healthfirst
Health Insurance for New Yorkers

Provider Alert

Correct Coding Equals Accurate Risk Scores and Medicaid/Medicare Compliance

The Risk Adjustment Payment System (RAPS), a diagnostic coding system that enables the Centers for Medicare and Medicaid Services to predict the 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/condition can be expressed through the fourth (4th), fifth (5th), sixth (6th), and/or seventh (7th) digit of some ICD-10-CM diagnostic codes. Documentation in the medical record of a face-to-face encounter with a Medicare or Medicaid member must include all conditions and comorbidities 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:

- Code all claims for Medicare and Medicaid members to the highest level of specificity using the fourth (4th), fifth (5th), sixth (6th), and/or seventh (7th) digit of 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, the date of service, the signature(s) 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; coexisting acute conditions; chronic conditions; or relevant past conditions.
- Respond to request for an onsite appointment by Healthfirst within seven (7) business days.