

CRCS EXAM CONTENT OUTLINE

Topic	What I know	Need more information or review	What I don't know
Patient Access / Front Office: Section 1			
Trends in Patient Access Process			
Functions and Responsibilities			
Scheduling			
Preadmission and Preregistration			
Precertification and Preauthorization			
Before the Appointment			
Registration and Admission			
During and After the Appointment			
Insurance Verification			
Financial Counseling			
Collection			
Control Points			
Deposit Collection Program			
Compliance			
Important Message from Medicare			
Medicare Outpatient Observation Notice (MOON)			
Refusal to Sign			
Advance Beneficiary Notice of Noncoverage and Hospital Issued Notice of Noncoverage			
Purpose of the ABN			
ABN Triggering Events			
Completing the ABN			
Retention of the ABN			
Hospital Issued Notice of Noncoverage			
Services that Do Not Require an ABN (or HINN)			
Patient Access and Case Management / Utilization Review			
Levels of Patient Care			
Consent Forms, Types, and Requirements			
Consent Forms			
Types of Consent			
Assignment of Benefits			
Emancipation			
Conditions Preventing Consent			
Health Information Management / Medical Records			
Electronic Records			
Verbal Orders			
Coverage Determinations			
NCDs vs. LCDs			

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Topic	What I know	Need more information or review	What I don't know
Definitive vs. Non-Definitive			
Medicare Secondary Payer			
Initial Enrollment Questionnaire			
MSP Questionnaire			
Common Working File			
Financial Policies in Patient Access / Front Office			
Monitoring Performance			
Average Length of Stay			
Midnight Census			
Average Daily Census			
Percentage of Occupancy			
Number of Patients Seen per Day			
Billing: Section 2			
Types of Insurance and Payers			
Medicare			
Part A – Hospital Insurance			
Part A Deductibles, Coinsurance, and Copayments			
Part B – Medical Insurance			
Part B Deductibles, Coinsurance, and Copayments			
Part B Preventive Services			
Other Part B Services			
Items Not Covered by Part A or Part B in the Original Medicare Plan			
Part C – Medicare Advantage			
Medicare Advantage Billing Period			
Part D – Medicare Prescription Drug Plan			
Medicare Administrative Contractor (MAC)			
Medicare Participating Physician Program			
Medicare Cards			
Medigap			
Medicaid			
Dual Eligibility			
Workers' Compensation			
TRICARE			
Children's Health Insurance Program (CHIP)			
Self-Insured			
Commercial Insurance			
Liability Insurance			
Self-Pay			

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Topic	What I know	Need more information or review	What I don't know
Health Savings Accounts (HSAs)			
Coordination of Benefits			
Medicare as Primary vs. Secondary			
Other COB Determining Factors			
Conditional Payment			
HIPAA's Impact on Billing			
HIPAA-Required Standard Transactions			
Mandated Transaction Code Sets			
ICD-10			
Present on Admission (POA) Indicators			
CPT and HCPCS			
Evaluation and Management (E&M) Levels			
HCPCS and CPT Modifiers			
NPIs and Taxonomy Codes			
National Drug Code (NDC)			
Payment Methodologies			
Medicare Severity Diagnosis-Related Group (MS-DRG)			
Ambulatory Payment Classification (APC)			
Units Exempt from OPPI			
Fee Schedule			
Resource-Based Relative Value Scale (RBRVS)			
Usual, Customary, and Reasonable (UCR)			
Skilled Nursing Facility Patient-Driven Payment Model (SNF PDPM)			
Critical Access Hospital (CAH)			
Capitation			
Per Diem			
Percent of Charges			
Fee-for-Service			
Chargemaster			
Contracting			
Insurance Payer Contracts			
Locum Tenens and Reciprocal Agreements			
Common Billing Forms			
UB-04 and 837I			
Superbill			
CMS-1500 and 837P			
Completing the CMS-1500 Form			
Itemized Statement			
Data Mailer / Statement			

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Medicare Summary Notice (MSN)			
Explanation of Benefits (EOB) or Remittance Advice (RA) and 835			
The Role of EOBs in Identifying Healthcare Fraud and Abuse			
Mandatory Filing			
Billing Time Frames			
Importance of Timely Filing			
Late Charges			
1-Day and 3-Day Payment Window Rule			
Claim Edits and Processing			
Considerations for Electronic Claim Processing			
Medicare Edits			
National Correct Coding Initiative (NCCI)			
Outpatient Code Editor (OCE) Edits			
Medicare Code Editor			
Medically Unlikely Edits (MUE)			
Clean Claims			
Non-Standard Claims			
Incomplete, Invalid, and "Unprocessable" Claims			
Incomplete and Invalid Claims			
Unprocessable Claims			
Compliance			
Credit and Collections: Section 3			
Defining Terms			
Effective Collection Policies			
Self-Pay Options			
Credit Card Payments			
Extended Payment Plans			
Personal Bankruptcy			
Types of Bankruptcy			
Potential Outcomes			
Creditor Actions Upon Notification			
Determining the Responsible Party			
Courtesy Discharge			
Common Stalls and Delays with Third-Party Payers			
Debt Collection Methods and Practices			
In-House Collection			
In-House Collection Calls			
"Mini Miranda"			
Collection Agencies			

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Topic	What I know	Need more information or review	What I don't know
Collection Lawsuits			
Skip Tracing			
Generally Accepted Accounting Principles (GAAP) Applied to Cashier Functions			
Calculating Metrics			
Average Daily Revenue			
Average Days of Revenue in Accounts Receivable (ADRR)			
Federal Agencies and Regulations (throughout)			
Federal Agencies			
U.S. Department of Health and Human Services (HHS)			
HHS Operating Divisions			
Centers for Medicare & Medicaid Services (CMS)			
Quality Improvement Organization (QIO) Program			
Office of Inspector General (OIG)			
Federal Regulations			
Patient Rights			
Right to Privacy and Security of Health Information			
Protected Health Information (PHI)			
Administrative Simplification			
Right to Participate in Treatment Decisions			
Affordable Care			
Anti-Fraud and Abuse			
False Claims Act			
Administrative Sanctions			
Telephone Consumer Protection			
Credit and Collections			
Truth in Lending Act (Regulation Z)			
Fair Credit Billing Act			
Fair Credit Reporting Act			
Fair Debt Collection Practices Act (FDCPA)			
Equal Credit Opportunity Act			
Patient Anti-Dumping			
Performance Improvement			
The Joint Commission (TJC)			
Notes:			

