CORRINA R. LYNCH

40 PATIENT REPORTS

ICD-10-CM CODING CHALLENGE

FY 2026 | GUIDELINE-BASED PRACTICE

Read each fictional medical report. Use your FY 2026 ICD-10-CM Index, Tabular List and Official Guidelines to answer both parts of the coding task. No answers appear in this student packet.

WHAT TO SUBMIT

For each of the 40 cases: (1) assign the requested code(s), showing sequence where required; (2) explain the coding decision and cite the applicable guideline. Case 30 asks for a documentation action instead of a final diagnosis code.

EXERCISE BOUNDARIES

Code only the conditions requested in the report. Do not add procedures, E/M, medication status, external cause or other background codes unless the task specifically asks for them. Do not infer diagnoses from findings.

EDITION & DATES

All encounter or inpatient discharge dates in these fictional records fall in February or March 2026. Use the original FY 2026 release effective October 1, 2025. These are classroom exercises, not a complete patient chart or treatment guidance.

SETTING MATTERS

Each report identifies its setting. Use outpatient rules for offices, clinics, urgent care and ED discharges. Use inpatient rules only for the acute hospital records. POA questions are limited to cases 14 and 15.

Student: _____ Date: _____

PATIENT REPORT 01

Amara Ellis

Age 45 | Female | Encounter/discharge: Feb 01, 2026



Office visit

CHIEF COMPLAINT

Left knee pain

HISTORY OF PRESENT ILLNESS

Pain began after a long walk. There was no fall or other injury.

FINDINGS / DOCUMENTATION

Left knee tenderness; imaging shows no fracture. No arthritis diagnosis is established.

PROVIDER ASSESSMENT

Left knee pain.

PLAN / CODING SCOPE

Activity modification and follow-up. No other conditions are addressed.

YOUR CODING + GUIDELINE QUESTIONS

Assign the diagnosis code. Explain how the Index and Tabular List establish the complete code.

Guideline reference(s) to consult: I.A.1; I.B.2; I.B.13

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 02

Leon Brooks

Age 55 | Male | Encounter/discharge: Feb 02, 2026



Office visit

CHIEF COMPLAINT

Pain in both knees

HISTORY OF PRESENT ILLNESS

Both knees ache during stair climbing. There was no injury.

FINDINGS / DOCUMENTATION

Tenderness of both knees. No definitive underlying diagnosis.

PROVIDER ASSESSMENT

Bilateral knee pain.

PLAN / CODING SCOPE

Evaluate both knees; arrange physical therapy.

YOUR CODING + GUIDELINE QUESTIONS

Assign all diagnosis codes needed for both knees. Explain whether one bilateral code or two side-specific codes are needed.

Guideline reference(s) to consult: I.B.12; I.B.13

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 03

Elena Cruz

Age 35 | Female | Encounter/discharge: Feb 03, 2026



Emergency department; discharged home

CHIEF COMPLAINT

Right lower abdominal pain

HISTORY OF PRESENT ILLNESS

One day of focal pain. No fever, vomiting, or other symptoms are reported.

FINDINGS / DOCUMENTATION

Mild right lower quadrant tenderness. Imaging is inconclusive.

PROVIDER ASSESSMENT

Possible appendicitis; right lower quadrant abdominal pain.

PLAN / CODING SCOPE

Discharge with return precautions and next-day reassessment. No confirmed diagnosis.

YOUR CODING + GUIDELINE QUESTIONS

Assign the supported diagnosis code for this ED encounter. Can the possible diagnosis be coded as established?

Guideline reference(s) to consult: IV.H; I.B.4

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 04

Walter Reed

Age 70 | Male | Encounter/discharge: Feb 04, 2026



Acute inpatient hospital; final discharge summary

CHIEF COMPLAINT

Fever and productive cough

HISTORY OF PRESENT ILLNESS

Admitted after several days of worsening cough and fever.

FINDINGS / DOCUMENTATION

Imaging and clinical findings support pneumonia; no organism is identified.

PROVIDER ASSESSMENT

Probable pneumonia, unspecified organism, after study. No other reportable diagnosis.

PLAN / CODING SCOPE

Inpatient antibiotics; discharged improved.

YOUR CODING + GUIDELINE QUESTIONS

Assign the principal diagnosis at inpatient discharge. Explain how the uncertain-diagnosis rule differs from an ED visit.

Guideline reference(s) to consult: II.H; II principal diagnosis definition

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 05

Grace Ito

Age 65 | Female | Encounter/discharge: Feb 05, 2026



Office visit

CHIEF COMPLAINT

Burning urination

HISTORY OF PRESENT ILLNESS

Two days of dysuria. No dizziness or other complaints.

FINDINGS / DOCUMENTATION

Urinalysis supports infection. No blood in urine.

PROVIDER ASSESSMENT

Acute cystitis without hematuria; dysuria is caused by the cystitis.

PLAN / CODING SCOPE

Treat cystitis with an oral antibiotic.

YOUR CODING + GUIDELINE QUESTIONS

Assign the diagnosis code. Should the dysuria receive a separate code?

Guideline reference(s) to consult: I.B.5

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 06

Marisol Vega

Age 35 | Female | Encounter/discharge: Feb 06, 2026



Office visit

CHIEF COMPLAINT

Burning urination and dizziness

HISTORY OF PRESENT ILLNESS

Dysuria for two days. Intermittent dizziness began earlier and is separately evaluated.

FINDINGS / DOCUMENTATION

No hematuria. Neurologic examination is nonfocal; no cause for dizziness is established.

PROVIDER ASSESSMENT

Acute cystitis without hematuria. Dizziness, unrelated to cystitis.

PLAN / CODING SCOPE

Treat cystitis; review hydration and arrange further dizziness evaluation.

YOUR CODING + GUIDELINE QUESTIONS

Assign the two reportable diagnosis codes. Explain why the second symptom is reportable here.

Guideline reference(s) to consult: I.B.6; IV.J

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 07

Nadine Price

Age 70 | Female | Encounter/discharge: Feb 07, 2026



Office visit

CHIEF COMPLAINT

Persistent urinary symptoms

HISTORY OF PRESENT ILLNESS

Urine culture results are reviewed at follow-up.

FINDINGS / DOCUMENTATION

Culture identifies E. coli, without a more specific strain; no hematuria.

PROVIDER ASSESSMENT

Acute cystitis without hematuria due to E. coli.

PLAN / CODING SCOPE

Targeted antibiotic treatment. No sepsis or drug resistance documented.

YOUR CODING + GUIDELINE QUESTIONS

Assign the infection and any required organism code in the correct order.

Guideline reference(s) to consult: I.B.7; I.C.1.b

Code(s) / sequence:

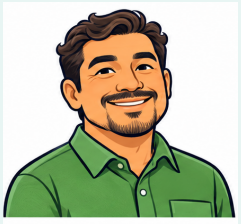
Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 08

Daniel Ruiz

Age 40 | Male | Encounter/discharge: Feb 08, 2026



Office visit

CHIEF COMPLAINT

Diabetes management

HISTORY OF PRESENT ILLNESS

Established type 2 diabetes is managed with diet alone. No insulin or other medication use.

FINDINGS / DOCUMENTATION

Glucose is elevated; no other diabetic complication.

PROVIDER ASSESSMENT

Type 2 diabetes mellitus with hyperglycemia.

PLAN / CODING SCOPE

Adjust diet and arrange glucose monitoring.

YOUR CODING + GUIDELINE QUESTIONS

Assign the diagnosis code. Does uncomplicated type 2 diabetes need an additional code?

Guideline reference(s) to consult: I.B.9; I.C.4.a

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 09

Malcolm Hayes

Age 55 | Male | Encounter/discharge: Feb 09, 2026



Office visit

CHIEF COMPLAINT

Diabetic kidney disease follow-up

HISTORY OF PRESENT ILLNESS

Diet-controlled type 2 diabetes. No hypertension or medication use.

FINDINGS / DOCUMENTATION

Stable renal function; clinician confirms CKD stage 3b.

PROVIDER ASSESSMENT

Type 2 diabetes with diabetic chronic kidney disease, stage 3b.

PLAN / CODING SCOPE

Monitor kidney function and reinforce diet.

YOUR CODING + GUIDELINE QUESTIONS

Assign the diabetes and kidney disease codes, showing sequence.

Guideline reference(s) to consult: I.B.7; I.B.9; I.C.4.a

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 10

Howard Lane

Age 70 | Male | Encounter/discharge: Feb 10, 2026



Office visit

CHIEF COMPLAINT

Blood pressure and kidney follow-up

HISTORY OF PRESENT ILLNESS

Established hypertension and CKD are both managed. No diabetes or heart failure.

FINDINGS / DOCUMENTATION

Provider confirms CKD stage 3b.

PROVIDER ASSESSMENT

Essential hypertension and CKD stage 3b. The chart does not state that they are unrelated.

PLAN / CODING SCOPE

Continue management of both conditions.

YOUR CODING + GUIDELINE QUESTIONS

Assign the hypertension and CKD codes. Is an explicit due-to statement required for this pair?

Guideline reference(s) to consult: I.A.15; I.C.9.a.2

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 11

Keiko Tan

Age 65 | Female | Encounter/discharge: Feb 11, 2026



Office visit

CHIEF COMPLAINT

Kidney and blood pressure follow-up

HISTORY OF PRESENT ILLNESS

Hypertension and CKD are managed at the same visit.

FINDINGS / DOCUMENTATION

No heart failure. CKD is stage 3b.

PROVIDER ASSESSMENT

Essential hypertension. CKD stage 3b is explicitly unrelated to hypertension.

PLAN / CODING SCOPE

Continue separate management plans.

YOUR CODING + GUIDELINE QUESTIONS

Assign both diagnoses. Explain how the provider statement changes the hypertensive CKD decision.

Guideline reference(s) to consult: I.A.15; I.C.9.a.2

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 12

Chloe Marsh

Age 30 | Female | Encounter/discharge: Feb 12, 2026



Office visit

CHIEF COMPLAINT

Sinus pressure

HISTORY OF PRESENT ILLNESS

Long-standing maxillary sinusitis with a new acute episode. Recurrence of the acute episode is not specified.

FINDINGS / DOCUMENTATION

Maxillary sinus tenderness; no other diagnosis.

PROVIDER ASSESSMENT

Acute and chronic maxillary sinusitis.

PLAN / CODING SCOPE

Treat the acute episode and continue chronic care.

YOUR CODING + GUIDELINE QUESTIONS

Assign the diagnosis codes in order. Explain why both acute and chronic codes apply.

Guideline reference(s) to consult: I.B.8

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 13

Ruth Bell

Age 70 | Female | Encounter/discharge: Feb 13, 2026



Wound clinic

CHIEF COMPLAINT

Sacral wound

HISTORY OF PRESENT ILLNESS

Patient attends a focused ulcer-care visit. No other reportable problem.

FINDINGS / DOCUMENTATION

Physician diagnoses pressure ulcer at the sacrum. The wound nurse documents stage 3 in the official record.

PROVIDER ASSESSMENT

Sacral pressure ulcer; staging detail documented by the wound nurse.

PLAN / CODING SCOPE

Wound treatment and pressure-relief plan.

YOUR CODING + GUIDELINE QUESTIONS

Assign the pressure ulcer code. Can the nurse provide the stage for this provider-diagnosed ulcer?

Guideline reference(s) to consult: I.B.14; I.C.12.a

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 14

Evelyn Shaw

Age 70 | Female | Encounter/discharge: Feb 14, 2026



Acute inpatient hospital; POA reporting required

CHIEF COMPLAINT

Admission for sacral pressure ulcer treatment

HISTORY OF PRESENT ILLNESS

The ED clinician diagnoses the ulcer at 10:00 AM. The inpatient admission order is placed at noon.

FINDINGS / DOCUMENTATION

Stage 3 sacral pressure ulcer is documented before the order.

PROVIDER ASSESSMENT

Stage 3 pressure ulcer of sacral region, chiefly responsible for admission.

PLAN / CODING SCOPE

Admitted for wound care; no other diagnosis is requested in this exercise.

YOUR CODING + GUIDELINE QUESTIONS

Assign the principal diagnosis and its POA indicator. Which time controls POA?

Guideline reference(s) to consult: Appendix I: General Reporting Requirements and POA Explicitly Documented

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 15

Gordon Miles

Age 70 | Male | Encounter/discharge: Feb 15, 2026



Acute inpatient hospital; additional diagnosis task

CHIEF COMPLAINT

New kidney dysfunction during hospital stay

HISTORY OF PRESENT ILLNESS

Admitted for an unrelated condition. Renal function is normal at the admission order.

FINDINGS / DOCUMENTATION

Acute kidney failure develops on day 3 and requires treatment and monitoring.

PROVIDER ASSESSMENT

Acute kidney failure, unspecified type, definitively not present on admission.

PLAN / CODING SCOPE

Treat kidney failure. Code only this additional diagnosis for the exercise; do not code the unrelated admission condition.

YOUR CODING + GUIDELINE QUESTIONS

Assign the additional diagnosis and its POA indicator. Does the condition meet additional-diagnosis reporting criteria?

Guideline reference(s) to consult: III; Appendix I: POA Explicitly Documented

Code(s) / sequence:

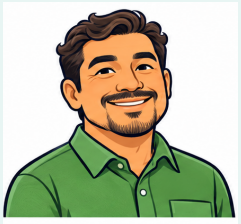
Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 16

Rafael Soto

Age 40 | Male | Encounter/discharge: Feb 16, 2026



Urgent care; active treatment

CHIEF COMPLAINT

Foreign body in left eye

HISTORY OF PRESENT ILLNESS

A small particle entered the eye today.

FINDINGS / DOCUMENTATION

Provider confirms a foreign body on the external left eye; exact external part is not specified.

PROVIDER ASSESSMENT

Foreign body on external left eye, part unspecified.

PLAN / CODING SCOPE

Provider removes the foreign body today. No residual complication. Omit external cause codes for this exercise.

YOUR CODING + GUIDELINE QUESTIONS

Assign the complete injury code. Show the placeholder and encounter character.

Guideline reference(s) to consult: I.A.4; I.A.5; I.C.19.a

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 17

Andre Cole

Age 40 | Male | Encounter/discharge: Feb 17, 2026



Ophthalmology; routine recovery visit

CHIEF COMPLAINT

Recheck after left-eye foreign body removal

HISTORY OF PRESENT ILLNESS

Active treatment was completed. This visit is routine recovery care only.

FINDINGS / DOCUMENTATION

The same external left-eye foreign body, part unspecified, has been removed; no new injury or complication.

PROVIDER ASSESSMENT

Routine recovery following external left-eye foreign body.

PLAN / CODING SCOPE

Routine healing check. Omit external cause codes for this exercise.

YOUR CODING + GUIDELINE QUESTIONS

Assign the injury code for this recovery encounter. Explain the encounter character.

Guideline reference(s) to consult: I.A.5; I.C.19.a

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 18

Tessa Morgan

Age 30 | Female | Encounter/discharge: Feb 18, 2026



Office visit

CHIEF COMPLAINT

Review of mildly elevated glucose

HISTORY OF PRESENT ILLNESS

No diabetes treatment or symptoms.

FINDINGS / DOCUMENTATION

Provider reviews labs and does not diagnose diabetes mellitus.

PROVIDER ASSESSMENT

Borderline diabetes.

PLAN / CODING SCOPE

Diet counseling and repeat testing.

YOUR CODING + GUIDELINE QUESTIONS

Assign the diagnosis code. Does borderline diabetes follow the generic confirmed-diagnosis approach?

Guideline reference(s) to consult: I.B.17

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 19

Mina Park

Age 65 | Female | Encounter/discharge: Feb 19, 2026



Office visit

CHIEF COMPLAINT

Fatigue assessment follow-up

HISTORY OF PRESENT ILLNESS

Anemia is established; its cause and type remain undetermined.

FINDINGS / DOCUMENTATION

Provider does not diagnose iron deficiency or blood loss.

PROVIDER ASSESSMENT

Anemia, unspecified; fatigue is attributed to the anemia.

PLAN / CODING SCOPE

Further evaluation planned.

YOUR CODING + GUIDELINE QUESTIONS

Assign the diagnosis code. Explain whether unspecified coding is appropriate with this documentation.

Guideline reference(s) to consult: I.A.6; I.A.9.b; I.B.18

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 20

Isaac Grant

Age 55 | Male | Encounter/discharge: Feb 20, 2026



Office visit

CHIEF COMPLAINT

Elevated blood pressure follow-up

HISTORY OF PRESENT ILLNESS

Provider confirms hypertension.

FINDINGS / DOCUMENTATION

No CKD, heart disease, or hypertensive crisis is diagnosed.

PROVIDER ASSESSMENT

Essential hypertension. The phrase acute hypertension is also used descriptively.

PLAN / CODING SCOPE

Adjust antihypertensive treatment; follow up.

YOUR CODING + GUIDELINE QUESTIONS

Assign the diagnosis code. Does the word acute establish hypertensive urgency or emergency?

Guideline reference(s) to consult: I.A.18; I.A.1

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 21

Julian Avery

Age 40 | Male | Encounter/discharge: Feb 21, 2026



Infectious disease office

CHIEF COMPLAINT

Routine HIV follow-up

HISTORY OF PRESENT ILLNESS

Provider documents HIV-positive status. No current or previous HIV-related illness.

FINDINGS / DOCUMENTATION

Asymptomatic. No long-term medication coding is requested.

PROVIDER ASSESSMENT

Asymptomatic HIV infection status.

PLAN / CODING SCOPE

Continue status monitoring. Code the HIV status only.

YOUR CODING + GUIDELINE QUESTIONS

Assign the appropriate HIV code. Explain why HIV disease coding does or does not apply.

Guideline reference(s) to consult: I.C.1.a.2(e)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 22

Dominic Stone

Age 55 | Male | Encounter/discharge: Feb 22, 2026



Infectious disease office

CHIEF COMPLAINT

HIV disease management

HISTORY OF PRESENT ILLNESS

Provider explicitly diagnoses AIDS. No individual opportunistic illness is included in this exercise.

FINDINGS / DOCUMENTATION

Stable at this visit.

PROVIDER ASSESSMENT

AIDS/HIV disease.

PLAN / CODING SCOPE

Disease management; assign the HIV diagnosis only.

YOUR CODING + GUIDELINE QUESTIONS

Assign the HIV code. Which documented term determines the choice?

Guideline reference(s) to consult: I.C.1.a.2(a)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 23

Naomi Carter

Age 45 | Female | Encounter/discharge: Feb 23, 2026



Infectious disease office

CHIEF COMPLAINT

HIV follow-up

HISTORY OF PRESENT ILLNESS

The official record documents a prior HIV-related illness. The patient is asymptomatic today.

FINDINGS / DOCUMENTATION

No current opportunistic illness is addressed.

PROVIDER ASSESSMENT

HIV disease with documented past HIV-related illness.

PLAN / CODING SCOPE

Continue disease follow-up. Code the HIV diagnosis only.

YOUR CODING + GUIDELINE QUESTIONS

Assign the HIV code. Can the patient return to an asymptomatic-status code?

Guideline reference(s) to consult: I.C.1.a.2(g)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 24

Sadie Flynn

Age 30 | Female | Encounter/discharge: Feb 24, 2026



Preventive testing office

CHIEF COMPLAINT

Routine HIV test

HISTORY OF PRESENT ILLNESS

No symptoms, known exposure, or high-risk behavior is documented.

FINDINGS / DOCUMENTATION

No illness is diagnosed.

PROVIDER ASSESSMENT

Encounter for HIV screening.

PLAN / CODING SCOPE

Screening test performed.

YOUR CODING + GUIDELINE QUESTIONS

Assign the encounter code. Explain why screening applies.

Guideline reference(s) to consult: I.C.1.a.2(i)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 25

Bernard King

Age 55 | Male | Encounter/discharge: Feb 25, 2026



Office visit

CHIEF COMPLAINT

Productive cough and fever

HISTORY OF PRESENT ILLNESS

Several days of respiratory symptoms.

FINDINGS / DOCUMENTATION

Provider confirms pneumonia and identifies MRSA as its cause.

PROVIDER ASSESSMENT

Pneumonia due to methicillin-resistant Staphylococcus aureus.

PLAN / CODING SCOPE

Targeted treatment. No sepsis, colonization status, or other complication.

YOUR CODING + GUIDELINE QUESTIONS

Assign the diagnosis code. Is an additional MRSA organism or resistance code required?

Guideline reference(s) to consult: I.C.1.e.1(a)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 26

Irene Moss

Age 70 | Female | Encounter/discharge: Feb 26, 2026



Preoperative evaluation; code only carrier finding

CHIEF COMPLAINT

Review of nasal screening result

HISTORY OF PRESENT ILLNESS

Screening result is reviewed; provider documents carrier status.

FINDINGS / DOCUMENTATION

No active MRSA infection.

PROVIDER ASSESSMENT

MRSA colonization.

PLAN / CODING SCOPE

Record carrier status. Code only the documented colonization for this task.

YOUR CODING + GUIDELINE QUESTIONS

Assign the colonization code. Explain the distinction from an active infection.

Guideline reference(s) to consult: I.C.1.e.1(c)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 27

Felix Ward

Age 70 | Male | Encounter/discharge: Feb 27, 2026



Acute inpatient hospital; final discharge summary

CHIEF COMPLAINT

Admission for systemic infection

HISTORY OF PRESENT ILLNESS

Sepsis chiefly occasioned admission.

FINDINGS / DOCUMENTATION

No organism, localized source, acute organ dysfunction, or shock is identified.

PROVIDER ASSESSMENT

Sepsis, unspecified organism.

PLAN / CODING SCOPE

Treat sepsis; discharged improved.

YOUR CODING + GUIDELINE QUESTIONS

Assign the principal diagnosis. Should a severe sepsis code be added?

Guideline reference(s) to consult: I.C.1.d.1(a); II

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 28

Caleb Dean

Age 55 | Male | Encounter/discharge: Feb 28, 2026



Acute inpatient hospital; final discharge summary

CHIEF COMPLAINT

Admission for severe systemic infection

HISTORY OF PRESENT ILLNESS

Sepsis and its kidney complication are present at admission.

FINDINGS / DOCUMENTATION

No organism or localized source is identified. No septic shock.

PROVIDER ASSESSMENT

Severe sepsis due to unspecified organism, with acute kidney failure due to sepsis; kidney failure subtype not specified.

PLAN / CODING SCOPE

Treat systemic infection and kidney failure. No procedural or obstetric association.

YOUR CODING + GUIDELINE QUESTIONS

Assign the required diagnosis codes in order. Identify which code represents acute organ dysfunction.

Guideline reference(s) to consult: I.C.1.d.1(b); I.C.1.d.3

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 29

Thomas Vale

Age 70 | Male | Encounter/discharge: Mar 01, 2026



Acute inpatient hospital; final discharge summary

CHIEF COMPLAINT

Admission for sepsis with pneumonia

HISTORY OF PRESENT ILLNESS

Both systemic and localized infection are present on admission; sepsis chiefly occasioned admission.

FINDINGS / DOCUMENTATION

No organism, shock, or acute organ dysfunction identified.

PROVIDER ASSESSMENT

Sepsis due to pneumonia; unspecified organism for both.

PLAN / CODING SCOPE

Treat both infections. No procedural association.

YOUR CODING + GUIDELINE QUESTIONS

Assign the principal diagnosis and additional infection code. Explain the sequence.

Guideline reference(s) to consult: I.C.1.d.4

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 30

Owen Mercer

Age 55 | Male | Encounter/discharge: Mar 02, 2026



Acute inpatient hospital; documentation review task

CHIEF COMPLAINT

Urinary symptoms with systemic concern

HISTORY OF PRESENT ILLNESS

The discharge diagnosis contains only urosepsis.

FINDINGS / DOCUMENTATION

No definite UTI site, sepsis diagnosis, or organ dysfunction is established elsewhere.

PROVIDER ASSESSMENT

Urosepsis; terminology not clarified.

PLAN / CODING SCOPE

Before code finalization, review the wording with the provider.

YOUR CODING + GUIDELINE QUESTIONS

Can a final sepsis or UTI diagnosis code be assigned from this term alone? State the next coding action.

Guideline reference(s) to consult: I.C.1.d.1(a)(ii)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 31

Lydia Hart

Age 45 | Female | Encounter/discharge: Mar 03, 2026



Office visit

CHIEF COMPLAINT

Respiratory infection follow-up

HISTORY OF PRESENT ILLNESS

Current COVID-19 is confirmed by the provider.

FINDINGS / DOCUMENTATION

Provider confirms pneumonia caused by COVID-19.

PROVIDER ASSESSMENT

COVID-19 pneumonia. No pregnancy or other sequencing exception.

PLAN / CODING SCOPE

Treat the active infection and pneumonia.

YOUR CODING + GUIDELINE QUESTIONS

Assign the two diagnosis codes in sequence.

Guideline reference(s) to consult: I.C.1.g.1(b); I.C.1.g.1(c)(i)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 32

Alma Reyes

Age 35 | Female | Encounter/discharge: Mar 04, 2026



Office visit

CHIEF COMPLAINT

Evaluation after household contact

HISTORY OF PRESENT ILLNESS

A household member has confirmed COVID-19. The patient has no symptoms.

FINDINGS / DOCUMENTATION

No infection diagnosed; testing does not establish infection.

PROVIDER ASSESSMENT

Contact with and suspected exposure to COVID-19.

PLAN / CODING SCOPE

Exposure evaluation and counseling.

YOUR CODING + GUIDELINE QUESTIONS

Assign the encounter code. Is this a screening encounter or an exposure encounter?

Guideline reference(s) to consult: I.C.1.g.1(e)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 33

Marta Lin

Age 65 | Female | Encounter/discharge: Mar 05, 2026



Preoperative testing; code screening only

CHIEF COMPLAINT

Routine preoperative COVID-19 test

HISTORY OF PRESENT ILLNESS

No symptoms or known exposure. The encounter is solely for the screening test.

FINDINGS / DOCUMENTATION

No infection diagnosed.

PROVIDER ASSESSMENT

Encounter for screening for COVID-19.

PLAN / CODING SCOPE

Test performed under preoperative protocol.

YOUR CODING + GUIDELINE QUESTIONS

Assign the screening code. Explain why an exposure code is not supported.

Guideline reference(s) to consult: I.C.1.g.1(f)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 34

Patricia Wells

Age 70 | Female | Encounter/discharge: Mar 06, 2026



Office visit

CHIEF COMPLAINT

Persistent shortness of breath

HISTORY OF PRESENT ILLNESS

A prior COVID-19 infection has resolved; no active infection now.

FINDINGS / DOCUMENTATION

Provider finds no more specific cause for the persistent symptom.

PROVIDER ASSESSMENT

Shortness of breath due to prior COVID-19 infection.

PLAN / CODING SCOPE

Evaluate and manage the residual symptom.

YOUR CODING + GUIDELINE QUESTIONS

Assign the symptom and relationship codes in order. Is active COVID-19 coding appropriate?

Guideline reference(s) to consult: I.C.1.g.1(m)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 35

Sofia Bennett

Age 35 | Female | Encounter/discharge: Mar 07, 2026



Office follow-up

CHIEF COMPLAINT

Post-treatment COVID-19 follow-up

HISTORY OF PRESENT ILLNESS

Treatment is completed. There are no residual symptoms or conditions.

FINDINGS / DOCUMENTATION

Follow-up test is negative; provider confirms full recovery.

PROVIDER ASSESSMENT

Follow-up after resolved COVID-19, without residual illness.

PLAN / CODING SCOPE

No further treatment required.

YOUR CODING + GUIDELINE QUESTIONS

Assign the follow-up and history codes. Explain why a post-COVID residual code is not used.

Guideline reference(s) to consult: I.C.1.g.1(j)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 36

Marcus Tate

Age 55 | Male | Encounter/discharge: Mar 08, 2026



Outpatient oncology infusion

CHIEF COMPLAINT

Scheduled chemotherapy

HISTORY OF PRESENT ILLNESS

Active malignant neoplasm of sigmoid colon.

FINDINGS / DOCUMENTATION

No complication or additional diagnosis addressed.

PROVIDER ASSESSMENT

Encounter solely for administration of antineoplastic chemotherapy for sigmoid colon cancer.

PLAN / CODING SCOPE

Chemotherapy administered as scheduled.

YOUR CODING + GUIDELINE QUESTIONS

Assign the first-listed encounter code and the malignancy code.

Guideline reference(s) to consult: I.C.2.e.2

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 37

Raymond Frost

Age 70 | Male | Encounter/discharge: Mar 09, 2026



Acute inpatient hospital; final discharge summary

CHIEF COMPLAINT

Admission for treatment of anemia

HISTORY OF PRESENT ILLNESS

Active sigmoid colon cancer. No current chemotherapy adverse effect or bleeding is diagnosed.

FINDINGS / DOCUMENTATION

Provider links the anemia directly to the malignancy.

PROVIDER ASSESSMENT

Anemia in neoplastic disease due to active sigmoid colon cancer. Admission is only for treatment of this anemia.

PLAN / CODING SCOPE

Transfusion and monitoring. No other reportable diagnosis.

YOUR CODING + GUIDELINE QUESTIONS

Assign the principal and additional diagnosis codes. Which rule overrides a symptom-first assumption?

Guideline reference(s) to consult: I.C.2.c.1

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 38

Audrey Nash

Age 70 | Female | Encounter/discharge: Mar 10, 2026



Office visit; code personal history only

CHIEF COMPLAINT

Review of prior breast cancer history

HISTORY OF PRESENT ILLNESS

Breast malignancy was fully excised. No disease remains at the site; all directed treatment is complete.

FINDINGS / DOCUMENTATION

Provider confirms no current malignancy. This is not a dedicated cancer follow-up examination.

PROVIDER ASSESSMENT

Personal history of malignant neoplasm of breast.

PLAN / CODING SCOPE

Record relevant history. Code only the history in this exercise.

YOUR CODING + GUIDELINE QUESTIONS

Assign the history code. What facts establish history rather than current malignancy?

Guideline reference(s) to consult: I.C.2.d; I.C.2.m

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 39

Estelle Boyd

Age 70 | Female | Encounter/discharge: Mar 11, 2026



Pain management office

CHIEF COMPLAINT

Cancer-related pain control

HISTORY OF PRESENT ILLNESS

Active sigmoid colon cancer. Visit is for pain management only, not cancer-directed treatment.

FINDINGS / DOCUMENTATION

Provider attributes the pain to the malignancy.

PROVIDER ASSESSMENT

Neoplasm-related pain due to sigmoid colon cancer.

PLAN / CODING SCOPE

Adjust pain treatment. No chemotherapy or tumor-directed procedure today.

YOUR CODING + GUIDELINE QUESTIONS

Assign the first-listed diagnosis and additional malignancy code. Explain the reason for the order.

Guideline reference(s) to consult: I.C.6.b.5; I.C.2.h

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason:

PATIENT REPORT 40

Megan Reed

Age 30 | Female | Encounter/discharge: Mar 12, 2026



Emergency department; active treatment

CHIEF COMPLAINT

Nausea and vomiting after medication error

HISTORY OF PRESENT ILLNESS

Patient accidentally took twice the prescribed diazepam dose. No self-harm intent.

FINDINGS / DOCUMENTATION

Provider confirms acute poisoning. No other manifestations are diagnosed.

PROVIDER ASSESSMENT

Accidental diazepam poisoning, causing nausea and vomiting.

PLAN / CODING SCOPE

Active treatment and monitoring in the ED. Omit external cause and place codes for this exercise.

YOUR CODING + GUIDELINE QUESTIONS

Assign the poisoning and manifestation codes in order. Is this poisoning or an adverse effect of correct use?

Guideline reference(s) to consult: I.C.19.e.5(b)

Code(s) / sequence:

Index main term(s) and Tabular notes:

Guideline and reason: