1. All of the following may be done by the care manager at some point, but which of the
following is a primary function of a care manager?
a. To assist in LTAC placement
b. To assist in educating the customer about medications
c. To assist in controlling costs and continuity of care
d. To assist the customer in filling out medical documents
2. While many customers can be helped by the services of a care manager, which of the following would benefit most from the services of a care manager?
a. A primigravida who was discharged from the hospital 3 days ago. Lactation consultation needed.
b. The mother of child with Down's syndrome, who is experiencing behavioral disturbance and uncontrolled thyroid issues.
c. A customer discharged from the emergency department due to a left tibia fracture, with insurance, who needs to follow up with an orthopedic specialist.
d. An affluent geriatric patient with a strong familial support system, LTAC insurance, a living will, and an advanced directive.
3. Care managers assist customers often in all of the following except:
a. Assisting geriatric and disabled customers to find engaging social and recreational activities
b. Communicating medical information to family members and providers
c. Assisting the customer to choose the most appropriate type of housing for their needs
d. Deciding on a standard care plan for the customer

Using the following scenario to answer questions 4-9:
A certified care manager in Miami, Florida, is contacted by the daughter of a potential customer. She lives in New York and is hoping to find help for her 85 yearold father, Mr. Bennett, who lives in Miami. Her father lives in a retirement community where he has been managing all his own affairs for years, since his wife passed away. He has one other son, who also resides in New York. He had been doing fine until the last two months when he began noticeably forgetting important things. He visited his primary care provider and, after an extensive work up, was given the diagnosis of Alzheimer's disease, stage 2. She states that he is devastated and that she is now exploring options for help in managing his care.
4. Mr. Bennett's daughter asks if now is the right time to enlist the help of a certified care manager. Based on the scenario, which of the following answers would be most appropriate?
a. The best time to consult a certified care manager is when your father can no longer make decisions on his own and needs you to step in and intervene.
b. The best time to consult a certified care manager is when someone is young and has no immediate or long term needs to be met at this time.
c. The best time to consult a certified care manager is when a customer is managing pretty well on their own but small change or a diagnosis shows that it may be time to start making long term plans.
d. The best time to consult a care manager is after a customer is in a nursing home, hospital, or long term care facility and has exhausted their length of stay.
5. A few days later, Mr. Bennett comes to see the care manager. He verifies the information given by his daughter. What further information is most pertinent to illicit during the initial assessment?
a. Age of diagnosis
b. Years married
c. Ability to pay for service
d. Goals for care
6. Mr. Bennett adds that he is concerned that his current housing situation will eventually not be able to provide for his needs as his disease progresses. Which of the following would not be appropriate?
a. Explain the different types of housing and facility options that Mr. Bennett could choose from.
b. Ask Mr. Bennett if he would prefer staying in Florida or being closer to one of his children as his disease progresses.
c. Explain to Mr. Bennett that his needs will be able to be met in his retirement community throughout the progression of his disease.
d. Explain to Mr. Bennett the different types of home care management options available.
7. Mr. Bennett reveals he would like to remain in Florida as long as he is able to function appropriately here, as he has an active social life, a girlfriend, and loves playing golf with his retirement community friends. He mentions that when he is no longer able to take care of himself he would like to move back to New York. He states he would prefer to move in with one of them, but if they couldn't house him, he would be willing to move into a facility nearby. Which of the following would best aide Mr. Bennett in maintaining his goal of remaining in Florida independently?
a. Home health aide/home helper
b. Physical therapy
c. Occupational therapy
d. Adult Day Care
8. Based on the information in the previous question, what would the first step be in determining where Mr. Bennett should live when he returns to New York?
a. Determining which of the adult children's home would be safest
b. Determining the social support of his children and if they are able and willing for him to live there
c. Determining the cost of inpatient facilities in that area of New York
d. Determining which of the inpatient facilities Mr. Bennett would most like to live in
9. Mr. Bennett admits that he has not mentioned to his children that he has a girlfriend here. He states that she knows all about his health condition and he would like her to be able to make decisions on his behalf. Which advice is most appropriate?
a. Discuss with Mr. Bennett that this solution is impractical as he will eventually move to New York and his girlfriend will not be able to go with him.
b. Discuss with Mr. Bennett that if he wants his girlfriend to be able to make decisions that he needs to notify his adult children so that they will allow her to make decisions when he is unable.
c. Discuss with Mr. Bennett what types of decisions that he would like to allow his girlfriend to make, to gain clarity, and if needed assist him with getting an advanced directive or living will.
d. Discuss with Mr. Bennett that if he wants his girlfriend to be able to make health care decisions for him that he will have to be legally married to her, as the state will otherwise not recognize her authority to do so.
10. A care manager has been working with a 76 -year old female with lung cancer. She was placed on hospice care by her physician 6 months earlier (two 90-day periods), but she is still alive. Her family asks the care manager if the patient will be removed from hospice care. The best response is:
a. "She will be removed from hospice care until her condition worsens because she has exceeded the 6-month period."
b. "She has exhausted all of her hospice care benefits and will be removed from hospice care."
c. "She can continue with hospice care as long as the physician authorizes the care every 60 days."
d. "She can continue with hospice care if the physician continues to authorize care every 90 days."
11. The care manager is working with a consumer with end-stage bone cancer that has elected hospice and palliative care. The patient is experiencing severe bone pain from a tumor, and the physician orders radiotherapy to reduce the tumor's size and to reduce pain. Is this treatment acceptable under hospice care criteria?
a. No, the patient has elected to forego curative treatment, so Medicare will not pay for the radiotherapy.
b. No, the patient needs to be removed from hospice care first.
c. Yes, hospice recommends only palliative care but curative treatment is acceptable.
d. Yes, if the purpose of the treatment is to relieve pain, it is essentially palliative.
12. A legal document that specifically designates someone to make decisions regarding medical and end-of-life care if a consumer is mentally incompetent is $a(n)$ :
a. Advance directive.
b. Do-not-resuscitate order.
c. Durable Power of Attorney for Health Care.
d. General power of attorney.
13. A 67-year-old terminally ill consumer wishes to receive comfort care measures in his home. The consumer's physician recommends placement in a hospice facility so that Medicare will cover the cost of hospice care. Which of the following statements made by the care manager would most accurately describe the Medicare hospice benefit?
a. The Medicare hospice benefit applies to consumers who have a life expectancy of 12 months or less
b. The Medicare hospice benefit does not cover the cost of medications used to treat symptoms of terminal illness
c. The Medicare hospice benefit covers the cost of hospice services in multiple settings, including the consumer's home
d. Services provided under the Medicare hospice benefit vary from state to state
14. Disagreement between family members about the plan of care when a palliative care consumer lacks the capacity to make treatment decisions should be managed by:
a. Pursuing legal action to expedite designation of a single family member as medical decisionmaker
b. Encouraging the family to consider and discuss what they believe the consumer would choose if he or she were able to express his or her wishes
c. Informing the family that palliative care planning is inappropriate unless the family can reach an agreement
d. Encouraging each family member to consider what they would choose for themselves in similar circumstances
15. The most cost-effective solution for an elderly consumer with mild to moderate Alzheimer's disease who can no longer stay alone while her primary caregiver works parttime outside the home is:
a. residential care facility.
b. adult day-care program.
c. adult day healthcare.
d. home health agency.
16. The type of healthcare insurance that pays in the form of predetermined payments for loss or damages rather than for healthcare services is:
a. liability insurance.
b. no-fault auto insurance.
c. indemnity insurance.
d. accident and health insurance.
17. A consumer who has been with a care manager is planning to have a hip replacement. The consumer would like to be admitted to an inpatient rehabilitation facility after surgery. The care manager knows that a consumer 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 of $\geq 40$.
b. BMI of $\geq 50$.
c. age $\geq 65$.
d. age $\geq 75$.
18. 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 may exclude certain treatments.
d. limit the types of services covered.
19. 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.
20. 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.
21. 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.
22. After being admitted to a long-term care facility, a 70-year-old consumer 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.
23. 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.
24. When an insurance plan negotiates a specific fee for a procedure (including all charges) and pays one bill, this is referred to as:
a. unbundling.
b. bundling.
c. fee-for-service.
d. discounted fee-for-service.
25. Appeals for denial of urgent care must be decided by the insurance company within:
a. 72 hours.
b. 48 hours.
c. 24 hours.
d. 12 hours.
26. Under a healthcare management program for diabetics, a targeted approach to reducing complications includes:
a. providing posters in physicians' offices.
b. providing television commercials.
c. participating in a community health fair.
d. providing nutritional counseling.
27. The primary consideration in medication management for a consumer with chronic kidney disease is:
a. drug clearance.
b. drug frequency.
c. drug dosage.
d. drug absorption.
28. In a subacute facility, a stroke patient who requires 20 days of care and rehabilitation and/or nursing services four hours a day is categorized as:
a. chronic subacute.
b. general subacute.
c. transitional subacute.
d. long-term transitional subacute.
29. Which evaluation is performed to determine if a consumer has the capability to return to work?
a. pain tolerance evaluation
b. functional capacity evaluation
c. disability evaluation
d. evaluation by consumer interview
30. The primary role of the care manager is to act as a:
a. consumer advocate
b. disease manager
c. utilization reviewer
d. care plan creator
31. A terminally ill consumer is exhausting all financial resources to pay medical costs. The care manager has suggested obtaining cash value on his life insurance policy prior to death. This process is known as a:
a. nontraditional policy
b. supplementary policy
c. viatical settlement
d. gatekeeping

## Answer Key and Explanations

1. C: Primary functions of care managers include: personalized service- which includes tailoring interventions and care plans to what the customer actually wants; controlling costs- this is often done by avoiding unnecessary hospital placements, avoiding services being duplicated, and using long term planning as opposed to crisis intervention; Easy access- because most care manager services are available around the clock, the customer has somewhere to turn no matter the time of day; and continuity of care- one of the main aspects of the care manager's job is to promote collaboration between the professionals providing care to the customer.
2. B: Care Managers often work with geriatric consumers to help plan their care, but other categories of consumers who often greatly benefit from a care manager include those with: mental health issues, chronic illnesses, disabilities (both physical and developmental), and brain injuries. While a care manager may be able to assist in any of the listed answers, in the answer choices provided the care manager could most benefit the mother of the child with Down syndrome, as the thyroid issue and behavioral issues could likely be managed better with the continuity of a care manager.
3. D: This answer is incorrect because the goal of the care manager is to create with input of the customer and family, a unique care plan that is specific for that person's circumstances. Care managers can assist with social activities for geriatric and disabled customers, communicating medical information, choosing the most appropriate type of housing and services needed in that environment and with legal and financial options.
4. C: The best time to consult a certified care manager is when a customer is managing pretty well on their own but small change or a diagnosis shows that it may be time to start making long term plans. While a care manager may be consulted at any time and point to assist the customer or family with needs, the most optimal time to consult a care manager is this, as the customer can foresee some real needs and understand the gravity of making decisions and giving directives now, but still has cognitive and functional capacity.
5. D: After the goals for care are decided upon, ability to pay for different services can be assessed. The number of years he was married is not applicable and the scenario tells you that his diagnosis was given in the last few months.
6. C: At the end stages of Alzheimer disease, it would not be appropriate for him to remain at the retirement community living alone as he will likely require total care. All the other options would be good options for opening communication, educating the customer on options and building a care plan.
7. A: Many of the home helpers currently available, especially to someone who has the finances to pay for it, can help with everything from cooking and cleaning to assisting someone to appointments. Many are trained to monitor nutrition and assist with medication. This would be the best option for Mr. Bennett at this point to help him maintain independence as long as possible. Adult Day Care would be for when he is no longer independent and his plan includes returning to New York at that time.
8. B: As Mr. Bennett voiced that he would like to live with one of his children, one of the first steps in creating a long term plan would be determining if his children would be willing and also able. All steps after that are secondary to making that decision, as it does not matter how safe the place
would be if they would not be able to have him live there, and while he will need to know which inpatient facilities he likes and their prices, that would come tertiary per his stated wishes.
9. C: This is an important situation to clarify at this point. Mr. Bennett needs to decide what is practical for his girlfriend to have decisions on and what would not be possible. He should be notified that if he does in fact decide that he wants her to make his medical decisions that he should not just mention it to his adult children, because without necessary paperwork (advance directives) his children would legally be his next of kin and could make decisions with or without her agreement. He does not have to marry her for her to have this right; advanced directives are legally binding documents. However, it would be good to discuss with Mr. Bennett his long term plans and how much involvement he truly foresees for his girlfriend, for example, who would make the decision that it is time to move back to New York when he is no longer competent etc., but at this juncture it is probably hard for him to truly grasp the gravity of these decisions so discussion and clarification are needed.
10. C: Initially, the physician must certify that a consumer who is eligible under Medicare $A$ is terminal with a life expectancy $\leq 6$ months (two 90 -day periods). However, if the consumer remains alive, the physician can extend coverage by authorizing continued hospice care every 60 days. The goal is to maintain the consumer in the home environment with home health aides, homemakers, durable goods, pain management, case management, counseling, and care manager assistance. Routine intermittent home care must comprise $80 \%$ of total care, with in-home continuous care and in-patient hospice care available for short augmenting periods only.
11. D: Palliative care provides comfort rather than curative treatment, although curative treatment may also relieve pain or symptoms. Thus, there is no clear line between the two. Palliative care is meant to improve the quality of life and to relieve suffering, but it does not include treatments solely intended to prolong life or hasten death. The goals of palliative care are to provide adequate pain management and relief of symptoms (such as nausea or shortness of breath), to provide support for both the consumer and caregivers or family, and to ensure that consumers and family receive psychosocial, spiritual, and bereavement support.
12. C: The legal document that designates someone to make decisions regarding medical and end-of-life care if a patient is mentally incompetent is a Durable Power of Attorney for Health Care. This is one type of advance directive, which can also include a living will, a medical power of attorney, and other specific requests of the patient regarding his or her health care. A do-not-resuscitate order is a physician-generated document that is completed when a patient does not want resuscitative treatment in an end-of-life situation. A general power of attorney allows a designated person to make decisions for a person over broader areas, including financial concerns.
13. C: The Medicare hospice benefit is a federal program for Medicare-eligible patients with an estimated life expectancy of 6 months or less. Because Medicare is a federally funded program, eligibility requirements and benefits do not vary from state to state. The cost of all supplies and medications being used in relation to the terminal illness are covered under the Medicare hospice benefit. Hospice care may be provided in multiple settings, including home, outpatient, and inpatient settings. A patient need not have a "Do not resuscitate" order to qualify for the Medicare hospice benefit. Patients who have activated the Medicare hospice benefit may opt to return to "regular" Medicare (i.e., Medicare Part A) at any time.
14. B: When terminally ill consumers lack the mental capacity to make end-of-life treatment decisions, family members usually become the primary medical decision-makers in the absence of a predetermined health care power of attorney. Family members may have conflicting values and
opinions about end-of-life issues. Convening a family conference with palliative care providers is helpful in cases where there is disagreement among family members regarding the plan of care. Once the family members are updated about the medical status of the consumer, a respectful and honest conversation should take place in which each family member's opinions and concerns about what the plan of care should be are elicited. Members of the palliative care team can encourage family members to consider what they believe the consumer would have wanted if he or she were able to decide for him- or herself. This may be quite different from what they would choose for themselves in a similar situation.
15. B: An adult day-care program designed for Alzheimer's consumers is the most cost-effective solution. These programs vary, but average about $\$ 65$ per day, and some are supported by grants to defray costs for those with low income. Adult day healthcare programs are health-focused programs with RNs and therapists (speech, physical, occupational) available with costs depending on services utilized. Residential care facilities may cost from $\$ 2,000$ to $\$ 8,000$ or more monthly. Home Health Agencies charge on an hourly basis, usually about $\$ 25$ per hour for an aide.
16. C: Indemnity insurance pays in the form of predetermined payments for loss or damages rather than for healthcare service. Liability insurance pays damages for bodily injury or loss of property, such as injury resulting from unsafe conditions. No-fault auto insurance pays for injury/damages resulting from driving a car, with coverage varying according to state regulations. Accident and health insurance pays for healthcare costs and may or may not include disability payments, depending on the type of policy.
17. B: 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 patient's conditions must meet at least one additional criterion, which includes body mass index (BMI) of $\geq 50$ (extreme obesity), bilateral knee and/or hip surgery, or age $\geq 85$
18. A: 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.
19. B: 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.
20. D: 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.
21. B: Under Medicare, the eligibility for home health care includes being "homebound," but this does not literally mean the consumer is never able to leave home. The consumer 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). Consumers are considered homebound if a physician recommends the consumer not leave the home because of a condition (such as TB) or if leaving the home requires difficult effort.
22. D: Consumers 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. Consumers who have lived out of the country and moved back to the U.S. may apply within two months after returning to the U.S. Consumers 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.
23. C: The protective strategy 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.
24. B: Bundling occurs when an insurance plan negotiates a specific fee for a procedure, including all associated costs, and pays one bill. Unbundling occurs when a bundled agreement is dissolved, and the insurance plan pays separate bills (hospital, anesthesiologist, surgeon, etc.). Fee-for-service is the traditional billing method in which services are billed separately. Discounted fee-for-service is similar to fee-for-service except that reimbursements are discounted.
25. A: Appeals for denial of urgent care must be decided by the insurance company within 72 hours. Insurance companies have 30 days to review and make a decision about nonurgent care that a consumer has not yet received but 60 days for care that the consumer has already received. A consumer can appeal directly to their insurance companies if care is denied or ruled medically unnecessary and if the insurance company claims the consumer is not eligible, treatment is experimental, or the consumer is filing claims for a preexisting condition that is not covered.
26. D: In a targeted approach, healthcare management focuses on the needs of a specific consumer or a group of consumers with similar problems. In this case, providing nutritional counseling directly to consumers who are not adequately controlling their diabetes may improve outcomes by preventing complications and frequent hospitalizations and may reduce costs. These programs may set individual target goals as well, such as a specific weight loss or maintenance of a specific range for blood glucose levels.
27. A: The primary consideration for medication management for a consumer with kidney disease is drug clearance. Most drugs are cleared through the liver and/or kidneys. While kidney disease may also affect absorption and metabolism, resulting in ineffective dosage, the inability of the kidneys to clear the drug may result in toxic reactions or adverse reactions. Drug dosing often must be adjusted, according to the consumer's condition and glomerular filtration rate. Adjustments can include lowered doses, less frequent drug administration, or a combination of both approaches.
28. B: These correspond to general subacute. Categories of subacute patients include: Transitional subacute: Estimated stay of three to 30 days and rehabilitation and/or nursing services five to eight hours per day. General subacute: Estimated stay of 10 to 40 days and rehabilitation and/or nursing services three to five hours per day. Chronic subacute: Estimated stay of 60 to 90 days and rehabilitation and/or nursing services three to five hours per day. Long-term transitional subacute:

Estimated stay of $\geq 25$ days and rehabilitation and/or nursing services six to nine hours per day. (Patients are often transferred to long-term care facilities.)
29. B: The functional capacity exam is a process of assessing a person's physical and functional abilities to perform tasks. The consumer's performance level should match the demands of the occupation in question. The purpose of the exam is to determine if a consumer is ready to go back to work after an injury.
30. A: Consumer advocate is the best answer. Advocacy is essential to a care manager's daily practice. A care manager acts on behalf of consumers who may not be able to speak for themselves or who are not knowledgeable about health care. Above all, the care manager should always have the consumer's best interest in mind.
31. C: This scenario describes the process known as a viatical settlement whereby a consumer can obtain cash value from a life insurance policy prior to death.
32. A: A care manager establishes a relationship with a consumer to advocate for his best interests. This makes the care manager a fiduciary. The term ex parte refers to a legal proceeding or a legal order. A tort, on the other hand, refers to a wrongful act performed willfully. When a person investigates a business or personal relationship prior to signing a contract, he is performing due diligence.
33. C: The relationship that exists between the care manager and a referral provider is an ostensible agency. If that provider were to perform negligent actions, the referring care manager may also become subject to litigation. A fiduciary is a relationship whereby the care manager acts in the consumer's best interests. The care manager is an advocate for the consumer, not the provider.
34. D: A care manager has to have knowledge of the referral provider's credentials and clinical experience. If a care manager sends a consumer to an unqualified referral provider, this constitutes a negligent referral. It is important for the care manager to check in with consumers afterward to assure that they had a positive experience with the provider. It is also the care manager's responsibility to report any misconduct on the part of that provider.
35. B: Sometimes consumers oppose treatment due to inadequate understanding of clinical information and treatment options. Before proceeding with other actions, the care manager should ensure that the consumer has a complete understanding. Discussions and decisions are carefully documented.
36. A: In cases such as this one where no parent, spouse, sibling, significant other, or close friend is available to make decisions, two physicians can serve as surrogates.
37. B: Consumers under subacute care don't need diagnostic work-ups. Subacute care includes all levels of care not requiring acute hospitalization. The consumers are medically stable and have a constant treatment plan.
38. C: The scenario describes intermediate care. Under assisted living or custodial care, the consumer is stable, takes a consistent regimen of oral medications, and does not need suctioning. Skilled nursing is for complex, but generally stable, consumers who may need central line care, IV push medications, variable adjustments in dosages of medicines, and assessment of laboratory values.

