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

Study Guide

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Questions

1. **What is the correct coding methodology for chronic kidney disease?**
   - **A. ICD-9-CM coding**
   - **B. ICD-10-PCS coding**
   - **C. ICD-10-CM coding**
   - **D. ICD-11 coding**

2. **What factor do health plans often consider when using predictive modeling?**
   - **A. Patient demographics**
   - **B. Hospital admission rates**
   - **C. Potential future diagnoses for an individual patient**
   - **D. Staffing requirements for healthcare providers**

3. **What is a common purpose of conducting chart reviews in risk adjustment coding?**
   - **A. To determine the number of patients served**
   - **B. To identify missed chronic conditions that need coding**
   - **C. To ensure complete patient satisfaction**
   - **D. To train new coding staff members**

4. **Which of the following represents a coding error in the outpatient setting?**
   - **A. Using a symptom code instead of a definitive diagnosis code**
   - **B. Including both principal diagnosis and related symptoms**
   - **C. Utilizing the latest guidelines for code selection**
   - **D. Exclusively coding based on documented symptoms**

5. **How many records must health plans submit per patient in a RADV audit?**
   - **A. One**
   - **B. Five**
   - **C. Ten**
   - **D. None; it is based on claim data**

6. Which data elements are beneficial for identifying a person with diabetes in predictive modeling?

A. Rx claims only

B. Rx and medical claims only

C. Medical and DME claims only

D. Rx, medical, and DME claims

7. Which condition would be coded with a history of code?

A. Patient with controlled asthma.

B. Patient with a history of MI six months ago.

C. Patient with breast cancer receiving chemotherapy.

D. Patient with a history of HIV.

8. What is considered an appropriate signature for a medical provider?

A. Dr. Smith

B. Dr. Michael R. Smith

C. Michael R. Smith, MD

D. M. Smith

9. What type of documentation can support diagnoses reported under risk adjustment models?

A. Inpatient admission note

B. CT scan results

C. CBC lab test

D. Comprehensive problem list

10. Which diagnoses can be coded from a medical record that states a member has the condition, but does not contain supporting documentation?

A. COPD, Croup

B. A-Fib, GERD, Parkinson's disease, MS

C. Croup, Parkinson's disease, MS

D. COPD, A-Fib, Parkinson's disease, MS

Answers

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

Explanations

1. What is the correct coding methodology for chronic kidney disease?

A. ICD-9-CM coding

B. ICD-10-PCS coding

C. ICD-10-CM coding

D. ICD-11 coding

Chronic kidney disease (CKD) is classified using the ICD-10-CM coding system, which is specifically designed for diagnosis coding in the outpatient and inpatient settings. The ICD-10-CM system allows for more detailed and specific coding of conditions compared to its predecessor, ICD-9-CM. In the context of CKD, the ICD-10-CM includes different codes that specify the stage of kidney disease, such as stage 1, stage 2, and so forth, as well as codes that indicate if the disease is associated with hypertension or diabetes. This granularity in coding helps in accurately reflecting the patient's condition, which is crucial for appropriate management and reimbursement processes. The other coding systems mentioned do not apply as directly. ICD-9-CM is outdated and no longer properly reflects the complexities of current medical diagnoses. ICD-10-PCS is intended for procedural coding rather than diagnosing conditions, making it irrelevant for CKD. ICD-11 is still in the process of being adopted globally and is not yet widely utilized for coding in the United States, potentially leading to inconsistencies in data collection and reporting regarding CKD. Therefore, utilizing ICD-10-CM for coding chronic kidney disease ensures that coders can accurately

2. What factor do health plans often consider when using predictive modeling?

A. Patient demographics

B. Hospital admission rates

C. Potential future diagnoses for an individual patient

D. Staffing requirements for healthcare providers

Health plans frequently use predictive modeling to anticipate future healthcare needs, and a key aspect of this process involves assessing potential future diagnoses for an individual patient. By analyzing historical data, including patient medical history, treatment patterns, and current health status, predictive modeling can forecast the likelihood of future health issues. This allows health plans to manage resources effectively, identify high-risk populations, and tailor interventions aimed at preventing complications before they arise. The focus on potential future diagnoses is crucial in risk adjustment since it directly impacts the planning and allocation of healthcare services. Understanding the likelihood of certain conditions developing in a patient can influence care management strategies, provide insights into cost projections, and ultimately contribute to better patient outcomes.

3. What is a common purpose of conducting chart reviews in risk adjustment coding?

A. To determine the number of patients served

B. To identify missed chronic conditions that need coding

C. To ensure complete patient satisfaction

D. To train new coding staff members

The common purpose of conducting chart reviews in risk adjustment coding is to identify missed chronic conditions that need coding. This process is vital because accurate coding of chronic conditions impacts the risk adjustment factor (RAF) scores, which ultimately influence reimbursement rates for healthcare providers. By reviewing charts, coders can ensure that all relevant diagnoses are documented and coded appropriately, reflecting the true health status of the patient population. This enables healthcare organizations to receive appropriate funding for the level of care they provide and promotes better health outcomes by ensuring that chronic conditions are managed adequately. The other options do not align with the primary focus of chart reviews in the context of risk adjustment. While determining the number of patients served, ensuring patient satisfaction, or training new coding staff are important aspects of healthcare management, they do not directly relate to the core objective of improving coding accuracy for chronic conditions through chart reviews.

4. Which of the following represents a coding error in the outpatient setting?

A. Using a symptom code instead of a definitive diagnosis code

B. Including both principal diagnosis and related symptoms

C. Utilizing the latest guidelines for code selection

D. Exclusively coding based on documented symptoms

Using a symptom code instead of a definitive diagnosis code represents a coding error because it does not provide the most accurate representation of a patient's condition. In coding, definitive diagnosis codes are utilized to convey the primary reason for the patient's visit or treatment, based on a condition that has been clearly identified or confirmed by a healthcare professional. Symptom codes, on the other hand, can suggest that the condition is not fully understood or is still under evaluation. Code selection should prioritize definitive diagnoses to ensure that the coding accurately reflects the clinical picture and services provided, impacting the quality of care and reimbursement processes. In contrast, including both the principal diagnosis and related symptoms can enhance the documentation and understanding of patient encounters, which is considered appropriate coding practice. Utilizing the latest guidelines for code selection is essential for maintaining compliance and accuracy in coding. Exclusively coding based on documented symptoms alone could lead to incomplete or inaccurate patient representations, but it is not as fundamentally erroneous as using a symptom code when a definitive diagnosis is available.

5. How many records must health plans submit per patient in a RADV audit?

A. One

B. Five

C. Ten

D. None; it is based on claim data

In a RADV (Risk Adjustment Data Validation) audit, health plans are required to submit a total of five medical records per patient. This is to ensure a comprehensive review of the patient's medical conditions and the accuracy of the diagnosis coding. By requesting multiple records, auditors can verify that the reported diagnoses accurately reflect the patient's health status and adherence to coding guidelines. This approach enhances the integrity of risk adjustment efforts and ensures that the data submitted aligns with the patient's clinical documentation, ultimately supporting appropriate reimbursement based on the patient's true health condition.

6. Which data elements are beneficial for identifying a person with diabetes in predictive modeling?

A. Rx claims only

B. Rx and medical claims only

C. Medical and DME claims only

D. Rx, medical, and DME claims

Identifying a person with diabetes in predictive modeling requires a comprehensive approach that incorporates multiple data sources to ensure accurate risk assessment. The correct choice indicates that a combination of prescription (Rx), medical claims, and durable medical equipment (DME) claims is essential. Prescription claims provide information on medications prescribed to a patient, including diabetes-related treatments such as insulin or oral hypoglycemic agents. This data is crucial as it reflects ongoing management and control of the condition. Medical claims contribute additional context about a patient's diagnosis and treatment history. They can include information on physician visits, lab tests, and any complications or co-morbidities associated with diabetes, which are important for evaluating overall health risks. DME claims can highlight the need for medical equipment used by patients with diabetes, such as blood glucose monitors, which further supports the diagnosis and ongoing management of the condition. Together, these data elements create a fuller picture of the patient's health status and treatment patterns, improving the accuracy of predictive modeling for identifying diabetes. This multi-faceted approach is key in risk adjustment efforts where a comprehensive understanding of each patient's healthcare utilization is necessary.

7. Which condition would be coded with a history of code?

A. Patient with controlled asthma.

B. Patient with a history of MI six months ago.

C. Patient with breast cancer receiving chemotherapy.

D. Patient with a history of HIV.

The condition that is appropriately coded with a history code is the patient with a history of myocardial infarction (MI) six months ago. In risk adjustment coding, a history code represents conditions that have been treated or have resolved but may still have implications for the patient's health. Since the patient had an MI six months prior, it indicates that while the event has occurred and is currently not active, it is significant enough that it needs to be documented as it can influence future healthcare management. Coding a history of MI is essential because it can affect the patient's overall health status, potential future care plans, and risk assessment. The healthcare provider needs to be aware of the patient's cardiac history to make informed decisions regarding treatment and follow-up care. In contrast, controlled asthma, ongoing chemotherapy for breast cancer, or a current HIV diagnosis would not typically be coded as a history because they reflect active management of existing conditions rather than a resolved issue.

8. What is considered an appropriate signature for a medical provider?

A. Dr. Smith

B. Dr. Michael R. Smith

C. Michael R. Smith, MD

D. M. Smith

The choice of "Michael R. Smith, MD" is recognized as an appropriate signature for a medical provider because it conveys both the physician's full name and their professional designation clearly. Including the full name ensures that there is no ambiguity regarding the provider's identity, while the "MD" designation confirms their qualifications as a medical doctor. This level of detail is particularly important for ensuring accurate record-keeping, compliance with regulations, and establishing the provider's credentials. In contrast, options like "Dr. Smith" and "Dr. Michael R. Smith" may not contain the full name or professional designation in a manner that is as standardized or widely recognized for formal documentation. While they do indicate a medical title, they do not provide complete clarity regarding the doctor's identity in the way that "Michael R. Smith, MD" does. The option "M. Smith" lacks specificity as it only provides an initial and last name, which may not be sufficient for legal or administrative purposes where identification is critical.

9. What type of documentation can support diagnoses reported under risk adjustment models?

A. Inpatient admission note

B. CT scan results

C. CBC lab test

D. Comprehensive problem list

The correct answer is an inpatient admission note. This type of documentation is crucial for risk adjustment models because it typically provides comprehensive and detailed information about a patient's current health status at the time of admission. Admission notes often include the patient's history, physical examination findings, and any diagnoses that the healthcare provider has made based on their evaluation. This thorough documentation is essential as it helps ensure that all pertinent diagnoses are captured accurately, which is critical for risk adjustment purposes. While CT scan results and CBC lab tests can support diagnoses, they generally do not convey the same level of comprehensive clinical context as an admission note. A CT scan may show a specific condition, but it doesn't communicate the patient's overall health or the physician's reasoning for a diagnosis. Similarly, a CBC test provides valuable blood information but lacks the overall clinical assessment and context that are essential for risk adjustment coding. A comprehensive problem list is important in providing an overview of the patient's health but does not carry the same weight in a risk adjustment scenario as the detailed narrative found in an inpatient admission note. Thus, the admission note stands out for its detailed narrative and context, making it the strongest option for supporting diagnoses under risk adjustment models.

10. Which diagnoses can be coded from a medical record that states a member has the condition, but does not contain supporting documentation?

A. COPD, Croup

B. A-Fib, GERD, Parkinson's disease, MS

C. Croup, Parkinson's disease, MS

D. COPD, A-Fib, Parkinson's disease, MS

The correct answer is appropriate because the conditions listed—COPD (Chronic Obstructive Pulmonary Disease), A-Fib (Atrial Fibrillation), Parkinson's disease, and MS (Multiple Sclerosis)—are all chronic conditions that can be coded based on a provider's documentation specifying the diagnosis, even if additional supporting documentation is not present. In coding practices, particularly in risk adjustment coding, it is permissible to assign diagnoses when the provider has clearly indicated the diagnosis in their notes, regardless of the presence of further documentation to support it. These conditions often require chronic management and have clear diagnostic criteria, making them valid for coding if the provider has stated the diagnosis. The other choices include diagnoses that may not meet the same criteria. For instance, conditions like Croup are typically acute and may require additional documentation for proper coding. Additionally, not all the conditions in the other options meet the standard for coding based solely on a diagnosis mentioned in the medical record without further documentation. Thus, the comprehensive nature of the conditions listed in the correct answer allows for their coding in compliance with risk adjustment coding guidelines.