Certified Coding Specialist – Physician-Based (CCSP)
Examination Content Outline

Number of Questions on Exam:
• 88 Multiple Choice (18 unscored/pretest)
• 8 Multiple Select (2 unscored/pretest)
• 13 Medical record cases

Exam Time: 4 hours – no breaks

Domain 1 – Health Information Documentation (8-12%)

Tasks:

1. Interpret health record documentation using knowledge of anatomy, physiology, clinical indicators and disease processes, pharmacology and medical terminology to identify codeable diagnoses and/or procedures
2. Determine when additional clinical documentation is needed to assign the diagnosis and/or procedure code(s)
3. Consult with physicians and other healthcare providers to obtain further clinical documentation to assist with code assignment
4. Consult reference materials to facilitate code assignment
5. Identify patient encounter type
6. Identify and post charges for healthcare services based on documentation

Domain 2 – Diagnosis and/or Procedure Coding (60-64%)

Tasks:

Diagnosis:

1. Interpret conventions, formats, instructional notations, tables, and definitions of the classification system to select diagnoses, conditions, problems, or other reasons for the encounter that require coding
2. Select the diagnoses that require coding according to current coding and reporting requirements for outpatient services
3. Sequence diagnoses and other reasons for encounter according to notations and conventions of the classification system and standard data set definitions
4. Apply the official ICD-9-CM coding guidelines

Procedure:

1. Interpret conventions, formats, instructional notations, and definitions of the classification system and/or nomenclature to select procedures/services that require coding
2. Select the procedures that require coding according to current reporting requirements for professional services in any setting
3. Sequence procedures according to notations and conventions of the classification system/nomenclature and standard data set definitions
4. Apply the official CPT/HCPCS Level II coding guidelines

Domain 3 – Regulatory Guidelines and Reporting Requirements for Outpatient Services (8-12%)

Tasks:

1. Select the reason for encounter, pertinent secondary conditions, primary procedure, and other procedures that require coding according to CPT Assistant, Coding Clinic, and HCPCS
2. Apply appropriate reporting requirements:
   a. Modifiers
   b. CPT/HCPCS Level II
   c. Evaluation and Management code assignment
3. Validate medical necessity for appropriate relationships between diagnosis and coded procedures/services

Domain 4 – Data Quality and Management (5-7%)

Tasks:
1. Review the results of aggregate coded data as required
2. Communicate with healthcare providers regarding reimbursement methodologies, documentation rules, and regulations related to coding
3. Analyze health record documentation for quality and completeness of coding
4. Review the accuracy of abstracted data elements for database integrity and claims processing
5. Resolve coding edits such as National Correct Coding Initiative (NCCI)

Domain 5 – Information and Communication Technologies (2-4%)

Tasks:
1. Use computer and mobile devices (tablet, hand-held, etc.) to ensure data collection, storage, analysis, and reporting of information
2. Use common software and web-based applications in the execution of work processes
3. Use specialized software in the completion of HIM processes

Domain 6 – Privacy, Confidentiality, Legal, and Ethical Issues (4-6%)

Tasks:
1. Apply policies and procedures for access and disclosure of protected health information
2. Apply AHIMA Code of Ethics/Standards of Ethical Coding
3. Report privacy and/or security concerns
4. Protect data integrity and validity using software or hardware technology

Domain 7 – Compliance (3-5%)

Tasks:
1. Evaluate the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards
2. Monitor compliance with organization-wide coding guidelines
3. Report compliance concerns