Exam Questions AHM-540

Medical Management

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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
Serena Wilson, a registered nurse, is employed at a TRICARE Service Center (TSC) located at a military installation. Ms. Wilson serves as a primary point of contact between enrollees and the TRICARE system and answers enrollees' questions about plan options, eligibility, provider selection, and claims. This information indicates that Ms. Wilson serves as a

A. lead agent
B. beneficiary services representative
C. health plan support contractor
D. primary care manager (PCM)

Answer: B

NEW QUESTION 3
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
Many health plans use data warehouses to assist with the performance of medical management activities. With respect to the characteristics of data warehouses, it is generally correct to say

A. that the construction of a data warehouse is quick and simple
B. that a data warehouse addresses the problems associated with multiple data management systems
C. that a data warehouse stores only current data
D. all of the above

Answer: B

NEW QUESTION 4
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 5
The paragraph below contains two pairs of terms enclosed in parentheses. Select the term in each pair that correctly completes the paragraph. Then select the answer choice containing the two terms you have chosen.
A primary distinction between skilled care and subacute care relates to the extent and medical complexity of the patient's needs. Generally, subacute care patients require (more
/ fewer) services from physicians and nurses and (more / less) extensive rehabilitation services than do skilled care patients.

A. more / more
B. more / less
C. fewer / more
D. fewer / less

Answer: A

NEW QUESTION 6
Helena Ray, a member of the Harbrace Health Plan, suffers from migraine headaches. To treat Ms. Ray's condition, her physician has prescribed Upzil, a medication that has Food and Drug Administration (FDA) approval only for the treatment of depression. Upzil has not been tested for safety or effectiveness in the treatment of migraine headache. Although Harbrace's medical policy for migraine headache does not include coverage of Upzil, Harbrace has agreed to provide extra-contractual coverage of Upzil for Ms. Ray.
In this situation, the prescribing of Upzil for Ms. Ray's headaches is an example of

A. a cosmetic service
B. an investigational service
C. an off-label use
D. a quality-of-life service

Answer: C

NEW QUESTION 7
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 8
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 9
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 10
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 10
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
Each quality standard used by a health plan is associated with quality indicators. A _____ indicator is a form of aggregate data indicator that produces results that fit within a specified range, such as the length of time to schedule an appointment.

A. yes/no
B. sentinel event
C. discrete variable
D. continuous variable

Answer: D

NEW QUESTION 15
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 20
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 21
The Carlyle Health Plan uses the following clinical outcome measures to evaluate its diabetes and asthma disease management programs:

Measure 1: The percentage of diabetic patients who receive foot exams from their providers according to the program's recommended guidelines Measure 2: The number of asthma patients who visited emergency departments for acute asthma attacks
From the answer choices below, select the response that correctly identifies whether these measures are true outcome measures or intermediate outcome measures. Measure 1- Measure 2-

A. Measure 1-true outcome measure Measure 2-true outcome measure
B. Measure 1-true outcome measure Measure 2-intermediate outcome measure
C. Measure 1-intermediate outcome measure Measure 2-true outcome measure
D. Measure 1-intermediate outcome measure Measure 2-intermediate outcome measure

Answer: C

NEW QUESTION 26
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 28
The Strathmore Health Plan uses clinical pathways to manage its acute care services. In order to reduce the risk of financial liability associated with the use of clinical pathways, Strathmore and its network hospitals should

A. base pathways on relevant evidence reported in medical literature
B. restrict each pathway to a single medical condition
C. use pathways to establish a new standard of care
D. allow providers to use only those interventions listed in the pathways

Answer: A

NEW QUESTION 33
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 34
CMS has developed two prototype programs—Programs of All-inclusive Care for the Elderly (PACE) and the Social Health Maintenance Organization (SHMO) demonstration project—to deliver healthcare services to Medicare beneficiaries. From the answer choices below, select the response that correctly identifies the features of these programs.

A. PACE-annual limits on benefits for nursing home and community-based care SHMO-no limits on long-term care benefits
B. PACE-provide long-term care only SHMO-provide acute and long-term care
C. PACE-enrollees must be age 65 or older SHMO-enrollees must be age 55 or older
D. PACE-enrollment open to nursing home certifiable Medicare beneficiaries only SHMO- enrollment open to all Medicare beneficiaries

Answer: D

NEW QUESTION 38
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 terms or phrases that you have chosen.
The Millway Health Plan received a 15% reduction in the price of a particular pharmaceutical based on the volume of the drug Millway purchased from the manufacturer. This reduction in price is an example of a (rebate / price discount) and (is / is not) dependent on actual provider prescribing patterns.

A. rebate / is
B. rebate / is not
C. price discount / is
D. price discount / is not

Answer: D

NEW QUESTION 39
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 40
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 42
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 46
All states have laws describing the conditions under which pharmacists can substitute a generic drug for a brand-name drug. With respect to these laws, it is correct to say that in every state,

A. pharmacists must obtain physician approval before substituting generics for brand-name drugs
B. pharmacists must obtain authorization from the health plan before substituting generics for brand-name drugs
C. prescribers must obtain authorization from the health plan before prescribing a brand- name drug
D. prescribers have some mechanism that allows them to prevent pharmacists from substituting generics for brand-name drugs

Answer: D

NEW QUESTION 51
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 terms or phrases that you have chosen.
Due to competitive pressures and consumer demand, many health plans now offer direct access or open access products. Under a direct access product, a member is (required / not required) to select a primary care provider (PCP), and is (required / not required) to obtain a referral from a PCP or the health plan before visiting a network specialist.

A. required / required
B. required / not required
C. not required / required
D. not required / not required

Answer: B

NEW QUESTION 56
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 58
Skilled nursing facilities (SNFs) are required by law to have formal programs for quality improvement and to monitor these programs using established standards. These requirements are described in
* 1.The Omnibus Budget Reconciliation Act (OBRA) of 1986
* 2.The Balanced Budget Act (BBA) of 1997

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 or 2

Answer: B

NEW QUESTION 59

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 63
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 65
MCOs usually have a formal program for the oversight of delegated activities. The following statements concern typical delegation oversight programs. Select the answer choice containing the correct statement.

A. A letter of intent is the contractual document that describes the delegated functions and the responsibilities of the MCO and the delegate.
B. In most cases, the evaluation of a candidate for delegation is based entirely on the candidate's application and supporting documentation and does not include an on-site assessment of the candidate.
C. Under most delegation agreements, an MCO cannot terminate the agreement before the end date stated in the agreement.
D. One objective for a delegation oversight program is to integrate any delegated activities into the MCO's overall programs for medical management and other functions.

Answer: D

NEW QUESTION 70
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 74
The following statement(s) can correctly be made about accrediting agency standards for delegation:
* 1. The National Committee for Quality Assurance (NCQA) allows health plans to delegate
all medical management functions, including the responsibility to perform delegation oversight activities
* 2. In some cases, accreditation standards for delegation oversight are reduced if the delegate has already been certified or accredited by the delegator's accrediting agency

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

Answer: C

NEW QUESTION 77

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 81
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 83
One method of transferring the information in electronic medical records (EMRs) is through a health information network (HIN). The following statements are about HINs. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. A HIN may afford a health plan better measurements of outcomes and provider performance.
B. The use of a HIN typically increases a health plan's exposure to liability for poor care.
C. Most HINs are Internet-based rather than built on proprietary computer networks.
D. Currently, the majority of health plans do not have HINs that are capable of transferring medical records among their network providers.

Answer: B

NEW QUESTION 86
Michelle Durden, who is enrolled in a dental health maintenance organizations (DHMO) offered by her employer, is due for a routine dental examination. If the plan is typical of most DHMOs, then Ms. Durden

A. must pay the entire cost of the examination
B. must obtain a referral to a dentist from her primary care provider (PCP)
C. can schedule the examination without preauthorization of payment by the DHMO
D. can schedule an unlimited number of examinations and cleanings per year

Answer: C

NEW QUESTION 91
The delivery of quality, cost-effective healthcare is a primary goal of both group healthcare and workers' compensation programs. One difference between group healthcare and workers' compensation is that workers' compensation

A. provides health and disability benefits to employees injured on the job only if the employer is at fault for the injury
B. provides coverage for a variety of direct and indirect healthcare, disability, and workplace costs
C. manages costs by including employee cost-sharing features in its benefit design
D. places limits on benefits by restricting the amount of benefit payments or the number of covered hospital days or provider office visits

Answer: B

NEW QUESTION 93
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 terms or phrases that you have chosen.
One component of UR is an administrative review. An administrative review compares the proposed medical care to the applicable (medical policy / contract provision). This type of review (can / cannot) be conducted by a nonclinical staff member.

A. medical policy / can
B. medical policy / cannot
C. contract provision / can
D. contract provision / cannot

Answer: C

NEW QUESTION 96
In most health plans, the formulary system is developed and managed by a P&T committee. The P&T committee is responsible for

A. evaluating and selecting drugs for inclusion in the formulary
B. overseeing the manufacture, distribution, and marketing of prescription drugs
C. certifying the medical necessity of expensive, potentially toxic, or nonformulary drugs
D. all of the above

Answer: A

NEW QUESTION 99
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 101
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 106
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 109
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 113
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 116
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 120
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 124
The following statements describe situations in which health plan members have medical problems that require care. Select the statement that describes a situation in which self- care most likely would not be appropriate.

A. Two days after bruising her leg, Avis Bennet notices that the pain from the bruise has increased and that there are red streaks and swelling around the bruised area.
B. Calvin Dodd has Type II diabetes and requires blood glucose monitoring tests several times each day.
C. Caroline Evans has severe arthritis that requires regular exercise and oral medication to reduce pain and help her maintain mobility.
D. Oscar Gracken is recovering from a heart attack and requires ongoing cardiac rehabilitation.

Answer: A

NEW QUESTION 129
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 131
Performance variance can be classified as either common cause variance or special cause variance. The following statement(s) can correctly be made about special cause variance:
* 1. Inadequate staffing levels, employee errors, and equipment malfunctions are examples of special cause variance
* 2. Special cause variance is typically more difficult to detect and correct than is common cause variance

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

Answer: B

NEW QUESTION 135
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 137
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 138
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 143
Determine whether the following statement is true or false:
The utilization review (UR) process produces the greatest number of case management referrals.

A. True
B. False

Answer: A

NEW QUESTION 147
Since its inception, Medicare has undergone a number of changes because of legal and regulatory action. One result of the Balanced Budget Act (BBA) of 1997 has been to

A. expand Medicare benefits by mandating coverage for certain preventive services
B. reduce the number of organizations that can deliver covered services
C. encourage growth of managed Medicare programs in all markets
D. increase the number of “zero premium” plans available to Medicare beneficiaries

Answer: A

NEW QUESTION 150
Determine whether the following statement is true or false:
All health plans participating in the Federal Employee Health Benefits Program (FEHBP) are required to use the Consumer Assessment of Health Plans (CAHPS) to measure customer satisfaction.

A. True
B. False

Answer: A

NEW QUESTION 154
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 159
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 164
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 167
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 168

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 169
The following statement(s) can correctly be made about medical management considerations for the Federal Employee Health Benefits Program (FEHBP):
* 1. FEHBP plan members who have exhausted the health plan's usual appeals process for a disputed decision can request an independent review by the Office of Personnel Management (OPM)
* 2. All health plans that cover federal employees are required to develop and implement patient safety initiatives

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

Answer: A

NEW QUESTION 171
The following statements are about health plans' use of electronic data interchange (EDI). Three of the statements are true and one is false. Select the answer choice containing the FALSE ALSE statement.

A. One advantage of EDI over manual data management systems is improved data integrity.
B. EDI may use the Internet as the communication link between the participating parties.
C. EDI involves back-and-forth exchanges of information concerning individual transactions.
D. The data format for EDI is agreed upon by the sending and receiving parties.

Answer: C

NEW QUESTION 176
The following statements are about medical management considerations for dental care. Select the answer choice containing the correct statement.

A. Managed dental care organizations are regulated at the state rather than the federal level.
B. Dental care differs from medical care in that most dental care is provided by specialists.
C. Dental preferred provider organizations (Dental PPOs) are subject to more regulation than are dental health maintenance organizations (DHMOs).
D. Managed dental plans are accredited by the National Association of Dental Plans (NADP).

Answer: A

NEW QUESTION 181
Demetrius Farrell, age 82, is suffering from a terminal illness and has consulted his health plan about the care options available to him. In order to avoid unwanted, futile interventions, Mr. Farrell signed an advance directive that indicates the types of end-of-life medical treatment he wants to receive. His family is to use this document as a guide should Mr. Farrell become incapacitated.
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
Decisions regarding Mr. Farrell's end-of-life care are legally the right and responsibility of

A. M
B. Farrell and his family
C. M
D. Farrell's physician
E. M
F. Farrell's health plan
G. All of the above

Answer: A

NEW QUESTION 184
Access to services is an important issue for both fee-for-service (FFS) Medicaid and managed Medicaid programs. Access to services under managed Medicaid is affected by the

A. lack of qualified providers in provider networks
B. lack of resources necessary to establish case management programs for patients with complex conditions
C. unstable eligibility status of Medicaid recipients
D. inability of Medicaid recipients to change health plans or PCPs

Answer: C

NEW QUESTION 188
The nature of behavioral healthcare creates unique medical management challenges for health plans. One method health plans have used to support the delivery of appropriate services in a cost-effective manner is to

A. remove behavioral healthcare services from the primary care setting
B. shift behavioral healthcare from acute inpatient settings to alternative settings when feasible
C. reserve the use of psychotherapy for treatment of those conditions that persist over long periods of time or for the life of the patient
D. offer the same level of compensation to all of the professional disciplines that provide behavioral healthcare services to plan members

Answer: B

NEW QUESTION 190
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 191
In order to achieve changes in outcomes, health plans make changes to existing structures and processes. The introduction of preauthorization as an attempt to control overuse of services is an example of a reactive change. Reactive changes are typically

A. both planned and controlled
B. planned, but they are rarely controlled
C. controlled, but they are rarely planned
D. neither planned nor controlled

Answer: C

NEW QUESTION 193
Administrative action plans are used when performance problems or opportunities are related to the way the organization itself operates. The following statement(s) can correctly be made about administrative action plans:
* 1.Administrative action plans allow health plans to coordinate management activities
* 2.One function of administrative action plans is to integrate service across all levels of the organization
* 3.Administrative action plans are designed to improve outcomes by helping plan members assume responsibility for their own health

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

Answer: B

NEW QUESTION 198
A health plan's coverage policies are linked to its purchaser contracts. The following statement(s) can correctly be made about the purchaser contract and coverage decisions:
* 1. In case of conflict between the purchaser contract and a health plan's medical policy or benefits administration policy, the contract takes precedence
* 2. Purchaser contracts commonly exclude custodial care from their coverage of services and supplies
* 3. All of the criteria for coverage decisions must be included in the purchaser contract

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

Answer: B

NEW QUESTION 203
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 206
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
The QAPI (Quality Assessment Performance Improvement Program) is a Centers for Medicaid and Medicare Services (CMS) initiative designed to strengthen health plans' efforts to protect and improve the health and satisfaction of Medicare beneficiaries. QAPI quality assessment standards apply to

A. standard medical-surgical services
B. mental health and substance abuse services
C. services offered to Medicare enrollees as optional supplementary benefits
D. all of the above

Answer: D

NEW QUESTION 208
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