



Healthcare Billing & Coding Compliance Checklist

 Show only Checklist

Display Style
Default 

Patient Demographics & Insurance Verification

Ensuring accurate patient information and insurance coverage before services are rendered.

Patient First Name

Write something...

Patient Last Name

Write something...



Patient Date of Birth

Write something...

Patient Phone Number

Enter a number...

Insurance Primary?

Yes

No

Insurance Provider Name

Write something...

Insurance Member ID

Enter a number...

Insurance Group Number

Enter a number...

Procedure & Diagnosis Coding (ICD-10)

Verification of correct diagnosis codes based on medical documentation.

ICD-10 Code Primary Diagnosis

- Select Code
- A00 – Cholera

ICD-10 Code Secondary Diagnosis (if applicable)

- None
- I10 – Essential (primary) hypertension

Supporting Documentation Notes (e.g., physician documentation, lab results)

Write something...

Number of Diagnoses Documented

Enter a number...

Date of Diagnosis Documentation

Enter date...

Physician Signature (Verify)

Write something...

Procedure Coding (CPT/HCPCS)

Ensuring proper coding of procedures performed, adhering to guidelines.

CPT/HCPCS Code

Enter a number...

Procedure Description (from CPT/HCPCS)

Write something...

Modifier Applied (if applicable)

- No Modifier
- 25
- 50
- 59
- Other (Specify in Long Text)

Modifier Description (if 'Other' selected)

Write something...

Units of Service

Enter a number...

Service Date

Enter date...

Procedure Identifiers (e.g., Modality, Approach)

- Endoscopic
- Open
- Radiological
- Other

Modifier Application

Accurate use of modifiers to reflect specific circumstances of the service.

Modifier Applied (if any)

- None
- 26 - Professional Component
- 50 - Reduced Fee
- 59 - Distinct Procedural Level
- LT - Left Side
- RT - Right Side

Modifier Justification (if applicable)

Write something...

Modifier Percentage Adjustment (if applicable)

Enter a number...

Applicable Billing Policy Adherence

Yes

No

Date of Modifier Review

Enter date...

Charge Entry and Documentation

Properly entering charges and verifying supporting documentation.

Total Charges Entered

Enter a number...

Detailed Description of Services Rendered (for clarity)

Write something...

Units of Service Billed

Enter a number...

Date of Service

Enter date...

Billor Signature (Confirmation of Accuracy)

Charge Entry Method (Manual/Automated)

Manual

Automated

Claim Submission & Electronic Data Interchange (EDI)

Verification of claim format and adherence to EDI standards.

Claim Control Number

Enter a number...

Transmission Method (e.g., Direct, Clearinghouse)

- Direct
- Clearinghouse

Number of Claims Submitted

Enter a number...

Submission Date

Enter date...

EDI Format Version (e.g., 837 Professional)

- 837 Professional
- 837 Health Care Claim
- Other

Functional Acknowledgement (FA) Status Codes

- 00 Accepted
- 02 Accepted with corrections
- 03 Rejected
- Other

Denial Management & Appeals

Tracking and addressing claim denials with appropriate appeals.

Date of Denial Received

Enter date...

Denial Code (from payer)

Enter a number...

Payer's Reason for Denial (copy from denial letter)

Write something...

Assigned to Appeals Reviewer

- Not Assigned
- Reviewer 1
- Reviewer 2
- Reviewer 3

Appeal Submission Date

Enter date...

Documentation Submitted with Appeal (description)

Write something...

Appeal Status

- Pending
- Approved
- Denied
- Resolved
- Abandoned

Notes/Comments on Appeal Outcome

Write something...

Auditing & Compliance Reviews

Regular audits to ensure ongoing compliance with billing and coding regulations.

Audit Start Date

Enter date...

Audit End Date

Enter date...

Number of Claims Reviewed

Enter a number...

Number of Coding Errors Found

Enter a number...

Coding Guideline Areas Reviewed

- ICD-10 Official Guidelines
- CPT Assistant
- Medicare/CMS Guidance
- Private Payer Policies

Summary of Audit Findings

Write something...

Auditor Signature

Overall Compliance Rating

- Excellent
- Good
- Fair
- Needs Improvement

Fraud and Abuse Prevention

Identifying and preventing fraudulent billing practices.

Describe any recent unusual billing patterns observed.

Write something...

Has any employee been identified for potential training on fraud prevention?

- Yes
- No

Number of referrals received from a single referring physician in the last month:

Enter a number...

Which of the following are potential red flags for fraud? (Select all that apply)

- Upcoding
- Unbundling
- Phantom Billing
- Kickbacks
- None of the above

Date of last fraud risk assessment review

Enter date...

Reviewer Signature confirming fraud prevention protocols are in place

Staying Updated on Regulatory Changes

Maintaining awareness of current coding guidelines and regulatory updates.

Last Regulatory Update Review Date

Enter date...

Summary of Key Regulatory Changes

Write something...

Source of Regulatory Information (e.g., CMS, AAPC, AHIMA)

- CMS
- AAPC
- AHIMA
- Internal Updates
- Other

Number of Continuing Education Credits Completed (Regulatory Updates)

Enter a number...

Next Scheduled Regulatory Training Date

Enter date...