Current Certified Billing & Coding Specialist (CBCS) Test Plan

National Healthcareer Association®

NHA Certified Billing and Coding Specialist (CBCS) Test Plan (Detailed)* *100 scored items, 20 pretest items* *Exam Time: 2 hours*	# scored items
1. Regulatory Compliance	19
A. Identify appropriate documentation required for release of patient information.	6
• Verify consent forms are signed and contain all relevant information before the services are rendered.	
• Verify pertinent patient information is released only to authorized individuals.	
• Compare and contrast informed and implied consent.	
• Compare and contrast use and disclosure.	
B. Audit billing against medical documentation to prevent fraud and abuse.	7
• Verify medical documentation with the codes.	
• Compare and contrast fraud and abuse.	
C. Identify major laws, regulations, and administrative agencies relevant to medical billing.	6
• Adhere to HIPAA, the Stark Law, the Fair Debt Collection Act, and the False Claims Act.	
• Describe the role of the Office of the Inspector General.	
2. Claims Processing	28
A. Apply procedures for transmitting claims to third-party payers.	14
• Identify causes of claim transmission errors.	

*based on the results of the Job Analysis Study completed in 2013

• Determine the appropriate resubmission method.	
• Differentiate between primary and secondary insurance plans to initially process crossover claims.	
• Compare and contrast “clean” and “dirty” claims.	
• Determine the timely filing limits for claim submission.	
• Apply knowledge of coordination of benefits.	
B. Apply knowledge of the CMS-1500 form to accurately complete the appropriate fields.	14
• Identify appropriate placement of NPI numbers.	
• Identify appropriate placement of service codes, DX codes, modifiers, and procedures.	
• Identify appropriate placement of authorization codes.	
• Identify appropriate placement of primary and secondary insurance.	
3. Front-end Duties	10
A. Ensure accurate collection of appropriate patient demographic and insurance information.	2
• Verify changes to demographic and insurance information.	
• Determine pertinent documents (e.g., insurance cards, identifications, authorizations, referrals) to collect and update.	
B. Verify insurance eligibility to determine benefits.	2
• Identify how and where to access insurance verification information.	
• Apply appropriate patient insurance rules (e.g., birthday rules, coordination of benefits).	
C. Compare and contrast government and private insurance.	2
• Identify major types of commercial insurance.	

• Identify the three government insurance plans.	
• Compare and contrast HMO and PPO plans.	

D. Process appropriate patient authorization and referral forms.	2
• Determine when a referral is needed.	
• Compare and contrast preauthorization, precertification, and predetermination.	
E. Prior to the visit, determine appropriate balances due.	2
• Calculate the patient's balance due.	
• Verify the copayment, deductible, and co-insurance percentage.	
4. Payment Adjudication	23
A. Analyze aging report.	5
• Identify which accounts need to be worked first according to office protocol.	
• Identify reasons for an outstanding balance and appropriate follow-up actions.	
B. Post payment accurately.	6
• Verify patient name, account number, and date of birth prior to posting.	
• Calculate write-off and adjustment amounts.	
C. Interpret remittance advice to determine financial responsibility of patient and insurance company.	6
• Determine patient financial responsibility based on remittance advice.	
• Analyze the remittance advice to determine accurate assignment of benefits.	
D. Determine reason for insurance company denial.	6

• Interpret denial codes and denial key codes.	
• Apply definitions of denial codes and denial key codes to determine appropriate resolution.	

5. Apply Knowledge of Coding	20
A. Apply specific coding guidelines and conventions for diagnoses and procedures.	10
• Identify the correct code to the highest level of specificity using appropriate ICD, CPT and modifiers, and HCPCS codes.	
• Identify the HCPCS coding convention levels.	
• Identify the structure of ICD coding manuals.	
• Identify the sections and organization of the CPT coding manual.	
• Recognize situations where encounter forms should be reviewed with physicians.	
B. Abstract the medical documentation by applying knowledge of medical terminology and anatomy and physiology.	10
• Apply knowledge of medical terminology and acronyms.	
• Apply knowledge of anatomy and physiology.	

**The bulleted tasks under each content domain are examples that are representative of the content. Items reflective of these stated tasks may or may not appear on the examination. Additionally, items that are reflective of tasks other than those included in the above outline may appear on the examination, as long as they represent information that is considered part of the major content domain by experts in the billing and coding profession.

Certified Billing & Coding Specialist (CBCS) Test Plan

— New Exam Coming Summer 2021

National Healthcareer Association®

NHA Certified Billing and Coding Specialist (CBCS)

Test Plan for the CBCS Exam

100 Scored Items/25 Pretest Items
Exam Time: 3 hours

**Based on The Results of a Job Analysis Completed in 2020*

As a result of these important updates, coding manuals will be required to take the new certification exam (CPT®, ICD-10-CM, and HCPCS).

This document provides both a summary and detailed outline of the topics that may be covered on the CBCS Certification Examination. The summary examination outline specifies domains that are covered on the examination and the number of test items per domain.

The detailed outline adds to the summary outline by including task and knowledge statements associated with each domain on the test plan. Task statements reflect the duties that a candidate will need to know how to properly perform. Knowledge statements reflect information that a candidate will need to know and are in support of task statements. Items on the examination might require recall and critical thinking pertaining to a knowledge statement, a task statement, or both.

CBCS Summary Examination Outline

DOMAIN	# of Items on Examination
1. The Revenue Cycle and Regulatory Compliance	15
2. Insurance Eligibility and Other Payer Requirements	20
3. Coding and Coding Guidelines	32
4. Billing and Reimbursement	33
Total	**100**

CBCS Detailed Examination Outline

Domain 1: The Revenue Cycle and Regulatory Compliance (15 items)

Tasks	Knowledge of:
1A Integrate revenue cycle concepts with knowledge of business and payer requirements to support accurate coding and timely reimbursement. 1B Clearly and accurately communicate with stakeholders (e.g., providers, patients, payers) throughout all phases of the revenue cycle. 1C Maintain confidentiality and security of protected health information (PHI). 1D Release PHI when required in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and facility policy. 1E Ensure compliance with federal laws, regulations, and guidelines and help prevent fraud and abuse by adhering to billing policies, coding rules, and conventions to submit clean and accurate claims.	k1. The phases of the revenue cycle and how they interact/impact each other k2. Laws, regulations, and administrative agency requirements relevant to billing and coding roles (e.g., HIPAA, Health Information Technology for Economic and Clinical Health Act [HITECH Act], Fair Debt Collection Practices Act, False Claims Act, Stark Law) k3. Types of data considered PHI (e.g., email addresses, next of kin, phone numbers, Social Security numbers) k4. Permitted use and disclosure of patient information (including proper documentation, Health and Human Services [HHS]/Centers for Medicare & Medicaid Services [CMS] use of data) k5. The role of the Office of the Inspector General (OIG) in medical billing k6. Components of a compliance plan and the application of the Provider Self-Disclosure Protocol (SDP) k7. Indicators of potential billing fraud and abuse k8. Informed, written, and implied consent k9. Internal and third-party auditing requirements (e.g., Medicare Recovery Audit Contractor (RAC), Zone Program Integrity Contractor (ZPIC), payer-focused)

CBCS Detailed Examination Outline

Domain 2: Insurance Eligibility and Other Payer Requirements (20 items)

Tasks	Knowledge of:
2A Verify patient insurance information and ensure collection of all pertinent documentation (e.g., demographic information, insurance cards, identification, authorizations). 2B Verify insurance eligibility to determine benefits, applicable copayments, deductibles, and coinsurance due from patient. 2C Differentiate among primary, secondary, and tertiary insurance plans to determine the filing order of claims and update Coordination of Benefits (COB) information.	k10. Required insurance documentation (e.g., insurance cards, identification, authorizations, referrals, Assignment of Benefits [AOB]) k11. Insurance eligibility and benefits verification processes k12. Considerations for out-of-network coverage k13. Insurance filing rules (e.g., dependent rule, birthday rule, COB) k14. Commercial insurance plan types (e.g., employer-sponsored, indemnity, health maintenance organization [HMO], preferred provider organization [PPO]), requirements, provisions, and limitations k15. Government insurance plans (e.g., Medicare Parts A, B, C, and D, Medicaid, Medigap, TRICARE), requirements, and limitations k16. Other third-party payers (e.g., auto, homeowners, workers' compensation plans) k17. Referral, precertification/preauthorization, and predetermination requirements k18. Patient financial responsibilities (e.g., copayments, deductibles, coinsurance, and out-of-pocket and stop-loss maximums) k19. Policies and procedures regarding uninsured or self-pay patients k20. Advanced beneficiary notice (ABN)

CBCS Detailed Examination Outline

Domain 3: Coding and Coding Guidelines (32 items)

Tasks	Knowledge of:
3A Abstract required health information from clinical documentation by applying knowledge of medical terminology and anatomy and physiology. 3B Identify and apply ICD-10-CM codes to the highest level of specificity and in the proper sequence based on coding guidelines and provider documentation in the health record. 3C Identify and apply HCPCS and CPT codes to the highest level of specificity and in the proper sequence based on coding guidelines and provider documentation in the health record. 3D Identify and apply the correct modifiers in HCPCS and CPT coding. 3E Identify and apply Evaluation and Management (E/M) codes to the correct level of specificity and in the proper sequence based on key components, medical decision-making, time, coding guidelines, and provider documentation in the health record. 3F Review medical procedures and codes as documented by providers and other clinicians and query providers or clinicians when clarification is needed.	k21. Anatomy and physiology k22. Medical terminology k23. Allowed/standard medical acronyms k24. Clinical vocabulary and terminology used in health information systems k25. Types of clinical documentation (e.g., progress notes, operative reports) and location of relevant information in the medical record k26. Organizations responsible for publishing and updating coding manuals, guidelines, and advisory bulletins (e.g., World Health Organization [WHO], American Medical Association [AMA], Centers for Medicare & Medicaid Services [CMS], National Center for Health Statistics [NCHS]) k27. Purpose of various code sets (e.g., ICD-10-CM, ICD-10-PCS, CPT, HCPCS) k28. ICD-10-CM coding manual use, application, organizing structure, coding conventions, symbols, and coding guidelines k29. CPT manual use, application, organizing structure, coding conventions, and coding guidelines k30. HCPCS manual use, application, organizing structure, coding conventions, and coding guidelines k31. Modifier use k32. Code sequencing k33. Evaluation and Management (E/M) levels, key components, contributory factors, medical decision-making, and time k34. Use of place of service codes k35. Coding for specialty areas (e.g., anesthesia, burns, pathology and laboratory, orthopedic) k36. Medicare coding requirements (e.g., G-codes, quality reporting codes) k37. Medical necessity criteria and requirements k38. Special considerations related to remote visits (e.g., telemedicine, virtual visits)

CBCS Detailed Examination Outline

Domain 4: Billing and Reimbursement (33 items)

Tasks	Knowledge of:
4A Ensure all applicable charges are captured (including diagnosis codes, procedure codes, and modifiers) based on information from patient encounter forms and progress notes found in the EHR to support optimal reimbursement. 4B Identify and complete all areas of the CMS-1500 claim form/837P form, based on the type of payer. 4C Transmit claims to payers electronically (e.g., direct entry, through a clearinghouse) or by mail. 4D Determine financial responsibility of patient and third-party payers. 4E Determine if appropriate payment has been made and work with patients and payers to obtain correct payments. 4F Process payments, including verification of patient demographics, interpretation of remittance advice (RA), and posting of contractual adjustments, write-offs, charge-offs, take-backs, and withholds. 4G Review claim rejections and denials including interpreting denial codes, determining reason for denial, and determining appropriate resolution. 4H Submit reconsideration or appeal when appropriate according to proper procedures. 4I Resubmit claims following proper procedures. 4J Analyze aging reports to identify and prioritize accounts for appropriate follow-up with insurance carriers (within timely filing guidelines), patients, or other payers. 4K Analyze billing and reimbursement data and reports to identify areas for improvement. 4L Evaluate, reconcile, and resolve payer screens and coding edits. 4M Engage in collection process for patients or other third-party payments (e.g., generate and remit statements, direct calls, bankruptcy, estate claims).	k39. Electronic claims submission processes k40. Paper claims submission processes k41. Use and purpose of various medical claim forms (e.g., CMS-1500 claim form, CMS-1450/UB-04 claim form) k42. Required fields and appropriate placement of information in the CMS-1500 claim form (e.g., national provider identifiers (NPI) numbers, place of service, diagnosis codes, modifiers, procedure codes, authorization codes, insurance) k43. Electronic data interchange (EDI) transmission (e.g., EDI 837, EDI 835) k44. Payer-specific guidelines k45. Code sequencing for optimal reimbursement k46. Payer screens and edits (e.g., National Correct Coding Initiative [NCCI], Local Coverage Determination [LCD], National Coverage Determination [NCD], Medically Unlikely Edits [MUE], National Physician Fee Schedule) k47. Aging report analysis k48. Timely filing limits and requirements for claim submission k49. Payment policies by type of payer k50. Types of claim transmission errors and potential resolutions k51. Reconsideration and appeals processes k52. Resubmission methods and guidelines k53. Claim Adjustment Reason Codes (CARC) including denial codes k54. Collection processes, strategies, and laws (e.g., using patient statements, dunning, Truth in Lending Act [TILA], Fair and Accurate Credit Transactions [FACT], Equal Credit Opportunity Act [ECOA], bankruptcy, estate claims) k55. Electronic remittance advice (ERA) and explanation of benefits (EOB) interpretation k56. Posting of payments, contractual adjustments, write-offs, charge-offs, take-backs, and withholds k57. Clearinghouse and claim scrubbing processes