Nursing

CCMC-CCM

Commission for Case Manager Certification: Certified Case Manager®

Latest Version: 6.0

Question: 1

Which of the following is the best definition of health literacy?

A. The ability to read medical information
B. General knowledge of healthcare topics
C. The ability to speak to healthcare professionals
D. The ability to effectively deal with healthcare information

Answer: D

Explanation:
Correct answer: The ability to effectively deal with healthcare information
Health literacy is the ability to effectively deal with healthcare information, whether that be reading, understanding, or processing. The health literacy of a given patient is key to understanding their status as a partner in healthcare.
Health literacy is not the ability to read medical information, to speak to healthcare professionals, or a gauge of general knowledge of healthcare topics; though all of these are represented in some way in the concept.

Question: 2

Is there a copay or deductible to offset the costs of the Home Health Care benefit, according to Medicare Part A?

A. No
B. There are both copays and deductibles
C. Yes, there is a deductible
D. Yes, there is a copay

Answer: A

Explanation:
Correct answer: No
There is neither a copay nor a deductible due from the consumer under the Home Health Care benefit, according to Medicare Part A.

Question: 3

Who funds Medicaid?

A. The federal government
B. The federal government and the states
C. The states
D. Since 1996, a private sector-government partnership

Answer: B

Explanation:
Correct answer: The federal government and the states
Medicaid is a health insurance program funded in part by the federal government and in part by state governments.
It is not part of a private partnership.

Question: 4

Do quality indicators provide answers to problems found in healthcare?

A. No, they are used for actuarial purposes only
B. Yes, that is the purpose of studying them
C. Yes, but only when used in a survey process
D. No, they suggest the presence of problems

Answer: D

Explanation:
Correct answer: No, they suggest the presence of problems
Quality indicators in healthcare are studied for a variety of reasons that center around the process of improving quality, cutting costs, and reducing waste. When these indicators are studied, most often they do not provide answers in their own right; rather, they indicate the presence of problems.
Quality indicators are gathered both inside and outside survey processes, and are not only used for actuarial purposes.

Question: 5

What is the typical caseload in a hospital setting for case managers?

A. 15-30 patients
B. No more than 20 patients
C. 5-10 patients
D. 20-40 patients

Answer: A

Explanation:
Correct answer: 15-30 patients
Though circumstances vary, the typical caseload in a hospital setting for case managers is 15-30 patients.

Question: 6

In terms of insurance, what would "underutilization" mean for a patient?

A. Not understanding the benefit
B. Not receiving any benefit
C. Not receiving minimum benefit
D. Not receiving maximum benefit

Answer: D

Explanation:
Correct answer: Not receiving maximum benefit
In terms of insurance, underutilization would mean not getting the maximum of the allowable benefits due to a patient. Full utilization is achieved when the patient is getting all of the services appropriate to their condition and situation.
Not understanding the benefit would not be a concern of underutilization.

Question: 7

Which of the following is false about assisted living?

A. They can be covered by a long-term care policy
B. They do not provide skilled nursing care
C. They are regulated by the state government
D. They are regulated by the federal government

Answer: D

Explanation:
Correct answer: They are regulated by the federal government
Assisted living facilities provide housing and support with activities of daily living amongst other potential services, though not skilled nursing care. They are regulated by the state government, and can be covered by a long-term care policy.

Question: 8

Of the following, what is the first step in the URAC accreditation process?

A. Validation review
B. Monitoring
C. Committee review
D. Desktop review

Answer: D

Explanation:
Correct answer: Desktop review
The URAC (Utilization Review Accreditation Committee) accredits healthcare organizations in general and specific ways. The accreditation process goes through several steps:
• Application
• Desktop record review (basic review of records)
• Validation review (onsite review of records)
• Committee review (a formal assessment of findings)
• Monitoring and quality measurement
At the end of this process, the organization either will or will not have met the standard established by the URAC for accreditation.

Question: 9

Which of the following supports is not offered by the Area Agency on Aging?

A. Psychotherapy
B. Respite care
C. Senior housing
D. Legal assistance

Answer: A

Explanation:
Correct answer: Psychotherapy
The Area Agency on Aging is an organization that offers various supports to those who are 60 years of age or older and those with disabilities. These supports include respite care, senior housing, and legal assistance, among many others.
Psychotherapy is not usually provided by the Area Agency on Aging.

Question: 10

Which of the following would be an example of primary nonadherence?

A. Not filling a prescription
B. Not taking medication
C. Skipping doses
D. Changing dosage

Answer: A

Explanation:
Correct answer: Not filling a prescription
Primary nonadherence would be the basic failure to maintain one's course of treatment, such as not filling a prescription for medication.
Such things as not taking medication, skipping doses, and changing dosage would be examples of secondary nonadherence.

Question: 11

In the context of the legal terminology of healthcare, which of the following would be the most likely meaning of "best interest"?

A. Improving outcomes for particular patients
B. Helping patients deemed incompetent
C. The overall ethical mandate to do competent care
D. Improving outcomes for patients in general

Answer: B

Explanation:
Correct answer: Helping patients deemed incompetent
In the context of the legal terminology of healthcare, best interest refers to the array of decisions that must be made to assist a patient who has been deemed incompetent when no proxy has been designated and the healthcare team must make decisions for that individual.
In this context, the term does not refer to improving outcomes or the overall ethical mandate to do competent care.

Question: 12

Which of the following would not be treated by vision therapy?

A. Visual processing disorders
B. Ocular motor dysfunctions
C. Amblyopia

D. Nearsightedness

Answer: D

Explanation:
Correct answer: Nearsightedness
Vision therapy is a kind of rehabilitation that seeks to restore lost visual function. It addresses such things as amblyopia, visual processing disorders, and ocular motor dysfunctions.
This kind of therapy would most likely not treat nearsightedness, which could be adequately addressed by ordinary optometry.

Question: 13

Is respite care covered under the Home Health Care benefit, according to Medicare Part A?

A. Only if the patient is covered by hospice
B. Yes, in cases of End Stage Renal Disease (ESRD)
C. No, under no circumstances
D. Yes

Answer: D

Explanation:
Correct answer: Yes
Respite care, a type of care meant to give relief to the regular caregivers of a patient, can be covered under the Home Health Care benefit, according to Medicare Part A.
This benefit is not limited to those suffering from ESRD, and hospice would be a different kind of Medicare benefit altogether.

Question: 14

How is the Health Risk Assessment (HRA) used by Medicare?

A. It is used for advance directive planning
B. It is required by Medicare annually
C. It is used to formulate payment strata
D. It is not required by Medicare

Answer: B

Explanation:
Correct answer: It is required by Medicare annually

A Health Risk Assessment (HRA) is an instrument that helps a patient understand their health risks. It is a collaborative process wherein the patient self-reports data, this data is then evaluated by a case manager to arrive at a risk calculation, and the feedback is then reported back to the patient. The Affordable Care Act (ACA) stipulates that the HRA is part of an annual screen for all Medicare beneficiaries.
The purpose of the HRA is not to formulate payment strata, nor is it designed to be used for advance directive planning.

Question: 15

When is an intermediate outcome met?

A. During a long-term care stay
B. After a patient stay
C. During a patient stay
D. During a hospice reimbursement period

Answer: C

Explanation:
Correct answer: During a patient stay
As opposed to discharge outcomes, an intermediate outcome is an outcome that does not determine the end of a patient stay. It is met during the patient stay and is more of a milestone of care that is met before other outcomes can be achieved.
This kind of outcome is not met after a patient stay, nor is it specifically a matter of long-term care or hospice reimbursement.

Question: 16

Which of the following best defines Transitional Care as it relates to case management?

A. The specialty of long-term care outcomes
B. Measurement of quality indicators related to care
C. Evaluation of end-of life care and treatment
D. Continuity of care between treatments and/or providers

Answer: D

Explanation:
Correct answer: Continuity of care between treatments and/or providers
Transitional Care in terms of case management refers to the attention paid to the continuity of care between treatments and/or providers. It has been found that much waste and negative outcome arises from gaps in care continuity; for example, between acute hospital care and community treatment.

Measurement of quality indicators is important, but it is not transitional care; nor is the concept limited to end-of-life care and treatment or long-term care.

Question: 17

Which of the following would be the best description of "apparent authority" in the context of case management and healthcare?

A. When an agent acts on their own to assume authority on behalf of a principal
B. When a principal acts in ways that indicate an agent has authority
C. When an agent indicates that they have authority on the part of a principal
D. When a principal openly states that an agent has authority

Answer: B

Explanation:
Correct answer: When a principal acts in ways that indicate an agent has authority
In the context of case management and healthcare, apparent authority refers to when a principal takes actions that indicate an agent has authority to act on their behalf. Including a list of personnel in published material about an organization would be an example.
The term does not refer to an agent acting on their own or assuming authority, or a principal explicitly stating that authority.

Question: 18

Which of the following refers to the meaningfulness of the data being measured?

A. Validity
B. Reliability
C. Repeatability
D. Integrity

Answer: A

Explanation:
Correct answer: Validity
The validity of data refers to the meaningfulness of that data; in other words, is this data what we intend to measure?
Reliability refers to the accuracy of the instrument measuring the data. Integrity and repeatability are not terms used in this context.

Question: 19

Which of the following is the most accurate statement about the "hardball/aggressive" style of negotiation?

A. Research has proven its effectiveness
B. It is sometimes recommended for case managers
C. It does not involve manipulation or trickery
D. It often fails to deliver agreement

Answer: D

Explanation:
Correct answer: It often fails to deliver agreement
The "hardball/aggressive" style of negotiation often fails to deliver agreement. It involves threats to end the negotiation, manipulation, trickery, and any other tactic that might be considered effective in the situation. It is not recommended to case managers because of its frequent failure, as well as ethical concerns about the practice.
Research does not show this style of negotiation to be effective.

Question: 20

What is different about reimbursement under a Diagnosis Related Group (DRG) system?

A. Payment can be held for review purposes
B. Payment is dependent on qualifying factors
C. Payment is coordinated by the insurance company
D. Payment is negotiated by diagnosis

Answer: D

Explanation:
Correct answer: Payment is negotiated by diagnosis
The key differentiating factor in a Diagnosis Related Group (DRG) system is that payment is negotiated by diagnosis. Payment is made on the basis of a diagnosis rather than specific instances of care.
In managed care, payment is usually dependent on qualifying factors, coordinated by the insurance company, and can be held for purposes of review.

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