

**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:
<p>1A Integrate revenue cycle concepts with knowledge of business and payer requirements to support accurate coding and timely reimbursement.</p> <p>1B Clearly and accurately communicate with stakeholders (e.g., providers, patients, payers) throughout all phases of the revenue cycle.</p> <p>1C Maintain confidentiality and security of protected health information (PHI).</p> <p>1D Release PHI when required in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and facility policy.</p> <p>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.</p>	<p>k1. The phases of the revenue cycle and how they interact/impact each other</p> <p>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)</p> <p>k3. Types of data considered PHI (e.g., email addresses, next of kin, phone numbers, Social Security numbers)</p> <p>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)</p> <p>k5. The role of the Office of the Inspector General (OIG) in medical billing</p> <p>k6. Components of a compliance plan and the application of the Provider Self-Disclosure Protocol (SDP)</p> <p>k7. Indicators of potential billing fraud and abuse</p> <p>k8. Informed, written, and implied consent</p> <p>k9. Internal and third-party auditing requirements (e.g., Medicare Recovery Audit Contractor (RAC), Zone Program Integrity Contractor (ZPIC), payer-focused)</p>

CBCS Detailed Examination Outline

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

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

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.	k21. 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.	k22. Medical terminology
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.	k23. Allowed/standard medical acronyms
3D Identify and apply the correct modifiers in HCPCS and CPT coding.	k24. Clinical vocabulary and terminology used in health information systems
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.	k25. Types of clinical documentation (e.g., progress notes, operative reports) and location of relevant information in the medical record
3F Review medical procedures and codes as documented by providers and other clinicians and query providers or clinicians when clarification is needed.	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.	k39. Electronic claims submission processes
4B Identify and complete all areas of the CMS-1500 claim form/837P form, based on the type of payer.	k40. Paper claims submission processes
4C Transmit claims to payers electronically (e.g., direct entry, through a clearinghouse) or by mail.	k41. Use and purpose of various medical claim forms (e.g., CMS-1500 claim form, CMS-1450/UB-04 claim form)
4D Determine financial responsibility of patient and third-party payers.	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)
4E Determine if appropriate payment has been made and work with patients and payers to obtain correct payments.	k43. Electronic data interchange (EDI) transmission (e.g., EDI 837, EDI 835)
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.	k44. Payer-specific guidelines
4G Review claim rejections and denials including interpreting denial codes, determining reason for denial, and determining appropriate resolution.	k45. Code sequencing for optimal reimbursement
4H Submit reconsideration or appeal when appropriate according to proper procedures.	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)
4I Resubmit claims following proper procedures.	k47. Aging report analysis
4J Analyze aging reports to identify and prioritize accounts for appropriate follow-up with insurance carriers (within timely filing guidelines), patients, or other payers.	k48. Timely filing limits and requirements for claim submission
4K Analyze billing and reimbursement data and reports to identify areas for improvement.	k49. Payment policies by type of payer
4L Evaluate, reconcile, and resolve payer screens and coding edits.	k50. Types of claim transmission errors and potential resolutions
4M Engage in collection process for patients or other third-party payments (e.g., generate and remit statements, direct calls, bankruptcy, estate claims).	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