Ultimate IT Test Preparation Material

Medical Professional
CCM
Certified Case Manager Certification Exam (CCM)

- **Up to Date products, reliable and verified.**
- **Questions and Answers in PDF Format.**

Full Version Features:

- **90 Days Free Updates**
- **30 Days Money Back Guarantee**
- **Instant Download Once Purchased**
- **24 Hours Live Chat Support**

For More Information:

https://www.testsexpert.com/

- **Product Version**

Latest Version: 6.0

Question: 1

Under the 60 percent rule, the condition that requires additional clinical criteria to qualify for CMS payment for stay in an inpatient rehabilitation facility (IRF) is:

A. Stroke.
B. Amputation.
C. Brain injury.
D. Severe osteoarthritis.

Answer: D

Explanation:
Under the 60 percent rule, 13 medical conditions qualify. Those that require additional clinical criteria beyond diagnosis include severe osteoarthritis, systemic vasculitides, other arthritis conditions (active polyarticular, psoriatic, and seronegative arthropathia) and complex knee and/or hip joint replacement. The other conditions (based on diagnosis) include stroke, spinal cord injury, hip fracture, brain injury, congenital deformity, amputation, major multiple traumas, burns, and neurological disorders (multiple sclerosis, motor neuron disease, muscular dystrophy, polyneuropathy, and Parkinson's disease).

Question: 2

A patient with a hip and/or knee replacement qualifies for CMS admission to an inpatient rehabilitation facility (IRF) if additional criteria are met, including:

A. BMI ≥ 240.
B. BMI ≥ 250.
C. Age ≥ 265.
D. Age ≥ 275.

Answer: B

Explanation:
In order to qualify for CMS coverage of rehabilitation care in an inpatient rehabilitation hospital or rehabilitation unit of an acute care hospital for knee and/or hip replacement, the patients conditions must meet at least one additional criterion, which includes body mass index (BMI) of 250 (extreme obesity), bilateral knee and/or hip surgery, or age 285. The classification is important because the rate of reimbursement is different for those who qualify for care in an IRF.

Question: 3

In cost analysis, conformance costs are:

A. Costs related to errors, failures, or defects, including duplications of service and malpractice.
B. All costs (processes, services, equipment, time, material, staff) necessary to provide products or processes without error.
C. Costs related to preventing errors, such as monitoring and evaluation.
D. Costs that are shared, such as infrastructure costs.

Answer: C

Explanation:
Conformance costs include those related to preventing errors, such as monitoring and evaluation. Nonconformance costs are those related to errors, failures, and defects. These may include adverse events (such as infections), poor access due to staff shortages or cancellations, lost time, duplications of service, and malpractice. Error-free costs are all those costs in terms of processes, services, equipment, time, materials, and staffing that are necessary to providing a product or process that is without error from the onset. Indirect costs are shared costs, such as infrastructure costs and the cost of custodial services.

Question: 4

Under the Affordable Care Act, an Accountable Care Organization (ACO) is part of:

A. Mandated service delivery system.
B. Private insurance initiative.
C. Medicaid.
D. Medicare Shared Savings Program (MSSP).

Answer: D

Explanation:
Under the Affordable Care Act, an Accountable Care Organization (ACO) is part of Medicare Shared Savings Program (MSSP), in which volunteer groups of physicians and other healthcare providers and medical facilities form an organization to provide and coordinate care to groups of beneficiaries (minimum 5,000) in return for financial incentives. The ACO must participate for a minimum of three years and must institute quality measures and cost-containment strategies. The ACO receives a percentage of savings based on benchmark levels.

Question: 5

The purpose of stop-loss insurance is to:

A. Protect the insurance company against excessive payments.
B. Defer medical expenses until a time when funds become available.

C. Replace a part of insurance coverage and exclude certain treatments.
D. Limit the types of services covered.

Answer: A

Explanation:
The purpose of stop-loss insurance, a form of reinsurance, is to protect an insurance company against excessive payments. Thus, the primary insurance may cover the first $150, 000 of medical bills, and then the stop-loss insurance pays a percentage (usually around 80 percent) of bills over that amount, with the primary insurance paying the remainder (usually around 20 percent). Stop-loss is especially valuable for smaller self-funded insurance plans.

Question: 6

The difference between a Medigap plan and Medicare Select is that:

A. Medicare Select offers fewer plans.
B. Medicare Select requires use of specific providers.
C. Medicare Select offers more flexibility in choosing providers.
D. Medicare Select is usually more expensive.

Answer: B

Explanation:
Medicare Select requires use of specific providers, so it is a form of managed care. Provider lists can include hospitals as well as physicians. Patients who receive care outside of this network generally do not receive full benefits or may even be denied benefits, although some forms of emergency care may be covered. Medicare Select offers the same 12 basic programs as Medigap insurance, but premiums are usually lower because patients have less flexibility in accessing health care.

Question: 7

Spend down is the process by which:

A. Insurance companies pay benefits.
B. Insurance companies contract with stop-loss plans.
C. People spend down funds in a health savings account.
D. People spend down assets on medical bills to qualify for Medicaid.

Answer: D

Explanation:
Spend down is the process by which people spend down assets on medical bills to qualify for Medicaid. Medicaid is administered by states, so regulations vary, but in order to qualify, people

must be low income. However, if they have inadequate or no insurance, they can deduct the costs (paid or unpaid bills) they have incurred for medical services from their excess income in order to qualify. Once the spend down reaches the income requirement, Medicaid will pay the remaining medical bills.

Question: 8

When a patient has two (or more) health plans, the case manager should initially:

A. Determine which plan provides the best coverage and will provide the hospital with the most revenue.
B. Determine which plans provide primary and secondary (tertiary, etc.) coverage.
C. Ask the patient to choose which plan to use.
D. Assume both plans will pay for coverage.

Answer: B

Explanation:
When patients have two or more health plans, the case manager should initially determine which plan provides primary coverage and which provides secondary coverage and so on. Rules vary widely regarding the order of payment, so the case manager may need to contact the health plans and determine the order of insurance responsibility on an individual basis. Double coverage is usually precluded, and the patient is often not able to choose. Medicare is primary over supplementary insurances, and private insurances are primary over Medicaid.

Question: 9

The criteria for being "homebound" for eligibility for home health coverage under Medicare include:

A. Leaving home under emergency circumstances only.
B. Leaving home with assistance for medical treatment or short nonmedical purposes.
C. Use of assistive device to be able to leave home for treatment or nonmedical purposes.
D. Inability to drive.

Answer: B

Explanation:
Under Medicare, the eligibility for home health care includes being "homebound," but this does not literally mean the patient is never able to leave home. The patient may leave the home with assistance (wheelchair, walker, special transportation) for short periods for medical (doctor's office visit, therapy) or nonmedical purposes (such as attending church). Patients are considered homebound if a physician recommends the patient not leave the home because of a condition (such as TB) or if leaving the home requires difficult effort.

Question: 10

After being admitted to a long-term care facility, a 70-year-old patient with Medicare can enroll in Medicare Part D:

A. Up to two months after moving out of the facility.
B. Any time during the stay only.
C. Up to one month before moving into the facility and up to two months after moving out.
D. Any time during the stay and up to two months after moving out of facility.

Answer: D

Explanation:
Patients with Medicare admitted to live in a skilled nursing or long-term care facility are eligible to apply for Medicare Part D at any time during the time they are living in the facility and for two months after leaving. Patients who have lived out of the country and moved back to the US may apply within two months after returning to the US Patients who move out of their prescription drug plan's service area can change plans beginning a month prior to the move and up to two months after the move.

Question: 11

The Indian Health Service (IHS) provides health services to members of:

A. Any federally recognized Indian tribes or Alaska natives.
B. Federally recognized Indian tribes or Alaska natives residing in the state of the service center.
C. Specific federally recognized Indian tribes or Alaska natives.
D. Federally recognized Indian tribes or Alaska natives residing in a specified regional area.

Answer: A

Explanation:
The Indian Health Service, a division of HHS, provides health services to members of any federally recognized Indian tribes and Alaska natives directly or through contracted service. If IHS provides service through a specific tribal contract, in that case, services are provided first to tribal members and then to members of other tribes/Alaskan natives as space allows. There are currently 33 IHS hospitals, 50 health stations, and 59 IHS health centers, but the availability of IHS health services is not adequate to meet needs, especially outside of reservation areas.

Question: 12

The protective strategy for insurance companies that involves limiting the maximum dollar benefits for a policy is:

A. Reinsurance.
B. Deferred liability.

C. A cap.
D. Third-party liability.

Answer: C

Explanation:
The protective strategvr for insurance companies that involves limiting the maximum dollar benefits for a policy is a cap. Caps may vary depending on the type of insurance. A routine accident and health benefits plan for one person may set a specific dollar maximum for that person, but a family plan may set a plan cap for the entire family and individual caps. Automobile insurance that covers bodily injury also usually has a category cap (such as $1 million for bodily injury) and per person caps (such as $250,000 per person), so one injured person cannot receive the entire amount.

For More Information – **Visit link below:**

https://www.testsexpert.com/

16$ Discount Coupon: 9M2GK4NW

Features:

- Money Back Guarantee……..……...…. 

- 100% Course Coverage…… 

- 90 Days Free Updates…… 

- Instant Email Delivery after Order……