

CCDS-O合格内容 & CCDS-O独学書籍



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試験準備のための学習資料を見つけている場合、当社の資料は検索を終了します。私たちのCCDS-O試験トレントは、あなたが期待できない高品質を持っています。CCDS-O試験トレントは時間を大幅に節約するのに役立ち、あなたがやりたいことをする自由時間が増えると思います。私たちのCCDS-Oテスト問題集の使用について後悔がないことを保証できます。アクションの時間が来たら、思考を止めて、入って、私たちのCCDS-O試験トレントを試してください。CCDS-O試験に合格し、短時間で証明書を取得する必要があります。

>> CCDS-O合格内容 <<

有用的なCCDS-O合格内容 & 資格試験のリーダープロバイダー & 初段のCCDS-O独学書籍

Pass4TestのCCDS-O問題集を買ったら1年間の無料オンラインのアップデートを提供する一方で、試験に失敗したら、お客様に全額で返金いたします。

ACDIS CCDS-O 認定試験の出題範囲:

トピック	出題範囲
トピック 1	<ul style="list-style-type: none">• Risk Adjustment Models and Impact of Documentation and Coding: Covers CMS-HCC model fundamentals, RAF scoring, Medicare Advantage payments, hierarchies, disease interactions, and compliant HCC reporting requirements.

トピック 2	<ul style="list-style-type: none"> • Quality, Regulatory, and Health Initiatives: Covers population health, MSSP, ACO models, MACRA • MIPS, compliant query development, RADV audits, OIG compliance, problem list maintenance, and HIPAA requirements in outpatient CDI.
トピック 3	<ul style="list-style-type: none"> • Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding

ACDIS Certified Clinical Documentation Specialist-Outpatient 認定 CCDS-O 試験問題 (Q58-Q63):

質問 # 58

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

正解: C

解説:

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.

質問 # 59

The primary purpose of the RADV program is to

- A. support accuracy of Evaluation and Management billing.
- B. identify over-payments rendered to individual physicians.
- C. ensure risk-adjusted payment integrity and accuracy.
- D. verify medical necessity of care provided.

正解: C

解説:

RADV (Risk Adjustment Data Validation) is a CMS audit program used in Medicare Advantage to confirm that diagnoses submitted for risk adjustment are supported by medical record documentation and meet reporting requirements. Its central aim is payment integrity—ensuring that risk-adjusted capitation payments to Medicare Advantage organizations are accurate based on valid, documented conditions. In outpatient CDI practice, RADV risk underscores why documentation must clearly support each reported diagnosis (e.g., condition evaluated/assessed/treated, clinically relevant, and properly documented by an eligible provider), because unsupported diagnoses can lead to payment recoupment and compliance exposure. RADV is not designed to assess medical necessity of the services provided (that is typically addressed through utilization review and other payer audits), nor is it focused on identifying overpayments to individual physicians (it targets plan-level risk adjustment payments). It also is separate from E/M leveling accuracy, which is governed by CPT/E/M guidelines and distinct audit processes. Therefore, the best definition of RADV's primary purpose is ensuring the integrity and accuracy of risk-adjusted payments.

質問 # 60

During a PCP visit, a provider notes a patient's history of pathological fracture of the thoracic spine related to osteoporosis.

Documentation states: "Decreased muscle mass and significant weight loss in the last six months." Which of the following should the CDI specialist query for?

- A. Type of osteoporosis
- **B. Presence of malnutrition**
- C. Degree of muscle atrophy
- D. Acuity of the pathological fracture

正解: B

解説:

The documentation "decreased muscle mass and significant weight loss in the last six months" raises a strong clinical indicator for a nutrition-related condition (e.g., malnutrition, cachexia, or other clinically significant weight loss) that should be clarified by the provider. In outpatient CDI practice, ACDIS-based guidance emphasizes querying when there are objective or clearly stated indicators suggesting an additional diagnosis that is clinically relevant, affects management, or reflects patient complexity. Malnutrition is particularly important because it can explain functional decline, frailty, and increased risk of falls/fractures, and it often changes the care plan (dietary counseling, nutrition referral, supplementation, labs, monitoring). While "degree of muscle atrophy" and "acuity of the fracture" could matter in other contexts, the note explicitly highlights a systemic decline over six months rather than an acute fracture issue. "Type of osteoporosis" is relevant for specificity, but the new, clinically significant clue here is unintended weight loss with muscle wasting-making malnutrition the most appropriate clarification opportunity.

質問 # 61

Upon retrospective review of a patient visit 2 weeks prior, a CDI specialist notes physician documentation stating the following: "Sick Sinus Syndrome in 2016 s/p pacemaker placement. Latest EKG shows normal paced rhythm." There are no codes noted for Sick Sinus Syndrome or the pacemaker. Which of the following is the BEST course of action for the CDI specialist?

- A. Request the provider amend the codes to reflect the Sick Sinus Syndrome and pacemaker status.
- **B. Capture code for pacemaker status only.**
- C. Ask the coder to re-bill based upon the documentation.
- D. Educate the provider that a pacemaker status code as well as a Sick Sinus Syndrome code should be assigned.

正解: B

解説:

In outpatient CDI, diagnoses reported for an encounter must be supported as current and clinically relevant to that visit (evaluated, monitored, assessed, treated, or otherwise affecting care). The note documents a history of sick sinus syndrome with pacemaker placement in 2016 and indicates the current rhythm is paced. The most clearly reportable, present condition is the presence of a cardiac pacemaker, which is a status that can affect clinical decision-making (e.g., interpretation of rhythm findings, medication choices, procedures, and future cardiac evaluation) and is appropriate to code when documented. However, the documentation does not show that sick sinus syndrome itself was actively assessed or managed during this visit; it is referenced as a past condition leading to the device. Because outpatient coding does not assume an active diagnosis solely from historical mention, the best action is to capture the pacemaker status code only. Retrospective amendment requests or rebilling steps are not the first-line CDI action when the documentation does not support active management of the underlying arrhythmia.

質問 # 62

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 is not reporting unspecified diagnoses
- D. The provider has a less complex patient population

正解: B

解説:

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

