Certified Coding Specialist – Physician-Based (CCS-P) Examination Content Outline (Effective May 1, 2020)

The objective of the Certified Coding Specialist – Physician-Based (CCS-P) examination is to verify that candidates have met AHIMA's criteria for a mastery level of physician coding practice before awarding certification.

Number of questions on the Exam:
97 multiple-choice questions (79 scored/18 pretest)
8 medical scenarios (6 scored/2 pretest)

Exam time:
4 hours – Any breaks taken will count against time

Multiple-Choice Questions

Domain 1 – Diagnosis Coding (16.5%)

Tasks:

1. Given a scenario, review medical record documentation and accurately assign ICD-10-CM codes based on the documentation
2. Apply ICD-10-CM conventions and guidelines to accurately code to the highest level of specificity

Domain 2 – Procedure Coding (32.9%)

Tasks:

1. Given a scenario, review medical record documentation and accurately assign CPT/HCPCS codes based on the documentation
2. Given a scenario, interpret Evaluation & Management (E&M) coding guidelines
3. Given a definition, assign appropriate modifiers
4. Apply CPT/HCPCS guidelines to sequence procedure codes
5. Apply CPT/HCPCS manual instructions to select correct code(s)
6. Apply knowledge of National Correct Coding Initiative (NCCI) edits and guidelines

Domain 3 – Research (7.6%)

Tasks:

1. Differentiate and apply physician-based coding rules based on federal, state, and third-party guidelines
2. Determine appropriate primary authoritative source to determine correct coding

Domain 4 – Compliance (31.6%)

Tasks:

1. Given a scenario, determine if a query is appropriate based on existing documentation and apply a non-leading, ethical query
2. Evaluate medical records to determine documentation that is permissible to support code assignment

3. Apply ethical coding standards (OIG, CMS, AHIMA, etc.)
4. Ensure medical record signature requirements are met
5. Given a scenario, audit medical records for compliance with coding and documentation rules
6. Apply knowledge of risk adjustment in ICD-10-CM
7. Demonstrate an understanding of HIPAA privacy and security regulations
8. Given a scenario, develop and deliver education for providers and ancillary staff
9. Identify place of service
10. Given a scenario, ensure incident to billing guidelines are met where applicable

Domain 5 – Revenue Cycle (11.4%)

Tasks:

1. Apply knowledge of claims development and filing processes
2. Apply knowledge of insurance response (remittance advice, EOB)
3. Demonstrate an understanding of Resource Based Relative Value Scale (RBRVS)
4. Link diagnosis code(s) to procedure code correctly

Medical Scenarios

1. Evaluation and Management (E&M) (33.3%)
2. Surgery (33.3%)
3. Medicine (33.3%)