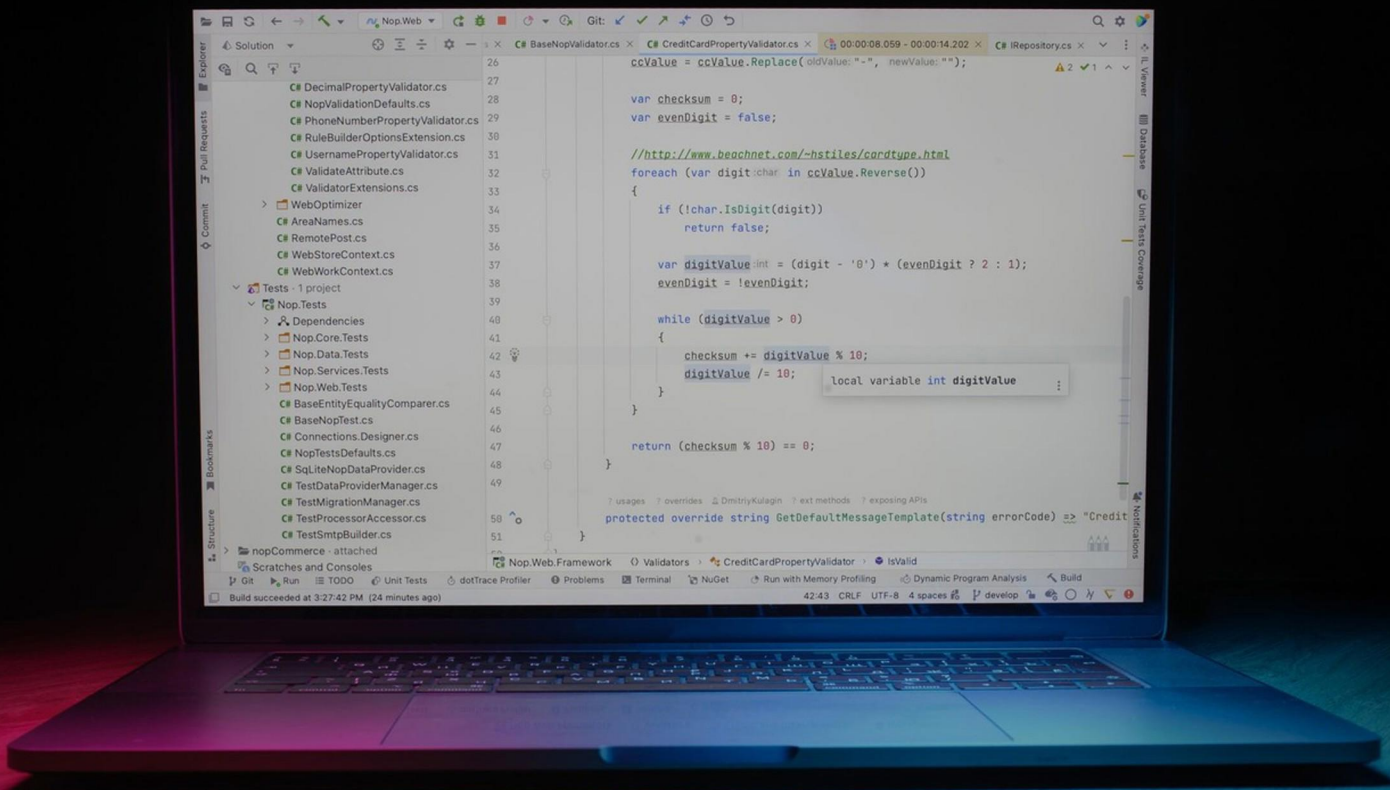


# HCC CODING AND RISK ADJUSTMENT PRACTICE TEST (SAMPLE)

## STUDY GUIDE



## SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR  
THE FULL VERSION STUDY GUIDE

<https://hcccodingriskadjustment.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. What does RAF score stand for in healthcare?**
  - A. Risk Adjustment Factor score
  - B. Relative Assessment Factor score
  - C. Risk Analysis Framework score
  - D. Registered Assessment Frequency score
- 2. What is one key factor that influences HCC risk scores?**
  - A. The age of the patient
  - B. The patient's socioeconomic status
  - C. The number and type of documented diagnoses
  - D. The healthcare provider's experience
- 3. Which audit-related process might a selected plan need to perform under CMS guidelines?**
  - A. Request payment adjustments
  - B. Request medical record documentation
  - C. Analyze beneficiary data
  - D. Implement new diagnoses
- 4. When is it appropriate to use HCC coding?**
  - A. For all new patients regardless of medical history.
  - B. When reporting chronic conditions that require ongoing care.
  - C. Only during hospital admissions.
  - D. Exclusively for laboratory test interpretations.
- 5. What does the term "medical homes" refer to in the context of the MLR provision?**
  - A. A specific type of insurance plan
  - B. Primary health care services model as defined in the ACA
  - C. Administrative health care services model
  - D. Home-based health care services

- 6. What does AWW stand for in a healthcare setting?**
- A. Annual Wellness Visit
  - B. Advanced Wellness Validation
  - C. Annual Weight Verification
  - D. Assessment of Wellness Variants
- 7. What type of diagnoses are most likely to be reported using HCC codes?**
- A. Acute conditions and transient illnesses
  - B. Chronic conditions and complex medical issues
  - C. Minor injuries and short-term ailments
  - D. Preventive health measures and screenings
- 8. What is the significance of annual wellness visits in HCC coding?**
- A. They are primarily for preventive health measures
  - B. They provide an opportunity to document chronic conditions that can affect risk adjustment
  - C. They are used for scheduling follow-up appointments
  - D. They focus only on mental health assessments
- 9. What is the focus of the Interactive Data Submission System?**
- A. Real-time patient feedback
  - B. Integration of qualitative data
  - C. Submission of healthcare performance data
  - D. Patient satisfaction analysis
- 10. How does medical history influence HCC coding?**
- A. It creates a database for research.
  - B. It offers context and supports the necessity of certain diagnoses being reported.
  - C. It allows coders to guess potential future diagnoses.
  - D. It has no significant impact.

## **Answers**

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

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## **Explanations**

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## 1. What does RAF score stand for in healthcare?

- A. Risk Adjustment Factor score
- B. Relative Assessment Factor score
- C. Risk Analysis Framework score
- D. Registered Assessment Frequency score

RAF score stands for Risk Adjustment Factor score. It is a crucial metric in healthcare that is used to measure the expected healthcare costs of a patient population based on their health conditions and demographic factors. The RAF score takes into account various factors, including age, gender, and specific diagnoses that might affect an individual's health and healthcare needs. A higher RAF score indicates a higher risk profile for a patient, which can affect reimbursement rates and funding for healthcare organizations. This risk adjustment is essential for ensuring that providers receive appropriate compensation for treating patients with more complex health conditions. By accurately calculating RAF scores, healthcare providers can better understand and manage the care for their patient populations, ensuring they allocate resources effectively and improve patient outcomes. The other choices do not accurately represent the term used in healthcare coding and risk adjustment, as they do not pertain to the established system for adjusting healthcare reimbursement based on patient risk profiles.

## 2. What is one key factor that influences HCC risk scores?

- A. The age of the patient
- B. The patient's socioeconomic status
- C. The number and type of documented diagnoses
- D. The healthcare provider's experience

One key factor that influences HCC risk scores is the number and type of documented diagnoses. HCC, or Hierarchical Condition Categories, relies heavily on the documentation of diagnoses to accurately reflect a patient's health status and potential healthcare costs. Each specific diagnosis is associated with a predetermined risk adjustment factor that contributes to the overall risk score. The risk score is a reflection of the complexity and severity of a patient's condition, which is why thorough and accurate documentation is crucial. The more comprehensive the recorded diagnoses are—especially those that indicate chronic, severe, or long-term conditions—the higher the risk score can potentially be. This, in turn, impacts funding and resource allocation for care, highlighting the importance of comprehensive and precise documentation in the HCC model.

### 3. Which audit-related process might a selected plan need to perform under CMS guidelines?

- A. Request payment adjustments
- B. Request medical record documentation**
- C. Analyze beneficiary data
- D. Implement new diagnoses

*Under CMS guidelines, when a selected plan is undergoing an audit, it may need to request medical record documentation. This process is essential as it allows the plan to validate the accuracy of the data submitted for risk adjustment and reimbursement purposes. The provision of comprehensive and accurate medical records is crucial to demonstrate that the diagnoses attributed to beneficiaries are supported by clinical evidence documented during the care provided. Additionally, when audits are conducted, the focus is on ensuring that the services billed were necessary and that the diagnosis codes submitted are applicable and substantiated by the actual medical treatments received. Therefore, requesting medical record documentation aligns directly with the goal of maintaining compliance with CMS standards, ensuring the integrity of the data that impacts funding and quality of care initiatives. The other options pertain to different processes that may not directly relate to the immediate actions triggered by an audit. For example, while analyzing beneficiary data can occur as part of ongoing monitoring, it is not a direct response to an audit. Similarly, implementing new diagnoses and requesting payment adjustments may arise in different contexts, but they are not core actions specifically tied to the audit-related process identified by CMS.*

### 4. When is it appropriate to use HCC coding?

- A. For all new patients regardless of medical history.
- B. When reporting chronic conditions that require ongoing care.**
- C. Only during hospital admissions.
- D. Exclusively for laboratory test interpretations.

*Using HCC coding is particularly important when reporting chronic conditions that require ongoing care. This type of coding is integral to accurately capturing the complexity of a patient's health status, especially for those with chronic illnesses that necessitate continuous management. It enables healthcare organizations to document specific health conditions in a way that reflects the patient's overall healthcare needs. Chronic conditions often involve long-term treatment plans, regular follow-up appointments, and interdisciplinary care coordination. By documenting these conditions through HCC coding, healthcare providers can ensure that the patient's care is well-represented, which is crucial for risk adjustment purposes. This helps to secure appropriate reimbursement and maintain healthcare quality. It is also essential for predictive modeling and ensuring that the healthcare system can appropriately allocate resources based on the patient population's needs. In contrast, using HCC coding for all new patients without regard for their medical history or limiting its use to hospital admissions or laboratory tests doesn't capture the ongoing care requirements of chronic conditions effectively. Such approaches would miss the essence of risk adjustment and the proper representation of patient complexity.*

**5. What does the term "medical homes" refer to in the context of the MLR provision?**

- A. A specific type of insurance plan
- B. Primary health care services model as defined in the ACA**
- C. Administrative health care services model
- D. Home-based health care services

*The term "medical homes" refers to a primary health care services model that is defined in the Affordable Care Act (ACA). This model emphasizes a patient-centered approach to health care delivery, wherein a primary care provider leads a team that coordinates comprehensive health care services for patients. The goal is to enhance care quality and improve health outcomes by providing accessible, comprehensive services that are tailored to each patient's needs. The medical home model promotes continuous and effective communication, fosters a holistic view of patient care, and often includes preventive services, chronic disease management, and coordination of specialists, which aligns perfectly with the objectives set forth by the ACA. This approach aims to reduce costs and improve efficiency in the health care system by minimizing unnecessary hospitalizations and emergency room visits. In contrast, the other options do not accurately capture the essence of what medical homes entail within the context of the MLR provision. A specific type of insurance plan or home-based health care services do not encompass the comprehensive and coordinated care that characterizes the medical home model. Likewise, while administrative health care services can play a role in managing health systems, they do not represent the patient-centered, care coordination element central to the medical home concept.*

**6. What does AWV stand for in a healthcare setting?**

- A. Annual Wellness Visit**
- B. Advanced Wellness Validation
- C. Annual Weight Verification
- D. Assessment of Wellness Variants

*AWV stands for Annual Wellness Visit, which is an important preventive service provided under Medicare. This visit is designed to promote health and wellness in elderly patients by assessing their health status, establishing a personalized prevention plan, and providing screenings and counseling services as needed. During an Annual Wellness Visit, healthcare providers review the patient's medical and family history, identify risk factors, conduct a routine examination, and update vaccinations if necessary. The goal is to prevent potential health issues rather than just treating them when they arise, encouraging patients to engage in a proactive approach to their health management. This service enhances care coordination and helps ensure that patients receive the necessary preventive services tailored to their individual health needs, thus improving overall healthcare outcomes. The provision of such visits is integral to fostering preventive healthcare practices among the Medicare population.*

## 7. What type of diagnoses are most likely to be reported using HCC codes?

- A. Acute conditions and transient illnesses
- B. Chronic conditions and complex medical issues**
- C. Minor injuries and short-term ailments
- D. Preventive health measures and screenings

*The most likely diagnoses to be reported using Hierarchical Condition Category (HCC) codes are chronic conditions and complex medical issues because HCC coding is specifically designed to capture risk factors associated with long-term health problems. These codes reflect the severity and complexity of a patient's health status over an extended period, which directly impacts risk adjustment and reimbursement for healthcare providers. Chronic conditions, such as diabetes, heart disease, and chronic obstructive pulmonary disease (COPD), require ongoing management and treatment. Reporting these diagnoses using HCC codes allows healthcare systems to receive appropriate funding based on the patient population's complexity and needs. These codes help support additional care requirements and resource allocation, which are essential for managing patients with multifaceted health issues. In contrast, acute conditions and transient illnesses, minor injuries, short-term ailments, and preventive health measures are typically not captured by HCC codes, as they do not reflect the ongoing resource use and complexity necessary for risk adjustment. Preventive measures and screenings focus on maintaining health rather than managing conditions that require continual medical attention. Thus, the focus of HCC coding is squarely on chronic and complex conditions, highlighting the importance of these categories in effective healthcare management and financial planning.*

## 8. What is the significance of annual wellness visits in HCC coding?

- A. They are primarily for preventive health measures
- B. They provide an opportunity to document chronic conditions that can affect risk adjustment**
- C. They are used for scheduling follow-up appointments
- D. They focus only on mental health assessments

*Annual wellness visits hold significant importance in HCC coding primarily because they provide an opportunity to document chronic conditions that can affect risk adjustment. These visits allow healthcare providers to perform comprehensive assessments of a patient's health status, including reviewing existing chronic conditions and identifying any new issues that may need to be addressed. By documenting chronic conditions during these visits, providers can ensure that the patient's health data is accurately reflected in their medical records. This documentation is crucial for risk adjustment because it directly impacts the risk scores that determine reimbursement levels and the allocation of resources. A thorough record of a patient's complex health status during annual wellness visits can lead to more accurate HCC coding, ultimately improving the quality of care and financial support for patients with chronic illnesses. Other options do not capture the full significance of these visits in the context of HCC coding. While preventive health measures are part of wellness visits, the key value lies in the comprehensive documentation of health conditions that influence care planning and reimbursement. The visits are not primarily for scheduling follow-ups or only focusing on mental health; instead, they address a wide range of health concerns, making the correct choice critical to understanding their role within the HCC coding framework.*

## 9. What is the focus of the Interactive Data Submission System?

- A. Real-time patient feedback
- B. Integration of qualitative data
- C. Submission of healthcare performance data**
- D. Patient satisfaction analysis

*The Interactive Data Submission System primarily focuses on the submission of healthcare performance data. This system is designed to facilitate the reporting and collection of data related to various performance metrics in healthcare settings, which are crucial for quality measurement and improvement initiatives. By enabling healthcare organizations to submit data efficiently, the system supports regulatory requirements and helps in assessing the effectiveness of care provided. The emphasis on healthcare performance data is essential, as it allows for benchmarking and tracking outcomes, which ultimately contributes to better healthcare practices and patient care standards. Collecting and analyzing this data can also play a significant role in risk adjustment models, helping to maintain the integrity and reliability of health assessments and reimbursements. In this context, while real-time patient feedback, qualitative data integration, and patient satisfaction analysis are all important facets of healthcare, they do not align directly with the primary focus of the Interactive Data Submission System, which is centered on the systematic collection and submission of performance-related data.*

## 10. How does medical history influence HCC coding?

- A. It creates a database for research.
- B. It offers context and supports the necessity of certain diagnoses being reported.**
- C. It allows coders to guess potential future diagnoses.
- D. It has no significant impact.

*Medical history plays a crucial role in HCC coding by providing context and validating the need for certain diagnoses to be reported. The comprehensive understanding of a patient's medical history allows coders to accurately capture all relevant conditions and chronic illnesses, which are essential for reflecting the patient's health status. This accuracy directly affects risk adjustment calculations, as HCC coding aims to ensure that healthcare providers are appropriately reimbursed for the complexity and severity of the patients they treat. When coders thoroughly review a patient's medical history, they can substantiate the presence of certain chronic conditions that may otherwise be overlooked. This thorough documentation is vital, as many chronic diseases can significantly impact the cost and type of care a patient requires. Additionally, certain current diagnoses may stem from historical conditions, reinforcing their inclusion in the coding process. Data derived from medical history not only supports the accuracy of HCC coding but also provides a basis for healthcare policy decisions, resource allocation, and patient management strategies. Thus, understanding and documenting the patient's complete medical history is integral to effective coding and compliance with regulations.*

## 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](mailto:hello@examzify.com).

Or visit your dedicated course page for more study tools and resources:

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

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