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Topic Break Down

Topic	No. of Questions
Topic 1, Clinical	23
Topic 2, Coding	58
Topic 3, Quality	37
Topic 4, Compliance	18
Topic 5, CDI	30
Total	166

QUESTION NO: 1

In which of the following situations would a yes/no query format be considered compliant?

A. Clarifying acuity of disease process

B. Obtaining a new (previously undocumented) diagnosis

C. Obtaining a specification of a contributing organism to an infection

D. Resolving conflicting documentation from multiple providers

ANSWER: D

Explanation:

Resolving conflicting documentation from multiple providers is an appropriate use of a yes/no query when the query is limited to reconciling an existing inconsistency in the health record. For example, when documentation contains contradictory statements about whether a condition was present, active, or clinically applicable during the encounter, a concise confirmation question can enable the responsible provider to clarify the record. The query should accurately identify the conflicting documentation, be supported by relevant clinical facts when needed, and allow the provider to decline or indicate that the issue cannot be determined. Its purpose is to establish a clear, consistent account of the patient's condition based on information already documented—not to suggest or introduce a diagnosis. The 2022 Guidelines for Achieving a Compliant Query Practice recognize yes/no queries as suitable for clarifying conflicting documentation, provided the wording remains non-leading and the query is clinically and documentation supported. This clarification supports accurate code assignment, reliable quality reporting, and a complete outpatient record while preserving provider autonomy and the integrity of the documentation. See the 2022 Guidelines for Achieving a Compliant Query Practice and ACDIS guidance on compliant query practice.

QUESTION NO: 2

A patient presents to the PCPâ€™s office with LLE edema and pain for 3 days. The problem list indicates morbid obesity and a history of DVT. Vital signs are T 37.9, P 76, R 12, BP 142/88, BMI 46. Documentation states: â€œPatient presents with LLE edema, increased pain, and hx of DVT. Sedentary lifestyle and contraindications to anticoagulation therapy. LLE warm to touch, 3+ edema from ankle to knee. Pedal pulses 2+ on L and 3+ on R.â€ Doppler exam indicates DVT. The PCP should be queried for which of the following diagnoses?

A. Morbid obesity and status of the DVT

B. Hypercoagulability and hypertensive urgency

C. Hypertensive urgency and status of the DVT

D. Hypercoagulability and morbid obesity

ANSWER: A

Explanation:

“Morbid obesity and status of the DVT” is correct because the record contains clinically meaningful evidence that warrants clarification for complete, accurate outpatient documentation. A body mass index of 46 supports the documented diagnosis of morbid obesity, but the provider should clearly establish its clinical relevance when it affects assessment, risk, or management. In this case, obesity is pertinent to thrombotic risk and may influence care planning for a patient with confirmed venous thrombosis and stated contraindications to anticoagulation.

Most importantly, the Doppler finding of DVT is not sufficiently characterized in the provider documentation. The patient also has a history of DVT, so the clinician should clarify whether the current finding represents an acute new thrombosis, recurrent thrombosis, chronic/residual thrombosis, or another applicable status. This distinction materially affects the diagnostic representation of the encounter and supports the rationale for treatment or monitoring decisions. A compliant query may be used when the health record contains clinical indicators and diagnostic ambiguity, provided it is non-leading and offers clinically reasonable choices. Outpatient diagnosis reporting must be based on conditions documented by the

responsible provider, rather than an interpretation of test results alone. See the ACDIS query-practice guidance and the CDC ICD-10-CM resources.

QUESTION NO: 3

A patient is seen by an endocrinologist to manage his poorly controlled diabetes with peripheral neuropathy and claudication. The patient has had several toes amputated in prior years and currently has a non-healing ulcer on the left foot. The patient's additional chronic conditions consist of the following: HF, CAD, COPD, history of prostate cancer, arthritis, depression, and sleep apnea. Which of the following chronic conditions should the CDI specialist consider for future education regarding RAF impact with the endocrinologist?

A. Sleep apnea, depression, and HF

B. Diabetes, amputation, and skin ulcer

C. CAD, diabetes, and COPD

D. History of prostate cancer, arthritis, and A1C

ANSWER: B

Explanation:

Diabetes, amputation, and skin ulcer is correct because these diagnoses are directly relevant to the endocrinologist's ongoing management of the patient's diabetes and represent important areas for complete, specific documentation and risk adjustment capture. The record describes diabetes with neurologic and circulatory manifestations, a current non-healing foot ulcer, and prior toe amputations. When these conditions are assessed and managed, documentation should clearly establish the causal relationship of the ulcer and other complications to diabetes when clinically supported, as well as the ulcer's site, laterality, and severity. Coding guidance requires both the diabetes combination code and an additional code to identify the site and severity of a diabetic foot ulcer. Amputation status should likewise be documented when clinically relevant to current care, since it reflects lasting patient complexity and can affect risk-model classification. Education should emphasize accurate reporting of all active, evaluated conditions rather than simply listing historical facts. CMS publishes the diagnosis mappings and model software used for risk adjustment, which should be checked for the applicable payment year. See the CMS Risk Adjustment resources and the ICD-10-CM Official Guidelines for Coding and Reporting.

QUESTION NO: 4

Which of the following BEST represents performance metrics important to an outpatient CDI program?

A. Medicare Case Mix Index, aggregate RAF scores, and clinical denial rate

B. HCC capture rate, unspecified code utilization rate, and query response rate

C. Severity of illness, HCC capture rate, and Medicare Case Mix Index

D. Number of secondary diagnoses per claim, aggregate RAF score, and quality indicators

ANSWER: B

Explanation:

HCC capture rate, unspecified code utilization rate, and query response rate best represent meaningful outpatient CDI performance metrics because they measure the central effects of outpatient documentation-improvement work: complete risk capture, clinically specific documentation, and successful provider engagement. HCC capture monitoring helps an organization determine whether conditions that are evaluated, assessed, and managed during the encounter are being documented and coded with sufficient specificity to accurately represent patient risk. This is particularly important in value-based and Medicare Advantage settings, where CMS risk-adjustment models use diagnosis information to reflect expected patient costs and complexity. Unspecified-code utilization provides a practical way to identify documentation patterns that may need focused education, such as missing acuity, anatomical detail, disease stage, or causal relationships. Query response rate measures whether the CDI workflow is obtaining timely clarification from providers and supports monitoring of

provider participation and query-process effectiveness. Together, these measures are actionable and align CDI activity with accurate outpatient clinical representation, coding integrity, and risk-adjustment readiness. CMS describes the role of diagnosis data in its risk-adjustment program at CMS Risk Adjustment. Additional outpatient CDI practice resources are available from ACDIS Outpatient CDI.

QUESTION NO: 5

The table below provides data indicating the use of Major Depressive Disorder (MDD) diagnosis code assignment for years 1 and 2 of an ambulatory CDI program. Based on the data and if the HCC value assigned to MDD was 0.299, which of the following should be inferred?

A. The number of patients increased with an equal increase in use of MDD specified and a decrease in MDD, unspecified, not impacting future cost benchmarking.

B. The number of patients increased with an increase in use of MDD specified and a decrease in MDD, unspecified, impacting future cost benchmarking.

C. The number of patients increased with the difference between MDD specified and MDD, unspecified insignificant, not impacting future cost benchmarking.

D. The number of patients increased with an increase in use of MDD specified and an increase in MDD, unspecified, impacting future cost benchmarking.

ANSWER: B

Explanation:

The number of patients increased with an increase in use of MDD specified and a decrease in MDD, unspecified, impacting future cost benchmarking. This inference reflects both the reported change in the patient population and the shift toward more specific documentation and code assignment. When a diagnosis maps to an HCC with a value of 0.299, it contributes to the beneficiary's risk-adjustment factor. Therefore, a greater number of patients assigned a supported, risk-adjustable MDD diagnosis changes the aggregate risk profile of the population. That change is meaningful for future cost benchmarking because expected costs are evaluated in the context of the documented disease burden and associated risk scores. Accurate capture of clinically supported MDD specificity helps ensure that the population's measured risk more closely reflects the conditions being managed in the ambulatory setting. CMS explains that its risk-adjustment methodology uses diagnoses to predict expected costs for enrolled beneficiaries; HCCs and their coefficients are central to that process. See the CMS Risk Adjustment resource and CMS's ICD-10-to-HCC mappings for supporting methodology and mappings.

QUESTION NO: 6

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

Explanation:

First-listed diagnosis is the correct outpatient sequencing term because it identifies the condition, symptom, problem, or other reason for the encounter that is chiefly responsible for the services furnished and documented at that visit. In an outpatient record, this selection reflects the focus of the encounter as supported by the provider's documentation, including evaluation, treatment, management, diagnostic workup, or follow-up care. The first-listed diagnosis should accurately

communicate why the patient received services on that date and should be sequenced before additional reportable conditions that were also addressed or that affected care.

The Official Guidelines for Coding and Reporting distinguish outpatient coding from inpatient admission coding by directing coders to report the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided as the first-listed diagnosis. This convention is especially important in physician-office, clinic, emergency department, and other ambulatory encounters, where the documented reason for care may be a confirmed condition or, when appropriate, a sign or symptom. Applying first-listed diagnosis sequencing supports a clear, faithful representation of the encounter and appropriate claim reporting. See the ICD-10-CM Official Guidelines for Coding and Reporting and the CMS ICD-10 coding resources.

QUESTION NO: 7

A patient is seen in the office for a persistent cough. Provider documentation states: “History of chronic obstructive pulmonary disease, asthma, and hypertension. Hypertension treated with Enalapril. Cough an adverse effect of the ACE inhibitor; discontinue Enalapril. COPD stable. Instructed to continue meds for COPD/asthma.” Which of the following diagnoses should be reported for this encounter?

A. COPD, unspecified; asthma, unspecified, uncomplicated; hypertension

B. Cough; adverse effect of an ACE inhibitor; COPD, unspecified; hypertension

C. COPD, unspecified; hypertension

D. Cough; adverse effect of an ACE inhibitor; COPD, unspecified; asthma, unspecified, uncomplicated; hypertension

ANSWER: D

Explanation:

Cough; adverse effect of an ACE inhibitor; COPD, unspecified; asthma, unspecified, uncomplicated; hypertension is correct because each condition is either evaluated, managed, or affects medical decision-making during this office encounter. The persistent cough is the presenting problem and is expressly linked by the provider to a correctly administered ACE inhibitor. For an adverse drug effect, outpatient coding reports the manifestation—in this case, cough—together with the applicable adverse-effect code for the medication. The provider’s decision to discontinue enalapril is active treatment directed at the medication-related adverse effect and also demonstrates that hypertension remains relevant to management at the visit.

The chronic pulmonary conditions are also reportable. COPD is assessed as stable, which constitutes provider evaluation of an active condition, and the instruction to continue medications for COPD and asthma reflects continued management of both diagnoses. “History of” does not prevent reporting a condition when the remainder of the note establishes that it is current and being managed. Outpatient coding guidelines instruct coders to report all conditions that coexist at the time of the encounter and require or affect patient care, treatment, or management. See the ICD-10-CM Official Guidelines for Coding and Reporting, especially outpatient reporting and adverse-effect guidance, and the CMS ICD-10-CM resources.

QUESTION NO: 8

A female patient who underwent total hip replacement 2 weeks ago is in for a follow-up visit with her PCP. The visit note states: “Patient complains of fatigue and lethargy. Hgb on discharge was 10.4gm/dL - now is 8.6 gm/dL. Will start FeSO4 325mg po daily with food. Repeat H/H in 2 weeks. She has return visit with Ortho then.” Which of the following is the BEST course of action for the CDI specialist?

A. Instruct the provider to add iron deficiency anemia to the problem list.

B. Review the lab work referenced by the provider in the progress note for congruence.

C. Query the provider for a diagnosis related to fatigue, decreased Hgb, and FeSO4.

D. Add acute blood loss anemia to the diagnoses reported on the claim.

ANSWER: C

Explanation:

"Query the provider for a diagnosis related to fatigue, decreased Hgb, and FeSO4" is the best action because the note presents clinically relevant indicators of a possible anemia but does not establish a reportable diagnosis or its type. The patient has fatigue and lethargy, a documented hemoglobin decline from 10.4 g/dL to 8.6 g/dL after recent hip replacement, and a management plan that includes oral ferrous sulfate and repeat hemoglobin/hematocrit testing. These facts support clarification, but they do not permit the CDI specialist to independently diagnose anemia, determine iron deficiency, or assign a postsurgical blood-loss relationship. A non-leading query gives the treating provider an opportunity to state the clinically supported condition, if any, and to document relevant specificity such as type, acuity, and relationship to the recent procedure when clinically appropriate. The query should include the relevant objective and clinical indicators, be framed to allow the provider to document another diagnosis or no diagnosis, and remain consistent with organizational compliant-query policy. In the outpatient setting, code assignment is based on the provider's documented diagnoses rather than CDI inference from laboratory results or treatment alone. This approach supports accurate, complete documentation and appropriate reporting. See the ICD-10-CM Official Guidelines for Coding and Reporting and AHIMA's Guidelines for Achieving a Compliant Query Practice.

QUESTION NO: 9

HCC category assignment methodology is similar to which of the following?

A. DRG diagnostic categories

B. 835 claim submission

C. ICD-10-PCS coding

D. CPT coding

ANSWER: A

Explanation:

DRG diagnostic categories is correct because both HCC assignment and diagnosis-related group methodology transform detailed diagnosis information into a smaller set of clinically meaningful categories used in payment-related methodologies. In the CMS-HCC risk-adjustment model, reported ICD-10-CM diagnoses are mapped through a classification system to condition categories representing conditions with similar anticipated healthcare costs. The model then applies a hierarchy when related conditions are present, so that the condition category reflecting the most severe manifestation is retained rather than cumulatively counting related diagnoses. This is conceptually similar to DRG logic, which organizes a patient stay using clinical classification and diagnosis information to create a payment group that reflects expected resource use. In each approach, the individual diagnosis code is the input, while the assigned category is the payment or risk-adjustment construct. The comparison concerns the grouping methodology, not the care setting: HCCs estimate prospective patient risk and expected cost, whereas Medicare Severity DRGs classify inpatient hospital stays for payment. CMS provides the CMS-HCC model mappings and methodology at CMS Risk Adjustment and describes the Medicare Severity DRG payment framework at CMS MS-DRG Classifications and Software.

QUESTION NO: 10

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

Explanation:

Symbicort® is used for persistent asthma because it combines budesonide, an inhaled corticosteroid, with formoterol, a long-acting beta$_2$-agonist. Budesonide reduces the airway inflammation that contributes to asthma symptoms and exacerbation risk, while formoterol provides prolonged bronchodilation to help maintain airway patency. This combination is a controller medication for patients whose asthma requires treatment with both an inhaled corticosteroid and a long-acting bronchodilator; it is not simply a short-acting rescue inhaler for immediate symptom relief. Persistent asthma is therefore the best match among the listed conditions. In outpatient documentation review, the presence of this medication can be a useful clinical indicator to evaluate whether asthma is clearly documented, assessed, and managed at the encounter, including relevant details such as severity, control, and exacerbation status when supported by the record. The FDA-approved prescribing information identifies Symbicort for asthma treatment in appropriate patients, and product information also describes its maintenance role in chronic airway disease. See the FDA Drugs@FDA record for Symbicort and Symbicort prescribing and patient information.

QUESTION NO: 11

A CDI specialist reviews the record of a patient with a history of CHF and DM Type 2 who was seen in the clinic earlier that day for possible bronchitis, fever, congestion, dyspnea, and cough. A chest x-ray indicated LLL infiltrate, and a nebulizer treatment was administered while in the office. Levofloxacin and albuterol were prescribed. Which of the following is MOST appropriate to query?

A. Presence of pneumonia

B. Diabetic complications

C. Acuity of bronchitis

D. Specificity of heart failure

ANSWER: A

Explanation:

Presence of pneumonia is the most appropriate query focus because the encounter contains clinical indicators that may support a diagnosis more specific and clinically significant than the documented possible bronchitis. These indicators include fever, cough, dyspnea, a left-lower-lobe infiltrate identified on chest radiography, administration of a nebulizer treatment during the visit, and treatment with levofloxacin. Taken together, the findings reasonably create a documentation clarification opportunity regarding the condition the clinician evaluated and treated.

In the outpatient setting, diagnoses documented as uncertain, such as “possible,” are not reported as established conditions. Instead, coding is based on the highest degree of certainty documented for that encounter, including symptoms and confirmed findings. A compliant, non-leading query can therefore ask the treating clinician to clarify the diagnosis associated with the infiltrate and the treatment plan, while presenting the relevant clinical evidence and allowing clinically appropriate response options, including pneumonia, bronchitis, another diagnosis, or inability to determine. This clarification supports complete and accurate documentation of the condition chiefly responsible for the services provided. See the ICD-10-CM Official Guidelines for Coding and Reporting and the AHIMA compliant query practice guidelines.

QUESTION NO: 12

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: C

Explanation:

DM Type 2 without complications, HTN, alcohol dependence is supported by the provider's assessment and the care addressed during the encounter. The provider explicitly states that the patient "continues to be dependent on alcohol," while documenting a pattern of substantial daily consumption and early-morning drinking. The provider also offered treatment options for the alcohol dependence, establishing that this condition was evaluated and managed during the visit. In outpatient coding, code assignment is based on the provider's documented diagnosis; the more specific documented alcohol-related diagnosis should be reported when supported by the record.

Hypertension is supported by the elevated blood-pressure measurement of 165/89 and by the documented discussion of medications and diet, demonstrating active management. Type 2 diabetes without complications is the supported diabetes category because diabetes is included among the chronic conditions followed, but the note does not document a diabetic complication. Outpatient coding should not infer complications that the provider has not diagnosed. These principles are consistent with the ICD-10-CM Official Guidelines for Coding and Reporting and the CDC's ICD-10-CM resources: CMS ICD-10-CM Official Guidelines and CDC ICD-10-CM information.

QUESTION NO: 13

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: D

Explanation:

The expected yearly cost is **$5,836.80**. The patient's RAF is 0.608, calculated from the applicable demographic, condition-category, and interaction factors. RAF is a relative risk measure: a score of 1.000 represents average predicted expenditure for the applicable reference population, while 0.608 represents 60.8% of that benchmark. Using the stated $800 per-member-per-month baseline, the predicted monthly amount is $800 × 0.608 = $486.40. Because the question asks for a yearly amount, multiply the monthly predicted cost by 12: $486.40 × 12 = $5,836.80. In outpatient CDI, complete, specific, and clinically supported documentation is essential because valid coded diagnoses may map to risk-adjustment categories and contribute to the patient's prospective risk profile. RAF-based calculations support projected costs and resource planning; they do not establish clinical severity independently and should never encourage reporting diagnoses that are not documented and supported by the encounter record. CMS describes its risk-adjustment models and associated model software at CMS Risk Adjustment. Additional coding guidance for diagnosis reporting in outpatient settings is available in the ICD-10-CM Official Guidelines.

QUESTION NO: 14

The primary purpose of the RADV program is to

A. ensure risk-adjusted payment integrity and accuracy.

B. verify medical necessity of care provided.

C. identify over-payments rendered to individual physicians.

D. support accuracy of Evaluation and Management billing.

ANSWER: A

Explanation:

RADV, or Risk Adjustment Data Validation, is designed to protect the accuracy and integrity of risk-adjusted payments in the Medicare Advantage program. Medicare Advantage organizations receive capitated payments that are adjusted to reflect enrolled beneficiaries' documented health status and expected costs of care. RADV audits compare diagnosis information submitted for risk adjustment with supporting medical-record documentation to determine whether the diagnoses satisfy applicable reporting requirements. This validation helps CMS confirm that payments reflect conditions that were actually documented and reportable for the audited beneficiaries. When submitted diagnoses are unsupported, RADV findings may affect the risk-adjustment payment amount and can result in recovery of improper payments. For outpatient CDI professionals, this purpose reinforces the importance of clear, complete, and clinically supported provider documentation for conditions reported in risk-adjustment data. Documentation should establish that a condition was relevant to the encounter and appropriately evaluated, assessed, addressed, monitored, or treated, as applicable. CMS describes RADV as an effort to validate the accuracy of diagnosis data used to calculate Medicare Advantage risk-adjusted payments. See CMS's Medicare Risk Adjustment Data Validation program overview and its Medicare Advantage risk adjustment resources.

QUESTION NO: 15

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

Explanation:

Depth of diabetic ulcer is the appropriate query opportunity because the record identifies a diabetic ulcer of the left great toe but does not document the ulcer's severity. ICD-10-CM reporting for a diabetes mellitus foot ulcer requires the diabetes combination code and an additional code from category L97 to identify the ulcer site and severity. For a non-pressure chronic ulcer of the foot, the severity is reported as limited to breakdown of skin, with fat layer exposed, with necrosis of muscle, with necrosis of bone, or unspecified severity. A clinically appropriate, non-leading query can ask the provider to clarify the deepest level of tissue involved, if known and clinically supported by the encounter documentation. This clarification enables complete and accurate code assignment for the diabetic foot ulcer and supports accurate capture of the patient's chronic disease burden for applicable risk-adjustment models. The ICD-10-CM Official Guidelines specifically instruct coders to use an additional L97.- code to identify the site of a diabetic foot ulcer; that code includes the required severity detail. See the CMS ICD-10-CM resources and the ICD-10-CM Official Guidelines for Coding and Reporting.

QUESTION NO: 16

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

Explanation:

“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.” is the most compliant query because it seeks clarification of the provider’s clinical intent using relevant, encounter-specific facts. The absence of documented gastrointestinal symptoms and the presence of a family history of colon cancer provide a clear clinical basis for asking whether the planned service is preventive screening or is being performed to evaluate a condition. That distinction can materially affect accurate documentation, reporting, coverage, and medical-necessity support.

The wording is appropriately neutral: it does not direct the provider to select either screening or diagnostic status, assert an undocumented diagnosis, or tie the requested clarification to reimbursement. Instead, it leaves the final clinical determination to the provider after evaluation. This approach aligns with compliant-query principles that queries should be supported by clinical indicators, be non-leading, and clarify the health record rather than introduce unsupported information. The request also appropriately identifies the documentation issue that needs resolution before coding and reporting. See the ACDIS guidance on compliant queries and CMS information on colorectal cancer screening services.