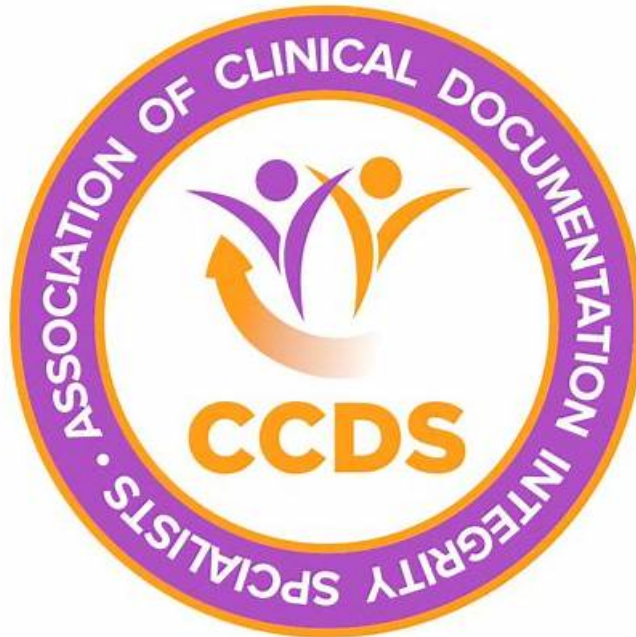


ACDIS CCDS-O 시험유료덤프 & CCDS-O 높은 통과율 시험대비 공부자료



2026 PassTIP 최신 CCDS-O PDF 버전 시험 문제집과 CCDS-O 시험 문제 및 답변 무료 공유:
https://drive.google.com/open?id=1XPxmBEX8nXLKhH6d_2zLzviG9F7IF6Az

한번에 ACDIS 인증 CCDS-O 시험을 패스하고 싶으시다면 완전 페펙트한 준비가 필요합니다. 완벽한 관련 지식터득은 물론입니다. 우리 PassTIP의 자료들은 여러분의 이런 시험준비에 많은 도움이 될 것입니다.

ACDIS CCDS-O 시험요강:

주제	소개
주제 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.
주제 2	<ul style="list-style-type: none">• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding
주제 3	<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.

>> ACDIS CCDS-O 시험유료덤프 <<

CCDS-O 시험유료덤프 완벽한 덤프 샘플문제

ACDIS CCDS-O 시험을 한번에 합격할 수 없을가봐 두려워 하고 계시나요? 이 글을 보고 계신 분이라면 링크를 클릭하여 저희 사이트를 방문해주세요. 저희 사이트에는 ACDIS CCDS-O 시험의 가장 최신 기출문제와 예상문제를 포함하고 있는 ACDIS CCDS-O 덤프자료를 제공해드립니다. 덤프에 있는 문제와 답을 완벽하게 기억하시면 가장 빠른 시일내에 가장 적은 투자로 자격증 취득이 가능합니다.

최신 Clinical Documentation Specialist CCDS-O 무료샘플문제 (Q35-Q40):

질문 # 35

A patient with a PMH of DM, GERD, and HTN is seen in the clinic with complaints of stuffy nose, fever, and feeling tired for the past four days. The patient's medication list includes SSI, Prilosec, and Diovan. The provider documented: "Congestion, fever, malaise, DM, GERD, HTN. Continue OTC medications for congestion and fever. Rest. Return to the clinic in one week if symptoms persist." Which of the following ICD-10-CM guidelines BEST applies to how this scenario should be coded?

- A. Selection of first-listed condition
- B. Uncertain diagnoses
- C. Encounters for general medical examination with abnormal finding
- **D. Codes that describe symptoms and signs**

정답: D

설명:

In the outpatient setting, when the provider does not document a definitive diagnosis for the acute complaint (e.g., influenza, sinusitis, URI), ICD-10-CM guidance directs coders to report the signs and symptoms that are documented and addressed. Here, the clinician documents congestion, fever, and malaise and provides treatment instructions for those symptoms (OTC meds, rest, follow-up). That makes the symptom codes the most appropriate representation of the reason for the encounter. Outpatient CDI principles further emphasize that chronic conditions like DM, GERD, and HTN should only be coded when the documentation shows they were evaluated, monitored, assessed/managed, or treated during the visit (e.g., status, control, medication adjustment, related testing, counseling). In this note, the plan targets only the acute symptoms and does not demonstrate active management of the chronic conditions beyond listing history/medications. Therefore, the guideline most directly applicable to correct coding of the encounter is codes that describe symptoms and signs.

질문 # 36

An established patient is defined as one who has received professional services from the same or another physician or qualified healthcare professional from the exact same specialty and sub-specialty and belongs to the same group practice, within the past how many years?

- A. 0
- **B. 1**
- C. 2
- D. 3

정답: B

설명:

For outpatient E/M reporting, "new vs. established patient" status is determined using a lookback period based on prior professional services. An established patient is one who has received face-to-face (or other qualifying professional) services from the same physician or another physician/qualified healthcare professional of the same specialty and subspecialty in the same group practice within the previous three years. This definition is critical for compliant coding because it drives which E/M code family is available (new patient codes vs established patient codes), and it affects relative valuation, documentation expectations, and audit risk. Outpatient CDI education emphasizes helping providers document the medical necessity and complexity of the visit regardless of patient status, but also ensuring correct administrative classification so coders select the correct code set. The three-year window prevents inappropriate use of new patient codes when the patient has an ongoing clinical relationship with the practice/specialty, supporting accurate reimbursement and consistent reporting.

질문 # 37

A CDI specialist receives a call from a disgruntled provider regarding recent documentation queries. The provider claims to only have 15 minutes to see patients and does not have time for interruptions like this if it does not increase reimbursement. Which of the following is the BEST course of action to effectively facilitate communication?

- A. Explain to the provider that queries may affect reimbursement, however not directly, and he should comply.
- **B. Request a time at the provider's convenience to review the query process and collaborate to facilitate the best workflow.**
- C. Call the provider's superior and report him as being non-compliant with organizational processes.
- D. Listen to the provider, agree this does not affect reimbursement, and explain that the CDI team will stop querying.

정답: B

설명:

Effective outpatient CDI depends on provider engagement, efficient workflows, and respectful communication. When a provider is frustrated about time pressures, the most productive approach is to partner with them to reduce friction while preserving compliant documentation improvement. ACDIS outpatient CDI concepts emphasize collaboration and provider education-meeting the provider where they are, understanding their workflow constraints, and jointly designing a query process that is minimally disruptive (e.g., batching queries, aligning with clinic schedules, using prospective queries, leveraging templates, or routing through agreed channels). Option C directly addresses the root issue (workflow burden) and builds trust by seeking the provider's input and scheduling the discussion at their convenience. Option A is confrontational and frames CDI as a compliance demand rather than a clinical accuracy initiative. Option B is inappropriate because CDI cannot stop querying when clarification is needed for accurate documentation, coding, quality reporting, and risk adjustment. Option D escalates prematurely and damages relationships; escalation is typically reserved for persistent, unresolved non-responsiveness after collaborative efforts and leadership-supported education.

질문 # 38

A patient returns to a PCP for follow-up care related to a UTI. The provider documents "stage 3 CKD" as determined by a single eGFR of 52 mL/min. Which of the following actions should the CDI specialist take?

- A. Delete CKD diagnosis from claim as it was not treated during this encounter.
- B. Query for stage 4 CKD.
- C. Add diagnosis of CKD stage 3 to claim, as it is reportable.
- **D. Review CKD staging criteria with provider.**

정답: D

설명:

The CDI specialist should review CKD staging criteria with the provider because assigning CKD based on a single eGFR value can be clinically unreliable and may lead to inaccurate documentation and coding. Outpatient CDI guidance emphasizes that documentation must reflect a condition that is clinically valid, supported by the record, and accurately described, especially for chronic diseases. CKD is generally established by evidence of decreased kidney function or kidney damage that is persistent, not a one-time lab that could be affected by hydration status, acute illness, medications, or transient physiologic changes. While an eGFR of 52 falls within the numeric range commonly associated with stage 3a, the key CDI issue is the foundation for diagnosing chronic disease, not simply whether the number is "reportable." Option A inappropriately directs CDI to add diagnoses to claims; CDI supports providers and coding, but does not independently "add" conditions. Option C is incorrect because chronic conditions may be coded when addressed/impact care, not only when actively treated. Option D is unsupported because eGFR 52 does not suggest stage 4.

질문 # 39

A patient is scheduled to see his PCP in 3 days. A CDI specialist notes that during the patient's last visit earlier this year, the problem list shows both DM 2 associated erectile dysfunction and DM 2 without complications. The last clinic note states that DM 2 with autonomic neuropathy was addressed. The CDI specialist should do which of the following FIRST?

- A. Query the provider for the link between erectile dysfunction and DM 2
- B. Ask the patient if he still has DM 2 with autonomic neuropathy
- **C. Query if the DM 2 is with or without complications**
- D. Remove DM 2 without complications from the problem list

정답: C

설명:

The record contains conflicting documentation: the problem list includes both "type 2 diabetes without complications" and diabetes with complications (erectile dysfunction association), while the most recent clinic note indicates the provider addressed "DM2 with autonomic neuropathy," which is clearly a diabetic complication. In outpatient CDI, the first priority is to resolve internal inconsistency so coding accurately reflects the patient's current clinical status and what was evaluated/managed at the encounter. A query should therefore focus on whether the patient's diabetes is with complications (and which complications are active/being addressed) versus truly without complications, because "without complications" is generally not appropriate when neuropathy/other manifestations are present and being managed. CDI staff also should not unilaterally remove items from the provider-maintained problem list, and asking the patient is not a reliable documentation/coding source for establishing diagnoses. Once the provider clarifies diabetes complication status, a follow-up clarification can address specific linkages (e.g., erectile dysfunction due to

diabetes) if needed for correct code assignment

질문 # 40

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PassTIP의 ACDIS인증 CCDS-O덤프는 거의 모든 실제시험문제 범위를 커버하고 있습니다.ACDIS인증 CCDS-O시험덤프를 구매하여 덤프문제로 시험에서 불합격성적표를 받을시PassTIP에서는 덤프비용 전액 환불을 약속드립니다.

CCDS-O높은 통과율 시험대비 공부자료 : <https://www.passtip.net/CCDS-O-pass-exam.html>

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