

Boost up Your Certification Score

ACDIS CCDS

Certified Clinical Documentation Specialist



For More Information – Visit link below:

<https://www.examsboost.com/>

Product Version

- ✓ Up to Date products, reliable and verified.
- ✓ Questions and Answers in PDF Format.

Visit us at: <https://www.examsboost.com/test/ccds>

Latest Version: 6.0

Question: 1

A CDI specialist is asked to develop an educational presentation for a physician group on how documentation affects patient outcome measures within the CDI department. Which of the following is the MOST important measure to include when developing the presentation?

- A. CC/MCC capture rate
- B. number of patients reviewed monthly
- C. expected/observed mortality ratio
- D. CDI/Coder agreement rates

Answer: C

Explanation:

The mortality ratio is the option most directly associated with patient outcome measurement and risk-adjusted quality reporting. Although the question uses the phrase expected/observed mortality ratio, mortality analytics are frequently expressed operationally as an observed-to-expected (O/E) mortality ratio. Documentation affects the expected component because severity-of-illness and risk-of-mortality models depend substantially on accurately reported diagnoses and comorbid conditions.

If important acute or chronic conditions are not documented or are insufficiently specified, coded data may portray a patient as less severely ill than the clinical reality. The expected mortality calculated by a risk-adjustment model may therefore be lower, potentially making actual mortality performance appear less favorable. This makes mortality analysis particularly useful when teaching physicians why documentation affects quality measures independently of reimbursement.

CC/MCC capture is useful for examining documentation and reimbursement performance but is not itself an outcome measure. Monthly review volume is a productivity metric, while CDI/coder agreement evaluates internal process performance.

The CCDS examination content specifically includes mortality reviews, interpretation of observed/expected ratios, severity of illness, risk of mortality, and documentation effects on publicly reported quality data.

Question: 2

A patient undergoes outpatient surgery at 9:00 AM. At 1:00 PM, while still in outpatient status, the patient develops an acute complication. The physician writes an inpatient admission order at 4:00 PM. The complication remains present at that time. How is the condition generally treated for POA purposes?

- A. POA = N because it occurred in the hospital
- B. POA = Y because it was present when inpatient admission occurred
- C. POA = U because it began during outpatient care
- D. POA cannot apply to complications

Answer: B

Explanation:

POA status is determined in relation to the time of inpatient admission, not the patient's physical arrival at the hospital. Therefore, a condition that develops during outpatient surgery, emergency-department care, or observation and remains present when the inpatient admission order occurs is generally considered present on admission for inpatient POA reporting.

This concept can be counterintuitive because the condition technically developed after the patient entered the hospital building. However, CMS's POA framework distinguishes outpatient care from the subsequent inpatient admission.

The fact that the condition is a complication does not automatically make it POA = N. POA status and classification as a complication are separate concepts.

A "U" indicator signifies insufficient documentation to determine whether the condition was present at admission; it should not be selected merely because a condition arose during outpatient care before admission.

CDI specialists frequently need to establish precise clinical timelines involving emergency services, observation, procedures, admission orders, and onset of complications. Clear timing supports accurate POA assignment and is especially important when diagnoses intersect with CMS HAC payment logic. The CCDS framework specifically expects knowledge of POA and inpatient reimbursement regulations.

Question: 3

A CDI program reports the following monthly results:

- Provider response rate: 97%
- Provider agreement rate: 84%
- Queries issued after discharge: 38%
- CDI/coder agreement: 96%

Which metric presents the clearest opportunity to improve concurrent CDI workflow?

- A. Provider response rate
- B. Provider agreement rate
- C. Percentage of post-discharge queries
- D. CDI/coder agreement rate

Answer: C

Explanation:

The 38% post-discharge query rate represents the clearest workflow opportunity because a large proportion of clarification is occurring after the concurrent hospitalization period.

A 97% provider response rate reflects strong physician participation, while a 96% CDI/coder agreement rate indicates substantial alignment between concurrent CDI review and final coding. An 84% agreement rate is not inherently problematic because providers must remain free to disagree with a query based on their clinical judgment.

A high retrospective-query percentage can indicate that cases are being reviewed too late, that certain documentation opportunities are not recognized during hospitalization, that discharge documentation

introduces unresolved diagnoses, or that staffing/workflow does not adequately prioritize cases before discharge.

A CDI manager should drill further into the metric by service line, query type, day of stay, weekday/weekend discharge, provider group, and reason for retrospective clarification. This analysis helps distinguish unavoidable retrospective queries from remediable process problems.

The objective is not to eliminate every post-discharge query. Some documentation issues become apparent only after final testing, pathology, procedures, or discharge summaries are completed.

Question: 4

The physician evaluates a postoperative wound infection but states, "I cannot clinically determine whether the infection was already developing at admission or began after admission." Which POA indicator MOST accurately reflects this provider determination?

- A. Y
- B. N
- C. U
- D. W

Answer: D

Explanation:

POA indicator W means the provider is clinically unable to determine whether the condition was present on admission. That is precisely what is documented in this scenario.

This must be distinguished from POA indicator U. U means the documentation is insufficient to determine POA status, whereas W reflects an actual clinical determination that the timing cannot be established even after appropriate assessment.

Indicator Y means the condition was present when the inpatient admission order occurred, while N means it was not present at that point.

This distinction matters because POA status contributes to CMS Hospital-Acquired Condition payment logic and hospital quality analyses. CDI specialists should attempt to obtain clarification when timing is unclear, but they must accept a legitimate provider determination that onset cannot clinically be established.

Not every ambiguous timeline should be forced into either Y or N. When clinical evidence truly cannot resolve the timing, W is an appropriate reporting outcome.

CMS maintains separate annual POA-exempt resources and HAC/POA coding information for the applicable fiscal year.

Question: 5

The attending physician documents "acute systolic heart failure," while a consultant documents "chronic diastolic heart failure" for the same episode of care. Which provider should ultimately clarify the conflicting diagnostic documentation for coding purposes?

- A. Physician assistant
- B. Consulting physician

- C. Attending physician
- D. Emergency physician

Answer: C

Explanation:

The attending physician is the correct answer and this scenario is adapted from an official ACDIS CCDS sample item addressing conflicting medical-record documentation.

ICD-10-CM coding depends on provider documentation, but when clinically significant documentation conflicts within the record, the discrepancy must be clarified rather than resolved independently by the coder or CDI specialist. The FY 2026 Official Guidelines specifically state that when medical-record documentation conflicts, the patient's provider should be queried for clarification.

In the inpatient environment, the attending provider is generally responsible for synthesizing the patient's diagnoses and final clinical picture. A consultant's documentation may supply essential clinical information and may support code assignment when there is no conflict, but conflicting descriptions of heart-failure type or acuity should not simply be selected based on which diagnosis produces the higher-severity code.

The query should identify the conflicting statements objectively and request clarification of the clinically appropriate diagnosis. It should not suggest which diagnosis should be selected or mention reimbursement consequences.

This concept is central to CDI because unresolved contradictions can affect MS-DRG assignment, risk adjustment, severity measurement, quality reporting, and the clinical integrity of the record.

Question: 6

Which of the following programs specifically reduces applicable Medicare payments by 1% for hospitals in the worst-performing quartile based on hospital-acquired-condition measures?

- A. Hospital Value-Based Purchasing Program
- B. Hospital-Acquired Condition Reduction Program
- C. Medicare Shared Savings Program
- D. Inpatient Psychiatric Facility Quality Reporting Program

Answer: B

Explanation:

The Hospital-Acquired Condition Reduction Program (HACRP) imposes a 1% reduction in applicable Medicare fee-for-service payments on subsection (d) hospitals ranking in the worst-performing quartile based on the Total HAC Score.

For the current program, CMS uses six measures: the CMS Patient Safety and Adverse Events Composite (PSI 90) and five healthcare-associated infection measures—CLABSI, CAUTI, specified surgical-site infection, MRSA bacteremia, and C. difficile infection.

HACRP must be distinguished from the separate DRA Hospital-Acquired Condition/Present-on-Admission payment provision. CMS explicitly states that these are different programs.

Hospital Value-Based Purchasing also links quality performance with hospital payment, but its structure is different: it is funded through a 2% reduction of participating hospitals' base operating DRG payments that is redistributed through value-based incentives.

For CDI professionals, accurate clinical documentation helps ensure that quality data appropriately represent the patient's condition and hospital course. CDI should not attempt to suppress valid complications or create unsupported comorbidities to change quality performance.

Question: 7

A patient is admitted with nausea, confusion, and generalized weakness. Laboratory testing shows a serum sodium level of 119 mEq/L. The patient receives hypertonic saline and frequent serum sodium monitoring. The physician documents "electrolyte disturbance." Which condition is the MOST appropriate clarification opportunity?

- A. Hypernatremia
- B. Hyponatremia
- C. Hyperkalemia
- D. Metabolic alkalosis

Answer: B

Explanation:

The clinical findings strongly support clarification of hyponatremia. A serum sodium concentration of 119 mEq/L represents substantial reduction below the usual reference range, and neurologic manifestations such as confusion are consistent with clinically significant hyponatremia. Administration of hypertonic saline and frequent sodium monitoring further demonstrate that the electrolyte abnormality is clinically important.

The CDI specialist should not independently assign the diagnosis based solely on the laboratory result. Instead, the abnormal sodium level, neurologic symptoms, and targeted therapy provide an appropriate clinical basis for a neutral provider query.

Hypernatremia represents elevated serum sodium and therefore contradicts the laboratory finding. Hyperkalemia relates to potassium rather than sodium. Metabolic alkalosis is an acid-base disturbance requiring supporting blood-gas and chemistry findings and is not established by the information provided.

Further specificity may also matter. Depending on the clinical record, the physician may determine that the hyponatremia is related to SIADH, volume depletion, medication use, heart failure, cirrhosis, or another etiology.

The CCDS role is to recognize the clinical significance of laboratory abnormalities and obtain clinically meaningful provider documentation rather than simply translating abnormal values into diagnoses.

CCDS Reference Topics: Electrolyte abnormalities; hyponatremia; laboratory interpretation; clinical indicators; documentation clarification.

Question: 8

Two diagnoses both meet the definition of principal diagnosis and either could appropriately be sequenced first under the circumstances of admission. No specific sequencing instruction directs otherwise. Which rule applies?

- A. Always sequence the diagnosis with the higher reimbursement
- B. Either diagnosis may be sequenced first
- C. Always sequence the oldest diagnosis
- D. Query solely to determine which diagnosis produces the higher MS-DRG

Answer: B

Explanation:

When two diagnoses equally meet the definition of principal diagnosis, either condition may be sequenced first when the circumstances of admission, diagnostic workup, and treatment equally support both and no specific coding guideline, tabular instruction, or other sequencing rule directs otherwise.

The principal diagnosis cannot be selected based on which option generates higher payment. Financial outcome is not a legitimate sequencing criterion.

Likewise, chronological age of the diagnosis does not determine principal-diagnosis status. The principal diagnosis is established after study as the condition chiefly responsible for occasioning the admission.

A CDI query may be appropriate when the documentation does not actually establish whether both diagnoses equally occasioned the admission. However, querying simply because one sequencing choice would produce a more favorable MS-DRG is inappropriate.

This scenario tests the distinction between valid coding flexibility and improper reimbursement-driven documentation practices. CDI professionals must understand coding conventions well enough to avoid unnecessary queries while recognizing genuine ambiguity that requires provider clarification.

The FY 2026 MS-DRG grouper and Definitions Manual published by CMS provide the applicable grouper logic for the current fiscal year.

Question: 9

For FY 2026 Hospital Value-Based Purchasing, each of the four scored domains generally contributes what percentage to the Total Performance Score when all four domains are scored?

- A. 10%
- B. 20%
- C. 25%
- D. 40%

Answer: C

Explanation:

When all four Hospital VBP domains are scored, each domain contributes 25% of the hospital's Total Performance Score.

For FY 2026, the four domains are Clinical Outcomes, Person and Community Engagement, Safety, and Efficiency and Cost Reduction. CMS's Provider Data Catalog confirms that each contributes one-quarter of the Total Performance Score under the standard four-domain configuration.

The Clinical Outcomes domain includes mortality and complication measures. Person and Community Engagement incorporates HCAHPS patient-experience dimensions. The Safety domain contains healthcare-associated infection and safety-related measures, while Efficiency and Cost Reduction incorporates Medicare spending measures.

If a hospital receives valid scores in only three domains, CMS proportionately reweights the scored domains rather than simply assigning zero to the missing domain.

For CCDS practice, understanding these domains helps explain why accurate documentation influences more than MS-DRG reimbursement. Clinical documentation can affect severity adjustment, complications analysis, mortality calculations, and the reliability of administrative data used in performance measurement.

Question: 10

A hospital's case is assigned to an MS-DRG with a relative weight of 2.0000. What does the relative weight primarily indicate?

- A. The patient is twice as sick as the average Medicare patient
- B. The case is expected to consume approximately twice the average relative resources
- C. The hospital should bill twice its normal charges
- D. The patient's expected mortality is twice the national rate

Answer: B

Explanation:

An MS-DRG relative weight represents relative expected resource consumption, not a direct severity score or mortality probability. Therefore, a relative weight of approximately 2.0 means the MS-DRG is associated with roughly twice the resource intensity of the average case represented by the standardized reference point.

CMS calculates and recalibrates MS-DRG relative weights using national hospital data as part of IPPS rate setting. The FY 2026 final-rule materials include the MS-DRG weighting factors as well as supporting cost data used in the relative-weight methodology.

Clinically complex cases often consume more resources, so relative weight may correlate with severity. However, it is not equivalent to a patient's severity-of-illness score or risk-of-mortality score. Likewise, hospitals do not simply multiply their billed charges based on the DRG weight. IPPS payment involves the standardized amount plus various adjustments, including wage index and other applicable payment factors.

For CDI, accurate documentation matters because diagnoses and procedures drive MS-DRG assignment, and the assigned MS-DRG carries its specific relative weight

Thank You for Trying Our Product

For More Information – **Visit link below:**

<https://www.examsboost.com/>

15 USD Discount Coupon Code:

G74JA8UF

FEATURES

- ✓ **90 Days Free Updates**
- ✓ **Money Back Pass Guarantee**
- ✓ **Instant Download or Email Attachment**
- ✓ **24/7 Live Chat Support**
- ✓ **PDF file could be used at any Platform**
- ✓ **50,000 Happy Customer**



Visit us at: <https://www.examsboost.com/test/ccds>