Chapter 1

Pretest

The following questions are offered to assist you in targeting areas in which you may require an additional focus in preparing to earn designation as a board-certified case manager as presented by the Commission for Case Manager Certification (CCMC). To assist you in responding to these questions or any of the sample questions offered within this guide, consider the following test-taking techniques.

- Read each question twice. If you have a tendency to scan information, scanning the question rather than understanding the specific "ask" within that question is not recommended. Some questions may contain modifiers such as the words *not*, *never*, *always,* or *isn't*. If you do not read each unique word and any associated modifier, the intent of the question may be misunderstood.
- Read all four answers before making a choice. Sometimes, the first answer may appear to be correct and a subsequent answer may be even more accurate. The timeframe for taking the examination is more than adequate and rushing through the examination without giving appropriate time to each question is never recommended.
- Questions that are lengthy and offer a significant narrative require an even greater focus. Read the questions and all four answers and then review the question a second time. The computer system may allow you to delete or cross out responses that are inaccurate. If this option is available, cross out incorrect responses so that you can focus on those answers that may be right and choose the one answer that is most correct.
- If you are unable to decide between two answers, review each response in relationship to the question rather than comparing each response to the other responses.
- The questions presented within the examination were developed by a group of subject matter experts and validated within previously offered testing cycles. It is important to remember that case management is more of an art than a science and, as such, differing opinions may arise in response to both the questions offered within the examination and the sample questions presented within this study guide. Remember, in both instances, the answers identified as correct are based on the authors of those questions. It is fruitless to argue or to lament when you disagree with the response presented or the correct answer that was identified. Instead, remember the content of the examination is the sole responsibility of the

certification body and the answers they identify as correct are correct because they have been identified as such.

- When in doubt regarding the correct response, the computer offers the capability of striking out responses that you have identified as incorrect. Additionally, the system will allow you to highlight the responses you believe are correct. Instructions regarding the specific capabilities of the computer system are available prior to initiating the test. The time spent reviewing these instructions will not be deducted from the time allotted to finish the examination.
- Since there is no penalty in this examination for an incorrect response, guess based on your best judgment. If all else fails, choose the response with the most words.

Test Questions

1) **The extent to which an individual's behavior including taking medication, following a diet, and/or executing lifestyle changes corresponds with agreed recommendations from a health care provider is defined as**
   A. Patient activation.
   B. Patient compliance.
   C. Patient adherence.
   D. Concordance.

2) **Mrs. Brown has a history of 40 years of addiction to cigarette smoking. She was recently diagnosed with stage 2 chronic obstructive pulmonary disease. With the support of her significant other, she has stated that her current purchase of one pack of cigarettes will be the last cigarettes she will ever buy and has been researching available smoking-cessation support groups via the Internet. She also received a prescription for a medication that might assist in advancing her ability to quit smoking. Her current actions represent which stage of health behavioral change?**
   A. Precontemplation.
   B. Contemplation.
   C. Preparation.
   D. Taking action.

3) **Being of short stature, Mr. Jones utilizes a stepping stool and a reacher to gain access to items on the top shelf of his kitchen cabinets. The tools he utilizes to gain access to necessary items are an example of**
   A. Rehabilitative technology.
   B. Universal design.
   C. Adaptive devices.
   D. Assistive devices.

4) **The Patient Protection and Affordable Care Act more commonly referred to as the Affordable Care Act (ACA) includes the extension of health care benefits to children up to age 26 under a parent's health plan. The ACA also prohibits the exclusion of preexisting conditions from health care insurance policies and any increase in insurance premiums based on health status or gender. In addition to advancing the opportunity to obtain health care coverage, the ACA also supported the development of a National Quality Strategy. A component of this strategy that seeks to reward providers for the delivery of quality health care services is**
   A. A quality benchmarking database provided by the National Committee on Quality Assurance.
   B. The reporting and associated financial impact of the Hospital Consumer Assessment of Healthcare Providers and Systems surveys.
   C. The utilization of payment provisions associated with the incidence of hospital-acquired conditions.
   D. Value-based purchasing.

5) **A case management model that represents brief case management interventions in order to empower the patient to identify his or her own needs and to offer the patient ancillary or supportive services to meet those needs is**
   A. The integrated model of case management.
   B. The strengths-based model of case management.
   C. The engagement and empowerment model.
   D. The brokerage model.

6) **An important aspect of each case management evaluation is an assessment of the degree to which a patient demonstrates the capacity to obtain, process, and understand basic information and services needed to make appropriate health decisions. This is commonly referred to as an evaluation of the patient's**
   A. Literacy.
   B. Health literacy.
   C. Cultural-based understanding and competency.
   D. Goal-based learning process.

7) **The prospective payment model utilized to facilitate payment of Medicare claims for acute care hospitalization was introduced in 1983 and was based on a fixed, predetermined amount associated with the patient's diagnosis rather than the type and number of services provided. Following introduction of this reimbursement system, most hospitals developed**
   A. Risk management departments.
   B. Case management models.
   C. Targeted admission programs focused on diagnosis.
   D. Transitional care programs.

8) **A comprehensive process that matches human performance levels to the demands of a specific job, work activity, or occupation while establishing the appropriate level of work an injured employee can perform is**
   A. A work-hardening program.
   B. A functional independence measure and evaluation.
   C. A functional capacity evaluation.
   D. An independent medical evaluation.

9) **Clinical quality measures as defined by the Centers for Medicare and Medicaid Services include**
   A. Specific and detailed national standards of care that represent the best clinical practice across all practice settings.
   B. Written, quantifiable, and time-sensitive statements of the expected results of health care processes and procedures associated with the delivery of medically necessary care.
   C. Tools developed to detail accountability associated with research, proximity, accuracy, and adverse events.
   D. Tools that assist in the measurement and tracking of the quality of health care services with a focus on delivering care that is safe, timely, effective, efficient, equitable, and patient centered.

10) **Observation status is covered under Medicare**
   A. Part A.
   B. Part B.
   C. Part D.
   D. Part E or a Medigap program.

11) A patient who immigrated to the United States from Turkey over 20 years ago was recently admitted to an inpatient rehabilitation facility for comprehensive rehabilitative services associated with a cerebrovascular event with right-sided hemiparesis. His family is extremely attentive and will not allow him to actively feed himself at any meal. Members of the rehabilitation team identify that the patient's religious beliefs disallow using the left hand for eating and adapt the rehabilitation plan to reflect a consideration of the patient's culture. This action is a form of

A. Cultural competence.
B. Ethnocentrism.
C. Managing health disparities.
D. Cultural and linguistic sensitivity.

12) Confirmation and communication of each medication appropriately and consciously continued, discontinued, or modified at each transition of care is

A. A role of pharmacists within each environment of and setting for health care delivery.
B. Not required but recommended within a retail or managed pharmacy delivery system.
C. A National Patient Safety Goal presented by the Institute for Healthcare Improvement.
D. Medication reconciliation.

13) A map that assists the patient to move through all sites of care including the efficient transition from one setting of care to another is

A. Consistently developed and implemented to reflect and support evidence-based guidelines.
B. Considered to be a form of critical pathway.
C. A care coordination algorithm.
D. A case management plan.

14) The process by which a person with developmental disabilities is assisted in acquiring and maintaining life skills to cope more effectively with personal and developmental demands while increasing the level of physical, mental, vocational, and social ability through services is

A. Habilitation.
B. Supportive employment.
C. Residential rehabilitation.
D. Community living and education.

15) Which of the following offers the best description of Medicaid?

A. A national health insurance program established by the Social Security Act in 1935.
B. A federally funded health insurance program that grants eligibility to individuals who receive Social Security Disability Insurance.
C. A state-regulated program funded by federal, state, and local taxes.
D. A health insurance program jointly funded by federal and state taxes for low-income individuals.

16) Medicare Part B

A. Provides benefit coverage for inpatient rehabilitation facilities and skilled nursing care.
B. Is provided to American citizens over age 65 and individuals with certain qualifying disabilities with no additional cost to Medicare eligible beneficiaries.
C. Provides benefit coverage for physician services.
D. Is not subject to value-based purchasing initiatives.

17) **Beneficence, an ethical consideration for the case manager, is defined as**
A. Telling the truth.
B. Maintaining respect for an individual's right to self-determination.
C. Acting for the good of the individual.
D. Demonstrating loyalty and dedication to the individual served.

18) **Process of care measures that include medical information from medical records converted into a rate or percentage that demonstrate the effectiveness, efficiency, or efficacy of care include all of the following except**
A. The Surgical Care Improvement/Surgical Infection Prevention Process of Care Measures.
B. Core measures that reflect information associated with adult medical or surgical care.
C. The Hospital Consumer Assessment of Healthcare Providers and Systems Survey.
D. 30-day risk-adjusted mortality rates that are produced from Medicare claims and enrollment data using a complex statistical model.

19) **The five primary ethical principles associated with a practice of case management include beneficence, veracity, nonmaleficence, justice, and**
A. Competency.
B. Morality.
C. Confidentiality.
D. Autonomy.

20) **A process that assesses, analyzes, researches, and evaluates a patient's future medical, psychological, and economic needs is**
A. Case management.
B. Vocational rehabilitation counseling.
C. Life care planning.
D. Transitional care management.

21) **Disease management programs emphasize prevention of disease-related exacerbations and avoidable complications through the utilization of evidence-based practice guidelines and**
A. Pay for performance incentives.
B. Performance of regular cost-benefit analyses.
C. Annual risk management.
D. Patient empowerment strategies.

22) **A standardized program for evaluating health care organizations to ensure a specified level of quality, as defined by a set of national industry standards, is**
A. Certification.
B. Accreditation.
C. Endorsement.
D. Credentialing.

23) **A not-for-profit, nonpartisan, consensus, and membership-based organization that works to catalyze improvements in health care through the development of quality measures that are often incorporated into federal reporting and pay-for-performance initiatives is**
A. The Agency for Healthcare Research and Quality.
B. The American Board of Quality Assurance and Utilization Review Physicians.
C. URAC.
D. The National Quality Forum.

24) Negotiation is considered to be

A. A communication exchange for establishing agreement.
B. A process that includes the sending and receiving of information in order to facilitate discourse.
C. A mutual and formal communication process in order to identify and to achieve conversational goals.
D. A dialogue that advances the goals of both communication partners.

25) Groups of physicians, hospitals, and other health care providers that come together voluntarily to coordinate the delivery of high-quality care in order to ensure patients receive the right care, at the right time while avoiding the unnecessary duplication of services and reducing adverse events are considered to be

A. A Patient-Centered Medical Home.
B. An Accountable Care Organization.
C. A Physician Hospital Organization.
D. A Federally Qualified Health Center.

26) The patient has a complicated home health plan that includes multiple providers of home health care services including durable medical equipment, ancillary supplies, and infusion therapy; the continued oversight of both the primary care physician and a pulmonologist; and the engagement of the family as primary caregivers. The case manager coordinates the appropriate delivery of necessary equipment and services as well as facilitating comprehensive education to the patient and family regarding all elements of the continuing care plan and communicates each aspect of the plan to the treating physicians. The process that ensures the coordination and continuity of health care as the patient transfers between different locations of care is

A. Discharge planning.
B. Care management.
C. Patient navigation.
D. Care coordination.

27) A type of health insurance plan that offers lower copayments when the beneficiary utilizes the care and services offered by contracted providers is

A. An indemnity insurance plan.
B. An accountable care organization.
C. A health maintenance organization.
D. A preferred provider organization.

28) Utilization management is defined as

A. The use of communication and available resources to promote health, quality, and cost-effective outcomes in support of the "Triple Aim" of improving the experience of care, improving the health of populations, and reducing per capita costs of health care.
B. The process of evaluating the necessity, appropriateness, and efficiency of health care services against established guidelines and criteria.
C. A process that advances payment for health care interventions and services across all settings for and sites of care.
D. A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.

29) **An organized, coordinated, and collaborative network that provides a linkage to various health care providers in order to provide a coordinated, vertical continuum of services to a particular patient population or community is**
A. An integrated delivery system.
B. A health care home.
C. An accountable care organization.
D. A federal qualified health center.

30) **Performance measures developed by the National Committee for Quality Assurance that serve to measure the care and services provided by health plans are elements of the**
A. Wellness and Promotion Measure Set.
B. Healthcare Effectiveness Data and Information Set.
C. Star Ratings.
D. Shared Savings Program Quality Measurement Set.

31) **Hospital systems are reimbursed by the Centers for Medicare and Medicaid Services on a prospective payment system that provides a means of relating the type of patients a hospital treats or case mix to the costs incurred by the hospital. The operational means by which patients are classified in regard to treatment needs and resources consumed are**
A. Case-based classifications.
B. Diagnostic related groups.
C. Capitation-purposed groups.
D. ISSI grouping systems.

32) **A patient is admitted to acute care for the management of respiratory compromise secondary to a diagnosis of stage 2 chronic obstructive pulmonary disease. It is subsequently identified that the projected length of stay will not exceed two midnights. The process that enables a change of status from admission to observation is**
A. A self-denial of inpatient admission.
B. A certification of outlier admission.
C. Condition code 44.
D. An advanced beneficiary notice.

33) **In order to advance compliance with regulations associated with delivery of health care interventions and services for Medicare and Medicaid beneficiaries, hospitals must adhere to applicable Conditions of Participation (CoPs) as presented by the Centers for Medicare and Medicaid Services. CoPs detail certain hospital functions including a requirement for**
A. A utilization of review committee composed of both practitioners and clinicians with or without a direct financial interest in the facility.
B. A utilization of review committee composed of practitioners with at least two of the members of the committee identified as doctors of medicine or osteopathy in order to review professional services provided, to determine medical necessity, and to promote the most efficient use of available health facilities and services.
C. A discharge planning process dedicated to those patients who request or the family of patients who request a discharge plan.
D. Inclusion of all geographic available home health agencies within the discharge planning process.

34) Published and maintained by the American Psychiatric Association, this system for the classification of behavioral health disorders offers a comprehensive detailing and an authoritative compilation of common definitions and criteria sets associated with those disorders.

A. International Classification of Behavioral Health and Developmental Disorders.
B. Psychological Diagnostic and Procedural Coding System.
C. *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition.
D. ICD-10-CM.

35) The initial step in the case management process is generally considered to be

A. Assessment.
B. Client identification/case selection.
C. Planning.
D. Advocacy.

36) Developed by Eric Coleman, MD, MPH, and The Care Transitions Program at the University of Colorado Denver, the Care Transitions Measure details three domains of patient experience that impact the care transition process. These domains address patient engagement in post hospital self-care activities and evaluate the incorporation of patient preferences into the discharge plan, the patient's understanding of post acute medication management, and

A. Receipt of a transitional care plan.
B. Ability to name post acute providers of care.
C. Understanding of their own or their family's responsibilities for care in the post acute environment.
D. Patient satisfaction with the discharge planning or transitional care process.

37) Characterized by advocacy, communication, and resource management, this collaborative process assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human services needs.

A. Discharge planning.
B. Case management.
C. Utilization management.
D. Care coordination.

38) A viatical life insurance settlement is defined as the sale of a life insurance policy to a third party in order to utilize the funds associated with that policy prior to death with the understanding that the dollar amount of the sale is less than the death benefit but more than the cash value of the policy. The person selling the policy generally has a reported life expectancy of less than 24 months and

A. An insurance or policy broker is required by law to provide an equity payment that exceeds 40 percent of the value of the policy's face value or death benefit.
B. The person purchasing the policy is named the beneficiary and is responsible for payment of all subsequent policy premiums.
C. Is responsible for reporting the equity payments to the Internal Revenue Service and paying all taxes associated with that income.
D. Is prohibited from entering into both a viatical settlement and a reverse mortgage.

39) Because case management exists in an environment that may look to it to solve or resolve various problems in the health care delivery and payor systems, the case manager may experience situations in which there is a need to choose between two distinct courses of action that are either equally morally acceptable or unacceptable. These situations are often referred to as

A. Conflicts of divided loyalty.
B. Professional conflicts of interest.
C. Ethical dilemmas.
D. Obstructed objectivity.

40) A delivery system that advances patient care through the coordinated services of a primary care physician while maximizing the utilization of patient registries, health information technology, and exchanges to provide health care interventions and services when and where the patient requires those services in a manner that in culturally and linguistically competent is

A. A Patient-Centered Medical Home.
B. An Accountable Care Organization.
C. A Physician Hospital Organization.
D. A Federally Qualified Health Center.

41) The mental ability and cognitive capabilities required to execute a legally recognized action rationally as established by a court of law is

A. Capacity.
B. Decisional capacity.
C. Informed consent.
D. Competency.

42) The process of uncovering current and ongoing biopsychosocial and health system strengths as well as barriers to health improvement through information provided by the client/patient or obtained from other sources of information with the client/patient's permission, including but not limited to family, guardians/caregivers, providers/health records, employers, health plans, or law enforcement is

A. Selection.
B. Assessment.
C. Evaluation.
D. Referral.

43) Meaningful use is defined as

A. The extent to which systems and devices can exchange data, and interpret that shared data in an appropriate manner.
B. A system-generated comparison of standards of care, the generation of alerts regarding potential drug interactions, and electronic warnings regarding potential adverse events in order to advance an improved quality of care.
C. The use of a certified electronic health record technology to improve the quality, safety, and efficiency of provided care.
D. The provision of a patient health record with access to evidence-based decision support tools that can be used to support the clinical decision-making process.

44) The generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care in order to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels defines

A. Outcomes research.
B. Comparative effectiveness research.
C. The continuity assessment record and evaluation set.
D. Quality improvement.

45) Representing a lesson learned from *Wickline v. State of California*, this action represents a request to reconsider a benefit determination.

A. Extension of benefit coverage.
B. Explanation of benefit coverage.
C. Peer review.
D. Appeal.

46) A collaborative, person-centered form of guiding to elicit and to strengthen the individual's desire for health behavioral change is

A. Patient activation.
B. Motivational interviewing.
C. Constructive confrontation.
D. Ambivalence counseling.

47) Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances are

A. Standards of care.
B. Protocols.
C. Evidence-based guidelines.
D. Policies and procedures.

48) Mrs. Brown is a 72-year-old Medicare beneficiary who has been continuously hospitalized for 85 days with multiple clinical issues that meet both severity of illness and intensity of service criteria. There is a reasonable expectation that she will remain hospitalized for at least 10 to 14 more days. What action or actions should be taken to advance continual Medicare coverage?

A. Continuous discharge and transitional planning to assure a timely and appropriate transfer to a lower level of care.
B. Issuance of the Important Message from Medicare on or immediately before day 89.
C. Obtaining formal consent from the beneficiary or their health care agent to access available lifetime reserve days.
D. Delivery of a noncoverage or Hospital Issued Notice of Noncoverage form to the patient on day 89.

49) A reimbursement method typically used by health maintenance organizations based on a fixed amount of money paid to a provider that provides a per-member-per-month payment regardless of the number of covered services delivered is

A. Capitation.
B. A bundled payment.
C. A prospective payment initiative.
D. Most closely associated with a value-based purchasing initiative.

50) The comprehensive assessment of occupational aptitudes and potential, using information about a person's past history, medical and psychological status, and information from appropriate career testing, which may use paper and pencil instruments, work samples, simulated work stations, or assessment in a real work environment

A. Represents an essential element of case management in a workers' compensation practice setting.
B. Is the primary role of a disability management specialist.
C. Is generally representative of a vocational rehabilitation evaluation.
D. Is mandated by the Federal Office of Personal Management.

51) A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine including but not limited to mind-body interventions, herbalism, and energy therapies is

A. Holistic medicine.
B. Complementary alternative medicine or complementary health approaches.
C. Medical botany and plant-based therapies.
D. Integrative, preventive, and biological therapeutics.

52) The Americans with Disabilities Act defines an individual with a disability as

A. A person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.
B. A person who exhibits long-term physical, mental, intellectual, or sensory impairments, which, in interaction with various attitudinal and environmental barriers, hinders their full and effective participation in society on an equal basis with others.
C. A person who exhibits an impairment in bodily functions or structure, an activity limitation as indicated by any difficulty encountered in executing a task or action, or a participation restriction such as a problem experienced by an individual related to consistent involvement in life situations.
D. A person who has been diagnosed by a physician as having a condition that restricts the ability to function physically, mentally, or socially or a documented history of exhibiting such an impairment.

53) A physician knowingly submits claims to Medicare for a higher level of medical services than he or she provided or at a higher level than the medical record documents. This action is an example of a violation of

A. The Anti-kickback Statute.
B. The Physician Self-Referral Law.
C. The Federal False Claims Act.
D. The Criminal Health Care Fraud Statue.

54) A requirement of Medicare Part D that advances optimum therapeutic outcomes for targeted beneficiaries through improved medication use, reduces the risk of adverse events, and is coordinated by pharmacists or other qualified health care professionals is

A. Medication reconciliation.
B. A pharmacy benefit management program.
C. Medication therapy management.
D. Pharmacy reconciliation and accommodation program.

55) An assessment of cognitive function that includes 11 questions, is easily administered, evaluates recall, and uses a simple scoring process is

A. Mini-Mental Status Exam.
B. Minnesota Multiphasic Personality Inventory.
C. The Mini-Cog test.
D. The Karnofsky Performance Status Scale.

56) A type of continuous quality improvement that focuses on eliminating waste, streamlining processes, reducing costs, and improving the timely delivery of services is

A. PDSA.
B. Six Sigma.
C. LEAN.
D. HFMEA.

57) A federal program dedicated to improving the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries while seeking to protect the integrity of the Medicare Trust Fund, to protect Medicare beneficiaries by addressing individual complaints, and to investigate potential violations of the Emergency Medical Treatment and Labor Act is

A. The Quality Improvement Network.
B. The Beneficiary and Family Centered Care Innovation Program.
C. The National Quality Strategy Program.
D. The QIO Program.

58) A cost-benefit analysis represents

A. An analytical procedure for determining the economic efficiency of a program, expressed as the relationship between costs and outcomes, usually measured in monetary terms.
B. Case management recommendations based on the conservation of benefit dollars.
C. A comprehensive detailing of hard and soft savings obtained through the efforts of a health care case manager.
D. A comparative detailing of costs to facilitate an extension of benefit coverage.

59) Any activity, process, or policy to reduce liability exposure including effective communication with patients and members of the health care delivery team; continuous and timely peer review; facility maintenance and compliance with regulatory requirements is considered to be

A. Quality improvement and oversight.
B. Risk management.
C. Causal factor monitoring and resolution.
D. Loss protection.

60) Medical loss ratio is defined as

A. The amount of financial loss experienced by an insurer that is reimbursed by the Centers for Medicare and Medicaid Services.
B. A ratio that reflects both an insurer's annual aggregate performance and the cost of administrative services including case management and care coordination interventions.
C. A requirement that health insurance spend a significant portion of premium income on medical care and quality improvement.
D. A financial rebate to the United States Department of Health and Human Services based on the ratio between premium income spent on medical care and cost-containment efforts and established profits.

61) **Specialized medical care for people with significant illness that is focused on providing relief from both the symptoms and the stress of a serious illness with a primary goal of improving quality of life for both the patient and his or her support system is**
A. Hospice.
B. Supportive care.
C. Holistic care.
D. Palliative care.

62) **Initially named for Katie Beckett, this governmental initiative provides Medicaid coverage for children with special health needs who are under 18 years of age and require medical care outside of an institutional setting. This form of coverage is available regardless of parental income and is referred to as**
A. A Medicaid waiver or TEFRA option.
B. Social security disability income.
C. Social security income.
D. Extended care services provided by the Division of Family and Children Services.

63) **A group health plan that is self-funded by a large employer may contract with an insurance company to process claims, prepare plan descriptions, and file governmental reports. In this relationship, the insurance company is said to provide**
A. Fiduciary intermediary services.
B. Administrative services only.
C. Actuarial services.
D. Stop-loss coverage and services.

64) **Information regarding the quality of care delivered by more than 4,000 hospitals throughout the United States that minimally details surveys of patient experiences, the timeliness and effectiveness of care, and readmission rates is available from**
A. The Institute for Healthcare Improvement.
B. The Leapfrog Group.
C. Hospital Compare.
D. The Press Ganey Improvement Portal.

65) **Conflict resolution is defined as a dynamic process of reconciling opposing arguments in a manner that promotes and protects the rights of all concerned parties. The five strategies or styles that promote conflict resolution generally include avoidance, competition, compromise, collaboration, and**
A. Isolation.
B. Accommodation.
C. Communication.
D. Resilience.

66) **The process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each is**
A. Ethnocentrism.
B. Linguistic and cultural sensitivity.
C. The Core Principle within the Culturally and Linguistically Appropriate Services Standards.
D. Cultural competency.

67) **Mary is the director of transitional care at a large acute care facility in the Southeastern United States. She uses a number of mathematical strategies and analytics to gauge the health risks and adverse events specific patients might experience during the 30 days post discharge. This application of mathematical models to forecast negative outcomes such as the probability of a readmission is referred to as**
   A. Predictive modeling.
   B. Data mining.
   C. Diagnostic analytics.
   D. Linear regression modeling.

68) **A practice that fosters the careful shepherding of health care dollars while maintaining a primary and consistent focus on quality of care, safe transitions, timely access to and availability of services and most importantly patient self-determination, and the provision of client-centered, culturally relevant care is**
   A. Care coordination.
   B. Case management.
   C. Patient navigation.
   D. Risk management.

69) **Mr. Davis experienced a work-related injury to his right hand that precludes his ability to return to work. He has completed all prescribed medical and rehabilitative care and is working with a counselor to identify training and other vocational opportunities. The case manager who is working with Mr. Davis advises the claims adjuster that the injured employee's medical condition has stabilized and further functional improvement is unlikely, despite continued medical treatment or physical rehabilitation. This stabilization of functional status is referred to as**
   A. Maximum medical improvement.
   B. Functional stabilization with continued disability.
   C. Impairment with diminished functional capacity.
   D. A primary trigger for referral to a disability management specialist.

70) **A process that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time is**
   A. Case management.
   B. Disease management.
   C. Care coordination.
   D. Transitional care management.

71) **The Emergency Treatment and Active Labor Act (EMTALA) requires public access to emergency services regardless of the patient's ability to pay for those services. Based on this legislative action, Medicare-participating hospitals with emergency departments are required to provide a medical screening examination (MSE) to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition (EMC) including active labor. Additionally, EMTALA**
   A. Applies to all individuals not solely Medicare and Medicaid beneficiaries.
   B. Limits care to the provision of minimal emergency services with no provision for transfer unless a transfer is requested by the patient.
   C. Limits the delivery of such services to emergency departments operating within the auspices of a tertiary care facility.
   D. Is limited to the participating facility and does not include physicians who are responsible for the examination, treatment, or transfer of the individual.

72) **Medicare coverage for hospice services is provided under Part A and may be offered as a home or inpatient hospice benefit. Generally provided for a six-month period based on an expectation that death will be imminent during that period, the duration of hospice benefits may be extended**
   A. If at the start of each subsequent 60-day benefit period, the hospice medical director or other hospice doctor recertifies that the patient continues to be terminally ill.
   B. If hospice services continue to be medically necessary and appropriate as established by a utilization management process.
   C. When requested by a terminally ill patient and/or health care agent.
   D. Based on medical need, physician certification, and maintenance of Part B premiums in order to facilitate payment of physician and other provider services.

73) **An ongoing process and key function performed by a case manager that occurs intermittently along the case management continuum in order to determine the efficacy of the case management plan of care and client's progress toward achieving targeted goals is**
   A. Advocacy.
   B. Assessment.
   C. Evaluation.
   D. Outcomes management.

74) **The ethical principle that includes the concepts of fairness and equality in terms of access to resources and treatment by others is**
   A. Autonomy.
   B. Fidelity.
   C. Nonmaleficence
   D. Justice.

75) **Assisting the patient and his or her support system to navigate health care delivery systems based on the patient's individual values, beliefs, culture, interests, and desires is defined as**
   A. Planning.
   B. Advocacy.
   C. Facilitation.
   D. Ethical competency.

NOTES

Answer Key

1) ANSWER: C

According to information available from the World Health Organization, patient adherence is "the extent to which a person's behavior—taking medication, following a diet, and/or executing lifestyle changes—corresponds with agreed recommendations from a health care provider."

Compliance represents a more paternalistic attitude toward the patient on the prescriber's part and the use of this term is no longer recommended.

Concordance implies that the prescriber and patient have come to an agreement about the regimen that the patient will follow. It does not indicate or confirm adherence and persistence with the prescribed plan of care.

2) ANSWER: C

The stages of health behavior change are generally considered to be precontemplation, contemplation, preparation, taking action, and maintenance. The patient described in this question has moved beyond contemplation, the active process of planning to change, but has not yet implemented change-making behaviors. She is, therefore, in the preparation stage that includes developing a plan of action designed to promote the desired health behavioral change.

3) ANSWER: D

According to the Commission for Case Manager Certification, an assistive device is "any tool that is designed, made, or adapted to assist a person to perform a particular task." Rehabilitative technologies represent the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, employment, transportation, independent living, and recreation. Universal design advances the idea that all new environments and emerging products, to the greatest extent possible, should be usable by everyone regardless of their age, ability, or circumstance, providing the same means of use to all users, avoiding segregation, and making the design appealing to all.

4) ANSWER: D

Value-based purchasing (VBP) is a payment philosophy developed subsequent to the passage of the Affordable Care Act. VBP rewards providers for the provision of quality health care interventions and services. Although the specific components of the VBP program vary from year to year, key elements of the program include incentives based on the quality of care provided to Medicare beneficiaries, delivery of care in a manner that is reflective of best clinical practice, and the patient's experiences or satisfaction with care. The Hospital Consumer Assessment of Healthcare Providers and Systems is one avenue for gauging patient satisfaction and/or the patient experience of care.

5) ANSWER: D

Although there appears to be some discussion regarding the number, classification, and definitions of specific case management models, consensus regarding the brokerage model has been established. This case management model is defined as a minimal number of case management

interventions during which the case manager supports the patient in self-identification of needs and actively brokers ancillary or supportive services.

6) ANSWER: B

Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. The term *literacy* is limited to a person's capacity to read and write. Goal-based learning includes processes that empower learners to take control of their own learning journeys while encouraging social connections and knowledge sharing.

7) ANSWER: B

Prior to the implementation of prospective payment systems, acute care facilities were paid based on a fee-for-service schedule. Cost-containment processes were generally limited to establishing usual, reasonable, and customary charges and auditing charges to confirm the delivery of billed services. With the implementation of prospective payment, the financial viability of a hospital became dependent on the ability to provide quality and appropriate care in a cost-effective manner. A timely, safe, and efficient patient journey became the focus of every acute care provider in order to maximize reimbursement. To achieve those goals and foster a careful shepherding of resources, case management models were implemented to support the patient's health care journey in a manner that balanced fiscal responsibility with patient advocacy. Looking at both utilization management and appropriate transitional planning, case management became a vital element in advancing the ability of acute care environments to maximize reimbursement and enhance the quality of care across and through the health care continuum.

8) ANSWER: C

Although each of these terms is in some manner associated with return to work or an evaluation of a disabled individual's abilities, the only term that describes an evaluation of an individual's ability to perform major job responsibilities is a functional capacity evaluation (FCE). The Commission for Case Manager Certification defines an FCE as "a systematic process of assessing an individual's physical capacities and functional abilities. The FCE matches human performance levels to the demands of a specific job or work activity or occupation."

9) ANSWER: D

The Centers for Medicare and Medicaid Services defines clinical quality measures (CQMs) as "tools that help measure and track the quality of health care services provided by eligible professionals, eligible hospitals and critical access hospitals (CAHs) within our health care system. These measures use data associated with a providers' ability to deliver high-quality care or relate to long-term goals for quality health care. CQMs measure many aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagement, population and public health, and adherence to clinical guidelines."

10) ANSWER: B

Outpatient observation services are defined by the Centers for Medicare and Medicaid Services as a "well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge." As an outpatient service, it is covered under Medicare Part B.

11) ANSWER: A

Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professions to work effectively in cross-cultural situations. Understanding an individual's cultural beliefs assists in the formulation and delivery of a case management and care coordination plan that meets all the patient's biopsychosocial needs.

Ethnocentrism is the belief that one's culture is superior to all other cultures, and health disparities are population-specific differences in the presence of disease, health outcomes, or access to health care that are not necessarily related to cultural differences.

12) ANSWER: D

Medication reconciliation includes timely communication and confirmation of each medication appropriately and consciously continued, discontinued, or modified as the patient moves through each transition of care. Medication reconciliation is not solely the role of the pharmacist and is considered a responsibility of each member of the health care delivery team as the patient moves through the health care continuum. It is one of the National Patient Safety Goals presented by the Joint Commission.

13) ANSWER: D

The Standards of Practice for Case Management as presented by the Case Management Society of America define a case management plan as "a comprehensive plan that includes a statement of the client's care needs, opportunities, and goals determined upon a thorough assessment of the client; strategies to address these needs; and measurable outcomes to demonstrate resolution of the care needs and achievement of goals, the time frame, the resources available, and the desires and motivation of the client. The plan of care should address the multiple conditions the client suffers and the necessary involvement of providers and support service personnel within and across care settings."

14) ANSWER: A

The Commission for Case Manager Certification defines habilitation as "a process by which a person with developmental disabilities is assisted in acquiring and maintaining life skills to cope more effectively with personal and developmental demands; and to increase the level of physical, mental, vocational and social ability through services. Persons with developmental disabilities include anyone whose development has been delayed, interrupted, or stopped/fixed by injury or disease after an initial period of normal development, as well as those with congenital condition." Supportive employment is a type of paid employment for persons for developmental disabilities for whom competitive employment is unlikely because of their disabilities in a setting in which persons without disabilities are employed.

15) ANSWER: D

Established by Title XIX of the Social Security Act in 1965, Medicaid is a health insurance program that is a joint initiative of both state and federal governments. Medicaid is available to people with limited income and resources and may provide for some services not covered by Medicare. These services typically include custodial care in a nursing home and personal care services. Individuals with both Medicare and Medicaid coverage are considered to be dual eligibles.

16) ANSWER: C

According to information available at Medicare.gov, Medicare Part B covers medically necessary and preventive services including ambulance services, durable medical equipment, behavioral health care and services, outpatient services including observation, physician services, and some home health care services. Medicare beneficiaries are required to pay a monthly premium for Medicare Part B coverage.

17) ANSWER: C

The Case Management Society of America published a Statement of Ethical Case Management Practice that defines beneficence as "the obligation or duty to promote good, to further a person's legitimate interests, and to actively prevent or remove harm." *Veracity* is defined within that same document as "truth-telling" and *autonomy* is defined as "a form of personal liberty of action when the individual determines his or her own course in accordance with a plan chosen by himself or herself."

18) ANSWER: C

Of the four items listed, only the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) does not obtain information from medical records or claims processing systems. HCAHPS is a standardized survey instrument and data collection methodology that measures the patient's perspectives of and satisfaction with hospital care.

19) ANSWER: D

The five ethical principles associated with the practice of case management are beneficence, veracity, nonmaleficence, justice, and autonomy.

20) ANSWER: C

The Commission for Case Manager Certification defines a life care plan as "a dynamic document based upon published standards of practice, comprehensive assessment, research and data analysis, which provides an organized, concise plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic healthcare needs." Life care planning is the process that assesses, analyzes, researches, and evaluates a patient's future medical, psychological, and economic needs in order to develop that plan. Vocational rehabilitation counseling is a term more closely associated with a process that guides a disabled individual in the selection of a vocation or occupation.

21) ANSWER: D

Based on information available from the Academy of Managed Care Pharmacy, "disease management is the concept of reducing health care costs while improving the quality of life for individuals with chronic diseases by preventing or minimizing the effects of disease through integrated care." Disease managers empower individuals to understand their disease, understand the steps necessary to address the identified disease state, and comprehend the value of adhering to the established treatment plan.

Although health risk assessments facilitate the collection and analysis of information that may be utilized to identify and select individuals who might realize the benefits of a disease management program, that selection process does not guarantee the achievement of desired patient and program outcomes.

22) ANSWER: B

Accreditation is defined as a process for evaluating organizations to confirm a specified level of quality as defined by established standards. Certification is a process in which an individual not an organization is recognized for meeting both a recognized set of eligibility criteria and successfully achieving a passing score on an examination. The content of the examination represents the core body of knowledge required to practice in that professional field. Credentialing is a formal verification of a professional's licensure, certification, knowledge, skills, and abilities.

23) ANSWER: D

The National Quality Forum was created by a coalition of both private and public sector leaders to promote and ensure patient protections and health care quality through measurement and public reporting. This not-for-profit, nonpartisan organization develops defined measures and evidence-based approaches to improve health care delivery in America. The

Agency for Healthcare Research and Quality is a federal government agency that is charged with researching strategies that advance the quality and the delivery of safer health care services to the American public. URAC is a nonprofit organization that promotes accreditation of health care organizations including organizations that provide case management interventions and services.

24) ANSWER: A

Negotiation is a communication process or exchange with a primary goal of establishing agreement. Negotiation is not always a formal process and the goals of the engaged communication parties may not be met, but a mutually accepted outcome may be formulated and accepted by the negotiation partners. Communication is defined as the exchange of information between a sender and a receiver.

25) ANSWER: B

An Accountable Care Organization (ACO) is a group of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients with the primary goal of providing the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. ACOs that are successful in providing cost-efficient care share in the savings achieved for Medicare patients. A Patient-Centered Medical Home (PCMH) is a type of care provided by a primary physician that is patient-centered, multidisciplinary or team-based, coordinated, accessible, and focused on advancing quality, appropriate, and cost-efficient care. PCMHs frequently utilize case management professionals to assist in obtaining desired outcomes of care.

26) ANSWER: D

Although some may argue the correct response might be all or any of the potential answers, only care coordination specifically addresses the continuity of care across all locations or settings for care. Based on information available from the National Quality Forum, care coordination "is a multidimensional concept that encompasses effective communication between patients and their families, caregivers and health care providers; safe transitions; a longitudinal view of care that considers the past while monitoring delivery of care in the present and anticipating the needs of the future; and the facilitation of linkages between communities and the health care system to address medical, social, educational, and other support needs in alignment with patient goals." Case management is defined by the Case Management Society of America as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes."

27) ANSWER: D

A preferred provider organization (PPO) is a health insurance plan that provides enrollees or insureds with access to both in-network and out-of-network care. PPOs offer lower cost-sharing requirements when health care services are obtained from in-network providers and higher out-of-pocket costs when utilizing out-of-network providers.

A traditional indemnity plan or fee-for-service plan provides insurance coverage for health care interventions based on the amount of billed services. Indemnity plans offer the freedom to choose care from any provider, do not require referrals for specialty care, and offer compensation based on a set amount or percentage of billed charges.

A health maintenance organization (HMO) is a health care delivery system that presents the insured with a specific network of health care providers and limits benefit coverage to that network. While PPOs provide some benefit coverage for out-of-network providers, HMOs will only allow an extension of benefit coverage to out-of-network providers in limited emergencies. HMOs

utilize a number of care coordination and cost-containment strategies including the delivery of integrated care and a focus on disease prevention, disease management, and wellness strategies.

28) ANSWER: B

Utilization management is defined by the Commission of Case Manager Certification (CCMC) as a "review of services to ensure that they are medically necessary, provided in the most appropriate care setting, and are at or above quality standards."

Case management is defined by the CCMC as a "professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the 'Triple Aim' of improving the experience of care, improving the health of populations, and reducing per capita costs of health care."

29) ANSWER: A

An integrated delivery system "is an organized, coordinated, and collaborative network that links various healthcare providers to provide a coordinated, vertical continuum of services to a particular patient population or community. It is also accountable, both clinically and fiscally, for the clinical outcomes and health status of the population or community served, and has systems in place to manage and improve them."

A federal qualified health network is defined by the Centers for Medicare and Medicaid Services as "safety net" providers* such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the federal qualified health center program is to enhance the provision of primary care services in underserved urban and rural communities. (*Safety net providers organize or deliver care to uninsured, Medicaid, and other vulnerable patients.)

30) ANSWER: B

According to information available from the National Committee on Quality Assurance, the Healthcare Effectiveness Data and Information Set is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

Star Ratings as provided by the Centers for Medicare and Medicaid Services (CMS) represent an overall rating of the quality and performance offered by Medicare Advantage plans that offer insurance coverage to Medicare beneficiaries. The five areas rated by this system include health promotion, the management of chronic disease states, patient satisfaction, identified problems with the plan by CMS or plan members, and customer services including the handling of appeals. Medicare beneficiaries may switch from their current plan to a 5-star Medicare Advantage Plan that is available in their geographic area at any time during the year.

31) ANSWER: B

A Diagnosis-Related Group (DRG) is a statistical system of classifying any inpatient stay into groups for the purposes of payment. In 2007, the severity-adjusted DRG system was introduced. Referred to as the Medicare Severity DRG, this form of reimbursement strategy is based on specific calculations related to a set of patient attributes that include principal diagnosis, specific secondary diagnoses, procedures, sex, and discharge status.

32) ANSWER: C

According to information available from the Centers for Medicare and Medicaid Services, a physician may write an order to admit a Medicare beneficiary to an inpatient bed and if it is subsequently identified that an inpatient level of care does not meet established admission criteria, the patient's status may be changed from inpatient to observation. A change

to observation status can only occur if the delivery of outpatient services is deemed to be a medically necessary and appropriate level of care. The process that is utilized to facilitate this change from inpatient admission to outpatient status is referred to as Condition Code 44.

An advanced beneficiary notice is a notification that a provider must present to a Medicare patient in situations in which there is an expectation that Medicare coverage for prescribed services is not available.

33) ANSWER: B

According to information available from the Centers for Medicare and Medicaid Services, the hospital must have in effect a utilization review (UR) plan that provides for a review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. A component of that plan is the composition of the facility-specific UR committee. The committee shall be composed of two or more practitioners with at least two being doctors of medicine or osteopathy. Additionally, any individual who has a financial interest in the hospital may not perform committee reviews.

In regard to discharge planning, the Conditions of Participation: Discharge Planning require each hospital to have in effect a discharge planning process that applies to all patients. An evaluation of a patient's discharge needs shall include a review of the likelihood that post acute care and services will be needed. Medicare also requires that a list of Medicare-certified home health agencies that serve the geographic area in which the patient resides and that request to be included on the list be provided to patients as appropriate.

34) ANSWER: C

The *Diagnostic and Statistical Manual of Mental Disorders* is an authoritative guide to the diagnosis of mental disorders published by the American Psychiatric Association. This comprehensive tool for diagnosing behavioral health disorders includes descriptions and symptoms as well as criteria sets for facilitating an accurate diagnosis of behavioral health disorders.

35) ANSWER: B

The Standards of Practice for Case Management as presented by the Case Management Society of America list the primary steps of the case management process as screening patients to determine appropriateness for inclusion in case management programs, engagement of the patient and family in the case management process, and "obtaining consent for case management services as part of the case initiation process."

36) ANSWER: C

The Care Transitions Measure is a three-item measure of the patient's experience with the discharge planning or transitional care process. It addresses:

- The patient's understanding of his or her own role in providing necessary care post discharge.
- The patient's understanding of the post acute medication regimen.
- The extent to which the patient's preferences and values were incorporated into the post acute plan of care.

These three measures have been added to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The Centers for Medicare and Medicaid Services publishes hospital-specific HCAHPS scores on their Hospital Compare website as a resource for health care consumers. This advances the ability of a consumer to make more improved choices regarding providers of health care services. Additionally, acute care facilities may gain or lose a portion of their Medicare payments based on the results of these patient-directed surveys.

37) ANSWER: B

The Code of Professional Conduct for Case Managers with Standards, Rules, Procedures, and Penalties as presented by the Commission for Case Manager Certification (CCMC) defines case

management as "a professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the 'Triple Aim,' of improving the experience of care, improving the health of populations, and reducing per capita costs of health care."

CCMC also provides definitions for the terms *care coordination, discharge planning*, and *utilization management* as follows:

Care coordination: "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."

Discharge planning: "the process of assessing the patient's needs of care after discharge from a healthcare facility and ensuring that the necessary services are in place before discharge. This process ensures a patient's timely, appropriate, and safe discharge to the next level of care or setting including the appropriate use of resources necessary for ongoing care."

Utilization management: "review of services to ensure that they are medically necessary, provided in the most appropriate care setting, and at or above quality standards."

38) ANSWER: B

A viatical settlement is an arrangement whereby a person with a terminal illness sells their life insurance policy to a third party for less than its mature value, in order to benefit from the proceeds while alive. The entity that purchased the policy is able to obtain the full amount of the policy when the original owner dies. In order to maintain the viability of the policy, the purchaser who is now considered the beneficiary of that policy must provide payment of all insurance premiums until such time that the insured party dies and the death benefit is available.

Both a life insurance policy and a home are considered to be property and, therefore, the owner of a home may seek both a reverse mortgage and a viatical settlement.

39) ANSWER: C

An ethical dilemma arises when two or more ethical or moral principles are in conflict and no single resolution resolves the dilemma. For, example, a patient advises the case manager that she is unable to return to her home environment due to an inability to navigate the multiple levels and associated stairways within her home. She requests information regarding assisted living facilities in her geographic area and indicates she has the funds to self-pay. The patient's son contacts the case manager and indicates his mother has no available funds and only a skilled nursing environment, if covered by Medicare, would be acceptable to the family. Which site for discharge does the case manager research? What information is provided to the patient and/or her family? While discharge to an assisted living facility might be acceptable to the patient, is that environment able to meet the patient's continuing care needs? Conversely, would a skilled nursing environment provide a level of care that exceeds the patient's need? In many instances, the case manager stands at an intersection of two diverse continuing care options with the patient identified as the decision maker and the family challenging the patient's autonomy and decisional capacity.

A conflict of divided loyalty is an ethical concern that may arise when a case manager's duty to his or her employer and primary responsibility to the patient collide. For example, a patient is preparing to have joint replacement surgery. The case manager who is an employee of the orthopedic surgeon is developing a continuing care plan for the patient. The surgeon

is being reimbursed under a bundled payment system and the prescribed acute care length of stay is generally one day with the patient discharged to the home environment with outpatient physical therapy. The patient requests inpatient rehabilitation to advance her ability to independently live in her home environment. The case manager considers the mandates for cost-efficient care as detailed by her employer and the patient's preference for care delivery in a more structured environment.

It is this author's belief that when the economic or other interests of the employer are in conflict with the welfare of the patient, patient welfare and patient preference must take priority.

40) ANSWER: A

A Patient-Centered Medical Home (PCMH) is a type of care provided by a primary physician that is patient-centered, multidisciplinary or team-based, coordinated, accessible, and focused on advancing quality, appropriate, and cost-efficient care. PCMHs frequently utilize case management professionals to assist in obtaining desired outcomes of care. A Physician Hospital Organization is a formalized organization that represents both a hospital or hospitals and a group or groups of physicians. This group advances the mutual interests to the hospital and physicians within that contracted arrangement to achieve market and financial objectives such as obtaining and maintaining payor contracts or employer relationships.

A federally qualified health center includes outpatient clinics that generally deliver services to medically underserved populations and geographic areas. These federally supported centers are community based and patient directed, with reimbursement typically based on a sliding scale that reflects the ability of the patient to provide payment for delivered services.

41) ANSWER: D

The Commission for Case Manager Certification (CCMC) defines competence as "the mental ability and capacity to make decisions, accomplish actions, and perform tasks that another person of similar background and training, or any human being, would be reasonably expected to perform adequately." Additionally, CCMC defines capacity as "a construct that indicates the highest probable level of functioning a person may reach." Capacity may be established by a physician while competency can only be determined by a court of law.

42) ANSWER: B

According to the Commission for Case Manager Certification, assessment is defined as "the process of collecting in-depth information about a person's situation and functioning to identify individual needs in order to develop a comprehensive case management plan that will address those needs." Within the Standards of Practice for Case Management as detailed by the Case Management Society of America (CMSA), assessment is defined as a process that focuses on the evolving needs of the patient through and across the evolution and transitions of a patient's continuing care needs and the delivery of essential services to support those needs. CMSA also indicates that a comprehensive assessment process facilitates the development of a patient-focused case management plan that advances the delivery of quality, efficient, and patient-directed care. Additionally, assessment is a continuous process utilized to determine the "efficacy of the case management plan of care and client's progress toward achieving target goals."

43) ANSWER: C

Based on information available from HealthIT.gov, meaningful use is defined as the utilization of certified electronic health record (EHR) technology to improve the quality, safety, and efficiency of care while reducing health disparities. While the use of EHR technology contributes to improving care coordination and advancing positive population and public health outcomes, those goals do not represent the definition of meaningful use.

44) ANSWER: B

Comparative effectiveness research (CER) is commonly defined as research that focuses on supporting the informed decision-making process based on a comparison of available options for care. CER provides evidence regarding the effectiveness, benefits, and potential harms associated with various treatment options while seeking to identify which clinical interventions promote the best attainable outcomes.

Outcomes research is generally considered research focused on the results gained from specific health care interventions and policies. Quality improvement is a broad array of multiple techniques and strategies utilized to identify and resolve gaps in the delivery of quality in health care systems and advance the steps necessary to improve the outcomes of care.

45) ANSWER: D

One key aspect of *Wickline v. State of California* was the fact that Mrs. Wickline's surgeon abided with the utilization review organization's determination that further hospitalization was not medically necessary and appropriate. Because the surgeon did not appeal that decision, Mrs. Wickline was discharged and suffered a negative outcome. Initially, the courts sided with Mrs. Wickline, but, on appeal, it was determined that the treating physician was at fault for not protesting the decision presented by the utilization review organization that represented the payor. The court stated: "the physician who complies without protest with the [cost-containment] limitations imposed by a third-party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour." In other words, the physician had a responsibility to consider the patient's welfare, regardless of cost-containment or payor considerations and to appeal the determination presented by the utilization review provider.

An appeal is a formalized request for reconsideration of a benefit determination. The appeal may be initiated by the insured, their authorized representative, or their physician. A peer review is a comprehensive review by health care practitioners of the services ordered or furnished by other practitioners in the same professional field. A peer review is generally requested when a payor states that coverage for a certain product or service is not available based on a lack of medical necessity or appropriateness. In some cases, this is referred to as a physician-to-physician appeal or review.

An explanation of benefits is a document provided to the insured by a health insurance payor that details the specific services billed by a provider, claims paid based on the specific terms of the insurance policy, the amount the insured may be responsible for paying, the reason for any denial of submitted charges, and information regarding the process for appealing that benefit determination.

46) ANSWER: B

Motivational interviewing (MI) is a form of counseling that is collaborative, patient-centered, and provided to elicit and strengthen a patient's desire to achieve health behavioral change. The goal of MI is to assist the patient in identifying and resolving ambivalent feelings or insecurities in order to realize the internal motivation to change behaviors.

Patient activation focuses on a patient's willingness to initiate the independent actions necessary to manage his or her health including developing the knowledge, skills, confidence, and ability to move toward health behavioral change.

47) ANSWER: C

Evidence-based guidelines may also be referred to as clinical or practice guidelines. The Commission for Case Manager Certification (CCMC) defines these guidelines as "systematically developed statements on medical practices that assist a practitioner in making decisions about

appropriate diagnostic and therapeutic healthcare services for specific medical conditions." Guidelines are not recipes for care that must be followed but rather represent recommended interventions that a clinician and his or her patient might wish to consider as a treatment plan is developed and implemented in order to promote the attainment of the desired outcome of care. Standards of care are defined by the CCMC as "statements that delineate care that is expected to be provided to all clients. They include predefined outcomes of care clients can expect from providers and are accepted within the community of professionals, based upon the best scientific knowledge, current outcomes data, and clinical expertise." Standards of care are also defined as the care a reasonably prudent health care professional in a given community would provide or the caution that a reasonable person in similar circumstances would exercise in providing care to a patient.

Protocols are generally considered to be the framework for detailing the care that is appropriate to deliver to patients in a designated area of practice. Protocols do not describe how a procedure is performed, but rather the specific action to take in specific circumstances.

48) ANSWER: C

Medicare Part A provides coverage for inpatient hospitalization for days 1 to 90. In order to receive Medicare benefits beyond day 90, the Medicare beneficiary or their representative must elect to use all or a portion of their 60 lifetime reserve days. These days are not renewable.

An Important Message from Medicare is a document delivered to Medicare beneficiaries who are inpatients in an acute care facility. This document details discharge appeal rights and lists the quality improvement organization that will facilitate the appeal process. If the patient chooses to appeal the planned discharge, the hospital is required to provide the patient with a Detailed Notice of Discharge (DND). The DND offers the patient information regarding the reasons the hospital or the managed care plan believes inpatient services should come to an end.

A Hospital Issued Notice of Noncoverage is a document provided to Medicare beneficiaries when a hospital determines the care the patient is receiving or is about to receive is not covered because that care is not medically necessary, not provided in the most appropriate setting, or is custodial in nature.

49) ANSWER: A

As defined by the Commission for Case Manager Certification, capitation is a "fixed amount of money per-member-per-month (PMPM) paid to a care provider for covered services rather than based on specific services provided." Capitation is a common method of reimbursement utilized by health maintenance organizations. The physician, group of physicians, or the health plan receive the PMPM payment regardless of the actual number or nature of services provided to each plan member.

The Centers for Medicare and Medicaid Services (CMS) describes the Bundled Payment for Care Initiative (BPCI) as a distinct payment model that "bundles payments for multiple services a beneficiary receives during an episode of care." In one BPCI model, providers accept fiscal and performance accountability for the entire episode of care. If savings are identified due to the effective and efficient delivery of health care services, the providers share in the identified savings. If care is not well coordinated and total charges exceed the amount projected by the CMS, the awardee is responsible for reimbursing for those costs. In another BPCI model, CMS presents one bundled payment to a hospital that "encompasses all services provided by the hospital, physicians and other practitioners during the episode of care."

50) ANSWER: C

The Commission for Case Manager Certification defines a vocational evaluation as a "comprehensive assessment of vocational aptitudes and potential, using information about a person's

past history, medical and psychological status, and information from appropriate vocational testing, which may use paper and pencil instruments, work samples, simulated work stations, or assessment in a real work environment."

Case managers within the workers' compensation environment are charged with coordination of care and advancing return to work or achievement of maximum medical improvement. According to the Certified Disability Management Specialist (CDMS) Code of Professional Conduct as presented by the CDMS Commission, disability management services include "the prevention and minimization of the human and economic impact of illness and disability for the employee/employer to optimize the quality of care, productivity, organizational health, and regulatory compliance. The goal of disability management is to provide or facilitate obtaining necessary services, using appropriate resources in order to promote the ill or injured individual's maximum recovery and function. Disability management services include the following activities: case management; disability assessment and evaluation; return-to-work intervention; labor market analysis; career exploration and counseling; and disability management reporting."

51) ANSWER: B

The National Institutes of Health, National Center for Complementary and Integrative Health (NCCIH) advances the term "complementary health approaches to identify practices and products of non-mainstream origin." The NCCIH uses the term *integrative health* in identifying complementary approaches incorporated into mainstream health care. Common examples of complementary health approaches include botanicals, vitamins and minerals, and probiotics; yoga or tai chi; chiropractic manipulation; meditation; massage; homeopathy; progressive relaxation; and guided imagery.

Holistic medicine or holistic health is a form of medicine that focuses on the whole person rather than a disease that impacts that individual. Holistic health care delivery considers the physical, emotional, social, and spiritual aspects of a person's life.

52) ANSWER: A

The Americans with Disabilities Act defines an individual with a disability as "a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment." This definition is considered to be a legal definition rather than a medical definition or terminology.

53) ANSWER: C

The False Claims Act provides an avenue for the federal government to recover money when someone submits or causes to submit fraudulent claims to a governmental office or department including Medicare or Medicaid programs. Examples include the submission of claims that the provider knew were false as services were not rendered; services were upcoded and not supported by documentation within the medical record; or a component of a previously submitted claim. Claims also may be false if the referral associated with that claim is in violation of the Federal Anti-Kickback Statue or Stark Law.

The Anti-Kickback Statue "prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or to generate Federal health care program business." The Stark Law "prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies."

54) ANSWER: C

The Centers for Medicare and Medicaid Services (CMS) mandates Medicare Part D providers to establish medication therapy management programs that ensure covered Part D drugs are used "to optimize therapeutic outcomes through improved medication use; reduce the risk of

adverse events; are developed in cooperation with licensed and practicing pharmacists and physicians, and are furnished by pharmacists or other qualified providers."

Medication reconciliation as defined by CMS is "the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider." Medication reconciliation is one of the National Patient Safety Goals presented by the Joint Commission.

55) ANSWER: A

A mini-mental status examination is generally administered to evaluate cognitive impairment. The examination includes 11 questions, evaluates recall, and can be easily administered by a trained individual. The Minnesota Multiphasic Personality Inventory (MMPI) offers a psychometric assessment of adult psychopathology and personality. Delivered by a trained health care professional, the results of the examination may be helpful in the development of treatment plans as well as screening potential job candidates. The MMPI may also be utilized in vocational assessments and vocational rehabilitation evaluations.

A Mini-Cog test is a reliable, validated screening tool used to identify cognitive impairment. It includes a three-item recall test and a demonstration of clock drawing.

The Karnofsky Performance Scale facilitates the classification of patients based on an assessment of functional impairment and is most frequently utilized in oncology environments of care.

56) ANSWER: C

LEAN is a quality improvement process that distinguishes value-added steps from nonvalue-added steps while eliminating waste in order to assure that each step within a course of action brings value to the process. LEAN focuses on continuous quality improvement and the development of a culture that reflects the implementation and maintenance of interdisciplinary teams; the reduction of waste in time, materials, and efforts; the use of root cause analyses to facilitate the identification of timely and effective solutions; the timely sharing of information; and the consistent advancement of patient-centered care.

Six Sigma represents a set of actions designed to eliminate errors and advance consistent processes to improve quality.

PDSA represents a cyclic method of advancing change that includes four phases—plan, do, study, and act.

57) ANSWER: D

Quality Improvement Organization (QIO) programs were developed by the United States Department of Health and Human Services to improve the quality of health care interventions provided to Medicare beneficiaries. QIOs are integral to the advancement of the National Quality Strategy, which promotes better care and better health in a cost-efficient manner. QINs consist of 14 organizations that provide data-driven initiatives to advance patient safety, improved care transitions, and enhanced clinical quality of care.

58) ANSWER: A

According to information provided by the Case Management Society of America, a "cost-benefit analysis is an analytical procedure for determining the economic efficiency of a program, expressed as the relationship between costs and outcomes, usually measured in monetary terms." Although a cost-benefit analysis may detail cost savings, the detailing of specific hard or soft cost savings is not a component of every cost-benefit analysis.

59) ANSWER: B

According to the Commission for Case Manager Certification, risk management is "the science of the identification, evaluation, and treatment of financial (and clinical) loss. Risk management

may also represent a program that attempts to provide positive avoidance of negative results." The United States Department of Health and Human Services defines risk management as any activity, process, or policy to reduce liability exposure. Loss protection may be a component of some risk management programs but rarely serves as the primary focus of those programs.

60) ANSWER: C

The Centers for Medicare and Medicaid Services defines the term *medical loss ratio* as the proportion of health insurance revenues spent on clinical services and quality improvement. The Affordable Care Act requires health insurance organizations to spend either 80 percent or 85 percent of premium dollars on medical care for their beneficiaries and on initiatives that advance health care quality improvement. The remaining 15 percent to 20 percent is allocated to administrative costs, marketing, and profits. Case management interventions are generally considered to be a component of the medical care/quality improvement component of the ratio. Utilization review or utilization management is generally considered an administrative action.

61) ANSWER: D

The Center to Advance Palliative Care defines palliative care as "specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family." Although hospice and palliative care both advance compassionate care to an individual, palliative care may be provided while active treatment of the disease continues. Hospice services are generally provided during the final months of a patient's life. Palliative care may be provided to patients with a life-limiting disease throughout the course of care.

62) ANSWER: A

The TEFRA Act of 1982 grants individual states the ability to extend Medicaid coverage to children with a disability based on the child's income and not the income of the parents. Social Security Disability Income (SSDI) is available to individuals who have accumulated a sufficient amount of work credits. Additionally, an adult disabled prior to age 22 may be able to receive SSDI benefits based on the parent's work history. Supplemental Security Income (SSI) is provided to low-income individuals with a disability. SSI is need-based while SSDI is based solely on eligibility for social security benefits.

63) ANSWER: B

A health plan or insurance organization that provides claims processing services, development of plan documents and manuals for beneficiaries, determination of benefits based on contractual requirements, and required governmental reports for a self-funded employer is said to provide administrative services only (ASO). The self-insured employer assumes responsibility for funding all claims and associated liabilities.

Stop-loss insurance is a type of insurance purchased by self-funded groups to limit liability. This type of insurance protects self-funded plans from catastrophic losses and assumes responsibility for the payment of claims once a predetermined threshold is met. This insurance protection offers the self-insured employer a safeguard from large claims that might deplete the fund's insurance reserves.

Actuarial services represent a methodology utilized by corporations and self-funded plans to determine, project, and plan for the future financial impact of risk. This risk may be associated with health insurance, pension plans, and other forms of financial risk. Actuaries use mathematical and statistical models to quantify and predict risk.

64) ANSWER: C

Hospital Compare offers information regarding the quality of care provided by Medicare-certified hospitals to assist health care consumers to make informed decisions regarding potential

providers for care and to encourage acute care facilities to improve the quality of care they provide. Information provided on the Medicare.gov/hospitalcompare website includes: general information about the hospital such as size and location, an overall quality rating, information regarding the efficiency of care delivery, results of patient satisfaction surveys, readmission and mortality rates, timeliness and effectiveness of provided care, complication rates, and use of medical imaging.

The Institute for Healthcare Improvement (IHI) is focused on improving the delivery of quality health care interventions globally. IHI developed the Triple Aim, which served as a blueprint for the National Quality Strategy. Although IHI promotes improvements in health care delivery, it does not provide information regarding the quality provided by specific acute care facilities in specific geographic areas.

The Leapfrog Group does provide information regarding hospital quality and offers reporting of that information to both large purchasers of health care services including employers and the public. Participation in the surveys is voluntary and does not detail information regarding mortality rates, the results of patient satisfaction surveys, or the efficiency of care delivery.

Press Ganey is an organization that advances an improved understanding of patient satisfaction surveys and supports quality improvement initiatives. This organization does not provide information regarding the quality of care provided by Medicare-certified hospitals.

65) ANSWER: B

Conflict management generally includes five distinct strategies or styles for achieving resolution. These strategies include: avoidance, competition, compromise, collaboration, and accommodation. Accommodation focuses on meeting the goals and tasks of the other party. Avoidance represents evading, escaping, or ignoring the conflict. Compromise combines negotiation skills and cooperation to achieve a solution in which each party concedes to the other. Competition represents a situation in which only one party's objectives are met. Collaboration results in the development of a mutually acceptable solution in which each party's goals are achieved.

66) ANSWER: D

Another definition of cultural competency provided by the Substance Abuse and Mental Health Services Administration is "the ability to interact effectively with people of different cultures, helping to ensure the needs of all community members are addressed."

The core principle or principle standard associated with National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care is providing "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."

Ethnocentrism is the belief that one's own culture is superior to all other cultures and may also be referred to as a cultural superiority complex.

67) ANSWER: A

Predictive modeling or analytics include the application of mathematical and/or statistical models to predict outcomes for individual patients or populations of insured lives. Predictive modeling has been utilized to identify which patients may be at the greatest risk for readmission, or which populations may incur the highest health care costs or require the greatest number of continuing health care services. Predictive modeling may assist in predicting an event, behavior, or outcome that may compromise the patient's ability to safely move through the health care continuum. Based on that prediction, actions may be taken to support the patient and, hopefully, mitigate or avoid the predicted untoward outcome.

68) ANSWER: B

The Standards of Practice for Case Management (CMSA) state, "Professional case management today fosters the careful shepherding of health care dollars while maintaining a primary and consistent focus on quality of care, safe transitions, timely access to and availability of services, and most importantly client self-determination and provision of client-centered and culturally-relevant care."

CMSA describes patient navigation as "the process of helping clients/patients find needed health care providers, health-related services, and health impacting non-clinical support in a complicated health care system, health inhibiting personal situations, and destructive living environments so that they can accomplish the goals of a care plan."

69) ANSWER: A

Maximum medical improvement is generally defined as a treatment plateau at which no fundamental functional or physiological change can be expected within reasonable medical probability in spite of continuing medical or rehabilitative procedures.

70) ANSWER: C

Care coordination is defined by the National Quality Forum as a function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time.

Disease management is defined by the Case Management Society of America as "a subset of case management in which health-related assistance, characterized by education, health facilitation, care coordination, and client/patient advocacy, is given to all collaborating clients/patients within a population who have one or more selected chronic health conditions by licensed and trained health professionals, usually nurses and social workers, with the goal of reversing barriers to improvement and stabilizing health by connecting client/patient assessment findings to a plan of care."

71) ANSWER: A

Information available from the Centers for Medicare and Medicaid Services states, "The Emergency Medical Treatment & Labor Act (EMTALA) ensures public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act requires Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented." This statute applies to all patients "whether or not the patient is eligible for Medicare benefits."

72) ANSWER: A

According to information available from Medicare, hospice care is available to people with a life expectancy of six months or less (if the illness runs its normal course). Medicare beneficiaries who live longer than six months may continue to be eligible for hospice services based on continuing certification of a terminal illness by the hospice medical director or other hospice physician. Hospice is initially provided for two 90-day benefit periods that may be followed by an unlimited number of 60-day benefit periods as long as a continued certification of a terminal illness is received.

73) ANSWER: B

Based on the Standards of Practice for Case Management as presented by the Case Management Society of America, assessment is an ongoing process occurring intermittently, as needed, to determine efficacy of the case management plan of care and client's progress toward achieving target goals.

74) ANSWER: D

The Commission for Case Manager Certification defines the term *justice* as "maintaining what is right and fair and making decisions that are good for the patient. The Case Management Society of America published a Statement Regarding Ethical Case Management Practice that also defines *justice* as "maintenance of what is right and fair."

75) ANSWER: B

Advocacy is defined both by the Commission for Case Manager Certification (CCMC) and the Case Management Society of America (CMSA). CCMC defines advocacy as "acting on behalf of those who are not able to speak for or represent themselves. It is also defending others and acting in their best interest. A person or group involved in such activities is called an advocate." CMSA states advocacy as "the act of recommending, pleading the cause of another; to speak or write in favor of." Regardless of the unique definitions of case management as presented by CCMC and CMSA, advocacy is a key function of each case management role. The very definition of case management as offered by CCMC or CMSA includes the responsibility of the case manager to serve as a patient advocate and that advocacy role serves as a key element of all case management activities.

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