AUDIT-READY RESOURCE CENTER

Coding Decision Trees

Structured pathways for selecting supported codes based on documentation, official coding guidelines, and audit principles.

1	**Review the Record** Read the complete encounter and identify the documented diagnoses, services, procedures, and relevant details.
2	**Define the Coding Question** Determine whether the issue involves code selection, sequencing, specificity, linkage, or another coding requirement.
3	**Follow the Official Guidance** Apply the appropriate official coding guidelines, code-set instructions, payer policy, or organizational standard.
4	**Select the Supported Code** Choose the code that is fully supported by the documentation without inferring missing facts.
5	**Validate and Document** Confirm sequencing, edits, medical necessity implications, and document the rationale for the final decision.

Core principle: Code what the medical record supports. Do not select a code based on assumptions, expected reimbursement, or undocumented clinical intent.

Think Like an Auditor. Code with Intent. Defend with Confidence.

Review the record. Follow the guidance. Select the supported code.

Core Coding Decision Pathways

Use these pathways as a structured starting point for common coding decisions.

Diagnosis Selection	**Decision question:** Is the condition clearly documented and clinically supported?	**YES:** Assign the most specific supported diagnosis and apply sequencing instructions. **NO:** Do not infer the diagnosis; seek clarification or select a supported alternative.
Code Specificity	**Decision question:** Does the record contain the required site, laterality, acuity, episode, or other detail?	**YES:** Assign the most specific code supported by the record. **NO:** Use the appropriate less-specific code only when permitted, or query when clarification is needed.
Sequencing	**Decision question:** Do official guidelines or code-set instructions establish sequencing?	**YES:** Follow the governing sequencing instruction. **NO:** Apply the encounter circumstances and documented reason for the service.
Code First / Use Additional Code	**Decision question:** Does the classification include a code-first, use-additional-code, or manifestation instruction?	**YES:** Report the required codes in the directed order. **NO:** Do not independently sequence linked codes contrary to the classification.
Excludes Notes	**Decision question:** Does an Excludes1 or Excludes2 note affect the reported conditions?	**YES:** Apply the note based on the documented relationship and official guidance. **NO:** Review whether both conditions may be reported or whether the combination is prohibited.
Uncertain Documentation	**Decision question:** Can the coding decision be resolved from the available record and setting-specific guidelines?	**YES:** Assign the supported code and document the rationale. **NO:** Query, escalate, or hold the final coding decision according to organizational policy.

Coding Decision Safeguards

These safeguards help keep coding decisions accurate, consistent, and defensible.

Use the Complete Medical Record

Do not make a final coding decision from one note section, one diagnosis list, or one isolated data element.

Follow the Official Guidance

Apply the appropriate official coding guidelines, code-set instructions, payer policy, or organizational standard before reaching a conclusion.

Do Not Infer Missing Facts

Code only what is documented and supported; obtain clarification when required information is absent or conflicting.

Validate Sequencing and Instructions

Review code-first, use-additional-code, Excludes, inclusion, and other classification instructions.

Separate Coding From Coverage

A correctly assigned code does not automatically establish payer coverage or medical necessity.

Preserve the Rationale

Document the evidence, guidance, and reasoning supporting the final code assignment.

Three Questions Before Finalizing

QUESTION 1

Does the medical record support my coding decision?

QUESTION 2

Did I follow the applicable official coding guidelines and code-set instructions?

QUESTION 3

Could another coder or auditor reproduce the same conclusion from the same record?