AHIP

Exam Questions AHM-540

Medical Management

NEW QUESTION 1
Health plans that offer complementary and alternative medicine (CAM) services face potential liability because many types of CAM services

A. must be offered as separate supplemental benefits or separate products
B. lack clinical trials to evaluate their safety and effectiveness
C. are not covered by state or federal consumer protection statutes
D. focus on a specific illness, injury, or symptom rather than on the whole body

Answer: B

NEW QUESTION 2
The Medicaid population can be divided into subgroups based on their relative size and the costs of providing benefits. From the answer choices below, select the response that correctly identifies the subgroups that represent the largest percentages of the total Medicaid population and of total Medicaid expenditures. Largest % of Medicaid Population- Largest % of Medicaid Expenditures-

A. Largest % of Medicaid Population-dual eligibles Largest % of Medicaid Expenditures- children and low-income adults
B. Largest % of Medicaid Population-chronically ill or disabled individuals not eligible for MedicareLargest % of Medicaid Expenditures-dual eligibles
C. Largest % of Medicaid Population-children and low-income adults Largest % of Medicaid Expenditures-chronically ill or disabled individuals not eligible for Medicare
D. Largest % of Medicaid Population-chronically ill or disabled individuals not eligible for Medicare Largest % of Medicaid Expenditures-children and low-income adults

Answer: C

NEW QUESTION 3
Breanna Osborn is a case manager for a regional health plan. One component of Ms. Osborn's job is the collection and evaluation of medical, financial, social, and psychosocial information about a member's situation. This component of Ms. Osborn's job is known as

A. case identification
B. case management planning
C. healthcare coordination
D. case assessment

Answer: D

NEW QUESTION 4
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
Definitions of quality healthcare vary; however, four dimensions are essential to quality healthcare services. _____ is the quality dimension indicating that services result in the best care for a given cost or the lowest cost for a given level of care.

A. Accessibility
B. Effectiveness
C. Acceptability
D. Efficiency

Answer: D

NEW QUESTION 5
The following statement(s) can correctly be made about the characteristics of peer review:
* 1.Peer review is applicable to either single episodes of care or to entire programs of care
* 2.Most peer review is conducted concurrently
* 3.Under the Health Care Quality Improvement Program (HCQIP), peer review is required for services furnished to Medicare and Medicaid recipients enrolled in health plans

A. All of the above
B. 1 and 2 only
C. 1 and 3 only
D. 2 and 3 only

Answer: C

NEW QUESTION 6
The following statements are about health plans' development of medical policies. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. Technology assessment is applicable only to medical policy development for new medical procedures, devices, drugs, and tests.
B. Technology assessment provides the scientific rationale for the medical policy section that specifies when a medical service is appropriate and when it is not.
C. The medical policy development process includes both a clinical and an operational review of a proposed medical policy.
D. The decision to accept or reject a proposed medical policy often depends on how a new technology compares to currently used interventions.

Answer: A

NEW QUESTION 7
This agency oversees the Federal Employee Health Benefits Program (FEHBP).

A. Health Resources and Services Administration (HRSA)
B. Office of Personnel Management (OPM)
C. Department of Health and Human Services (HHS)
D. Department of Justice (DOJ)

Answer: B

NEW QUESTION 8
Health plan performance measures include structure measures, process measures, and outcome measures. The following statements are about the characteristics of these three types ofperformance measures. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. The most widely used structure measures relate to physician education and training.
B. One advantage of structure measures over process measures is that structures are often linked directly to healthcare outcomes.
C. Process measures are useful in identifying underuse, overuse, and inappropriate use of services.
D. One disadvantage of outcome measures is that they can be influenced by factors outside the control of the health plan.

Answer: B

NEW QUESTION 9
The following statements are about the characteristics of a utilization review (UR) program. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. A primary goal of UR is to address practice variations through the application of uniform standards and guidelines.
B. UR evaluates whether the services recommended by a member's provider are covered under the benefit plan.
C. UR recommends the procedures that providers should perform for plan members.
D. A health plan's UR program is usually subject to review and approval by the state insurance and/or health departments.

Answer: C

NEW QUESTION 10
Determine whether the following statement is true or false: Participation in disease management programs is currently voluntary.

A. True
B. False

Answer: A

NEW QUESTION 10
DUR can be conducted prospectively, concurrently, or retrospectively. One true statement about prospective DUR is that it

A. involves periodic audits of the medical records of a certain group of patients
B. is based on historical data
C. focuses on the drug therapy for a single patient rather than overall usage patterns
D. is conducted by physicians, without input from pharmacists

Answer: C

NEW QUESTION 12
The paragraph below contains two pairs of terms in parentheses. Determine which term in each pair correctly completes the paragraph. Then select the answer choice containing the two terms that you have chosen.
Health plans use both internal and external standards to assess the quality of the services that they provide. (Internal / External) standards are based on information such as published industry-wide averages or best practices of recognized industry leaders. Health plans primarily rely on (internal / external) standards to evaluate healthcare services.

A. Internal / internal
B. Internal / external
C. External / internal
D. External / external

Answer: D

NEW QUESTION 17
Determine whether the following statement is true or false:
Independent review organizations (IROs) can mediate disputes and offer advisory opinions to health plans on UR issues, but they cannot render binding decisions on appeals.

A. True
B. False

Answer: B

NEW QUESTION 22
Comorbidity can have a significant impact on the effective implementation of disease management programs. Comorbidity can correctly be defined as the

A. degree to which the progression of a disease or condition is understood
B. prevalence or rate of a sickness or injury within a given population
C. degree of severity of a particular disease or condition
D. presence of a chronic condition or added complication other than the condition that requires medical treatment

Answer: D

NEW QUESTION 26
The case management team at the Hightower Health Plan reviewed the medical records of the following two plan members to determine the type of care each one needs and the most appropriate setting for that care:
Ira Morton was hospitalized for a severe stroke. Although his medical condition is stable, the stroke left him partially paralyzed and he will require extensive rehabilitation and 24- hour medical care.
Theresa Finley is recovering from a total hip replacement and is in need of short-term physical therapy and twice-weekly visits from a licensed nurse to check her blood pressure and the healing of her incision.
From the answer choices below, select the response that correctly identifies the level of care that would be most appropriate for Mr. Morton and Ms. Finley.

A. M
B. Morton-acute care M
C. Finley-subacute care
D. M
E. Morton-palliative care M
F. Finley-acute care
G. M
H. Morton-subacute care M
I. Finley-skilled care
J. M
K. Morton-skilled care M
L. Finley-palliative care

Answer: C

NEW QUESTION 27
With respect to the activities of MCO medical directors, it is correct to say that medical directors typically perform all of the following activities EXCEPT

A. maintaining clinical practices
B. delivering performance feedback to providers
C. participating in utilization management (UM) activities
D. educating other MCO staff about new clinical developments or provider innovations that might impact clinical practice management

Answer: A

NEW QUESTION 29
Designing effective medical management programs for Medicare beneficiaries requires an understanding of the unique health needs of the Medicare population. One characteristic of Medicare beneficiaries is that they typically

A. do not experience mental health problems
B. consume more than half of all prescription drugs
C. are likely to equate quality with the technical aspects of clinical procedures
D. require longer and more costly recovery periods following acute illnesses or injuries than does the general population

Answer: D

NEW QUESTION 33
Health plans that offer healthcare programs for Medicare beneficiaries have a strong financial incentive for identifying high-risk seniors as early as possible. The identification of high-risk seniors is typically accomplished through the use of

A. case management
B. geriatric evaluation and management (GEM)
C. intervention identification
D. interdisciplinary home care (IHC)

Answer: C

NEW QUESTION 35
Federal laws, such as the Employee Retirement Income Security Act (ERISA), the Balanced Budget Act (BBA) of 1997, and the Health Insurance Portability and Accountability Act (HIPAA), have affected medical management activities by health plans. Consider the following provisions of federal regulations:
Provision 1—Limits damage awards in lawsuits related to noncoverage of benefits based on medical necessity decisions to the cost of noncovered treatment and does not allow health plan members to obtain compensatory or punitive damages
Provision 2—Establishes electronic data security standards, which define the security measures that healthcare organizations must take to protect the confidentiality of electronically stored and transmitted patient information From the answer choices below, select the response that correctly identifies the federal laws that include Provision 1 and Provision 2, respectively.

A. Provision 1- ERISA Provision 2- HIPAA
B. Provision 1- HIPAA Provision 2- ERISA
C. Provision 1- BBA of 1997 Provision 2- HIPAA
D. Provision 1- ERISA Provision 2- BBA of 1997

Answer: A

NEW QUESTION 39
As a follow-up to a performance improvement plan for member services, the Stellar Health Plan conducted an evaluation of the success of the plan. Stellar conducted its evaluation as the plan was being carried out. The evaluation focused on specific activities and assessed the relative importance of those activities to the plan as a whole. This information indicates that Stellar's evaluation of the plan was both

A. concurrent and formative
B. concurrent and summative
C. retrospective and formative
D. retrospective and summative

Answer: A

NEW QUESTION 42
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
Medical management programs often require the analysis of many types of data and information. _____ is an automated process that analyzes variables to help detect patterns and relationships in the data.

A. Unbundling
B. Outsourcing
C. Data mining
D. Drilling down

Answer: C

NEW QUESTION 46
Step-therapy is a form of prior authorization that reserves the use of more expensive medications for cases in which the use of less expensive medications has been unsuccessful. Step-therapy is appropriate for situations in which
* 1.A significant percentage of those treated with the initial therapy will require the second therapy
* 2.The delay created when a patient moves from one therapy to the next therapy will not cause serious or permanent effects

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: C

NEW QUESTION 50
The Harbor Health Plan's formulary policy encourages network pharmacists who are asked to fill a prescription for a costly, brand-name drug to dispense a different chemical entity within the same drug class in order to reduce costs. This type of drug substitution is referred to as

A. generic substitution, and prescriber approval is not required
B. generic substitution, and prescriber approval is always required
C. therapeutic substitution, and prescriber approval is not required
D. therapeutic substitution, and prescriber approval is always required

Answer: D

NEW QUESTION 51
The case management program director at the Nova Health Plan calculated the program's ratio of medical expense savings to case management administrative costs for the previous quarter based on the following cost information:
Administrative costs for case management $40,000
Actual medical care expenses for patients under case management $680,000
Projected medical care expenses for the same patients without case management
.....$900,000
This information indicates that, for the previous quarter, Nova's ratio of medical expense savings to case management administrative costs was

A. 0.71/1
B. 0.80/1
C. 5.50/1
D. 1.25/1

Answer: C

NEW QUESTION 52
Many health plans use clinical pathways to help manage the delivery of acute care services to plan members. One true statement about clinical pathways is that they

A. determine which healthcare services are medically necessary and appropriate for a particular patient in a particular situation
B. outline the services that will be delivered, the providers responsible for delivering the services, the timing of delivery, the setting in which services are delivered, and the expected outcomes of the interventions
C. cover only services delivered in an acute inpatient setting
D. address medical conditions that affect a small segment of a given population and with which the majority of providers are unfamiliar

Answer: B

NEW QUESTION 57
One of the steps in drug utilization review (DUR) is defining optimal drug use, which can be accomplished by applying diagnosis criteria and drug-specific criteria. Drug-specific criteria are standards that identify the

A. appropriate dosages, duration of treatment, and other elements related to the use of a particular drug
B. actual prescribing and dispensing patterns for a particular drug
C. types of diseases, conditions, or patients for which a drug should be used
D. cost-effectiveness of all possible drug treatments for a particular condition

Answer: A

NEW QUESTION 59
One way that health plans evaluate their UR programs is by monitoring utilization rates. By definition, utilization rates typically

A. indicate changes in the total amount of medical expenses or claim dollars paid for particular procedures
B. measure the number of services provided per 1,000 members per year
C. indicate standard approaches to care for many common, uncomplicated healthcare services
D. report the number of times that a particular provider performs or recommends a service excluded from the benefit plan

Answer: B

NEW QUESTION 60
Drugs included in a health plan's formulary can be classified according to how freely they can be prescribed. By definition, a drug that requires some sort of review or approval by a plan physician or group of physicians before the prescription can be filled is

A. an unrestricted drug
B. a monitored drug
C. a restricted drug
D. a conditional drug

Answer: B

NEW QUESTION 61
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
In most commercial health plans, the case management process is directed by a case manager whose responsibilities typically include

A. focusing on a disabled member's vocational rehabilitation and training
B. approving all care decisions for patients under case management
C. reducing the fragmentation of care that often results when individuals obtain services from several different providers
D. all of the above

Answer: C

NEW QUESTION 65
Examples of alternative healthcare practitioners are chiropractors, naturopaths, and acupuncturists. The only well-established credentialing standards for alternative healthcare practitioners are those available from NCQA. These NCQA credentialing standards apply to

A. chiropractors
B. naturopaths
C. acupuncturists
D. all of the above

Answer: A

NEW QUESTION 70
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Determine which term or phrase in each pair correctly completes the paragraph. Then select the answer choice containing the two terms or phrases that you have selected.
The process for collecting and analyzing data differs for quality assessment (QA) and quality improvement (QI). For QA, data collection focuses on (objective / both objective and subjective) data, and data analysis identifies the (degree / cause) of variance.

A. objective / degree
B. objective / cause
C. both objective and subjective / degree
D. both objective and subjective / cause

Answer: A

NEW QUESTION 71
The following statement(s) can correctly be made about the hospitalist approach to inpatient care management:
* 1. Management of inpatient care by hospitalists may significantly reduce the length of stay and the total costs of care for a hospital admission
* 2. Most health plans that use hospitalists do so through a voluntary hospitalist program
* 3.A hospitalist's familiarity with utilization management (UM) and quality management (QM) standards for inpatient care may reduce unnecessary variations in care and improve clinical outcomes

A. All of the above
B. 1 and 2 only
C. 1 and 3 only

D. 2 only

Answer: A

NEW QUESTION 75
Most health plans require a PCP referral or precertification for CAM benefits.

A. True
B. False

Answer: B

NEW QUESTION 76
Various government and independent agencies have created tools to measure and report the quality of healthcare. One performance measurement tool that was developed by the Agency for Healthcare Research and Quality (AHRQ) is

A. the Health Plan Employer Data and Information Set (HEDIS®), which is a report card system for hospitals and long-term care facilities
B. HEDIS, which is a performance measurement tool that addresses both effectiveness of care and plan member satisfaction
C. the Consumer Assessment of Health Plans (CAHPS®), which was established to develop and implement a national strategy for quality measurement and reporting
D. CAHPS, which is a tool that measures consumer satisfaction with specific aspects of health plan services

Answer: D

NEW QUESTION 79
Outcomes management is a tool that health plans use to maximize all the results
associated with healthcare processes. The following statement(s) can correctly be made about outcomes management:
* 1. The goal of outcomes management is to identify and implement treatments that are cost- effective and deliver the greatest value
* 2. Outcomes management introduces performance as a critical factor in the assessment and improvement of outcomes

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: A

NEW QUESTION 84
Readiness is an important consideration for the development of health promotion programs. Readiness refers to

A. the availability of previously established health promotion programs to an health plan’s members through employers, providers, or community service agencies
B. the appropriateness of a program’s educational approach, given the language, literacy level, and cultural sensitivities of the target population
C. a member’s level of knowledge about existing health risks and problems and the member’s ability and willingness to adopt new health-related behaviors
D. a member’s access to information technology, such as a video cassette recorder, a computer, or the Internet

Answer: C

NEW QUESTION 86
The following statement(s) can correctly be made about utilization guidelines:
* 1. When developing utilization guidelines, health plans balance evidence-based criteria with experience-based criteria
* 2. Utilization guidelines indicate when a UR nurse should refer a decision to a physician reviewer

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: A

NEW QUESTION 90
The BBA of 1997 allows states to provide Medicaid benefits to children through the State Children’s Health Insurance Program (SCHIP). Under the terms of the BBA, states can implement SCHIP as
* 1. Part of their existing Medicaid programs
* 2.Separate commercial insurance programs

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: A

NEW QUESTION 95
Health plans arrange for the delivery of various levels of healthcare, including
* 1.Emergency care

* 2. Urgent care
* 3. Primary care delivered in a provider’s office

In a ranking of these levels of care according to cost, beginning with the least expensive level of care and ending with the most expensive level of care, the correct order would be

A. 1—2—3
B. 2—3—1
C. 3—1—2
D. 3—2—1

Answer: D

NEW QUESTION 100

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