AHIP

Exam Questions AHM-540

Medical Management

NEW QUESTION 1
One method that health plans use to address provider compliance with formularies is academic detailing.

A. True
B. False

Answer: A

NEW QUESTION 2
Determine whether the following statement is true or false:
The delegation of medical management functions to providers can occur without the transfer of financial risk.

A. True
B. False

Answer: A

NEW QUESTION 3
State governments serve as both regulators and purchasers of health plan services. The influence of state governments as purchasers is focused on

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

Answer: B

NEW QUESTION 4
In order to provide a true measure of quality, the data collected by a quality indicator should accurately represent the service dimension being measured. This information indicates that the indicator should exhibit the characteristic known as

A. clarity
B. reliability
C. validity
D. feasibility

Answer: C

NEW QUESTION 5
Demetrius Farrell, age 82, is suffering from a terminal illness and has consulted his health plan about the care options available to him. In order to avoid unwanted, futile interventions, Mr. Farrell signed an advance directive that indicates the types of end-of-life medical treatment he wants to receive. His family is to use this document as a guide should Mr. Farrell become incapacitated.
The document that Mr. Farrell is using to communicate his end-of-life healthcare wishes to his family is known as a

A. medical power of attorney
B. patient assessment and care plan
C. living will
D. healthcare proxy

Answer: C

NEW QUESTION 6
The following statements are about risk management for case management. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. The use of a signed consent authorization form is consistent with accrediting agency standards for patient privacy and confidentiality of medical information.
B. Case management that is initiated after a member has incurred substantial medical expenses is more likely to be viewed as a tool to cut costs rather than to improve outcomes.
C. Health plan documents indicating that any case management delegates are separate, independent entities may reduce an health plan's exposure to risk.
D. A case management file cannot be used to support the health plan's position in the event of a lawsuit.

Answer: D

NEW QUESTION 7
All states have laws describing the conditions under which pharmacists can substitute a generic drug for a brand-name drug. With respect to these laws, it is correct to say that in every state,

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

Answer: D

NEW QUESTION 8
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Determine which term or phrase in each pair correctly completes the paragraph. Then select the answer choice containing the terms or phrases that you have chosen.
Due to competitive pressures and consumer demand, many health plans now offer direct access or open access products. Under a direct access product, a member is (required / not required) to select a primary care provider (PCP), and is (required / not required) to obtain a referral from a PCP or the health plan before visiting a network specialist.

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

Answer: B

NEW QUESTION 9
Medicare beneficiaries can obtain healthcare benefits through fee-for-service (FFS) Medicare programs, Medicare medical savings account (MSA) plans, Medigap insurance, or coordinated care plans (CCPs). Unlike other coverage options, CCPs

A. provide only those benefits covered by Medicare Part A and Part B
B. are not subject to federal or state regulation
C. place primary care at the center of the delivery system
D. are structured as indemnity plans

Answer: C

NEW QUESTION 10
The following statements are about the characteristics of a utilization review (UR) program. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

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

Answer: C

NEW QUESTION 10
Home healthcare encompasses a wide variety of medical, social, and support services delivered at the homes of patients who are disabled, chronically ill, or terminally ill. The time period(s) when health plans typically use home healthcare include
* 1. The period prior to a hospital admission
* 2. The period following discharge from a hospital

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

Answer: A

NEW QUESTION 12
The Garnet Health Plan uses provider profiling to measure and improve provider performance. Provider profiling most likely allows Garnet to

A. evaluate all providers without considering differences in risk
B. focus on specific clinical decisions of Garnet's providers rather than on patterns of care
C. identify the outliers and high-value providers in its provider network
D. measure the effectiveness, but not the efficiency, of Garnet's providers

Answer: C

NEW QUESTION 13
In order for a health plan's performance-based quality improvement programs to be effective, the desired outcomes must be

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

Answer: A

NEW QUESTION 16
The case management team at the Hightower Health Plan reviewed the medical records of the following two plan members to determine the type of care each one needs and the most appropriate setting for that care:
Ira Morton was hospitalized for a severe stroke. Although his medical condition is stable, the stroke left him partially paralyzed and he will require extensive rehabilitation and 24- hour medical care.
Theresa Finley is recovering from a total hip replacement and is in need of short-term physical therapy and twice-weekly visits from a licensed nurse to check her blood pressure and the healing of her incision.
From the answer choices below, select the response that correctly identifies the level of care that would be most appropriate for Mr. Morton and Ms. Finley.

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

Answer: C

NEW QUESTION 21
The Fairview Health Plan uses a dual database approach to integrate information needed for its disease management program. This information indicates that Fairview uses an information management system that

A. combines all existing information from all data sources into a single comprehensive system
B. connects multiple databases with a central interface engine that acts as an information clearinghouse
C. provides an outside vendor with pertinent data that the vendor compiles into an integrated database
D. creates a separate database that pulls pertinent information from the health plan's claims database, formats the information for easy analysis, and stores it in the separate database

Answer: D

NEW QUESTION 24
The following statements are about QAPI as it applies to Medicare+Choice plans and Medicaid health plan entities. Select the answer choice containing the correct statement.

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

Answer: D

NEW QUESTION 29
When analyzing and applying HRA results, the Multistate Health Plan noted sampling bias. This information indicates that the HRA results

A. do not accurately depict the characteristics of the Multistate member population under study because of errors in data collection
B. are more accurate for individual Multistate members than they are for the total population
C. cannot be stated in numerical terms
D. indicate variation in the number, types, and severity of behavioral risks presented by Multistate's members

Answer: A

NEW QUESTION 30
Economically, health plans cannot provide coverage for every drug available from every manufacturer. As a result, purchaser contracts often include provisions specifying that certain drugs or drug types will not be covered. These provisions are referred to as

A. limitations
B. exceptions
C. exclusions
D. drug edits

Answer: C

NEW QUESTION 35
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
To manage the delivery of healthcare services to their members, health plans use clinical practice parameters. _____ is the type of clinical practice parameter that a health plan uses to make coverage decisions concerning medical necessity and appropriateness.

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

Answer: B

NEW QUESTION 38
As a follow-up to a performance improvement plan for member services, the Stellar Health Plan conducted an evaluation of the success of the plan. Stellar conducted its evaluation as the plan was being carried out. The evaluation focused on specific activities and assessed the relative importance of those activities to the plan as a whole. This information indicates that Stellar's evaluation of the plan was both

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

Answer: A

NEW QUESTION 43
Benchmarking is a quality improvement strategy used by some health plans. With regard to benchmarking, it is correct to say that

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

Answer: D

NEW QUESTION 47
The Harbor Health Plan's formulary policy encourages network pharmacists who are asked to fill a prescription for a costly, brand-name drug to dispense a different chemical entity within the same drug class in order to reduce costs. This type of drug substitution is referred to as

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

Answer: D

NEW QUESTION 50
The following statement(s) can correctly be made about performance measurement systems:
* 1.The most difficult purpose for a performance measurement system to address is to measure changes in outcomes caused by modifications in administrative or clinical treatment processes
* 2.A health plan needs different performance measurement systems to evaluate its administrative services and the clinical performance of its providers

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

Answer: C

NEW QUESTION 55
Many health plans use clinical pathways to help manage the delivery of acute care services to plan members. One true statement about clinical pathways is that they

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

Answer: B

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

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

Answer: A

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

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

Answer: B

NEW QUESTION 61

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

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

Answer: A

NEW QUESTION 64
The following statements are about medical management considerations for dental care. Select the answer choice containing the correct statement.

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

Answer: A

NEW QUESTION 68
Demetrius Farrell, age 82, is suffering from a terminal illness and has consulted his health plan about the care options available to him. In order to avoid unwanted, futile interventions, Mr. Farrell signed an advance directive that indicates the types of end-of-life medical treatment he wants to receive. His family is to use this document as a guide should Mr. Farrell become incapacitated.
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
Decisions regarding Mr. Farrell's end-of-life care are legally the right and responsibility of

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

Answer: A

NEW QUESTION 71
To facilitate electronic commerce (eCommerce), a health plan may establish a secured extranet. One true statement about a secured extranet is that it is

A. based on Web-based technologies
B. available only to the employees of the health plan
C. publicly available, so the potential exists for unauthorized access to a health plan's proprietary systems
D. used to handle the majority of health plan eCommerce

Answer: A

NEW QUESTION 72
The Midwest Health Plan delegated utilization review (UR) activities to the Tri-City Utilization Review Organization. After Tri-City improperly recommended denial of payment for services to a Midwest plan member, the plan member filed suit. The court ruled that Midwest was responsible for Tri-City's actions because of the relationship between Midwest and Tri-City. This situation is an illustration of a legal concept known as

A. vicarious liability
B. fraud
C. a tying arrangement
D. subdelegation

Answer: A

NEW QUESTION 76
The following statement(s) can correctly be made about utilization guidelines:
* 1. When developing utilization guidelines, health plans balance evidence-based criteria with experience-based criteria
* 2. Utilization guidelines indicate when a UR nurse should refer a decision to a physician reviewer

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

Answer: A

NEW QUESTION 78
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