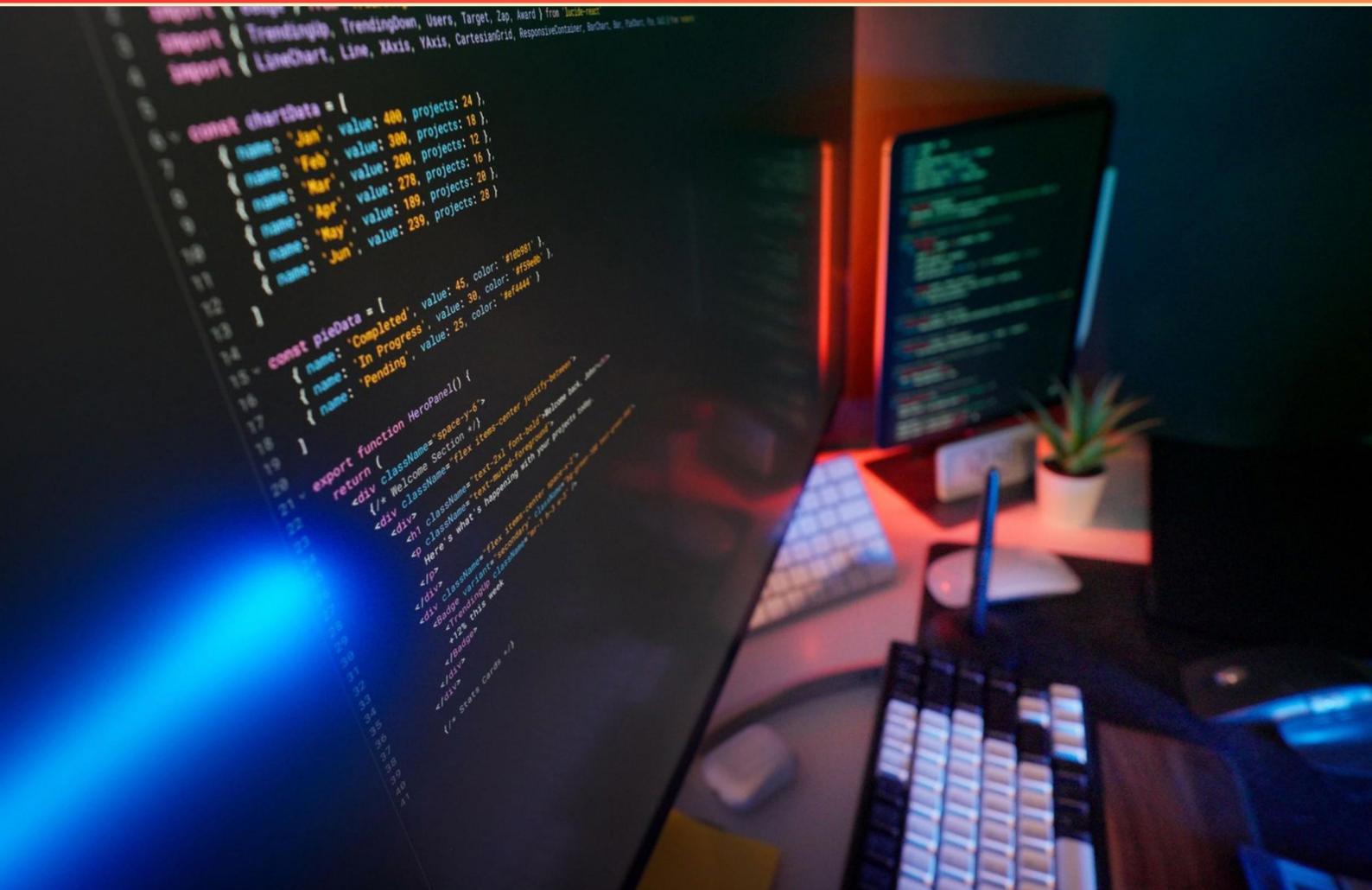


CERTIFIED RISK ADJUSTMENT CODER (CRC) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://certifiedriskadjustmentcoder.examzify.com>



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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 coding system is primarily used in the HCC risk adjustment model?

- A. ICD-10-CM
- B. SNOMED
- C. LOINC
- D. HCPCS

2. An AV fistula connects which of the following?

- A. The aorta to a vein
- B. An artery to a varicose vein
- C. An artery to a vein
- D. An artery to a ventricle

3. What is the goal of HEDIS?

- A. Allow for patients to rate their physicians.
- B. Allow patients to compare health plans.
- C. Allow patients to schedule appointments online.
- D. Allow patients to access their medical records.

4. What does the acronym MEAT stand for in medical documentation?

- A. Manage, Engage, Add, Therapy
- B. Monitor, Evaluate, Assess, or Treat
- C. Main, Encounter, Arrive, Treatment
- D. Monitor, Engage, Activate, Therapy

5. Do the HCC category hierarchies play a role in which medical record to submit for a RADV?

- A. A. No, there are no benefits in taking hierarchies into consideration.
- B. B. No, CMS will treat all diagnosis with the same financial weight.
- C. C. Yes, CMS will accept a lower or higher HCC to validate an HCC within the same category.
- D. D. Yes, there can be a financial gain by submitting a higher hierarchy HCC.

6. Which payer type uses HEDIS measures?

- A. A. Medicare
- B. B. Medicaid
- C. C. Private payers
- D. D. A variety of payer types

7. Which of the following is a requirement for a RADV audit submission?

- A. Records must include a list of unrelated past diagnoses
- B. Records must be incomplete but cover essential information
- C. Records must have a signature of the provider
- D. Records can be handwritten without legibility

8. Which medical record should be used for a RADV audit if CMS is requesting validation for diabetes mellitus with neuropathy?

- A. Chart #1: DOS 1/1/20XX—Diagnoses: DM, PVD
- B. Chart #2: DOS 4/2/20XX—Diagnoses: DM with neurologic manifestations, polyneuropathy, CKD
- C. Chart #3: DOS 7/7/20XX—Diagnoses: DM with neurologic manifestations
- D. Chart #4: DOS 9/9/20XX—Diagnosis: DM, HTN

9. Which of the following statements is TRUE regarding rule out diagnoses?

- A. A. A code for a rule out diagnosis can be coded when coding for HCC.
- B. B. A code for a rule out diagnosis can be coded in the outpatient setting only.
- C. C. The provider can document the rule out diagnosis but a code is not selected to report it.
- D. D. The provider can document the rule out diagnosis and select a secondary code to report it.

10. What is the primary purpose of a RADV audit?

- A. To ensure compliance with federal regulations
- B. To validate submitted HCC data
- C. To conduct random checks on patient records
- D. To assess provider performance and quality of care

Answers

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

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Explanations

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1. Which coding system is primarily used in the HCC risk adjustment model?

- A. ICD-10-CM**
- B. SNOMED
- C. LOINC
- D. HCPCS

The correct answer is that the ICD-10-CM coding system is primarily used in the HCC (Hierarchical Condition Category) risk adjustment model. ICD-10-CM is the International Classification of Diseases, 10th Revision, Clinical Modification, which is a comprehensive coding system utilized by healthcare providers to document diagnoses and conditions. The HCC risk adjustment model relies on these specific ICD-10-CM codes because they are designed to capture the complexity of patients' health statuses, including chronic conditions, which directly influence the expected healthcare costs. By using these codes, the model can accurately reflect the patient population's risk and ensure appropriate reimbursement levels based on the complexity and severity of patients' health conditions. The other coding systems mentioned serve different purposes. SNOMED is primarily used for electronic health record systems and facilitates interoperability by providing detailed clinical meanings. LOINC is focused on laboratory and clinical observations, enabling standardized lab results and clinical measurements, while HCPCS focuses on healthcare procedure coding and medical supply usage, which does not encompass the comprehensive diagnostic coding required for the HCC model.

2. An AV fistula connects which of the following?

- A. The aorta to a vein
- B. An artery to a varicose vein
- C. An artery to a vein**
- D. An artery to a ventricle

An arteriovenous (AV) fistula is a connection that facilitates direct blood flow between an artery and a vein. This procedure is commonly utilized in patients requiring hemodialysis, as it enhances blood flow for the treatment. The creation of an AV fistula allows the high-pressure arterial blood to flow into a lower-pressure venous system, which helps in maintaining adequate blood circulation during dialysis. The direct connection between an artery and a vein means that the blood can bypass the capillary beds, thus ensuring that there is sufficient volume and pressure for the dialysis machine to function properly. The other options do not accurately describe this specific medical connection; thus, choosing the connection between an artery and a vein aligns correctly with the purpose and function of an AV fistula.

3. What is the goal of HEDIS?

- A. Allow for patients to rate their physicians.
- B. Allow patients to compare health plans.**
- C. Allow patients to schedule appointments online.
- D. Allow patients to access their medical records.

The goal of HEDIS, which stands for Healthcare Effectiveness Data and Information Set, is to provide a standardized way to measure and compare the performance of health plans in delivering high-quality care. By offering essential metrics related to various aspects of healthcare delivery, HEDIS enables patients to evaluate and compare the effectiveness and quality of different health plans. This empowers consumers to make informed decisions about their healthcare based on the performance ratings and outcomes reported by health plans. While the other options touch on aspects related to patient interactions and healthcare accessibility, they do not align with the primary function of HEDIS. Patient ratings of physicians, online appointment scheduling, and access to medical records are services that contribute to patient experience and engagement but do not encapsulate the main purpose of HEDIS, which is focused on health plan performance measurement and comparison.

4. What does the acronym MEAT stand for in medical documentation?

- A. Manage, Engage, Add, Therapy
- B. Monitor, Evaluate, Assess, or Treat**
- C. Main, Encounter, Arrive, Treatment
- D. Monitor, Engage, Activate, Therapy

The acronym MEAT in medical documentation stands for Monitor, Evaluate, Assess, or Treat. This concept is integral to ensuring that a patient's ongoing care is properly documented, which is crucial for risk adjustment and reimbursement processes. Each component of the acronym plays a significant role in illustrating the complexity and thoroughness of patient care. Monitoring refers to the continuous observation of a patient's condition, which is essential for understanding changes over time. Evaluating involves reviewing the patient's overall health status and determining the effectiveness of current treatments. Assessing is about making clinical judgments based on both objective data and subjective patient reports, while treating refers to the actual actions taken to address the patient's health needs. Together, these elements ensure comprehensive documentation, which not only supports the medical necessity of care provided but also reinforces the accuracy of coding for risk adjustment purposes. Therefore, understanding MEAT helps coders and healthcare professionals provide clarity and justification for the services rendered.

5. Do the HCC category hierarchies play a role in which medical record to submit for a RADV?

- A. A. No, there are no benefits in taking hierarchies into consideration.
- B. B. No, CMS will treat all diagnosis with the same financial weight.
- C. C. Yes, CMS will accept a lower or higher HCC to validate an HCC within the same category.**
- D. D. Yes, there can be a financial gain by submitting a higher hierarchy HCC.

The correct answer highlights the importance of HCC (Hierarchical Condition Category) hierarchies in the context of RADV (Risk Adjustment Data Validation). HCC hierarchies are essential as they determine how various diagnoses relate to one another for purposes of risk adjustment. Specifically, CMS allows for flexibility when validating submitted diagnoses; if a lower HCC is documented, it can still be validated as part of the same category even if a higher HCC was submitted. This means that the validation process isn't strictly limited to the highest HCC; instead, it recognizes that various conditions can coexist and still be associated with a financial impact. Submitting a diagnosis that falls within the same HCC category but is of a different hierarchy can be beneficial for providers, as it allows them to demonstrate the complexity of patient conditions accurately. This is particularly important in cases where both the lower and higher HCCs accurately reflect the patient's health status, giving doctors a better chance of being reimbursed properly for the level of care they provide. In summary, understanding and utilizing HCC hierarchies effectively enhances a provider's ability to navigate RADV requirements and leads to accurate reimbursement based on validated diagnostic information.

6. Which payer type uses HEDIS measures?

- A. A. Medicare
- B. B. Medicaid
- C. C. Private payers
- D. D. A variety of payer types**

HEDIS, which stands for the Healthcare Effectiveness Data and Information Set, is a widely recognized set of performance measures that focus on various aspects of health care quality. These measures are utilized by a diverse array of payer types, including but not limited to Medicare, Medicaid, and private payers. The reason this answer is correct is that HEDIS measures were developed and are maintained by the National Committee for Quality Assurance (NCQA) and are designed to improve health care quality and encourage standardization so that patients receive appropriate and effective care regardless of their insurance coverage. As such, they are relevant not only to Medicare and Medicaid but also to many private insurance plans that aim to enhance care quality, monitor performance, and meet accountability standards. This broad applicability across multiple types of payers is essential for promoting overall public health initiatives and improving population health outcomes. Therefore, the use of HEDIS measures spans a variety of payer types, reflecting the commitment to standardized quality assessment in health care settings.

7. Which of the following is a requirement for a RADV audit submission?

- A. Records must include a list of unrelated past diagnoses
- B. Records must be incomplete but cover essential information
- C. Records must have a signature of the provider**
- D. Records can be handwritten without legibility

For a Risk Adjustment Data Validation (RADV) audit submission, it is crucial that the medical records presented contain a signature from the provider. This requirement ensures that the documentation is authenticated, verifying that the provider is acknowledging the contents and the accuracy of the records. A provider's signature is key in establishing accountability and legitimacy, which are essential for compliance and validation during the audit process. In the context of the options provided, signatures on medical records enhance the credibility of the information being submitted for risk adjustment. It serves as a legal affirmation and confirms that the data reflects the services provided, thereby assisting in the assessment of risk adjustment coding accuracy. Other options, such as including a list of unrelated past diagnoses or records being incomplete yet covering essential information, do not meet the stringent needs of RADV submissions, which require comprehensive and verifiable documentation to validate the risk adjustment claims made by providers. Similarly, handwritten records that lack legibility would not fulfill documentation requirements, as clear communication of patient information is paramount in audits.

8. Which medical record should be used for a RADV audit if CMS is requesting validation for diabetes mellitus with neuropathy?

- A. Chart #1: DOS 1/1/20XX—Diagnoses: DM, PVD
- B. Chart #2: DOS 4/2/20XX—Diagnoses: DM with neurologic manifestations, polyneuropathy, CKD**
- C. Chart #3: DOS 7/7/20XX—Diagnoses: DM with neurologic manifestations
- D. Chart #4: DOS 9/9/20XX—Diagnosis: DM, HTN

The correct choice is based on the specificity and clarity of the diagnoses documented in the medical record. In the context of a Risk Adjustment Data Validation (RADV) audit, it is essential to provide detailed evidence of the specific condition being audited—in this case, diabetes mellitus with neuropathy. Chart #2 includes a precise diagnosis of "DM with neurologic manifestations, polyneuropathy, CKD." This documentation clearly indicates that the patient suffers from diabetes mellitus along with neurological complications and provides a specific mention of polyneuropathy, which directly correlates with the auditor's request for validation of diabetes mellitus with neuropathy. The inclusion of chronic kidney disease (CKD) adds context but does not detract from the primary focus on the neuropathy associated with diabetes. The other charts do not provide the same level of specificity regarding neuropathy. For instance, Chart #1 only indicates diabetes mellitus and peripheral vascular disease without mentioning any neurologic implications. Chart #3 mentions neurologic manifestations but does not specify the type or nature of the neuropathy, making it less suitable for validating the specific condition of diabetes with neuropathy. Chart #4 lists diabetes and hypertension but lacks any reference to neuropathy entirely. Thus, Chart #2 is the most appropriate choice

9. Which of the following statements is TRUE regarding rule out diagnoses?

- A. A code for a rule out diagnosis can be coded when coding for HCC.
- B. A code for a rule out diagnosis can be coded in the outpatient setting only.
- C. The provider can document the rule out diagnosis but a code is not selected to report it.**
- D. The provider can document the rule out diagnosis and select a secondary code to report it.

The statement that a code for a rule out diagnosis can be coded in the outpatient setting only is not accurate in the context of coding standards. In coding practices, particularly for risk adjustment and Hierarchical Condition Categories (HCC), the documentation of rule out diagnoses follows specific guidelines. When a provider documents a rule out diagnosis, it indicates uncertainty about the presence of a condition at the time of evaluation. Coding guidelines typically dictate that if a provider has not confirmed the diagnosis—meaning it's still a possibility but has not been substantiated through further evaluation or testing—then a code would not typically be selected to report it in the context of risk adjustment coding. This is to ensure that only confirmed diagnoses that impact patient care and resources are included in HCC coding. The correct perspective involves understanding how these rule out diagnoses are addressed in risk adjustment coding. If a diagnosis has not been confirmed, it will not contribute to risk adjustment calculations, impacting reimbursement and data accuracy. Therefore, while documentation serves a purpose in clinical settings, it does not warrant the selection of a diagnosis code in the context of coding for HCC, leading to an emphasis on confirmed conditions only. In essence, true coding practice aligns this understanding with the importance of accuracy in diagnosis selection, ensuring that only

10. What is the primary purpose of a RADV audit?

- A. To ensure compliance with federal regulations
- B. To validate submitted HCC data**
- C. To conduct random checks on patient records
- D. To assess provider performance and quality of care

The primary purpose of a RADV audit is to validate submitted Hierarchical Condition Category (HCC) data. This process involves reviewing the medical records and the corresponding documentation to confirm that the risk adjustment coding reflects the patient's actual health status accurately. Accurate HCC coding is crucial as it impacts the reimbursement rates for Medicare Advantage plans and ensures that providers are appropriately compensated for the care of patients with varying health conditions. Through this audit, discrepancies between the reported HCC codes and the actual clinical documentation can be identified and corrected, helping to ensure data accuracy, which is essential for maintaining the integrity of risk adjustment programs. It ultimately serves to ensure that the healthcare system is both fair and effective in compensating providers based on the complexity of patient care. While ensuring compliance with federal regulations, conducting random checks on patient records, and assessing provider performance are important components of healthcare administration and quality improvement, they are not the primary focus of a RADV audit. The main objective is specifically to verify the accuracy of the HCC data related to patient diagnoses, which directly influences funding and resource allocation in health plans.

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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