National Center for Competency Testing

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EX-0510

NCICS National Certified Insurance & Coding Detailed Test Plan

Rev: September 2015

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.

Number of Scored Items	*Content Categories*
20	***Content Category: Medical Insurance***
	• Verify eligibility for insurance benefits • Determine the order of billing based on the Birthday Rule • Determine primary and secondary insurance based on the specifics of the case • Obtain pre-authorizations, pre-certifications, and pre-determinations from third party payers • Obtain referrals from primary care providers • Check for completion of registration/patient information forms • Collect co-pays from the patient • Complete and submit claims for different types of commercial health care insurance plans (e.g., PPO, HMO, traditional indemnity) • Complete and submit claims for Workers' Compensation or disability • Complete and submit claims for different types of government insurance plans (e.g., Medicare, Medicaid, Veteran's Administration, TRICARE) • Interpret the Explanation of Benefits • Collect co-insurances based on the insurance plan • Collect deductibles based on the insurance plan • Answer patient account inquiries • Submit appeals to third party payers
	Content Category: Medical Billing
5	• ***Subcategory: Electronic Medical Record (EMR)/Electronic Health Record (EHR)*** • Use the EMR and/or EHR to verify eligibility • Maintain the billing data bases (e.g. allowables, new, revised and deleted codes, claims addresses) • Capture charges from encounter forms or charts • Use an encoder to assign codes • Verify codes suggested by computer assisted coding (CAC) software • Perform front end audits

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- ***Subcategory: Collections***
  - Explain the financial policies and procedures of the practice to patients and/or responsible parties
  - Collect payment, copayment, coinsurance, or deductible owed by the patient
  - Post insurance payments to the patient's account
  - Post patient payments to financial records
  - Post remittance advices (RA) and Explanation of Benefits (EOB) to patient financial records
  - Handle denied claims
  - Correct rejected claims
  - Manage insurance A/R
  - Manage patient A/R
  - Manage patient statements/bills and other financial invoices
  - Manage payment arrangements from patients
  - Manage overpayments from patients or third party payers
  - Prepare monthly financial reports (e.g., AR, aging)
  - Follow up on suspended claims and claim denials
  - Process credit card transactions
  - Explain bill statements or non-coverage to patients and/or their designated representatives
  - Manage accounts that are in collection status within the organization
  - Adjust patient account balances based on case specifics

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

Content Category: Coding

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- ***Subcategory: ICD-10***
  - Abstract data from medical records to assign ICD-10 codes
  - Sequence ICD-10 codes according to guidelines
  - Apply ICD-10 guidelines for code selection
  - Determine when to use signs and symptoms for selecting ICD-10 codes

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- ***Subcategory: HCPCS***
  - Abstract data from medical records to assign HCPCS codes
  - Sequence HCPCS codes according to guidelines
  - Apply HCPCS guidelines for code selection
  - Apply Level II modifiers to code selection

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- ***Subcategory: CPT***
  - Abstract data from medical records to assign CPT codes
  - Sequence CPT codes according to guidelines
  - Apply CPT guidelines for code selection
  - Apply Level I modifiers to code selection

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9 ***Content Category: Law and Ethics***

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