ICD-10-CM Guidelines
Worked Student Examples

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18 practical examples for your 2026 course books. Read the rule, picture the patient, then explain why the code or next step fits.

How to use this companion

1. Read the short patient scenario.

2. Find the cited section in the official guidelines.

3. Discuss the rule before looking at the suggested coding approach.

4. Verify all codes in the Alphabetic Index and Tabular List, including category-level notes.

Edition guide

Examples were checked against the FY2026 April guidelines and FY2026 code descriptions. This handout supplements your course presentation; it does not replace the complete official guidelines.

FY2026 original: October 1, 2025 onward, with the April 1, 2026 update for April 1-September 30, 2026. FY2027: October 1, 2026-September 30, 2027. Use the applicable release for actual dates of service or inpatient discharge dates. Confirm the exam’s assigned book year separately.

These are simplified teaching cases. They show the codes relevant to the stated rule, not every possible code for a complete claim. Add treatment/status or other codes only when supported and required.

01 Index first, Tabular verification

Official reference: I.A.1; I.B.1

PATIENT SCENARIO

A patient is evaluated for pain in the right knee. No cause is diagnosed.

GUIDELINE AND EXPLANATION

Locate Pain in the Alphabetic Index, follow the knee/joint entries, then verify the complete code and notes in the Tabular List.

Coding approach: M25.561 - Pain in right knee.

Watch for: Do not stop at an Index suggestion. Confirm laterality and all Tabular instructions.

02 Complete codes and specificity

Official reference: I.A.2-5; I.B.2

PATIENT SCENARIO

The provider documents type 2 diabetes without complications.

GUIDELINE AND EXPLANATION

E11 is a category with subdivisions. A reportable code must include the characters required for the documented condition.

Coding approach: E11.9 - Type 2 diabetes mellitus without complications.

Watch for: A category is not reportable when further subdivision is required. Do not add an undocumented complication.

03 Laterality: both knees

Official reference: I.B.13

PATIENT SCENARIO

The provider documents pain in both knees, with no established cause.

GUIDELINE AND EXPLANATION

This code family has right and left codes but no bilateral code. Report both supported sides.

Coding approach: M25.561 - Right-knee pain; M25.562 - Left-knee pain.

Watch for: Bilateral does not always mean one code. Do not choose a side from assumption.

04 NEC versus NOS

Official reference: I.A.6; I.A.9

PATIENT SCENARIO

The assessment says anemia but gives no type or cause.

GUIDELINE AND EXPLANATION

NOS means unspecified and reflects missing diagnostic detail. NEC means a specific condition is described but a unique code is not available. This case supports unspecified anemia.

Coding approach: D64.9 - Anemia, unspecified.

Watch for: Do not infer iron deficiency. NEC and NOS are not interchangeable.

05 Excludes1: alternatives for the same condition

Official reference: I.A.12.a

PATIENT SCENARIO

The provider diagnoses sleep-related teeth grinding.

GUIDELINE AND EXPLANATION

Review the Excludes1 relationship involving sleep-related bruxism and psychogenic teeth grinding. Do not assign both alternatives for the same teeth-grinding problem.

Coding approach: G47.63 - Sleep related bruxism.

Watch for: Unrelated conditions can be an exception to Excludes1. Query when the relationship is unclear.

06 Excludes2: both conditions may exist

Official reference: I.A.12.b

PATIENT SCENARIO

Acute sinusitis and chronic sinusitis are both documented and addressed. The sites are unspecified.

GUIDELINE AND EXPLANATION

An Excludes2 note permits reporting the excluded condition together when both exist and qualify for reporting. Check the Index and sequencing instructions as well.

Coding approach: J01.90 - Acute sinusitis, unspecified; J32.9 - Chronic sinusitis, unspecified.

Watch for: Excludes2 is permission when appropriate, not a requirement to add a condition the patient does not have.

07 Combination code

Official reference: I.B.9; I.C.4.a

PATIENT SCENARIO

The diagnosis is type 2 diabetes with diabetic polyneuropathy.

GUIDELINE AND EXPLANATION

Use the combination code that describes the diabetes and its complication. Do not separately code the same manifestation merely to duplicate the combination code.

Coding approach: E11.42 - Type 2 diabetes mellitus with diabetic polyneuropathy.

Watch for: Read any additional instructions for other documented conditions or treatment status.

08 Use additional code: CKD stage

Official reference: I.A.13; I.B.7; I.C.4.a; I.C.14.a

PATIENT SCENARIO

The provider documents type 2 diabetes with diabetic CKD, stage 3b.

GUIDELINE AND EXPLANATION

The diabetes-with-CKD code does not supply the CKD stage. Follow the additional-code instruction and the CKD code-first note.

Coding approach: E11.22 followed by N18.32 - CKD stage 3b.

Watch for: A combination code can still require an additional code. Stage information must be supported.

09 The word with: a presumed relationship

Official reference: I.A.15; I.C.4.a

PATIENT SCENARIO

The record lists type 2 diabetes and CKD stage 3b without saying they are unrelated.

GUIDELINE AND EXPLANATION

The classification links diabetes and CKD under with. Apply the presumed relationship unless documentation or a specific guideline says otherwise.

Coding approach: E11.22 and N18.32, subject to the record and applicable instructions.

Watch for: Do not presume a link for every pair of conditions. Check the classification; explicit unrelated documentation changes the analysis.

10 Acute and chronic conditions

Official reference: I.B.8

PATIENT SCENARIO

The provider documents both acute pancreatitis without necrosis or infection, unspecified cause, and chronic pancreatitis without a specified cause.

GUIDELINE AND EXPLANATION

When acute and chronic Index subentries exist at the same indentation level, code both and sequence the acute condition first.

Coding approach: K85.90 followed by K86.1.

Watch for: Do not apply this rule mechanically when a combination code or different classification instruction applies.

11 Symptoms without a confirmed diagnosis

Official reference: I.B.4-6; IV.D

PATIENT SCENARIO

At an office visit, the patient has fever. No cause is confirmed.

GUIDELINE AND EXPLANATION

A symptom code can describe the reason for the encounter when no definitive related diagnosis is established.

Coding approach: R50.9 - Fever, unspecified.

Watch for: Do not invent an infection because the patient has fever. Routinely integral symptoms generally are not separately coded once the related disease is confirmed.

12 Uncertain outpatient diagnosis

Official reference: IV.H

PATIENT SCENARIO

An office note documents acute cough, fever and possible pneumonia. No pneumonia diagnosis is confirmed.

GUIDELINE AND EXPLANATION

Outpatient rules require the highest degree of certainty. Possible pneumonia does not establish confirmed pneumonia in this office encounter.

Coding approach: R05.1 and R50.9 when both symptoms are supported and reportable.

Watch for: This rule also applies to emergency department and observation encounters. Certain inpatient discharge rules differ.

13 First-listed diagnosis and coexisting conditions

Official reference: IV.A; IV.G; IV.I-J

PATIENT SCENARIO

An office visit is chiefly for right-knee pain. The provider also evaluates and manages essential hypertension.

GUIDELINE AND EXPLANATION

List the reason chiefly responsible for the services first, subject to applicable sequencing instructions. Report the other current condition because it affects care.

Coding approach: M25.561 first-listed; I10 additionally in this simplified case.

Watch for: Do not report every condition in a copied problem list. Establish that it is current and requires or affects care.

14 Seventh character: active treatment

Official reference: I.A.5; I.C.19.a

PATIENT SCENARIO

A patient receives active treatment for a right-ankle sprain. The injured ligament is not specified.

GUIDELINE AND EXPLANATION

For this injury code, A identifies active treatment; it does not simply mean the first visit in the patient’s life for that injury.

Coding approach: S93.401A - Sprain of unspecified ligament of right ankle, initial encounter.

Watch for: Use the specific ligament when documented. Fracture categories can have different seventh-character choices.

15 Placeholder X and adverse effects

Official reference: I.A.4-5; I.C.19.e.5

PATIENT SCENARIO

The provider documents nausea caused by correctly prescribed and properly administered penicillin. Active treatment is provided.

GUIDELINE AND EXPLANATION

For an adverse effect, code the nature of the reaction first, followed by the drug adverse-effect code. Required X preserves the seventh-character position.

Coding approach: R11.0 followed by T36.0X5A.

Watch for: An overdose or wrong drug may follow poisoning rules instead. Do not classify every drug reaction as an adverse effect.

16 Sequela: residual problem after healing

Official reference: I.B.10; I.C.19.a

PATIENT SCENARIO

An old, healed burn leaves a scar requiring care. The original burn’s site and degree are missing.

GUIDELINE AND EXPLANATION

Generally report the residual condition first and the appropriate burn code with sequela character S second. The original cause needs enough detail for accurate selection.

Coding approach: L90.5 identifies the scar; the exact burn-sequela code requires further documentation.

Watch for: Do not invent a burn site or degree. No universal time limit defines when a sequela can be coded.

17 Screening versus diagnostic care

Official reference: I.C.21.c.5; IV.Q

PATIENT SCENARIO

An asymptomatic patient presents for a screening mammogram. No breast complaint prompted the study.

GUIDELINE AND EXPLANATION

Screening looks for disease in a person without symptoms. A study prompted by a symptom has a different coding analysis.

Coding approach: Z12.31 - Encounter for screening mammogram for malignant neoplasm of breast.

Watch for: A breast lump changes the encounter from this screening example. Evaluate the documented reason for testing.

18 Conflicting documentation: seek clarification

Official reference: I.B.14; I.A.19

PATIENT SCENARIO

The narrative says left-knee pain, but the final assessment says right-knee pain.

GUIDELINE AND EXPLANATION

The record conflicts about laterality. Follow the organization’s clarification process before finalizing the side-specific code.

Coding approach: No final side-specific code can be selected from this conflicting record alone.

Watch for: Do not silently pick one side or default to unspecified to avoid resolving the conflict.

Your coding checklist

- Is this an outpatient encounter or an inpatient discharge?
- What diagnosis or reason for care is actually documented?
- Did I locate the term in the Index and verify it in the Tabular List?
- Did I read Includes, Excludes, Code first and Use additional code notes?
- Are laterality, placeholders and required seventh characters complete?
- Is there a supported combination code?
- Do I need clarification instead of guessing?

Official sources

FY2026 April official guidelines

FY2026 official code descriptions, Index and Tabular files

FY2027 official guidelines and files

CDC ICD-10-CM files and updates

Companion to ICD10CM_Guidelines_Book_Excerpts.pptx. Section identifiers are provided rather than page numbers because pagination differs by edition.

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