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

TIME ALLOWED: 240 Minutes (4 Hours)

NUMBER OF REQUIRED ANSWERS: 130

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 6-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.
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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
6. Medical Dictionary

EXAM TIPS AND INSTRUCTIONS:

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

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

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

(IV) Do not communicate with anyone other than the proctor/instructor during the exam. Cell phones/pagers must be turned off and stowed away.

(V) No other paper may be used during the exam. All work must be turned in upon completion of the examination.

(VI) 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.

CPT® is a trademark of the American Medical Association.
(VII) Read each question carefully.

(VIII) Clearly and legibly document answers

(IX) Attempt to answer each question even if you are not certain of the correct answer. However, 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.

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

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

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

(XIII) Good Luck!
### Terminology

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

Know the following medical terms:

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. pepsia</td>
<td>digestion</td>
</tr>
<tr>
<td>2. neo</td>
<td>new</td>
</tr>
<tr>
<td>3. gastr(o)</td>
<td>stomach</td>
</tr>
<tr>
<td>4. ortho</td>
<td>straight</td>
</tr>
<tr>
<td>5. tri</td>
<td>three</td>
</tr>
<tr>
<td>6. intra</td>
<td>within</td>
</tr>
<tr>
<td>7. ic</td>
<td>pertaining to</td>
</tr>
<tr>
<td>8. ab</td>
<td>away from</td>
</tr>
<tr>
<td>9. pathy</td>
<td>disease</td>
</tr>
<tr>
<td>10. posterior</td>
<td>after, behind, following, toward the rear</td>
</tr>
<tr>
<td>11. rrhaphy</td>
<td>repair</td>
</tr>
<tr>
<td>12. cysto/o</td>
<td>bladder</td>
</tr>
<tr>
<td>13. pnea</td>
<td>breathing</td>
</tr>
<tr>
<td>14. ad</td>
<td>to, toward</td>
</tr>
<tr>
<td>15. proximal</td>
<td>near, closer to the origin</td>
</tr>
<tr>
<td>16. otomy</td>
<td>incision into</td>
</tr>
<tr>
<td>17. ectomy</td>
<td>excision</td>
</tr>
<tr>
<td>18. ostomy</td>
<td>creating an artificial opening</td>
</tr>
<tr>
<td>19. oma</td>
<td>tumor</td>
</tr>
<tr>
<td>20. desis</td>
<td>bonding</td>
</tr>
<tr>
<td>21. nephr</td>
<td>kidney</td>
</tr>
<tr>
<td>22. brady</td>
<td>slow</td>
</tr>
<tr>
<td>23. ecto</td>
<td>outside</td>
</tr>
<tr>
<td>24. mal</td>
<td>bad, incorrect</td>
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<tr>
<td>25. scopy</td>
<td>examination, view</td>
</tr>
</tbody>
</table>
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. Many times abuse 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 contract 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.
<p>| | | |</p>
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<tbody>
<tr>
<td>9.</td>
<td>Fraud</td>
<td>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.</td>
</tr>
<tr>
<td>10.</td>
<td>Limitations</td>
<td>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.</td>
</tr>
<tr>
<td>11.</td>
<td>Limiting Charge</td>
<td>The highest amount of money that can be charged for a covered service by a provider who does not accept assignment from Medicare.</td>
</tr>
<tr>
<td>12.</td>
<td>Medical Ethic</td>
<td>A system of principles which guide moral or acceptable conduct.</td>
</tr>
<tr>
<td>13.</td>
<td>Medical Necessity</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) in accordance with generally accepted standards of medical practice;</td>
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<td></td>
<td></td>
<td>(2) clinically appropriate in terms of type, frequency, extent, site and duration; and</td>
</tr>
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<td></td>
<td></td>
<td>not primarily for the convenience of the patient, physician, or other health care provider.</td>
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<tr>
<td>14.</td>
<td>PHI</td>
<td>Protected Health Information; individually identifiable health information that is created, or received by, a covered entity and maintained and or transmitted by any means.</td>
</tr>
<tr>
<td>15.</td>
<td>Pre-existing condition</td>
<td>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.</td>
</tr>
<tr>
<td>15.</td>
<td>Prior Authorization</td>
<td>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.</td>
</tr>
</tbody>
</table>
Basics of Insurance – (No resources may be utilized for completion of this portion of the exam).

Review and understand the following:

- Categories of Insurance
- Concepts of a Valid Managed Care Contract
- Relative Value Unit, Resource–Based Relative Value Scale
- Medicare Secondary Payer
- Patient Education

Documentation -- (No resources may be utilized for completion of this portion of the exam).

Review and understand the following:

1. NCQA Guidelines
2. 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
Coding -- (CPT/HCPCS/ICD-10-CM coding books and a medical dictionary must be utilized for completion of this portion of the exam).

1. Understand Appropriate E/M Code Selection and Usage
2. Modifier Usage and Application
3. Utilize ICD-10-CM Coding to the Highest Degree of Specificity and Accuracy
4. Recognize Key Terms in Documentation that Indicates Procedure vs. Diagnosis
5. ICD-10-CM Coding:
   (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-4
   (a) Guidelines
   (b) Add on codes
   (c) Place of service
   (d) General guidelines
   (e) Unlisted procedures
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Claims Processing -- (No resources may be utilized for completion of this portion of the exam).

Review and understand the following:

1. Basics of Health Insurance
   (a) Distinguish among the types of insurance and carriers
   (b) The Revenue Cycle
   (c) Medicare Fee Schedule
   (d) RVUs
   (e) Disability income and benefits
   (f) Workers’ Compensation
   (g) Patient Education

2. Medicare Guidelines
   (a) Participating vs. Non-participating
   (b) Accepting Assignment vs. Not Accepting Assignment
   (c) Advance Beneficiary Notice Guidelines
   (d) Processing (CMS-1500) and Medicare Appeals Process
   (e) Secondary Payer Guidelines
   (f) Paid for Performance
   (g) LCD and NCD
   (h) NCCI Edits

3. Managed Care
   (a) Types of plans
   (b) Accountable Care Organizations
   (c) Coverage Guidelines
   (d) Contract Clauses
   (e) Types of authorization
   (f) Eligibility verification
   (g) Coordination of Benefits

4. Electronic Claim Submissions
   (a) Transaction and code sets
   (b) HIPAA 5010 testing deadlines
   (c) Carrier-direct vs. Clearinghouse transmission
   (d) Clean claim requirements
   (e) Claims processing reports
   (f) Accounts Receivables Analysis
   (g) Patient collections
   (h) Prompt Pay Laws
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Compliance: -- (No resources may be utilized for completion of this portion of the exam).

Review and understand the following:

1. Fraud vs. Abuse
2. Potential fines and penalties
3. OIG Compliance Program Guidance
4. False Claims Act, Anti-kickback Statute, Stark Law
5. RAs, MICs, ZPICs audit programs
6. HIPAA, ARRA, HITECH
   (a) Privacy rule
   (b) Protected health information
   (c) Security safeguards

Appeals and Denials: -- (No resources may be utilized for completion of this portion of the exam).

Review and understand the following:

1. Claim rejections and denials
2. Responding to Recoupment Requests
3. Key elements of successful appeals
4. Timelines for refunds
5. Medicare Appeals Process
6. Other carrier appeals
SAMPLE TEST QUESTIONS

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

INSTRUCTIONS: Match the medical term with its definition:

MEDICAL TERM:
1. emia
2. cyst/o
3. pathy
4. intra
5. oma
6. desis

DEFINITIONS:
_____ within _____ disease _____ bonding
_____ bladder _____ tumor _____ blood

FILL-IN-THE-BLANK

1. Under the ____________________ method of payment, healthcare providers receive a payment for each service they provide.

2. NCCI ____________________ are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B Medicare covered services.

3. __________ is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

4. A ____________________ is the highest amount of money that can be charged for a covered service by a provider who does not accept assignment

5. The ____________________ covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf.
6. ________________ indicates that health care services or products that a prudent physician provided to a patient were delivered in a manner that is a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.

INSTRUCTIONS: Read each question carefully and select the best answer.

1. The term third-party payer is best defined as:
   (a) An entity that pays for medical services but does not receive or provide health care services
   (b) A government agency that pays for and provides health care services
   (c) A private insurance company that offers a variety of health care plans services
   (d) Medicare

2. This modifier does not indicate a time in the global period:
   (a) -54
   (b) -55
   (c) -56
   (d) -57

3. ________ codes are alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits.
   (a) HCPCS Level I
   (b) HCPCS Level II
   (c) CPT
   (d) ICD-10-CM
4. The ___________ Law prohibits a physician from making referrals for certain designated health services to an entity with which he or she (or an immediate family member) has a financial relationship.

(a) Affordable Care Act
(b) HIPAA
(c) Stark
(d) Prompt Pay

5. For children and adolescents (18 years and younger), past medical history relates to all of the following, except:

(a) Prenatal care
(b) birth
(c) morbidity
(d) operations

6. Which of the following is not a reason that insurance companies perform audits?

(a) The risk of significant complications, morbidity and/or mortality
(b) Areas where problems have been encountered in practice
(c) Where there is a clear potential for improving service delivery
(d) Areas of high volume, high risk or high cost, in which improvements can be made

INSTRUCTIONS: Read each question carefully and select the correct answer.

1. Workers’ Compensation insurance covers employees’ medical and disability expenses related to work-related illnesses and on-the-job injuries.

   (a) True
   (b) False

2. Medicaid is jointly funded by the federal and state governments and is subject to state-specific rules.

   (a) True
   (b) False
3. Private insurance plans are standardized and provide the same covered services.
   (a) True
   (b) False

4. Collecting insurance co-payments is at the discretion of the medical provider.
   (a) True
   (b) False

5. The Medicare Fee Schedule was developed to pay physicians and other health care providers for care provided to Medicare beneficiaries.
   (a) True
   (b) False

6. Time is always a key or controlling factor to qualify for a particular level of E/M service.
   (a) True
   (b) False

CODING

*CPT/HCPCS/ICD-10-CM coding books and a medical dictionary must be utilized for completion of the coding portion of the sample test.*

**INSTRUCTIONS:** Select and document the appropriate **ICD-10-CM** code for each question below. Write your answer on the space provided.

1. Unilateral primary osteoarthritis of the right hip
   
2. Elevated prostate specific antigen [PSA]
   
3. Underdosing of mineralocorticoids and their antagonists, initial encounter
   
4. Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
   
5. Acute osteomyelitis of the left scapula
6. Nasopharyngeal abscess
7. Chronic kidney disease Stage 5, requiring dialysis
8. Benign giant cell tumor of the right hand

INSTRUCTIONS: Select and document the appropriate CPT/HCPCS code for each question below. Write your answer on the space provided.

1. Colonoscopy with biopsy
2. Administration of the flu vaccine for a Medicare patient
3. Partial thyroidectomy
4. Removal of marble from child’s nose in office
5. Annual wellness visit; includes a personalized Prevention plan of service (PPS), initial visit
6. Newborn clamp circumcision
7. Exploratory nephrotomy
8. Excision of rectal tumor, transanal approach, full thickness

INSTRUCTIONS: Read the question carefully. Clearly and legibly document the appropriate codes in the spaces provided.

1. Physician performs a radical resection of a malignant tumor of the soft tissue of the back or flank which is 6 cm in size. Assign the correct CPT and ICD-10-CM codes.

   CPT ________________  ICD-10-CM ________________
## Medical Terminology Matching:

1. intra = within  
2. cyst/o = bladder  
3. pathy = disease  
4. desis = bonding  
5. oma = tumor  
6. emia = blood

## Terminology Fill-in-the-Blank:

1. fee-for-service  
2. code pair edits  
3. ROS  
4. limiting charge  
5. Privacy rule  
6. Medical necessity

## CPT/HCPCS Coding:

1. 45380  
2. G0008  
3. 60210  
4. 30300  
5. G0438  
6. 54150  
7. 50045  
8. 45172

## Multiple Choice:

1. a  
2. d  
3. b  
4. c  
5. c  
6. a

## ICD-10-CM Coding:

1. M16.11  
2. R97.2  
3. T50.0X6A  
4. I25.110  
5. M86.112  
6. J39.1  
7. N18.6, Z99.2  
8. D48.5

## True or False:

1. True  
2. True  
3. False  
4. False  
5. True  
6. False

## Scenario:

CPT 21936  
ICD-10-CM C49.6