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Exam : **CCDS**

Title : Certified Clinical Documentation Specialist

Version : DEMO

1.The table below shows physician performance:

Physician	# of discharges	# of Deaths	Observed Mortality Rate	Risk Adjusted Mortality Rate
1	300	5	1.6	1.5
2	250	7	2.8	2.0
3	150	5	3.3	2.5
4	350	7	2.0	1.3

Which of the following physicians will have the most favorable mortality rate on a public website, such as Healthgrades.com?

A. 1

B. 2

C. 3

D. 4

Answer: D

Explanation:

Physician 4 has the most favorable risk-adjusted mortality rate, at 1.3, compared with Physician 1 at 1.5, Physician 2 at 2.0, and Physician 3 at 2.5. Although Physician 1 has fewer observed deaths and an observed mortality rate of 1.6%, public outcome comparisons commonly incorporate risk adjustment rather than relying solely on raw mortality. Risk adjustment attempts to account for differences in patient complexity, comorbid disease burden, demographic factors, and other characteristics that influence expected outcomes.

This is directly relevant to CDI because incomplete documentation of clinically significant comorbidities can understate patient severity and therefore adversely affect the expected mortality component of risk-adjusted performance calculations. Conversely, accurate documentation allows coded data to represent the actual severity and risk of the population being treated. Healthgrades specifically states that its mortality methodology adjusts for patient risk factors to permit more meaningful comparisons of clinical outcomes.

The CCDS content outline specifically requires knowledge of mortality indices, severity of illness/risk of mortality, physician performance, and the effect of documentation on publicly reported data.

CCDS Reference Topics: Impact of reportable diagnoses on quality of care; Healthcare facility CDI program analysis; mortality index and risk adjustment.

2.A patient's baseline serum creatinine is 0.9 mg/dL. Forty-eight hours after admission, the creatinine is 1.5 mg/dL. Urine output has also decreased.

Which condition is most appropriate for the CDI specialist to consider as a clarification opportunity?

A. Chronic kidney disease

B. Acute kidney injury

C. End-stage renal disease

D. Nephrotic syndrome

Answer: B

Explanation:

The laboratory trajectory strongly supports consideration of acute kidney injury (AKI). The creatinine increased from 0.9 to 1.5 mg/dL, an absolute increase of 0.6 mg/dL over 48 hours and approximately 1.67 times the baseline value. Combined with decreased urine output, this represents a clinically

significant acute change in renal function.
The key distinction is the acute change from baseline. A single creatinine value cannot reliably establish AKI because renal function must be interpreted in context, including baseline creatinine, fluid status, urine output, medications, hemodynamics, and other contributing factors.
Chronic kidney disease requires evidence of persistent kidney abnormality over time rather than an isolated rapid deterioration. End-stage renal disease represents advanced irreversible kidney failure and is not supported by this scenario. Nephrotic syndrome is characterized by a different constellation including heavy proteinuria, hypoalbuminemia, and edema.
The CDI specialist should not independently diagnose AKI. Instead, the laboratory trend and reduced urine output create an appropriate basis for a provider query when no corresponding diagnosis has been documented.
CCDS Reference Topics: Renal pathophysiology; AKI clinical indicators; baseline comparison; diagnostic clarification.

3.A physician responds to a clinically supported CDI query by stating that the proposed diagnosis does not apply and documents a different diagnosis supported by the patient's condition.
What is the BEST action by the CDI specialist?
A. Ask the physician repeatedly until the desired diagnosis is documented
B. Accept the physician's clinical judgment and ensure the resulting documentation is clear
C. Escalate every disagreement to the chief medical officer
D. Replace the physician's diagnosis with the diagnosis preferred by CDI
Answer: B
Explanation:
The CDI specialist should respect the provider's independent clinical judgment, provided the response clearly addresses the query and the resulting documentation is clinically coherent.
A query is a request for clarification—not a mechanism for compelling the provider to select CDI's preferred diagnosis. Physician disagreement is therefore not inherently a failed query. The provider may appropriately document another condition, rule out a suspected condition, or explain why the indicators have another clinical interpretation.
Repeatedly querying until a desired diagnosis appears creates serious compliance risk and can undermine the integrity of the documentation process. Escalation may be appropriate in defined circumstances—for example, unresolved contradictions, unanswered high-priority queries, or persistent clinical-validation issues—but should follow organizational policy and should not occur merely because CDI dislikes the provider's answer.
The 2026 ACDIS/AHIMA guidance is the current foundational query-practice standard and emphasizes compliant clarification across healthcare settings.
Effective CDI communication requires clinical knowledge, professional dialogue, and recognition that final diagnostic determinations belong to the responsible provider. CCDS Reference Topics: Physician communication; query responses; provider independence; escalation; professional conduct.

4.A patient's chest x-ray shows pulmonary vascular congestion and pleural effusions.
These findings are most consistent with which of the following conditions?
A. COPD
B. Cor pulmonale

C. Heart failure
D. Pulmonary embolism
Answer: C
Explanation:
Pulmonary vascular congestion accompanied by pleural effusions is classically associated with congestive heart failure, particularly left-sided or biventricular decompensation. Increased left-sided cardiac filling pressure raises pulmonary venous and capillary hydrostatic pressure, promoting interstitial and alveolar fluid accumulation. Fluid may also migrate into the pleural space, producing unilateral or bilateral pleural effusions. Additional radiographic indicators of heart failure may include cardiomegaly, cephalization of pulmonary vessels, interstitial edema, Kerley B lines, perihilar alveolar opacities, and bilateral effusions. These findings should always be interpreted alongside symptoms and other clinical evidence such as dyspnea, orthopnea, edema, BNP/NT-proBNP, echocardiography, and response to diuretics.
COPD more commonly demonstrates hyperinflation, flattened diaphragms, and increased lucency rather than pulmonary vascular congestion. Cor pulmonale refers to right-sided cardiac dysfunction resulting from pulmonary disease and does not typically produce the classic pulmonary venous congestion pattern. Pulmonary embolism may have a normal chest radiograph or nonspecific abnormalities, but pulmonary vascular congestion with effusions is not its characteristic pattern.
For CDI purposes, imaging provides a clinical indicator but does not independently establish the diagnosis or acuity of heart failure.
CCDS Reference Topics: Heart failure pathophysiology; chest radiography; clinical indicators; cardiopulmonary terminology.

5.An 82-year-old patient with a urinary infection develops an acute fluctuating disturbance in attention, disorganized thinking, and altered level of consciousness. The family states the patient was cognitively normal three days earlier.
Which condition is MOST consistent with this presentation?
A. Chronic dementia
B. Delirium
C. Persistent vegetative state
D. Intellectual disability
Answer: B
Explanation:
The presentation is most consistent with delirium, an acute and fluctuating disturbance in attention, awareness, and cognition that frequently develops in medically ill hospitalized patients.
The abrupt onset over several days and fluctuating cognitive state distinguish delirium from most forms of dementia, which generally develop progressively over months or years. Infection, medications, metabolic abnormalities, dehydration, hypoxia, and organ dysfunction are common precipitants.
A urinary infection may be a contributing clinical factor, but CDI should not automatically establish a cause-and-effect relationship between infection and delirium unless supported by provider documentation.
The CDI specialist should also recognize that terms such as “altered mental status” are symptoms rather than equivalent substitutes for a more specific diagnosis. When the clinical record contains sufficient indicators and the provider has documented only nonspecific mental-status terminology, a query may be

warranted.
Intellectual disability represents a developmental condition rather than an acute change in cognition. A persistent vegetative state represents profound and persistent impairment of consciousness and is inconsistent with the described fluctuating presentation.
CCDS Reference Topics: Delirium; altered mental status; cognitive disorders; clinical indicators; documentation specificity.