Certified Coding Specialist (CCS) Examination Content Outline

Number of Questions on exam:

- **97 multiple-choice questions (79 scored/18 pretest)**
- **8 medical scenarios (6 scored/2 pretest)**

Exam Time: 4 hours – no breaks

Domain 1 – Health Information Documentation (8-10%)

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. Compose a compliant physician query
5. Consult reference materials to facilitate code assignment
6. Identify patient encounter type
7. Identify and post charges for healthcare services based on documentation

Domain 2 – Diagnosis & Procedure Coding (64-68%)

Tasks:

Diagnosis:

1. Select the diagnoses that require coding according to current coding and reporting requirements for acute care (inpatient) services
2. Select the diagnoses that require coding according to current coding and reporting requirements for outpatient services
3. 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
4. Sequence diagnoses and other reasons for encounter according to notations and conventions of the classification system and standard data set definitions (such as Uniform Hospital Discharge Data Set [UHDDS])
5. Apply the official ICD-10-CM coding guidelines

Procedure:

1. Select the procedures that require coding according to current coding and reporting requirements for acute care (inpatient) services
2. Select the procedures that require coding according to current coding and reporting requirements for outpatient services
3. Interpret conventions, formats, instructional notations, and definitions of the classification system and/or nomenclature to select procedures/services that require coding
4. Sequence procedures according to notations and conventions of the classification system/nomenclature and standard data set definitions (such as UHDDS)
5. Apply the official ICD-10-PCS procedure coding guidelines
6. Apply the official CPT/HCPCS Level II coding guidelines

Domain 3 – Regulatory Guidelines and Reporting Requirements for Acute Care (Inpatient) Service (6-8%)

Tasks:

1. Select the principal diagnosis, principal procedure, complications, comorbid conditions, other diagnoses and procedures that require coding according to UHDDS definitions and Coding Clinic
2. Assign the present on admission (POA) indicators
3. Evaluate the impact of code selection on Diagnosis Related Group (DRG) assignment
4. Verify DRG assignment based on Inpatient Prospective Payment System (IPPS) definitions
5. Assign and/or validate the discharge disposition

DOMAIN IV. Regulatory Guidelines and Reporting Requirements for Outpatient Services (6-8%)

Tasks:

1. Select the reason for encounter, pertinent secondary conditions, primary procedure, and other procedures that require coding according to UHDDS definitions, CPT Assistant, Coding Clinic, and HCPCS
2. Apply Outpatient Prospective Payment System (OPPS) reporting requirements:
   a. Modifiers
   b. CPT/ HCPCS Level II
   c. Medical necessity
   d. Evaluation and Management code assignment (facility reporting)
3. Apply clinical laboratory service requirements

DOMAIN V. Data Quality and Management (2-4%)

Tasks:

1. Assess the quality of coded data
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. Review and resolve coding edits such as Correct Coding Initiative (CCI), Medicare Code Editor (MCE) and Outpatient Code Editor (OCE)

DOMAIN VI. Information and Communication Technologies (1-3%)

Tasks:

1. Use computer to ensure data collection, storage, analysis, and reporting of information.
2. Use common software applications (for example, word processing, spreadsheets, and e-mail) in the execution of work processes

3. Use specialized software in the completion of HIM processes

DOMAIN VII. Privacy, Confidentiality, Legal, and Ethical Issues (2-4%)

Tasks:

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

DOMAIN VIII. Compliance (2-4%)

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 health record documentation and coding guidelines
3. Recognize and report compliance concerns