CRCS Exam Study Manual
Update for 2020

This document reflects updates made to the instructional content from the *AAHAM Certified Revenue Cycle Specialist (CRCS) Exam Study Manual 2019* to the 2020 version of the manual. This does not include updates to spelling, punctuation, the Introduction, dates in examples, Knowledge Checks and Answers, or the Glossary.

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Note: Throughout the manual, "I" icons flagging content for institutions have been replaced with "F" icons representing facilities. "P" icons now flag content for provider practices. But **all** the information in the study manual could appear on your exam, regardless of whether it is flagged for facilities or provider practices. The certification you are testing for and its exam are no longer separated by facility versus provider practice distinction.

Note: Unless otherwise stated, information in yellow below has been inserted and information struck through has been deleted.

Edit(s) to page 4-4 through 4-6: Part A Deductibles, Coinsurance, and Copayments

Medicare Part A		
Service	**Beneficiary Obligation**	**2020 ~~19~~ Amount**
Inpatient hospital stay – Semi-private room, meals, general nursing, other hospital services, and supplies. This includes care in critical access hospitals, but does not include private duty nursing, television, or telephone service in the room if billed separately. It also does not include a private room, unless medically necessary. Inpatient mental healthcare in an independent psychiatric facility is limited to 190 days in a lifetime.	Days 1 through 60*: ▪ Part A current year inpatient deductible *Renewable during the next benefit period	$1,408 ~~1,364~~ per spell of illness
	Days 61 through 90*: ▪ Part A coinsurance (1/4 or 25% of current year inpatient deductible) *Renewable during the next benefit period	$352 ~~341~~ per day
	Days 91 through 150*: ▪ Part A lifetime reserve (LTR, 1/2 or 50% of current year inpatient deductible) *Nonrenewable; hospitals alert patients when they have 5 days of coinsurance left so they can choose whether to use their LTR days	$704 ~~682~~ per day
SNF care – Semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies. (Patients need three midnights as an inpatient to qualify for Medicare coverage in a SNF.)	Days 1 through 20: ▪ No deductible or coinsurance	$0 per benefit period
	Days 21 through 100: ▪ 1/8 of current year inpatient deductible	$176 ~~170.50~~ per day

Edit(s) to page 4-6 and 4-7: Part B Deductibles, Coinsurance, and Copayments

Medicare Part B		
Service	**Beneficiary Obligation**	**2020 ~~19~~ Amount**
Medical and other services – Doctors services (except for routine physical exams); outpatient medical and surgical services; supplies; diagnostic tests; ambulatory surgery center facility fees for approved procedures; and DME. Also covers second surgical opinions; outpatient physical, occupational, and speech therapy; and outpatient mental healthcare.	Medical and other services: ▪ Current year deductible, then coinsurance (20% of Medicare-approved amount, except in the outpatient setting)	$198 ~~185~~ per year, then 20% of Medicare-approved amount
	Outpatient physical, occupational, and speech-language therapy services: ▪ Coinsurance	20% of Medicare-approved amount
	Outpatient mental healthcare: ▪ Coinsurance	20% of Medicare-approved amount

Edit(s) to page 4-18: Medicare Administrative Contractor (MAC)

Medicare Administrative Contractors (MACs) are the private firms that process Medicare claims. MACs were formerly known as fiscal intermediaries or carriers. MACs also serve as the primary operational contact for providers. They enroll providers in the Medicare program, provide education on Medicare billing requirements, and answer both provider and patient inquiries.

Currently there are 12 Part A / Part B MACs and four DME MAC~~s~~ jurisdictions in the program that process Medicare FFS claims based on the geographical location of the provider.

Edit(s) to page 4-20: Medicare Cards

~~***NOTE:*** As of April 2018, the law requires CMS to replace the Social Security numbers on Medicare cards with a Medicare Beneficiary Identifier (MBI). This initiative will start in April 2018 and should be completed by April 2019. Providers need to be ready to accept the new MBI by April 1, 2018.~~

~~The new MBI format is still 11 characters long, will contain numbers and uppercase letters, and will be unique to each beneficiary. Each MBI is randomly generated. The MBIs are "non-intelligent," meaning they will have no hidden or special meaning.~~

~~There will be a transition period from April 1, 2018, through December 31, 2019. During the transition period, providers may use either the previous Health Insurance Claim Number (HICN) or the MBI number on claims, but not both.~~

~~The new cards are anticipated to look like this:~~

NOTE: The Medicare Access and CHIP Reauthorization Act of 2015 required CMS to remove Social Security Numbers (SSNs) from all Medicare cards by 2019. The process of basing the previous Health Insurance Claim Number (HICN) on the patient's SSN violates HIPAA. Information such as member name and effective dates will still be present on the Medicare card. Each person is assigned their own unique identifier, known as the MBI, Medicare Beneficiary Identifier. Starting January 1, 2020, you MUST submit claims using MBIs (with a few exceptions), no matter what date you performed the service. The new MBI will:

- Have the same number of characters (11) as the HICN
- Contain uppercase letters and numeric characters, but no special characters
- Occupy the same field on HICN transactions
- Be unique to each beneficiary (in other words, husband and wife have their own MBIs)
- Be easy to read and limit the possibility of misinterpretation (uppercase letters only and no commonly misread letters S, L, O, I, B, and Z)

A sample card with the new MBI appears below.