Certified Risk Adjustment Coder (CRC) Practice Exam (Sample)

Study Guide

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Questions

1. **Under the Health and Human Services (HHS) Hierarchal Condition Category (HCC) model, which plan has the lowest out of pocket expense once the premium is paid?**

   A. Silver

   B. Gold

   C. Bronze

   D. Platinum

2. **What can result from inaccurate coding in the HCC model?**

   A. Increased healthcare costs

   B. Improved patient outcomes

   C. Enhanced data validation

   D. More efficient coding processes

3. **What is the guideline for coding terms like "probable," "suspected," or "questionable" in the INPATIENT setting?**

   A. Code the condition as if it was established

   B. Code the sign and symptoms

   C. Query the provider before coding

   D. Code with the sign and symptom and the condition

4. **Which element of the medical record is never allowed to be used to capture current diagnosis codes?**

   A. Exam

   B. Past medical history

   C. Radiology report

   D. Assessment

5. **What is essential to consider when submitting records for RADV audits?**

   A. All past diagnoses must be included

   B. Records must reflect a face-to-face encounter with an acceptable provider

   C. Diagnostic tests must be available at the time of submission

   D. Claims data should only include current conditions

6. What part of the eye is assessed during a gonioscopy examination?

- **A. Posterior segment**
- **B. Interior surface of the eye**
- **C. Anterior chamber of the eye**
- **D. Lacrimal duct**

7. Which statement is true regarding coding COPD when a specific type of asthma is documented?

- **A. The type of asthma is not reported**
- **B. Only the asthma should be reported**
- **C. Both COPD and asthma should be reported**
- **D. Only the COPD is reported**

8. Retrospective audits can be performed by which of the following?

- **A. Only internal employees**
- **B. Only external consultants who have prior experience**
- **C. Both internal employees and external consultants with a signed business agreement**
- **D. Only during the data submission process**

9. What is the frequency with which Health Risk is re-determined according to coding standards?

- **A. Every month**
- **B. Every 6 months**
- **C. Every year**
- **D. Every 2 years**

10. Which factors can impact the Risk Adjustment Factor (RAF) score?

- **A. Age of patient**
- **B. Diagnosis manifestation reporting**
- **C. Both age and diagnosis reporting**
- **D. Only acute illness reporting**

Answers

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

Explanations

1. Under the Health and Human Services (HHS) Hierarchal Condition Category (HCC) model, which plan has the lowest out of pocket expense once the premium is paid?

A. Silver

B. Gold

C. Bronze

D. Platinum

In the context of the Health and Human Services (HHS) Hierarchical Condition Category (HCC) model, the Platinum plan typically offers the lowest out-of-pocket expenses after premiums are paid. This is because Platinum plans are designed to cover a higher percentage of health care costs compared to other tier levels, meaning that enrollees pay lower deductibles, copayments, and coinsurance. When individuals select a Platinum plan, they benefit from a lower financial burden when accessing medical services, making it more affordable for those who anticipate needing frequent healthcare. This structure provides better cost-sharing for members, ultimately resulting in lower out-of-pocket expenses during the year, aside from the premium costs. The other plan options have different structures where cost-sharing is higher; thus, while they may have lower premiums, the out-of-pocket expenses for services rendered would typically be higher compared to a Platinum plan.

2. What can result from inaccurate coding in the HCC model?

A. Increased healthcare costs

B. Improved patient outcomes

C. Enhanced data validation

D. More efficient coding processes

Inaccurate coding in the Hierarchical Condition Category (HCC) model can lead to increased healthcare costs. The HCC model is used to risk-adjust payments to healthcare providers based on the health status and demographic characteristics of their patients. If coding is inaccurate, it can result in misclassification of a patient's health status, which may lead to either inadequate or excessive reimbursement for services rendered. When coding does not accurately reflect a patient's conditions, healthcare plans may end up paying more for patients who are not sicker than coded, or they may underfund care for patients who actually have more severe or numerous health issues. This discrepancy can have significant financial implications for both providers and payers in the healthcare system, leading to overall increased costs. In contrast, improved patient outcomes, enhanced data validation, and more efficient coding processes would typically not stem from inaccurate coding; instead, they are associated with accurate and meaningful coding practices that reflect true patient conditions and needs. Accurate coding supports better patient management, ensures appropriate resource allocation, and enhances the effectiveness of care delivered.

3. What is the guideline for coding terms like "probable," "suspected," or "questionable" in the INPATIENT setting?

A. Code the condition as if it was established

B. Code the sign and symptoms

C. Query the provider before coding

D. Code with the sign and symptom and the condition

In the inpatient setting, when a term such as "probable," "suspected," or "questionable" is used to describe a condition, the guideline is to code the condition as if it was established. This means that if a physician documents a condition with terms indicating a strong likelihood, it reflects their clinical judgment, and therefore, the coder is justified in coding it as if it is a confirmed diagnosis. This approach aligns with the coding guidelines that prioritize the provider's clinical assessment. It ensures that the medical record accurately reflects a patient's condition, which is essential for proper risk adjustment and reimbursement. This method contributes to capturing the severity of illness accurately and supports appropriate care management and treatment planning. While coding symptoms or querying the provider can be necessary in some contexts, those actions are not applicable when the provider has established a clear clinical impression that justifies coding the condition directly. In essence, when a condition is deemed probable or suspected by the physician, it should be treated as an established diagnosis for coding purposes.

4. Which element of the medical record is never allowed to be used to capture current diagnosis codes?

A. Exam

B. Past medical history

C. Radiology report

D. Assessment

The element of the medical record that is not permissible for capturing current diagnosis codes is the past medical history. Past medical history refers to the patient's previous health conditions, treatments, and surgeries. This information is crucial for understanding a patient's overall health status and can provide context for current medical decisions; however, it does not reflect the patient's present health status. Current diagnosis codes must be based on active conditions that are either treated or evaluated during the current office visit or encounter. Documentation such as the assessment or findings from an exam accurately reflects the current state of the patient, including ongoing or new conditions that require coding. Therefore, while past medical history is valuable for a comprehensive understanding of the patient's health, it cannot be used to represent current diagnoses which need to be actively documented in the medical record. This distinction is essential for accurate coding and compliance in risk adjustment programs.

5. What is essential to consider when submitting records for RADV audits?

A. All past diagnoses must be included

B. Records must reflect a face-to-face encounter with an acceptable provider

C. Diagnostic tests must be available at the time of submission

D. Claims data should only include current conditions

When submitting records for Risk Adjustment Data Validation (RADV) audits, it's essential to ensure that the documentation reflects a face-to-face encounter with an acceptable provider. This is crucial because the purpose of these audits is to validate the accuracy of the risk adjustment coding and ensure that the diagnoses reported for reimbursement are substantiated by appropriate clinical documentation. A face-to-face encounter with a provider indicates that there has been an actual interaction where the patient's conditions were assessed and documented, linking the diagnosis directly to the care rendered. Without such encounters, it becomes challenging to verify the legitimacy of the diagnoses reported. This supports the integrity of the risk adjustment process and the associated reimbursements tied to those diagnoses. In contrast, while including all past diagnoses may seem relevant, the focus of RADV audits is primarily on the diagnoses that pertain to the patient's condition as it relates to the most recent care provided and not necessarily historical data. Similarly, while having diagnostic tests available can enhance the completeness of medical records, it does not take precedence over ensuring direct provider engagement through face-to-face encounters. Lastly, while claims data should accurately reflect the patient's current conditions, this does not alone ensure the validity needed for RADV audits without the necessary provider encounter documentation.

6. What part of the eye is assessed during a gonioscopy examination?

A. Posterior segment

B. Interior surface of the eye

C. Anterior chamber of the eye

D. Lacrimal duct

The correct answer focuses on the anterior chamber of the eye, which is crucial in assessing the angle between the iris and the cornea. During a gonioscopy examination, a specialized lens is utilized that allows the clinician to visualize this angle directly, providing important information about the drainage pathways of the eye and potential conditions such as glaucoma. The anterior chamber is significant because it is the space filled with aqueous humor, and the angle can affect intraocular pressure. Understanding the condition and structure of the anterior chamber helps guide treatment decisions for eye diseases. In contrast, the other options address areas not pertinent to gonioscopy. The posterior segment relates to the back part of the eye, including the retina and optic nerve, while the interior surface encompasses other areas that do not involve the direct examination of the drainage angle. The lacrimal duct pertains to tear drainage and is unrelated to the pressures and angles assessed during gonioscopy. Thus, the focus on the anterior chamber presents a comprehensive understanding of the eye's anatomy relevant to this specific examination.

7. Which statement is true regarding coding COPD when a specific type of asthma is documented?

A. The type of asthma is not reported

B. Only the asthma should be reported

C. Both COPD and asthma should be reported

D. Only the COPD is reported

When coding for chronic obstructive pulmonary disease (COPD) alongside a specific type of asthma, it is essential to recognize that both conditions can coexist and significantly impact a patient's health management. The correct approach is to report both COPD and asthma since they are distinct diagnoses that require separate consideration for treatment and risk adjustment. COPD is a progressive condition characterized by limited airflow and includes emphysema and chronic bronchitis, while asthma is a reversible airway condition that can be triggered by various factors. Reporting both provides a more complete clinical picture of the patient's respiratory health. In risk adjustment coding, both conditions will have implications for the patient's management plan and the resources required for their care, making it crucial to document both when they are relevant to the patient's condition. This reflects the complexity of the patient's health status and ensures accurate coding that corresponds to the care provided.

8. Retrospective audits can be performed by which of the following?

A. Only internal employees

B. Only external consultants who have prior experience

C. Both internal employees and external consultants with a signed business agreement

D. Only during the data submission process

The option suggesting that both internal employees and external consultants with a signed business agreement can conduct retrospective audits is accurate because it recognizes the versatility and collaborative nature of audits in a healthcare setting. Retrospective audits are essential for ensuring the accuracy, compliance, and quality of coding and billing processes after the services have been rendered. Both internal employees, who have a deep understanding of the organization's practices and policies, and external consultants, who bring in fresh perspectives and specialized experience, can effectively assess and improve coding practices. The requirement of a signed business agreement ensures that there are clear expectations, confidentiality, and compliance with regulations when external consultants are involved. This collaboration can enhance the effectiveness of the audit, as it allows for diverse insights and expertise to address potential issues in risk adjustment coding. Other options restrict the auditing capability to a single group, which could limit the effectiveness and thoroughness of the audit process, as it relies solely on a single perspective that might miss critical insights or areas for improvement.

9. What is the frequency with which Health Risk is re-determined according to coding standards?

A. Every month

B. Every 6 months

C. Every year

D. Every 2 years

The frequency with which Health Risk is re-determined according to coding standards is annually. This annual review aligns with the need to ensure that health assessments and the associated risk scores accurately reflect a patient's current health status and chronic conditions. This regular update is crucial for risk adjustment purposes as it enables healthcare providers to receive appropriate reimbursement based on the severity of the patients' conditions. In coding standards, particularly those relevant to risk adjustment methodologies, it is emphasized that the health status of patients can change frequently, and an annual reassessment is a structured approach to capture those changes effectively. This process not only facilitates the accurate coding of diagnoses but also ensures the quality of care and management of chronic diseases over time. Regular intervals beyond a year may lead to outdated assessments that do not accurately represent the patient's current health risk.

10. Which factors can impact the Risk Adjustment Factor (RAF) score?

A. Age of patient

B. Diagnosis manifestation reporting

C. Both age and diagnosis reporting

D. Only acute illness reporting

The Risk Adjustment Factor (RAF) score is influenced by various factors that reflect the health status of a patient population. The most significant contributors to the RAF score include the patient's age and the reporting of their diagnosis manifestations. Age of the patient plays a crucial role in the RAF score calculation. Generally, older patients are presumed to have more complex and comorbid health conditions, which typically lead to a higher RAF score. This is because health risk increases with age, and populations with older individuals are often at greater risk for chronic diseases. Diagnosis manifestation reporting also impacts the RAF score as it captures the chronic conditions and acuity of illnesses present in a patient. Accurate and comprehensive documentation of these diagnoses is essential, as each documented condition can contribute additional weight to the overall RAF score, reflecting the patient's health complexity and expected healthcare costs. Thus, the correct choice incorporates both age and diagnosis manifestation reporting, demonstrating the multifaceted nature of the factors that contribute to the Risk Adjustment Factor score.