

Inclusion Criteria	
30400	Primary rhinoplasty, lateral and alar cartilages, and/or tip
30410	Primary rhinoplasty, bony pyramid, lateral and alar cartilage, and/or tip
30420	Primary rhinoplasty, bony pyramid, lateral and alar cartilages and/or tip, including major septal repair
30430	Secondary rhinoplasty, minor revision (nasal tip)
30435	Secondary rhinoplasty, intermediate revision (bony work with osteotomies)
30450	Secondary rhinoplasty, major revision (nasal tip and osteotomies)
30460	Cleft rhinoplasty, including columellar lengthening, tip only
30462	Cleft rhinoplasty, including columellar lengthening, tip, septum, and osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection with or without cartilage scoring, contouring, replacement with graft
Patient Comorbidities	
305.1, V15.82	Tobacco use
446.4, 135, 733.99, 710.0, G8859, G8860	Autoimmune disease
042, 279.x, 203.x, 204.x, 205.x, 206.x, 207.x, 288.x	Immunodeficiency
295.x, 296.x, 297.x, 298.x, 300.x, 301.x, 303.x, 304.x, 311.x	Psychiatric disorders
Patient Diagnoses	
V50.1	Plastic surgery for unacceptable cosmetic appearance
470	Deviated nasal septum (acquired)
478	Hypertrophy of nasal turbinate
478.19	Nasal airway obstruction or perforation
738	Acquired nasal deformity
748.1	Congenital nasal deformity
754	Congenital nasal or septal deformity
905	Late effect of craniofacial fracture
733.81	Malunion of nasal or septal fixation
959.09	Nose or septum injury
Other Surgical Procedures	
30130, 30140, 30930, 30801, 30802	Inferior turbinate reduction or outfracture
30560	Lysis of synechia
20912	Septal cartilage graft
21210	Bone graft to nose
21230	Rib cartilage graft to nose
21235	Ear cartilage graft to nose
30310, 20670, 20680	Removal of nasal foreign body, deep or superficial implant

# Icd 9 Procedure Codes 2011

**Carol J. Buck**



## **Icd 9 Procedure Codes 2011:**

*ICD-9-CM Inpatient Coding Reference and Study Guide* Ba Kobayashi, 2010-07 If you need to have a strong understanding of how ICD 9 CM diagnosis and procedure codes are determined then you have chosen the right book ICD 9 CM Inpatient Coding Reference and Study Guide The author designed a book that goes beyond the fundamentals that gets into the details of ICD 9 CM diagnosis and procedure code assignment as would be experienced on the job This user friendly reference teaches coders how to handle many coding situations while also being comprehensive enough to teach someone with a basic knowledge of medical coding how to move to the next level of advanced inpatient coding Updated every year to reflect the annual ICD 9 CM coding changes the text enables HIM professionals to master the concepts of medical coding while also gaining critical knowledge to pass the CCS exam administered by AHIMA and the CPC H exam from the AAPC The book also serves as an excellent desk reference and resource for coders who need to refresh their ICD 9 CM coding skills Among the topics covered in Volume 1 are inpatient coding guidelines coding conventions coding tables and a drug reference However the heart of this manual is the body system analysis based on chapters 1 17 of the Tabular list in Volume I of the ICD 9 CM Official Coding Guidelines The chapters are categorized by body system such as respiratory digestive et al The chapters in this study guide follow the same sequence as the Official Coding Guidelines All chapters in addition to highlighting basic coding guidelines contain situation based coding tips and coding examples A quiz follows each chapter reinforcing concepts in a rigorous manner that applies directly to the professional coding environment The book also contains a selective discussion of invasive procedures that the coder will most likely encounter on the job and on the exam At the end of ICD 9 CM Inpatient Coding Reference and Study Guide are 15 case studies providing the reader with an opportunity to assess their ICD 9 CM coding skill set and speed at coding inpatient medical records Each record contains a face sheet history physical progress notes and answer sheet Some of the case studies contain ER reports consultations as well as operative and pathology reports The answer key at the end of this study guide contains a rationale for all code assignments 456 short answer questions 116 multiple choice questions 15 full medical record case studies Each question is highly relevant and reflects a coding situation most hospital based inpatient coders will face The text strives to ensure the reader understands every diagnosis and procedure discussed thorough discussion of symptoms standard treatment protocols and medications Coding examples and quizzes help clarify the information presented Linda Kobayashi BA RHIT CCS has been a coder and coding manager for almost 20 years Since 1998 Ms Kobayashi has owned and operated Codebusters Inc a nationwide coding consulting company Widely regarded as a medical coding and auditing expert she has conducted workshops on a variety of coding topics including CCS Exam preparation workshops Throughout her career the author has remained professionally active as an AHIMA member as well as a member of her state association CHIA California health Information Association Her formal training includes a teaching credential from California State University Los Angeles a B A degree in English Literature

from University of California Los Angeles an RHIT from AHIMA after completing the RHIT program at East Los Angeles College and a CCS certificate from AHIMA Extensive experience as a hands on coder auditor and educator and has given the author the expertise to help coders prepare for the professional coding environment

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information to help you appropriately code related procedures Use Additional Digit s symbol in the index identifies codes that require an additional digit to remind you to check the tabular The Official Guidelines for Coding and Reporting OGCR are listed within the lists of codes and in a separate index for fast easy access to the coding rules when you need them Items provide detailed information on common diseases and conditions helping you code more effectively Symbols throughout the text alert you to new revised and deleted codes and clearly identify codes that require special consideration before assigning symbols including Unacceptable Principal Diagnosis Use Additional Includes and Excludes Non OR Procedure Code First Present on Admission Hospital Acquired Condition and CC and MCC Additional hints tips and definitions within specific codes provide extra guidance in coding anatomy pathophysiology or other coding directions References to the American Hospital Association s Coding Clinics help you find expanded information about specific codes and their usage Age and Sex edits alert you to codes that are used only with patients of a specific age or sex helping to ensure accurate reporting Omit and Code Also codes highlight government text needing special attention Coding updates on the companion codingupdates.com website keep you informed of changes to ICD codes

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*Federal Register*,2013-08

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