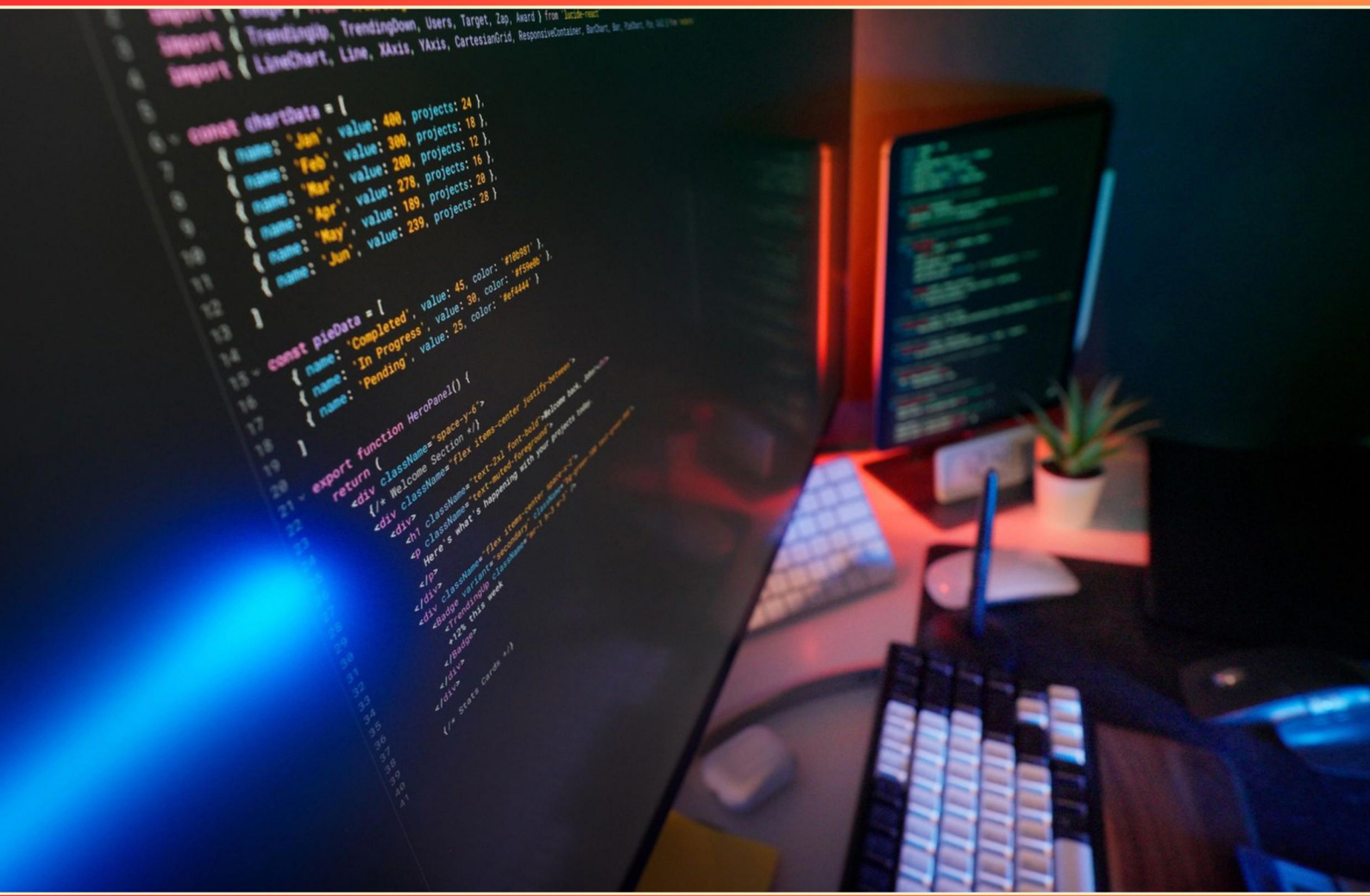
CERTIFIED RISK ADJUSTMENT CODER (CRC) PRACTICE EXAM (SAMPLE)

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.

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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!

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Questions

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1. **How should diagnoses be recorded to ensure compliance under the HCC model?**

   A. Only a primary diagnosis needs coding.

   B. All relevant conditions affecting patient care should be documented.

   C. Only diagnoses that are confirmed should be coded.

   D. Previous medical history is not relevant.

2. **Which condition is classified under F02.80 in ICD-10-CM?**

   A. Hypertension

   B. Alzheimer's dementia

   C. Dementia in other diseases

   D. Chronic obstructive pulmonary disease

3. **What is a risk adjustment coder's primary responsibility?**

   A. Ensuring accurate submissions to Medicare

   B. Performing clinical assessments

   C. Reviewing patient demographics

   D. Handling provider payments

4. **What is the lowest star rating a plan must achieve to avoid penalties?**

   A. 5

   B. 4

   C. 3

   D. 2

5. **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

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6. 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

7. What does the abbreviation RAPS stand for?

A. Risk Adjustment Provider Service

B. Risk Adjustment Processing System

C. Risk Auditing Provider System

D. Risk Assessment Processing System

8. Which statement is TRUE regarding the Past, Family, and Social Histories (PFSH)?

A. PFSH is not mandatory for coding.

B. PFSH can only include family history.

C. PFSH is critical for identifying risk factors.

D. PFSH should only include social habits.

9. Which plan provides the best value for savings on out-of-pocket costs?

A. Silver

B. Gold

C. Bronze

D. Platinum

10. Which condition is appropriate to assign the ICD-10-CM code N18.9?

A. Chronic Renal Disease

B. Chronic Renal Failure

C. Chronic Kidney Disease Unspecified

D. Chronic Renal Insufficiency

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Answers

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

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Explanations

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1. How should diagnoses be recorded to ensure compliance under the HCC model?

A. Only a primary diagnosis needs coding.

B. All relevant conditions affecting patient care should be documented.

C. Only diagnoses that are confirmed should be coded.

D. Previous medical history is not relevant.

The correct approach for recording diagnoses to ensure compliance under the Hierarchical Condition Category (HCC) model emphasizes capturing all relevant conditions that affect patient care. This comprehensive documentation is essential because the HCC model is designed to risk-adjust payments for Medicare Advantage plans based on the health status and the chronic conditions of their members. Recording all relevant diagnoses allows for accurate risk stratification, ensuring that healthcare providers receive appropriate reimbursements based on the complexity of patient care. When all conditions that may impact treatment, management, or patient outcomes are captured, it leads to a more complete picture of the patient's health and greater consistency in resource allocation. This practice aligns with the goal of providing high-quality, patient-centered care and fulfilling compliance requirements under the HCC model. In contrast, focusing solely on the primary diagnosis, coding only confirmed diagnoses, or disregarding previous medical history would result in an incomplete assessment of the patient's condition, ultimately leading to potential gaps in care, improper risk adjustment, and financial inequities in reimbursement. Therefore, careful and thorough documentation of all relevant conditions is fundamental in this context.

2. Which condition is classified under F02.80 in ICD-10-CM?

A. Hypertension

B. Alzheimer's dementia

C. Dementia in other diseases

D. Chronic obstructive pulmonary disease

The classification under F02.80 in ICD-10-CM is designated for dementia in other diseases that are classified elsewhere. This includes cases of dementia that are a consequence of diseases not specifically coded in the dementia categories, allowing healthcare professionals to accurately document and capture the complexity of a patient's condition. The ICD-10-CM system organizes conditions in a structured manner to ensure that all healthcare providers have a common understanding of the diagnosis, which is critical for treatment, research, and reimbursement purposes. F02.80 specifically implies that there is an underlying condition causing dementia, providing clarity and detail necessary for a comprehensive medical record. The other options refer to conditions that are distinctly categorized elsewhere in ICD-10-CM, such as hypertension or chronic obstructive pulmonary disease, which do not pertain to dementia classification. Alzheimer's dementia, while a form of dementia, is specifically coded under a different set of codes, which are more precise to that diagnosis, hence not applicable under F02.80.

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3. What is a risk adjustment coder's primary responsibility?

A. Ensuring accurate submissions to Medicare

B. Performing clinical assessments

C. Reviewing patient demographics

D. Handling provider payments

A risk adjustment coder's primary responsibility is to ensure accurate submissions to Medicare. This role is essential in the healthcare industry as it directly impacts the reimbursement process and the overall quality of care provided to patients. Accurate coding helps in reflecting the true health status of a patient population, which is crucial for risk adjustment models used by Medicare. These models account for the health complexity of beneficiaries, allowing for appropriate funding allocations to healthcare providers. In this context, the accuracy of coding is vital because it enables the identification of patients' chronic conditions and ensures that the data submitted truly represents the care that patients receive. This not only affects financial aspects for providers but also plays a significant role in maintaining compliance with regulations. Although performing clinical assessments, reviewing patient demographics, and handling provider payments may be associated functions in the healthcare setting, the focus of a risk adjustment coder lies greatly in the realm of coding and submitting accurate patient information that reflects their diseases and conditions, thus reinforcing the integrity of data used in risk adjustment calculations.

4. What is the lowest star rating a plan must achieve to avoid penalties?

A. 5

B. 4

C. 3

D. 2

To avoid penalties, a plan must achieve a star rating of 4. The star rating system evaluates Medicare Advantage and Part D plans on various performance metrics, including quality of care, patient satisfaction, and adherence to best practices. A rating of 4 stars indicates a high level of performance and quality in the plan, which not only helps in retaining members but also avoids penalties imposed by CMS (Centers for Medicare & Medicaid Services). Plans that score below this rating, particularly those with a rating of 3 or lower, may face financial penalties, which could affect their funding and ability to offer competitive services. Maintaining a rating of 4 or higher is essential for plans to access incentive payments and demonstrate their commitment to quality healthcare. Thus, achieving a star rating of 4 is crucial for a plan to avoid penalties and indicates that the plan is providing adequate service and care to its members.

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5. 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.

6. 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.

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7. What does the abbreviation RAPS stand for?

A. Risk Adjustment Provider Service

B. Risk Adjustment Processing System

C. Risk Auditing Provider System

D. Risk Assessment Processing System

The abbreviation RAPS stands for "Risk Adjustment Processing System." This refers to the system used by organizations to submit data regarding diagnoses and treatment plans for patients, which is critically important in the context of risk adjustment within healthcare. Accurate and timely data submission through RAPS helps ensure that healthcare plans receive appropriate risk-adjusted payments based on the health status of their enrolled populations. This system plays a pivotal role in the overall efficiency and effectiveness of healthcare risk adjustment methodologies. The other options, while they contain related terms, do not accurately reflect the established terminology used within the healthcare industry regarding risk adjustment systems. Understanding this distinction is vital for navigating the complexities of risk adjustment coding and billing practices.

8. Which statement is TRUE regarding the Past, Family, and Social Histories (PFSH)?

A. PFSH is not mandatory for coding.

B. PFSH can only include family history.

C. PFSH is critical for identifying risk factors.

D. PFSH should only include social habits.

The statement that Past, Family, and Social Histories (PFSH) is critical for identifying risk factors is true because PFSH provides essential information that clinicians use to assess a patient's health status comprehensively. This component of a patient's medical history allows healthcare providers to identify potential risk factors related to diseases that may not be evident through a physical exam or current symptoms. PFSH encompasses details about the patient's past medical history, family medical history, and social history, which can help highlight hereditary conditions, previous illnesses, lifestyle choices, and environmental factors that could influence a patient's current health situation. By thoroughly understanding these areas, healthcare providers can better evaluate and manage patient care, leading to improved outcomes. The other statements do not accurately reflect the importance or scope of PFSH. For example, PFSH is indeed a critical part of the coding process, and it is not restricted to just family history or social habits; it includes all three aspects, which work together to give a fuller picture of a patient's health.

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9. Which plan provides the best value for savings on out-of-pocket costs?

A. Silver

B. Gold

C. Bronze

D. Platinum

The Silver plan typically offers a balanced option that helps individuals strike a fair compromise between monthly premiums and out-of-pocket costs. It generally covers about 70% of healthcare expenses after deductibles are met, which means that while the monthly premiums are moderate, the plan still allows for manageable out-of-pocket costs when medical services are utilized. For individuals or families who expect to use healthcare services frequently, the Silver plan is advantageous due to its cost-sharing structure. It can also be particularly beneficial for those who qualify for cost-sharing reductions, significantly lowering their out-of-pocket expenses. Other plans like Gold and Platinum may have higher premiums but lower out-of-pocket costs, making them ideal for those who anticipate utilizing a significant amount of healthcare services. Conversely, the Bronze plan may have lower premiums but higher out-of-pocket costs when care is needed, making it less favorable for those who seek to minimize overall spending in scenarios where health services will be used regularly. While Gold and Platinum plans might have higher levels of coverage, the Silver plan tends to offer a more balanced approach for general consumers looking for the best value in terms of managing both premium costs and potential out-of-pocket expenses during the healthcare consumption.

10. Which condition is appropriate to assign the ICD-10-CM code N18.9?

A. Chronic Renal Disease

B. Chronic Renal Failure

C. Chronic Kidney Disease Unspecified

D. Chronic Renal Insufficiency

The ICD-10-CM code N18.9 is specifically designated for "Chronic Kidney Disease, unspecified." This code is used when the stage or specific details of the chronic kidney disease are not documented in the medical record, thus falling under the category of unspecified. In clinical coding, it is essential to match the code accurately to the condition described in the documentation. The phrase "Chronic Kidney Disease Unspecified" directly aligns with the definition of N18.9, indicating that this code is appropriate in situations where the healthcare provider has not specified the stage or type of chronic kidney disease present. On the other hand, conditions like Chronic Renal Disease and Chronic Renal Failure are more precise diagnoses that may have corresponding codes that indicate specific stages of renal failure or disease as per the ICD-10-CM coding guidelines. Chronic Renal Insufficiency is also a term that typically corresponds to defined stages of renal condition rather than unspecified categorization. Therefore, option C is the best fit for the code N18.9, as it directly correlates with the absence of specification regarding the kidney condition.

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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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