CORRINA R. LYNCH | CPC PREPARATION

ICD-10-CM GUIDELINES

2026 CARTOON LEARNING CARDS

I.A-I.B | Conventions & General Rules

FIND THE GUIDELINE FIRST

The large reference number is the primary label. IV.J means Section IV (four), letter J. Character names are memory aids, not guideline numbers.

EVERY TEACHING CARD

Read: guideline reference and topic > setting > rule in plain language > fictional patient example > code answer or coding action and why. Use the Index first and verify the Tabular List.

MARISOL VEGA: WHERE TO LOOK

The Marisol example has its own IV.J card in Part 4. Also see I.B.5-6 and I.C.18.b for integral versus unrelated symptoms.

WHAT THIS EDITION CONTAINS

This part has 77 teaching cards. The series has 362 teaching cards across Sections I-IV. Long rules have been split or summarized for instruction; the separate Official Text + Examples companion preserves all official wording on printed pages 7-115.

SOURCE & CODE DETAILS

Based on the original FY 2026 release updated October 1, 2025. All fully specified example codes were checked against the official FY 2026 code-description file. A code ending in a dash is a lookup family, not a reportable final code. When details are missing, the card gives the coding action rather than inventing them.

Official CMS guidelines (click to open)

GUIDELINE FINDER

Select an entry or search the PDF for a guideline number.

I.A.1 | The Alphabetic Index and Tabular List **5**

I.A.1 | The Alphabetic Index and Tabular List **5**

I.A.2 | Format and Structure **6**

I.A.3 | Use of codes for reporting purposes **6**

I.A.4 | Placeholder character **7**

I.A.5 | 7th Characters **7**

I.A.6.a | Abbreviations **8**

I.A.6.a | Abbreviations **8**

I.A.6.b | Abbreviations **9**

I.A.6.b | Abbreviations **9**

I.A.7 | Punctuation **10**

I.A.7 | Punctuation **10**

I.A.7 | Punctuation **11**

I.A.7 | Punctuation **11**

I.A.7 | Punctuation **12**

I.A.7 | Punctuation **12**

I.A.8 | Use of "and" **13**

I.A.9.a | Other and Unspecified codes **13**

I.A.9.b | Other and Unspecified codes **14**

I.A.9.b | Other and Unspecified codes **14**

I.A.10 | Includes Notes **15**

I.A.11 | Inclusion terms **15**

I.A.12.a | Excludes Notes **16**

I.A.12.a | Excludes Notes **16**

I.A.12.b | Excludes Notes **17**

I.A.13 | Etiology/manifestation convention **17**

I.A.13 | Etiology/manifestation convention **18**

I.A.14 | "And" **18**

I.A.15 | "With" **19**

I.A.15 | "With" **19**

GUIDELINE FINDER

Select an entry or search the PDF for a guideline number.

I.A.15 | "With" **20**

I.A.16 | "See" and "See Also" **20**

I.A.16 | "See" and "See Also" **21**

I.A.17 | "Code also" note **21**

I.A.18 | Default codes **22**

I.A.19 | Code assignment and Clinical Criteria **22**

I.A.19 | Code assignment and Clinical Criteria **23**

I.B.1 | Locating a code in the ICD-10-CM **23**

I.B.2 | Level of Detail in Coding **24**

I.B.3 | Codes for reasons for encounters **24**

I.B.4 | Signs and symptoms **25**

I.B.5 | Conditions integral to a disease process **25**

I.B.6 | Conditions not integral to a disease process **26**

I.B.7 | Multiple coding for a single condition **26**

I.B.7 | Multiple coding for a single condition **27**

I.B.7 | Multiple coding for a single condition **27**

I.B.8 | Acute and Chronic Conditions **28**

I.B.9 | Combination Code **28**

I.B.9 | Combination Code **29**

I.B.10 | Sequela (Late Effects) **29**

I.B.10 | Sequela (Late Effects) **30**

I.B.11 | Impending or Threatened Condition **30**

I.B.11 | Impending or Threatened Condition **31**

I.B.11 | Impending or Threatened Condition **31**

I.B.12 | Reporting Same Diagnosis Code More than Once **32**

I.B.13 | Laterality **32**

I.B.13 | Laterality **33**

I.B.13 | Laterality **33**

I.B.13 | Laterality **34**

I.B.13 | Laterality **34**

GUIDELINE FINDER

Select an entry or search the PDF for a guideline number.

I.B.14 | Documentation by clinicians other than the patient's provider **35**

I.B.14 | Documentation by clinicians other than the patient's provider **35**

I.B.14 | Documentation by clinicians other than the patient's provider **36**

I.B.14 | Documentation by clinicians other than the patient's provider **36**

I.B.15 | Syndromes **37**

I.B.15 | Syndromes **37**

I.B.16 | Documentation of Complications of Care **38**

I.B.16 | Documentation of Complications of Care **38**

I.B.17 | Borderline Diagnosis **39**

I.B.18 | Use of Sign/Symptom/Unspecified Codes **39**

I.B.19.a | Coding in Hurricane Aftermath **40**

I.B.19.a | Coding in Hurricane Aftermath **40**

I.B.19.b | Coding in Hurricane Aftermath **41**

I.B.19.b | Coding in Hurricane Aftermath **41**

I.B.19.c | Coding in Hurricane Aftermath **42**

I.B.19.d | Coding in Hurricane Aftermath **42**

I.B.20 | Multiple Sites Coding **43**

I.A.1

The Alphabetic Index and Tabular List

OUTPATIENT EXAMPLE

GUIDELINE IN PLAIN LANGUAGE

Start with the documented term in the Index; verify the complete code and notes in the Tabular List.

FICTIONAL PATIENT EXAMPLE

Fictional record: An office note documents left knee pain. The lookup starts under Pain.



CODING ANSWER / ACTION + WHY

M25.562. The Tabular List confirms knee pain on the left.

I.A.1

The Alphabetic Index and Tabular List

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Use the appropriate part of the Index: diseases and injuries, external causes, neoplasms, or drugs and chemicals.

FICTIONAL PATIENT EXAMPLE

Fictional record: Four charts contain asthma, a fall, a malignant tumor by site, and an accidental drug overdose.



CODING ANSWER / ACTION + WHY

Start in the disease Index, external cause Index, Neoplasm Table, and Drug and Chemical Table, respectively. Verify the results in the Tabular List.

I.A.2

Format and Structure

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

A three-character category is a complete code only if it has no subdivisions. Indents show the hierarchy.

FICTIONAL PATIENT EXAMPLE

Fictional record: The chart documents essential hypertension. The Tabular List shows no subdivisions under I10.



CODING ANSWER / ACTION + WHY

I10 is complete. Three characters are enough in this case.

I.A.3

Use of codes for reporting purposes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Report the final code, including any required seventh character.

FICTIONAL PATIENT EXAMPLE

Fictional record: A coder stops at M25 for documented right knee pain.



CODING ANSWER / ACTION + WHY

Use M25.561. M25 is a category with subdivisions.

I.A.4

Placeholder character

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Insert X wherever the classification requires a placeholder.

FICTIONAL PATIENT EXAMPLE

Fictional record: Active treatment for a foreign body on the external left eye, part unspecified. A coder writes T15.92A.



CODING ANSWER / ACTION + WHY

T15.92XA. X fills position six so A lands in position seven.

I.A.5

7th Characters

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Use the seventh character the Tabular List requires. The encounter phase, not the visit number, can determine it.

FICTIONAL PATIENT EXAMPLE

The patient returns for routine recovery after active treatment of the same external eye foreign body.



CODING ANSWER / ACTION + WHY

T15.92XD. D reflects routine recovery; X preserves the seventh position.

I.A.6.a

Abbreviations

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

In the Index, NEC points to an other-specified option when no separate code exists.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider names a particular disorder. The Index entry for it is marked NEC.



CODING ANSWER / ACTION + WHY

Verify the other-specified option in the Tabular List. The record has detail, but the classification groups it.

I.A.6.a

Abbreviations

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

In the Index, NOS means unspecified.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider documents anemia without identifying its type. The Index leads to the NOS option.



CODING ANSWER / ACTION + WHY

Verify D64.9. No anemia type is documented.

I.A.6.b

Abbreviations

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

In the Tabular List, NEC identifies an other-specified grouping.

FICTIONAL PATIENT EXAMPLE

Fictional record: An Index candidate points to a Tabular entry marked NEC for a named condition without its own code.



CODING ANSWER / ACTION + WHY

Use that grouping if the entry and notes match the diagnosis. NEC is not a cue to discard documented detail.

I.A.6.b

Abbreviations

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

In the Tabular List, NOS indicates an unspecified option.

FICTIONAL PATIENT EXAMPLE

Fictional record: The chart says pneumonia and does not identify the organism. The coder finds the unspecified-organism entry.



CODING ANSWER / ACTION + WHY

J18.9. The entry fits the documented level of detail; do not guess an organism.

I.A.7

Punctuation

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Tabular brackets can hold a synonym, alternative wording, or an explanation.

FICTIONAL PATIENT EXAMPLE

Fictional record: A Tabular entry in a practice lookup shows a synonym in square brackets beside its title.



CODING ANSWER / ACTION + WHY

Read the bracketed words as clarification of that entry, not as a second diagnosis code.

I.A.7

Punctuation

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

A bracketed manifestation code in the Index follows the underlying condition.

FICTIONAL PATIENT EXAMPLE

Fictional record: A practice Index lookup for a disease with dementia displays an underlying disease code and a bracketed manifestation code.



CODING ANSWER / ACTION + WHY

Verify both in the Tabular List and place the underlying disease first. The brackets identify the manifestation.

I.A.7

Punctuation

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

A word in parentheses generally may be present or absent without changing the code.

FICTIONAL PATIENT EXAMPLE

Fictional record: Two charts say essential hypertension and hypertension, respectively; neither adds qualifying details.



CODING ANSWER / ACTION + WHY

I10 for both. The optional modifier does not change the default lookup.

I.A.7

Punctuation

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

When a parenthetical modifier conflicts with a subentry, the subentry controls.

FICTIONAL PATIENT EXAMPLE

Fictional record: The chart says chronic enteritis. The main term has acute in parentheses and a separate chronic subentry.



CODING ANSWER / ACTION + WHY

Follow chronic. The parenthetical acute modifier does not override it.

I.A.7

Punctuation

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

After a colon in the Tabular List, read the completing words before using the entry.

FICTIONAL PATIENT EXAMPLE

Fictional record: A trainee sees an incomplete term followed by a colon but skips the list below it.



CODING ANSWER / ACTION + WHY

Match the documented wording to a completing modifier. The fragment alone does not establish a match.

I.A.7

Punctuation

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

An Index comma can signal alternative wording, a modifier, or an and/or relationship, depending on context.

FICTIONAL PATIENT EXAMPLE

Fictional record: A practice Index entry uses a comma between a main term and a descriptive phrase.



CODING ANSWER / ACTION + WHY

Read the entire entry and its indentation, then verify the candidate. A comma alone does not tell you how the phrase functions.

I.A.8

Use of "and"

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

This heading points you to the code-title rule in I.A.14.

FICTIONAL PATIENT EXAMPLE

Fictional record: A trainee reads a title containing and and assumes that both conditions must be present.



CODING ANSWER / ACTION + WHY

Check I.A.14 before rejecting the title. See the two-door example on the I.A.14 card.

I.A.9.a

Other and Unspecified codes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Use other specified when a documented detail has no separate code and the lookup directs there.

FICTIONAL PATIENT EXAMPLE

Fictional record: A provider names a specific type of disorder. The Index routes that type to an other-specified entry.



CODING ANSWER / ACTION + WHY

Use that entry after verification. The detail is known even though it has no dedicated code.

I.A.9.b

Other and Unspecified codes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Use unspecified when documentation cannot support a more specific option; check the category's available codes.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider documents pneumonia but no organism is identified.



CODING ANSWER / ACTION + WHY

J18.9. The organism is not documented; do not substitute a named organism.

I.A.9.b

Other and Unspecified codes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

In some categories without an unspecified code, the other-specified entry can also cover unspecified cases.

FICTIONAL PATIENT EXAMPLE

Fictional record: A practice category has no NOS option, and the Index directs an unqualified diagnosis to the other-specified code.



CODING ANSWER / ACTION + WHY

Verify and use the directed code. Do not assume this exception applies to every category.

I.A.10

Includes Notes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

An Includes note under a category explains its scope or gives examples.

FICTIONAL PATIENT EXAMPLE

Fictional record: A coder sees the chart diagnosis named in a category's Includes note.



CODING ANSWER / ACTION + WHY

Use the note to confirm scope, then choose the complete code. The note does not make a subdivided category reportable.

I.A.11

Inclusion terms

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Inclusion terms identify conditions assigned to a code; the list need not contain every term mapped there.

FICTIONAL PATIENT EXAMPLE

Fictional record: The Index points to a code even though the diagnosis phrase is not repeated in its inclusion list.



CODING ANSWER / ACTION + WHY

Verify the code and instructions. Absence from the inclusion list alone does not invalidate a supported match.

I.A.12.a

Excludes Notes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

An Excludes1 note generally bars reporting the excluded code together with the code carrying the note.

FICTIONAL PATIENT EXAMPLE

Fictional record: The chart documents sleep-related teeth grinding only. A coder proposes both F45.8 and G47.63 for it.



CODING ANSWER / ACTION + WHY

Report G47.63 for this diagnosis. Do not report both codes for the same teeth-grinding condition.

I.A.12.a

Excludes Notes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Both codes may be allowed under Excludes1 if the conditions are unrelated. Query when the relationship is unclear.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider documents unrelated psychogenic dysmenorrhea and sleep-related teeth grinding, both managed at the visit.



CODING ANSWER / ACTION + WHY

F45.8 and G47.63 may both be reported. They describe two unrelated conditions.

I.A.12.b

Excludes Notes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Excludes2 means the excluded condition is not included in this code. Both may be coded when both are reportable.

FICTIONAL PATIENT EXAMPLE

Fictional record: A practice Tabular entry excludes a different condition using Excludes2. The provider treats both diagnoses.



CODING ANSWER / ACTION + WHY

Verify and report both applicable codes. Excludes2 does not prohibit the pair.

I.A.13

Etiology/manifestation convention

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

When the classification directs etiology-first sequencing, place the underlying condition before the manifestation.

FICTIONAL PATIENT EXAMPLE

Fictional record: A practice lookup identifies a cause and a manifestation labeled in diseases classified elsewhere.



CODING ANSWER / ACTION + WHY

Sequence the cause before the manifestation. The manifestation cannot stand first or alone.

I.A.13

Etiology/manifestation convention

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Follow sequencing instructions even for pairs that are not classic cause-and-manifestation codes.

FICTIONAL PATIENT EXAMPLE

Fictional record: The chart documents type 2 diabetes with diabetic CKD, stage 3b.



CODING ANSWER / ACTION + WHY

E11.22 followed by N18.32. The additional code identifies the CKD stage.

I.A.14

"And"

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

In a code title, and can mean either term or both.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider documents tuberculosis involving a joint only. A trainee rejects the bones-and-joints heading.



CODING ANSWER / ACTION + WHY

Look under A18.0 and verify the specific joint code. The heading can cover joint disease alone.

I.A.15

"With"

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

A link made by with or in in the classification is presumed unless documentation or a more specific guideline overrides it.

FICTIONAL PATIENT EXAMPLE

Fictional record: Hypertension and stage 3b CKD are managed; the chart does not state they are unrelated.



CODING ANSWER / ACTION + WHY

I12.9 followed by N18.32. The classification links hypertension and CKD in this case.

I.A.15

"With"

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Do not presume a link that the provider rules out, that the classification does not make, or that a specific guideline requires to be documented.

FICTIONAL PATIENT EXAMPLE

The provider explicitly says the patient's stage 3b CKD is unrelated to essential hypertension.



CODING ANSWER / ACTION + WHY

Do not use the hypertensive CKD combination for this pair. Verify I10 and N18.32 separately.

I.A.15

"With"

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Look directly below the main term or subterm for with instead of hunting for it alphabetically.

FICTIONAL PATIENT EXAMPLE

Fictional record: A trainee looking up diabetes with CKD scrolls to the end of the entry to find with.



CODING ANSWER / ACTION + WHY

Return to the area immediately after the main term or subterm. Then verify the selected code and notes.

I.A.16

"See" and "See Also"

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

A see note directs you to a different main term. Follow it.

FICTIONAL PATIENT EXAMPLE

Fictional record: The first term in a practice lookup ends with a see instruction rather than giving a code.



CODING ANSWER / ACTION + WHY

Go to the referenced term, then verify the code. The original entry is a redirect.

I.A.16

"See" and "See Also"

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Follow see also if the current entry does not give you what you need.

FICTIONAL PATIENT EXAMPLE

Fictional record: A trainee finds the exact documented diagnosis under the original entry plus a see also note.



CODING ANSWER / ACTION + WHY

The side trail is optional when the original entry suffices. Still verify the code in the Tabular List.

I.A.17

"Code also" note

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

A code also note may call for two codes, but the note itself does not determine their order.

FICTIONAL PATIENT EXAMPLE

Fictional record: Two documented conditions are reportable, and one entry has a code also note for the other.



CODING ANSWER / ACTION + WHY

Report both as appropriate. Decide order from applicable sequencing guidance and the circumstances of the encounter.

I.A.18

Default codes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

When the diagnosis has no qualifying detail, verify the default code beside the main term.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider documents hypertension without further qualification.



CODING ANSWER / ACTION + WHY

I10. The Index default applies in this case after Tabular verification.

I.A.19

Code assignment and Clinical Criteria

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Base code assignment on the provider's diagnostic statement; do not diagnose from test values.

FICTIONAL PATIENT EXAMPLE

Fictional record: A report shows elevated glucose, but the provider has not diagnosed diabetes.



CODING ANSWER / ACTION + WHY

Do not infer diabetes from the value. Code only a supported diagnosis or finding as appropriate for the encounter.

I.A.19

Code assignment and Clinical Criteria

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

When the record contains conflicting diagnostic documentation, query the provider.

FICTIONAL PATIENT EXAMPLE

Fictional record: One note diagnoses acute kidney failure, while another explicitly rules it out in the same encounter.

CODING ANSWER / ACTION + WHY

Query before finalizing the disputed diagnosis. The coder should not settle the conflict by interpreting lab results.

I.B.1

Locating a code in the ICD-10-CM

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

A dash means more characters are needed. Verify every candidate in the Tabular List even when there is no dash.

FICTIONAL PATIENT EXAMPLE

Fictional record: The Index gives a partial entry for documented left knee pain.

CODING ANSWER / ACTION + WHY

Verify M25.562. The complete code captures the left knee.

I.B.2

Level of Detail in Coding

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Use the complete code at the most specific level the record supports.

FICTIONAL PATIENT EXAMPLE

Fictional record: A clinician documents right knee pain. The coder considers unspecified knee pain.



CODING ANSWER / ACTION + WHY

Use M25.561. The chart identifies the side.

I.B.3

Codes for reasons for encounters

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Choose a diagnosis, symptom, or encounter code that accurately describes why the patient received care.

FICTIONAL PATIENT EXAMPLE

A healthy patient comes only for vaccination.



CODING ANSWER / ACTION + WHY

Z23. The encounter reason is immunization, even though there is no disease.

I.B.4

Signs and symptoms

OUTPATIENT EXAMPLE

GUIDELINE IN PLAIN LANGUAGE

Report symptoms when no related definitive diagnosis has been established and the setting allows symptom reporting.

FICTIONAL PATIENT EXAMPLE

Fictional record: An office visit ends with right lower quadrant pain and no confirmed cause.



CODING ANSWER / ACTION + WHY

R10.31. The symptom is the most certain finding.

I.B.5

Conditions integral to a disease process

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Do not separately code symptoms routinely associated with a confirmed disease unless the classification directs it.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider confirms acute cystitis without hematuria and notes dysuria caused by it.



CODING ANSWER / ACTION + WHY

N30.00. Do not add R30.0 for routine dysuria in this case.

I.B.6

Conditions not integral to a disease process

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

A separately reportable symptom that is not routine for the disease may be coded.

FICTIONAL PATIENT EXAMPLE

Fictional record: The clinician treats cystitis and separately evaluates unrelated dizziness.



CODING ANSWER / ACTION + WHY

N30.00 and R42. The dizziness is a separate evaluated problem.

I.B.7

Multiple coding for a single condition

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

When a use-additional-code instruction applies, report the documented detail after the main code.

FICTIONAL PATIENT EXAMPLE

Fictional record: Acute cystitis without hematuria is attributed to unspecified E. coli.



CODING ANSWER / ACTION + WHY

N30.00 then B96.20. The second code identifies the organism.

I.B.7

Multiple coding for a single condition

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Follow code-first notes when a documented underlying condition applies; the instruction can apply outside classic manifestation pairs.

FICTIONAL PATIENT EXAMPLE

Fictional record: A practice Tabular entry says to code a known cause first. The provider has documented the cause.



CODING ANSWER / ACTION + WHY

Sequence the verified cause code ahead of the affected condition as instructed.

I.B.7

Multiple coding for a single condition

INPATIENT EXAMPLE

GUIDELINE IN PLAIN LANGUAGE

A conditional code-first note can allow the condition to lead when the cause is unknown or not applicable.

FICTIONAL PATIENT EXAMPLE

Fictional record: The documented condition chiefly occasioned admission, and its conditional note applies only if a cause is known. None is identified.



CODING ANSWER / ACTION + WHY

The condition may be principal if all other requirements are met. Do not invent a cause.

I.B.8

Acute and Chronic Conditions

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

If separate acute and chronic subentries for the same condition sit at the same Index level, report both, acute first.

FICTIONAL PATIENT EXAMPLE

Fictional record: The clinician diagnoses acute and chronic maxillary sinusitis without specifying recurrence.

CODING ANSWER / ACTION + WHY

J01.00 then J32.0. The separate Index entries support both.

I.B.9

Combination Code

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

Use a combination code alone when it fully captures the documented conditions.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider documents type 2 diabetes with hyperglycemia.

CODING ANSWER / ACTION + WHY

E11.65. It captures the disease and manifestation; do not add uncomplicated diabetes.

I.B.9

Combination Code

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

If the combination code lacks a needed detail, report an additional code when applicable.

FICTIONAL PATIENT EXAMPLE

Fictional record: Type 2 diabetes with diabetic CKD, stage 3b, is documented.



CODING ANSWER / ACTION + WHY

E11.22 followed by N18.32. The combination does not identify the stage.

I.B.10

Sequela (Late Effects)

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

After the acute phase ends, generally code the residual first and the sequela code second. There is no time limit.

FICTIONAL PATIENT EXAMPLE

Fictional record: A healed burn left a scar contracture that is now treated.



CODING ANSWER / ACTION + WHY

Code the scar or contracture first and the applicable burn code with S second. Do not report the acute burn as current.

I.B.10

Sequela (Late Effects)

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Follow any exception that builds the residual into the sequela code or gives a specific sequencing instruction.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider documents aphasia from a prior cerebral infarction.



CODING ANSWER / ACTION + WHY

I69.320 captures both the prior infarction relationship and the aphasia.

I.B.11

Impending or Threatened Condition

INPATIENT EXAMPLE

GUIDELINE IN PLAIN LANGUAGE

If an impending or threatened condition actually occurred, code the established diagnosis.

FICTIONAL PATIENT EXAMPLE

Fictional record: The admission note warns of impending respiratory failure; discharge confirms acute respiratory failure with hypoxia.



CODING ANSWER / ACTION + WHY

Verify J96.01. The condition occurred and was diagnosed.

I.B.11

Impending or Threatened Condition

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

If the condition did not occur, look for the condition's subentry and the main terms Impending and Threatened.

FICTIONAL PATIENT EXAMPLE

Fictional record: A threatened condition never occurs, but a specific threatened-condition entry exists.

CODING ANSWER / ACTION + WHY

Use the code directed by that entry, after Tabular verification.

I.B.11

Impending or Threatened Condition

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

If the threatened condition did not occur and no applicable entry exists, report the existing condition instead.

FICTIONAL PATIENT EXAMPLE

A patient with confirmed asthma is discharged without the anticipated complication; no relevant impending entry exists.

CODING ANSWER / ACTION + WHY

Code the documented asthma as supported. Do not code a complication that never occurred.

I.B.12

Reporting Same Diagnosis Code More than Once

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Report each unique diagnosis code only once per encounter.

FICTIONAL PATIENT EXAMPLE

Fictional record: Two separately documented findings both map to the same exact diagnosis code.



CODING ANSWER / ACTION + WHY

Report the code once. Two descriptions do not create two unique codes.

I.B.13

Laterality

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

If both sides are affected and no bilateral code exists, report both side-specific codes.

FICTIONAL PATIENT EXAMPLE

A patient has pain in both knees.



CODING ANSWER / ACTION + WHY

M25.561 and M25.562. The classification has separate knee pain codes.

I.B.13

Laterality

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Use the bilateral code when both sides still have the condition, even when only the first side is treated.

FICTIONAL PATIENT EXAMPLE

Fictional record: Both eyes have the documented cataract type; surgery today treats only the right eye.



CODING ANSWER / ACTION + WHY

Use the applicable bilateral code if available. Both cataracts exist at this encounter.

I.B.13

Laterality

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

At the second treatment encounter, code only the remaining side if the condition resolved on the first side.

FICTIONAL PATIENT EXAMPLE

Fictional record: The right cataract resolved after treatment; today only the left cataract remains.



CODING ANSWER / ACTION + WHY

Use the applicable left-side code. If both sides still had the condition, bilateral would still apply.

I.B.13

Laterality

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

If the provider omits laterality, a permitted clinician's documentation may establish the side.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider diagnoses knee pain; the physical therapist's official note specifies the right knee.



CODING ANSWER / ACTION + WHY

Verify M25.561 if there is no conflicting documentation.

I.B.13

Laterality

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Query conflicting laterality. Use unspecified only when detail cannot be determined or clarified.

FICTIONAL PATIENT EXAMPLE

Fictional record: The notes disagree about which knee hurts.



CODING ANSWER / ACTION + WHY

Query the provider. Do not guess the side. If clarification cannot be obtained, verify the unspecified option.

I.B.14

Documentation by clinicians other than the patient's provider

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

A permitted clinician can document certain code details, but the provider must establish the associated diagnosis where required.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider diagnoses a sacral pressure ulcer and the wound nurse documents stage 3.

CODING ANSWER / ACTION + WHY

L89.153. The stage may come from the nurse's official record.

I.B.14

Documentation by clinicians other than the patient's provider

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

A permitted clinician can document BMI; the associated diagnosis must be provider documented. BMI is secondary only.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider documents obesity and a dietitian records the adult BMI.

CODING ANSWER / ACTION + WHY

Report the supported obesity diagnosis and applicable BMI as secondary when reportable. Do not infer obesity from BMI alone.

I.B.14

Documentation by clinicians other than the patient's provider

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

Other exceptions include non-pressure ulcer depth, coma scale, NIHSS, blood alcohol level, SDOH, underimmunization, and firearm injury intent. Check the specific rule.

FICTIONAL PATIENT EXAMPLE

Fictional record: The provider diagnoses acute stroke. A permitted clinician records NIHSS.

CODING ANSWER / ACTION + WHY

Add the applicable NIHSS as secondary when reportable. Coma scale, blood alcohol level, SDOH and underimmunization are also secondary only under this rule.

I.B.14

Documentation by clinicians other than the patient's provider

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

If documentation conflicts, query the provider even when the detail normally can come from another clinician.

FICTIONAL PATIENT EXAMPLE

Fictional record: Two permitted clinicians document different depths for the same non-pressure chronic ulcer.

CODING ANSWER / ACTION + WHY

Query the provider. Do not choose the deeper ulcer code on your own.

I.B.15

Syndromes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Follow the Index when it gives a syndrome entry.

FICTIONAL PATIENT EXAMPLE

Fictional record: A provider documents Down syndrome without a specified cytogenetic type.



CODING ANSWER / ACTION + WHY

Verify Q90.9. The syndrome has an Index route; do not replace it with its component findings.

I.B.15

Syndromes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

If the syndrome has no Index guidance, report documented manifestations. Consider additional nonintegral manifestations as applicable when there is no unique code.

FICTIONAL PATIENT EXAMPLE

Fictional record: A named syndrome has no Index route, and the provider documents evaluated dysphagia and dizziness as manifestations.



CODING ANSWER / ACTION + WHY

Verify codes for the documented manifestations. Do not invent a code for the syndrome.

I.B.16

Documentation of Complications of Care

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

Unless the classification directs otherwise, a complication requires a documented causal relationship and clinical significance. The word complication is not required.

FICTIONAL PATIENT EXAMPLE

Fictional record: The surgeon documents an unintended laceration caused by the operation that required repair and changed the procedure.

CODING ANSWER / ACTION + WHY

Verify the applicable complication code. The provider documented causation and impact.

I.B.16

Documentation of Complications of Care

ALL SETTINGS UNLESS STATED



GUIDELINE IN PLAIN LANGUAGE

An event that follows care is not necessarily caused by it. Query if the relationship is unclear.

FICTIONAL PATIENT EXAMPLE

A patient develops pain after a procedure, but the record does not clarify the cause.

CODING ANSWER / ACTION + WHY

Do not assume a procedural complication. Query for clarification when indicated.

I.B.17

Borderline Diagnosis

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Treat a borderline diagnosis as confirmed unless the classification supplies a specific entry. The rule applies in both settings.

FICTIONAL PATIENT EXAMPLE

Fictional record: At discharge the provider documents borderline diabetes.



CODING ANSWER / ACTION + WHY

Follow the specific Index entry and verify R73.03 rather than coding confirmed diabetes.

I.B.18

Use of Sign/Symptom/Unspecified Codes

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Use a symptom or unspecified code when it best reflects what is known. Do not guess detail or seek unnecessary testing for coding.

FICTIONAL PATIENT EXAMPLE

Fictional record: Pneumonia is confirmed; the organism is not known.



CODING ANSWER / ACTION + WHY

J18.9. The diagnosis is established; its organism is not.

I.B.19.a

Coding in Hurricane Aftermath

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

A hurricane-related injury code goes before external cause codes. Report applicable cause details for injury-care encounters.

FICTIONAL PATIENT EXAMPLE

A patient receives active treatment in a temporary clinic for a laceration directly caused by hurricane debris.



CODING ANSWER / ACTION + WHY

Report the supported injury first and the hurricane external cause afterward, with the proper encounter character.

I.B.19.a

Coding in Hurricane Aftermath

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Do not add a hurricane external cause code to medical care without injury, adverse effect or poisoning.

FICTIONAL PATIENT EXAMPLE

Fictional record: An evacuee receives routine treatment for established hypertension only.



CODING ANSWER / ACTION + WHY

Report hypertension as appropriate. Evacuation alone does not justify a hurricane injury cause code.

I.B.19.b

Coding in Hurricane Aftermath

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

A cataclysmic cause generally leads other external causes, except abuse or terrorism. It follows the injury code.

FICTIONAL PATIENT EXAMPLE

Fictional record: A building collapses because of a hurricane, injuring a resident.



CODING ANSWER / ACTION + WHY

Code the injury, then the hurricane, then any other applicable external causes. Do not use the collapse code reserved for earth movement.

I.B.19.b

Coding in Hurricane Aftermath

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Distinguish a hurricane-related levee break from direct storm flooding.

FICTIONAL PATIENT EXAMPLE

Fictional record: One person is hurt by a hurricane-related levee break; another by flooding directly from the storm.



CODING ANSWER / ACTION + WHY

Verify X37.0- for the levee-break case and X38.- for the direct flood case; complete the codes as required.

I.B.19.c

Coding in Hurricane Aftermath

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

For a clearly unrelated evacuation injury, report its actual cause. If direct hurricane involvement is unclear, this guideline directs assuming it.

FICTIONAL PATIENT EXAMPLE

Fictional record: A documented traffic crash unrelated to hurricane conditions injures an evacuee.



CODING ANSWER / ACTION + WHY

Report the crash causes as appropriate, without X37.0-. If direct linkage is unclear, apply the guideline and verify the hurricane code.

I.B.19.d

Coding in Hurricane Aftermath

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Use applicable Z codes to explain access barriers or other documented circumstances, checking sequencing restrictions.

FICTIONAL PATIENT EXAMPLE

A ventilator-dependent patient presents because their power failed after the hurricane.



CODING ANSWER / ACTION + WHY

Verify Z99.12 and other supported codes as needed; apply any sequencing instructions.

I.B.20

Multiple Sites Coding

ALL SETTINGS UNLESS STATED

GUIDELINE IN PLAIN LANGUAGE

Follow chapter-specific directions first. Otherwise, code individually named sites; use the appropriate multiple-sites code when sites are not specified.



FICTIONAL PATIENT EXAMPLE

Fictional record: A condition affects several sites. One record names each site, while a second does not.

CODING ANSWER / ACTION + WHY

For the first record, report the specified sites individually when no chapter rule says otherwise. For the second, verify the multiple-sites option.