CCDS-O Prüfungsguide: Certified Clinical Documentation Specialist-Outpatient & CCDS-O echter Test & CCDS-O sicherlich-zu-bestehen

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ACDIS CCDS-O Prüfungsplan:

Thema	Einzelheiten
Thema 1	• 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.

Thema 2	• and billing: Covers Official Coding Guidelines, OPPS reimbursement (APCs), and professional billing concepts including CPT E • M codes and Medicare Physician Fee Schedule documentation.
Thema 3	• 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.

>> CCDS-O Prüfungsaufgaben <<

CCDS-O Vorbereitungsfragen - CCDS-O Dumps Deutsch

Unsere Garantie, Die Prüfungsfragen und Antworten zu ACDIS CCDS-O （Certified Clinical Documentation Specialist-Outpatient） von ZertFragen ist eine Garantie für eine erfolgreiche Prüfung! Bisher fiel noch keiner unserer Kandidaten durch! Falls aber jemand durch die Zertifizierungsprüfung fallen sollte, zahlen wir die 100% Material-Gebühr zurück. Wir übernehmen die volle Geld-zurück-Garantie auf Ihre Zertifizierungsprüfungen! Unsere Fragen und Antoworten sind alle aus dem Fragenpool, alle sind echt und original.

ACDIS Certified Clinical Documentation Specialist-Outpatient CCDS-O Prüfungsfragen mit Lösungen (Q132-Q137):

132. Frage
A patient with stage 3 CKD presents to the clinic for evaluation. Upon review of labs, an elevated iPTH and a normal phosphorus level are noted. Which of the following diagnoses may be appropriately queried based upon these lab values?

- A. CKD stage 3 with hypoparathyroidism
- B. Hyperparathyroidism secondary to hypophosphatemia
- C. Primary hyperparathyroidism
- D. Secondary hyperparathyroidism of renal origin

Antwort: D

Begründung:
In stage 3 chronic kidney disease, impaired vitamin D activation and early disturbances in calcium-phosphate regulation commonly drive a compensatory rise in parathyroid hormone (PTH), known as secondary hyperparathyroidism of renal origin. Outpatient CDI chart review looks for clinical indicators that suggest a condition being evaluated or requiring management, and an elevated iPTH in a CKD patient is a classic indicator that supports querying the provider for CKD-related mineral and bone disorder, specifically renal secondary hyperparathyroidism, if it is clinically being assessed/treated (e.g., monitoring trends, prescribing vitamin D analogs, calcimimetics, dietary counseling, nephrology follow-up). Primary hyperparathyroidism is less supported here because it typically requires a different biochemical pattern and clinical context (often hypercalcemia) rather than being driven by CKD physiology. Hypoparathyroidism is the opposite process (low PTH), making option C inconsistent with the lab finding. Option D is not supported because phosphorus is normal, not low, and hypophosphatemia is not documented as a driver. Therefore, querying for renal secondary hyperparathyroidism is most appropriate.

133. Frage
The principal diagnosis is defined as:

- A. The condition established after study to be chiefly responsible for occasioning the admission
- B. The first diagnosis listed on the chart
- C. The most severe condition present
- D. Any condition treated during the hospital stay

Antwort: A

Begründung:
The definition in option B is the official Uniform Hospital Discharge Data Set (UHDDS) definition used for inpatient coding: the

principal diagnosis is the condition determined-after evaluation-to be chiefly responsible for the admission. It is not simply the first condition written, nor necessarily the "worst" or most severe condition; it is the reason for admission once the workup clarifies the clinical picture. CDI practice reinforces this because principal diagnosis selection drives DRG assignment, quality metrics, and reporting, and errors often stem from confusing presenting symptoms with the final established diagnosis. Although outpatient settings use different concepts (e.g., first-listed diagnosis for the encounter), ACDIS education frequently contrasts inpatient "principal diagnosis" with outpatient "first-listed" to prevent documentation and coding misalignment. Clinicians should document the definitive condition when known (and link symptoms to that condition), and clearly describe diagnostic uncertainty when not yet established. This clarity supports compliant coding, accurate benchmarking, and defensible medical necessity across settings.

134. Frage
Calculate the expected yearly cost for this patient based on the RAF score.

- A. $5,836.80
- B. $12,672.00
- C. $486.40
- D. $17,011.20

Antwort: A

Begründung:
In outpatient risk adjustment (commonly Medicare Advantage), the patient's predicted cost is derived from the Risk Adjustment Factor (RAF), which is the sum of component risk contributions. Here, the RAF is calculated by adding the HCC diagnoses score (0.166), disease interactions (0.112), and demographic score (0.330). That total equals 0.608. The PMPM (per-member-per-month) baseline cost is $800. To estimate the patient's expected monthly cost, multiply PMPM by RAF: $800 × 0.608 = $486.40 per month. The question asks for the expected yearly cost, so convert PMPM to annual: $486.40 × 12 = $5,836.80. ACDIS outpatient CDI teaching emphasizes that accurate documentation and compliant coding directly affect RAF through captured HCCs and interactions (when supported), which in turn drives expected resource needs and plan payment. Missing or unsupported diagnoses can understate RAF; vague documentation can prevent valid HCC capture.

135. Frage
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 is not reporting unspecified diagnoses
- B. The provider cares for patients of a higher acuity
- C. The provider has a less complex patient population
- D. The provider is failing to capture all relevant diagnoses

Antwort: D

Begründung:
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 documentation/coding under-capture: the clinical complexity driving utilization is not being fully documented and coded to HCC-relevant diagnoses. This creates a mismatch-actual resource use is high, but the recorded risk profile is artificially low-leading to unfavorable benchmarking because costs are compared against an expected spend that is too low for the true acuity. Option A would typically raise HCC scores, not lower them. Option C could explain both low HCC and low cost; it conflicts with the high-cost finding. Option D misunderstands HCC mechanics: "unspecified" does not reliably increase HCC capture and often reduces coding specificity/validity rather than improving risk adjustment. Therefore, incomplete capture of relevant diagnoses is the most likely driver.

136. Frage
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 the difference between MDD specified and MDD, unspecified insignificant, not impacting future cost benchmarking.
- B. 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.
- C. The number of patients increased with an increase in use of MDD specified and a decrease in MDD, unspecified, 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.

Antwort: C

Begründung:
Year 2 shows a higher total volume of MDD diagnoses (185,090 vs. 155,501), but the key CDI signal is the shift in coding specificity: "MDD, specified" increases substantially (118,516 vs. 76,318), while "MDD, unspecified" decreases (66,574 vs. 79,193). In outpatient CDI terms, this pattern is consistent with improved documentation quality and code capture-providers are describing the condition with greater clinical detail (episode type, severity, remission status, recurrence, etc.), allowing assignment of more specific ICD codes. When an HCC value (0.299) is associated with MDD, improved capture of qualifying, specific MDD codes supports more accurate risk adjustment. That increases the accuracy of projected resource need and affects future cost benchmarking (and potentially quality/utilization comparisons) because the population's documented burden of illness is better represented. Therefore, the appropriate inference is increased patients plus increased "specified" use and decreased "unspecified," with an impact on future benchmarking.

137. Frage
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