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.