PRACTICE® MANAGEMENT INSTITUTE

Certified Medical Insurance Specialist

CANDIDATE PREPARATION HANDBOOK

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012920

CERTIFIED MEDICAL INSURANCE SPECIALIST

CANDIDATE PREPARATION HANDBOOK

ABOUT THE EXAM:

The **Certified Medical Insurance Specialist** examination is designed to test a well-defined body of knowledge representative of professional practice in the discipline of medical insurance processing. Successful completion of this certification examination verifies that the candidate has met competency standards set forth by the **PMI Certification Board** for this specific specialty area.

FORMAT: Fill-in-the-blank, matching, true/false, multiple choice, and claim form completion.

TIME ALLOWED: 240 Minutes (4 Hours)

NUMBER OF REQUIRED ANSWERS: 120

APPROXIMATE WEIGHT:

Basics of Insurance	15%
Medical Documentation	5%
Diagnostic & Procedural Coding	20%
Compliance	20%
Claims Processing	40%

AVERAGE TIME PER ANSWER: Approximately 2 minutes

COMPETENCY: Candidates must compile an aggregate score of 70% in order to meet the minimal certification standards set forth by the PMI Certification Board.

SCORE: Scores are determined by totaling the number of incorrect answers selected in each section. This total is then multiplied by a predetermined point value and then subtracted from 100 to determine the overall percentage value. Each answer blank is of equal value.

RESULTS: Results are usually determined within a 4-week period and are reported to the home address the candidate provides on the exam cover sheet. Candidates are asked not to inquire about results until this period has expired. PMI exam results are provided in writing only and will not be obtained over the phone.

BYLAWS: Candidates are encouraged to access the PMI website: www.pmiMD.com for information regarding the PMI Certification Bylaws. This includes inquiries regarding appeals, re-testing and re-certification.

WHAT TO BRING ON THE DATE OF THE EXAM:

1. Picture Identification
2. Three #2 Pencils and/or Blue/Black ballpoint pens
3. Current ICD-10-CM Manual*
4. Current **CPT®** Manual*
5. Current HCPCS Manual*
6. Medical Dictionary

*The following coding manuals were used in the preparation of this exam. While the usage of these materials does not in any way indicate the endorsement of a particular brand by Practice Management Institute, these resources are recommended to minimize potential discrepancies in coding information provided.

- *ICD-10-CM 2020: The Complete Official Codebook,* American Medical Association
- *CPT® 2020 Professional Edition*, American Medical Association
- *HCPCS 2020 Level II Professional Edition,* American Medical Association

EXAM TIPS AND INSTRUCTIONS:

(I) Take advantage of all the practice questions in your manual, note what type of questions you get wrong, and review those sections of your manual.

(II) Verify the location and time of the exam at least two days prior to the test date.

(III) Allot adequate time for nourishment, rest, and relaxation on the day before and day of the exam.

(IV) Arrive at least 15 minutes prior to the start time.

(V) Have all materials listed above available and ready for use upon arrival to exam site (i.e., pens, pencils, reference materials).

(VI) Be familiar with your coding books and medical dictionary. It may be beneficial to tab your manuals in a way that makes sense to you.

(VII) Do not communicate with anyone other than the proctor/instructor during the exam. All electronic devices must be turned off and stowed away. Use of such electronic devices may result in disqualification of your exam.

(VIII) No other paper may be used during the exam; this includes placing exam related notes in your reference materials. All work must be turned in upon completion of the examination.

(IX) Listen carefully to all exam instructions. Do not start the exam until instructed to do so. Be sure to complete the contact information sections on the exam, recording your name on each section. PMI will be unable to notify you if the information is incomplete or illegible.

(X) Read each question carefully.

(XI) Clearly and legibly document answers.

(XII) Attempt to answer each question even if you are not certain of the correct answer. You are not scored differently for an incorrect response versus a blank response, so it is in your best interest to attempt to answer each question. Answer the easiest questions first. As this is a timed test, it may be advisable to skip a question if you are unsure of the answer and then return to it after completing the rest of the exam.

(XIII) It may be advantageous to bring a silent timer or watch. (Remember that you will not be able to have your cell phone out during the exam.)

(XIV) Completely erase mistakes or indicate mistakes with one line drawn through the incorrect answer.

(XV) Upon completion, review the exam to ensure all questions were answered and that all personal contact information has been completed correctly and is legible.

(XVI) Leave the exam site immediately after turning in your exam.

(XVII) Good Luck!

CPT® is a trademark of the American Medical Association.

STUDY LIST

Know the following insurance terms:

1.	ABN	Advance Beneficiary Notice of Non-coverage; the ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case.
2.	Abuse	Abuse describes practices that either directly or indirectly results in unnecessary costs to the Medicare Program. Abuse often appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally. Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud if there is evidence that the subject was knowingly and willfully conducting an abusive practice.
3.	Assignment of Benefits	An agreement in which a patient assigns to the physician or healthcare provider the right to receive payment from the insurance carrier.
4.	COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985, federal legislation that contains provisions giving certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events.
5.	Contractual Allowance	The difference between billing at established charges and amounts received or due from third party payers under contractual agreements.
6.	Coordination of Benefits	Applied when an insured person is covered by more than one policy. It stipulates that the involved insurers will each pay their share of the insured's total covered expenses, but will not pay, in the aggregate, more than those expenses.
7.	Exclusions	Specific hazards or conditions listed in the policy for which the policy will not provide benefit payments.
8.	FFS	Fee-for-service is the method of payment in which healthcare providers receive a payment for each service they provide.

9.	Fraud	Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.
10.	Limitations	Exceptions or exclusions to the general coverage. They may be dollar limits of liability, exclusions of specific types of illness, exclusions while performing certain activities, etc.
11.	Limiting Charge	The highest amount of money that can be charged for a covered service by a provider who does not accept assignment from Medicare.
12.	Medical Ethic	A system of principles which guide moral or acceptable conduct.
13.	Medical Necessity	Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating or rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.
14.	PHI	Protected Health Information; individually identifiable health information that is created, or received by, a covered entity and maintained and or transmitted by any means.
15.	Pre-existing condition	A physical condition of an insured person that existed prior to the issuance of his policy or his enrollment in a plan and which may result in a limitation in the contract on coverage of benefits.
16.	Prior Authorization	Requirement imposed by some third-party payers that a provider must justify the need for delivering a service to a patient prior to the actual delivery of that service. Usually prior authorization is limited to the delivery of non-emergency services.

Module 1 - Basics of Insurance

No resources may be utilized for completion of this portion of the exam.

Review and understand the following:

1. Insurance Terminology
2. Roles/responsibilities of a Medical Insurance Specialist
3. Medical Ethics and Etiquette
4. Categories of Insurance
5. Distinguish among Managed Care Organizations/Plans
6. Affordable Care Act /Value-based healthcare
7. Health Insurance Marketplace
8. Concepts of a valid Managed Care Contract
9. Credentialing/ Accrediting Organizations
10. Relative Value Unit, Resource –Based Relative Value Scale
11. MACRA and the Quality Payment Program
12. Insurance Processing preparation
13. Patient Education
14. Coordination of Benefits

Module 2 - Medical Documentation

No resources may be utilized for completion of this portion of the exam.

Review and understand the following:

1. Chart documentation
2. Completing standard CMS-1500 claim form
3. NCQA Guidelines
4. Understand Appropriate E/M Code Selection and Usage
5. Documentation guidelines for E/M coding
    (a) General Principles of Medical Record Documentation
    (b) Documentation of E&M Services
    (c) Documentation of History
    (d) Documentation of Examination
    (e) Documentation of the Complexity of Medical Decision Making

Module 3 - Diagnostic and Procedural Coding

Current CPT®, HCPCS, and ICD-10-CM coding books (a medical dictionary is optional) must be utilized for completion of this portion of the exam.

Review and understand the following:

1. Accurate CPT®, ICD-10-CM and HCPCS code selection
2. Modifier Usage and Application
3. Utilize ICD-10-CM Coding to the highest degree of specificity and accuracy provided in documentation
4. Recognize Key Terms in Documentation that Indicates Procedure vs. Diagnosis
5. ICD-10-CM:
    (a) Conventions
        i. Alphabetic Index and Tabular List
        ii. Format and Structure
        iii. Placeholder character
        iv. 7th characters
        v. Excludes Notes
    (b) General guidelines
    (c) Chapter specific guidelines
6. CPT/HCPCS:
    (a) Guidelines
    (b) Add on codes
    (c) Place of service
    (d) General guidelines
    (e) Unlisted procedures
7. Coverage Determination
8. National Correct Coding Initiative

Module 4 – Compliance

No resources may be utilized for completion of this portion of the exam.

Review and understand the following:

1. HIPAA
    (a) Privacy rule
    (b) Protected health information
    (c) ARRA/HITECH
    (d) Business Associate Agreements
    (e) Security safeguards
    (f) OCR Enforcement
    (g) Transaction Code Set Standards
2. Distinguish between Fraud and Abuse
    (a) Federal mandates and legal actions
    (b) Administrative Sanctions / Civil and Criminal Penalties
    (c) Investigations and Audits
    (d) Government auditing agencies of healthcare providers
3. OIG Compliance Program Guidance / Work Plan

Module 5 - Claims Processing

No resources may be utilized for completion of this portion of the exam.

Review and understand the following:

1. Revenue Cycle fundamentals
2. Claim filing, editing, and processing
3. Clearinghouse reports
4. Errors, rejections and denials
5. Claims follow-up
6. Automated payment posting
7. Adjustments and Write Offs
8. Balance billing
9. How to Use an A/R report
10. Overpayments
11. Appealing denied or poorly paid claims
12. Refunds and Recoupments
13. Timelines for refunds
14. Medicare Appeals Process
15. Patient responsibility
16. Billing and collection processes
17. Legalities of collections
18. Prompt pay laws