YOUR FREE READER'S COMPANION

The CCA Rapid-Review Pack (2026 Edition)

A companion to The Certified Coding Associate CCA Exam Study Guide · by Regina Alvarez

Thanks for picking up the study guide and the practice workbook. This companion is the part you carry with you: fold it into your notebook, keep it on your phone, or read it in the parking lot before you walk in to test. It pulls the highest-yield terminology, the ICD-10-CM conventions that trip up beginners, the six exam domains with their weights, and fifty rapid-fire questions into a few pages you can drill in an afternoon. Everything here matches the book and the current AHIMA CCA content outline, so nothing here contradicts what you studied.

Most people who struggle with the CCA do not fail because coding is impossible. They fail because they tried to memorize a code book instead of learning a method. The exam is open book. You bring your ICD-10-CM, ICD-10-PCS, and HCPCS manuals with you. So the game is not recall, it is knowing how to read a code, follow the conventions, and pace yourself through 105 questions in two hours. Learn the terminology roots so unfamiliar words stop scaring you, learn the ten conventions cold, and practice looking things up fast. Do that and you have already beaten most of what sinks people. Carry this, drill it, and walk in calm. - Regina

High-Yield Medical Terminology

You do not have to memorize ten thousand words. You have to learn the building blocks. Almost every medical term is a root plus a prefix or a suffix, and once you can take a word apart, you can decode one you have never seen. Read the root for the body part or system, the prefix for position or number or direction, and the suffix for the condition or procedure. That skill alone answers a surprising number of questions and speeds up your code lookups.

Common word roots (body parts and systems)

Root	Meaning
cardi/o	heart
angi/o, vas/o	vessel
hem/o, hemat/o	blood
pneum/o, pulmon/o	lung
bronch/o	bronchus (airway)
nephr/o, ren/o	kidney
hepat/o	liver
gastr/o	stomach
enter/o	small intestine
col/o, colon/o	colon
oste/o	bone
arthr/o	joint
my/o	muscle
neur/o	nerve
cerebr/o, encephal/o	brain
derm/o, dermat/o	skin
cyt/o	cell
carcin/o	cancer
aden/o	gland
hyster/o, metr/o	uterus
oophor/o	ovary
cyst/o	bladder or sac

Common prefixes (position, number, direction)

Prefix	Meaning
a-, an-	without, absence of
hyper-	above, excessive
hypo-	below, deficient
tachy-	fast
brady-	slow
dys-	painful, difficult, abnormal
endo-	within
peri-	around
epi-	upon, above
sub-	under, below
intra-	within
inter-	between
pre-	before
post-	after
poly-	many
bi-	two
hemi-	half
neo-	new
anti-	against

Common suffixes (conditions and procedures)

Suffix	Meaning
-itis	inflammation
-osis	abnormal condition
-oma	tumor, mass
-pathy	disease
-megaly	enlargement
-algia, -dynia	pain
-emia	blood condition
-uria	urine condition
-rrhage, -rrhagia	bursting forth, excessive bleeding
-rrhea	flow, discharge

-sclerosis	hardening
-stenosis	narrowing
-ectomy	surgical removal
-otomy	cutting into, incision
-ostomy	creating an opening
-plasty	surgical repair
-pexy	surgical fixation
-scopy	visual examination with a scope
-gram	record or image
-graphy	process of recording
-plegia	paralysis
-penia	deficiency, too few

Decode it, do not memorize it

- gastritis = gastr/o (stomach) + itis (inflammation) = inflammation of the stomach
- cardiomegaly = cardi/o (heart) + megaly (enlargement) = enlarged heart
- nephrectomy = nephr/o (kidney) + ectomy (removal) = removal of a kidney
- polyneuropathy = poly (many) + neur/o (nerve) + pathy (disease) = disease of many nerves
- tachycardia = tachy (fast) + cardi/o (heart) + ia (condition) = fast heart rate

ICD-10-CM Conventions Cheat Sheet

This is the part beginners underestimate, and it is where the exam quietly earns its money. The conventions are the rules printed in your code book that tell you how to read and sequence codes. Know these ten cold and read every note in the Tabular List before you assign a code. All of these come straight from the ICD-10-CM Official Guidelines for Coding and Reporting.

Excludes1 versus Excludes2 (the classic trap)

- Excludes1 means NOT CODED HERE. The two codes can never be reported together because the conditions cannot occur at the same time (for example a congenital form versus an acquired form of the same condition).
- Excludes2 means NOT INCLUDED HERE. The excluded condition is not part of this code, but a patient can have both at the same time, so you may report both codes together when documented.
- Memory hook: Excludes ONE means only ONE of the two. Excludes TWO means you can code TWO.

NEC versus NOS

- NEC = Not Elsewhere Classifiable. It means "other specified." The record names a condition, but the code book has no more specific code, so you use the "other specified" code.
- NOS = Not Otherwise Specified. It is the equivalent of "unspecified." The documentation does not give you enough detail to pick a more specific code.
- Memory hook: NEC = we know it, no code exists. NOS = we do not know it, not documented.

Placeholder X

- Some codes reserve empty character positions for future expansion. When a code needs a 7th character but is shorter than six characters, you fill the empty positions with the placeholder X.
- The X holds the place so the 7th character lands in the 7th position. Do not skip it.

7th character

- Certain categories require a 7th character that adds meaning, most famously the injury and fracture chapters (A = initial encounter, D = subsequent encounter, S = sequela).
- The 7th character must always be in the 7th position of the code. If the code is not six characters long, use placeholder X to pad it out.

The word "with"

- The word "with" (or "in") in the Alphabetic Index or a code title means the two conditions are assumed to be related, read as "associated with" or "due to."
- This causal link is assumed even when the provider did not explicitly connect the two conditions. The classic example is diabetes "with" a listed complication.

Code first and Use additional code

- These notes appear in etiology and manifestation pairs. "Code first" appears at the manifestation and tells you to sequence the underlying cause first. "Use additional code" appears at the etiology and tells you to add the manifestation code second.
- Sequencing is etiology first, manifestation second. A "code first" code can never be the principal or first-listed diagnosis.

A few more you should know

- "See" and "See also" in the Index direct you to another main term. "See" is mandatory; "See also" is a suggestion when the first entry does not fit.
- A combination code is a single code that captures two diagnoses, or a diagnosis with an associated complication. Assign it whenever it fully describes the condition rather than coding the pieces separately.
- Default codes are the codes listed next to a main term in the Index; use them when the documentation gives no further detail.
- Laterality (right, left, bilateral) is built into many codes. Read for it.
- Always confirm the code in the Tabular List. Never assign straight from the Alphabetic Index.

The Six Domains and What They Weigh

The CCA exam has 105 questions, 90 scored and 15 unscored pretest questions, and you get 2 hours. The passing score is a scaled 300. The questions fall into six domains, and the two coding-heavy domains alone are more than half the exam. Spend your study time in proportion to the weights below.

Domain	Approximate weight
1. Clinical Classification Systems	30 to 34 percent
2. Reimbursement Methodologies	21 to 25 percent
3. Health Records and Data Content	14 to 18 percent
4. Compliance	12 to 16 percent
5. Information Technologies	6 to 10 percent
6. Confidentiality and Privacy	6 to 10 percent

Domain 1: Clinical Classification Systems (the biggest)

- This is applied coding. Read the scenario, look it up, apply the conventions, sequence correctly.
- You use ICD-10-CM for diagnoses, ICD-10-PCS for inpatient procedures, and HCPCS Level II for supplies, drugs, and durable medical equipment.
- ICD-10-PCS codes are always seven characters, and every character is a position with meaning (section, body system, root operation, body part, approach, device, qualifier).
- Know the difference between the principal diagnosis (inpatient, the condition chiefly responsible for admission) and the first-listed diagnosis (outpatient).

Domain 2: Reimbursement Methodologies

- MS-DRG (Medicare Severity Diagnosis Related Groups) is the inpatient prospective payment system, IPPS. Similar cases group together and the hospital is paid a set weighted amount per group.
- APC (Ambulatory Payment Classification) is the outpatient prospective payment system, OPPS, for hospital outpatient services.
- A CC is a complication or comorbidity and an MCC is a major complication or comorbidity. They can push a case into a higher-paying MS-DRG, which is why accurate coding matters to payment.
- The chargemaster (CDM) is the master list of billable items. The UB-04 is the institutional claim form; the CMS-1500 is the professional claim form.
- Know the difference between fee-for-service and prospective payment, and the role of the NCCI (National Correct Coding Initiative) edits in preventing improper unbundling.

Domain 3: Health Records and Data Content

- Know the parts of the health record, the difference between a source-oriented and problem-oriented record, and the role of documentation in supporting codes.

- If it is not documented, it cannot be coded. When documentation is unclear, the coder queries the provider rather than assuming.
- Understand data quality basics: accuracy, completeness, consistency, and timeliness.

Domain 4: Compliance

- The False Claims Act (FCA) makes it illegal to knowingly submit false claims to the government; penalties include treble (triple) damages plus per-claim fines.
- The Anti-Kickback Statute (AKS) is a criminal law that bars paying or receiving anything of value to induce referrals for services paid by federal health programs.
- Upcoding (billing a higher code than supported) and unbundling (billing separately for parts that should be one code) are classic compliance violations.
- A compliance program and regular auditing are the coder's defense. Code what is documented, no more and no less.

Domain 5: Information Technologies

- Know the electronic health record (EHR), computer-assisted coding (CAC), and encoder software basics.
- Understand data sets and standard code sets, and the coder's role in maintaining data integrity in electronic systems.

Domain 6: Confidentiality and Privacy (HIPAA)

- The Privacy Rule protects PHI (protected health information). The Security Rule protects electronic PHI.
- Minimum necessary standard: use or disclose only the least amount of PHI needed to accomplish the purpose.
- Breach notification: individuals must be notified without unreasonable delay and no later than 60 calendar days after discovery of a breach.
- TPO (treatment, payment, and health care operations) uses generally do not require a separate patient authorization; most other disclosures do.

Fifty Rapid-Fire Practice Questions

Cover the answers, say each one out loud, then check the key. Do the whole set the night before and again the morning of. If you miss one, flag the domain and reread that section. These are recall drills, not the graded exam, so use them to find your soft spots.

1. What does the CCA credential stand for?
2. How many total questions are on the CCA exam?
3. How many of those are scored?
4. How much time do you get?
5. What is the passing scaled score?
6. Which two domains together are more than half the exam?
7. Which code set is used for inpatient procedures?
8. Which code set is used for diagnoses?
9. Which code set covers supplies, drugs, and durable medical equipment?
10. How many characters is every ICD-10-PCS code?
11. What does Excludes1 mean?
12. What does Excludes2 mean?
13. Can two codes with an Excludes1 note be reported together?
14. What does NEC stand for and mean?
15. What does NOS stand for and mean?
16. What is the placeholder character in ICD-10-CM?
17. In what position must the 7th character always appear?
18. What does a 7th character of "A" usually indicate?
19. What does a 7th character of "S" indicate?
20. When the word "with" links two conditions, what relationship is assumed?
21. Where in the code do you sequence a "code first" condition?
22. Where do you sequence a "use additional code" condition?
23. Can a "code first" code be the principal diagnosis?
24. What is a combination code?
25. Which list must you always confirm a code in before assigning it?
26. What does the prefix hyper- mean?
27. What does the suffix -itis mean?
28. What does the suffix -ectomy mean?
29. What does the root nephr/o refer to?
30. What does cardiomegaly mean?
31. What is the inpatient prospective payment system called?
32. What is the outpatient prospective payment system called?
33. What does MS-DRG stand for?

34. What does APC stand for?
35. What is the difference between a CC and an MCC?
36. What is the chargemaster?
37. Which claim form is used for institutional billing?
38. Which claim form is used for professional billing?
39. What do NCCI edits prevent?
40. What is upcoding?
41. What is unbundling?
42. What does the False Claims Act prohibit?
43. What kind of damages can the False Claims Act impose?
44. What does the Anti-Kickback Statute prohibit?
45. What does the Privacy Rule protect?
46. What does the Security Rule protect?
47. State the minimum necessary standard.
48. How many days do you have to notify individuals of a breach?
49. What does TPO stand for?
50. When documentation is unclear, what should the coder do?

Answer key

Q	Answer
1	Certified Coding Associate
2	105
3	90 scored (plus 15 unscored pretest)
4	2 hours
5	300 (scaled)
6	Clinical Classification Systems and Reimbursement Methodologies
7	ICD-10-PCS
8	ICD-10-CM
9	HCPCS Level II
10	Seven
11	NOT CODED HERE; the two codes are never used together
12	NOT INCLUDED HERE; both codes may be used together
13	No
14	Not Elsewhere Classifiable; other specified
15	Not Otherwise Specified; unspecified
16	X

17	The 7th (seventh) position
18	Initial encounter
19	Sequela
20	A causal relationship, read as associated with or due to
21	First (sequence it first)
22	Second (as an additional code)
23	No
24	One code that captures two diagnoses, or a diagnosis with a complication
25	The Tabular List
26	Above or excessive
27	Inflammation
28	Surgical removal
29	Kidney
30	Enlarged heart
31	IPPS (Inpatient Prospective Payment System)
32	OPPS (Outpatient Prospective Payment System)
33	Medicare Severity Diagnosis Related Groups
34	Ambulatory Payment Classification
35	An MCC is a major complication or comorbidity; a CC is a lesser one; MCC usually pays more
36	The master list of billable items and charges (CDM)
37	UB-04
38	CMS-1500
39	Improper unbundling and incorrect code pairs
40	Billing a higher-level code than the documentation supports
41	Billing separately for parts that should be reported as one code
42	Knowingly submitting false or fraudulent claims to the government
43	Treble (triple) damages plus per-claim penalties
44	Paying or receiving value to induce referrals for federally funded services
45	Protected health information (PHI)
46	Electronic protected health information (ePHI)
47	Use or disclose only the minimum PHI needed for the purpose
48	No later than 60 calendar days after discovery
49	Treatment, Payment, and health care Operations

That is the whole pack. Learn the terminology roots so no word scares you, drill the conventions until they are automatic, and practice looking things up fast because the exam is open book and timed. You have done the work. Walk in, work steadily, and pass. - Regina