Exam Questions AHM-540

Medical Management

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NEW QUESTION 1
Emilio Martinez, a member of the Bloom Health Plan, has recently been diagnosed with prostate cancer by his physician, Dr. Robert Cohen. Mr. Martinez has decided to participate in Bloom's shared decision-making program for prostate cancer. On the basis of this information, it is most likely correct to say
* 1. That verification of Mr. Martinez's understanding about his care options protects both Dr. Cohen and Bloom against charges of malpractice
* 2. That Mr. Martinez and Dr. Cohen will discuss the care options available to Mr. Martinez, but the ultimate decision about care is up to Dr. Cohen

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

Answer: D

NEW QUESTION 2
Determine whether the following statement is true or false:
Immunization programs are a direct means of reducing health plan members' needs for healthcare services and are typically cost-effective.

A. True
B. False

Answer: A

NEW QUESTION 3
Determine whether the following statement is true or false:
With respect to the size of a managed care organization (MCO) and its medical management operations, it is correct to say that large health plans typically have more integration among activities and less specialization of roles than do small MCOs.

A. True
B. False

Answer: B

NEW QUESTION 4
Determine whether the following statement is true or false:
The delegation of medical management functions to providers can occur without the transfer of financial risk.

A. True
B. False

Answer: A

NEW QUESTION 5
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 6
State governments serve as both regulators and purchasers of health plan services. The influence of state governments as purchasers is focused on

A. Medicare and TRICARE programs
B. Medicaid and workers' compensation programs
C. Medicare and Medicaid programs
D. TRICARE and workers' compensation programs

Answer: B

NEW QUESTION 7
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
Ways that workers' compensation health plans can help control the costs of job-related injuries and illnesses include

A. applying strict definitions of medical necessity
B. developing prevention and recovery programs
C. applying out-of-network benefit reductions
D. all of the above

Answer: B

NEW QUESTION 8
In recent years, the demand for prescription drugs has increased dramatically. Factors that have contributed to this increase include

A. increased education regarding the purpose and benefits of drug formularies
B. reductions in the cost of prescription drugs
C. increased use of direct-to-consumer (DTC) advertising
D. all of the above

Answer: C

NEW QUESTION 9
Increased demands for performance information have resulted in the development of various health plan report cards. With respect to most of the report cards currently available, it is correct to say

A. that they are focused primarily on health maintenance organization (HMO) plans
B. that they are based on data collected for the Health Plan Employer Data and Information Set (HEDIS) 3.0
C. that they are used to rank the performance of various health plans
D. all of the above

Answer: D

NEW QUESTION 10
To see that utilization guidelines are consistently applied, UR programs rely on authorization systems. Determine whether the following statement about authorization systems is true or false:
Only physicians can make nonauthorization decisions based on medical necessity.

A. True
B. False

Answer: A

NEW QUESTION 10
The following statements are about the use of hospitalists to manage inpatient care. Select the answer choice containing the correct statement.

A. A patient who has been transferred to a hospitalist for management of inpatient care usually continues to receive care from the hospitalist after discharge.
B. Hospitalists are used primarily to manage care for obstetric, pediatric, and oncology patients.
C. In order to serve as a hospitalist, a physician must have a background in critical care medicine.
D. Hospitalists typically spend at least one-quarter of their time in a hospital setting.

Answer: D

NEW QUESTION 12
One difference between outcomes research and clinical research is that outcomes research

A. provides an absolute measure of treatment results, whereas clinical research provides a relative measure of results
B. focuses on treatment effectiveness, whereas clinical research focuses on treatmentefficacy
C. examines diseases and treatments in isolation, whereas clinical research considers the effects of changes in health status and quality of life
D. gathers outcomes data from controlled clinical trials, whereas clinical research collects and analyzes clinical, financial, and administrative data

Answer: B

NEW QUESTION 15
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Select the term or phrase in each pair that correctly completes the paragraph. Then select the answer choice containing the two terms or phrases you have chosen.
TRICARE enrollees have the right to challenge authorization and coverage decisions. Such challenges are referred to as (appeals / grievances) and are typically handled by the (TRICARE contractor / Area Field Office).

A. appeals / TRICARE contractor
B. appeals / Area Field Office
C. grievances / TRICARE contractor
D. grievances / Area Field Office

Answer: A

NEW QUESTION 18
The following statement(s) can correctly be made about the scope of case management:
* 1. Case management incorporates activities that may fall outside a health plan's typical responsibilities, such as assessing a member's financial situation
* 2. Case management generally requires a less comprehensive and complex approach to a course of care than does utilization review
* 3. Case management is currently applicable only to medical conditions that require inpatient hospital care and are categorized as catastrophic in terms of health and/or costs

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

Answer:

D

NEW QUESTION 21
Recent laws and regulations have established new requirements for Medicaid eligibility. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 affected Medicaid eligibility by

A. severing the link between Medicaid and public assistance
B. eliminating the need for applications for Medicaid and public assistance
C. allowing states to provide healthcare benefits to groups outside the traditional Medicaid population
D. providing supplemental funding for dual eligibles in the form of five-year block grants

Answer: A

NEW QUESTION 26
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
The Balanced Budget Act (BBA) of 1997 established the use of _____ to determine coverage of emergency services for Medicare and Medicaid enrollees in health plans.

A. utilization management standards
B. the prudent layperson standard
C. preauthorization
D. diagnosis-based retrospective review

Answer: B

NEW QUESTION 28
The following statements are about the use of provider profiling for pharmacy benefits. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. Health plans typically use provider profiles to improve the quality of care associated with the use of prescription drugs.
B. Provider profiles identify prescribing patterns that fall outside normal ranges.
C. Health plans can motivate providers to change their prescribing patterns by sharing profile information with plan members and the general public.
D. Provider profiles are effective in modifying individual prescribing patterns, but they have little effect on group prescribing patterns.

Answer: D

NEW QUESTION 32
Home healthcare encompasses a wide variety of medical, social, and support services delivered at the homes of patients who are disabled, chronically ill, or terminally ill. The time period(s) when health plans typically use home healthcare include
* 1. The period prior to a hospital admission
* 2. The period following discharge from a hospital

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

Answer: A

NEW QUESTION 34
In order for a health plan's performance-based quality improvement programs to be effective, the desired outcomes must be

A. achievable within a specified timeframe
B. defined in terms of multiple results
C. expressed in subjective, qualitative terms
D. all of the above

Answer: A

NEW QUESTION 38
Private employers are key purchasers of health plan services. The following statement(s) can correctly be made about employer expectations about the quality and cost- effectiveness of healthcare services:
* 1. For both health maintenance organizations (HMOs) and non-HMO plans, employers typically have access to accreditation results and performance measurement reports to help them evaluate the quality of healthcare and service
* 2. Because of employers' concern about the quality and costs of healthcare services available through health plans, direct contracting has become a dominant model among employers who sponsor health benefit programs for their employees

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

Answer: D

NEW QUESTION 42
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 43
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 46
Patient safety and medical errors are important concerns for both quality management (QM) and risk management. The following statement(s) can correctly be made about medical errors:
* 1. The complexity of modern medicine and healthcare delivery systems increases patients' exposure to the risks of medical errors
* 2. Licensing boards for healthcare professionals in all states provide a consistent system of quality oversight and accountability
* 3. Provider compliance with internal incident reporting requirements is low

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

Answer: C

NEW QUESTION 48
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 50
Nilay Sharma suffered a small wound while working in his yard and was taken to a local hospital for treatment. A triage nurse at the hospital evaluated Mr. Sharma's condition and directed him to an outpatient unit in the hospital where a physician assistant examined, cleaned, and sutured the wound. Mr. Sharma returned home following treatment. The care Mr. Sharma received at the hospital is an example of the type of care known as

A. specialty referral
B. primary prevention
C. urgent care
D. emergency care

Answer: C

NEW QUESTION 53
The following statements are about QAPI as it applies to Medicare+Choice plans and Medicaid health plan entities. Select the answer choice containing the correct statement.

A. QAPI provides separate sets of standards for Medicaid MCEs and Medicare+Choice plans.
B. Medicaid primary care case management (PCCM) programs are required to comply with all QAPI standards.
C. QISMC standards for quality measurement and improvement apply only to clinical services delivered to Medicare and Medicaid enrollees.
D. States that require Medicaid MCEs to comply with QAPI standards are considered to be in compliance with CMS quality assessment and improvement regulations.

Answer: D

NEW QUESTION 56
Economically, health plans cannot provide coverage for every drug available from every manufacturer. As a result, purchaser contracts often include provisions specifying that certain drugs or drug types will not be covered. These provisions are referred to as

A. limitations
B. exceptions
C. exclusions

D. drug edits

Answer: C

NEW QUESTION 57
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 60
The Mental Health Parity Act (MHPA) of 1996 is a federal law that establishes requirements for behavioral healthcare coverage for group plan members. The MHPA

A. requires health plans to offer mental health benefits to all eligible members
B. prohibits health plans that offer mental health benefits from imposing lower annual or lifetime dollar limits on mental illnesses than they do on physical illnesses
C. provides an exemption for health plans that can demonstrate cost savings of more than 1 percent
D. prohibits health plans from limiting the number of outpatient visits or inpatient dayscovered under the plan

Answer: B

NEW QUESTION 63
Elaine Newman suffered an acute asthma attack and was taken to a hospital emergency department for treatment. Because Ms. Newman's condition had not improved enough following treatment to warrant immediate release, she was transferred to an observation care unit. Transferring Ms. Newman to the observation care unit most likely

A. resulted in unnecessarily expensive charges for treatment
B. prevented M
C. Newman from receiving immediate attention for her condition
D. gave M
E. Newman access to more effective and efficient treatment than she could have obtained from other providers in the same region
F. allowed clinical staff an opportunity to determine whether M
G. Newman required hospitalization without actually admitting her

Answer: D

NEW QUESTION 66
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
To manage the delivery of healthcare services to their members, health plans use clinical practice parameters. _____ is the type of clinical practice parameter that a health plan uses to make coverage decisions concerning medical necessity and appropriateness.

A. A clinical practice guideline (CPG)
B. Medical policy
C. Benefits administration policy
D. A standard of care

Answer: B

NEW QUESTION 69
Acute care refers to healthcare services for medical problems that

A. are expected to continue for a minimum of 30 days
B. are typically treated in a provider's office or outpatient facility
C. require prompt, intensive treatment by healthcare providers
D. require low utilization of resources

Answer: C

NEW QUESTION 71
This agency oversees fraud and abuse matters as they relate to medical management.

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: D

NEW QUESTION 72
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 73
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 77
The Riverside Health Plan is considering the following provider compensation options to use in its contracts with several provider groups and hospitals:
* 1. A discounted fee-for-service (DFFS) payment system
* 2. A case rate system
* 3. Capitation
If Riverside wants to use only those compensation methods that encourage the efficient use of resources, then the compensation method(s) that Riverside should consider for its new contracts include

A. 1, 2, and 3
B. 1 and 2 only
C. 2 and 3 only
D. 3 only

Answer: C

NEW QUESTION 82
To measure performance for quality management, health plans collect and analyze three types of data: financial data, clinical data, and customer satisfaction data. The following statement(s) can correctly be made about the sources of clinical data:
* 1.Patient surveys are the most widely used source of disease-specific clinical information
* 2.Outcomes research studies sponsored by academic institutions and professional organizations have limited usefulness for particular health plans or individual providers
* 3.The SF-36 and the HSQ-39 (Health Status Questionnaire) surveys address both physical and mental health status

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

Answer: C

NEW QUESTION 84
Benchmarking is a quality improvement strategy used by some health plans. With regard to benchmarking, it is correct to say that

A. cost-based benchmarking reveals why some areas of a health plan perform better or worse than comparable areas of other organizations
B. diagnosis-related groups (DRGs) are a source of benchmarking data that describe individual procedures and cover both inpatient and outpatient care
C. patient billing records provide a much more accurate account of procedure costs for benchmarking than do current procedural terminology (CPT) codes
D. the focus of benchmarking for health plan has shifted from identifying the lowest cost practices to identifying best practices

Answer: D

NEW QUESTION 86
The following statements are about health plans' complaint resolution procedures (CRPs). Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. An health plan's CRPs reduce the likelihood of errors in decision making.
B. CRPs typically provide for at least two levels of appeal for formal appeals.
C. CRPs include only formal appeals and do not apply to informal complaints.
D. Most complaints are resolved without proceeding through the entire CRP process.

Answer: C

NEW QUESTION 89
Health plans often use accreditation as a means of evaluating the quality of care delivered to plan members. Accreditation of subacute care providers is available from the

A. National Committee for Quality Assurance (NCQA)
B. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
C. American Accreditation HealthCare Commission/URAC (URAC)
D. Foundation for Accountability (FACCT)

Answer: B

NEW QUESTION 91
Selene Varga is participating in her health plan's disease management program for congestive heart failure. Ms. Varga's health status is regularly monitored and managed by a licensed nurse who visits Ms. Varga at her home to administer treatment and assess the need for changes in Ms. Varga's overall care plan. This information indicates that Ms. Varga is participating in the type of disease management program known as a

A. coordinated outreach model program
B. case management model program
C. hub-and-spoke model program
D. group clinic model program

Answer: B

NEW QUESTION 93
For this question, if answer choices (a) through (c) are all correct, select answer choice (d). Otherwise, select the one correct answer choice.
Well-crafted clinical practice guidelines (CPGs) can benefit healthcare delivery processes and outcomes by

A. providing a framework for care while also allowing for patient-specific variations, based on physician judgment
B. serving as a basis for evaluating whether providers are practicing in accordance with accepted standards
C. focusing on the prevention or early detection of a particular condition
D. all of the above

Answer: D

NEW QUESTION 98
Comparing the quality of managed Medicare programs with the quality of FFS Medicare programs is often difficult. Unlike FFS Medicare, managed Medicare programs

A. can measure and report quality only at the provider level
B. use a single system to deliver services to all plan members
C. provide an organizational focus for accountability
D. can use the same performance measures for all products and plans

Answer: C

NEW QUESTION 101
Vision care is typically separated into two categories: routine eye care and clinical eye care. The standard benefit plans offered by most health plans include coverage for
* 1. Routine eye care
* 2. Clinical eye care

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

Answer: C

NEW QUESTION 102
Health plans have a specified number of working days to respond to Level One appeals, as stated by company policy or regulatory requirements. With regard to the timeframes for appeals, it is generally correct to say
* 1. That the typical timeframe requires a health plan to respond to appeals in fewer than 20 days
* 2. That the timeframe is accelerated for expedited appeals
* 3. That the review period begins when the appeal arrives at a health plan

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

Answer: D

NEW QUESTION 104
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 105
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 106
Health plans communicate proposed performance changes through action statements. Select the answer choice containing an action statement that includes all of the required elements.

A. The proportion of adult members who are screened for hypertension will increase by ten percent.
B. Primary care providers (PCPs) will increase the proportion of children under the age of two who are up-to-date on immunizations by seven percent within one year.
C. The QM program director will evaluate the level of provider compliance with clinicalpractice guidelines (CPGs).
D. The disease management program director will increase participation by asthmatic children in the health plan's pediatric asthma disease management program.

Answer: B

NEW QUESTION 109
Some health plans administer a questionnaire known as the Behavioral Risk Factor Surveillance System (BRFSS) as part of their health risk assessment (HRA) processes. The following statements are about the BRFSS. If statements (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct statement.

A. This questionnaire was designed specifically for use by health plans.
B. Each health plan must use the same form of the questionnaire, with no additions or modifications.
C. This questionnaire monitors the prevalence of the major behavioral risks associated with illness and injury among adults.
D. All of the above statements are correct.

Answer: C

NEW QUESTION 111
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 115
A health plan's preventive care initiatives may be classified into three main categories: primary prevention, secondary prevention, and tertiary prevention. Secondary prevention refers to activities designed to

A. develop an appropriate treatment strategy for patients whose conditions require extensive, complex healthcare
B. educate and motivate members to prevent illness through their lifestyle choices
C. prevent the occurrence of illness or injury
D. detect a medical condition in its early stages and prevent or at least delay disease progression and complications

Answer: D

NEW QUESTION 119
The American Accreditation HealthCare Commission/URAC (URAC) has an accreditation program specifically for case management services. From the answer choices below, select the response that correctly identifies the type(s) of case management services addressed by URAC's standards and the type(s) of organizations to which these standards may be applied.

A. Type(s) of Services-on-site services only Type(s) of Organization-health plans only
B. Type(s) of Services-on-site services only Type(s) of Organization-any organization that performs case management functions
C. Type(s) of Services-both telephonic and on-site services Type(s) of Organization-health plans only
D. Type(s) of Services-both telephonic and on-site services Type(s) of Organization-any organization that performs case management functions

Answer: D

NEW QUESTION 121
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 126
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 130
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