Chapter 9 Guideline Teaching Guide

Corrina R. Lynch | CPC Preparation Course | 2026 Books
Introduction to CPT: Procedure Coding Foundations

CPT Instructions for Use, section/subsection notes and Appendix A; Medicare NCCI policies are identified separately. This is not an ICD-10-CM chapter guide. Course chapter numbers differ from official code-book chapter numbers. Selected teaching priorities; verify the complete rule and exceptions.

Find the Complete Service

Topic & reference	Rule, fictional example & reasoning
Index is a starting point CPT Instructions for Use; section notes	Locate candidates, then verify the full procedure description, section guidance and parenthetical instructions. **Example:** A documented two-view chest radiographic study leads to **71046**; verify views, service components and reporting context. **Why:** Do not select by a keyword alone or assume an Index reference is the final answer.
Full procedure versus a component CPT Appendix A: 26; HCPCS: TC; CMS PFS indicators	Determine whether the reporting clinician supplied the professional component, technical component or eligible global service. **Example:** Radiologist supplies only interpretation/report of an eligible two-view chest study: **71046-26**. **Why:** Do not report the full global service for interpretation alone. Component-only codes have different instructions.
Read the parenthetical directions CPT skin-biopsy instructions; CMS NCCI I.R	Notes can identify which primary procedure goes with an add-on code. **Example:** Two separate skin lesions receive tangential diagnostic biopsies: **11102 + 11103** when both meet the code requirements. **Why:** Use 11103 for the additional lesion; do not report 11102 twice for this scenario.
Add-on codes are not standalone CPT add-on conventions; CMS NCCI I.R	An add-on describes a qualifying additional service with an eligible primary procedure; do not attach modifier 51 to the add-on. **Example:** If **11103** is proposed alone for the only tangentially biopsied lesion, review and select the appropriate primary code instead. **Why:** The plus symbol in the book identifies add-on status; it is not part of the submitted code.

Class practice

Read the cited rule together. Identify the controlling words in the record, verify the complete code(s), then explain the answer before moving to a new case.

Included Services & Modifiers

Topic & reference	Rule, fictional example & reasoning
Do not unbundle included work CPT repair instructions; CMS NCCI I.B-I.C	Report the supported comprehensive service rather than separately billing its routine included steps. **Example:** A simple 2-cm forearm wound closure supports **12001** when all criteria apply; routine local infiltration by the repairing clinician is included. **Why:** Do not add a separate anesthesia service for that routine local infiltration.
Simple closure included in lesion excision CPT benign-lesion instructions; NCCI	Read inclusion rules even when the record separately describes a closure. **Example:** Excision of an eligible small benign lesion reported as **11400** includes its simple closure; do not add **12001** for that same closure. **Why:** An independently reportable repair depends on the actual repair type and applicable instructions.
Separate E/M on a procedure day CPT Appendix A: 25; CMS NCCI I.E	A significant, separately identifiable E/M beyond usual procedural work may be reported with modifier 25. **Example:** A separate established-patient evaluation meets low-MDM requirements on a minor-procedure day: **99213-25**, if all criteria are met. **Why:** The decision and routine evaluation for a minor procedure alone do not justify separate E/M.
Distinct non-E/M service CPT Appendix A: 59; CMS NCCI I.E	Only use an appropriate modifier when the documentation and applicable edit permit separate reporting. **Example:** Two procedures involve genuinely separate, supported circumstances: evaluate **XE, XP, XS, XU** or **59** when no more specific modifier fits. **Why:** Do not use 59 on E/M or merely to force payment. A Medicare edit with modifier indicator 0 cannot be bypassed with these modifiers.

Class practice

Read the cited rule together. Identify the controlling words in the record, verify the complete code(s), then explain the answer before moving to a new case.

Scope, Units & Payer Rules

Topic & reference	Rule, fictional example & reasoning
Global postoperative care CPT surgical package; CMS Global Surgery	Routine related follow-up may already be part of the surgical package. **Example:** A routine healing check by the same surgeon during the applicable global period does not automatically justify another paid **99213**. **Why:** Unrelated E/M and unplanned return procedures have specific modifier criteria; do not use them automatically.
Unlisted service rather than a near match CPT section unlisted instructions; CMS NCCI I.S	When no specific applicable code accurately describes the service, use the appropriate unlisted process with a supporting report. **Example:** A service not described by a specific code should not be forced into a similar but inaccurate code. Select the appropriate unlisted code only after checking the full code set. **Why:** Document the actual work and follow payer submission instructions. A code's existence does not guarantee coverage.
Count services according to code rules CPT full description; CMS NCCI I.R and MUE policies	Units reflect the code's defined service, not automatically each action, image or instrument used. **Example:** For a two-view chest study represented by **71046**, do not bill two units merely because two images/views were obtained. **Why:** Verify the actual study and unit instructions. Do not confuse additional views with repeat studies.
Procedure, diagnosis and supplies differ CPT scope; ICD-10-CM purpose; HCPCS Level II	Use the appropriate code set for the documented service, reason and separately reportable item. **Example:** A two-view chest study for unexplained cough may involve **71046** for the service and **R05.9** for the supported diagnosis. **Why:** A separately reportable drug or item may require HCPCS Level II. Do not turn a diagnosis code into a procedure or assume every supply is separately payable.

Ask for the evidence

What is documented? Which rule applies? What complete code(s) and sequence follow? Why is the alternative wrong? Verify each code in the Index and Tabular List or the CPT section, as applicable.

Sources & use

2026 Medicare NCCI Policy Manual, Chapter I; CMS Global Surgery; AMA CPT categories and unlisted services. Use the licensed 2026 CPT Professional book for complete official instructions. CPT rules and Medicare payment policies are not interchangeable. All examples are fictional and rules are paraphrased. Additional reportable diagnoses/status codes depend on the full record. Reviewed November 9, 2026.