National Certified Insurance and Coding Specialist Detailed Test Plan

Effective: 2020
EX-0510

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).

Number of Scored Items	Content Categories
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

NCCT
NATIONAL CENTER FOR COMPETENCY TESTING