CCMC CCM - Quiz Questions with Answers

1. Care Delivery and Reimbursement Methods

1.

Which of the following is **true** regarding fee-for-service?

- **Every aspect of the care provided is billed separately**
- One fee covers all services related to a condition
- Fee-for-service tends to result in lower costs
- One fee covers all services in a given episode of care

Correct answer: Every aspect of the care provided is billed separately

In a fee-for-service reimbursement model, each individual aspect of the care provided is billed separately. For example, a patient undergoing treatment for a broken bone would be billed for the physician, the supplies, the room, and so on.

Fee-for-service models do not cover all services related to a condition or all services in a given episode of care. They generally do not result in lower costs.

2.

Which of the following would be the **least** likely type of patient to be found in a Long-Term Acute Care Hospital?

A patient with diabetes and heart failure

A patient receiving multiple intravenous medications

A patient receiving total parenteral nutrition

Ventilator-dependent patients

Correct answer: A patient with diabetes and heart failure

Long-Term Acute Care Hospitals are meant for patients who have acute needs that will need management in a hospital setting for an indefinite period; at least as long as the treatment or condition lasts that requires such a stay. Examples would include patients receiving multiple intravenous medications, patients receiving total parenteral nutrition, or ventilator-dependent patients.

A patient with diabetes has one long-term, potentially stable, manageable condition and one acute condition. The acute condition will be treated in acute care in the short term. The long-term condition can be managed outside any health care setting by the patient.

3.

How is SSDI funded?

- **Through the Social Security Trust Fund**
- Through the U.S. Treasury General Fund
- Through a public-private partnership
- Through nonprofit organizations

Correct answer: Through the Social Security Trust Fund

Social Security Disability Insurance (SSDI) is funded through the Social Security Trust Fund.

It is not funded through the U.S. Treasury General Fund, any public-private partnership, or nonprofit organizations.

4.

Which part of a case management assessment deals with how a patient understands their need and plan for treatment?

Cognitive status

Health behavior

Physical functioning

Functional status

Correct answer: Cognitive status

Assessing the cognitive status of a patient is a key part of case management; it can be described as the degree to which a patient understands their need and plan for treatment. A person with a compromised cognitive status, such as exists in many neurocognitive disorders, may not understand their need and plan for treatment and will require a different plan of care.

Health behavior assesses high-risk behaviors such as smoking. Physical functioning assesses the overall physical health of the patient. Functional status assessment deals with how the patient goes about dealing with the functional demands of daily life, such as the activities of daily living.

5.

Which of the following is **not** an expectation identified by the Institutes of Medicine (IOM) that are meant to control healthcare costs?

Regular auditing processes

Timely provision of care

Reasonable cost of care

Quality of care

Correct answer: Regular auditing processes

The Institutes of Medicine (IOM) identified three expectations that in their view would help drive down the costs of healthcare. These are:

- *Timely provision of care*
- *Reasonable cost of care*
- *Quality of care*

A regular auditing process was not one of the expectations identified by this body.

6.

Which of the following would be the correct order in which to administer the PHQ-2 and the PHQ-9?

PHQ-2 first, then PHQ-9 if warranted

PHQ-2 first, then PHQ-9 in all cases

PHQ-9 first, then PHQ-2 if warranted

PHQ-9 first, then PHQ-2 in all cases

Correct answer: PHQ-2 first, then PHQ-9 if warranted

Screening for depression is crucial in many health assessments performed by case managers. One way this is done is to use the Patient Health Questionnaire-2 (PHQ-2), which is a basic screen for depression, followed by the Patient Health Questionnaire-9 (PHQ-9), which goes into more detail.

7.

Is there a deductible for hospice coverage under Medicare Part A?

No

Yes, after the first benefit period

Yes, after 30 days

Yes, it is a per diem rate assessed after decease

Correct answer: No

Hospice care takes the place of other Medicare benefits during the time when it is being administered to a patient. There is never a deductible due to the patient.

8.

Which of the following would be **most** characteristic of retrospective utilization management?

A review of care that has already occurred

Review of upcoming care

Review of care that is underway

Appealing a decision

Correct answer: A review of care that has already occurred

There are three types of utilization review: prospective, concurrent, and retrospective. Retrospective utilization review deals with care that has already taken place.

Prospective utilization review engages in a prior determination of necessity to authorize an upcoming treatment. Concurrent utilization review deals with care that is underway. A review or appeal might be possible at any stage of utilization review, and is not necessarily part of any in particular.

9.

Is full time nursing covered under the Home Health Care benefit, according to Medicare Part A?

No

Yes, in all circumstances

Yes, for 30 days

Yes, if there has been a qualifying stay

Correct answer: No

Full time nursing is not covered under the Home Health Care benefit, according to Medicare Part A. A home health aide would be covered under some circumstances.

This lack of coverage is not a function of benefit days or qualifying stay.

10.

For which of the following are InterQual Level of Care Criteria **not** available?

Custodial care

Acute pediatric care

Acute rehabilitation

Long term acute care

Correct answer: Custodial care

InterQual Level of Care Criteria are designed to help healthcare organizations and personnel in assessing clinical appropriateness of patients for various levels of care. They are available for such things as acute pediatric care, acute rehabilitation, long term acute care, and others.

These criteria are not available for custodial care.

11.

Which of the following is **true** regarding a case rate?

- **It is a flat fee paid to a provider**
- It is not inclusive
- It is assessed by physician
- It is assessed according to geographic region

Correct answer: It is a flat fee paid to a provider

A case rate is an inclusive, flat fee paid to a provider based on the model of a single fee for all services related to a given treatment or condition.

It is not assessed according to physician or geographic region.

12.

Which of the following is a type of managed care organization?

Preferred Provider Organizations (PPO)

Health Treatment Organizations (HTO)

Care and Treatment Organizations (CTO)

Physician Referral Organizations (PRO)

Correct answer: Preferred Provider Organizations (PPO)

The two types of managed care organization are Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO).

Health Treatment Organizations (HTO), Care and Treatment Organizations (CTO), and Physician Referral Organizations (PRO) are all fabricated terms.

13.

Which of the following **most** operates on the premise of negotiating costs for services?

Preferred Provider Organizations (PPO)

Health Maintenance Organizations (HMO)

Market Captiation Organizations (MCO)

Physician Cost Organizations (PCO)

Correct answer: Preferred Provider Organizations (PPO)

Preferred Provider Organizations (PPO) operate on the premise of negotiating costs for services among healthcare providers. The benefit to the provider for this negotiation is to be a part of a referral network.

Health Maintenance Organizations (HMO) operate on the principle of preventative care and the gatekeeper provider model, with a yearly fee assessed to the member.

Market Captiation Organizations (MCO) and Physician Cost Organizations (PCO) are both fabricated terms.

14.

Which of the following correctly describes SMART goals?

Specific, Measurable, Achievable, Realistic, Timely

Specific, Measurable, Achievable, Responsible, Timely

Specific, Meaningful, Achievable, Responsible, Timely

Specific, Measurable, Achievable, Reportable, Timely

Correct answer: Specific, Measurable, Achievable, Realistic, Timely

One standard way of arriving at patient goals for treatment and care is the acronym SMART. It refers to the qualities that good goals have: specific, measurable, achievable, realistic, and timely.

The other answers do not accurately describe SMART goals.

15.

What has been the effect of managed care contracts on price negotiations between case managers and providers?

It has decreased the need for price negotiations

It has increased the need for price negotiations

It has had no effect on price negotiations

It has had no effect yet, but that is expected to change

Correct answer: It has decreased the need for price negotiations

The advent of managed care contracts has decreased the need for price negotiations between case managers and providers, due to the fact that much of what would otherwise be negotiated is now decided in advance.

16.

To which of the following groups would TRICARE apply?

Service members and their families

Federal government workers and their families

State government workers and their families

The elderly over 65

Correct answer: Service members and their families

TRICARE is the healthcare program for service members and their families.

It is not intended for all federal government workers, state government workers, or the elderly over 65.

17.

How long does COBRA coverage last?

18 months

12 months

24 months

6 months

Correct answer: 18 months

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 allows for alternate coverage in the case of changes to working conditions, such as the loss of a job or hours worked at that job. COBRA coverage usually lasts 18 months, but can be extended.

18.

What is the **most** accurate statement regarding Prospective Payment Systems (PPS)?

They are designed to promote efficiency

They are designed to maximize revenue per service

They decide on payments after the fact

They are not related to direct patient care

Correct answer: They are designed to promote efficiency

A Prospective Payment System (PPS) is a reimbursement method in which care is provided based on a predetermined, fixed amount. This approach is designed to promote and enforce efficiency in the entire system of care.

A PPS is not designed to maximize revenue per service, and this type of system decides on payments in advance. A PPS is highly related to the provision of direct patient care.

19.

About how many people are served in custodial care/boarding care settings?

4 to 6 patients per setting

1 patient per setting

10 patients per setting

Up to 50 patients per setting

Correct answer: 4 to 6 patients per setting

Custodial care/boarding settings are those which give total care to a small number of patients. About 4 to 6 patients are usually served in individual custodial care/boarding care settings.

20.

Which of the following is a likely type of treatment in inpatient psychiatric care?

Psychiatric stabilization

Long-term therapy

Classical psychoanalysis

Residential treatment

Correct answer: Psychiatric stabilization

In terms of level of care, the emphasis in inpatient psychiatric care is psychiatric stabilization. This is a relatively short-term process, with the goal being the return of the patient to the community as quickly as the remission of their symptoms permit.

Long-term therapy, classical psychoanalysis, and residential treatment are all long-term treatments that would be outside the scope of inpatient psychiatric care.

21.

Which of the following models of transitional care uses "embedded case managers"?

Proven Health Navigator

Patient Activation Model

Coleman's model of care transitions

Qualis Health Initiative

Correct answer: Proven Health Navigator

The Proven Health Navigator model is distinguished by its use of "embedded case managers" that help coordinate care across systems.

The Patient Activation Model is an approach of engaging patients. Coleman's model of care transitions uses transitions coaching instead of embedded case managers. The Qualis Health Initiative is a model of healthcare innovation that concentrates on coordinating quality across systems.

22.

Which of the following uses "transitions coaches"?

Coleman's model of care transitions

Proven Health Navigator

Patient Activation Model

Qualis Health Initiative

Correct answer: Coleman's model of care transitions

Coleman's model of care transitions uses "transitions coaches" to guide the patient across the continuum of care.

The Proven Health Navigator model uses "embedded case managers" that help coordinate care across systems. The Patient Activation Model is an approach of engaging patients. The Qualis Health Initiative is a model of healthcare innovation that concentrates on coordinating quality across systems.

23.

Which of the following is **not** a step in the Patient Activation Model (PAM)?

Auditing engagement

Disengaged and overwhelmed

Taking action toward engagement

Maintaining gainful behaviors

Correct answer: Auditing engagement

The purpose of the Patient Activation Model (PAM), created by Insignia Health, is to engage patients by creating a single point of contact within the system and motivating and moving patients through a stepwise process toward greater engagement in their own care.

The process contains four steps:

- *Disengaged and overwhelmed*
- *Struggling with the plan of care*
- *Taking action toward engagement*
- *Maintaining gainful behaviors*

Auditing the engagement of the patient is not a step in the process per se.

24.

In facilities operating on a day rate, when does the new billing "day" usually start?

Midnight

At treatment planning

Morning shift change

Evening shift change

Correct answer: Midnight

In most facilities operating on a day rate, the new billing "day" starts at midnight and runs until the next midnight.

Treatment planning and shift change are highly variable occasions and are not usually a billing occasion per se.

25.

What is the focus of Value-Based Purchasing?

Quality of care for Medicare beneficiaries

Quality of care for Medicaid beneficiaries

Quality of care for VA beneficiaries

Quality of care in any acute care hospital

Correct answer: Quality of care for Medicare beneficiaries

Value-Based Purchasing (VBP) is a CMS initiative that seeks to incentivize certain quality of care indicators with direct payments if these measures are achieved. Examples might include patient experiences of the care domain and the efficiency domain.

VBP is not addressed toward Medicaid or VA beneficiaries, and is specifically addressed toward Medicare beneficiaries and not any recipient of services in an acute care hospital.

26.

Which part of Medicare generally pays for outpatient services?

Part B

Part A

Part C

Part D

Correct answer: Part B

Medicare Part B covers professional fees, diagnostics, and outpatient services.

Part A covers hospital care, laboratory services, surgery, and hospice, among other areas. Part C refers to a Managed Medicare plan. Part D pays for pharmaceutical drugs.

27.

Can Medicaid coverage ever be retroactive?

Yes, for up to three months

No, under no circumstances

Yes, with no time limit

Yes, for up to a year

Correct answer: Yes, for up to three months

Medicaid coverage can be retroactive for up to three months prior to filing the application, if the person would have been eligible when services were received.

28.

Which of the following is **least** likely to be covered by Medicaid?

Vocational training

Mental health care

Medications

Vision care for children

Correct answer: Vocational training

Medicaid is a state-administered system that offers variable benefits according to state, all of which are intended to help those whose financial resources are not adequate to pay for care under specific federal guidelines. Depending on the jurisdiction, Medicaid can help pay for things such as mental health care, medications, and vision care for children.

Medicaid generally does not cover vocational training.

29.

Which of the following **best** describes capitation?

A mode of reimbursement

A business model

A financial penalty

A Medicare calculation

Correct answer: A mode of reimbursement

Capitation refers to a monthly or regular fee paid to a care provider for covered services rather than a payment for specific services.

It is not a business model, financial penalty, or Medicare calculation.

30.

Which of the following would **not** be considered one of the "5 Rs" of care delivery?

Right medication

Right client

Right setting

Right time

Correct answer: Right medication

The "5 Rs" of care delivery are ways health plans and health care organizations refer to optimized care. They are:

- *Right Client*
- *Right Provider*
- *Right Setting*
- *Right Level of Care*
- *Right Time*

31.

What is a viatical settlement?

The selling of a life insurance policy

An agreement to increase benefits

An agreement to settle a case of early death

An agreement not to prosecute negligence

Correct answer: The selling of a life insurance policy

A viatical settlement is the selling of the life insurance policy of a person with terminal or life-threatening illness who is not expected to live more than five years.

It is not an agreement to increase benefits, an agreement to settle a case of early death, or an agreement not to prosecute negligence.

32.

Which of the following **most** determines the risk level of a patient?

The case management assessment

Predictive analytics

Physician consult

Diagnosis code

Correct answer: The case management assessment

Though predictive analytics can help in many ways by sorting patients according to known factors, it is the case management assessment that finally determines the level of risk or complexity of a patient.

Physician consults can be part of gathering collateral information, but do not determine risk level. Similarly, diagnosis codes are significant data, but are only one piece of data in a larger assessment and risk assignment.

33.

Who provides the majority of client care?

Clients and their families

Physicians

Nurses

Volunteers

Correct answer: Clients and their families

Clients and their families perform the majority of client care, which is one of the main reasons they must be so carefully engaged in treatment planning and wellness strategies.

34.

In general, when determining which plan is primary, when does Medicaid pay?

Medicaid always pays last

Medicaid always pays first

Medicaid sometimes pays first

Medicaid reimbursement varies by state

Correct answer: Medicaid always pays last

Coordinating care often amounts to determining who pays first. In determining who is the primary payer, it is important to remember that Medicaid always pays last.

This does not vary by jurisdiction.

35.

Which of the following is **untrue** about mediation?

It is an involuntary process

It is a voluntary process

A third party is involved

It is an informal process

Correct answer: It is an involuntary process

Mediation is a conflict resolution strategy in which the parties engage in an informal, voluntary process overseen by a third party (the mediator). The intention is to reach a mutually acceptable agreement.

36.

Which of the following does EMTALA stand for?

The Emergency Medical Treatment and Labor Act

The Emergency Mandation of Treatment and Liability Act

The Emergency Medical Treatment and Liability Act

The Emergency Mandation of Treatment and Labor Act

Correct answer: The Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 is a law mandating emergency care for individuals regardless of ability to pay, as well as the stabilization of patients or transfer of patients to a place where they can be stabilized. It ensures that hospitals and other emergency facilities cannot turn emergency patients away for financial reasons.

37.

Who funds Medicaid?

The federal government and the states

The states

The federal government

Since 1996, a private sector-government partnership

Correct answer: The federal government and the states

Medicaid is a health insurance program funded in part by the federal government and in part by state governments.

It is not part of a private partnership.

38.

What is the **most** appropriate level of care for people with drug and alcohol problems who have been unsuccessful with outpatient treatment, but are not appropriate for inpatient care?

Residential treatment

Group home

Assisted living

Intermediate care

Correct answer: Residential treatment

Residential treatment is a level of care that is appropriate for people with drug and alcohol (or other mental health issues) that have been unsuccessful with outpatient treatment but who do not meet the requirements for inpatient care.

A group home would be more appropriate for those with chronic disabilities. Assisted living would be more useful for those who have difficulty completing activities of daily living on their own. Intermediate care is a step above custodial care, but does not include skilled nursing; it is not ideally suited for psychiatric issues.

39.

Which of the following distinguishes a Group Model HMO from others?

The physicians are employed by the physician group

The physicians audit their own billing

The physicians observe a multipractice agreement

The physicians are all specialists

Correct answer: The physicians are employed by the physician group

As opposed to other models that involve the physicians working for the health maintenance organization directly or in another arrangement, the distinguishing feature of a Group Model HMO is that the physicians concerned are employed by their own group and share profits and losses with the HMO.

In this model, the physicians do not necessarily audit their own billing, observe multipractice agreements, and they are likely not specialists.

40.

Who administers Medicaid?

State governments

Federal government agencies

Local municipalities

Hospital systems

Correct answer: State governments

Medicaid is a benefit program intended to support those whose financial resources are limited, among other factors of vulnerability. It is administered by state governments.

It is not administered by the federal government, local municipalities, or hospital systems.

41.

Can a skilled care setting have various levels of care?

Yes

No, skilled nursing is a level of care

No, only nursing is offered in skilled care

Yes, when state regulations allow it

Correct answer: Yes

A skilled care setting can have many different levels of care depending on the need of the client. Level of care refers more to the specific resources used to meet the need of the patient. For example, a client may need occupational therapy or physical therapy or nursing. The skilled care setting is the location of care and not the level of care.

This differentiation is not a matter of state law.

42.

Which of the following is **untrue** about negotiation?

It involves a third party

The parties form their own decisions

Agreement is reached without oversight

The intention is compromise

Correct answer: It involves a third party

Negotiation is a conflict resolution strategy that takes place between the two parties concerned, in which they are allowed to pursue the process in their own way and form their own solutions with the intention of reaching compromise.

There is no oversight or third party interference in a negotiation.

43.

Which part of Medicare pays for pharmaceutical drugs?

- **Part D**
- Part A
- Part B
- Part C

Correct answer: Part D

Medicare Part D pays for pharmaceutical drugs.

Part A covers hospital care, laboratory services, surgery, and hospice, among other areas. Part B covers professional fees, diagnostics, and outpatient services. Part C refers to a Managed Medicare plan.

44.

Is a copay ever required when receiving services through the VA?

Yes, under some circumstances

No, under no circumstances

Yes, in cases of dishonorable discharge

Yes, in almost all circumstances

Correct answer: Yes, under some circumstances

A copay is sometimes required of those receiving services through the VA (Veterans Health Administration), most notably when care is provided for a non-service related condition.

This copay is not a function of dishonorable discharge, which would, in most circumstances, disqualify a person for VA services.

45.

Which of the following is **most** characteristic of prospective utilization management?

Prior determination of necessity

Reviewing current care

Review of care that has already happened

Appeal of a utilization decision

Correct answer: Prior determination of necessity

There are three types of utilization review: prospective, concurrent, and retrospective. Prospective utilization review engages in a prior determination of necessity to authorize an upcoming treatment.

Concurrent utilization review deals with care that is underway. Retrospective utilization review deals with care that has already taken place. An appeal might be possible at any stage of utilization review, and is not necessarily part of any in particular.

46.

What is the normal limit on inpatient days per benefit period?

90 days

30 days

60 days

There is no limit per se

Correct answer: 90 days

The normal limit on inpatient days per Medicare benefit period is 90 days. In some cases, a beneficiary can tap a "lifetime reserve" of up to 60 days.

47.

Which of the following correctly defines the acronym DEATH as it refers to Activities of Daily Living (ADL)?

Dressing/bathing, Eating, Ambulating, Toileting, Hygiene

Dressing/bathing, Eliminating, Ambulating, Transitioning, Hygiene

Diagnosis, Exacerbation, Achievement, Tasks, Health

Diagnosis, Exacerbation, Achievement, Treatment, Health

Correct answer: Dressing/bathing, Eating, Ambulating, Toileting, Hygiene

Assessing a person's ability to meet their functional needs on a daily basis is referred to as the Activities of Daily Living (ADL) and is part of a functional case management assessment. A helpful acronym to help remember these functional activities is DEATH: Dressing/bathing, Eating, Ambulating, Toileting, Hygiene.

48.

Who or what was responsible for the implementation of the Diagnosis Related Group (DRG) system?

Medicare

Medicaid

American Medical Association

American Psychiatric Association

Correct answer: Medicare

Medicare implemented the Diagnosis Related Group (DRG) system as a way to link costs to diagnosis in an attempt to control costs. In this system, the cost is paid per diagnosis regardless of what treatment is provided.

Medicaid, the American Medical Association, and the American Psychiatric Association were not responsible for this implementation.

49.

How many parties are needed for a trust?

Three

One

Two

Four

Correct answer: Three

A trust requires three parties; a donor of funds, a trustee or manager, and a beneficiary.

50.

Can family members of SSDI recipients receive benefits under SSDI?

Yes, in some circumstances

No, under no circumstances

No, unless also receiving SSI

No, unless also receiving Medicare

Correct answer: Yes, in some circumstances

Family members of those receiving Social Security Disability Income, or SSDI, can, in some circumstances, receive benefits. These include spouses over 62 years old, an unmarried child of 18 or 19 years of age if that child is still attending high school, spousal caregivers of disabled children, and others.

This benefit to family members is not relative to SSI or Medicare.

51.

How old must a person be to have a reverse mortgage as an option?

62

55

30

There is no age requirement

Correct answer: 62

A reverse mortgage is an option sometimes used by homeowners who are 62 years old or older. In a reverse mortgage, the patient borrows against the home's value without leaving the home or making payments.

52.

Who actually administers Medicare?

The Centers for Medicare & Medicaid Services

State governments through legislation

Regional accrediting bodies

Private physicians

Correct answer: The Centers for Medicare & Medicaid Services

Medicare is a public benefit program administered by the Centers for Medicare and Medicaid Services.

State governments, regional accrediting bodies, and private physicians definitely interface with the Medicare system, but the program is ultimately administered by the federal government.

53.

What is the reimbursement model under capitation?

A regular fee for all services

A single fee for some services

A single fee for all services

Fees paid for individual services

Correct answer: A regular fee for all services

Capitation is a reimbursement model whose defining characteristic is a regular fee paid for all services. It is the typical structure used by Health Management Organizations (HMOs).

54.

Which of the following would **not** be considered a level of care?

Hospital

Intensive care unit

Telemetry

Definitive observation unit

Correct answer: Hospital

A level of care is a measure of the effort made to treat a patient properly, and can differ from the place of care. At a hospital, one may be involved in many different levels of care, such as intensive care, telemetry, and definitive observation.

55.

With respect to HMOs, which of the following types of provider is the key figure in determining type of HMO?

Physician

Case manager

Utilization review coordinator

Discharge planner

Correct answer: Physician

Health Maintenance Organizations (HMO) are organizations that manage the care of individuals mainly through the organization and activity of physicians. The main distinguishing feature of the type of HMO is the management and reimbursement structure of physicians within that HMO.

Case managers, utilization review coordinators, and discharge planners are less central in determining the type of HMO.

56.

Which of the following is **false** about medical necessity?

It is the same across health plans

It determines what is reimbursed

Only medically necessary items are covered

It varies by health plan

Correct answer: It is the same across health plans

Medical necessity is the doctrine that only evidence-based, appropriate, and necessary items are covered by a healthcare plan. What is deemed medically necessary will be reimbursed; what is not will not be. What is considered medically necessary varies by health plan.

57.

Which of the following models helps a case manager educate a client about their need for care?

Health Belief Model

Self-vulnerability Model

Chronic Care Model

Care Ownership Model

Correct answer: Health Belief Model

The Health Belief Model of education attempts to educate a client about their risk through assessing how much at risk they believe themselves to be, how effective they think treatment could be, and how able they feel to be a participant, among others.

The Self-vulnerability Model, the Chronic Care Model, and the Care Ownership Model are all fabricated terms.

58.

Which of the following is **not** a part of the Primary Care Provider's gatekeeper role in managed care?

To negotiate costs

To provide corrective care

To provide preventative care

To offer referrals

Correct answer: To negotiate costs

In Health Maintenance Organizations (HMO), a Primary Care Provider often acts as a gatekeeper for the patient. This role includes providing corrective and preventative care and offering appropriate referrals to other providers or other services.

Negotiating costs would not be part of this gatekeeper role.

59.

Which of the following would **most** likely be measured by an actuarial study?

Demographic trends

Opinions about healthcare

Outcomes of healthcare

Organizational outcomes

Correct answer: Demographic trends

An actuarial study examines large populations in terms of their demographics and use of healthcare resources.

Such a study is less likely to deal with opinions about healthcare, or outcomes of healthcare or organizations.

60.

Which of the following measures a client's potential for suicidal behavior?

SAFE-T

PHQ-9

Clock drawing test

Sentence completion test

Correct answer: SAFE-T

The Suicide Assessment Five-Step Evaluation and Triage Assessment (SAFE-T) is a scale used to measure a client's potential suicidality.

The Patient Health Questionnaire (PHQ-9) is an instrument designed to measure a client's depression. The clock drawing test involves the attempt to draw a clock as a gauge of potential neurological damage. The sentence completion test is used to measure a client's beliefs and motivations and involves finishing a set of prepared sentences.

61.

Which part of a case management assessment deals with how a patient accomplishes daily tasks in their life?

Functional status

Health behavior

Physical functioning

Cognitive status

Correct answer: Functional status

A functional status assessment deals with how the patient goes about dealing with the functional demands of daily life, such as the activities of daily living. Such things as walking, hygiene, and feeding would be part of this assessment.

Health behavior assesses high-risk behaviors such as smoking. Physical functioning assesses the overall physical health of the patient. A cognitive status assessment can be seen as gauging the degree to which a patient understands their need and plan for treatment.

62.

How is a primary insurance plan related to one covered in a supplementary medical insurance plan?

They are not related

They are usually covered by the same agency

They are both covered under Medicare

They are both covered under Medicaid

Correct answer: They are not related

A supplemental medical insurance plan (SMI) is one which is added to, and completely separate from, the primary/secondary insurance, whatever it might be.

They would not be covered by the same agency, and they would not both be covered under Medicaid/Medicare as these are primary and secondary in most cases.

63.

Who funds SSI?

The U.S. Treasury General Fund

The Social Security Trust Fund

A public-private partnership

A consortium of nonprofit organizations

Correct answer: The U.S. Treasury General Fund

SSI, or Supplemental Security Income, is funded through the U.S. Treasury General Fund.

It is not funded through the Social Security Trust Fund, any public-private partnership, or any consortium of nonprofit organizations.

64.

Which disability classification accounts for most workers' compensation injuries?

TTD

PTD

TPD

PPD

Correct answer: TTD

Temporary Total Disability (TTD), in which the worker is totally unable to work for a limited amount of time, accounts for the majority of workers' compensation injuries.

PTD (Permanent Total Disability), where a worker cannot ever work again, TPD (Temporary Partial Disability), where a worker is unable to fully work for a limited time, and Permanent Partial Disability (PPD), where a worker is permanently unable to fully work, are less common.

65.

Is custodial care covered by medical insurance?

No

Yes, if the patient is 65 or older

Yes, if it takes place in a skilled nursing facility

Yes, if specially contracted for

Correct answer: No

Custodial care is a kind of care that assists with personal and home care. It does not require licensed personnel or skilled nursing, and is not reimbursable by medical insurance.

The patient's age and location are not relevant to this status, and it is not a subject of special contract with medical insurance.

66.

Which of the following refers to the amount a person pays each time for a specific service?

Copayment

Deductible

Coinsurance

Reimbursement

Correct answer: Copayment

A copayment is the amount a person pays each time for a specific service.

A deductible is a specific amount of money a person has to pay before the insurance company pays. Coinsurance refers to the insurance company and the patient sharing costs. Reimbursement refers to what the provider receives by way of compensation.

67.

Which of the following is **not** measured by the IADL tool?

Depression

Using the telephone

Preparing food

Housekeeping

Correct answer: Depression

The IADL (Instrumental Activities of Daily Living) tool is a gauge of eight independent living skills that helps establish how well a patient can care for themselves. These include shopping, using the telephone, paying bills, preparing food, housekeeping, laundry, using transportation, and handling medications.

Depression is not measured by this tool.

68.

Which of the following is the **most** accurate statement about the "hardball/aggressive" style of negotiation?

It often fails to deliver agreement

Research has proven its effectiveness

It does not involve manipulation or trickery

It is sometimes recommended for case managers

Correct answer: It often fails to deliver agreement

The "hardball/aggressive" style of negotiation often fails to deliver agreement. It involves threats to end the negotiation, manipulation, trickery, and any other tactic that might be considered effective in the situation. It is not recommended to case managers because of its frequent failure, as well as ethical concerns about the practice.

Research does not show this style of negotiation to be effective.

69.

Into which of the following sets of categories is risk stratified by case managers?

Low, medium, and high

Non-acute, acute, and post-acute

Mental, physical, and spiritual

Occupational, physical, and functional

Correct answer: Low, medium, and high

Case managers use assessment tools to broadly categorize individuals into categories of risk. These categories delineate low, medium, or high risk. This categorization allows for the proper treatment of patients according to their need.

70.

Which of the following assesses for potential neurological damage?

Clock drawing test

PHQ-9

Sentence completion test

SAFE-T

Correct answer: Clock drawing test

The clock drawing test involves the attempt to draw a clock as a gauge of potential neurological damage.

The Patient Health Questionnaire (PHQ-9) is an instrument designed to measure a client's depression. The sentence completion test is used to measure a client's beliefs and motivations and involves finishing a set of prepared sentences. The Suicide Assessment Five-Step Evaluation and Triage Assessment (SAFE-T) is a scale used to measure a client's potential suicidality.

71.

Which part of a case management assessment deals with high-risk behavior such as smoking?

Health behavior

Cognitive status

Physical functioning

Functional status

Correct answer: Health behavior

The health behavior part of a case management assessment deals with high-risk behaviors such as smoking or illicit drug use. It is some of the more difficult information to obtain, but it can be highly significant in understanding a patient's overall health picture.

The cognitive status of a patient can be described as the degree to which a patient understands their need and plan for treatment. Physical functioning assesses the overall physical health of the patient. Functional status assessment deals with how the patient goes about dealing with the functional demands of daily life, such as the activities of daily living.

72.

Are states required to offer hospice benefits?

Yes, for at least 210 days

No, hospice is administered at the federal level

Yes, for 90 days

It depends on the state

Correct answer: Yes, for at least 210 days

Under Medicaid, all states are required to offer hospice benefits for at least 210 days.

This is a separate consideration from federal benefits.

73.

Which of the following would **not** be an example of an appeal procedure in healthcare?

Arbitration

Peer-to-peer review

First level appeal

Second level appeal

Correct answer: Arbitration

Decisions about healthcare reimbursement can be appealed, often with such procedures as peer-to-peer review, and first and second level appeals. These involve healthcare professionals and reimbursers who reconsider key decisions.

Arbitration is not usually considered a kind of appeal procedure in healthcare.

74.

What is another name for the implementation phase of case management?

Care coordination

Patient coordination

Care implementation

Case implementation

Correct answer: Care coordination

The phase of case management in which plans are put into place can be referred to as implementation. Another name for this phase, in which the interventions decided upon are enacted, is called care coordination.

Patient coordination, care implementation, and case implementation are all fabricated terms in this context.

75.

Which of the following **best** describes an Accelerated Death Benefit (ADB)?

Using policy benefits before death

A greater payout in case of early death

A recalculation of benefits

A sliding scale

Correct answer: Using policy benefits before death

An Accelerated Death Benefit (ADB) is a rider in some health insurance policies that allows a person with terminal illness to enjoy some of the policy benefit before death.

An ADB is not a greater payout in case of early death, a recalculation of benefits, or a sliding scale.

76.

What is the purpose of the Patient Activation Model (PAM)?

To engage patients

To hold healthcare organizations accountable

To hold patients accountable

To identify common risks among different classes of patients

Correct answer: To engage patients

The purpose of the Patient Activation Model (PAM), created by Insignia Health, is to engage patients by creating a single point of contact within the system and motivating and moving patients through a stepwise process toward greater engagement in their own care.

The purpose of the PAM is not to hold healthcare organizations or patients accountable, or to identify risks among patient populations.

77.

Which of the following is the **least** accurate statement about the cooperative style of negotiation?

It slows down agreements

It speeds up agreements

It enables future negotiations

It results in more satisfying outcomes

Correct answer: It slows down agreements

The cooperative style of negotiation, where the parties concerned behave in objective, fair, and reasonable ways aimed at a win-win, tends to speed up agreements and enable future negotiations based on established trust. Generally speaking, it results in more satisfying outcomes more of the time than a more aggressive or "hardball" strategy.

78.

Which of the following is the **best** brief description of "coordination of benefits"?

Determining who pays first

Determining what should be paid

Enabling proper documentation

Determining level of care

Correct answer: Determining who pays first

Among the many roles a case manager can play is that of helping coordinate varying client benefits. The situation can be very complex, with various payors responsible for various parts of care, different timing intervals for payment, and so on. Coordinating benefits often amounts to determining who pays first.

Determining what should be paid is usually the role of the payor and not the case manager. Proper documentation is necessary in all circumstances, but coordination of benefits involves a payment component. Determining level of care may or may not involve the case manager.

79.

Which of the following groups would most likely **not** be covered under Medicaid?

An individual over 65

Eligible immigrants

Pregnant women

Parents caring for children

Correct answer: An individual over 65

Medicaid coverage varies from state to state; specific provisions often cover such groups as eligible immigrants, pregnant women, and parents caring for children, among others.

Individuals over 65 are covered, in most circumstances, by Medicare.

80.

In terms of insurance, what is a "withhold"?

A conditional payment based on utilization rates

A payment held until quality benchmarks are achieved

A payment conditional to patient recovery

A bonus payment generated by extra revenue

Correct answer: A conditional payment based on utilization rates

In terms of insurance, a withhold is a portion of payment that is controlled by the managed care organization until the end of the year that will not be given to the provider of care unless utilization benchmarks are achieved.

Such a portion of payment is not based on quality benchmarks per se, nor is it conditional to patient recovery. It is not a bonus, but a withheld portion of payment.

81.

Which of the following is the **best** brief definition of "level of care"?

Intensity of services received

Location of services received

The type of professionals providing services

The disease process of the client

Correct answer: Intensity of services received

The term level of care essentially refers to the intensity of services received by the client. A client may move through several physical locations, be treated by many different kinds of professional, and experience many different kinds of disease process or health issue. The main distinguishing factor is how intense the service needs to be to treat the client appropriately.

82.

Which of the following two disciplines formed the basic ideas surrounding case management as a care specialty?

Nursing and social work

Nursing and medicine

Social work and medicine

Nursing and palliative care

Correct answer: Nursing and social work

Case management as a care specialty has its roots in the disciplines of nursing and social work.

Though medicine and palliative care are important to case management, they were not part of the two original founding disciplines.

83.

Who coordinates medical services in managed care scenarios?

The insurance company

The individual physician

A medical board

A physician group

Correct answer: The insurance company

In a managed care scenario, the insurance company is responsible for coordinating medical services.

Though physicians play the key role in service delivery, the insurance company is responsible for coordinating the care provided; deciding what will be reimbursed and to what extent.

In managed care scenarios, medical services are not coordinated by individual physicians, medical boards, or physician groups.

84.

Is total care reimbursable by Medicare or Medicaid?

No

Yes, total care is reimbursable by both Medicare and Medicaid

It is reimbursable by Medicare but not Medicaid

It is reimbursable by Medicaid but not Medicare

Correct answer: No

Total care is a level of care defined by constant assistance with the activities of daily living. It is not reimbursable by Medicare or Medicaid.

85.

In terms of insurance and reimbursement, what is a Third Party Administrator responsible for?

Only administrative functions

Clinical and administrative functions

Clinical functions only

Only claims processing

Correct answer: Only administrative functions

A Third Party Administrator is only responsible for administrative functions, such as processing claims and utilization review.

Claims processing would only be one part of the administrative functions involved. Clinical functions would be excluded.

86.

Can children receive SSI benefits?

Yes, under some circumstances

No, under no circumstances

No, unless their parent is receiving Medicaid

No, unless their parent is disabled

Correct answer: Yes, under some circumstances

Children can receive SSI (Supplemental Security Income) benefits in some circumstances, most notably if disabled according to the qualifying criteria of SSI.

This coverage is not determined by parental involvement with Medicaid, or their parent's disability.

87.

Which of the following would be an example of primary nonadherence?

Not filling a prescription

Not taking medication

Skipping doses

Changing dosage

Correct answer: Not filling a prescription

Primary nonadherence would be the basic failure to maintain one's course of treatment, such as not filling a prescription for medication.

Such things as not taking medication, skipping doses, and changing dosage would be examples of secondary nonadherence.

88.

Is there a waiting period for short-term disability insurance?

Yes, from 7-30 days

No, benefits are immediate

Yes, less than 2 weeks

No, unless the policy states otherwise

Correct answer: Yes, from 7-30 days

There is a waiting period for short-term disability insurance, that lasts from 7 to 30 days.

89.

How is level of care **most** determined?

Evidence-based guidelines

Federal law and CMS guidelines

Clinical judgment of the state board

Patient desire for treatment

Correct answer: Evidence-based guidelines

The appropriate level of care for a patient is most determined by the utilization of evidence-based guidelines such as InterQual or the Milliman Care Guidelines.

Federal law and CMS guidelines and state boards do not have as significant a role, if any. Patient desire is significant, but patients do not determine their own level of care.

90.

Which of the following are the **main** concerns of utilization management?

Necessity and cost

Outcomes and cost

Necessity and outcomes

Patients' rights and cost

Correct answer: Necessity and cost

The main concerns of utilization management are the determination of medical necessity, and providing the right level of care at the least costly rate.

Outcomes per se are not the main concern of utilization management. Though patients' rights are represented in the process, they are not the explicit concern.

91.

Is respite care covered under the Home Health Care benefit, according to Medicare Part A?

Yes

No, under no circumstances

Yes, in cases of End Stage Renal Disease (ESRD)

Only if the patient is covered by hospice

Correct answer: Yes

Respite care, a type of care meant to give relief to the regular caregivers of a patient, can be covered under the Home Health Care benefit, according to Medicare Part A.

This benefit is not limited to those suffering from ESRD, and hospice would be a different kind of Medicare benefit altogether.

92.

In terms of HMO care, what is a "carve out"?

Services not included in the provider-HMO contract

Services specifically included as exceptions

Services involving medications not covered in the main contract

Services that are deemed non-essential care

Correct answer: Services not included in the provider-HMO contract

In terms of the operations of health maintenance organizations (HMO) a carve out refers to services that are not included in the provider-HMO contract. These are usually specialty services not offered by the primary care providers.

These services are not specifically included as exceptions, but excluded. They do not necessarily have to do with medications, and may or may not involve services deemed non-essential care.

93.

How is a diagnosis related group (DRG) used?

It is used to determine payments

It is used to determine diagnosis

It is used to determine prognosis

It is used to determine hospice eligibility

Correct answer: It is used to determine payments

A diagnosis related group (DRG) is used in a Prospective Payment System to determine how much a specific service will be reimbursed based on a wider classification in that diagnostic category.

A DRG is not used to determine diagnosis, prognosis, or hospice eligibility.

94.

Which of the following is **untrue** about arbitration?

It is an informal process

It is a formal process

It is facilitated by a third party

Testimony may be presented

Correct answer: It is an informal process

Arbitration is a formal process of conflict resolution that is facilitated by a third party or parties. It is structured more formally than either negotiation or mediation, and within the process testimony, documents, and other collateral may be reviewed.

95.

Which of the following is **not** a key factor identified by the Case Management Society of America as impacting the practice of case management?

Increasing severe and persistent mental illness

Increasing frail elderly population

Increasing chronically ill patients

Increasing state and regulatory requirements

Correct answer: Increasing severe and persistent mental illness

In 2017, the Case Management Society of America identified four key factors that impact the practice of case management:

- *The explosion of managed care*
- *Increasing frail elderly population*
- *Increasing chronically ill patients*
- *Increasing state and regulatory requirements*

Though significant, severe and persistent mental illness was not identified as one of these key factors.

96.

What were the two drivers for the creation of the case management specialty?

Cost control and waste of resources

Cost control and patient satisfaction

Patient satisfaction and waste of resources

Patient satisfaction and physician surveys

Correct answer: Cost control and waste of resources

The case management specialty was created out of a need for cost control and waste of resources in healthcare. Case management attempts to deal with both by providing streamlined and appropriate care.

Though patient satisfaction is a factor in any kind of healthcare, it was not one of the main drivers for the creation of the specialty. Physicians and many other kinds of professionals have input, but physician surveys were not a driver for the creation of the case management specialty.

97.

Which of the following **best** defines Transitional Care as it relates to case management?

Continuity of care between treatments and/or providers

Measurement of quality indicators related to care

Evaluation of end-of life care and treatment

The specialty of long-term care outcomes

Correct answer: Continuity of care between treatments and/or providers

Transitional Care in terms of case management refers to the attention paid to the continuity of care between treatments and/or providers. It has been found that much waste and negative outcome arises from gaps in care continuity; for example, between acute hospital care and community treatment.

Measurement of quality indicators is important, but it is not transitional care; nor is the concept limited to end-of-life care and treatment or long-term care.

98.

From Medicare's perspective, what is the **key** qualifier for admission to skilled care?

A qualifying stay

A mental health diagnosis

A physical health diagnosis

Patient consent

Correct answer: A qualifying stay

Medicare covers up to 100 skilled days per benefit period. However, admission to this level of care generally requires a 3-day qualifying stay in acute care.

Diagnoses and patient consent are also key areas, but from Medicare's perspective the 3-day stay is the key qualifier.

99.

How is the Home Health Care benefit administered under Medicare Part A?

By number of visits

By ability to pay

By number of days

By level of professional

Correct answer: By number of visits

The Home Health Care benefit under Medicare Part A is administered under number of visits by qualified personnel.

It is not administered according to a patient's ability to pay, by a structure counting the number of days provided, or by the level of the professional involved.

100.

What is a "gatekeeper" in HMO care?

The provider of all primary and preventative care

The utilization review manager

The discharge planner/coordinator

The case manager

Correct answer: The provider of all primary and preventative care

In a health maintenance organization (HMO), a gatekeeper is the primary care physician of the patient, who provides all primary and preventative care. They also make decisions about the need for care that lies outside these two areas.

Utilization review managers, discharge planner/coordinators, and case managers are not gatekeepers in HMO care.