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our CCDS-O exam prep is renowned for free renewal in the whole year. As you have experienced various kinds of exams, you must have realized that renewal is invaluable to study materials, especially to such important CCDS-O exams. And there is no doubt that being acquainted with the latest trend of exams will, to a considerable extent, act as a driving force for you to pass the CCDS-O Exams and realize your dream of living a totally different life.

## ACDIS CCDS-O Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> <li>• and billing: Covers Official Coding Guidelines, OPSS reimbursement (APCs), and professional billing concepts including CPT E</li> <li>• M codes and Medicare Physician Fee Schedule documentation.</li> </ul>
Topic 2	<ul style="list-style-type: none"> <li>• CDI Program Concepts: Department Metrics and Provider Education: Covers provider education development, CDI performance metrics including query rates, RAF progression, HCC capture, ACO</li> <li>• MSSP impact, and physician documentation's effect on quality reporting.</li> </ul>
Topic 3	<ul style="list-style-type: none"> <li>• Coding and Reporting, the Outpatient Prospective Payment System (OPPS), and provider coding</li> </ul>
Topic 4	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
Topic 5	<ul style="list-style-type: none"> <li>• Diseases and Disease Processes and Application to the Clinical Chart Review: Covers clinical indicators across all ICD-10-CM chapters, applied to chart reviews, with recognition of medications, diagnostic tests, and abbreviations as documentation clarification triggers.</li> </ul>
Topic 6	<ul style="list-style-type: none"> <li>• Quality, Regulatory, and Health Initiatives: Covers population health, MSSP, ACO models, MACRA</li> <li>• MIPS, compliant query development, RADV audits, OIG compliance, problem list maintenance, and HIPAA requirements in outpatient CDI.</li> </ul>

>>> CCDS-O Training Tools <<<

## CCDS-O Test Dumps.zip | CCDS-O Valid Exam Format

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industry. Because this exam is difficult, through it, you may be subject to international recognition and acceptance, and you will have a bright future and holding high pay attention. Itcertkey has the world's most reliable IT certification training materials, and with it you can achieve your wonderful plans. We guarantee you 100% certified. Candidates who participate in the ACDIS CCDS-O Certification Exam, what are you still hesitant? Just do it quickly!

## ACDIS Certified Clinical Documentation Specialist-Outpatient Sample Questions (Q28-Q33):

### NEW QUESTION # 28

Which of the following best differentiates inpatient from outpatient coding guidelines?

- A. Inpatient guidelines emphasize diagnosis sequencing and MS-DRGs
- B. Both use the same guidelines with no differences
- C. Outpatient coding ignores encounter diagnoses
- D. Outpatient guidelines focus on principal diagnoses

**Answer: A**

Explanation:

A key distinction is that inpatient coding is tightly linked to MS-DRG assignment and inpatient-specific sequencing rules, including selection of the principal diagnosis using the "after study" standard and capture of secondary diagnoses that qualify as complications/comorbidities (CC/MCC) when they meet reporting criteria. This makes diagnosis sequencing and documentation of severity/acuity central to inpatient reimbursement and quality measurement. Outpatient coding does not use MS-DRGs; instead, it typically uses "first-listed" diagnosis concepts for the encounter and assigns ICD-10-CM based on conditions addressed that day, with procedure payment often driven by CPT/HCPCS and, in hospital outpatient departments, packaging/OPPS logic. Therefore, statement A is incorrect (principal diagnosis is not the outpatient focus), C is incorrect (there are meaningful differences), and D is incorrect because outpatient coding absolutely depends on encounter diagnoses being documented and supported. Outpatient CDI education stresses documenting the reason for visit, linking symptoms to confirmed conditions when known, and showing MEAT for chronic conditions so outpatient coding is accurate and defensible.

### NEW QUESTION # 29

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

**Answer: A**

Explanation:

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.

### NEW QUESTION # 30

Which statement is MOST accurate about the problem list?

- A. A well-maintained problem list is vital in the continuity of patient care.
- B. More diagnoses on the problem list assist the provider in caring for the patient.

- C. Problem list diagnoses should be removed after one year.
- D. A CDI specialist should update the problem list to provide continuity of care.

**Answer: A**

Explanation:

A well-maintained problem list supports continuity of care by giving the care team an accurate, up-to-date clinical "snapshot" of active and relevant historical conditions that affect ongoing management, decision-making, and risk assessment. Outpatient CDI education emphasizes that the problem list should be curated-conditions should be current, clinically meaningful, and appropriately resolved or clarified (e.g., active vs history, controlled vs uncontrolled). Option A is incorrect because diagnoses are not removed based on an arbitrary time threshold; they are updated based on clinical status (resolved, inactive, erroneous, or no longer relevant). Option C is inaccurate because simply adding more diagnoses can introduce noise and increase the risk of outdated or incorrect conditions being propagated ("problem list bloat"), which can harm patient safety and lead to inaccurate coding. Option D is inaccurate because CDI professionals typically do not independently update the problem list; rather, they support providers through compliant queries, education, and process improvements so the treating provider validates and maintains the record. Therefore, B best reflects outpatient documentation best practice.

### NEW QUESTION # 31

A female patient presents for her yearly wellness check-up. Her vital signs are within normal limits with the exception of dyspnea. Her weight is 165 lbs, up 10 lbs from her previous clinic visit 2 weeks prior. Problem list includes diagnoses of obesity, COPD, heart failure, and diabetes without complications. The patient's A1c noted 9.2 up from 7.2 from previous year wellness exam. Based on the clinical indicators, which of the following medications should be evaluated and addressed during this clinic visit?

- A. Wellbutrin and Allegra
- **B. NovoLog and Lasix**
- C. Megace and ferrous sulfate
- D. Metformin and methotrexate

**Answer: B**

Explanation:

In ambulatory CDI chart review, clinical indicators should align with assessment and management captured in the note (problem relevance and MEAT-style support: monitor, evaluate, assess/address, treat). This visit has two strong indicators that warrant medication evaluation. First, dyspnea plus a rapid 10-lb weight increase over two weeks is a classic signal of possible fluid overload in a patient with heart failure, making a loop diuretic such as Lasix clinically relevant to assess (effectiveness, adherence, dose changes, exacerbation risk, and whether HF is stable vs decompensated). Second, the A1c has worsened significantly (9.2 from 7.2), indicating inadequate glycemic control that should prompt review and adjustment of diabetes therapy; insulin such as NovoLog is directly tied to diabetes treatment escalation or optimization. The other medication pairs do not logically match the documented problems and indicators (e.g., appetite stimulant/anemia therapy, immunosuppressant, antidepressant/antihistamine). Therefore, NovoLog and Lasix best reflect what should be evaluated and addressed

### NEW QUESTION # 32

Which diagnosis and treatment plan may generate a query?

- **A. Severe major depressive disorder and immunotherapy**
- B. Malnutrition and parenteral nutrition
- C. Atrial fibrillation and amiodarone
- D. Prostate carcinoma and luteinizing hormone-releasing hormone

**Answer: A**

Explanation:

Outpatient CDI queries are most commonly triggered when there is a disconnect between the documented diagnosis and the documented treatment plan, suggesting that the clinician may be managing an additional condition that is not clearly stated, or that the diagnosis is inaccurately documented. Options A and B reflect typical, clinically aligned management: luteinizing hormone-releasing hormone therapy is a standard treatment pathway for prostate carcinoma, and amiodarone is a recognized antiarrhythmic used in atrial fibrillation management in appropriate circumstances. Option C can also be clinically consistent because parenteral nutrition is often used when malnutrition is present and the patient cannot meet nutritional needs enterally. Option D is the outlier: "immunotherapy" is not a standard treatment for severe major depressive disorder and more commonly aligns with oncology or

