

NCICS Detailed Test Plan

This detailed test plan reflects the results of a national job analysis study that determined the critical job competencies to be tested by NCCT in this certification examination. It contains 100 scored items, 25 unscored pretest items, and candidates are allowed three (3) hours to complete the examination. This certification examination is comprised of 90-95% standard, 4-option multiple-choice items and 5-10% alternative items (e.g., Drag and Drop, Multi-Select, Hotspot).

National Certified Insurance & Coding Specialist NCICS Detailed Test Plan

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EX-0510

Number of Scored Items Content Categories



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25 1 Medical Insurance

- A1 Verify eligibility for insurance benefits
- A2 Determine the order of billing based on the Birthday Rule
- A3 Determine primary and secondary insurance based on the specifics of the case
- A4 Obtain pre-authorizations, pre-certifications, and pre-determinations from third party payers
- A5 Obtain referrals from primary care providers
- A6 Check for completion of registration/patient information forms
- A7 Collect co-pays from the patient
- A8 Complete and submit claims for different types of commercial health care insurance plans (e.g., PPO, HMO, traditional indemnity)
- A9 Complete and submit claims for Workers' Compensation or disability
- A10 Complete and submit claims for different types of government insurance plans (e.g., Medicare, Medicaid, Veteran's Administration, TRICARE)
- A11 Interpret the Explanation of Benefits
- A12 Collect co-insurances based on the insurance plan
- A13 Collect deductibles based on the insurance plan
- A14 Answer patient account inquiries
- A15 Submit appeals to third party payers
- A16 Understand claims for auto insurance
- A17 Complete and submit claims for personal liability insurance

26 2 Medical Billing

A Electronic Medical Record (EMR)/Electronic Health Record (EHR)

- A1 Use the EMR and/or EHR to verify eligibility
- A2 Maintain the billing data bases (e.g. allowables, new, revised and deleted codes, claims addresses)
- A3 Capture charges from encounter forms or charts
- A4 Use an encoder to assign codes
- A5 Verify codes suggested by computer assisted coding (CAC) software
- A6 Perform front end audits
- A7 Understand EMR and/or EHR templates

B Collections

- B1 Explain the financial policies and procedures of the practice to patients and/or responsible parties
- B2 Collect payment, copayment, coinsurance, or deductible owed by the patient
- B3 Post insurance payments to the patient's account
- B4 Post patient payments to financial records
- B5 Post remittance advices (RA) and Explanation of Benefits (EOB) to patient financial records
- B6 Handle denied claims
- B7 Correct rejected claims
- B8 Manage insurance A/R
- B9 Manage patient A/R
- B10 Manage patient statements/bills and other financial invoices
- B11 Manage payment arrangements from patients
- B12 Manage overpayments from patients or third party payers
- B13 Prepare monthly financial reports (e.g., AR, aging)
- B14 Follow up on suspended claims and claim denials
- B15 Process credit card transactions
- B16 Explain bill statements or non-coverage to patients and/or their designated representatives
- B17 Manage accounts that are in collection status within the organization
- B18 Adjust patient account balances based on case specifics
- B19 Manage no-show charges
- B20 Post patient payments to financial records
- B21 Manage accounts involving hardship cases
- B22 Process returned checks (NSF)

C Claims Process

- C1 Obtain signed documentation of financial responsibility
- C2 Obtain the information needed for clean claim submission (e.g. medical necessity, CCI)
- C3 Review encounter forms for completion
- C4 Revise encounter forms after annual code changes
- C5 Complete the CMS 1500 form
- C6 Reconcile the day's financial transactions
- C7 Maintain fee schedules for the medical office
- C8 Enter charges into the patient's ledger
- C9 Apply capitation payments to the daily ledger (e.g., HMO, managed care)
- C10 Prepare financial reports (e.g., AR, aging, monthly)

33 3 Coding

A ICD

- A1 Abstract data from medical records to assign ICD-10 codes
- A2 Sequence ICD-10 codes according to guidelines
- A3 Apply ICD-10 guidelines for code selection
- A4 Determine when to use signs and symptoms for selecting ICD-10 codes

B HCPCS

- B1 Abstract data from medical records to assign HCPCS codes
- B2 Sequence HCPCS codes according to guidelines
- B3 Apply HCPCS guidelines for code selection
- B4 Apply Level II modifiers to code selection

C CPT

- C1 Abstract data from medical records to assign CPT codes
- C2 Sequence CPT codes according to guidelines
- C3 Apply CPT guidelines for code selection
- C4 Apply Level I modifiers to code selection

16 4 Law and Ethics

- A1 Comply with fraud and abuse regulations (e.g., Stark Law, Anti-Kickback Law, Federal False Claims Act)
- A2 Comply with disclosure laws (e.g., HIPAA, HITECH)
- A3 Comply with state and federal regulations related to the collections process (e.g., Truth In Lending, Fair Debt Collection Practices Act)
- A4 Comply with state and federal regulations related to insurance, billing, and/or coding (e.g., OIG, Compliance Plans)
- A5 Recognize legal responsibilities and the scope of practice for the insurance, billing, and/or coding specialist
- A6 Recognize and respond to violations of medical law

Essential Knowledge Base:

Apply a working understanding of these integrated concepts:

- 1 Medical Terminology
- 2 Anatomy and Physiology
- 3 Insurance Codes (i.e., ICD, CPT, HCPCS)
- 4 Customer Service
- 5 Practice Management Software
- 6 Electronic Medical Records Software
- 7 Word Processing Software
- 8 Privacy Laws (e.g., HIPAA, HITECH)
- 9 Medical Ethics
- 10 Front Desk Procedures
- 11 Patient Education
- 12 Communication Etiquette (e.g., phone, text, email, social media, face to face)
- 13 Compliance Regulations (e.g., emergency procedures, OSHA, hazardous wastes)
- 14 Payment Collections
- 15 Insurance Plans
- 16 Accounts Receivable