



Certified Coding Specialist— Physician-Based 2012 Job Analysis Summary Report

Prepared for the
American Health Information Management Association

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INTRODUCTION

In May 2012, the American Health Information Management Association (AHIMA) commissioned a national job analysis study to identify: (a) the professional tasks and knowledge required to competently perform the role of the physician-based coding specialist and (b) the changes that had occurred in professional practice since the last job analysis study, which was conducted in 2006. The procedures used in conducting the job analysis study involved an interactive process that combined:

- the job analysis expertise of Knapp & Associates International, Inc. (Knapp) staff;
- the professional knowledge of a task force comprised of experienced coding specialists from physician settings; and,
- the judgments of a nationwide sample of coding specialists.

METHOD

The design and implementation of the job analysis study consisted of a number of steps carried out between May and October of 2012. These steps are described in subsequent sections of this report.

The methodology selected for the job analysis study is consistent with the validation processes recommended in the *Standards for Educational and Psychological Testing* (1999), published jointly by the American Psychological Association, the American Educational Research Association, and the National Council on Measurement in Education; the National Commission for Certifying Agencies' *Standards for the Accreditation of Certification Programs*; and international standard *ISO/IEC 17024 - General requirements for bodies operating certification schemes for persons*, published by the International Organization for Standardization/International Electrotechnical Commission.

Establishment of a Job Analysis Task Force

Early in the job analysis process, AHIMA formed a Job Analysis Task Force comprised of individuals with significant experience in the coding role in physician settings. Task force members were selected to be representative of the diversity of the profession with respect to:

- education/training;
- type of work setting;
- geographic location;
- gender; and
- ethnic diversity.

The role of the task force was to participate in the: (a) identification of tasks and knowledge associated with the role of the physician-based coding specialist, (b) development of the job analysis survey instrument, (c) interpretation of the survey findings, and (d) creation of examination specifications based on the survey findings. Appendix A contains a list of the task force members.

At the start of the job analysis, the task force was convened via web conference for an orientation meeting. The purpose of this meeting was to:

- explain the goals of the job analysis process and its role in supporting the validity of the Certified Coding Specialist – Physician-Based (CCS-P) certification examination;
- review the action plan for the CCS-P job analysis study and outline the task force’s role and responsibilities with respect to the study; and
- explain the work which task force members were expected to do prior to the survey development meeting (i.e., review the tasks and knowledge areas derived from the prior job analysis and evaluate their relevancy to current practice and with respect to trends/changes anticipated to occur over the next five years).

Creation of Draft Job Analysis Survey

Analysis of Changes in Professional Practice

The CCS-P Job Analysis Task Force was convened June 6-7, 2012 to create the draft survey instrument. The survey development meeting began with a lengthy and in-depth discussion of the changes which have taken place in the work environment of the physician-based coding specialist over the last five years and those expected to occur over the next five years. Changes relating to the broader healthcare environment and to the settings in which professionals work were cited, followed by an exploration of whether and how these changes have/will impact the role and practices of the coding specialist.

Review and Updating of Tasks

Historically, there has been substantial overlap between the tasks performed by physician-based coding specialists and coding specialists working in other settings (e.g., inpatient facilities). Indeed, since the last job analysis, the tasks included in the examination specifications for the CCS-P certification examination have been identical to those for the Certified Coding Specialist (CCS) certification examination. Consequently, after consultation with AHIMA staff, it was decided that the task list developed for the 2012 CCS job analysis survey would serve as the starting point for selecting tasks to be included on the 2012 CCS-P job analysis survey.

Following the discussion of changes in the practice of coding specialists,, the task force reviewed the task list generated by the CCS task force and were asked to consider the following questions:

- What tasks can remain “as is”?
- What tasks should be revised?
- What new tasks should be added?
- What tasks should be deleted?

The task force took into consideration how well the tasks reflected coding practice in general, and also what modifications might be needed to capture any unique aspects of coding in physician (vs. other) settings.

The final task list consisted of a total of 32 tasks.

Review of Survey Rating Scale and Demographic Questions

The task force reviewed and discussed an “importance” rating scale for the tasks which was proposed by Knapp and AHIMA staff. The task force concurred that the scale and anchor points were appropriate for use with the survey tasks. This scale is presented below.

IMPORTANCE
How important is this task to competent performance of your current coding role?
Not at all important
Slightly important
Moderately important
Very important

The final survey was structured such that respondents were first asked whether they performed a task (Yes/No), and if they answered in the affirmative, the importance scale was then presented for the task.

Knapp and AHIMA staff also proposed a series of demographic questions for the survey which would aid in describing the survey sample and provide a basis for identifying differences in subgroup responses. These questions were reviewed and discussed, and in some cases, revised by the task force.

Identification of Required Knowledge and Task-Knowledge Linkages

Identification of Knowledge Areas


In addition to identifying the tasks performed by coding specialists, the task force was asked to specify the knowledge necessary to competently perform the tasks. Unlike the process used to identify the tasks, the group did not use the CCS knowledge areas as a starting point for discussion. Although the *tasks* performed in the job roles are similar, there are some notable differences in the *knowledge* expected of physician-based coding specialists. Consequently, the task force reviewed the knowledge areas generated by the prior CCS-P job analysis and were asked to consider the following questions:

- What knowledge areas can remain “as is”?
- What knowledge areas should be revised?

- What new knowledge areas should be added?
- What knowledge areas should be deleted?

The final knowledge list consisted of a total of 45 knowledge areas.

Completion of Preliminary Task-Knowledge Linkages

After finalizing the knowledge areas, the task force established the preliminary linkages between the tasks and knowledge areas. For each task, the group selected from the list of knowledge areas those required for competent performance of the task. This activity was conducted in break-out groups and the output of each group was subsequently reviewed and discussed by the entire task force and, when appropriate, revised (the linkages are presented in Appendix B). These linkages were deemed “preliminary,” as it was necessary to validate the tasks via the job analysis survey prior to finalizing the linkages. AHIMA currently is in the process of finalizing the linkages. 

It should be noted that the knowledge areas and the task-knowledge linkages were not included on the job analysis survey. Rather, the purpose of compiling this information was to provide more detailed guidance to: (a) candidates preparing for the CCS-P certification examination and (b) the subject matter experts responsible for creating and reviewing the items for the examination.


Piloting of Survey

The survey drafted by the task force was piloted online with a group of practitioners who had no previous involvement in the development of the survey. These individuals, who were recommended by Job Analysis Task Force members, were asked to:


- confirm that the directions were clear and the rating scale was easy to use;
- evaluate whether the survey content was accurate; and
- determine whether there were any important tasks missing from the draft survey instrument.

Based on the feedback received from the pilot participants, Knapp and AHIMA staff determined that no changes to the draft survey were necessary. AHIMA staff subsequently approved the survey for administration. The final survey can be found in Appendix C.

Selection of the Survey Sample

The survey sample was drawn randomly  from the population of CCS-P certificants for whom AHIMA had e-mail addresses.

Administration of the Job Analysis Survey

In July 2012, the job analysis survey was administered  by AHIMA. The mailing list consisted of 1,552 e-mail addresses, of which 10 bounced back, leaving 1,542 potentially viable addresses.

The sample was invited to participate in the survey via an e-mail communication explaining the purpose and importance of the study. An incentive of two Continuing Education Units was offered to those who completed the survey. To further encourage participation, two follow-up e-mail reminders were sent to the sample following the initial invitation. These communications can be found in Appendix D.

RESULTS

Response Rate

As shown in Table 1 the overall survey return rate was 29% (441 completed surveys). This return rate could be a conservative estimate as an unknown number of surveys may have been trapped by SPAM filters and not delivered. The percentage of surveys completed is acceptable for surveys of this type.

Table 1. Survey response rate

# surveys sent	# successful e-mail transmissions	# surveys completed	return rate
1,552	1,542	441	29%

The confidence interval at the 95% confidence level was +/- 4.4, which is acceptable.

Demographic Characteristics of Respondents

The demographic characteristics of the survey sample are presented in Tables 2-11. It was the consensus of the CCS Analysis Task Force that the demographic characteristics of the respondents were reasonably consistent with those of CCS certificants nationwide.

Table 2. Number of years CCS-P credential has been held

Number of years	% survey respondents*
Less than 1	13
1-2	18
3-5	24
6-10	20
11-15	18
16 or more	7

* Figures may not add up to 100 due to rounding

Table 3. Other credentials held

Credential	% survey respondents*
CCS	23
RHIT	21
RHIA	17
CPC	17
CCA	3
CPC-H	3
CPMA	2
CPC-C	1
CDIP	1
CHDA	<1
CIRCC	0
CHP	0
CHPS	0
No other credentials held	34

* *Multiple responses permitted*

Table 4. Primary work setting

Work setting	% survey respondents*
Hospital	22
Multi-specialty group practice	13
Physician office	12
Consultant/vendor	10
Independent coding company	6
Integrated delivery system (hospital, physician, home health, SNF)	6
Educational institution (university/community college)	5
Corporate office of a multi-hospital system	4
Multi-hospital system	4
Government	3
Ambulatory care facility	3
Insurance	3
Non-provider setting	2
HIM specialty setting	1
Currently not employed	1
Home health care agency	<1
Managed care/HMO/PPO office	<1
Behavioral/mental health facility	0
Other	5

* Figures may not add up to 100 due to rounding

Table 5. Geographic location of the facility(ies) in which the majority of work related to coding is conducted

Geographic location	% survey respondents*
AL	1
AK	1
AZ	2
AR	1
CA	7
CO	<1
CT	<1
DE	0
FL	4
GA	2
HI	<1
ID	1
IL	11
IN	3
IA	1
KS	2
KY	1
LA	1
ME	<1
MD	2
MA	2
MI	3
MN	5
MS	<1
MO	2
MT	<1

* Figures may not add up to 100 due to rounding

Table 5. (cont'd)

Geographic location	% survey respondents
NE	1
NV	0
NH	0
NJ	<1
NM	<1
NY	5
NC	4
ND	1
OH	4
OK	1
OR	<1
PA	3
RI	0
SC	<1
SD	<1
TN	<1
TX	5
UT	1
VT	<1
VA	2
WA	2
WV	0
WI	6
WY	<1
District of Columbia (DC)	0
Puerto Rico (PR)	<1
Multiple states	7
Other (International)	4

Table 6. Current job role

Job role	% survey respondents*
Coder	28
Coder/biller/reimbursement specialist	21
Auditor	11
Coding manager	9
Consultant	6
Director	5
Academic educator	4
Compliance officer/manager	3
Office manager	3
DRG and/or APC coordinator	1
Charge master analyst/coordinator	1
Revenue cycle manager	1
Currently not employed	1
Facility-based educator	<1
Nurse	<1
Student	<1
Physician	0
Privacy officer	0
Registrar, cancer or other	0
Retired	0
Other	6

* Figures may not add up to 100 due to rounding

Table 7. Percentage of time spent performing coding and/or coding-related activities daily

Percentage of time	% survey respondents*
0	1
1-9	4
10-19	6
20-29	4
30-39	4
40-49	5
50-59	11
60-69	6
70-79	14
80-89	14
90-100	31

* Figures may not add up to 100 due to rounding

Table 8. Years of experience in coding

Years of experience	% survey respondents*
Less than 1	2
1-2	9
3-5	13
6-10	17
11-15	14
16-20	19
21 or more	25

* Figures may not add up to 100 due to rounding

Table 9. Highest level of education completed

Level of education	% survey respondents*
High school diploma/GED	20
Associate's degree	33
Baccalaureate degree	35
Master's degree	10
Doctorate degree	1
Doctor of Law/Doctor of Jurisprudence	<1
Doctor of Medicine/Doctor of Osteopathic Medicine	1

* Figures may not add up to 100 due to rounding

Table 10. Type of coding education

Coding education	% survey respondents*
Coding certificate program	46
AHIMA ICD-10-CM/PCS Academy	18
AHIMA Coding Basics	6
AHIMA ISP Program	4
Other	20
No coding education completed	14

* Multiple responses permitted

Table 11. Gender

Gender	% survey respondents
Male	8
Female	92

Analysis of Importance Ratings for Professional Tasks

Total means and standard deviations for the task importance ratings were calculated. These data can be found in Appendix E. Table 12 presents the means and standard deviations for the task domains.

Table 12. Mean importance ratings for task domains

Domain	Mean*	Standard deviation
I. Health Information Documentation	2.78	.32
II. Diagnosis and Procedure Coding	2.82	.32
III. Regulatory Guidelines and Reporting Requirements for Outpatient Services	2.85	.30
IV. Data Quality and Management	2.72	.41
V. Information and Communication Technologies	2.67	.49
VI. Privacy, Confidentiality, Legal, and Ethical Issues	2.83	.37
VII. Compliance	2.77	.44

* On a scale of 0-3 where 0 = not at all important, 1 = slightly important, 2 = moderately important, 3 = very important

Task Domain Weights

Respondents were asked to indicate what percentage of future CCS-P examinations should be devoted to each of the seven task domains included on the survey. This information was used to inform the task force's decision making regarding the relative weighting of each domain included in the specifications for the examination. The mean percentages and standard deviations of the respondent data for each domain are shown in Table 13.

Table 13. Mean percentages and standard deviations for weighting of examination content

Domain	Mean*	Standard deviation
I. Health Information Documentation	16	8.52
II. Diagnosis and Procedure Coding	39	16.36
III. Regulatory Guidelines and Reporting Requirements for Outpatient Services	13	6.07
IV. Data Quality and Management	8	3.80
V. Information and Communication Technologies	7	3.31
VI. Privacy, Confidentiality, Legal, and Ethical Issues	9	5.84
VII. Compliance	9	5.60

** Figures do not add up to 100 due to rounding*

Survey Content Coverage

Survey respondents were asked to judge the adequacy of the survey content by rating how well the tasks within each domain represented the job role of the coding specialist. Table 14 presents the mean ratings, based on a scale of 0-4 where 0 = very poorly and 4 = very well. The ratings indicate that the survey content was reflective of the job role.

Table 14. Survey coverage

Domain	Mean*	Standard Deviation
I. Health Information Documentation	3.58	.66
II. Diagnosis and Procedure Coding	3.67	.59
III. Regulatory Guidelines and Reporting Requirements for Outpatient Services	3.62	.61
IV. Data Quality and Management	3.48	.69
V. Information and Communication Technologies	3.42	.74
VI. Privacy, Confidentiality, Legal, and Ethical Issues	3.48	.75
VII. Compliance	3.45	.76

* On a scale of 0-4 where 0 = very poorly, 1 = poorly, 2 = adequately, 3 = well, and 4 = very well

Education and Work Experience Required for Competence

The survey respondents were asked, “In your opinion, what is the minimum level of education required to competently perform the tasks listed in this survey? The findings (Table 15) indicate that respondents believed the desired level of education (associate’s degree or above) is higher than that currently required (high school diploma or equivalent).

Table 15. Level of education necessary to competently perform the tasks required of a coding specialist

Level of education	% survey respondents*
Less than a high school diploma	<1
High school diploma /GED	28
Associate's degree	60
Baccalaureate degree	11

*Figures may not add up to 100 due to rounding

Respondents also were asked how many years of on-the-job experience in physician-based coding were necessary to competently perform the tasks listed in this survey. Although work-related experience is not currently required for CCS-P certification, AHIMA may wish to consider the survey findings (Table 16) when evaluating program eligibility requirements in the future.

Table 16. Years of on-the-job experience in physician-based coding necessary to competently perform the tasks required of a coding specialist

Years experience	% survey respondents*
Less than 1 year	6
1-2 years	42
3-5 years	46
6-10 years	4
10 years or more	2

*Figures may not add up to 100 due to rounding

DEVELOPMENT OF EXAMINATION SPECIFICATIONS

Review of Survey Data

The CCS-P Job Analysis Task Force met via web conferences on October 8 and 10, 2012 to review and discuss the survey findings and to develop the examination specifications. The first step in the process of developing the examination specifications was a review of the overall patterns in the survey data. Next, the task force conducted an item-by-item review and discussion of the mean importance ratings for each task. To facilitate this process, the item means were assigned to quartiles and color coded to indicate that they were in the first (i.e., highest means), second, third, or fourth quartile compared to other items in the survey. The use of decision rules for determining whether to include or exclude individual tasks from the examination specifications was discussed at this time. Given that even the lowest means fell above the mid-point between “moderately important” and “very important,” the task force concluded that a decision rule was not necessary. Ultimately, the task force confirmed that all of the tasks should be retained for the examination specifications.

Determination of Examination Content

Following its review of the job analysis survey data, the CCS-P Job Analysis Task Force proceeded to develop the proposed specifications for the examination. These examination specifications outline:

- the specific tasks to be covered on the CCS-P examination;
- the relative weighting of each domain and task; and
- the types of items to be used to assess examinees on each task.

Basing the examination specifications on the findings of the job analysis study ensures that the assessment procedures will realistically reflect the tasks necessary for effective performance of the coding specialist role. Realistic examination content and assessment procedures are required to meet both legal guidelines and testing industry standards. Each facet of the specifications development process is described below.

Weighting of Item Types

The CCS-P certification examination is comprised of three item types:

- *Multiple-Choice.* Four options are provided and there is a single correct answer.
- *Multiple-Select.* A list of options is provided and examinees are instructed to select X number of options. A point is received for each correct option selected.
- *Quantity Fill-in-the-Blank.* A series of text boxes is provided following the presentation of a medical case and examinees are instructed to type in the codes for the case. A point is received for each correct code submitted by the examinee.

The current examination specifications require that 69 points come from multiple-choice items, 6 points from multiple-select items, and 50 from quantity fill-in-the-blank items (a total of 125 points from scored items). The task force re-affirmed that this weighting was appropriate for the new examination specifications.

For the Quantity Fill-in-the-Blank items, the task force also determined, based on their expert consensus, the type and number of cases to be assessed with this item type (see Appendix F).

Task Domain Weights

Although all of the tasks included in the job analysis survey are part of the scope of practice for coding specialists, they do not all necessarily contribute equally to competent professional practice. Some tasks may be of greater importance or may be utilized more frequently than others when carrying out day-to-day responsibilities. Consequently, the CCS-P Job Analysis Task Force assigned weights to each task domain and each specific task within the domains to indicate their relative emphasis within the scope of practice and correspondingly, within the CCS-P examination. The task force assigned domain and task weights based on the survey findings and their expert judgment.

Table 17 presents the overall weightings for the major task domains.

Table 17. Weighting of major task domains on examination specifications

Domain	% of examination points
I. Health Information Documentation	9-11
II. Diagnosis and Procedure Coding	60-62
III. Regulatory Guidelines and Reporting Requirements for Outpatient Services	9-11
IV. Data Quality and Management	5-7
V. Information and Communication Technologies	3-5
VI. Privacy, Confidentiality, Legal, and Ethical Issues	4-6
VII. Compliance	3-5

The weighting of the *Diagnosis and Procedure Coding* domain is considerably higher than that suggested by data obtained from survey respondents. The rationale for this lies in the types of items used on the CCS-P examination. The multiple-select and quantity fill-in-the-blank items assess application of knowledge and focus exclusively on the *Diagnosis and Procedure Coding* domain. And because the scope of the codes is so broad, AHIMA also uses standard multiple-choice items to ensure adequate sampling of the domain. Thus, the total weighting (from a point perspective) for the examination specifications is necessarily higher than that suggested by respondents.

Weights for each task can be found in the examination specifications in Appendix F.

CONCLUSION

The primary purpose of the job analysis study was to validate the scope of practice for physician-based coding specialists. The survey results confirmed the tasks identified by the CCS-P Job Analysis Task Force and provided data to inform the determination of the most crucial tasks associated with the job role. The linkage of the CCS-P examination specifications to the findings of the job analysis study will serve as evidence of the content validity of future examinations.

APPENDIX A

CCS-P Job Analysis Task Force

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APPENDIX B

DOMAIN I: Health Information Documentation

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.
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.3. Clinical concepts:
 - 1.3a. Medical terminology and standard abbreviations
 - 1.3b. Anatomy and physiology
 - 1.3c. Pharmacology
 - 1.3d. Clinical findings
 - 1.3e. Clinical indicators
 - 1.3f. Signs and symptoms
 - 1.3g. Pathophysiology (disease processes)
 - 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.4b. AMA CPT Assistant
 - 2.4c. Medical Dictionary
 - 2.4d. Abbreviations/acronyms
 - 2.4e. Pharmacology
 - 2.4f. Anatomy and Physiology

2. Determine when additional clinical documentation is needed to assign the diagnosis and/or procedure code(s).
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.3. Clinical concepts:
 - 1.3a. Medical terminology and standard abbreviations
 - 1.3b. Anatomy and physiology
 - 1.3c. Pharmacology
 - 1.3d. Clinical findings
 - 1.3e. Clinical indicators
 - 1.3f. Signs and symptoms
 - 1.3g. Pathophysiology (disease processes)

2.4. Coding references:

2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)

2.4b. AMA CPT Assistant

2.4c. Medical Dictionary

2.4d. Abbreviations/acronyms

2.4e. Pharmacology

2.4f. Anatomy and Physiology

2.5. Official coding for diagnoses and procedures:

2.5a. Definitions

2.5b. Sequencing

2.5c. Coding and reporting requirements outpatient services

2.5d. Coding conventions:

2.5d1. Formats

2.5d2. Instructional notations

2.5d3. Tables

2.5d4. Symbols

2.5e. Signs, symptoms, or manifestations requiring separate code assignments

2.5f. Coding specificity (fourth or fifth digit)

2.5g. V-Codes

2.5h. E-Codes

2.5i. Modifiers

2.5j. CPT/HCPCS Level II

2.5k. Evaluation and management code assignment

3.8. National Correct Coding Initiative (NCCI) bundling edits

3. Consult with physicians and other healthcare providers to obtain further clinical documentation to assist with code assignment.

1.5. Roles and responsibilities of health care providers

2.4. Coding references:

2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)

2.4b. AMA CPT Assistant

4.3. Physician Query (follow correct guidelines)

5.1. Computer concepts (e.g., hardware, software)

5.2. Common software and web-based applications

5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)

4. Consult reference materials to facilitate code assignment.

2.4. Coding references:

2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)

2.4b. AMA CPT Assistant

2.4c. Medical Dictionary

2.4d. Abbreviations/acronyms

2.4e. Pharmacology

2.4f. Anatomy and Physiology

4.1. National Correct Coding Initiative (NCCI) content and use

5. Identify patient encounter type.

1.1. Components of a record

1.2. Contents of a record

1.4. Data Sets (e.g., demographics, identifiers)

1.6. Documentation requirements for professional services in any place of service

3.6. Claim form data elements

6. Identify and post charges for healthcare services based on documentation.

1.4. Data Sets (e.g., demographics, identifiers)

1.6. Documentation requirements for professional services in any place of service

2.5. Official coding for diagnoses and procedures:

2.5a. Definitions

2.5b. Sequencing

2.5c. Coding and reporting requirements outpatient services

2.5d. Coding conventions:

2.5d1. Formats

2.5d2. Instructional notations

2.5d3. Tables

2.5d4. Symbols

2.5e. Signs, symptoms, or manifestations requiring separate code assignments

2.5f. Coding specificity (fourth or fifth digit)

2.5g. V-Codes

2.5h. E-Codes

2.5i. Modifiers

2.5j. CPT/HCPCS Level II

2.5k. Evaluation and management code assignment

- 3.1. CMS Claims Processing Manual content and use
- 3.2. Impact of payer specific guidelines on reimbursement (e.g., Medicare, local coverage determinations)
- 3.3. Clinical Laboratory Improvement Act (CLIA) (e.g., waived tests, modifier use)
- 3.4. RBRVS and Medicare physicians' fee schedule database
- 3.5. Participating versus non-participating (PAR vs. non-PAR) billing requirements
- 3.6. Claim form data elements
- 3.7. HIPAA designated code sets
- 3.8. National Correct Coding Initiative (NCCI) bundling edits
- 3.10. Advanced Beneficiary Notice (ABN) content and use
- 3.12. Basic insurance terminology (e.g., co-pay, co-insurance, deductible, primary payer)
- 3.13. Basic accounting terminology (e.g., accounts receivable, write-offs)
- 4.8. Payor types
- 4.9. Payor documentation requirements
- 4.11. Revenue cycle components (from registration to payment)
- 5.1. Computer concepts (e.g., hardware, software)
- 5.2. Common software and web-based applications
- 5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)
- 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security

DOMAIN II: Diagnosis and Procedure Coding

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.
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.3. Clinical concepts:
 - 1.3a. Medical terminology and standard abbreviations
 - 1.3b. Anatomy and physiology
 - 1.3c. Pharmacology
 - 1.3d. Clinical findings
 - 1.3e. Clinical indicators
 - 1.3f. Signs and symptoms
 - 1.3g. Pathophysiology (disease processes)

- 1.5. Roles and responsibilities of health care providers
- 1.6. Documentation requirements for professional services in any place of service
- 2.1. ICD-9-CM
- 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.4c. Medical Dictionary
 - 2.4d. Abbreviations/acronyms
 - 2.4e. Pharmacology
 - 2.4f. Anatomy and Physiology
- 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5e. Signs, symptoms, or manifestations requiring separate code assignments
 - 2.5f. Coding specificity (third, fourth, or fifth digit)
 - 2.5g. V-Codes
 - 2.5h. E-Codes
- 3.2. Impact of payer specific guidelines on reimbursement (e.g., Medicare, local coverage determinations)
- 3.7 HIPAA designated code sets
- 3.8. National Correct Coding Initiative (NCCI) content and use
- 3.10. Advanced Beneficiary Notice (ABN) content and use
- 4.3. Physician Query (follow correct guidelines)
- 4.8. Payor types
- 4.9. Payor documentation requirements
- 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
- 7.3. Definition of fraud
- 7.4. Definition of abuse

2. Select the diagnoses that require coding according to current reporting requirements for professional services in any setting.
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.3. Clinical concepts:
 - 1.3a. Medical terminology and standard abbreviations
 - 1.3b. Anatomy and physiology
 - 1.3c. Pharmacology
 - 1.3d. Clinical findings
 - 1.3e. Clinical indicators
 - 1.3f. Signs and symptoms
 - 1.3g. Pathophysiology (disease processes)
 - 1.4. Data Sets (e.g., demographics, identifiers)
 - 1.5. Roles and responsibilities of health care providers
 - 1.6. Documentation requirements for professional services in any place of service
 - 2.1. ICD-9-CM
 - 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.4c. Medical Dictionary
 - 2.4d. Abbreviations/acronyms
 - 2.4e. Pharmacology
 - 2.4f. Anatomy and Physiology
 - 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5e. Signs, symptoms, or manifestations requiring separate code assignments
 - 2.5f. Coding specificity (third, fourth, or fifth digit)
 - 2.5g. V-Codes
 - 2.5h. E-Codes

- 3.2. Impact of payer specific guidelines on reimbursement (e.g., Medicare, local coverage determinations)
 - 3.6. Claim form data elements
 - 3.7 HIPAA designated code sets
 - 3.8. National Correct Coding Initiative (NCCI) content and use
 - 3.10. Advanced Beneficiary Notice (ABN) content and use
 - 4.3. Physician Query (follow correct guidelines)
 - 4.8. Payor types
 - 4.9. Payor documentation requirements
 - 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
 - 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security
 - 7.3. Definition of fraud
 - 7.4. Definition of abuse
3. Sequence diagnoses and other reasons for encounter according to notations and conventions of the classification system and standard data set definitions.
- 2.5. Official coding for diagnoses and procedures:
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5e. Signs, symptoms, or manifestations requiring separate code assignments
4. Apply the official ICD-9-CM coding guidelines.
- 2.1. ICD-9-CM
 - 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services

- 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
- 2.5e. Signs, symptoms, or manifestations requiring separate code assignments
- 2.5f. Coding specificity (fourth or fifth digit)
- 2.5g. V-Codes
- 2.5h. E-Codes
- 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
- 7.3. Definition of fraud
- 7.4. Definition of abuse

Procedure:

1. Interpret conventions, formats, instructional notations, and definitions of the classification system and/or nomenclature to select procedures/services that require coding.
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.3. Clinical concepts:
 - 1.3a. Medical terminology and standard abbreviations
 - 1.3b. Anatomy and physiology
 - 1.3c. Pharmacology
 - 1.3d. Clinical findings
 - 1.3e. Clinical indicators
 - 1.3f. Signs and symptoms
 - 1.3g. Pathophysiology (disease processes)
 - 1.5. Roles and responsibilities of health care providers
 - 1.6. Documentation requirements for professional services in any place of service
- 2.2. CPT
- 2.3. HCPCS Level II
- 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.4b. AMA CPT Assistant
 - 2.4c. Medical Dictionary
 - 2.4d. Abbreviations/acronyms
 - 2.4e. Pharmacology
 - 2.4f. Anatomy and Physiology

- 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5i. Modifiers
 - 2.5j. CPT/HCPCS Level II
 - 2.5k. Evaluation and management code assignment
- 3.1. CMS Claims Processing Manual content and use
- 3.2. Impact of payer specific guidelines on reimbursement (e.g., Medicare, local coverage determinations)
- 3.3. Clinical Laboratory Improvement Act (CLIA) (e.g., waived tests, modifier use)
- 3.7. HIPAA designated code sets
- 3.10. Advanced Beneficiary Notice (ABN) content and use
- 4.1. National Correct Coding Initiative (NCCI) content and use
- 4.2. Medicare Code Editor (MCE)
- 4.3. Physician Query (follow correct guidelines)
- 4.8. Payor types
- 4.9. Payor documentation requirements
- 5.1. Computer concepts (e.g., hardware, software)
- 5.2. Common software and web-based applications
- 5.3. HIM specific software applications (e.g., Encoder, grouper, Record Completion, CAC, EHR, EMR)
- 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
- 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security
- 7.2. Government agencies:
 - 7.2a. Centers for Medicare and Medicaid Services (CMS)
 - 7.2b. Office of Inspector General (OIG)
 - 7.2c. CMS Contractors [e.g., Revenue Audit Contractor (RAC), Medicare Administrative Contractor (MAC)]
- 7.3. Definition of fraud
- 7.4. Definition of abuse

2. Select the procedures that require coding according to current reporting requirements for professional services in any setting.
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.3. Clinical concepts:
 - 1.3a. Medical terminology and standard abbreviations
 - 1.3b. Anatomy and physiology
 - 1.3c. Pharmacology
 - 1.3d. Clinical findings
 - 1.3e. Clinical indicators
 - 1.3f. Signs and symptoms
 - 1.3g. Pathophysiology (disease processes)
 - 1.4. Data Sets (e.g., demographics, identifiers)
 - 1.5. Roles and responsibilities of health care providers
 - 1.6. Documentation requirements for professional services in any place of service
 - 2.2. CPT
 - 2.3. HCPCS Level II
 - 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.4b. AMA CPT Assistant
 - 2.4c. Medical Dictionary
 - 2.4d. Abbreviations/acronyms
 - 2.4e. Pharmacology
 - 2.4f. Anatomy and Physiology
 - 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5i. Modifiers
 - 2.5j. CPT/HCPCS Level II
 - 2.5k. Evaluation and management code assignment

- 3.1. CMS Claims Processing Manual content and use
 - 3.2. Impact of payer specific guidelines on reimbursement (e.g., Medicare, local coverage determinations)
 - 3.3. Clinical Laboratory Improvement Act (CLIA) (e.g., waived tests, modifier use)
 - 3.6. Claim form data elements
 - 3.7. HIPAA designated code sets
 - 3.10. Advanced Beneficiary Notice (ABN) content and use
 - 4.1. National Correct Coding Initiative (NCCI) content and use
 - 4.2. Medicare Code Editor (MCE)
 - 4.3. Physician Query (follow correct guidelines)
 - 4.8. Payor types
 - 4.9. Payor documentation requirements
 - 5.3. HIM specific software applications (e.g., Encoder, grouper, Record Completion, CAC, EHR, EMR)
 - 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
 - 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security
 - 7.2. Government agencies:
 - 7.2a. Centers for Medicare and Medicaid Services (CMS)
 - 7.2b. Office of Inspector General (OIG)
 - 7.2c. CMS Contractors [e.g., Revenue Audit Contractor (RAC), Medicare Administrative Contractor (MAC)]
 - 7.3. Definition of fraud
 - 7.4. Definition of abuse
3. Sequence procedures according to notations and conventions of the classification system/nomenclature and standard data set definitions.
- 2.5. Official coding for diagnoses and procedures:
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5i. Modifiers
 - 2.5j. CPT/HCPCS Level II
 - 2.5k. Evaluation and management code assignment

- 3.4. RBRVS and Medicare physicians' fee schedule database
- 3.6. Claim form data elements
- 3.7. HIPAA designated code sets
- 4.1. National Correct Coding Initiative (NCCI) content and use

- 4. Apply the official CPT/HCPCS Level II coding guidelines.
 - 2.2. CPT
 - 2.3. HCPCS Level II
 - 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.4b. AMA CPT Assistant
 - 2.4c. Medical Dictionary
 - 2.4d. Abbreviations/acronyms
 - 2.4e. Pharmacology
 - 2.4f. Anatomy and Physiology
 - 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5i. Modifiers
 - 2.5j. CPT/HCPCS Level II
 - 2.5k. Evaluation and management code assignment
- 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
- 7.3. Definition of fraud
- 7.4. Definition of abuse

DOMAIN III: Regulatory Guidelines and Reporting Requirements for Outpatient Services

1. Select the reason for encounter, pertinent secondary conditions, primary procedure, and other procedures that require coding according to, CPT Assistant, Coding Clinic for ICD-9-CM, and HCPCS.
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.3. Clinical concepts:
 - 1.3a. Medical terminology and standard abbreviations
 - 1.3b. Anatomy and physiology
 - 1.3c. Pharmacology
 - 1.3d. Clinical findings
 - 1.3e. Clinical indicators
 - 1.3f. Signs and symptoms
 - 1.3g. Pathophysiology (disease processes)
 - 1.6. Documentation requirements for professional services in any place of service
 - 2.1. ICD-9-CM
 - 2.2. CPT
 - 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.4b. AMA CPT Assistant
 - 2.4c. Medical Dictionary
 - 2.4d. Abbreviations/acronyms
 - 2.4e. Pharmacology
 - 2.4f. Anatomy and Physiology
 - 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5i. Modifiers
 - 2.5j. CPT/HCPCS Level II
 - 2.5k. Evaluation and management code assignment

7.3. Definition of fraud

7.4. Definition of abuse

2. Apply appropriate reporting requirements:

a. Modifiers

b. CPT/ HCPCS Level II

c. Evaluation and Management code assignment

1.3. Clinical concepts:

1.3a. Medical terminology and standard abbreviations

1.3b. Anatomy and physiology

1.3c. Pharmacology

1.3d. Clinical findings

1.3e. Clinical indicators

1.3f. Signs and symptoms

1.3g. Pathophysiology (disease processes)

1.6. Documentation requirements for professional services in any place of service

2.2. CPT

2.3. HCPCS Level II

2.4. Coding references:

2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)

2.4b. AMA CPT Assistant

2.4c. Medical Dictionary

2.4d. Abbreviations/acronyms

2.4e. Pharmacology

2.4f. Anatomy and Physiology

2.5. Official coding for diagnoses and procedures:

2.5i. Modifiers

2.5j. CPT/HCPCS Level II

2.5k. Evaluation and management code assignment

3.2. Impact of payer specific guidelines on reimbursement (e.g., Medicare, local coverage determinations)

3.4. RBRVS and Medicare physicians' fee schedule database

3.6. Claim form data elements

4.1. National Correct Coding Initiative (NCCI) content and use

7.1. Accrediting bodies (e.g., The Joint Commission, Medicare Conditions of Participation)

- 7.2. Government agencies:
 - 7.2a. Centers for Medicare and Medicaid Services (CMS)
 - 7.2b. Office of Inspector General (OIG)
 - 7.2c. CMS Contractors [e.g., Revenue Audit Contractor (RAC), Medicare Administrative Contractor (MAC)]
- 7.4. Definition of abuse
- 7.5. Corporate policy and procedures

- 3. Validate medical necessity for appropriate relationships between diagnosis and coded procedures/services.
 - 1.3. Clinical concepts:
 - 1.3a. Medical terminology and standard abbreviations
 - 1.3b. Anatomy and physiology
 - 1.3c. Pharmacology
 - 1.3d. Clinical findings
 - 1.3e. Clinical indicators
 - 1.3f. Signs and symptoms
 - 1.3g. Pathophysiology (disease processes)
 - 1.5 Roles and responsibilities of health care providers
 - 3.2. Impact of payer specific guidelines on reimbursement (e.g., Medicare, local coverage determinations)
 - 3.6. Claim form data elements
 - 3.8. National Correct Coding Initiative (NCCI) bundling edits
 - 4.1. National Correct Code Initiative (NCCI) content and use
 - 4.3. Physician Query (follow correct guidelines)
 - 4.9. Payor documentation requirements
 - 7.3. Definition of fraud
 - 7.4. Definition of abuse

DOMAIN IV: Data Quality and Management

- 1. Review the results of aggregate coded data as required.
 - 1.4. Data Sets (e.g., demographics, identifiers)
 - 4.4. Abstracted data
 - 4.5. Public data (e.g., Core Measures, Registries)
 - 4.7. Data Integrity
 - 4.11. Revenue cycle components (from registration to payment)
 - 5.1. Computer concepts (e.g., hardware, software)
 - 5.2. Common software and web-based applications

- 5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)
- 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security

- 2. Communicate with healthcare providers regarding reimbursement methodologies, documentation rules, and regulations related to coding.
 - 1.1. Components of a record
 - 1.5. Roles and responsibilities of health care providers
 - 1.6. Documentation requirements for professional services in any place of service
 - 3.4. RBRVS and Medicare physicians' fee schedule database
 - 4.3. Physician Query (follow correct guidelines)
 - 4.9. Payor documentation requirements
 - 7.3. Definition of fraud
 - 7.4. Definition of abuse
 - 7.5. Corporate policy and procedures

- 3. Analyze health record documentation for quality and completeness of coding.
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.4. Data Sets (e.g., demographics, identifiers)
 - 1.5. Roles and responsibilities of health care providers
 - 1.6. Documentation requirements for professional services in any place of service
 - 3.7. HIPAA designated code sets
 - 4.6. Institutional coding productivity and accuracy standards
 - 4.7. Data Integrity
 - 4.9. Payor documentation requirements
 - 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
 - 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security
 - 7.1. Accrediting bodies (e.g., The Joint Commission, Medicare Conditions of Participation)
 - 7.2. Government agencies:
 - 7.2a. Centers for Medicare and Medicaid Services (CMS)
 - 7.2b. Office of Inspector General (OIG)
 - 7.2c. CMS Contractors [e.g., Revenue Audit Contractor (RAC), Medicare Administrative Contractor (MAC)]

4. Review the accuracy of abstracted data elements for database integrity and claims processing.
 - 3.4. RBRVS and Medicare physicians' fee schedule database
 - 3.6. Claim form data elements
 - 3.7. HIPAA designated code sets
 - 3.8. National Correct Coding Initiative (NCCI) bundling edits
 - 4.4. Abstracted data
 - 4.5. Public data (e.g., Core Measures, Registries)
 - 4.6. Institutional coding productivity and accuracy standards
 - 4.7. Data Integrity
 - 4.10. Unbilled accounts management
 - 4.11. Revenue cycle components (from registration to payment)

5. Resolve coding edits such as National Correct Coding Initiative (NCCI).
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.6. Documentation requirements for professional services in any place of service
 - 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5e. Signs, symptoms, or manifestations requiring separate code assignments
 - 2.5f. Coding specificity (fourth or fifth digit)
 - 2.5g. V-Codes
 - 2.5h. E-Codes
 - 2.5i. Modifiers
 - 2.5j. CPT/HCPCS Level II
 - 2.5k. Evaluation and management code assignment
 - 3.1. CMS Claims Processing Manual content and use
 - 3.2. Impact of payer specific guidelines on reimbursement (e.g., Medicare, local coverage determinations)
 - 3.3. Clinical Laboratory Improvement Act (CLIA) (e.g., waived tests, modifier use)
 - 3.6. Claim form data elements

- 3.7. HIPAA designated code sets
- 3.10. Advanced Beneficiary Notice (ABN) content and use
- 3.11. Claims denial and appeal process
- 4.1. National Correct Coding Initiative (NCCI) content and use
- 4.2. Medicare Code Editor (MCE)
- 4.4. Abstracted data
- 4.7. Data Integrity
- 4.8. Payor types
- 4.9. Payor documentation requirements
- 5.1. Computer concepts (e.g., hardware, software)
- 5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)
- 7.5. Corporate policy and procedures

DOMAIN V: Information and Communication Technologies

1. Use computer and mobile devices (tablet, hand-held, etc.) to ensure data collection, storage, analysis, and reporting of information.
 - 1.5. Roles and responsibilities of health care providers
 - 1.6. Documentation requirements for professional services in any place of service
 - 4.3. Physician Query (follow correct guidelines)
 - 4.5. Public data (e.g., Core Measures, Registries)
 - 4.7. Data Integrity
 - 5.1. Computer concepts (e.g., hardware, software)
 - 5.2. Common software and web-based applications
 - 5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)
 - 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security
 - 7.5. Corporate policy and procedures

2. Use common software and web-based applications in the execution of work processes.
 - 1.5. Roles and responsibilities of health care providers
 - 1.6. Documentation requirements for professional services in any place of service
 - 4.4. Abstracted data
 - 4.7. Data Integrity
 - 5.1. Computer concepts (e.g., hardware, software)
 - 5.2. Common software and web-based applications

6.2. HIPAA:

6.2a. Privacy

6.2b. Security

7.5. Corporate policy and procedures

3. Use specialized software in the completion of HIM processes.

1.1. Components of a record

1.2. Contents of a record

1.4. Data Sets (e.g., demographics, identifiers)

1.6. Documentation requirements for professional services in any place of service

4.4. Abstracted data

4.7. Data Integrity

5.1. Computer concepts (e.g., hardware, software)

5.2. Common software and web-based applications

5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)

6.2. HIPAA:

6.2a. Privacy

6.2b. Security

7.5. Corporate policy and procedures

DOMAIN VI: Privacy, Confidentiality, Legal, and Ethical Issues

1. Apply policies and procedures for access and disclosure of protected health information.

1.1. Components of a record

1.2. Contents of a record

1.4. Data Sets (e.g., demographics, identifiers)

6.2. HIPAA:

6.2a. Privacy

6.2b. Security

7.5. Corporate policy and procedures

2. Apply AHIMA Code of Ethics/Standards of Ethical Coding.

1.3. Clinical concepts:

1.3a. Medical terminology and standard abbreviations

1.3b. Anatomy and physiology

1.3c. Pharmacology

1.3d. Clinical findings

1.3e. Clinical indicators

- 1.3f. Signs and symptoms
- 1.3g. Pathophysiology (disease processes)
- 2.1. ICD-9-CM
- 2.2. CPT
- 2.3. HCPCS Level II
- 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.4b. AMA CPT Assistant
 - 2.4c. Medical Dictionary
 - 2.4d. Abbreviations/acronyms
 - 2.4e. Pharmacology
 - 2.4f. Anatomy and Physiology
- 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations
 - 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5e. Signs, symptoms, or manifestations requiring separate code assignments
 - 2.5f. Coding specificity (fourth or fifth digit)
 - 2.5g. V-Codes
 - 2.5h. E-Codes
 - 2.5i. Modifiers
 - 2.5j. CPT/HCPCS Level II
 - 2.5k. Evaluation and management code assignment
- 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
- 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security
- 7.3. Definition of fraud
- 7.4. Definition of abuse

3. Report privacy and/or security concerns.
 - 1.5. Roles and responsibilities of health care providers
 - 5.1. Computer concepts (e.g., hardware, software)
 - 5.2. Common software and web-based applications
 - 5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)
 - 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
 - 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security
 - 7.2. Government agencies:
 - 7.2b. Office of Inspector General (OIG)
 - 7.5. Corporate policy and procedures

4. Protect data integrity and validity using software or hardware technology.
 - 1.4. Data Sets (e.g., demographics, identifiers)
 - 4.7. Data Integrity
 - 5.1. Computer concepts (e.g., hardware, software)
 - 5.2. Common software and web-based applications
 - 5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)
 - 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security
 - 7.5. Corporate policy and procedures

DOMAIN VII: Compliance

1. Evaluate the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards.
 - 1.1. Components of a record
 - 1.2. Contents of a record
 - 1.3. Clinical concepts:
 - 1.3a. Medical terminology and standard abbreviations
 - 1.3b. Anatomy and physiology
 - 1.3c. Pharmacology
 - 1.3d. Clinical findings
 - 1.3e. Clinical indicators
 - 1.3f. Signs and symptoms
 - 1.3g. Pathophysiology (disease processes)

- 1.4. Data Sets (e.g., demographics, identifiers)
 - 1.5. Roles and responsibilities of health care providers
 - 1.6. Documentation requirements for professional services in any place of service
 - 4.4. Abstracted data
 - 4.7. Data Integrity
 - 4.9. Payor documentation requirements
 - 5.2. Common software and web-based applications
 - 5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)
 - 7.1. Accrediting bodies (e.g., The Joint Commission, Medicare Conditions of Participation)
 - 7.2. Government agencies:
 - 7.2a. Centers for Medicare and Medicaid Services (CMS)
 - 7.2b. Office of Inspector General (OIG)
 - 7.2c. CMS Contractors [e.g., Revenue Audit Contractor (RAC), Medicare Administrative Contractor (MAC)]
 - 7.3. Definition of fraud
 - 7.4. Definition of abuse
 - 7.5. Corporate policy and procedures
2. Monitor compliance with organization-wide coding guidelines.
- 2.1. ICD-9-CM
 - 2.2. CPT
 - 2.3. HCPCS Level II
 - 2.4. Coding references:
 - 2.4a. AHA Coding Clinics (ICD-9-CM and HCPCS Level II)
 - 2.4b. AMA CPT Assistant
 - 2.4c. Medical Dictionary
 - 2.4d. Abbreviations/acronyms
 - 2.4e. Pharmacology
 - 2.4f. Anatomy and Physiology
 - 2.5. Official coding for diagnoses and procedures:
 - 2.5a. Definitions
 - 2.5b. Sequencing
 - 2.5c. Coding and reporting requirements outpatient services
 - 2.5d. Coding conventions:
 - 2.5d1. Formats
 - 2.5d2. Instructional notations

- 2.5d3. Tables
 - 2.5d4. Symbols
 - 2.5e. Signs, symptoms, or manifestations requiring separate code assignments
 - 2.5f. Coding specificity (third, fourth, or fifth digit)
 - 2.5g. V-Codes
 - 2.5h. E-Codes
 - 2.5i. Modifiers
 - 2.5j. CPT/HCPCS Level II
 - 2.5k. Evaluation and management code assignment
 - 4.1. National Correct Coding Initiative (NCCI) content and use
 - 4.2. Medicare Code Editor (MCE)
 - 4.3. Physician Query (follow correct guidelines)
 - 4.6. Institutional coding productivity and accuracy standards
 - 4.8. Payor types
 - 4.9. Payor documentation requirements
 - 5.1. Computer concepts (e.g., hardware, software)
 - 5.2. Common software and web-based applications
 - 5.3. HIM specific software applications (e.g., Encoder, Grouper, Record Completion, CAC, EHR, EMR)
 - 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
 - 7.1. Accrediting bodies (e.g., The Joint Commission, Medicare Conditions of Participation)
 - 7.2. Government agencies:
 - 7.2a. Centers for Medicare and Medicaid Services (CMS)
 - 7.2b. Office of Inspector General (OIG)
 - 7.2c. CMS Contractors [e.g., Revenue Audit Contractor (RAC), Medicare Administrative Contractor (MAC)]
 - 7.3. Definition of fraud
 - 7.4. Definition of abuse
 - 7.5. Corporate policy and procedures
3. Report compliance concerns.
- 4.7. Data Integrity
 - 5.1. Computer concepts (e.g., hardware, software)
 - 5.2. Common software and web-based applications
 - 6.1. AHIMA Code of Ethics/Standards of Ethical Coding
 - 6.2. HIPAA:
 - 6.2a. Privacy
 - 6.2b. Security

- 7.1. Accrediting bodies (e.g., The Joint Commission, Medicare Conditions of Participation)
- 7.2. Government agencies:
 - 7.2a. Centers for Medicare and Medicaid Services (CMS)
 - 7.2b. Office of Inspector General (OIG)
 - 7.2c. CMS Contractors [e.g., Revenue Audit Contractor (RAC), Medicare Administrative Contractor (MAC), etc]
- 7.3. Definition of fraud
- 7.4. Definition of abuse
- 7.5. Corporate policy and procedures

APPENDIX C

Welcome to the 2012 CCS-P Job Analysis Survey!

Thank you for participating in this important research study. The purpose of this job analysis survey is to identify the tasks that physician-based coding specialists must master in order to perform their jobs competently. Your input is vital to the success of this research project.

This survey is divided into two parts. The first part covers tasks performed by coding specialists; the second focuses on background information about you and asks some questions about the CCS-P credential.

Those who submit a completed survey will receive two (2) continuing education units (CEUs).

Part One

The purpose of this section of the survey is to determine the most important tasks performed by coding specialists. For each task listed, you will first be asked whether you perform the task in your current coding role. If you do perform the task, you will then be asked to make a judgment about its importance using the rating scale presented below.

How important is this task to the competent performance of your current coding role?

Not at all important
Slightly important
Moderately important
Very important

DOMAIN I: Health Information Documentation

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.

Adequacy of Survey Content

How well do the items you just rated cover the tasks that coding specialists should be able to perform within the domain of Health Information Documentation?

Very poorly
Poorly
Adequately
Well
Very well

Please list any important tasks that you believe should be added to this domain.

DOMAIN II: Diagnosis and Procedure Coding

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.

Adequacy of Survey Content

How well do the items you just rated cover the tasks that coding specialists should be able to perform within the domain of Diagnosis and Procedure Coding?

- Very poorly
- Poorly
- Adequately
- Well
- Very well

Please list any important tasks that you believe should be added to this domain.

DOMAIN III: Regulatory Guidelines and Reporting Requirements for Outpatient Services

1. Select the reason for encounter, pertinent secondary conditions, primary procedure, and other procedures that require coding according to CPT Assistant, Coding Clinic for ICD-9-CM, 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.

Adequacy of Survey Content

How well do the items you just rated cover the tasks that coding specialists should be able to perform within the domain of Regulatory Guidelines and Reporting Requirements for Outpatient Services?

- Very poorly
- Poorly
- Adequately
- Well
- Very well

Please list any important tasks that you believe should be added to this domain.

DOMAIN IV: Data Quality and Management

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).

Adequacy of Survey Content

How well do the items you just rated cover the tasks that coding specialists should be able to perform within the domain of Data Quality and Management?

Very poorly
Poorly
Adequately
Well
Very well

Please list any important tasks that you believe should be added to this domain.

DOMAIN V: Information and Communication Technologies

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.

Adequacy of Survey Content

How well do the items you just rated cover the tasks that coding specialists should be able to perform within the domain of Information and Communication Technologies?

Very poorly
Poorly
Adequately
Well
Very well

Please list any important tasks that you believe should be added to this domain.

DOMAIN VI: Privacy, Confidentiality, Legal, and Ethical Issues

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.

Adequacy of Survey Content

How well do the items you just rated cover the tasks that coding specialists should be able to perform within the domain of Privacy, Confidentiality, Legal, and Ethical Issues?

Very poorly
Poorly
Adequately
Well
Very well

Please list any important tasks that you believe should be added to this domain.

DOMAIN VII: Compliance

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.

Adequacy of Survey Content

How well do the items you just rated cover the tasks that coding specialists should be able to perform within the domain of Compliance?

Very poorly
Poorly
Adequately
Well
Very well

Please list any important tasks that you believe should be added to this domain.

Weighting of Examination Content

Below are seven domains that might be covered on future CCS-P examinations. What percentage of the examination should be devoted to each domain?

Indicate by distributing (in whole numbers) 100% across the domains below.

Do not list the percent (%) sign.

- I. Health Information Documentation _____
- II. Diagnosis and Procedure Coding _____
- III. Regulatory Guidelines and Reporting Requirements for
Outpatient Services _____
- IV. Data Quality and Management _____
- V. Information and Communication Technologies _____
- VI. Privacy, Confidentiality, Legal, and Ethical Issues _____
- VII. Compliance _____

Part Two

Please answer each item by marking the response that most clearly describes you and your professional activities. Background information is collected for purposes of group analysis. Your responses are anonymous and confidential.

For how long have you held the CCS-P credential?

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 11-15 years
- 16 years or more

What other credentials do you currently hold? (Select all that apply)

- I hold no other AHIMA credentials
- CCA -- Certified Coding Associate
- CCS -- Certified Coding Specialist
- CDIP -- Certified Documentation Improvement Practitioner
- CHP -- Certified in Healthcare Privacy
- CHPS -- Certified in Healthcare Privacy and Security
- RHIA -- Registered health Information Administrator
- RHIT -- Registered Health Information Technician
- CHDA -- Certified Health Data Analyst

What is your PRIMARY work setting?

- Ambulatory care facility
- Behavioral/mental health facility
- Consultant/vendor
- Corporate office of a multi-hospital system
- Educational institution (university/community college)
- Government
- HIM specialty setting
- Home health care agency
- Hospital
- Independent coding company
- Insurance
- Integrated delivery system (hospital, physician, home health, SNF)
- Long-term care facility
- Managed care/HMO/PPO/office
- Multi-hospital system
- Multi-specialty group practice
- Non-provider setting
- Physician office
- Currently not employed
- Other

What is the geographic location of the facility(ies) in which you conduct the majority of your work related to coding? (Select only one location)

- AL
- AK
- AZ
- AR
- CA
- CO
- CT
- DE
- FL
- GA
- HI
- ID
- IL
- IN
- IA
- KS
- KY
- LA
- ME
- MD
- MA
- MI
- MN
- MS
- MO
- MT
- NE
- NV
- NH
- NJ
- NM
- NY
- NC
- ND
- OH
- OK
- OR
- PA
- RI
- SC
- SD
- TN
- TX
- UT
- VT

VA
WA
WV
WI
WY
District of Columbia (DC)
Puerto Rico (PR)
Multiple states
Other (International)

Which of the following BEST describes your current job role?

Academic educator
Auditor
Charge master analyst/coordinator
Coder
Coder/biller/reimbursement specialist
Coding manager
Compliance officer/manager
Consultant
Director
DRG and/or APC coordinator
Facility-based educator
Nurse
Office manager
Physician
Privacy officer
Registrar, cancer or other
Revenue cycle manager
Student
Retired
Currently not employed
Other

On an average day, what percentage of time do you spend performing coding and/or coding-related activities?

0
1-9%
10-19%
20-29%
30-39%
40-49%
50-59%
60-69%
70-79%
80-89%
90-100%

How many years of experience do you have in coding?

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21 years or more

What is the highest level of education you have completed to date? (Select one)

- High school diploma /GED
- Associate's degree
- Baccalaureate degree
- Master's degree
- Doctorate degree
- Doctor of Law/Doctor of Jurisprudence
- Doctor of Medicine/ Doctor of Osteopathic Medicine

What type of coding education have you completed? (Select all that apply)

- I have not completed coding education
- AHIMA ICD-10-CM/PCS Academy
- AHIMA ISP Program
- AHIMA Coding Basics
- Coding certificate program
- Other (please specify) _____

What is your gender?

- Male
- Female

In your opinion, what is the minimum level of education required to competently perform the tasks listed in this survey?

- Less than a high school diploma
- High school diploma /GED
- Associate's degree
- Baccalaureate degree

In your opinion, how many years of on-the-job experience in physician-based coding are necessary to competently perform the tasks listed in this survey?

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 10 years or more

Do you plan to seek any other AHIMA credentials? (Select all that you plan to seek)

- I do not plan to seek another AHIMA credential
- CCS -- Certified Coding Specialist
- CHPS -- Certified in Healthcare Privacy and Security
- CHDA -- Certified Health Data Analyst
- CDIP -- Certified Documentation Improvement Practitioner
- RHIA -- Registered Health Information Administrator
- RHIT -- Registered Health Information Technician

The CCS-P certification has benefited me in the following ways: (Check all that apply)

- Increased salary
 - Job promotion
 - Job retention
 - Better job opportunities
 - Professional recognition by co-workers
 - Professional recognition by supervisor
 - Professional recognition from other peers in the healthcare industry
 - Personal satisfaction from attaining the certification
 - Increased knowledge/skills (through the preparation for certification)
 - Other (please explain)
-

How can AHIMA increase the value of the CCS-P designation?

How likely is it that you would recommend the CCS-P certification to other coding specialists?

0	1	2	3	4	5	6	7	8	9	10
Not at all likely					Neutral					Extremely likely

Thank you for completing the survey. We greatly appreciate your time and input.

You can report two (2) continuing education units (CEUs) for completion of this survey.

APPENDIX D

CCS-P Survey Invitation Letter

Subject: CCS-P Job Analysis Survey Invitation

Body: [FirstName] [LastName]

I'd like to invite you to take the CCS-P job analysis survey. The purpose of this job analysis survey is to identify the tasks that physician-based coding specialists must master in order to perform their jobs competently. This data will also be used to develop the CCS-P exam blueprint.

You can report 2 CEUs for completion of this survey.

Please complete the survey by Friday, August 10th. You can access the survey here:

<https://www.surveymk.com/s.aspx>

Thank you for your participation!

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list.

<https://www.surveymk.com/optout.aspx>

Inger Sorlie, MA
Test Development Specialist
American Health Information Management Association

APPENDIX E

Certified Coding Specialist - Physician-Based (CCS-P) Survey Results

	% Perform	Importance		
		N	Mean	Std Dev
CCS-P TASKS	79	441	2.79	0.28
DOMAIN I: Health Information Documentation	84	438	2.78	0.32
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.	96	425	2.88	0.39
2 Determine when additional clinical documentation is needed to assign the diagnosis and/or procedure code(s).	90	399	2.85	0.39
3 Consult with physicians and other healthcare providers to obtain further clinical documentation to assist with code assignment.	79	349	2.76	0.51
4 Consult reference materials to facilitate code assignment.	96	426	2.78	0.46
5 Identify patient encounter type.	83	368	2.71	0.56
6 Identify and post charges for healthcare services based on documentation.	57	254	2.80	0.53
DOMAIN II: Diagnosis and Procedure Coding	87	435	2.82	0.32
Diagnosis:	88	425	2.83	0.33
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.	84	368	2.83	0.41
2 Select the diagnoses that require coding according to current coding and reporting requirements for outpatient services.	87	379	2.87	0.39
3 Sequence diagnoses and other reasons for encounter according to notations and conventions of the classification system and standard data set definitions.	86	375	2.75	0.52
4 Apply the official ICD-9-CM coding guidelines.	96	417	2.91	0.33
Procedure:	85	416	2.81	0.37
1 Interpret conventions, formats, instructional notations, and definitions of the classification system and/or nomenclature to select procedures/services that require coding.	87	378	2.85	0.40
2 Select the procedures that require coding according to current reporting requirements for professional services in any setting.	84	367	2.85	0.40
3 Sequence procedures according to notations and conventions of the classification system/nomenclature and standard data set definitions.	79	344	2.74	0.54
4 Apply the official CPT/HCPCS Level II coding guidelines.	90	386	2.82	0.48

Red shading=top quartile, Red font=2nd quartile, Blue font=3rd quartile, Blue shading=bottom quartile

Certified Coding Specialist - Physician-Based (CCS-P) Survey Results

	% Perform	Importance		
		N	Mean	Std Dev
DOMAIN III: Regulatory Guidelines and Reporting Requirements for Outpatient Services	84	406	2.85	0.30
1 Select the reason for encounter, pertinent secondary conditions, primary procedure, and other procedures that require coding according to CPT Assistant, Coding Clinic for ICD-9-CM, and HCPCS.	80	344	2.83	0.43
2 Apply appropriate reporting requirements: a. Modifiers b. CPT/ HCPCS Level II c. Evaluation and Management code assignment	89	380	2.91	0.31
3 Validate medical necessity for appropriate relationships between diagnosis and coded procedures/services.	83	355	2.83	0.43
DOMAIN IV: Data Quality and Management	64	402	2.72	0.41
1 Review the results of aggregate coded data as required.	50	213	2.56	0.64
2 Communicate with healthcare providers regarding reimbursement methodologies, documentation rules, and regulations related to coding.	71	306	2.75	0.51
3 Analyze health record documentation for quality and completeness of coding.	76	325	2.82	0.44
4 Review the accuracy of abstracted data elements for database integrity and claims processing.	48	207	2.74	0.51
5 Resolve coding edits such as National Correct Coding Initiative (NCCI).	72	307	2.78	0.51
DOMAIN V: Information and Communication Technologies	81	412	2.67	0.49
1 Use computer and mobile devices (tablet, hand-held, etc.) to ensure data collection, storage, analysis, and reporting of information.	74	314	2.67	0.53
2 Use common software and web-based applications in the execution of work processes.	92	392	2.71	0.54
3 Use specialized software in the completion of HIM processes.	76	323	2.72	0.53
DOMAIN VI: Privacy, Confidentiality, Legal, and Ethical Issues	78	413	2.83	0.37
1 Apply policies and procedures for access and disclosure of protected health information.	74	313	2.81	0.49
2 Apply AHIMA Code of Ethics/Standards of Ethical Coding.	93	396	2.86	0.43
3 Report privacy and/or security concerns.	74	282	2.91	0.32
4 Protect data integrity and validity using software or hardware technology.	71	301	2.85	0.43
DOMAIN VII: Compliance	67	373	2.77	0.44
1 Evaluate the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards.	60	257	2.77	0.54
2 Monitor compliance with organization-wide coding guidelines.	62	263	2.81	0.46
3 Report compliance concerns.	78	331	2.78	0.49

Red shading=top quartile, Red font=2nd quartile, Blue font=3rd quartile, Blue shading=bottom quartile

APPENDIX F

CCS-P Exam	# points
DOMAIN I: Health Information Documentation (9-11%)	13
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.	5
2 Determine when additional clinical documentation is needed to assign the diagnosis and/or procedure code(s).	3
3 Consult with physicians and other healthcare providers to obtain further clinical documentation to assist with code assignment.	2
4 Consult reference materials to facilitate code assignment.	1
5 Identify patient encounter type.	1
6 Identify and post charges for healthcare services based on documentation.	1
DOMAIN II: Diagnosis and Procedure Coding (60-62%)	76
Multiple Select	6
Cases	50
Diagnosis:	10
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.	3
2 Select the diagnoses that require coding according to current coding and reporting requirements for outpatient services.	3
3 Sequence diagnoses and other reasons for encounter according to notations and conventions of the classification system and standard data set definitions.	3
4 Apply the official ICD-9-CM coding guidelines.	1
Procedure:	10
1 Interpret conventions, formats, instructional notations, and definitions of the classification system and/or nomenclature to select procedures/services that require coding.	3
2 Select the procedures that require coding according to current reporting requirements for professional services in any setting.	3
3 Sequence procedures according to notations and conventions of the classification system/nomenclature and standard data set definitions.	3
4 Apply the official CPT/HCPCS Level II coding guidelines.	1
DOMAIN III: Regulatory Guidelines and Reporting Requirements for Outpatient Services (9-11%)	13
1 Select the reason for encounter, pertinent secondary conditions, primary procedure, and other procedures that require coding according to CPT Assistant, Coding Clinic for ICD-9-CM, and HCPCS.	5
2 Apply appropriate reporting requirements:	5
a. Modifiers	X
b. CPT/ HCPCS Level II	
c. Evaluation and Management code assignment	
3 Validate medical necessity for appropriate relationships between diagnosis and coded procedures/services.	3

	# points
DOMAIN IV: Data Quality and Management (5-7%)	7
1 Review the results of aggregate coded data as required.	1
2 Communicate with healthcare providers regarding reimbursement methodologies, documentation rules, and regulations related to coding.	2
3 Analyze health record documentation for quality and completeness of coding.	1
4 Review the accuracy of abstracted data elements for database integrity and claims processing.	1
5 Resolve coding edits such as National Correct Coding Initiative (NCCI).	2
DOMAIN V: Information and Communication Technologies (3-5%)	5
1 Use computer and mobile devices (tablet, hand-held, etc.) to ensure data collection, storage, analysis, and reporting of information.	1
2 Use common software and web-based applications in the execution of work processes.	2
3 Use specialized software in the completion of HIM processes.	2
DOMAIN VI: Privacy, Confidentiality, Legal, and Ethical Issues (4-6%)	6
1 Apply policies and procedures for access and disclosure of protected health information.	2
2 Apply AHIMA Code of Ethics/Standards of Ethical Coding.	1
3 Report privacy and/or security concerns.	1
4 Protect data integrity and validity using software or hardware technology.	2
DOMAIN VII: Compliance (3-5%)	5
1 Evaluate the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards.	1
2 Monitor compliance with organization-wide coding guidelines.	1
3 Report compliance concerns.	3
TOTAL POINTS	125

CCS-P Exam - Multiple Response Section

items

Diagnosis and Procedure Coding	6
Total	6

CCS-P Exam - Case Section

of cases

CPT E/M	3
CPT Anesthesia	1
CPT Surgery	3
CPT Radiology	2
CPT Laboratory	1
CPT Medicine	2
HCPCS II	1
Total	13