

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: Multiple Choice / Answer, True and False, Fill in Blank

WEIGHT:	Section I: <i>Medical Terminology</i>	10%
	Section II: <i>Insurance Processing, Claim Adjudication and Follow Up, Fraud and Abuse, Compliance</i>	70%
	Section III: <i>Coding/Billing</i>	20%

TIME ALLOWED: 240 Minutes (4 Hours)

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 question/section is weighed individually.

RESULTS: Results are usually determined within a 6-week period. **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.PMI.md.com**, for questions 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-9-CM Coding Manual
4. Current CPT-4 Coding Manual
5. Current HCPCS Coding Manual
6. Medical Dictionary
7. Exam Fee and/or Confirmation of Payment for Exam

EXAM TIPS:

1. Allot adequate time for nourishment, rest, and relaxation on the day before and day of the exam.
2. Arrive at least 30 minutes prior to the exam start time.
3. Have all materials listed above available and ready for use upon arrival to exam site (i.e., pens, pencils, reference materials).
4. Turn off and put away all pagers and/or cell phones.
5. Listen carefully to all exam instructions.
6. Do not start the exam until instructed to do so.
7. Take your time.
8. Read each question carefully.
9. Clearly and legibly document answers.
10. Attempt to answer each question (even if you are not certain of the correct answer).
11. Print your name at the top of each page of the exam
12. Completely erase mistakes or indicate mistakes with one line drawn through the incorrect answer.
13. Upon completion, review the exam to ensure all questions were answered.
14. Do not communicate with other candidates during the exam.
15. Before turning in the exam, ensure that all personal contact information has been completed correctly.
16. Leave the exam site immediately after turning in your exam.
17. Good Luck!

STUDY GUIDE

Section I: Medical Terminology (10%)

NO RESOURCE MATERIALS MAY BE USED FOR THIS PORTION OF THE EXAM.

Section II: Insurance Processing, Claim Adjudication and Follow Up, Fraud and Abuse, and Compliance (70%)

YOU MAY USE YOUR CODING BOOKS AND A MEDICAL DICTIONARY FOR THIS PORTION OF THE EXAM.

Review and understand the following:

1. Insurance Processing and Coding Methodologies for the following:
 - A. Critical Care
 - B. Prolonged Services
 - C. E/M Code Selection and Guidelines
 - D. Correct CPT Modifier Usage
 - E. Complicated Wounds
 - F. Casting Services
 - G. Global Services
 - H. Observation Services
 - I. Classification of ICD-9 Codes
 1. Types
 2. Proper usage
2. Medicare Guidelines
 - A. Participating vs. Non-participating
 - B. Advance Beneficiary Notice
 - C. Processing (CMS-1500) and Medicare appeals process
 - D. Secondary Payer Guidelines
 - E. Accepting Assignment vs. Not Accepting Assignment
 - F. Limiting Charge
3. Categories and functions of billing specialists.
 - A. Hospital
 - B. Physician
4. Definition of CPT, ICD-9 and HCPCS and their purpose.
5. Fraud and Abuse
6. Billing Cycle – Insurance claims process.
7. Golden Rule of Billing and Coding.
8. Claim forms for Hospital and Physician Billing.
9. NPI Numbers
10. Common Billing Errors
11. Appeal or Write-off
12. Know the difference between an error and a denial.
13. What is an EOB?
14. HIPAA
15. RACs

Section III: Coding/Billing (20%)

YOU MAY USE YOUR CODING BOOKS AND A MEDICAL DICTIONARY FOR THIS PORTION OF THE EXAM.

1. Understand Appropriate E/M Code Selection and Usage
2. Modifier Usage and Application
3. Utilize ICD-9 Coding to the Highest Degree of Specificity and Accuracy
4. Recognize Key Terms in Documentation that Indicates Procedure vs. Diagnosis
5. Correcting Claims based on knowledge of Billing Errors