



CCS Item Types FAQ

Background on New Item Types for the CCS exams:

The Commission on Certification for Health Informatics and Information Management (CCHIIM) appointed a task force to conduct a comprehensive review of AHIMA's coding credentials and develop strategies to better position the credentials in light of the increasing competitive landscape and to pave the way towards 3rd party accreditation.

After a review of the Coding Credential Taskforce Executive Summary, CCHIIM approved the implementation of the new item types for the CCS exam.

Outlined below are descriptions of each item type that is presented on the CCS exam.

Description of the CCS Item types:

1. Multiple Choice: One best answer item format requires the test taker to select the single best response from four (4) options. AHIMA certification exams currently utilize this format for all objective items. *Please refer to the screen shots that are provide at the end of this document.*

2. Clinical Scenario Cases: Consist of a clinical scenario and 2-3 questions. The first question for the Clinical scenario will ask for the Primary or Principal diagnosis and will require only one answer. The following 1-2 questions will ask for the Additional Diagnoses and/or the Procedure codes. For these you will need to select all that apply. *Please refer to the screen shots that are provided at the end of this document.*

FAQ's – Frequently Asked Questions

Has the Delivery of the CCS exam changed?

No. Candidates will still continue to test at Pearson VUE Professional Testing Centers both US based and internationally.

Has the content within the exam change?

The CCS exam content has not changed. Candidates will still be tested in accordance to the same exam blueprint that is posted to the Certification Website. The Domains and Tasks have not changed.

Why did CCHIIM change the item types?

CCHIIM developed these item types to reflect the practical application of selecting and applying codes. These innovative item types will provide a more accurate measure of a candidate's knowledge and skills.

Will the new item types require more training or study efforts?

No. The new item types are testing the same skills and knowledge that the previous exam structure offered.

Did the exam time change?

No, the CCS exam will still be four (4) hours in length.

Can you still use your code books for the CCS exam?

Yes. Candidates will be allowed to use their code books during the entire exam.

Is there still two distinct parts to the CCS exam?

No. The exam is one continuous exam without breaks. However the exam will be given in sections as shown below:

1. Multiple Choice
2. Clinical Scenario Cases

Each section will have instruction on how to answer the questions. Candidates are required to monitor their own time throughout the exam.

How is the exam scored?

The exam is scored as follows:

- Multiple Choice questions are worth 1 point.
- Clinical Scenario Cases are worth up to 21 points. Over- or under-coding will result in a loss of points.

Are the new item types more difficult?

No. The exam has the same level of difficulty as in previous versions. The exam is still testing the same knowledge and skills that are presented in the exam blueprint/content outline. The new items types are presenting the question in a new way.

Example of the CCS launch screen:

Certified Coding Specialist (CCS) Exam - Candidate Name



Candidate Name

Certified Coding Specialist (CCS) Exam

Click on the **Next** button in the bottom right corner to begin the test.

↩ End Exam

Next →

Example of the CCS intro screen:

Certified Coding Specialist (CCS) Exam - Candidate Name

🕒 Time Remaining 3:54:54

🧮 Calculator

Exam Instructions

Features of the Exam

- The exam questions will be presented in two sections. You will have four hours to complete the exam.
- You may use your codebooks to complete the questions on this exam.
- You will not be allowed to skip a question. Instead, you must select an answer before moving to the next question.
- You are able to mark questions for later review by clicking the **Flag for Review** button in the top right hand corner of the screen. At the end of the exam you will have the opportunity to review and change any answers you flag.

Information that will be available during the exam:

- To access the calculator click the **Calculator** icon in the top left corner of the screen.
- The **Time Remaining** in the exam will be displayed in the upper right corner of the screen.

When you are ready to begin the exam, select the **Next** button.

Next →

Sample of CCS Multiple Choice intro screen:

Certified Coding Specialist (CCS) Exam - Candidate Name

⌚ Time Remaining 3:53:06

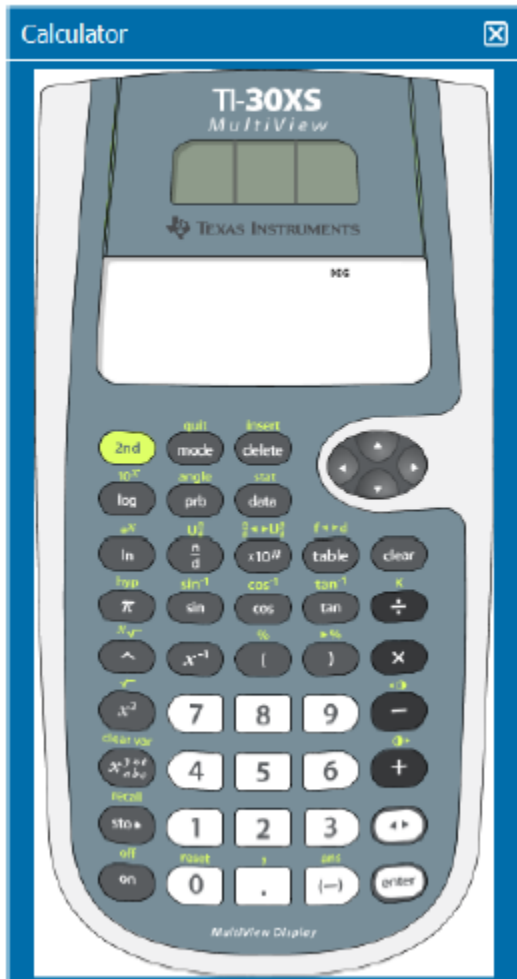
📎 Calculator

Multiple Choice Items

- You will now begin the Multiple Choice section of the exam.
- This section contains 97 Multiple Choice items.
- Each item requires only one response.
- If an item is marked as **Flag for Review** and you run out of time, the response(s) you previously selected will be scored.

Next →

Sample of Calculator:



Sample of CCS Medical/Clinical Scenario Case intro screens:

Certified Coding Specialist (CCS) Exam - Candidate Name

⌚ Time Remaining 3:48:57

 Calculator

Medical Scenarios

- You will now begin the Medical Scenarios section of the exam.
- This section contains 8 Medical Scenarios with a total of 22 questions.
- To view Case Instructions and Coding Instructions you will need to navigate back to the beginning of this section.
- If an item is marked as **Flag for Review** and you run out of time, the response(s) you previously selected will be scored.

← Previous

Next →

Case Instructions

Read the clinical scenario. Many of the cases will be longer than the screen. Please make sure to scroll all the way to the bottom of the cases to read all of the information. Following the clinical scenario are 2 to 3 questions. The questions will ask you to code the:

Principal diagnosis: Select only one diagnosis for this question. All cases will ask you this question.

Additional diagnosis codes: Select as many as are appropriate. You may select none if no additional diagnosis codes apply to the case. Over-coding will result in a loss of points. Some cases may exclude this question but please note that "NONE" is always an option for this question.

Procedure codes: Select as many as are appropriate. You may select none if no procedure codes apply to the case. Over-coding will result in a loss of points. Some cases may exclude this question but please note that "NONE" is always an option for this question.

The sequencing of codes is not being tested in this section. Please only select the appropriate codes. Over or under coding will result in a loss of points.

Please note that the number of options available to select the codes from is not an indicator of the number of correct options and that in some instances "NONE" should be selected as the correct answer.

Sample of CCS Item Review screen:

Certified Coding Specialist (CCS) Exam - Candidate Name

🕒 Time Remaining 3:45:28

Item Review Screen

📄 Instructions

Below is a summary of your answers. You can review your questions in three (3) different ways.

The buttons in the lower right-hand corner correspond to these choices:

1. Review all of your questions and answers.
2. Review questions that are incomplete.
3. Review questions that are flagged for review. (Click the 'flag' icon to change the flag for review status.)

You may also click on a question number to link directly to its location in the exam.

📁 Multiple Choice Items Section

(0 Unseen/Incomplete)

📁 Case Items Section

(22 Unseen/Incomplete)

Procedures for Coding Inpatient Medical Record Cases for the CCS Examination

Instructions and official guidelines for coding medical records are included in the following resources: ICD-10-CM/PCS, CPT, UHDDS, Coding Clinic for ICD-10-CM/PCS, and CPT Assistant. However, hospitals and other organizations may develop their own procedures in the absence of approved guidelines. To ensure consistent coding, the following procedures listed below have been developed for use in the CCS examination. The procedures do not supersede or replace official coding advice and guidelines included in the resources identified above.

These procedures are to be used only in completing the CCS examination. They will be provided to test takers as part of the examination packet. Not adhering to these procedures may result in the miscoding of an exercise, which may result in the deduction of points when the item is scored.

Inpatient Coding

1. Apply UHDDS definitions, ICD-10-CM/PCS instructional notations and conventions, and current approved national ICD-10-CM/PCS coding guidelines to assign correct ICD-10-CM/PCS diagnostic and procedural codes to hospital inpatient medical records.
2. Sequence the ICD-10-CM codes, listing the principal diagnosis first.
3. Code other diagnoses that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. These represent additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring.
 - A. Code diagnoses that require active intervention during hospitalization. For example: Admission for small-bowel ileus and subsequent aspiration pneumonia that is treated with antibiotics and respiratory therapy. Code the ileus and aspiration pneumonia.
 - B. Code diagnoses that require active management of chronic disease during hospitalization, which is defined as a patient who is continued on chronic management at time of hospitalization. For example: Admission for acute exacerbation of COPD. The patient has depression that extends the stay and for which psychiatric consultation is obtained. Code the COPD and depression. For example: Admission for acute exacerbation of COPD. Physician lists "history of depression" on face sheet, and the patient is given Desyrel. Code the COPD and depression.
 - C. Code diagnoses of chronic systemic or generalized conditions that are not under active management when a physician documents them in the record and that may have a bearing on the management of the patient. For example: Admission for breast mass; diagnosis is carcinoma. Patient is blind and requires increased care. Code the breast carcinoma and blindness.
 - D. Code status post previous surgeries or conditions likely to recur that may have a bearing on the management of the patient. For example: Admission for pneumonia; status post cardiac bypass surgery. Code the pneumonia and status post cardiac bypass surgery (Z code)

E. Do not code status post previous surgeries or histories of conditions that have no bearing on the management of the patient. For example: Admission for pneumonia; status post hernia repair six months prior to admission. Code only the pneumonia. Previous surgeries involving transplants, internal devices, and prosthetics should be coded.

F. Do not code localized conditions that have no bearing on the management of the patient. For example: Admission for hernia repair; the patient has a nevus on his leg that is not treated or evaluated. Code only the hernia and its repair.

G. Do not code abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) unless there is documentary evidence from the physician of their clinical significance. For example: Admission for elective joint replacement for degenerative joint disease. The laboratory report shows a serum sodium of 133; no further documentation addresses this laboratory result. Code only the degenerative joint disease and the replacement surgery. For example: Admission for elective joint replacement for degenerative joint disease. The laboratory report shows a low potassium level, and the physician documents hypokalemia. Intravenous potassium was administered by the physician for hypokalemia. Code the degenerative joint disease, the replacement surgery, and hypokalemia.

H. Do not code symptoms and signs that are characteristic of a diagnosis. For example: A patient has dyspnea due to COPD. Code only the COPD.

I. Do not code condition(s) in the Social History section that has no bearing on the management of the patient.

4. Do not assign External Causes of Morbidity V01-Y99 codes.

5. Do not assign Morphology codes (M codes).

6. Code all procedures that fall within the code range 001 through 10Y.

7. Do not code procedures that fall within the code range 2W0 (Placement) through HZ9 (Substance Abuse Treatment) sections. But code procedures in the following ranges:

Cholangiograms

Retrogrades, urinary systems

Arteriography and angiography

Radiation therapy

Psychiatric therapy

Alcohol/drug detoxification and rehabilitation.

Insertion of endotracheal tube

Other lavage of bronchus and trachea

Mechanical ventilation

ESWL

Chemotherapy

Procedures for Coding Outpatient Medical Record Cases for the CCS Examination

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Ambulatory Care Coding

1. Apply ICD-10-CM instructional notations and conventions and current approved Diagnostic Coding and Reporting Guidelines for Outpatient Services (Section IV of the official ICD-10-CM Guidelines for Coding and Reporting), to select diagnoses, conditions, problems, or other reasons for care that require ICD-10-CM coding in an ambulatory care encounter/visit either in a hospital clinic, outpatient surgical area, emergency room, physician's office, or other ambulatory care setting.

2. Sequence the ICD-10-CM codes so that the first diagnosis shown in the medical record is the one chiefly responsible for the outpatient services provided during the encounter/visit.

3. Code the secondary diagnoses as follows:

A. Chronic diseases that are treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

B. Code all documented conditions that coexist at the time of the encounter/visit that require or affect patient care, treatment, or management.

C. Conditions previously treated and no longer existing should not be coded.

4. Do not assign External Causes V01-Y99 codes

5. Do not assign Morphology codes (M codes).

6. Do not assign ICD-10-PCS procedure codes.

7. Assign CPT codes for all surgical procedures that fall in the surgery section.

8. Assign CPT codes from the following ONLY IF indicated on the case cover sheet:

a) Anesthesia section

b) Medicine section

c) Evaluation and management services section d) Radiology section

e) Laboratory and pathology section

9. Assign CPT/HCPCS modifiers for hospital-based facilities, if applicable (regardless of payer).

10. Do not assign HCPCS Level II (alphanumeric) codes.

Review Incomplete

Review Flagged