Practice Exam Questions

ABMCN

AMERICAN BOARD OF MANAGED CARE NURSING

CMCN

Certified Managed Care Nurse

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Total Question: 396 QAs

Question No: 1
Several factors determine healthcare units of payment. Select the statement that most accurately describes how units of payment are derived.
A. Timeframe and date
B. Recipient and beneficiary
C. Type of service and cost/charges
D. All of the above
Answer: D
Explanation: A unit of payment is derived by the use of timeframe and date, recipient and beneficiary, and the type of service and cost/charges. The healthcare system has 10 basic models of payment.

Question No: 2
The primary care provider for a 75-year-old male writes orders to refer the patient to oncology, hematology, and pulmonology following abnormal chest x-ray and blood lab results.
These referrals and joint care planning between multiple providers can help patients and their families function more efficiently to manage care. It will also reduce duplication of service and expensive tests.
Select the type of payment plan described based on the above scenario.
A. Fee-for-service
B. Upside shared savings program
C. Pay for coordination
D. Bundled payment
E. Global budget
Answer: C
Explanation: Pay for coordination describes a payment plan where joint care planning is provided to ensure efficient and cost-effective services. Pay for coordination is a type of payment plan describes joint care planning between multiple providers. This care coordination benefits the patient, family, and healthcare costs by reduction in duplication of services, tests, and procedures.

Question No: 3
Which of the following is not a type of payment model?
A. Pay for coordination
B. Bundled payment
C. Pay for performance
D. Pay for reimbursement
Answer: D
Explanation: The statement that inaccurately describes a payment model is “pay for reimbursement.” All of the other types listed are accurate payment models.

Question No: 4
Identify the statement that best encompasses the key factor in all of the health care payment models:
A. Profit

B. Quality
C. Cost analysis
D. Savings
E. Value
Answer: B
Explanation: The key to all health care payment models is quality. In the majority of the models, there are quality measures and indicators tied to payment outcomes.

Question No: 5
Which healthcare payment model allows for a specific amount of money to cover the “episode?”
A. Fee-for-service
B. Upside shared savings program
C. Downside shared savings program
D. Bundled payment
E. Full capitation
Answer: D
Explanation: “Bundled payment” describes a payment model in which a specified amount of money covers an episode of care. The other options are payment models that do not have this component.

Question No: 6
Which of the following statements is true regarding the payment model termed “the upside shared savings program?” Choose all that apply.
A. Most common with MSSP
B. Provider incentives based on patient populations
C. Percentage of net savings put back into program
D. Excess cost shared by payer and provider
Answer: A,B
Explanation: Upside shared savings programs are payment models that are most common with the Medicare shared savings program (MSSP) and have provider incentives based on patient populations.

Question No: 7
Which healthcare method assigns patients a per member per month (PMPM) payment based on specific criteria?
A. Global budget
B. Upside shared savings program
C. Downside shared saving program
D. Bundled payment
E. Full or partial capitation
Answer: E
Explanation: Full or partial capitation assigns a PMPM payment based on specific criteria. The assignment of payment rates are based on a formula of intended use whether the patient incurs visits or not.

Question No: 8
What type of payment model delivers high quality care economically, engages the patient, and requires

providers meet certain quality measures and performance indicators?
A. Pay for performance
B. Fee for service
C. Upside shared savings program
D. All of the above
Answer: A
Explanation: Pay for performance (P4P) is value-based reimbursement and places focus on value versus volume. It ensures delivery of high quality care economically, engages the patient, requires providers meet certain quality measures and performance indicators.

Question No: 9
All of the following are criteria used in full or partial capitation to determine PMPM payment except:
A. Age and gender
B. Lifestyle behaviors
C. Race
D. Religion and nationality
E. Medical history
Answer: D
Explanation: Religion and nationality are not a part of the criteria used in full or partial capitation to determine PMPM. Age, gender, race, medical history, and lifestyle behaviors are not part of the criteria.

Question No: 10
Which of the following is not an accurate description of the global budget payment model?
A. Set or fixed total dollar amount
B. Amount paid annually
C. Providers determine how the dollars are spent
D. Amount is intended to cover all healthcare costs
E. Patients determine how the dollars are spent and the money follows the patient
Answer: C
Explanation: The global budget payment model is determined by providers, not by patients. The set amount is intended to cover all health care costs and is paid annually. The money does not follow the patient.

Question No: 11
All of the following statements are true regarding healthcare payment models except:
A. The healthcare payment system has variables.
B. The healthcare payment system setup is similar to other professional business models.
C. The healthcare system has 10 basic models of payment.
D. Modes or methods are defined by units of payment.
Answer: C
Explanation: The statement of healthcare system having 10 basic models of payment is incorrect.The healthcare system has eight basic models of payment. These models are applied in most aspects of healthcare payment processes.

Question No: 12

Revenue cycle management in healthcare includes which of the following components.
A. Marketing
B. Coding and claims
C. Payments and refunds
D. Appointment scheduling
E. All of the above
Answer: E
Explanation: Revenue cycle management in healthcare includes marketing, coding, claims, payments/refunds, and appointment scheduling. The cycle begins with patient or member engagement and does not end until there is a no balance on account.

Question No: 13
A patient who was seen the previous week presents for a follow-up appointment. The patient checks in with the front office staff at 4:20 p.m. for a 4:15 p.m. appointment.
The following are important front office tasks to achieve accurate billing and reimbursements except:
A. Verify demographic information
B. Code visit
C. Collect copayment or deductible
D. Check insurance eligibility
Answer: B
Explanation: The front office staff is not responsible for coding the visit. The important tasks during front office check in should include verification of patient information, insurance eligibility, and collection of copayment or deductible, notify if there is an outstanding balance, and ensure HIPAA compliance.

Question No: 14
Which of the following “drivers” affect internal revenue cycles?
A. Patient comorbidity, status of health maintenance
B. Provider productivity, volume and fees
C. Ability to collect copayment or deductible at time of visit
D. Automated system in play
Answer: B
Explanation: The drivers that have an impact on internal revenue cycles include those related to provider productivity, volume of patients, and fees. Patient comorbidity, health maintenance status, ability to collect copayment and automated systems are important aspects of the business but not directly related to the internal revenue cycle drivers.

Question No: 15
Which of the following “drivers” affect external revenue cycles?
A. Commercial insurance payers
B. Patient payments
C. Medicare and Medicaid payers
D. All of the above
Answer: D
Explanation: Commercial insurance payers, patient payments and Medicare and Medicaid payers are drivers

that affect external revenue cycle drivers.

Question No: 16
What does the acronym MACRA represent?
A. Medicaid and Commercial Reimbursement Act
B. Medicare access and CHIP Reauthorization Act
C. Medicare and CHIP Reauthorization Act
D. Medicaid and Children's Healthcare Improvement Process Reauthorization Act
Answer: B
Explanation: The acronym MACRA represents Medicare access and CHIP Reauthorization Act. This act is an important legislation build on ensuring quality care.

Question No: 17
Through which actions does MACRA enable providers to obtain rewards and incentives for providing high quality care? Choose all that apply.
A. Participation in alternative payment plans and innovative reimbursement models
B. Participation in managing high risk populations
C. Participation in a merit based incentive payment system
Answer: A,C
Explanation: There are two methods that MACRA uses for incentives and rewards for providers to ensure high quality health care delivery. MACRA encourages quality care provided by physicians through incentives and rewards based on participation in alternative payment plans, innovative reimbursement models, and participation in a merit-based incentive payment system

Question No: 18
Which statement is not true regarding MACRA?
A. CMS released the final rule for MACRA in October of 2016
B. The MACRA effective date was January 1, 2017.
C. Providers who participate will receive a 2% increase of reimbursements by 2019.
D. Providers who do not participate will receive a 4% decrease of reimbursement by 2019.
Answer: C
Explanation: It is not true that providers who participate in MACRA receive a 2% increase of reimbursements by 2019.This Act allows providers to benefit through incentives and rewards for ensuring high quality health care delivery. There is not a definitive percentage increase to reimbursements. There is a penalty for providers who do not participate. They will receive a 4% decrease of reimbursement by 2019 and penalty applied each year.

Question No: 19
Which statement is incorrect with regard to Medicare PFS?
A. Medicare PFS is a formula that consists of GVPCI PE and work, RVUPE and work, RVU, and GVPI MP multiplied by the conversion factor (CF)
B. Payment for Physicians Services Act was enacted in 1992.
C. National relative values established for work, practice expense (PE), and malpractice (MP) are based on cost by geographic region, then multiplied by CF.

D. Providers will receive a 2% reimbursement increase for care of patients with two or more chronic diseases
Answer: D
Explanation: It is not true that providers will receive a 2% reimbursement increase for care of patients with two or more chronic diseases. All other statements above are correct regarding descriptions and components related to Medicare physician fee schedule (PFS).

Question No: 20
What Act of 2015 proposed and ruled to base reimbursements upon the Medicare physician fee schedule?
A. MACRA
B. Bipartisan Budget Act
C. Two-Midnight rule
D. CMS site neutral
E. None of the above
Answer: B
Explanation: The Bipartisan Budget Act of 2015 proposed to interpret reimbursement on Medicare physician fee schedule.

Question No: 21
The proposed Bipartisan Budget Act affects reimbursements and payments.
Which statement below is false regarding these proposed impacts?
A. $500 million reduction in payments under the hospital outpatient prospective system
B. $1.7 million in increased payments under the Medicare physician fee schedule
C. CMS site neutral payments
D. The proposal targets a subset of hospitals with over 350 beds
E. None of the above
Answer: D
Explanation: The Bipartisan Budget Act of 2015 does not propose to target a subset of hospitals with over 350 beds. (It does target a subset of hospitals with over 250 beds.)

Question No: 22
Under which rule did CMS discontinue the inpatient payment cut to hospitals?
A. Two-Midnight rule
B. CMS site neutral payments
C. Bipartisan budget
D. None of the above
Answer: A
Explanation: CMS discontinued an inpatient payment cut to hospitals under the Two-Midnight rule.

Question No: 23
What has been an effect under the 2016 CMS rule to discontinue the inpatient payment cut to hospitals?
A. CMS site neutral payments
B. Decreased quality of service
C. Increased patient observations
D. Increased Emergency room visits

E. None of the above
Answer: C
Explanation: The effect of the 2016 CMS rule to discontinue inpatient payment cuts to hospitals has been increased patient observations.

Question No: 24
What was the catalyst for CMS to propose site-neutral payments?
A. Quality of care across sites of care
B. Payment equalization across care sites
C. Guaranteed payments across care sites
D. Guaranteed and equalized reimbursement across CMS care sites
E. None of the above
Answer: B
Explanation: The catalyst for CMS to propose site-neutral payments was for payment equalization across care sites. There are examples of hospitals purchasing clinics/practices as provider based departments for which the hospital could bill as additional facilities.

Question No: 25
What actions did CMS take in fiscal year 2014 to control the increased costs related to the Two-Midnight rule in Medicare Part A?
A. Payment equalization across care sites
B. Guarantee payments across care sites
C. Reduced payments at 0.2% for inpatient services
D. Reduced payments at 0.4% for inpatient and outpatient services
Answer: C
Explanation: CMS reduced payments 0.2% for inpatient services in 2014 to control the cost increase due to the Two-Midnight rule in Medicare Part A.

Question No: 26
Which of the following is not key documentation components to accurate level of care coding for reimbursement?
A. ICD-9 codes
B. Medical decision making
C. Presenting problem
D. Examination
E. Patient history
Answer: A
Explanation: ICD-9 codes are not a key component to accurate level of care for reimbursement. This system has been replaced by ICD-10. CPT codes are key to level of care coding.

Question No: 27
Select the statement(s) that describe the CMS Two-Midnight rule.
A. Patients for whom a provider expects will need to spend two nights on inpatient status.
B. Patient presenting condition must match a specific criteria on the ICD-10 for a two-night inpatient stay.

C. Clarification and delineation of patients expected to be in an inpatient status for which a provider anticipates inpatient care will be necessary.
D. All of the above
Answer: D
Explanation: CMS Two-Midnight rule covers patient for whom a provider expects will spend two nights on inpatient status. It also provides clarification and delineation of patients expected to be in an inpatient status and anticipates inpatient level care will be needed. There are financial/reimbursement effects related to this ruling as inpatient and outpatient rates differ.

Question No: 28
Select the statement that describes aspects of SNOMED CT.
A. Foundational language for EHR with expansive computerized healthcare terms
B. Provides a standard healthcare language regardless of provider type
C. Enables clinical data to be aggregated for reportable usage
D. All of the above
Answer: D
Explanation: Systematized Nomenclature of Medicine-Clinical Terms (SNOMED CT) is the foundational language for EHR with expansive computerized healthcare terms. It provides a standard healthcare language regardless of provider type and enables clinical data to be aggregated for reportable usage.

Question No: 29
Which coding standard is utilized by insurance companies to standardize provider service rates, provider standard nomenclature and identifies services rendered.
A. ICD-9
B. CPT
C. ICD-10
D. SNOMED
E. LOINC
Answer: B
Explanation: Current Procedural Terminology (CPT) is a coding standard utilized by insurance companies to standardize provider service rates, provider standard nomenclature and identifies services rendered.

Question No: 30
Which coding standard is a set of international alphanumeric codes used to describe diagnosis, symptoms, diseases, and causes of death?
A. ICD-9
B. CPT
C. ICD-10
D. SNOMED
E. LOINC
Answer: C
Explanation: ICD-10 is a set of international alphanumeric codes used to describe diagnosis, symptoms, diseases, and causes of death. International Coding of Disease (ICD) is a commonly known and used set of alphanumeric codes used to describe diagnosis, symptoms, diseases, and causes of death. This system was

developed by World Health Organization (WHO).

Question No: 31
A provider who is unsure of the effect on their reimbursements wants to know how she will be impacted by the changes with PQRS and MIP.
What is an appropriate response in your role as a CMCN?
A. The quality concepts and metrics involved with PQRS and meaningful use are key elements to meeting quality measures.
B. The change involved a rollup of PQRS into the MIP system under MACRA effective January 1, 2017.
C. There are penalties as high as 50% of the reimbursable rate for not participating.
D. All of the above
Answer: D
Explanation: An appropriate response from the CMCN to the provider regarding changes with PQRS and MIP would include information on the change that involved a rollup of PQRS into the MIP system under MACRA effective January 1, 2017. The quality concepts and metrics involved with PQRS and meaningful use are key elements to meeting quality measures. If a provider has done well with these components, they are on the right track for quality metrics in the new MACRA system.

Question No: 32
In population care management, cost and/or risk are determined using statistical methods.
This is referred to as:
A. Productive modeling
B. Presumptive modeling
C. Predictive modeling
D. Prevention modeling
E. Patient population management modeling
Answer: C
Explanation: Predictive modeling is the use of statistical methods to determine possible cost or risk related to population care management.

Question No: 33
Identify the penalties associated with violating the Sherman Antitrust Act.
A. $100 million for organizations and up to 10 years in prison
B. Fines up to twice the amount gained by perpetrator or amount lost by victim if over $100 million
C. $1 million for individuals and up to 10 years in prison
D. All of the above
Answer: D
Explanation: The penalty for breaking the Sherman Antitrust Act is $100 million for organizations and up to 10 years in prison. For individuals, the penalty is $1 million and up to 10 years in prison. Fines can be twice the amount gained by perpetrator or amount lost by victim if over $100 million. The actions related to breaking the law tends to be civil and this federal criminal law can be prosecuted by the Department of Justice.

Question No: 34
What would be an applicable long-term action by a CMCN to reduce healthcare spending?