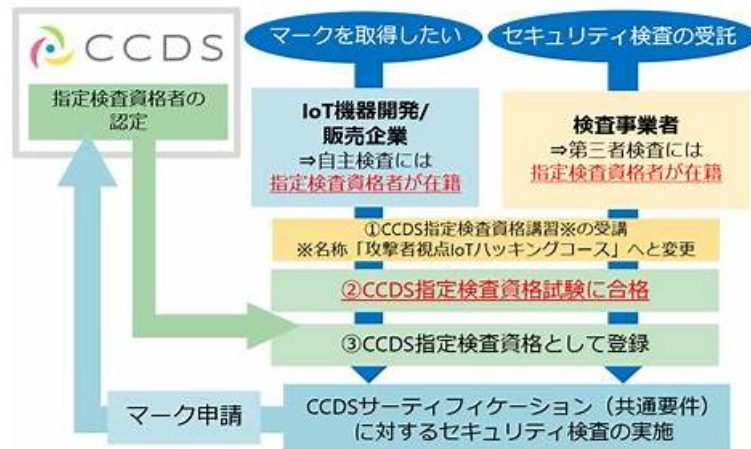


# CCDS-O資格トレーニング & CCDS-O日本語版テキスト内容



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>> CCDS-O資格トレーニング <<

## CCDS-O試験の準備方法 | 効果的なCCDS-O資格トレーニング試験 | 完璧なCertified Clinical Documentation Specialist-Outpatient日本語版テキスト内容

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### ACDIS Certified Clinical Documentation Specialist-Outpatient 認定 CCDS-O 試験問題 (Q92-Q97):

質問 # 92

Which of the following therapies is MOST likely to be recommended?

- A. Xarelto for hematemesis
- B. Tamoxifen for chronic congestive heart failure
- C. Ensure for morbid obesity
- **D. Metoprolol for atrial fibrillation**

正解: D

解説:

Metoprolol is a beta-blocker commonly used in atrial fibrillation to achieve ventricular rate control, reduce symptoms (palpitations,

dyspnea), and improve hemodynamic stability, especially when the rhythm is persistent or recurrent. From an outpatient CDI chart-review perspective, therapy-to-diagnosis consistency is a key clinical indicator that supports clarifying the condition being treated and ensuring it is documented as assessed/managed at the encounter. The other options are clinically mismatched: "Ensure" is a nutritional supplement typically used for inadequate intake or weight loss and would not be recommended for morbid obesity; rivaroxaban (Xarelto) is an anticoagulant and would be inappropriate in the setting of hematemesis (active GI bleeding) where anticoagulation generally increases risk and would typically be held or reassessed; tamoxifen is an endocrine therapy for hormone receptor-positive breast cancer risk/treatment and is not a standard therapy for chronic congestive heart failure. Therefore, metoprolol for atrial fibrillation is the most appropriate and likely recommendation among the choices.

#### 質問 # 93

In which of the following ways does payment determination (risk score calculation) differ between HHS-HCCs and CMS-HCCs?

- A. HHS-HCCs use the previous year's ICD-10-CM and CPT codes to predict the next year's spending.
- B. HHS-HCCs use current ICD-10-CM and CPT codes to predict the current year's spending.
- C. HHS-HCCs use the current year's demographics/diagnoses to predict the current year's spending.
- D. HHS-HCCs use the previous year's demographics/diagnoses to predict the next year's spending.

正解: C

解説:

A key ambulatory CDI distinction between the two major risk models is timing. The HHS-HCC model (used for ACA Marketplace risk adjustment) is commonly described as a concurrent model: it uses the enrollee's demographics and diagnoses from the same benefit year to reflect morbidity and support that year's risk transfer/payment balancing. In contrast, the CMS-HCC model (commonly applied in Medicare Advantage) is prospective: conditions documented and coded in the prior data collection year are used to predict expected cost for the following payment year. From an outpatient CDI perspective, this timing difference affects operational priorities. For CMS-HCC, accurate annual capture and recapture of active chronic conditions is essential because last year's documented conditions drive next year's risk score and revenue. For HHS-HCC, complete documentation and coding during the current year impacts the current year's risk measurement. Options referencing CPT codes are not correct for the core HCC risk score calculation, which is driven by demographics and ICD diagnosis reporting mapped to HCC categories.

#### 質問 # 94

In February, a patient is diagnosed with prostate cancer, which is classified as HCC 23. In October, the patient is diagnosed with prostate cancer with bone metastases, which is classified as HCC 18. Which of the following is true about the patient's risk score?

- A. The risk score will be calculated based upon HCC 23 because it was captured first.
- B. The risk score will be calculated based upon HCC 18 and HCC 23 because they were both documented and coded in the same calendar year.
- C. The risk score will not be impacted by the presence of HCC 18 or HCC 23 because they are not currently being treated.
- D. The risk score will be calculated based upon HCC 18 because it has the highest weight in the hierarchy HCC 23.

正解: D

解説:

In the CMS-HCC model, many related conditions are organized into hierarchies so that only the most severe manifestation within a disease family contributes to the RAF. This prevents double counting when multiple codes describe progressive severity of the same underlying condition. Cancer categories are a common example: a diagnosis reflecting metastatic disease represents substantially higher expected resource utilization than a diagnosis of localized/primary malignancy. In this scenario, the February prostate cancer maps to a lower-severity HCC (HCC 23), while the October documentation of prostate cancer with bone metastases maps to a higher-severity HCC (HCC 18). When both are captured within the applicable period, the hierarchy logic retains the higher-weighted metastatic category and suppresses the lower category. The timing of which was coded first does not control the hierarchy outcome, and both HCCs are not counted together when they fall within the same hierarchical grouping. Therefore, the patient's risk score calculation reflects HCC 18 rather than HCC 23.

#### 質問 # 95

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

正解: B

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 #96

When compliantly querying providers, CDI specialists or HIM/coding professionals may

- A. omit clinical indicators in a query as this may be leading to the provider.
- B. identify which diagnoses are HCCs.
- **C. offer a new diagnosis, that is supported by the clinical evidence, as an option in a multiple-choice query.**
- D. offer diagnoses choices supported by documentation solely from previous encounters.

正解: C

解説:

Compliant querying principles taught in outpatient CDI allow the CDI/coding professional to present a multiple-choice query that includes reasonable diagnostic options supported by the current encounter's clinical indicators. Including a "new" diagnosis as an option is acceptable when it is clinically supported by documented findings (signs/symptoms, test results, treatments, clinical course) and the query is written in a non-leading manner-typically with balanced options and an "other" and/or "unable to determine" choice. This approach helps the provider clarify the most accurate condition being evaluated or treated without steering toward a particular response. Option A is not compliant because relying solely on prior encounter documentation (without current relevance) risks coding historical conditions that are not addressed today. Option B is generally discouraged because calling out HCC status can be perceived as prompting for payment impact rather than clinical accuracy. Option D is incorrect because including relevant clinical indicators is essential; omitting them weakens the clinical basis and does not make a query less leading-rather, it makes it less defensible.

#### 質問 #97

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