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

Study Guide

BY EXAMZIFY

Everything you need from our exam experts!

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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.

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!

Questions

1. When is added value factored into the RAF for the HCC model for disease interaction?

    A. When two or more chronic conditions are reported.

    B. When there is an exacerbation of a chronic illness.

    C. When two chronic illnesses paired together are complex to treat.

    D. When a diagnosis code has been reported for at least three years.

2. When selecting a diagnosis code, which of the following statements is true?

    A. Report the default code found in the Alphabetic Index.

    B. Only use codes that are found in the Tabular List.

    C. Diagnosis with the highest RAF score is always first-listed.

    D. Codes should be confirmed using the Tabular List before reporting.

3. To enhance revenue, which strategy should a Medicare Advantage Plan employ?

    A. Code all diagnoses listed in the patient's problem list

    B. Develop a prospective approach for HCC capture

    C. Focus on high-risk diagnosis codes only

    D. Transfer healthy patients out of the network

4. Retrospective audits provide insurance companies with the ability to scrub/correct their data for which purpose?

    A. A. Provides opportunities to increase revenue by submitting additional codes.

    B. B. Provides opportunities to compare claims data to the documentation and submit deletions if the documentation does not support what was on the claim.

    C. C. Provides opportunities to correct coding errors prior to data being submitted.

    D. D. All of the above.

5. **Which purpose does HEDIS serve in healthcare quality assessment?**

    A. Regulating healthcare costs

    B. Ensuring equitable access to care

    C. Measuring and improving clinical quality

    D. Facilitating patient appointments

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 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.

8. **Which of the following is NOT a step in the HCC coding process?**

    A. Annual assessments and plans documenting all active chronic conditions

    B. Prospective chart reviews to capture missed chronic conditions

    C. HCC codes submitted without validation from the medical record

    D. The plan sends diagnosis codes to risk adjustment processing system for conversion

9. **According to the ICD-10-CM guidelines, when should co-existing conditions be reported?**

    A. When the condition is fully resolved

    B. If it affects treatment of an acute condition

    C. For chronic conditions only

    D. When the condition resolves and affects chronic management

10. When should a problem list in EHR be updated?

    A. Only when new problems emerge.

    B. When previous visit information is carried over.

    C. Regularly to reflect current patient problems.

    D. Only at the start of each year.

Answers

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

Explanations

1. When is added value factored into the RAF for the HCC model for disease interaction?

    A. When two or more chronic conditions are reported.

    B. When there is an exacerbation of a chronic illness.

    C. When two chronic illnesses paired together are complex to treat.

    D. When a diagnosis code has been reported for at least three years.

The correct choice emphasizes the significance of complexity in treating two chronic illnesses when determining risk adjustment factor (RAF) scores in the Hierarchical Condition Category (HCC) model. In healthcare risk adjustment, the interaction between multiple chronic conditions can affect a patient's overall health status and treatment needs, thus impacting their risk profile. When two chronic illnesses are particularly complex to manage together, this interplay may require more resources, make treatment more challenging, and lead to poorer health outcomes. The HCC model recognizes these interactions, thereby factoring in added value to the RAF score. This adjustment is crucial because it allows for a more accurate reflection of the health risks and needs of patient populations who are dealing with such complexities. Other scenarios mentioned, such as simply reporting two or more chronic conditions, experiencing exacerbations, or having diagnoses reported for several years, do not adequately account for the nuanced relationship and treatment difficulties that arise from the specific interaction of chronic illnesses. This highlights why the complexity in treatment is a focal point in assessing added value within the RAF calculations.

2. When selecting a diagnosis code, which of the following statements is true?

    A. Report the default code found in the Alphabetic Index.

    B. Only use codes that are found in the Tabular List.

    C. Diagnosis with the highest RAF score is always first-listed.

    D. Codes should be confirmed using the Tabular List before reporting.

The statement that codes should be confirmed using the Tabular List before reporting is true because the Tabular List provides critical details about each code, including its description, any necessary additional characters, and guidelines for its use. This confirmation process ensures that the diagnosis codes accurately reflect the patient's condition and meet all coding requirements. Using the Tabular List helps coders avoid potential errors and ensures that they are following the most current coding conventions, which can be essential for proper billing and reimbursement. It also provides necessary information about code relationships, exclusions, and other relevant instructional notes that are not found in the Alphabetic Index. This practice solidifies the validity of the coding choice and supports compliance with coding standards, ensuring that diagnoses are reported accurately.

3. To enhance revenue, which strategy should a Medicare Advantage Plan employ?

A. Code all diagnoses listed in the patient's problem list

B. Develop a prospective approach for HCC capture

C. Focus on high-risk diagnosis codes only

D. Transfer healthy patients out of the network

A Medicare Advantage Plan can enhance revenue effectively by developing a prospective approach for Hierarchical Condition Category (HCC) capture. This strategy involves proactively identifying and documenting patients' conditions that influence risk adjustment. By integrating this into their operations, the plan can ensure that all relevant diagnoses are recorded accurately and consistently throughout a patient's care continuum. This approach allows plans to better align patient care management efforts with documentation practices, which not only improves the capture of risk-adjusted revenue but also enhances the quality of care provided to members. It encourages the continuous assessment of patient health status rather than relying solely on retrospective reviews. Additionally, this strategy can lead to improved health outcomes by emphasizing early identification and management of chronic conditions, reinforcing a cycle of care that is beneficial both for the patient and the plan's financial health. Other methods, such as only coding all diagnoses in a patient's problem list or focusing solely on high-risk diagnosis codes, may miss broader opportunities for revenue capture because they don't consider the full scope of a patient's health and the potential for revenue based on both chronic and acute conditions. Transferring healthy patients out of the network is counterproductive, as it undermines the goal of maintaining a healthy member population, which is essential for sustainable revenue in Medicare Advantage plans

4. Retrospective audits provide insurance companies with the ability to scrub/correct their data for which purpose?

A. A. Provides opportunities to increase revenue by submitting additional codes.

B. B. Provides opportunities to compare claims data to the documentation and submit deletions if the documentation does not support what was on the claim.

C. C. Provides opportunities to correct coding errors prior to data being submitted.

D. D. All of the above.

Retrospective audits are a crucial process for insurance companies as they allow for a thorough review of claims data against the supporting documentation. This method helps ensure that the information submitted is accurate and compliant with coding guidelines. The ability to scrub or correct data through retrospective audits serves multiple purposes. First, it indeed provides opportunities to increase revenue by identifying potential additional codes that may have been overlooked in the initial claim submission. This not only enhances the revenue for the insurance companies but also ensures that the coding accurately reflects the patient's health status. Furthermore, these audits allow for comparing claims data to the actual documentation. If discrepancies arise, the company has the chance to submit deletions or corrections when the documentation does not support what was initially reported on the claim. This step is essential for maintaining integrity in the claims process and adhering to regulatory standards. Lastly, retrospective audits also serve the purpose of identifying and correcting coding errors before they lead to potential issues. By recognizing mistakes in coding prior to submission, insurance companies can avoid future complications, ensure compliant practices, and improve the overall quality of their reporting. Thus, all of these functions together illustrate why retrospective audits are invaluable for insurance companies in managing and accurately reporting their data.

5. Which purpose does HEDIS serve in healthcare quality assessment?

A. Regulating healthcare costs

B. Ensuring equitable access to care

C. Measuring and improving clinical quality

D. Facilitating patient appointments

HEDIS, which stands for the Healthcare Effectiveness Data and Information Set, serves a critical role in healthcare quality assessment by measuring and improving clinical quality. It encompasses a collection of standardized performance measures that organizations can use to evaluate the efficacy and quality of healthcare services provided to patients. These measures are based on various aspects of care, including preventive services, treatment protocols, and patient satisfaction, allowing healthcare providers and payers to identify areas needing improvement. By focusing on clinical quality metrics, HEDIS helps healthcare organizations implement changes that enhance patient outcomes, ensure adherence to best practices, and streamline care processes. The ultimate goal is to foster a higher standard of care and promote better health outcomes across populations, making this purpose fundamental to ongoing quality improvement initiatives in the healthcare sector.

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 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

8. Which of the following is NOT a step in the HCC coding process?

A. Annual assessments and plans documenting all active chronic conditions

B. Prospective chart reviews to capture missed chronic conditions

C. HCC codes submitted without validation from the medical record

D. The plan sends diagnosis codes to risk adjustment processing system for conversion

The correct answer focuses on a critical aspect of the HCC coding process, which is ensuring accuracy and compliance in the coding of chronic conditions. HCC, or Hierarchical Condition Categories, coding requires that all codes submitted to insurance payers be well-supported and validated against the medical record. This is essential for maintaining the integrity of the coding process, as improper coding can lead to inappropriate risk adjustment payments and could ultimately result in penalties for not adhering to coding guidelines. Submitting HCC codes without adequate validation from the medical record is contrary to best practices in coding. The medical record should serve as the basis for coding, ensuring that the conditions documented reflect the clinical reality of the patient's health status. Each condition that is coded must be substantiated by appropriate documentation in the medical record; therefore, the idea of submitting codes without this validation goes against the core principles of accurate coding. In this context, the other steps listed involve critical components of the HCC coding process. Annual assessments and plans are necessary for identifying and documenting all active chronic conditions, while prospective chart reviews help identify any missed conditions to ensure comprehensive coding. The final step of sending diagnosis codes for risk adjustment processing is also essential in the overall workflow to ensure appropriate risk adjustment payment based on documented clinical conditions.

9. According to the ICD-10-CM guidelines, when should co-existing conditions be reported?

A. When the condition is fully resolved

B. If it affects treatment of an acute condition

C. For chronic conditions only

D. When the condition resolves and affects chronic management

The correct choice is significant because co-existing conditions should be reported when they have a direct impact on the treatment of an acute condition. This aligns with the ICD-10-CM guidelines, which emphasize the importance of capturing all relevant diagnoses that influence the patient's care and treatment plans. When documenting conditions, it is essential to reflect the comprehensive nature of the patient's health status, particularly how other existing conditions can complicate, influence, or dictate the management of an acute episode. For example, if a patient with diabetes is treated for pneumonia, the diabetes is relevant and should be documented because it may affect the treatment protocol and the patient's recovery. This ensures that healthcare providers have a complete picture of the patient's health and can make informed decisions about their care. In contrast, the other options do not align with these guidelines. Conditions that are fully resolved do not play a role in current treatment and thus are not reported. Chronic conditions alone do not necessitate reporting unless they influence treatment, and simply resolving a condition does not warrant documentation if it does not affect the ongoing management of the patient's chronic illnesses.

10. When should a problem list in EHR be updated?

    A. Only when new problems emerge.

    B. When previous visit information is carried over.

    C. Regularly to reflect current patient problems.

    D. Only at the start of each year.

Updating the problem list in the Electronic Health Record (EHR) regularly to reflect current patient problems is essential for maintaining accurate and comprehensive patient records. It ensures that healthcare providers have access to an up-to-date summary of the patient's health status, which is vital for effective decision-making, treatment planning, and care coordination. Regular updates are crucial because patient conditions can change frequently due to various factors such as new diagnoses, changes in symptoms, or the resolution of previous conditions. An accurate problem list allows healthcare providers to identify trends in a patient's health over time and manage chronic diseases more effectively while also complying with documentation standards that support risk adjustment and reimbursement. Having an up-to-date problem list is also important for proper coding and billing, as it directly impacts the capture of clinically relevant diagnoses and promotes continuity of care among different providers and settings. Regular documentation and updates ensure that all healthcare professionals involved in a patient's care are informed of any changes in their health status, ultimately improving patient outcomes.

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://certifiedriskadjustmentcoder.examzify.com

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