

CMS RISK ADJUSTMENT DATA VALIDATION (RADV) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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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. What is the main objective of postpayment RADV?

- A. To determine plan premiums.
- B. To validate data after payments have been made.
- C. To validate data before payment.
- D. To reduce the overall RAF automatically.

2. What is chart abstraction in RADV?

- A. Chart abstraction is the process of assigning RAF directly from diagnosis lists.
- B. Chart abstraction is the process of reviewing medical records to extract diagnoses, timing, and evidence needed to validate RAF.
- C. Chart abstraction involves patient interviews to confirm diagnoses.
- D. Chart abstraction is performed solely by clinicians, not coders.

3. What is the Medicaid Integrity Program (MIP)?

- A. A program created by the Social Security Act to conduct audits of Medicaid providers, including managed care entities.
- B. A program to fund hospital expansion.
- C. A program for veterans' health services.
- D. A program to monitor Medicare Part D providers.

4. What is the difference between encounter data and chart documentation in RADV?

- A. Chart documentation is the data submitted in claims about patient encounters; encounter data are the actual medical records used to validate diagnoses.
- B. Encounter data are data submitted in claims about patient encounters; chart documentation is the actual medical records used to validate diagnoses.
- C. Encounter data refer to patient surveys; chart documentation refers to physician notes.
- D. They are interchangeable terms.

5. What causes a risk score to increase or decrease?

- A. A risk score increases if additional conditions are reported and decreases if chronic conditions are not recaptured from the previous year
- B. A risk score decreases with age only
- C. A risk score is fixed and never changes
- D. A risk score depends only on treatment intensity

- 6. What is the purpose of the RADV audit checklist created by CMS?**
- A. To audit only billing codes for completeness.
 - B. To help determine a record's suitability for a RADV audit, including verifying the date of service and provider credentials.
 - C. To evaluate patient satisfaction scores.
 - D. To determine hospital capacity for surge.
- 7. RAPS data sources are primarily from what?**
- A. Laboratory results.
 - B. Patient surveys.
 - C. Claims and audits.
 - D. Pharmacy claims.
- 8. What are Hierarchical Condition Categories (HCCs)?**
- A. A data submission format.
 - B. A coding standard for hospital billing durations.
 - C. Individual patient health metrics used for marketing.
 - D. Groups of related diagnoses used in risk adjustment; each HCC has a weight that contributes to the RAF.
- 9. Which statement best describes the purpose of risk adjustment scoring?**
- A. To determine annual payment amounts for plans based on enrollee risk.
 - B. To verify beneficiary eligibility for enrollment
 - C. To assess provider performance
 - D. To set beneficiary premiums
- 10. What types of organizations perform RADV audits?**
- A. CMS directly or through contracted third-party auditors, evaluation contractors, or QIOs may perform RADV audits.
 - B. Only private firms conduct RADV audits without CMS involvement.
 - C. Hospitals only perform RADV audits on their own data without CMS oversight.
 - D. RADV audits are optional and may be skipped by plans.

Answers

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

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Explanations

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1. What is the main objective of postpayment RADV?

- A. To determine plan premiums.
- B. To validate data after payments have been made.**
- C. To validate data before payment.
- D. To reduce the overall RAF automatically.

Postpayment RADV is about validating the risk adjustment data after payments have already been issued. The goal is to verify that the diagnoses and other data used to calc the risk adjustment factors and corresponding payments are accurate and properly supported by medical records. If issues are found, adjustments or recoveries may follow, rather than changing payments upfront. This is different from prepayment RADV, which aims to catch problems before money flows. It does not determine plan premiums and it does not automatically reduce the RAF; the focus is on ensuring data accuracy after payments have been made.

2. What is chart abstraction in RADV?

- A. Chart abstraction is the process of assigning RAF directly from diagnosis lists.
- B. Chart abstraction is the process of reviewing medical records to extract diagnoses, timing, and evidence needed to validate RAF.**
- C. Chart abstraction involves patient interviews to confirm diagnoses.
- D. Chart abstraction is performed solely by clinicians, not coders.

Chart abstraction in RADV is the careful review of a patient's medical records to identify all diagnoses that should affect the Risk Adjustment Factor, along with when those conditions started or were active and the evidence that supports them. Abstractors comb through provider notes, test results, imaging, treatment plans, and other documentation to confirm that a condition is present during the measurement period and that there is concrete evidence linking it to the appropriate risk-adjustment category. This process ensures the diagnoses used to calculate the RAF are properly supported, reproducible, and auditable, which helps prevent payment errors and maintains accuracy in risk-adjusted payments. While clinicians contribute to the documentation, chart abstraction relies on trained abstractors or coders who pull and verify the information from the medical record, rather than simply assigning RAF from diagnosis lists or conducting patient interviews.

3. What is the Medicaid Integrity Program (MIP)?

- A. A program created by the Social Security Act to conduct audits of Medicaid providers, including managed care entities.**
- B. A program to fund hospital expansion.
- C. A program for veterans' health services.
- D. A program to monitor Medicare Part D providers.

The Medicaid Integrity Program is a federal effort established under the Social Security Act to protect the Medicaid program from improper payments. Its main purpose is to identify, deter, and recover fraud, waste, and abuse by conducting audits and reviews of Medicaid providers, including managed care entities, using data analysis and Provider billing review. It supports states with audits, training, and guidance, coordinating with CMS and other program integrity activities to strengthen compliance and oversight. This focus is specific to Medicaid and differs from initiatives like hospital expansion funding, veterans' health services, or Medicare Part D oversight, which fall outside MIP's scope.

4. What is the difference between encounter data and chart documentation in RADV?

- A. Chart documentation is the data submitted in claims about patient encounters; encounter data are the actual medical records used to validate diagnoses.
- B. Encounter data are data submitted in claims about patient encounters; chart documentation is the actual medical records used to validate diagnoses.
- C. Encounter data refer to patient surveys; chart documentation refers to physician notes.
- D. They are interchangeable terms.

In RADV, two sources of evidence are used to validate diagnoses on submitted claims: encounter data and chart documentation. Encounter data are the data submitted in claims about patient encounters; chart documentation is the actual medical records used to validate diagnoses. The encounter data provide billing-level information—the codes, dates of service, and provider details that feed into risk scores—while chart documentation offers the clinical proof that those codes are accurate and supported by the patient's records, notes, tests, and findings. If the chart documentation does not support a diagnosis listed on the encounter data, the diagnosis may be disallowed or adjusted.

5. What causes a risk score to increase or decrease?

- A. A risk score increases if additional conditions are reported and decreases if chronic conditions are not recaptured from the previous year
- B. A risk score decreases with age only
- C. A risk score is fixed and never changes
- D. A risk score depends only on treatment intensity

In CMS risk adjustment, the risk score is shaped by the set of diagnosed conditions captured for the year plus whether chronic conditions from the prior year are recaptured in the current year. When additional conditions are reported, the model adds the corresponding condition weights (HCCs), which increases the overall risk score because more predicted costs or resource use are inferred. If chronic conditions from the previous year are not recaptured in the current year, those conditions no longer contribute to the current calculation, so the risk score can decrease. Demographics and other factors can influence the score as well, but the essential idea is that more diagnosed conditions raise the score, and failing to capture prior chronic conditions lowers it.

6. What is the purpose of the RADV audit checklist created by CMS?

- A. To audit only billing codes for completeness.
- B. To help determine a record's suitability for a RADV audit, including verifying the date of service and provider credentials.**
- C. To evaluate patient satisfaction scores.
- D. To determine hospital capacity for surge.

The main idea is that a RADV audit checklist acts as a pre-screening tool to decide whether a medical record should be pulled for a risk adjustment data validation review. It focuses on essential elements that make a record eligible for auditing and on whether the documentation can reliably support the diagnoses used to calculate risk scores. Verifying the date of service ensures the care documented matches the period being audited and that the clinical encounter aligns with the codes tied to those risk-adjustment diagnoses. Verifying provider credentials confirms the record actually comes from the correct, authorized clinician and can be credibly attributed to the member's care. These checks help ensure the record can be accurately evaluated and matched to the appropriate risk-adjustment data. This isn't about evaluating patient satisfaction or hospital surge capacity, and it isn't simply about whether billing codes are present. The purpose is to determine if the record has the necessary, verifiable documentation and identifiers to support a credible RADV review.

7. RAPS data sources are primarily from what?

- A. Laboratory results.
- B. Patient surveys.
- C. Claims and audits.**
- D. Pharmacy claims.

RAPS data sources are primarily from medical claims and related audits. The Risk Adjustment Processing System relies on diagnosis codes submitted on provider and facility claims, which CMS uses to map conditions to health risk factors (HCCs) and determine a patient's risk score. To ensure accuracy, these coded diagnoses are often verified or supported by chart audits that review medical records. While laboratory results can provide supporting evidence and pharmacy claims may contribute to Rx-based risk adjustments, the central feed for RAPS is the combination of claims data and audit documentation.

8. What are Hierarchical Condition Categories (HCCs)?

- A. A data submission format.
- B. A coding standard for hospital billing durations.
- C. Individual patient health metrics used for marketing.
- D. Groups of related diagnoses used in risk adjustment; each HCC has a weight that contributes to the RAF.**

Hierarchical Condition Categories are groups of related diagnoses used in risk adjustment to estimate future healthcare costs. Each HCC has an assigned weight, and these weights are summed to produce the Risk Adjustment Factor (RAF) for a patient. The hierarchy ensures that when multiple related diagnoses are present, only the most severe (highest weight) category counts, preventing double counting. This RAF then influences risk-adjusted payments in programs like Medicare Advantage and ACA risk adjustment. HCCs are not data submission formats, not a coding standard for durations of hospital billing, and not used for marketing metrics; they specifically map diagnoses to risk and payment adjustments.

9. Which statement best describes the purpose of risk adjustment scoring?

- A. To determine annual payment amounts for plans based on enrollee risk.**
- B. To verify beneficiary eligibility for enrollment
- C. To assess provider performance
- D. To set beneficiary premiums

Risk adjustment scoring is about aligning payments with how costly an enrollee's care is likely to be based on health status. By assigning a risk score to each person from their diagnosed conditions, plans with sicker enrollees receive higher payments to reflect expected medical costs, while healthier enrollees lead to lower payments. This system helps ensure that plan funding mirrors actual risk rather than enrollment size or health status incentives. So the statement that risk adjustment scoring determines annual payments for plans based on enrollee risk best captures its purpose. It's not about verifying eligibility, measuring provider performance, or directly setting beneficiary premiums.

10. What types of organizations perform RADV audits?

- A. CMS directly or through contracted third-party auditors, evaluation contractors, or QIOs may perform RADV audits.**
- B. Only private firms conduct RADV audits without CMS involvement.
- C. Hospitals only perform RADV audits on their own data without CMS oversight.
- D. RADV audits are optional and may be skipped by plans.

RADV audits are conducted by CMS or by entities that CMS designates to carry them out, ensuring that risk-adjusted diagnoses used for payment are supported by medical records and properly coded. This can include CMS directly, contracted third-party auditors, evaluation contractors, or Quality Improvement Organizations (QIOs). The other options aren't correct because audits aren't performed only by private firms without CMS involvement, hospitals don't independently conduct RADV audits on their own data without CMS oversight, and RADV audits are not optional or skip-able for 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://cmsradv.examzify.com>

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

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