

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

Study Guide



Everything you need from our exam experts!

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

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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

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- 1. Which code set is primarily used for HCC coding?**
 - A. CPT**
 - B. HCPCS Level II**
 - C. ICD-10-CM**
 - D. ICD-10-PCS**

- 2. Which type of health claims are generally NOT used in predictive modeling for chronic conditions?**
 - A. Rx claims**
 - B. Inpatient claims**
 - C. DME claims**
 - D. Dental claims**

- 3. In order for a code to be counted as part of the current CMS HCC model, which criterion must a diagnosis code meet?**
 - A. The diagnosis is included in the CMS-Hierarchical Condition Category (CMS-HCC)**
 - B. The diagnosis is a history code**
 - C. The diagnosis has never been reported**
 - D. The diagnosis is an acute condition**

- 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. In the CDPS risk adjustment model, what category do heart attacks fall under?**
 - A. Low**
 - B. Medium**
 - C. High**
 - D. Very high**

6. If a diabetic patient presents with a laceration on the foot requiring closure repair, which conditions should be reported?

- A. Diabetes only**
- B. Open wound of the foot only**
- C. Open wound of the foot and diabetes**
- D. Open wound of the foot and a diabetic manifestation**

7. What information is typically required in RADV/IVA audit submissions?

- A. Provider printed name**
- B. Two patient identifiers**
- C. Provider's signature**
- D. All of the above**

8. When coding multiple diagnoses, which principle must be adhered to according to coding guidelines?

- A. Only the most severe diagnosis should be coded**
- B. All chronic conditions should be excluded**
- C. Code those conditions that are actively treated and relevant to the visit**
- D. Previous conditions should not affect current coding**

9. Which of the following is the main purpose of the MEAT acronym in risk adjustment coding?

- A. To summarize patient conditions**
- B. To validate treatment effectiveness**
- C. To document patient assessment and treatment history**
- D. To streamline coding processes**

10. Which of the following statements about coding assessments in EMR records is TRUE?

- A. Coding should only reflect the primary diagnosis.**
- B. Coding must encompass all conditions listed, even those not relevant.**
- C. Coding should reflect the most specific diagnosis available.**
- D. Old diagnoses should not be included in coding.**

Answers

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

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Explanations

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1. Which code set is primarily used for HCC coding?

- A. CPT
- B. HCPCS Level II
- C. ICD-10-CM**
- D. ICD-10-PCS

The primary code set used for HCC (Hierarchical Condition Category) coding is ICD-10-CM. This coding system includes diagnosis codes that capture patient conditions and comorbidities, which are essential for risk adjustment in Medicare Advantage programs. HCC coding specifically relies on the accuracy of the ICD-10-CM codes to represent the complexity and severity of the patient's health status. ICD-10-CM codes are utilized to indicate the presence of specific health conditions that affect the risk adjustment process, which ultimately impacts reimbursement rates for health plans. Each condition corresponds to an HCC, and the health status of patients is assessed through these codes. Proper documentation and coding of the conditions lead to accurate risk scores that reflect resource needs and predict future healthcare expenditures. Other code sets, such as CPT, are focused on procedures and services rendered, while HCPCS Level II includes codes for non-physician services, supplies, and equipment. ICD-10-PCS, on the other hand, is primarily used for inpatient procedure coding rather than diagnosis coding. This highlights the unique role of ICD-10-CM in the HCC framework.

2. Which type of health claims are generally NOT used in predictive modeling for chronic conditions?

- A. Rx claims
- B. Inpatient claims
- C. DME claims
- D. Dental claims**

Dental claims are generally not used in predictive modeling for chronic conditions because they primarily pertain to oral health care rather than systemic health issues. Predictive modeling aims to forecast the likelihood of health outcomes based on a range of medical data pertinent to chronic diseases. Dental claims usually cover services related to the prevention, diagnosis, and treatment of dental-related issues, which are considered separate from the management of chronic conditions such as diabetes, heart disease, or respiratory disorders. In contrast, Rx claims provide information about medication usage, inpatient claims include hospital admissions that are critical for assessing the severity of chronic conditions, and DME claims—related to durable medical equipment—offer insights into the ongoing care needs of patients with chronic illnesses. These three types of claims are much more relevant in understanding and predicting the course of chronic conditions, making dental claims the least applicable in this context.

3. In order for a code to be counted as part of the current CMS HCC model, which criterion must a diagnosis code meet?

- A. The diagnosis is included in the CMS-Hierarchical Condition Category (CMS-HCC)**
- B. The diagnosis is a history code**
- C. The diagnosis has never been reported**
- D. The diagnosis is an acute condition**

For a code to be counted as part of the current CMS HCC model, it is essential that the diagnosis is included in the CMS-Hierarchical Condition Category (CMS-HCC). The CMS-HCC model is designed to capture the complexities of patient health conditions, and it operates by utilizing specific diagnosis codes that have been determined to have a significant impact on expected healthcare costs. When a diagnosis code is part of the CMS-HCC, it means that the condition is recognized as contributing to the risk adjustment process, which accounts for the varying health statuses of patients in Medicare Advantage programs. Only those diagnoses listed in the official CMS-HCC categories are eligible for inclusion, ensuring that the model reflects relevant and quantifiable health issues within the patient population. This is crucial for risk adjustment, as it affects payment structures and healthcare resource allocations. The other options presented do not align with the criteria necessary for inclusion in the CMS-HCC model. While history codes may be relevant in certain contexts, they do not qualify under the criteria for risk adjustment if they are not included in the CMS-HCC. Acute conditions are significant in healthcare, but not all acute conditions are included in the CMS-HCC categories. Similarly, a diagnosis being reported or not is irrelevant if it does

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. In the CDPS risk adjustment model, what category do heart attacks fall under?

- A. Low**
- B. Medium**
- C. High**
- D. Very high**

In the CDPS (Chronic Disease and Payment System) risk adjustment model, heart attacks are classified under the medium risk category. This classification reflects the associated costs and resource utilization implications that typically arise from a diagnosis of a heart attack. The medium category is indicative of conditions that have a significant but not the most extreme impact on health care resources and costs. Heart attacks often require substantial medical intervention and ongoing management, which justifies their placement in this category. The risk adjustment model is designed to account for the severity of health conditions and their implications for patient care, leading to appropriate funding and resource allocation for healthcare providers. Conditions classified as low and very high represent lesser and more severe impacts, respectively, but heart attacks, due to their complexity and potential complications, are appropriately placed within the medium risk category.

6. If a diabetic patient presents with a laceration on the foot requiring closure repair, which conditions should be reported?

- A. Diabetes only**
- B. Open wound of the foot only**
- C. Open wound of the foot and diabetes**
- D. Open wound of the foot and a diabetic manifestation**

The correct choice is the one that indicates both the open wound of the foot and the associated diabetes should be reported. This is because in risk adjustment coding, it is essential to capture the full clinical picture of the patient's condition. In this scenario, diabetes can significantly affect treatment and healing processes, especially when it comes to wounds on extremities such as the foot. The presence of diabetes not only influences the management of the laceration but also carries implications for the patient's overall health status and the potential for complications. By reporting both the open wound and the diabetes, coders ensure comprehensive documentation that reflects the complexity of the patient's condition. This approach helps in accurately portraying the patient's risk profile, which is essential for proper reimbursement and for guiding future healthcare interventions.

7. What information is typically required in RADV/IVA audit submissions?

- A. Provider printed name**
- B. Two patient identifiers**
- C. Provider's signature**
- D. All of the above**

In RADV (Risk Adjustment Data Validation) and IVA (Interactive Validation Audit) audit submissions, it's essential to include comprehensive documentation that establishes the authenticity of the patient records and the accuracy of the risk adjustment coding. This typically encompasses several key components. The provider's printed name is crucial as it identifies the healthcare professional responsible for the patient's care and the documentation. This helps establish accountability and traceability in the medical record. Including two patient identifiers, such as the patient's name and date of birth or medical record number, is standard practice. This information helps to accurately match the submitted records with the correct patients, thereby ensuring that the data being audited corresponds to the individuals in question. The provider's signature is also necessary as it serves as a confirmation that the provider has reviewed and approved the medical record, ensuring that the documentation reflects an accurate and complete record of the patient's care. Since all these elements contribute to creating a robust and verifiable submission that meets the auditing standards, the inclusion of all of the specified components is required in RADV/IVA audit submissions. Thus, selecting the option that states "All of the above" is the correct choice, as it encompasses the necessary requirements.

8. When coding multiple diagnoses, which principle must be adhered to according to coding guidelines?

- A. Only the most severe diagnosis should be coded**
- B. All chronic conditions should be excluded**
- C. Code those conditions that are actively treated and relevant to the visit**
- D. Previous conditions should not affect current coding**

When coding multiple diagnoses, it is essential to prioritize coding for those conditions that are actively treated and relevant to the visit. This principle aligns with the coding guidelines and ensures that the patient's current health status is accurately represented. Active conditions reflect the healthcare needs that require attention during the encounter, thus guiding treatment decisions and care management. Additionally, relevant diagnoses provide crucial information for reimbursement purposes, as they demonstrate the medical necessity for the services rendered. Collectively, coding only those conditions that contribute to the patient's visit ensures compliance with regulations and maintains the integrity of the medical record. The other principles do not align with established coding practices. For example, coding just the most severe diagnosis would overlook other important conditions that require attention, while excluding chronic conditions does not accurately reflect a patient's comprehensive health status. Lastly, disregarding previous conditions undermines the importance of a patient's medical history, which can be significant in understanding their current health complexities.

9. Which of the following is the main purpose of the MEAT acronym in risk adjustment coding?

- A. To summarize patient conditions**
- B. To validate treatment effectiveness**
- C. To document patient assessment and treatment history**
- D. To streamline coding processes**

The main purpose of the MEAT acronym in risk adjustment coding refers to attributes that validate the documentation of a patient's health status. MEAT stands for Monitoring, Evaluation, Assessment, and Treatment. This framework emphasizes the importance of thoroughly documenting the patient's condition and the healthcare provider's response to that condition, which is crucial for accurate risk adjustment coding. In risk adjustment coding, comprehensive documentation is essential because it supports the coding of diagnoses that reflect the patient's true medical complexity. This, in turn, impacts reimbursement and quality of care measures. The MEAT criteria ensure that the documentation demonstrates not just the existence of a diagnosis, but also the ongoing management of that diagnosis through various measures. Ultimately, the focus on documentation of patient assessment and treatment history allows coders to capture a more complete picture of the patient's health needs, ensuring that care is appropriately represented in coding systems.

10. Which of the following statements about coding assessments in EMR records is TRUE?

- A. Coding should only reflect the primary diagnosis.**
- B. Coding must encompass all conditions listed, even those not relevant.**
- C. Coding should reflect the most specific diagnosis available.**
- D. Old diagnoses should not be included in coding.**

The statement that coding should reflect the most specific diagnosis available is true because specificity in coding ensures that the medical record accurately represents the patient's current health status and the nature of their medical conditions. By using the most specific diagnosis, coders provide a clearer picture of the patient's health and help support appropriate care and reimbursement. Specific coding also plays a crucial role in risk adjustment models, which rely on accurate documentation of a variety of conditions to assess resource utilization, risk profiles, and ultimately, patient care outcomes. Including specific diagnoses allows healthcare providers and payers to understand the complexities of a patient's health, leading to better treatment plans and proper funding from payers. This practice enhances the overall quality of the data collected, which is essential for effective clinical decision-making and health outcomes measurement. Other statements do not accurately represent best coding practices. For instance, coding should not be limited only to the primary diagnosis or to old diagnoses that are no longer relevant, as this may omit important information regarding the patient's medical history and could affect quality of care and risk assessment. Similarly, all active conditions that are pertinent to the patient's treatment should be documented, but not irrelevant conditions that do not contribute to the current care plan.

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!

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