ACMA CASE MANAGEMENT CERTIFICATION PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. HINN 12 is given to inform beneficiaries about potential financial liability for non-covered continued stay and is given along with which notices?

A. The Detailed Notice of Discharge

B. The Hospital Discharge Appeal Notices

C. The Notice of Hospital Required Review

D. The Important Message from Medicare

2. What is a medical necessity denial and how would you structure an appeal?

A. A denial is simply the result of billing errors with no impact on care.

B. A denial occurs when a payer determines the service is not medically necessary; structure an appeal with a clear rationale, supporting evidence, and relevant guidelines within deadlines.

C. A denial occurs automatically for all new services; structure an appeal with generic statements.

D. A denial can be ignored if it is not evident.

3. Which strategy is specifically designed to bridge care after hospitalization to reduce readmissions?

A. Transitional care management

B. Early follow-up

C. Home visits when needed

D. Medication reconciliation

4. Which requirement must be met to bill a Condition Code 44?

A. The change must be made prior to discharge.

B. The claim has not been submitted.

C. The MD concurs with the UM decision.

D. The occurrence is documented in the medical record.

5. What is the purpose of including red flags in a discharge summary?

A. To inform patient or caregiver about warning signs requiring attention

B. To confuse the patient

C. To meet regulatory requirements without relevance

D. To delay follow-up

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6. Discharge planning often includes which administrative step?

A. Scheduling follow-up appointments

B. Authorization of insurance for services

C. Selecting a new primary care physician

D. Providing only discharge instructions

7. Effective discharge planning requires communication with which groups?

A. Only the patient

B. The patient and family, the health care team, outside services, and the health plan

C. Only the hospital administrator

D. Only the patient's primary care physician

8. Which is an allowed method for delivering HINN notices?

A. In person delivery

B. Email to patient

C. Fax to patient

D. Postal mail

9. What is cost-to-care analysis and how is it used to demonstrate value?

A. It only tallies costs without outcomes.

B. It is used solely for budgeting for staff salaries.

C. It compares costs across departments without outcomes data.

D. Analyzing the costs of care relative to outcomes to show ROI and justify program investments and care improvements.

10. Which part of Medicare pays for hospice services?

A. Medicare Part A

B. Medicare Part B

C. Medicare Part C

D. Medicare Part D

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Answers

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1. B
2. B
3. A
4. A
5. A
6. B
7. B
8. A
9. D
10. A

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Explanations

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1. HINN 12 is given to inform beneficiaries about potential financial liability for non-covered continued stay and is given along with which notices?

A. The Detailed Notice of Discharge

B. The Hospital Discharge Appeal Notices

C. The Notice of Hospital Required Review

D. The Important Message from Medicare

When a hospital stay might involve liability for non-covered days, the patient needs both the financial information and the right to challenge the decision. HINN 12 serves to inform the beneficiary about potential financial liability for non-covered continued stay, and it is paired with the Hospital Discharge Appeal Notice to convey the appeal rights and how to initiate an appeal. This pairing ensures the patient understands not only the potential cost but also the steps they can take if they disagree with the discharge decision. The other notices serve different purposes or contexts and do not specifically provide the required appeal-right information together with the non-coverage notice.

2. What is a medical necessity denial and how would you structure an appeal?

A. A denial is simply the result of billing errors with no impact on care.

B. A denial occurs when a payer determines the service is not medically necessary; structure an appeal with a clear rationale, supporting evidence, and relevant guidelines within deadlines.

C. A denial occurs automatically for all new services; structure an appeal with generic statements.

D. A denial can be ignored if it is not evident.

Medical necessity denial means the payer has concluded that the requested service is not medically necessary under their coverage criteria. It isn't about billing mistakes or automatic denials for new services; it centers on whether the service meets the insurer's standards for medical necessity and appropriateness of care. When you structure an appeal, the goal is to show why the service is needed for the patient in a clear, evidence-based way, and to align that argument with the payer's criteria and deadlines. Begin with a concise overview: identify the patient and the service being appealed, the date of service, and the specific denial reason. Then present a strong clinical rationale that links the patient's diagnosis, symptoms, functional impact, and prior treatment history to the medical necessity for the requested service. Tie the rationale to precise criteria used by the payer, such as medical necessity policies or guideline recommendations, and cite relevant guidelines or policy language to support the decision. Include concrete evidence from the patient's records: problem list, progress notes, physical findings, diagnostic test results, treatment response, and any prior authorization or step-therapy requirements that were satisfied or documented. Attach supporting documentation: full medical records, test results, treatment notes, summaries from the treating clinician, and any prior authorization documentation. Provide a clear narrative that interprets this evidence in the context of the payer's criteria, and specify the CPT/HCPCS codes and ICD-10 codes that justify the service. If applicable, address the denial reason directly and explain how each criterion for medical necessity is met, including expected clinical benefits, alternatives considered, and the risks of withholding the service. Include a plan for monitoring outcomes and a continuation or escalation plan if appropriate, and remember to submit within the stated deadlines. The other options describe scenarios that don't reflect how denials work or how to argue them effectively, which is why they're not suitable.

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3. Which strategy is specifically designed to bridge care after hospitalization to reduce readmissions?

A. Transitional care management

B. Early follow-up

C. Home visits when needed

D. Medication reconciliation

The main idea behind this concept is creating a structured plan that carries a patient smoothly from hospital discharge back into the home and ongoing care, with the goal of preventing readmissions. Transitional care management is built specifically for that bridge. It isn't just one action, but a coordinated process that starts soon after discharge and continues with a clear plan: timely contact with the patient, arranging and ensuring follow-up with a clinician, reconciliation of medications, and good communication among the patient, caregiver, and all providers involved. This approach also links hospital care with home or community supports as needed, so potential problems—like confusing prescriptions, missed follow-ups, or unmanaged symptoms—don't derail the patient's recovery. Early follow-up and home visits can be parts of this process, and medication reconciliation is important, but they aren't by themselves the full bridge. Transitional care management brings these elements together into a cohesive strategy focused on continuity of care across settings, which is what reduces the chance of patients returning to the hospital.

4. Which requirement must be met to bill a Condition Code 44?

A. The change must be made prior to discharge.

B. The claim has not been submitted.

C. The MD concurs with the UM decision.

D. The occurrence is documented in the medical record.

Timing of changes to a hospital claim matters. To bill this code, the change must be entered before the patient is discharged. Implementing the adjustment while the claim is still open ensures the claim reflects the final status and billing details at the time of discharge, which keeps payments and DRG calculations accurate and avoids post-discharge edits that can delay payment or trigger audits. If the discharge has already occurred, this code isn't billable; other adjustment pathways would apply instead. The other options describe conditions that aren't about when the change can be made, so they don't determine eligibility for this code.

5. What is the purpose of including red flags in a discharge summary?

A. To inform patient or caregiver about warning signs requiring attention

B. To confuse the patient

C. To meet regulatory requirements without relevance

D. To delay follow-up

The main idea is that red flags in a discharge summary are there to guide safety after leaving care by signaling what warning signs require prompt medical attention. Including these flags helps patients or caregivers recognize when a condition may be getting worse and knows exactly how to respond, such as when to seek urgent help or contact a clinician, which supports timely escalation and safer transitions from hospital to home. This practice also reinforces patient involvement in their own care and can reduce unnecessary delays and complications by making expectations clear. It's not about confusing the patient, ticking a regulatory box, or delaying follow-up.

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6. Discharge planning often includes which administrative step?

A. Scheduling follow-up appointments

B. Authorization of insurance for services

C. Selecting a new primary care physician

D. Providing only discharge instructions

Discharge planning centers on coordinating what happens after the patient goes home, including ensuring that post-discharge care is approved and paid for. The administrative step most central is obtaining authorization from the patient's insurer to cover upcoming services. This ensures post-discharge needs like home health, equipment, or follow-up care are funded and available, reducing delays in recovery. Scheduling follow-up appointments is part of care coordination but not the payer authorization itself; selecting a new primary care physician isn't necessary for everyone; and giving discharge instructions is essential but focuses on care instructions rather than securing coverage.

7. Effective discharge planning requires communication with which groups?

A. Only the patient

B. The patient and family, the health care team, outside services, and the health plan

C. Only the hospital administrator

D. Only the patient's primary care physician

Effective discharge planning hinges on broad, coordinated communication among everyone involved in the transition. The patient should be informed and engaged; family or caregivers need to understand the plan and support adherence; the health care team must align on medical care, medications, follow-up, and safety needs; outside services (such as home health, rehabilitation, social work, and transportation) arrange post-discharge support; and the health plan often coordinates coverage and any required services or authorizations. This comprehensive communication reduces the risk of medication errors, missed follow-ups, or gaps in services, which can lead to avoidable readmissions. Focusing only on the patient misses essential support and coordination; focusing only on the hospital administrator omits clinical and patient-centered elements; focusing only on the primary care physician excludes the patient and other critical providers and services.

8. Which is an allowed method for delivering HINN notices?

A. In person delivery

B. Email to patient

C. Fax to patient

D. Postal mail

The method focuses on ensuring privacy, security, and verifiable delivery of sensitive information. Delivering a HINN notice in person provides immediate confirmation that the notice was received, allows you to verify the recipient's identity on the spot, and gives a clear, auditable record in the chart. This direct handoff minimizes the risk of PHI being intercepted, misdelivered, or accessed by someone not authorized, which is a key concern with notices containing protected health information. Email, fax, or postal mail can introduce security risks or require additional safeguards (encryption, return receipts, or secure portals) that may not be consistently in place. They also make it harder to verify that the intended recipient actually received and acknowledged the notice. Therefore, in-person delivery is typically the preferred, and often the allowed, method when delivering a HINN notice.

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9. What is cost-to-care analysis and how is it used to demonstrate value?

A. It only tallies costs without outcomes.

B. It is used solely for budgeting for staff salaries.

C. It compares costs across departments without outcomes data.

D. Analyzing the costs of care relative to outcomes to show ROI and justify program investments and care improvements.

Cost-to-care analysis measures how much is spent on care in relation to the outcomes achieved, so it can quantify value rather than just costs. By linking financial inputs to measurable health or quality outcomes, it shows ROI and provides a clear basis to justify investing in specific programs and care improvements. This approach helps decision-makers compare alternative strategies not only on price but on the value they deliver, guiding resource allocation toward interventions that yield better results. The other options fall short because they either ignore outcomes, focus only on budgeting (like salaries), or compare costs without considering the outcomes that determine value.

10. Which part of Medicare pays for hospice services?

A. Medicare Part A

B. Medicare Part B

C. Medicare Part C

D. Medicare Part D

The main idea is how Medicare pays for hospice. Hospice is a benefit under Medicare Part A, available to people with a terminal illness who elect hospice and agree to forego curative treatment. When you opt in, Medicare pays for most hospice services under Part A, including skilled nursing, home health visits, medical equipment and supplies, social work and counseling, and medications specifically for controlling pain and symptoms, plus short-term inpatient respite care. Part A is the payer for the hospice benefit itself; Part B covers outpatient medical services but not the hospice package. Part C (Medicare Advantage) is another way to receive Medicare benefits but doesn't replace the hospice coverage under Part A. Part D covers prescription drugs, typically outside the hospice scope, and is not the source for the hospice medications (which are covered under the hospice benefit in Part A).

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://acmacasemgmt.examzify.com

We wish you the very best on your exam journey. You've got this!

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