CORRECT CODING EQUALS ACCURATE RISK SCORES AND MEDICAID/MEDICARE COMPLIANCE

The Risk Adjustment Payment System (RAPS), a diagnostic coding system that enables the Center for Medicare & Medicaid Services to predict the future cost of a member's care and calculate the appropriate reimbursement to health plans, requires accuracy and specificity in diagnostic coding.

Clinical specificity of a disease and/or condition can be expressed in the 4th and/or 5th digit of some ICD-9CM diagnostic codes. Documentation in the medical record of a face-to-face encounter with a Medicare or Medicaid member must include all conditions and co-morbidities being treated and managed. Specificity of coding is based on the accuracy of information written in the medical records.

What you need to do:
To ensure compliance with these requirements, please adhere to the following guidelines:

- Code all claims for Medicare and Medicaid members to the highest level of specificity using the 4th and/or 5th digit codes, when applicable.
- Ensure medical record documentation is clear, concise, consistent, complete and legible.
- Include the member's identification on each page of the medical record, date of service, the signature of the person(s) doing the treatment, reason for the visit, care rendered, conclusion and diagnosis, and follow-up care plan in all medical records.
- Include the provider's credentials on the medical record, either written next to his/her signature or using a pre-printed stamp with the provider's name on the practice's stationery.
- Report and submit all diagnoses that impact the patient's evaluation, care and treatment; reason for the visit; co-existing acute conditions; chronic conditions or relevant past conditions.
- Respond to request for an onsite appointment by Healthfirst within seven (7) business days.

Healthfirst would like to thank you in advance for your cooperation and support.