2013 to 2020 CBCS Test Plan Crosswalk

Crosswalk Section: The following bridges tasks on the 2013 CBCS test plan with task statements on the 2020 CBCS test plan.

2013 NHA Test Plan Number	TASK DESCRIPTION	2020 NHA TEST PLAN NUMBER	TASK AND KNOWLEDGE DESCRIPTION
DOMAIN 1.	***REGULATORY COMPLIANCE***		
1.A.	Identify appropriate documentation required for release of patient information.	**1.C.**	Maintain confidentiality and security of protected health information (PHI).
		1.D.	Release PHI when required in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and facility policy.
1.B.	Audit billing against medical documentation to prevent fraud and abuse.	**1.E.**	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.
		4.A.	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.
1.C.	Identify major laws, regulations, and administrative agencies relevant to medical billing.	**1.A.**	Integrate revenue cycle concepts with knowledge of business and payer requirements to support accurate coding and timely reimbursement.
		1.B.	Clearly and accurately communicate with stakeholders (e.g., providers, patients, payers) throughout all phases of the revenue cycle.

		1.C.	Maintain confidentiality and security of protected health information (PHI).
		1.D.	Release PHI when required in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and facility policy.
		1.E.	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.
		2.C.	Differentiate among primary, secondary, and tertiary insurance plans to determine the filing order of claims and update Coordination of Benefits (COB) information.
		4.L.	Evaluate, reconcile, and resolve payer screens and coding edits.
DOMAIN 2.	***CLAIMS PROCESSING***		
2.A.	Apply procedures for transmitting claims to third-party payers.	**4.C.**	Transmit claims to payers electronically (e.g., direct entry, through a clearinghouse) or by mail.
		4.E.	Determine if appropriate payment has been made and work with patients and payers to obtain correct payments.
		4.G.	Review claim rejections and denials including interpreting denial codes, determining reason for denial, and determining appropriate resolution.
		4.I.	Resubmit claims following proper procedures.

2.B.	Apply knowledge of the CMS-1500 form to accurately complete the appropriate fields.	**4.B.** **2.C.**	Identify and complete all areas of the CMS-1500 claim form/837P form, based on the type of payer. Differentiate among primary, secondary, and tertiary insurance plans to determine the filing order of claims and update Coordination of Benefits (COB) information.
DOMAIN 3	***FRONT-END DUTIES***		
3.A.	Ensure accurate collection of appropriate patient demographic and insurance information.	**2.A.** **2.C.**	Verify patient insurance information and ensure collection of all pertinent documentation (e.g., demographic information, insurance cards, identification, authorizations). Differentiate among primary, secondary, and tertiary insurance plans to determine the filing order of claims and update Coordination of Benefits (COB) information.
3.B.	Verify insurance eligibility to determine benefits.	**2.B.** **4.D.**	Verify insurance eligibility to determine benefits, applicable copayments, deductibles, and coinsurance due from patient. Determine financial responsibility of patient and third-party payers.
3.C.	Compare and contrast government and private insurance.	**2.B.** **2.C.**	Verify insurance eligibility to determine benefits, applicable copayments, deductibles, and coinsurance due from patient. • *Comment: This is an element of 3C* Differentiate among primary, secondary, and tertiary insurance plans to determine the filing order of claims and update Coordination of Benefits (COB) information.

			• *Comment: This is also an element of 3C*
3.D.	Process appropriate patient authorization and referral forms.	**2.A.**	Verify patient insurance information and ensure collection of all pertinent documentation (e.g., demographic information, insurance cards, identification, authorizations).
3.E.	Prior to the visit, determine appropriate balances due.	**2.B.** **4.D.**	Verify insurance eligibility to determine benefits, applicable copayments, deductibles, and coinsurance due from patient. Determine financial responsibility of patient and third-party payers.
DOMAIN 4.	***PAYMENT ADJUDICATION***		
4.A.	Analyze aging report.	**4.E.** **4.J.** **4.K.**	Determine if appropriate payment has been made and work with patients and payers to obtain correct payments. Analyze aging reports to identify and prioritize accounts for appropriate follow-up with insurance carriers (within timely filing guidelines), patients, or other payers. Analyze billing and reimbursement data and reports to identify areas for improvement.
4.B.	Post payment accurately.	**4.E.**	Determine if appropriate payment has been made and work with patients and payers to obtain correct payments.

		4.F.	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.
4.C.	Interpret remittance advice to determine financial responsibility of patient and insurance company.	**4.E.** **4.F.**	Determine if appropriate payment has been made and work with patients and payers to obtain correct payments. 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.
4.D.	Determine reason for insurance company denial.	**4.E.** **4.G.**	Determine if appropriate payment has been made and work with patients and payers to obtain correct payments. Review claim rejections and denials including interpreting denial codes, determining reason for denial, and determining appropriate resolution.
DOMAIN 5.	***APPLY KNOWLEDGE OF CODING***		
5.A.	Apply specific coding guidelines and conventions for diagnoses and procedures.	**3.A.** **3.B.** **3.C.**	Abstract required health information from clinical documentation by applying knowledge of medical terminology and anatomy and physiology. 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. 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.

		3.D.	Identify and apply the correct modifiers in HCPCS and CPT coding.
		3.E.	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.
		3.F.	Review medical procedures and codes as documented by providers and other clinicians and query providers or clinicians when clarification is needed.
		4.A.	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.
		4.G.	Review claim rejections and denials including interpreting denial codes, determining reason for denial, and determining appropriate resolution.
		4.L.	Evaluate, reconcile, and resolve payer screens and coding edits.
5.B.	Abstract the medical documentation by applying knowledge of medical terminology and anatomy and physiology.	**3.A.**	Abstract required health information from clinical documentation by applying knowledge of medical terminology and anatomy and physiology.
		3.B.	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. • *Comment: code assignment often includes anatomy and physiology*
		3.C.	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. • *Comment: code assignment often includes anatomy and physiology*
		3.D.	Identify and apply the correct modifiers in HCPCS and CPT coding. • *Comment: modifier assignment often includes anatomy*
		3.F.	Review medical procedures and codes as documented by providers and other clinicians and query providers or clinicians when clarification is needed.
		4.A.	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.

New Tasks **The following is a list of the tasks that will be new areas of coverage on the 2020 CBCS test plan**	
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4.H.	Submit reconsideration or appeal when appropriate according to proper procedures.
4.M.	Engage in collection process for patients or other third-party payments (e.g., generate and remit statements, direct calls, bankruptcy, estate claims).
	• *Comment: Both of the above tasks are considered typical to billing/coding curriculum. Task 4H is covered during claim form completion, and 4M is often a separate unit addressing collections.*