CORRINA R. LYNCH | CPC PREPARATION

ICD-10-CM GUIDELINES

2026 CARTOON LEARNING CARDS

II-IV | Inpatient & Outpatient 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 48 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)

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II

Selection of principal diagnosis

INPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

The principal diagnosis is established after study as chiefly responsible for the inpatient admission. Classification sequencing rules take precedence.

FICTIONAL PATIENT EXAMPLE

Jordan is admitted because of pneumonia; after study, pneumonia remains the reason for admission.

CODING ANSWER / ACTION + WHY

J18.9 principal when organism is unspecified and no priority rule changes it. Do not use an unrelated chronic diagnosis first.

II.A

Symptoms, signs and ill-defined conditions

INPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

Do not use a related symptom as principal when a definitive diagnosis has been established.

FICTIONAL PATIENT EXAMPLE

Jordan is admitted for fever and cough; the discharge diagnosis is pneumonia.

CODING ANSWER / ACTION + WHY

J18.9 principal. Routine related fever and cough do not replace it.

II.B

Two or more interrelated conditions

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Either interrelated condition may lead only when each could meet the principal definition and circumstances, treatment and coding instructions do not determine order.

FICTIONAL PATIENT EXAMPLE

Two interrelated conditions could occasion Jordan's admission, but one has a code-first note.



CODING ANSWER / ACTION + WHY

Follow the code-first note. The apparent either-choice option cannot override classification instructions.

II.C

Two diagnoses equally meeting the principal definition

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

If two diagnoses truly equally meet principal criteria and no instruction determines order, either may lead.

FICTIONAL PATIENT EXAMPLE

Jordan has two independently established conditions; the workup, therapy and admission circumstances equally support each, and no sequencing rule applies.



CODING ANSWER / ACTION + WHY

Either verified condition may be principal. Document why the equal-criteria rule is met rather than choosing arbitrarily.

II.D

Comparative or contrasting conditions

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Rare either/or diagnoses at discharge are coded as established; sequence by admission circumstances. If undetermined, either may lead.

FICTIONAL PATIENT EXAMPLE

Jordan's final discharge diagnoses remain either one of two specified conditions after inpatient study.



CODING ANSWER / ACTION + WHY

Code both verified diagnoses under this rule; choose principal by the admission circumstances, not an outpatient uncertainty rule.

II.E

Deleted guideline

REFERENCE ONLY

GUIDELINE IN PLAIN LANGUAGE

This heading is deleted effective October 1, 2014. It is not a current rule to teach.

FICTIONAL PATIENT EXAMPLE

A student finds an old slide for II.E concerning symptoms followed by comparative diagnoses.



CODING ANSWER / ACTION + WHY

Do not apply the deleted rule. Use current II.D, II.H and other applicable guidance.

II.F

Original treatment plan not carried out

INPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

The condition that after study occasioned admission remains principal even if the intended treatment is not performed due to unforeseen circumstances.

FICTIONAL PATIENT EXAMPLE

Jordan is admitted for surgery for right knee osteoarthritis, but the planned operation is cancelled.

CODING ANSWER / ACTION + WHY

M17.11 remains principal if it occasioned the admission; add a supported cancellation reason as applicable.

II.G

Complications of surgery and medical care

INPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

When admission treats a complication, that complication is principal; add detail if the complication code lacks specificity.

FICTIONAL PATIENT EXAMPLE

Jordan is readmitted specifically to treat a documented procedure complication.

CODING ANSWER / ACTION + WHY

Verify the specific complication code first, plus required detail. Do not lead with the original reason for surgery.

II.H

Uncertain diagnosis

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

At qualifying hospital inpatient discharge, probable, suspected or similar diagnoses are coded as established. Some disease-specific confirmation rules override.



FICTIONAL PATIENT EXAMPLE

Jordan's final inpatient discharge diagnosis is probable pneumonia with organism unspecified.

CODING ANSWER / ACTION + WHY

J18.9. This does not mean a possible HIV or COVID diagnosis can ignore its special confirmation rule.

II.I.1

Admission following medical observation

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

If a medical condition worsens or does not improve in observation and prompts same-hospital inpatient admission, that condition is principal.



FICTIONAL PATIENT EXAMPLE

Jordan is observed for pneumonia, fails to improve and becomes an inpatient for it.

CODING ANSWER / ACTION + WHY

J18.9 principal if organism remains unspecified. Observation itself was outpatient care.

II.I.2

Admission following postoperative observation

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

For observation of a post-surgery condition followed by inpatient admission, apply the principal diagnosis definition to the inpatient admission.

FICTIONAL PATIENT EXAMPLE

Jordan develops a documented surgical complication, is observed and then admitted for its treatment.



CODING ANSWER / ACTION + WHY

The verified complication is principal when it chiefly occasioned admission, subject to applicable coding instructions.

II.J

Admission from outpatient surgery: complication

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

If inpatient admission after outpatient surgery is because of a complication, the complication leads.

FICTIONAL PATIENT EXAMPLE

Jordan's outpatient surgery is followed by documented acute postprocedural respiratory failure requiring inpatient admission.



CODING ANSWER / ACTION + WHY

Verify the complication code as principal. Do not automatically carry over the surgery diagnosis.

II.J

Admission from outpatient surgery: no other reason

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

If no complication or other reason for inpatient admission is documented, use the reason for outpatient surgery as principal.

FICTIONAL PATIENT EXAMPLE

Jordan undergoes outpatient surgery for right knee osteoarthritis and is admitted for continuing care; no other reason is documented.



CODING ANSWER / ACTION + WHY

M17.11 as principal under this defined scenario.

II.J

Admission from outpatient surgery: unrelated condition

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

If another unrelated condition occasions inpatient admission, that unrelated condition is principal.

FICTIONAL PATIENT EXAMPLE

After outpatient surgery, Jordan is admitted specifically for treatment of unrelated pneumonia.



CODING ANSWER / ACTION + WHY

J18.9 principal if organism is unspecified. The surgery diagnosis does not automatically lead.

II.K

Rehabilitation for residual condition

INPATIENT OR OUTPATIENT REHABILITATION

GUIDELINE IN PLAIN LANGUAGE

When rehabilitation treats a condition still present, code that condition first.

FICTIONAL PATIENT EXAMPLE

Jordan receives rehab for right dominant hemiplegia following a prior cerebral infarction.



CODING ANSWER / ACTION + WHY

I69.351 first. Rehab targets the persistent deficit.

II.K

Rehabilitation after joint replacement

INPATIENT OR OUTPATIENT REHABILITATION

GUIDELINE IN PLAIN LANGUAGE

If the treated original condition is no longer present, use applicable aftercare unless the rehabilitation follows an injury.

FICTIONAL PATIENT EXAMPLE

Jordan receives rehab after hip replacement for arthritis.



CODING ANSWER / ACTION + WHY

Z47.1 first, with applicable joint-presence detail. Do not treat the removed arthritis as still present in the replaced joint.

II.K

Rehabilitation following injury

INPATIENT OR OUTPATIENT REHABILITATION

GUIDELINE IN PLAIN LANGUAGE

For rehab after active injury treatment, use the injury code with the appropriate subsequent/healing character.

FICTIONAL PATIENT EXAMPLE

Jordan receives routine-healing rehab after replacement for a displaced right intertrochanteric femur fracture, closed.



CODING ANSWER / ACTION + WHY

S72.141D first under the example. Injury recovery follows the fracture pathway.

III

Reporting additional diagnoses

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

An additional diagnosis must affect care through evaluation, treatment, testing, extended stay or increased nursing/monitoring, with applicable rules satisfied.

FICTIONAL PATIENT EXAMPLE

Jordan develops documented acute kidney failure requiring treatment during the admission.



CODING ANSWER / ACTION + WHY

N17.9 as an additional diagnosis when type is unspecified. It affects the stay even though it was not principal.

III.A

Previous conditions

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Exclude resolved prior conditions with no bearing on the stay except as required by policy. Relevant personal/family history may be reported as secondary.

FICTIONAL PATIENT EXAMPLE

Jordan's remote resolved pneumonia has no impact on this stay.



CODING ANSWER / ACTION + WHY

Do not report active pneumonia from the old problem list. Add a history code only when supported and relevant.

III.B

Abnormal findings

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Abnormal test findings are not coded unless the provider indicates clinical significance; clarification may be appropriate when further evaluation or treatment occurs.

FICTIONAL PATIENT EXAMPLE

Jordan has an abnormal test but no provider statement of clinical significance.



CODING ANSWER / ACTION + WHY

Do not turn the result into a diagnosis. Query when the record supports clarification.

III.C

Uncertain additional diagnoses

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Qualifying uncertain diagnoses at final inpatient discharge are coded as established, subject to specific disease exceptions and reporting criteria.

FICTIONAL PATIENT EXAMPLE

Jordan's discharge says probable additional pneumonia and it was evaluated and treated.



CODING ANSWER / ACTION + WHY

J18.9 as an additional diagnosis when organism is unspecified. This is not the outpatient rule.

IV

Outpatient diagnostic coding and reporting

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Use outpatient rules for offices, clinics, ED, observation and ambulatory surgery; inpatient principal and uncertain-diagnosis rules do not transfer automatically.

FICTIONAL PATIENT EXAMPLE

Jordan is seen in the ED and discharged with possible appendicitis and right lower quadrant pain.



CODING ANSWER / ACTION + WHY

R10.31. Code the supported symptom, not unconfirmed appendicitis.

IV.A

Selection of first-listed condition

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Use first-listed, not principal, for outpatient visits. Apply classification and disease-specific priorities before selecting order.

FICTIONAL PATIENT EXAMPLE

Jordan's office visit evaluates left knee pain without an established cause.



CODING ANSWER / ACTION + WHY

M25.562 first-listed for this encounter. Start in the Index and verify the Tabular List.

IV.A.1

Outpatient surgery

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

The reason for outpatient surgery is first-listed even if a contraindication prevents the procedure.

FICTIONAL PATIENT EXAMPLE

Jordan presents for surgery for right knee osteoarthritis, but it is cancelled because of a documented contraindication.



CODING ANSWER / ACTION + WHY

M17.11 first-listed for the planned surgical encounter; add supported circumstances as applicable.

IV.A.2

Observation stay for a medical condition

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

For medical observation, the condition prompting observation is first-listed.

FICTIONAL PATIENT EXAMPLE

Jordan is observed for documented pneumonia without an identified organism.



CODING ANSWER / ACTION + WHY

J18.9 first-listed. Observation status does not permit inpatient uncertain-diagnosis coding.

IV.A.2

Observation following outpatient surgery

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

For complications after outpatient surgery requiring observation, the surgical reason remains first-listed and complications are secondary under this rule.

FICTIONAL PATIENT EXAMPLE

Jordan's outpatient surgery for right knee osteoarthritis is followed by a diagnosed complication requiring observation, not inpatient admission.



CODING ANSWER / ACTION + WHY

M17.11 first-listed, followed by the verified complication. Do not apply II.J to observation-only care.

IV.B

Codes for reasons for encounter

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Use the appropriate classification code for diagnosis, symptom, problem, complaint or other reason for the encounter.

FICTIONAL PATIENT EXAMPLE

Jordan's sole visit is vaccination.



CODING ANSWER / ACTION + WHY

Z23. A disease is not required for a valid encounter code.

IV.C

Accurate reporting of diagnosis codes

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

The documentation must describe the diagnosis, symptom or reason for care accurately enough to support the selected code.

FICTIONAL PATIENT EXAMPLE

Jordan's clinician documents right knee pain without a cause.



CODING ANSWER / ACTION + WHY

M25.561. Do not add an arthritis diagnosis from assumption.

IV.D

Codes that describe symptoms and signs

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

A symptom code is acceptable when no definitive related diagnosis is established.

FICTIONAL PATIENT EXAMPLE

Jordan has evaluated dizziness without a determined cause.



CODING ANSWER / ACTION + WHY

R42. Do not invent a disease merely to avoid a symptom code.

IV.E

Circumstances other than disease or injury

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Z codes describe services or circumstances other than an illness/injury; choose the encounter-specific option.

FICTIONAL PATIENT EXAMPLE

Jordan comes solely for asymptomatic HIV screening, without known exposure.



CODING ANSWER / ACTION + WHY

Z11.4. Do not code HIV infection.

IV.F.1

Codes with three through seven characters

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Code length varies. A three-character category is a complete code only when it has no required subdivision.

FICTIONAL PATIENT EXAMPLE

Jordan has essential hypertension without related heart or kidney disease.



CODING ANSWER / ACTION + WHY

I10 is complete. More characters are not automatically better when none are required.

IV.F.2

Use the full number of required characters

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

A code missing any required character, including a seventh character, is invalid.

FICTIONAL PATIENT EXAMPLE

Jordan receives active removal of an external left-eye foreign body, exact external part unspecified.



CODING ANSWER / ACTION + WHY

T15.92XA. Include X and the seventh character A.

IV.F.3

Highest supported specificity

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Select the most specific code the record supports, including documented side.

FICTIONAL PATIENT EXAMPLE

Jordan's record documents left knee pain.



CODING ANSWER / ACTION + WHY

M25.562 rather than unspecified knee pain. Do not guess more detail than the record provides.

IV.G

Reason chiefly responsible for services

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

List first the condition or reason chiefly responsible for services and add reportable coexisting conditions, subject to sequencing priorities.

FICTIONAL PATIENT EXAMPLE

Jordan's main office service treats cystitis; unrelated dizziness is also evaluated.



CODING ANSWER / ACTION + WHY

N30.00 first, then R42 in this defined visit. The care provided supports both.

IV.H

Uncertain diagnosis

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Do not code possible, probable, suspected or rule-out diagnoses as established. Report the highest certainty known.

FICTIONAL PATIENT EXAMPLE

Jordan is discharged from the ED with possible appendicitis and right lower quadrant pain.



CODING ANSWER / ACTION + WHY

R10.31. The unconfirmed appendicitis is not coded as established.

IV.I

Chronic diseases

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

A chronic disease treated on an ongoing basis may be coded at each encounter receiving treatment/care for that disease.

FICTIONAL PATIENT EXAMPLE

Jordan's hypertension is monitored and medication is adjusted at each follow-up.



CODING ANSWER / ACTION + WHY

I10 each applicable visit when uncomplicated essential hypertension is documented. Stability does not mean resolved.

IV.J

Code all documented conditions that coexist

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

Code documented coexisting conditions that require or affect care, treatment or management. Do not code resolved conditions as current; relevant history can be secondary.

FICTIONAL PATIENT EXAMPLE

Marisol Vega has acute cystitis without hematuria and separately evaluated unrelated dizziness.



CODING ANSWER / ACTION + WHY

N30.00 and R42. Both affect today's care. Routine dysuria is not separately coded; also see I.B.5-6.

IV.J

Resolved conditions and relevant history

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

A previous condition no longer present is not current disease. A history code may be secondary if it affects current care.

FICTIONAL PATIENT EXAMPLE

Marisol's old breast cancer is eradicated; that history changes today's management of another problem.



CODING ANSWER / ACTION + WHY

Z85.3 may be additional when relevant. Do not assign active breast cancer or history with no bearing on care.

IV.K

Diagnostic services only: reason for test

OUTPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

For a diagnostic-only encounter, list the documented reason chiefly responsible for the service; add reportable chronic conditions.

FICTIONAL PATIENT EXAMPLE

Jordan has a knee radiograph for left knee pain; the final report finds no definitive cause.

CODING ANSWER / ACTION + WHY

M25.562 first-listed. The symptom remains the test indication.

IV.K

Diagnostic services: definitive interpretation

OUTPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

When a physician's final diagnostic interpretation is available at coding, report the definitive diagnosis instead of its related symptoms.

FICTIONAL PATIENT EXAMPLE

Jordan has imaging for cough; the final physician interpretation confirms pneumonia, organism unspecified.

CODING ANSWER / ACTION + WHY

J18.9. Do not separately add related routine cough for this diagnostic encounter.

IV.K

Routine diagnostic testing

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

For routine lab/radiology testing with no symptoms or associated diagnosis, use the specific instruction for that service; IV.K directs Z01.89 in its stated circumstance.

FICTIONAL PATIENT EXAMPLE

Jordan attends routine laboratory testing without symptoms, known diagnosis, screening or another more specific encounter purpose.



CODING ANSWER / ACTION + WHY

Z01.89 under this defined rule. Do not use it when a specific screening/encounter code applies.

IV.L

Therapeutic services only

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

List the condition chiefly responsible for therapeutic services first, except where therapy-specific priorities apply.

FICTIONAL PATIENT EXAMPLE

Jordan receives therapy directed at a documented condition, without a special encounter-code rule.



CODING ANSWER / ACTION + WHY

Use that verified condition first; do not replace it with a generic therapy encounter code without instruction.

IV.L

Antineoplastic therapy exception

OUTPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

For encounters chiefly for antineoplastic therapy, follow the therapy encounter-code priority and add the cancer.

FICTIONAL PATIENT EXAMPLE

Jordan attends only for chemotherapy for active sigmoid colon cancer.

CODING ANSWER / ACTION + WHY

Z51.11 then C18.7. This differs from surgical or complication-directed care.

IV.M

Preoperative evaluations only

OUTPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

List the applicable preprocedural examination code first, then the surgery condition and findings addressed.

FICTIONAL PATIENT EXAMPLE

Jordan receives a general preprocedural examination before surgery for right knee osteoarthritis; no new findings.

CODING ANSWER / ACTION + WHY

Z01.818 then M17.11. Verify the examination type; a specific cardiovascular/respiratory evaluation may differ.

IV.N

Ambulatory surgery

OUTPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

Use the diagnosis for which surgery was performed; if a definitive postoperative diagnosis differs from the preoperative one, use the postoperative diagnosis.

FICTIONAL PATIENT EXAMPLE

Jordan has a preoperative suspected condition but surgery establishes a different definitive diagnosis.

CODING ANSWER / ACTION + WHY

Code the verified postoperative diagnosis. Do not keep a less definitive preoperative guess.

IV.O

Routine outpatient prenatal visits

OUTPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

Use the appropriate normal or high-risk pregnancy supervision code for routine prenatal care; a treated complication uses its own pathway.

FICTIONAL PATIENT EXAMPLE

Rae has routine normal first-pregnancy supervision in the second trimester, without complications.

CODING ANSWER / ACTION + WHY

Z34.02 and applicable gestational-week detail. Do not use normal supervision for a complication-management visit.

IV.P

General examination with abnormal findings

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

When a general exam identifies a new condition or change in severity, the with-abnormal-findings examination code leads; add the finding.

FICTIONAL PATIENT EXAMPLE

Jordan's routine adult exam newly diagnoses essential hypertension.



CODING ANSWER / ACTION + WHY

Z00.01 then I10. A stable pre-existing condition alone is not automatically a new abnormal finding.

IV.Q

Routine health screenings

OUTPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

The screening code leads when screening is the specific purpose; it may be additional when screening occurs during another visit. Diagnostic testing for symptoms is different.

FICTIONAL PATIENT EXAMPLE

Jordan receives an asymptomatic screening mammogram without known breast symptoms.



CODING ANSWER / ACTION + WHY

Z12.31. Do not use screening to describe workup of a breast symptom.