ACDIS CCDS-O Practice Questions

Shared by Matthews on 21-08-2026

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Question 1

Question Type: MultipleChoice

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

Options:

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

Explanation:

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.

Question 2

Question Type: MultipleChoice

Documentation states: ''Patient with history of STEMI five weeks ago. Returning to office for follow-up. Problem list includes CAD, hypertension, heart failure, leukemia, malnutrition, and atrial fibrillation, all were relevant to the encounter. CBC and WBC reviewed and referred to

oncologist. Follow-up with dietitian to further evaluate nutritional status.'' Which of the following is the MOST impactful risk adjusted query opportunity?

Options:

A- Status (remission, or relapse) and acuity of leukemia
B- Type (diastolic, systolic, combined) and acuity of heart failure
C- Differentiation of atrial fibrillation (paroxysmal, persistent, permanent)
D- Severity of the malnutrition (mild, moderate, severe)

Answer:

A

Explanation:

In outpatient risk adjustment, the highest-impact clarification is often the one that determines whether a condition is currently active (and therefore risk-adjustable) versus historical/resolved. ''Leukemia'' listed on the problem list, plus active review of CBC/WBC and referral to oncology, strongly suggests ongoing disease evaluation/management. ACDIS outpatient CDI principles emphasize querying to confirm whether the leukemia is active, in relapse, or in remission because that distinction can change code selection from an active malignancy to a history code, and history codes typically do not carry the same risk adjustment impact as an active HCC-bearing diagnosis. While heart failure type/acuity and malnutrition severity are also important for specificity and may affect risk capture, they generally represent refinement of already-established chronic conditions rather than a potential ''on/off'' determination of a major disease category. Likewise, atrial fibrillation subtype differentiation is clinically useful but usually does not materially change risk adjustment compared with confirming an active hematologic malignancy. Therefore, clarifying leukemia status/acuity is the most impactful risk-adjusted query opportunity.

Question 3

Question Type: MultipleChoice

How does accurate documentation impact APC assignment in outpatient services?

Options:

A- It has no effect
B- It delays reimbursement

C- It ensures appropriate APC assignment, impacting reimbursement
D- It reduces coding accuracy

Answer:

C

Explanation:

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.

Question 4

Question Type: MultipleChoice

The principal diagnosis is defined as:

Options:

A- The first diagnosis listed on the chart
B- The condition established after study to be chiefly responsible for occasioning the admission
C- Any condition treated during the hospital stay
D- The most severe condition present

Answer:

B

Explanation:

The definition in option B is the official Uniform Hospital Discharge Data Set (UHDDS) definition used for inpatient coding: the principal diagnosis is the condition determined---after evaluation---to be chiefly responsible for the admission. It is not simply the first condition written, nor necessarily the ''worst'' or most severe condition; it is the reason for admission once the workup clarifies the clinical picture. CDI practice reinforces this because principal diagnosis selection drives DRG assignment, quality metrics, and reporting, and errors often stem from confusing presenting symptoms with the final established diagnosis. Although outpatient settings use different concepts (e.g., first-listed diagnosis for the encounter), ACDIS education frequently contrasts inpatient ''principal diagnosis'' with outpatient ''first-listed'' to prevent documentation and coding misalignment. Clinicians should document the definitive condition when known (and link symptoms to that condition), and clearly describe diagnostic uncertainty when not yet established. This clarity supports compliant coding, accurate benchmarking, and defensible medical necessity across settings.

Question 5

Question Type: MultipleChoice

Ambulatory Payment Classifications (APCs) are similar to Diagnosis-Related Groups (DRGs) in which of the following ways?

Options:

A- Multiple APCs can be assigned for a given encounter.
B- APC assignment is dependent on diagnoses codes.
C- APCs classify payment identifying similar resource use.
D- Only one APC can be assigned for a given encounter.

Answer:

C

Explanation:

APCs and DRGs are both prospective payment classification systems designed to group services that consume similar resources, supporting standardized reimbursement. DRGs group inpatient stays largely around the principal diagnosis, key procedures, complications/comorbidities, and discharge status to estimate expected hospital resource use for the admission. APCs, used primarily for hospital outpatient services, group billable procedures and services that are clinically comparable and expected to require similar levels of resources (staff time, supplies,

equipment, intensity). While APCs often allow multiple payment classifications within a single outpatient encounter (because multiple procedures may be performed), that feature is not the fundamental similarity to DRGs---it's a key difference in operational payment mechanics. Likewise, APC assignment is generally driven by CPT/HCPCS and revenue codes rather than being primarily diagnosis-dependent. The shared concept emphasized in outpatient CDI education is that both systems aim to align payment with anticipated resource utilization, which is why complete, accurate documentation is essential to support correct coding of the services and conditions that justify the level of care provided.

Question 6

Question Type: MultipleChoice

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If a patient is being seen for follow-up and the documentation indicates that the patient was admitted to the hospital 28 days ago with an acute cerebral infarction with remaining right-sided weakness, Which option best diagnoses would be MOST appropriate?

Options:

A- Cerebral infarction, unspecified, hemiparesis affecting right dominant side
B- Hemiparesis following cerebral infarction affecting unspecified side
C- Hemiparesis following cerebral infarction affecting right dominant side
D- Other sequelae of cerebral infarction

Answer:

C

Explanation:

In the outpatient follow-up setting, when the acute stroke event has occurred in the recent past and the patient is now being evaluated for residual deficits, documentation and coding should focus on the sequelae (late effects) rather than re-coding the acute infarction itself---unless the provider clearly states the stroke is still in the acute phase and being actively treated as such. ACDIS outpatient CDI principles stress selecting the diagnosis that best reflects the reason for today's encounter and the condition being assessed/managed. Here, the ongoing clinical issue driving follow-up care is the persistent neurologic deficit (right-sided weakness/hemiparesis) after the cerebral infarction. Option C is the most specific and clinically accurate because it captures (1) the relationship to the prior cerebral infarction (''following cerebral infarction'') and (2) laterality and dominance (''right dominant side''), which improves code specificity and reflects functional impact. Option A incorrectly keeps the focus on an unspecified cerebral

infarction rather than the residual deficit, and option D is too nonspecific compared with a clearly described hemiparesis.

Question 7

Question Type: MultipleChoice

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?

Options:

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

Answer:

B

Explanation:

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.

Question 8

Question Type: MultipleChoice

While away on vacation, a patient sustained a compound right femoral shaft fracture requiring ORIF. Upon the patient's return home, the fracture site is determined by the orthopedist to be healing well without any complication. Which of the following diagnoses is best for this office follow-up?

Options:

A- Unspecified fracture of shaft of right femur, initial encounter, closed fracture
B- Unspecified fracture of shaft of right femur, initial encounter, open fracture type I or II
C- Unspecified fracture of shaft of right femur, subsequent encounter for routine healing, closed fracture type I or II
D- Unspecified fracture of shaft of right femur, subsequent encounter for routine healing, open fracture type I or II

Answer:

D

Explanation:

For ICD-10-CM injury coding, fracture codes require the correct 7th character to reflect the encounter type and healing status. Because the patient is being seen in the office after surgical treatment (ORIF) and the orthopedist documents the fracture is ''healing well without any complication,'' this is a subsequent encounter for routine healing, not an initial encounter. Therefore, options A and B are incorrect because they use ''initial encounter.'' Next, the injury is described as a compound fracture, which is synonymous with an open fracture. That makes a closed-fracture option inappropriate, eliminating option C. The remaining correct choice is the subsequent-encounter routine-healing option that also identifies the fracture as open. Outpatient CDI principles emphasize ensuring providers document key fracture elements---laterality, anatomic site, open vs closed, and healing status---because these drive compliant code assignment and correct sequencing for follow-up care. While real-world documentation ideally includes Gustilo type specificity, based on the provided choices, the best match is routine healing, subsequent encounter, open fracture.

Question 9

Question Type: MultipleChoice

Which coding guideline is primarily used to assign ICD-10-CM codes in outpatient settings?

Options:

A- Inpatient Coding Guidelines
B- Outpatient Coding Guidelines
C- Uniform Hospital Discharge Data Set
D- CPT Coding Guidelines

Answer:

B

Explanation:

ICD-10-CM diagnosis code assignment in the outpatient setting is governed primarily by the ICD-10-CM Official Guidelines for Coding and Reporting sections applicable to outpatient services. Outpatient rules differ from inpatient because there is no ''principal diagnosis'' established ''after study'' for an admission; instead, outpatient coding generally relies on the reason for the encounter and the conditions evaluated/managed that day, including documented chronic conditions that meet reporting criteria (often framed operationally as MEAT: monitor, evaluate, assess/address, treat). UHDDS is an inpatient discharge dataset concept used to define principal diagnosis and other inpatient reporting constructs, not the outpatient foundation. CPT guidelines govern procedure coding, not diagnosis coding; while CPT and ICD-10-CM must be consistent, CPT guidance does not replace ICD-10-CM outpatient diagnostic rules. From an outpatient CDI perspective, this is why documentation must clearly support encounter diagnoses, their status (active vs history), specificity (type, acuity, manifestations), and medical necessity for services rendered---so the outpatient ICD-10-CM guidelines can be applied correctly and consistently.

Question 10

Question Type: MultipleChoice

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PCP notes describe declining renal function with creatinine trending upward over the last 12 months. Nephrology consult ordered. Which of the following diagnostic tests could support a query to identify status of the patient's baseline renal function?

Options:

A- Creatinine
B- BUN (Blood urea nitrogen)
C- eGFR (glomerular filtration rate)
D- ACR (albumin to creatinine ratio)

Answer:

C

Explanation:

To establish and query for a patient's baseline renal function in the outpatient setting, eGFR is the most direct and standardized measure because it estimates kidney filtration capacity using serum creatinine (and patient factors such as age/sex, and sometimes race depending on the equation used). Outpatient CDI concepts emphasize that chronic kidney disease staging is based primarily on eGFR categories (G1--G5) and persistence over time, making eGFR trends particularly useful for determining whether the patient has CKD, whether it is worsening, and what stage should be documented. Serum creatinine alone can suggest decline but does not translate cleanly to CKD stage without calculating eGFR and considering patient characteristics. BUN is influenced by hydration status, protein intake, bleeding, and catabolic states, so it is less reliable for baseline kidney function assessment. ACR is important for detecting albuminuria and refining CKD classification/risk stratification, but it complements eGFR rather than replacing it as the primary indicator of baseline filtration function.

Question 11

Question Type: MultipleChoice

CMS-HCC risk adjustment methodology seeks to measure

Options:

A- an individual's anticipated cost of care.
B- a beneficiary's risk of mortality.
C- group beneficiary costs.
D- physician cost of care provision.

Answer:

A

Explanation:

The CMS-HCC risk adjustment methodology is designed to estimate an individual beneficiary's expected healthcare resource use and cost relative to an average Medicare beneficiary. It does this by converting demographic factors (such as age/sex and certain eligibility variables) plus documented, coded chronic conditions into a Risk Adjustment Factor (RAF). That RAF is then used to forecast the likely cost of caring for that specific patient in the payment year and to adjust benchmarks/payments so plans and providers managing sicker patients are compared more fairly to those managing healthier patients. This is why outpatient CDI emphasizes accurate, specific documentation and annual recapture of active conditions that are monitored, evaluated, assessed/addressed, or treated---because those coded conditions drive the predicted cost profile. CMS-HCC is not a mortality prediction tool (eliminating B), nor is it intended to measure ''group costs'' as the primary target (C), even though aggregated risk scores can be used for population analytics. It also does not measure an individual physician's cost of care provision (D); it measures patient-level expected cost burden.