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

Study Guide

BY EXAMZIFY

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Questions

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1. **Why is it often difficult for companies to follow CMS directives regarding deletion of conditions in retrospective audits?**
   - **A. There is a potential loss of revenue**
   - **B. Billing compliance issues may come to light**
   - **C. All companies follow CMS directives**
   - **D. I and II**

2. **Which component of a patient's history is NOT included in PFSH?**
   - **A. Chronic diseases.**
   - **B. Social habits.**
   - **C. Family health history.**
   - **D. Physical examination results.**

3. **Which statement is TRUE regarding the Coding Intensity Adjustment?**
   - **A. MA plan risk scores and FFS scores typically decrease.**
   - **B. FFS scores and MA plan risk scores increase at the same rate.**
   - **C. FFS scores increase faster than MA plan risk scores.**
   - **D. MA plan risk scores increase faster than FFS scores.**

4. **What should a clinical coder do with the diagnosis if it is documented as "probable" at the time of discharge?**
   - **A. Code the condition as if it was established**
   - **B. Code the sign and symptoms**
   - **C. Query the provider before coding**
   - **D. Do not code until the diagnosis is confirmed**

5. **Who developed and maintains HEDIS?**
   - **A. CMS**
   - **B. OIG**
   - **C. BCBS**
   - **D. NCQA**

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6. What is the primary purpose of risk adjustment models?

- **A. Limit coverage of chronic conditions.**
- **B. Determine projected healthcare costs based on patient conditions.**
- **C. Assess return on investment for disease prevention programs.**
- **D. Restrict hospital admissions.**

7. What should a RADV audit focus on regarding medical records?

- **A. Availability of electronic records only**
- **B. Completeness, legibility, and provider identification**
- **C. Records should be outdated and irrelevant**
- **D. Provider identification is optional**

8. What is a risk adjustment coder's primary responsibility?

- **A. Ensuring accurate submissions to Medicare**
- **B. Performing clinical assessments**
- **C. Reviewing patient demographics**
- **D. Handling provider payments**

9. When are prospective reviews performed in relation to CMS?

- **A. Before diagnosis data is reported**
- **B. After diagnosis data is reported**
- **C. Once the patient is enrolled in a Medicare Part C plan**
- **D. After the provider finalizes documentation**

10. A diabetic patient comes in with pain in his foot. He is found to have a diabetic foot ulcer. The provider treats the foot ulcer. What conditions should be coded?

- **A. Diabetes**
- **B. Foot ulcer**
- **C. Foot pain and ulcer**
- **D. Diabetes and foot ulcer**

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Answers

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

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Explanations

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1. Why is it often difficult for companies to follow CMS directives regarding deletion of conditions in retrospective audits?

A. There is a potential loss of revenue

B. Billing compliance issues may come to light

C. All companies follow CMS directives

D. I and II

Retrospective audits can create challenges for companies in adhering to the Centers for Medicare & Medicaid Services (CMS) directives regarding the deletion of conditions due to a couple of significant factors. Firstly, the potential loss of revenue is a critical element. When conditions are deleted during retrospective audits, it can directly impact the reimbursement rates that a company receives. This loss of revenue can be a deterrent to fully complying with the directives because organizations are often focused on maintaining financial stability and operational funding. Secondly, auditing processes can reveal billing compliance issues. If errors or discrepancies are uncovered through the audit, it may lead to further investigations and possible penalties. Companies may hesitate to take action that could expose them to penalties or backlash from regulatory bodies concerning billing practices. Together, these reasons underscore why adherence to CMS directives can be particularly challenging during retrospective audits. The combined risks of revenue loss and compliance issues often result in complex decision-making processes for healthcare organizations.

2. Which component of a patient's history is NOT included in PFSH?

A. Chronic diseases.

B. Social habits.

C. Family health history.

D. Physical examination results.

The assessment of a patient's history, particularly in the context of the PFSH (Past Medical, Family, and Social History), is an essential part of a comprehensive evaluation. The PFSH consists of three main components: past medical history, family history indicating hereditary factors, and social history that encompasses social habits and lifestyle practices. Physical examination results do not fall under the PFSH category. Instead, they are part of the clinical assessments performed by healthcare providers during the patient’s visit. The physical examination focuses on the objective findings and indicators that result from hands-on examination techniques, including observation, palpation, percussion, and auscultation. It is distinct from history-taking, which aims to gather information about the patient’s previous medical conditions, family’s health background, and social activities that may impact health. By contrast, chronic diseases, social habits, and family health history all provide crucial context about the patient’s overall health and potential risk factors. These components inform treatment plans and highlight areas requiring closer monitoring, aiding in the understanding of how personal and familial patterns of illness may influence the patient's care. Therefore, the principal distinction lies in the nature of the information collected: PFSH is focused on subjective history information, while physical examination results are objective

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3. Which statement is TRUE regarding the Coding Intensity Adjustment?

A. MA plan risk scores and FFS scores typically decrease.

B. FFS scores and MA plan risk scores increase at the same rate.

C. FFS scores increase faster than MA plan risk scores.

D. MA plan risk scores increase faster than FFS scores.

The correct statement regarding the Coding Intensity Adjustment relates to the relationship between Medicare Advantage (MA) plan risk scores and fee-for-service (FFS) scores. The idea behind risk adjustment is to account for the health status and expected costs of beneficiaries, and both MA plans and FFS scores must be aligned to ensure that there is equitable payment for care based on the risk of the population served. When analyzing the coding intensity adjustment, it's important to understand that MA plans receive payments based on risk-adjusted factors derived from diagnoses coded. While both FFS and MA plan risk scores are influenced by similar factors, changes and adjustments to these scores happen at different rates and through distinct mechanisms. However, the assertion that FFS scores and MA plan risk scores increase at the same rate reflects the principle that, even with fluctuations and adjustments, the trajectories of these scores need to be comparably assessed to maintain a balanced payment system. The coding intensity adjustment is a mechanism to ensure that the coding practices between MA plans and FFS do not incentivize overcoding or undercoding inappropriately, aligning both systems despite different service delivery settings. This maintains fairness in how beneficiaries are categorized and funded based on their health needs. Understanding this dynamic helps reinforce the importance of accurate

4. What should a clinical coder do with the diagnosis if it is documented as "probable" at the time of discharge?

A. Code the condition as if it was established

B. Code the sign and symptoms

C. Query the provider before coding

D. Do not code until the diagnosis is confirmed

When a diagnosis is documented as "probable" at the time of discharge, the correct approach is to code the condition as if it were established. This practice adheres to guidelines established by coding authorities, which state that when a physician has a high level of certainty about a diagnosis, it may be appropriate to code it even if it is not definitively confirmed at the time of discharge. Coding "probable" conditions as established recognizes the clinician's professional judgment and the context of the patient's care. This is particularly important in scenarios that influence risk adjustment and reimbursement, as the documentation reflects the physician's assessment that there is a significant likelihood the diagnosis is accurate. This approach helps ensure that the healthcare facility receives proper reimbursement for the services rendered and accurately reflects the patient's medical history for appropriate risk profiling. Additionally, when the documentation provides a strong indication of diagnosis, it holds up under scrutiny for audits since it demonstrates that careful consideration was given by the physician in diagnosing the patient. To clarify why querying the provider might not be the best option in this scenario — if the physician has provided a diagnosis of "probable," further confirmation through queries could unnecessarily delay coding. Coding the signs and symptoms is not suitable here, as it detracts from the physician's assessment

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5. Who developed and maintains HEDIS?

A. CMS

B. OIG

C. BCBS

D. NCQA

The correct answer is that the National Committee for Quality Assurance (NCQA) developed and maintains HEDIS, which stands for the Healthcare Effectiveness Data and Information Set. HEDIS is a widely used set of performance measures in the healthcare industry, allowing for the evaluation of the quality of care provided by health plans. NCQA's role in HEDIS is crucial as they are responsible for updating and ensuring the relevance of the measures in response to changes in the healthcare landscape, making it an essential tool for organizations seeking to improve care quality and patient outcomes. Utilizing HEDIS metrics allows healthcare providers and insurers to gauge their performance and identify areas for improvement, ultimately aiming to enhance patient care and increase transparency in healthcare quality. The other organizations mentioned do play roles in healthcare, but they do not maintain HEDIS. The Centers for Medicare & Medicaid Services (CMS) focuses on administering federal healthcare programs. The Office of Inspector General (OIG) works on oversight for federal healthcare programs to prevent fraud and abuse. Blue Cross Blue Shield (BCBS) is a federation of health insurance organizations and does not have a governing role with HEDIS.

6. What is the primary purpose of risk adjustment models?

A. Limit coverage of chronic conditions.

B. Determine projected healthcare costs based on patient conditions.

C. Assess return on investment for disease prevention programs.

D. Restrict hospital admissions.

The primary purpose of risk adjustment models is to determine projected healthcare costs based on patient conditions. This is crucial for healthcare organizations, as these models help to predict how much a patient's health status and demographic information will likely affect their future healthcare expenses. By adjusting for the risk associated with different patient populations, these models allow for a more equitable distribution of healthcare resources and reimbursement rates. In practical terms, this means that insurers and providers can analyze the risk profiles of their enrolled populations to anticipate the cost of care and ensure that they are adequately funded to meet those needs. As a result, risk adjustment plays an integral role in managing healthcare spending and improving patient outcomes by identifying high-risk patients and allocating appropriate resources for their care. The other options do not reflect the primary focus of risk adjustment. For instance, limiting coverage of chronic conditions would not advance the overarching goal of equitable care management; instead, risk adjustment seeks to account for the complexities and costs associated with such conditions. Similarly, while assessing return on investment for disease prevention programs and restricting hospital admissions might be part of broader healthcare strategies, they are not the central aim of risk adjustment models, which focus specifically on forecasting costs derived from patient conditions.

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7. What should a RADV audit focus on regarding medical records?

A. Availability of electronic records only

B. Completeness, legibility, and provider identification

C. Records should be outdated and irrelevant

D. Provider identification is optional

The focus of a RADV (Risk Adjustment Data Validation) audit on medical records should include assessing the completeness, legibility, and provider identification. This is essential because the accuracy and validity of the risk adjustment process heavily rely on the quality of the medical documentation. Completeness ensures that all necessary information is present to support diagnoses and medical claims. This includes documenting all relevant patient encounters, diagnostic information, and treatment plans that were provided during the year in question. Legibility is crucial for external reviewers to understand the provided information. If the records are difficult to read, it can lead to misunderstandings about the patient's health status and treatment, potentially affecting the risk scores and reimbursement processes. Provider identification ensures that the documentation is authenticated by a qualified healthcare provider. This verification helps uphold the integrity of the medical records, as each entry in the record must be traceable back to a responsible practitioner to confirm the services rendered and their justification. In summary, focusing on these three aspects during a RADV audit helps ensure that the data used for risk adjustment is accurate, reliable, and maintains the integrity necessary for proper healthcare reporting and reimbursement.

8. What is a risk adjustment coder's primary responsibility?

A. Ensuring accurate submissions to Medicare

B. Performing clinical assessments

C. Reviewing patient demographics

D. Handling provider payments

A risk adjustment coder's primary responsibility is to ensure accurate submissions to Medicare. This role is essential in the healthcare industry as it directly impacts the reimbursement process and the overall quality of care provided to patients. Accurate coding helps in reflecting the true health status of a patient population, which is crucial for risk adjustment models used by Medicare. These models account for the health complexity of beneficiaries, allowing for appropriate funding allocations to healthcare providers. In this context, the accuracy of coding is vital because it enables the identification of patients' chronic conditions and ensures that the data submitted truly represents the care that patients receive. This not only affects financial aspects for providers but also plays a significant role in maintaining compliance with regulations. Although performing clinical assessments, reviewing patient demographics, and handling provider payments may be associated functions in the healthcare setting, the focus of a risk adjustment coder lies greatly in the realm of coding and submitting accurate patient information that reflects their diseases and conditions, thus reinforcing the integrity of data used in risk adjustment calculations.

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9. When are prospective reviews performed in relation to CMS?

A. Before diagnosis data is reported

B. After diagnosis data is reported

C. Once the patient is enrolled in a Medicare Part C plan

D. After the provider finalizes documentation

Prospective reviews are conducted before diagnosis data is reported to the Centers for Medicare & Medicaid Services (CMS). This means that the review takes place prior to the submission of any relevant data for the patient's diagnoses. The purpose of a prospective review is to evaluate the accuracy and quality of the anticipated coding and documentation based on the care the patient is expected to receive. This proactive approach is essential to ensure that the coding reflects true clinical conditions, which can ultimately affect risk adjustment and reimbursement processes managed by CMS. In this context, conducting reviews prior to data reporting enables providers to identify any potential gaps or issues in documentation and coding, thereby enhancing the accuracy of the information submitted. This also helps in maintaining compliance with CMS guidelines and ensuring that providers receive appropriate reimbursement based on the patient's health status and care needs.

10. A diabetic patient comes in with pain in his foot. He is found to have a diabetic foot ulcer. The provider treats the foot ulcer. What conditions should be coded?

A. Diabetes

B. Foot ulcer

C. Foot pain and ulcer

D. Diabetes and foot ulcer

The correct answer is to code both diabetes and the foot ulcer because each condition significantly impacts the patient's treatment, management, and potential complications. Diabetes mellitus is a chronic condition that can lead to various complications, including diabetic foot ulcers. Proper coding requires acknowledgment of the underlying condition as well as any consequential complications—such as the ulcer in this case. By coding the diabetes along with the foot ulcer, the medical record accurately reflects the patient's comprehensive health issues and supports appropriate risk adjustment and reimbursement. When both conditions are documented, it provides a clearer picture of the patient's health status, which is crucial for managing ongoing care effectively. Additionally, coding both conditions aids in identifying the severity and complexity of the patient's clinical profile, essential for tracking outcomes and planning treatment strategies. The option that includes just the foot ulcer would overlook the importance of the diabetes diagnosis as a contributing factor. Similarly, considering only foot pain without acknowledging the ulcer fails to recognize the clinical significance of the ulcer's presence, which directly correlates with the patient's diabetic condition. Hence, coding both diabetes and the foot ulcer gives a complete representation of the patient's situation.

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