Coding Accuracy Checklist

ENSURE EVERY CODE IS ACCURATE, SUPPORTED, AND DEFENSIBLE

This practical checklist helps medical coders perform a final quality review before claim submission. Use it to verify documentation support, coding accuracy, proper sequencing, modifier usage, and medical necessity.

Patient & Encounter Verification

- ■ Correct patient selected
- ■ Correct date of service
- ■ Correct rendering provider
- ■ Correct place of service
- ■ Correct encounter type

Documentation Review

- ■ Provider documentation is complete and authenticated
- ■ Chief complaint or reason for the encounter is documented
- ■ Assessment and plan support reported diagnoses
- ■ Procedures and services performed are clearly documented
- ■ Documentation is clear, complete, and internally consistent
- ■ No conflicting or contradictory documentation exists

ICD-10-CM Coding

- ■ Every diagnosis code is supported by provider documentation
- ■ Highest level of specificity is assigned
- ■ Laterality is reported correctly
- ■ Combination codes are used when applicable
- ■ Symptoms are not coded separately when integral to a confirmed diagnosis
- ■ History, status, follow-up, and screening codes are assigned appropriately
- ■ Official ICD-10-CM Coding Guidelines have been followed

CPT® & HCPCS Level II Coding

- ■ Reported procedures accurately reflect documented services
- ■ Documentation supports every CPT® and HCPCS Level II code assigned
- ■ Units of service are accurate
- ■ Supplies, medications, and devices are appropriately documented
- ■ Add-on codes are paired with the appropriate primary procedure
- ■ Bundled services are not reported separately
- ■ Current CPT® and HCPCS Level II code sets are used

Evaluation & Management (E/M)

- ■ Correct E/M category is selected
- ■ Medical decision-making supports the reported level
- ■ Time-based coding requirements are met, when applicable
- ■ A separately identifiable E/M service supports Modifier 25 when reported

Modifier Validation

- ■ Every modifier is supported by documentation
- ■ Modifier 25 is used appropriately
- ■ Modifier 59 or X{EPSU} modifier is supported
- ■ Bilateral and anatomical modifiers are accurate
- ■ Assistant surgeon modifiers are appropriate
- ■ No modifier is used solely to bypass an edit

Sequencing Review

- ■ Principal or first-listed diagnosis is correct
- ■ Secondary diagnoses are appropriately sequenced
- ■ Procedure sequencing follows official coding guidelines

Medical Necessity

- ■ Diagnoses support the medical necessity of reported services
- ■ Documentation supports the level of service billed
- ■ Services provided are reasonable and medically necessary

Final Quality Check

- ■ Diagnosis and procedure codes match the provider documentation
- ■ Code descriptions have been verified
- ■ Applicable payer or organizational coding policies have been reviewed
- ■ No unsupported diagnoses or procedures have been reported
- ■ Claim is ready for submission

Final Self-Assessment

- ■ Does the documentation support every reported code?
- ■ Have I followed the official coding guidelines?
- ■ Are all diagnoses and procedures coded to the highest appropriate specificity?
- ■ Are modifiers accurate and fully supported?
- ■ Is the sequencing correct?
- ■ Does the documentation support medical necessity?
- ■ Would I be able to confidently defend these code assignments during an audit?

Code what is documented—not what is assumed.
If it's not documented, it's not supported.

Disclaimer: This educational resource is intended as a coding quality reference and should be used with current ICD-10-CM Official Guidelines for Coding and Reporting, CPT®, HCPCS Level II, CMS guidance, NCCI edits, applicable payer policies, and organizational standards.

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