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

## Study Guide


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# Questions

**1. 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**

**2. What is the reporting period for risk adjustment coding?**

**A. October to September**

**B. January to October**

**C. January to December**

**D. June to May**

**3. Which medical records can be submitted for HCC validation?**

**A. Physician office progress note, Outpatient Hospital, Critical Access Hospital**

**B. Laboratory test results**

**C. Physician office progress note, Outpatient Hospital, Critical Access Hospital, Laboratory test results**

**D. All of the above**

**4. Which of the following statements about the prostate is true?**

**A. It is part of the male reproductive system**

**B. It helps make and store seminal fluid**

**C. It makes testosterone**

**D. It is part of the female urinary system**

**5. When are HCCs typically utilized in patient care?**

**A. A. During emergency visits only.**

**B. B. When planning preventive care strategies.**

**C. C. For diagnostic purposes only.**

**D. D. On a monthly basis for coders.**

**6. What ICD-10-CM code should be assigned for a patient still symptomatic after 10 weeks post-myocardial infarction?**

- **A. Z51.89 Encounter for other specified aftercare**
- **B. I21.29 ST elevation (STEMI) MI involving other sites**
- **C. I22.8 Subsequent ST elevation (STEMI) MI of other sites**
- **D. I24.2 Old MI**

**7. In terms of risk adjustment, what does the term "active chronic conditions" refer to?**

- **A. Conditions that are currently managed and treated**
- **B. Conditions that have been previously diagnosed but resolved**
- **C. Conditions that are not documented in patient records**
- **D. Temporary illnesses that do not require ongoing treatment**

**8. What is a key advantage of the blended model used in HCC risk adjustment?**

- **A. Eases the transition from one year's model to the next**
- **B. Requires more resources for coding under two different models**
- **C. Allows fee-for-service model into the risk adjustment factor score**
- **D. Results in substantial revenue loss in the first year**

**9. What is the purpose for capturing diagnosis codes in an HCC model?**

- **A. Determine the correct fee for service payment.**
- **B. Determine the combined risk adjustment factor.**
- **C. Determine the QPP bonus payment.**
- **D. Determine the patient premium.**

**10. 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**

# Answers

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

# Explanations

## 1. 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.**

## 2. What is the reporting period for risk adjustment coding?

**A. October to September**

**B. January to October**

**C. January to December**

**D. June to May**

**The reporting period for risk adjustment coding is based on the calendar year, which is from January to December. This period is crucial for gathering and analyzing data that reflects the health status of patients covered under risk adjustment models, particularly in the context of Medicare Advantage plans. The coding during this time accounts for diagnoses and care that occur throughout the entire year, which contributes to calculating risk scores that determine funding levels. By utilizing a full calendar year, the information captured can better inform health plans of the population they are serving and help in assessing the resource needs based on the chronic conditions present in the patient population. This comprehensive approach ensures that coding reflects all relevant conditions that might influence a patient's health status, ultimately aiding in providing appropriate care and funding. Other options suggest different, non-standard reporting periods that do not align with typical practices in risk adjustment coding and may lead to incomplete data or miscalculations of risk scores.**

## 3. Which medical records can be submitted for HCC validation?

**A. Physician office progress note, Outpatient Hospital, Critical Access Hospital**

**B. Laboratory test results**

**C. Physician office progress note, Outpatient Hospital, Critical Access Hospital, Laboratory test results**

**D. All of the above**

**The correct answer focuses on the types of medical records that are typically substantiated for Hierarchical Condition Category (HCC) validation, which primarily includes detailed documentation from healthcare providers that reflect a patient's medical condition and care. Physician office progress notes, outpatient hospital records, and critical access hospital documentation are specifically designed to capture a patient's health status and reflect the provider's evaluations and assessments, which are essential for accurate risk adjustment coding and HCC validation. These records contain the necessary clinical details, such as diagnoses, treatment plans, and follow-up care that are integral for validating HCCs. While laboratory test results can provide useful clinical information, they often do not contain the comprehensive assessment and context necessary for HCC validation on their own. They may supplement the information found in the progress notes but are not usually sufficient for standalone validation. As such, they play a supportive role in confirming the overall health status but are not usually submitted independently for HCC validation. Thus, the focus on physician notes and hospital records as the primary sources for HCC validation accurately reflects the requirements for submitting comprehensive and context-rich documentation essential for proper coding and validation.**

## 4. Which of the following statements about the prostate is true?

**A. It is part of the male reproductive system**

**B. It helps make and store seminal fluid**

**C. It makes testosterone**

**D. It is part of the female urinary system**

**The statement that the prostate is part of the male reproductive system is accurate. The prostate gland plays a crucial role in male reproduction as it is responsible for producing some of the components of seminal fluid, which is important for sperm viability and mobility. Its primary function is to secrete a fluid that nourishes and protects sperm during ejaculation. In addition to being integral to the reproductive system, the prostate also contributes to the overall male anatomy and health. It is located below the bladder and surrounds the urethra, which is the duct through which urine and semen exit the body, indicating its dual role. The other statements provided do not correctly reflect the functions or associations of the prostate gland. The prostate does help in making and storing seminal fluid, but it is not solely responsible for its production, thus making the statement about its role in the male reproductive system the more comprehensive and accurate choice. Additionally, the prostate does not produce testosterone; that hormone is primarily created in the testes. Lastly, the prostate is not part of the female urinary system, as it is exclusively a male anatomical structure.**

## 5. When are HCCs typically utilized in patient care?

**A. A. During emergency visits only.**

**B. B. When planning preventive care strategies.**

**C. C. For diagnostic purposes only.**

**D. D. On a monthly basis for coders.**

**The correct choice emphasizes the role of Hierarchical Condition Categories (HCCs) in planning preventive care strategies. HCCs are used in risk adjustment models to identify patients with specific chronic conditions that may require tailored care management or preventive interventions. By utilizing HCCs, healthcare providers can better understand the health status of their patients and develop strategies that aim to prevent the worsening of these conditions. Incorporating HCCs into care planning allows providers to allocate resources effectively, prioritize preventive measures, and ultimately improve patient outcomes. Utilizing HCCs for this purpose also aligns with value-based care initiatives that emphasize proactive management of chronic diseases and prevention, rather than reactive care. Other contexts, such as emergency visits or diagnostic purposes, do not focus on ongoing patient care and management. Coders typically focus on HCCs on a regular basis, but the utilization of HCCs is not confined to monthly activities; rather, it is heavily integrated into care planning processes. Hence, emphasizing preventive care strategies captures the essence of HCC application best in patient care.**

## 6. What ICD-10-CM code should be assigned for a patient still symptomatic after 10 weeks post-myocardial infarction?

**A. Z51.89 Encounter for other specified aftercare**

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**D. I24.2 Old MI**

**The scenario presents a patient who remains symptomatic 10 weeks after a myocardial infarction (MI). In ICD-10-CM coding, symptom persistence after an MI typically requires coding that reflects the ongoing need for management and care. Assigning the code for "Encounter for other specified aftercare" is appropriate in this case because it encompasses situations where patients continue to need medical attention for residual symptoms after a significant medical event, such as a myocardial infarction. The time frame of 10 weeks suggests the patient is no longer in the acute phase of the MI but requires continued observation or therapy for lingering effects. This aligns with the intention of aftercare coding in ICD-10-CM, which is used for follow-ups related to specific diagnoses that have not fully resolved. In contrast, the other options either code for acute conditions or for older instances of myocardial infarction. For instance, codes relating to specific sites of a STEMI or an old infarction do not accurately capture the ongoing symptomatology seen in this patient. The coding for subsequent or old MIs would misrepresent the patient's current status, as they still exhibit symptoms, necessitating continued professional attention rather than being classified as having resolved or being an old event. Thus, the code for after**

## 7. In terms of risk adjustment, what does the term "active chronic conditions" refer to?

**A. Conditions that are currently managed and treated**

**B. Conditions that have been previously diagnosed but resolved**

**C. Conditions that are not documented in patient records**

**D. Temporary illnesses that do not require ongoing treatment**

**The term "active chronic conditions" refers to those health conditions that are currently managed and treated. In the context of risk adjustment, it's essential to differentiate between conditions that still impact a patient's health and require ongoing attention and those that have either resolved or are not significant at present. Active chronic conditions are typically indicative of patients who may have continuing healthcare needs; therefore, they play a crucial role in determining a patient's risk score for healthcare providers and insurers. These conditions are recognized in coding practices and influence how healthcare systems allocate resources and determine payment models. When these conditions are documented accurately in patient records, they provide a clearer picture of the patient's health status, which is vital for risk adjustment purposes. This understanding can lead to more appropriate care management strategies tailored to the active health issues a patient faces. The other options do not fit this definition, focusing either on conditions that are no longer influencing patient care or transient issues that do not indicate ongoing healthcare needs.**

## 8. What is a key advantage of the blended model used in HCC risk adjustment?

**A. Eases the transition from one year's model to the next**

**B. Requires more resources for coding under two different models**

**C. Allows fee-for-service model into the risk adjustment factor score**

**D. Results in substantial revenue loss in the first year**

**The blended model in Hierarchical Condition Categories (HCC) risk adjustment incorporates elements from both the previous and current coding models, creating a smoother transition. This approach allows healthcare providers and coders to adapt over time, minimizing disruption that can come from a sudden shift to a new model. By easing the transition, providers can maintain more consistent coding practices, which helps in stabilizing reimbursement rates during times of change. This blend ensures that the risk adjustment factor scores reflect patient risk more accurately, as it captures a broader range of conditions that could be relevant under both models. In contrast, requiring more resources for coding under two different models would complicate the process rather than streamline it. Allowing the fee-for-service model to influence risk adjustment scores does not necessarily connect with the aspect of the blended approach, as it primarily focuses on integrating different risk adjustment methodologies. Finally, rather than resulting in substantial revenue loss, the blended model aims to provide stability and mitigate significant financial impacts during transitions, which enhances confidence in the reimbursement process.**

## 9. What is the purpose for capturing diagnosis codes in an HCC model?

**A. Determine the correct fee for service payment.**

**B. Determine the combined risk adjustment factor.**

**C. Determine the QPP bonus payment.**

**D. Determine the patient premium.**

**Capturing diagnosis codes in a Hierarchical Condition Category (HCC) model serves the primary purpose of determining the combined risk adjustment factor. The HCC model uses these codes to reflect the health status of patients and quantify their risk, which is essential for accurately adjusting payments to healthcare plans based on the expected cost of providing care to enrollees. By coding specific diagnoses, healthcare providers can demonstrate the complexity and severity of a patient's conditions. This information is vital for the risk adjustment process, as it helps to ensure that plans receive appropriate financial reimbursement relative to the risk profile of their patient population. The combined risk adjustment factor then informs overall funding and resource allocation, ensuring that higher-risk patients are adequately compensated and that healthcare plans can deliver necessary care. This mechanism is particularly important because it addresses variations in patient health status, allowing for a more equitable comparison of plan performance. Therefore, capturing accurate and comprehensive diagnosis codes directly impacts the risk adjustment factor that ultimately influences financial reimbursements and supports the sustainability of health insurance models.**

## 10. 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.**