: 49

When a CDI specialist identifies a discrepancy in documentation, the next step is to:

- A.** Change the record
- B.** Query the provider for clarification
- C.** Escalate to compliance
- D.** Code the record as is

Answer: B ([LEAVE A REPLY](#))

CDI staff do not alter the legal health record and should not "code it as is" when documentation is unclear, conflicting, or incomplete in a way that impacts accurate reporting. The compliant next step is to issue a provider query for clarification, ensuring the final record accurately reflects the provider's clinical judgment. ACDIS-guided outpatient CDI emphasizes that queries are a quality and compliance tool: they reconcile discrepancies (e.g., conflicting diagnoses across notes, missing linkage between symptoms and conditions, unclear acuity such as "CHF" without type/status, or ambiguous infection documentation). The query should be supported by clinical indicators from the chart and should ask the provider to document the clarified diagnosis/status in the record (progress note, addendum, or appropriate attestation). Escalation to compliance is reserved for patterns of nonresponse, suspected integrity concerns, or systemic issues, not routine discrepancies. The objective is to achieve a complete, consistent clinical story that supports coding, risk adjustment, quality reporting, and medical necessity-through provider clarification, not CDI edits.

NEW QUESTION: 50

Which of the following section(s) of the Official Guidelines for Coding and Reporting are applicable to outpatient settings?

- A.** Section I, Conventions, General Coding Guidelines, and Chapter Specific Guidelines
- B.** Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services
- C.** Section III, Reporting Additional Diagnoses; and Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services
- D.** Section I, Conventions, General Coding Guidelines and Chapter Specific Guidelines; and Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services

Answer: ([SHOW ANSWER](#))

In outpatient CDI and coding, the Official ICD-10-CM Guidelines that apply are the universal rules plus the outpatient-specific rules. Section I contains conventions, general coding guidelines, and chapter-specific guidance that govern code assignment in every setting (e.g., code structure, "use additional code," laterality, sequencing instructions, and condition-specific rules). Section IV is specifically written for outpatient services and drives core outpatient behaviors such as selecting the "first-listed" diagnosis based on the main reason for the encounter, reporting additional diagnoses that are evaluated/assessed/treated or impact care, and applying outpatient-only restrictions (for example, diagnoses documented as "rule out," "probable," or "suspected" generally are not coded in outpatient the way they may be for inpatient reporting). ACDIS outpatient CDI education emphasizes teaching providers to document clearly the reason for visit, the assessment/clinical relevance of each condition addressed, and the linkage between conditions and services rendered so Section I and Section IV rules can be applied accurately for compliant reimbursement and reporting.

NEW QUESTION: 51

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

- A.** Third degree heart block
- B.** Coronary artery disease
- C.** Sinus bradycardia
- D.** Cardiomyopathy

Answer: ([SHOW ANSWER](#))

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: 52

A patient is seen in the obstetrical clinic, 6 weeks postpartum. She presents with resting heart rate of 58 BPM, initial blood pressure of 154/90, and respiratory rate of 20. She also

complains of slight headaches, denies visual changes, and has no evidence of peripheral edema. History is significant for smoking and obesity. A blood pressure reading of 160/88 is taken at the end of the visit. The provider documents hypertension. Which of the following query opportunities is MOST appropriate?

- A. A more specific diagnosis, such as pre-eclampsia or eclampsia
- B. Whether the hypertension was pre-existing or developed during pregnancy
- C. Association of hypertension to smoking
- D. Hypertensive crisis - unspecified

Answer: (SHOW ANSWER)

In obstetric and postpartum coding, the most important clarification is the type/timing of hypertension because ICD-10-CM has distinct categories for chronic (pre-existing) hypertension, gestational hypertension, and hypertensive disorders that persist into or present during the postpartum period. At 6 weeks postpartum with elevated readings (including a systolic of 160) and headache, the documentation "hypertension" is not specific enough to determine whether this represents chronic hypertension that predates pregnancy, gestational hypertension that has not resolved, or another pregnancy-related hypertensive disorder requiring different obstetric coding and follow-up. ACDIS outpatient CDI guidance prioritizes queries that resolve coding-impactful ambiguity using clinically supported options without leading the provider. While postpartum preeclampsia could be a clinical consideration, the note does not provide key supporting elements (e.g., proteinuria or other definitive severe-feature criteria), so jumping directly to preeclampsia/eclampsia is less appropriate than clarifying onset and relationship to pregnancy. Linking hypertension to smoking is not a standard required linkage for diagnosis coding, and "hypertensive crisis" is not supported by the documentation provided.

NEW QUESTION: 53

Which of the following health record elements impacts HHS-HCC risk scores?

- A. CPT codes
- B. Discharge status
- C. Gender
- D. Ethnicity

Answer: C (LEAVE A REPLY)

The HHS-HCC risk adjustment model (used for ACA Marketplace plans) calculates a member's risk score using a combination of demographic factors and diagnosis codes that map to HHS-HCCs. Among the listed health record elements, gender is a core demographic variable used in the model's coefficients because expected healthcare utilization and cost patterns differ by age/sex groupings. In outpatient CDI terms, this is why accurate demographic data capture (including sex) matters alongside complete and specific condition reporting. CPT codes do not drive HHS-HCC risk scores; the model relies on diagnosis reporting (ICD-10-CM) rather than procedure codes for risk category assignment. Discharge status is an encounter/billing element relevant to certain facility

payment and quality measures, but it is not a standard HHS-HCC risk score input. Ethnicity is not used as a direct risk adjustment variable in the HHS-HCC model for score calculation. Therefore, gender is the correct element that impacts HHS-HCC risk scores.

NEW QUESTION: 54

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

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

Answer: ([SHOW ANSWER](#))

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: 55

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: ([SHOW ANSWER](#))

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.

NEW QUESTION: 56

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 (LEAVE A REPLY)

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.

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