



DESK REFERENCE

Coders' Desk Reference for ICD-10-PCS Procedures

Clinical descriptions with answers to your
toughest ICD-10-PCS coding questions

2022

optum360coding.com

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Introduction

Coding is a complicated business. It is not enough to have a current copy of an ICD-10-PCS book—coders must have a firm enough grasp of medical terminology, anatomy, and surgical techniques to be able to translate procedure descriptions in medical records into detailed codes. ICD-10-PCS guidelines state that the physician is not responsible for changing the common procedure terminology he or she uses to document procedures so that it better matches terminology used in the coding system. Rather, the burden is on the coder, who must interpret physicians' procedure descriptions and reflect them in the appropriate ICD-10-PCS codes. The *Coders' Desk Reference for ICD-10-PCS Procedures* addresses this challenge.

This book provides coders, coding managers, medical staff and health care professionals, payers, educators, and students with comprehensive, clear descriptions of procedures. The goal is to enrich users' clinical understanding of surgical procedures and how they relate to the way ICD-10-PCS classifies procedures. The result is improved coding confidence so that code selection becomes more accurate and efficient. The coding guidance in *Coders' Desk Reference for ICD-10-PCS Procedures* is based on the official version of the ICD-10 Procedure Coding System (ICD-10-PCS), effective October 1, 2020. (Please note that this procedure coding reference is intended to be used with an official ICD-10-PCS code book.)

This desk reference is organized by common procedure nomenclature used in the hospital setting, which is linked to the related root operation tables. The procedures are described in layman's terms, translated to ICD-10-PCS root operation terminology, and the corresponding root operation tables are identified.

Detailed descriptions using terminology coders see in medical documents, together with coding clarification and guidance and important instruction regarding ICD-10-PCS conventions, make *Coders' Desk Reference for ICD-10-PCS Procedures* an unparalleled guidebook to code selection.

Important Message: Not all categories, subcategories, or procedures have been represented in this edition of the *Coders' Desk Reference for ICD-10-PCS Procedures*. Additional procedures not part of the 2021 edition will gradually be incorporated into future editions.

ICD-10-PCS Overview

ICD-10-PCS Code Structure

ICD-10-PCS has a multi-axial, seven-character, alphanumeric code structure. Each character contains up to 34 possible values. Each value represents a

specific option for the general character definition. The 10 digits 0–9 and the 24 letters A–H, J–N, and P–Z may be used for each character. The letters O and I are not used so as to avoid confusion with the digits 0 and 1.

An ICD-10-PCS code is the result of a process rather than a single fixed set of digits or alphabetic characters. The process consists of combining semi-independent values from among a selection of values, according to the rules governing the construction of codes. A code is derived by choosing a specific value for each of the seven characters. Based on details about the procedure performed, values are assigned for each character specifying the section, body system, root operation, body part, approach, device, and qualifier. Because the definition of each character is also a function of its physical position in the code, the same letter or number placed in a different position in the code has a different meaning.

The seven characters that make up a complete code have specific meanings that vary for each of the 17 sections of the manual. Procedures are divided into sections that identify the general type of procedure (e.g., Medical and Surgical, Obstetrics, Imaging). The first character of the procedure code always specifies the section. The second through seventh characters have the same meaning within each section but may mean different things in other sections. In all sections, the third character specifies the general type, or root operation, of procedure performed (e.g., Resection, Transfusion, Fluoroscopy), while the other characters give additional information such as the body part and approach.

ICD-10-PCS Index

Codes may be found in the index based on the general type of procedure (e.g., Resection, Transfusion, Fluoroscopy), or a more commonly used term (e.g., appendectomy). For example, the code for percutaneous intraluminal dilation of the coronary arteries with an intraluminal device can be found in the ICD-10-PCS index under "Dilation" or a synonym for dilation (e.g., "Angioplasty"). The index then specifies the first three or four values of the code or directs the user to see another term.

The user can use the alphabetic index to locate the appropriate table containing all the information necessary to construct a procedure code. The PCS tables should always be consulted to find the most appropriate valid code. Coders may choose a valid code directly from the tables; they do not have to consult the index before proceeding to the tables to complete the code.

ICD-10-PCS Official Guidelines for Coding and Reporting 2022

Narrative changes appear in **bold** text.

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). These guidelines should be used as a companion document to the official version of the ICD-10-PCS as published on the CMS website. The ICD-10-PCS is a procedure classification published by the United States for classifying procedures performed in hospital inpatient health care settings.

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-PCS: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-PCS itself. They are intended to provide direction that is applicable in most circumstances. However, there may be unique circumstances where exceptions are applied. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tables, Index and Definitions of ICD-10-PCS, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-PCS procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The procedure codes have been adopted under HIPAA for hospital inpatient healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.

Conventions

A1. ICD-10-PCS codes are composed of seven characters. Each character is an axis of classification that specifies information about the procedure

performed. Within a defined code range, a character specifies the same type of information in that axis of classification.

Example:

The fifth axis of classification specifies the approach in sections 0 through 4 and 7 through 9 of the system.

A2. One of 34 possible values can be assigned to each axis of classification in the seven-character code: they are the numbers 0 through 9 and the alphabet (except I and O because they are easily confused with the numbers 1 and 0). The number of unique values used in an axis of classification differs as needed.

Example:

Where the fifth axis of classification specifies the approach, seven different approach values are currently used to specify the approach.

A3. The valid values for an axis of classification can be added to as needed.

Example:

If a significantly distinct type of device is used in a new procedure, a new device value can be added to the system.

A4. As with words in their context, the meaning of any single value is a combination of its axis of classification and any preceding values on which it may be dependent.

Example:

The meaning of a body part value in the Medical and Surgical section is always dependent on the body system value. The body part value 0 in the Central Nervous body system specifies Brain and the body part value 0 in the Peripheral Nervous body system specifies Cervical Plexus.

A5. As the system is expanded to become increasingly detailed, over time more values will depend on preceding values for their meaning.

Example:

In the Lower Joints body system, the device value 3 in the root operation Insertion specifies Infusion Device and the device value 3 in the root operation Replacement specifies Ceramic Synthetic Substitute.

A6. The purpose of the alphabetic index is to locate the appropriate table that contains all information

Root Operation Definitions for Other Sections

1 Obstetrics		Definition	
ICD-10-PCS Value		Definition	
2	Change	Definition:	Taking out or off a device from a body part and putting back an identical or similar device in or on the same body part without cutting or puncturing the skin or a mucous membrane
		Explanation:	None
		Examples:	Replacement of fetal scalp electrode
9	Drainage	Definition:	Taking or letting out fluids and/or gases from a body part
		Explanation:	None
		Examples:	Biopsy of amniotic fluid
A	Abortion	Definition:	Artificially terminating a pregnancy
		Explanation:	None
		Examples:	Transvaginal abortion using vacuum aspiration technique
D	Extraction	Definition:	Pulling or stripping out or off all or a portion of a body part by the use of force
		Explanation:	None
		Examples:	Low-transverse C-section
E	Delivery	Definition:	Assisting the passage of the products of conception from the genital canal
		Explanation:	None
		Examples:	Manually-assisted delivery
H	Insertion	Definition:	Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part
		Explanation:	None
		Examples:	Placement of fetal scalp electrode
J	Inspection	Definition:	Visually and/or manually exploring a body part
		Explanation:	Visual exploration may be performed with or without optical instrumentation. Manual exploration may be performed directly or through intervening body layers.
		Examples:	Bimanual pregnancy exam
P	Removal	Definition:	Taking out or off a device from a body part, region or orifice
		Explanation:	If a device is taken out and a similar device put in without cutting or puncturing the skin or mucous membrane, the procedure is coded to the root operation CHANGE. Otherwise, the procedure for taking out a device is coded to the root operation REMOVAL.
		Examples:	Removal of fetal monitoring electrode
Q	Repair	Definition:	Restoring, to the extent possible, a body part to its normal anatomic structure and function
		Explanation:	Used only when the method to accomplish the repair is not one of the other root operations
		Examples:	In utero repair of congenital diaphragmatic hernia

LOC	level of consciousness/loss of consciousness	MBS	modified barium swallow
LOM	limitation of motion	MCAD	medium chain acyl CoA dehydrogenase deficiency
LOP	left occiput posterior position	mcg	microgram
LOPS	loss of protective sensation	MCGR	magnetically controlled growing rod
LOS	length of stay	MCH	mean corpuscular hemoglobin
LOT	left occiput transverse position	MCHC	mean corpuscular hemoglobin concentration
LP	lumbar puncture	MCI	mild cognitive impairment
LPC	licensed professional counselor	MCL	midclavicular line
LPM	liters per minute	MCP	metacarpophalangeal
LPT	lymphatic pump treatment	MCT	mediastinal chest tube
LR	lactated Ringer's/log roll	MCV	mean corpuscular volume
LS	lumbar sacral	MD	manic depression/ medical doctor/ muscular dystrophy/myocardial disease
LSA	left sacrum anterior position	MDC	major diagnostic category
LSB	left sternal border	MDD	manic-depressive disorder
LSF	lumbar spinal fusion	MDS	myelodysplastic syndrome
LSH	laparoscopic supracervical hysterectomy	Mec	meconium
LSO	lumbar sacral orthosis	MED	minimal effective dose
LT	left	med/surg	medical, surgical
LTC	long term care	meds	medications
LUCL	lateral ulnar collateral ligament	MELAS	mitochondrial encephalopathy, lactic acidosis and stroke-like episodes
lul	left upper lobe	MEN	multiple endocrine neoplasia
luq	left upper quadrant	MEP	motor evoked potentials
LUTS	lower urinary tract symptoms	mEq	milliequivalent
LV	left ventriculography/ left ventricle	mEq/1	milliequivalent per liter
LVAD	left ventricular assist device	MERRF	myoclonus with epilepsy and with ragged red fibers
LVAS	left ventricle assist system	MFD	minimum fatal dose
LVB	lymphovenous bypass	MFR	myofascial release
LVHA	low velocity-high amplitude	MFT	muscle function test
LVO	large vessel occlusion	Mg	magnesium
lymphs	lymphocytes	mg	milligram
lytes	electrolytes	MH/CD	mental health/chemical dependency
M	manifest refraction/male	MH/SA	mental health/substance abuse
M1	mitral first sound	MHC	mental health clinic
M2	mitral second sound	MI	myocardial infarction
m ²	meters squared	min	minimum/minimal/minute
MA1	volume respirator	MIRPE	minimally invasive repair of pectus excavatum
MAA	macroaggregated albumin	misc.	miscellaneous
MAC	maximum allowable cost/monitored anesthesia care	MIVAT	minimally invasive video-assisted thyroidectomy
MALT	mucosa associated lymphoid tissue	ML	midline
man. prim.	first thing in the morning	ml	milliliter
MAO	monoamine oxidase (inhibitor)	MLC	midline catheter
MAP	mean arterial pressure	mm	millimeter
MARS	molecular adsorbent recirculating system	mmHg	millimeters of mercury
MASER	microwave amplification by stimulated emission of radiation		
MBC	minimum bactericidal concentration/ maximum breathing capacity		
MBD	minimal brain dysfunction		

Procedure Eponyms

Eponym	Description	ICD-10-PCS Table Reference
Abbe	Vaginal construction — creation of vaginal canal (vaginoplasty) without graft or prosthesis	0UQG Repair Vagina
Abbe	Vaginal construction — creation of vaginal canal (vaginoplasty) with graft or prosthesis	0UUG Supplement Vagina
AbioCor®	Implantation of total internal biventricular heart replacement system	02RK Replacement Ventricle, Right 02RL Replacement Ventricle, Left
Aburel	Intra-amniotic injection of abortifacient for abortion	10A Abortion Pregnancy
Adams	Excision of palmar fascia for release of Dupuytren's contracture	0JB Excision Subcutaneous Tissue and Fascia
Adams	Advancement of round ligament(s) of uterus	0US9 Reposition Uterus
Adams	Crushing of nasal septum	09SM Reposition Nasal Septum
AESOP®	Robotic assisted procedures — Automated Endoscopic System for Optimal Positioning	8E0 Other Procedures Physiological Systems and Anatomical Regions
Albee	Bone peg, femoral neck Graft for slipping patella Sliding inlay graft, tibia	0QU Supplement Lower Bones
Albert	Arthrodesis, knee	0SG Fusion Lower Joints
Aldridge (-Studdiford)	Urethral sling	0TSD Reposition Urethra
Alexander	Shortening of round ligaments of uterus	0US9 Reposition Uterus
Alexander-Adams	Shortening of round ligaments of uterus	0US9 Reposition Uterus
Almoor	Extrapetrosal drainage	099 Drainage Ear, Nose, Sinus
Altemeier	Perineal rectal pull-through operation	0DTP Resection Rectum
Ammon	Dacryocystotomy incision (for drainage) of a lacrimal sac	089 Drainage Eye
Anderson	Tibial lengthening	0Q8 Division Lower Bones 0QR Replacement Lower Bones 0QU Supplement Lower Bones
Anderson-Hynes	Dismembered Pyeloplasty	0TQ Repair Urinary System
Anel	Dilation of lacrimal duct	087X Dilation Lacrimal Duct, Right 087Y Dilation Lacrimal Duct, Left
Arslan	Fenestration of inner ear	09QD Repair Inner Ear, Right 09QE Repair Inner Ear, Left
Asai	Laryngoplasty	0CQS Repair Larynx 0CRS Replacement Larynx 0CUS Supplement Larynx
Baffles	Interatrial transposition of venous return	02U5 Supplement Atrial Septum
Baffle	Atrial/interatrial/intra-atrial transposition of venous return	02U5 Supplement Atrial Septum
Baldy-Webster	Uterine suspension	0US9 Reposition Uterus

Biopsy, Lymph Node

Body System

Lymphatic and Hemic Systems

PCS Root Operation

Excision

Extraction

Root Operation Table

07B Lymphatic and Hemic Systems, Excision

07D Lymphatic and Hemic Systems, Extraction

Body Part

Lymphatic, Head

Lymphatic, Right Neck

Lymphatic, Left Neck

Lymphatic, Right Upper Extremity

Lymphatic, Left Upper Extremity

Lymphatic, Right Axillary

Lymphatic, Left Axillary

Lymphatic, Thorax

Lymphatic, Internal Mammary, Right

Lymphatic, Internal Mammary, Left

Lymphatic, Mesenteric

Lymphatic, Pelvis

Lymphatic, Aortic

Lymphatic, Right Lower Extremity

Lymphatic, Left Lower Extremity

Lymphatic, Right Inguinal

Lymphatic, Left Inguinal

Approach

Open (Excision)

Percutaneous

Percutaneous Endoscopic

Via Natural or Artificial Opening Endoscopic (Extraction)

Qualifier

Diagnostic

Description

The lymphatic system picks up clear fluid that naturally leaks from blood vessels in the extremities and carries the fluid toward the chest, where it reenters blood circulation at the subclavian veins. Along the lymphatic channels are lymph nodes, which act as spongy filters to collect potentially dangerous cells to prevent spread of disease. Infectious agents and cancer cells may be captured by the lymph nodes, and biopsy identifies the infectious agent or extent of metastasis. Biopsy of lymph nodes may also be performed to diagnose conditions such as sarcoidosis or lymphoma.

A "sentinel node" is the lymph node immediately downstream, along the lymphatic chain, from a cancer site. In sentinel lymph node biopsy (SLNB) the sentinel

node(s) are identified and excised for pathologic examination. In lymph node sampling (LNS), multiple

nodes within an anatomical lymphatic chain (body part) are excised for pathologic examination. This is usually performed to stage a malignancy.

Excision

In LNS, the physician removes multiple lymph nodes using an Open or Percutaneous Endoscopic approach. The physician makes a small incision through the skin overlying the lymph node(s) in an Open approach to excise tissue. In a Percutaneous Endoscopic approach, the physician insufflates the targeted site and uses a laparoscope to dissect the nodes. In SLNB, an injection of a radiolabeled colloid or dye may precede surgery. This injection into the lymphatic channel helps the physician identify the lymph node nearest the malignancy. SLNB may also be performed using an Open or Percutaneous Endoscopic approach.

Extraction

In some cases, the sampling site is accessible by needle and a large tissue sample is not needed. When this occurs, fine needle aspiration (FNA) may be performed. In FNA, the physician aspirates a small amount of tissue into a needle. This may require radiologic guidance. Report the root operation Extraction for FNA.

Extraction is also reported for transbronchial needle aspiration (TBNA) lymph node biopsy, for which the approach is reported as Percutaneous Endoscopic. In TBNA, a bronchoscope is inserted and advanced through the nasal or oral cavity past the larynx to inspect the bronchus. The physician uses an FNA needle within the scope device to obtain one or more lymph node samples. The needle is inserted through the bronchial wall and into the lymph node(s). This is usually performed under endobronchial ultrasound (EBUS) guidance. The approach Percutaneous Endoscopic is used as the bronchoscope was used to help access the operative site (lymph node) via puncture through the bronchus (transbronchial).

Focus Point

The purpose of the procedure is to biopsy a sampling of lymphatic tissue rather than remove an entire string of interconnected lymph nodes. Since only a portion of the lymphatic chain (body part) is excised, the sampling procedure is reported as Excision, not Resection. Use Excision when the procedure is documented as a "regional lymph node excision" or "extended regional lymph node excision."

Focus Point

According to ICD-10-PCS guideline B3.4a, lymph node sampling for biopsy is coded to the root operation Excision with the qualifier Diagnostic.

Insertion, Cardiac Lead(s) (continued)

Focus Point

If a lead is displaced and needs only repositioning, the root operation Revision is reported with the body part Heart and the device value Cardiac Lead. See also Adjustment, Cardiac Pacemaker Lead(s).

Focus Point

Report the ICD-10-PCS device value according to the type of cardiac generator device the lead is attached to, rather than the manufacturer's designation as pacing or defibrillator. Some devices combine a pacemaker and ICD in one unit for patients who may require both. After the shock is delivered by the defibrillator lead, a pacing mode is available if needed intermittently.

Focus Point

Two codes are necessary if a lead is replaced. Use a code with the root operation Removal, Cardiac Lead, Heart and one with the root operation, Insertion, Cardiac Lead Pacemaker or Defibrillator, with the appropriate body part value.

Coding Guidance

AHA: 2018, 2Q, 19; 2015, 3Q, 32, 33; 2012, 4Q, 104

Insertion, Cardiac Pacemaker Generator

See also Insertion, Cardiac Lead(s)

Body System

Subcutaneous Tissue and Fascia

PCS Root Operation

Insertion

Root Operation Table

ØJH Subcutaneous Tissue and Fascia, Insertion

Body Part

Subcutaneous Tissue and Fascia, Chest

Subcutaneous Tissue and Fascia, Abdomen

Approach

Open

Device

Pacemaker, Single Chamber

Pacemaker, Single Chamber Rate Responsive

Pacemaker, Dual Chamber

Description

A pacemaker is an implantable cardiac device that controls the heart's rhythm and maintains regular beats using artificial electric discharges. This device consists of the generator with a battery and the electrodes, or leads. A single-chamber pacemaker has one lead in the right atrium or ventricle. A dual-chamber pacemaker has one lead in the right atrium and one in the right ventricle. Most modern

pacemakers have rate responsive capability in which a sensor detects differences in activity or respiratory rates and adjusts accordingly.

The root operation Insertion describes the implantation of the generator. An Open approach is used to make an incision into the subcutaneous tissue, creating a pocket either below the clavicle (chest), often referred to as prepectoral, or less commonly in an upper abdominal location. The generator is inserted into the pocket. Once the lead(s) are placed, they are tested and connected to the generator, and the pocket incision is closed. Insertion of the lead(s) is not included and must be coded additionally. See also Insertion, Cardiac Lead(s), for the description of the lead placement.

Focus Point

A single-chamber system may be converted to a dual-chamber system. The existing pacemaker generator pocket is opened and the single-chamber generator removed. The dual-chamber generator is then placed into the existing pocket. The existing pacer wire is tested and connected to the generator. A second lead is placed and tested. The pocket is closed. The root operation Removal, Cardiac Rhythm Related Device, Subcutaneous Tissue and Fascia of Trunk is used for the removal of the single-chamber generator along with Insertion, Pacemaker, Dual Chamber and Insertion, Cardiac Lead, Pacemaker into the appropriate location.

Recession, Extraocular Muscle

Body System

Eye

PCS Root Operation

Reposition

Root Operation Table

08S Eye, Reposition

Body Part

Extraocular Muscle, Right

Extraocular Muscle, Left

Approach

Open

Description

Recession of the extraocular muscle(s) is performed to correct strabismus or misaligned eyes, which interferes with normal binocular vision. Common types of strabismus are esotropia, exotropia, hypotropia, and hypertropia. During a recession, the extraocular muscle is detached and moved posteriorly along the surface of the eye. This lengthens the muscle, resulting in better eye alignment.

Using an Open Approach, the physician makes incisions in the conjunctiva about 7 mm posterior to the juncture of the sclera and cornea (the limbus) in the superior nasal quadrant of the globe. An incision is made to expose the sclera, and a muscle hook is used to engage the extraocular muscle initially. The tendon of the superior oblique may be located about 12 mm behind the medial or nasal edge of the insertion of the superior rectus. The physician recesses the muscle by detaching it and moving it posteriorly. The muscle is secured with sutures. The operative wound is closed with layered sutures.

During strabismus surgery, the extraocular muscle is isolated far posterior to its insertion. The borders or edges of the muscle are sutured to the eye posterior to the original insertion point in what is commonly called the Faden procedure. The surgical wound is closed with sutures. This posterior fixation suturing technique on an extraocular muscle is done in conjunction with the strabismus surgery.

Focus Point

There is no body part value for bilateral extraocular muscle recession. If the procedure is performed bilaterally, two codes must be assigned using the appropriate body part values (Right, Left).

Sinuplasty (Balloon Sinuplasty, Balloon Sinus Dilation (BSD))

Body System

Ear, Nose, Sinus

PCS Root Operation

Repair

Root Operation Table

09Q Ear, Nose, Sinus, Repair

Body Part

Maxillary Sinus, Right

Maxillary Sinus, Left

Frontal Sinus, Right

Frontal Sinus, Left

Sphenoid Sinus, Right

Sphenoid Sinus, Left

Approach

Percutaneous Endoscopic

Description

Balloon sinuplasty is a minimally invasive treatment that provides relief of chronic sinusitis symptoms by opening blocked sinus passageways in the frontal, sphenoid, and maxillary sinuses with a small, flexible sinus balloon catheter. No tissue is removed, and there is minimal bleeding during the procedure.

The physician uses an endoscope for surgical access to perform balloon dilation of the sinuses. Following application of a vasoconstrictor and with the patient

under appropriate anesthesia, the physician inserts a sinus guide cannula and positions it near the entrance of the involved sinus under endoscopic visualization. Using fluoroscopic guidance, the physician inserts a sinus guidewire through the cannula and into the sinus ostium. The physician advances a catheter with an attached balloon over the guidewire, through the cannula, and into the targeted sinus. Once correct placement is confirmed, the balloon is inflated using a radiopaque fluid. The balloon is left inflated for several seconds and then deflated; repositioning and reinflation may be necessary. Following deflation and removal of the balloon, the endoscope is used to inspect the sinus.

Focus Point

Repair is the most appropriate root operation to use for this procedure, as there is no specific code for dilation of the sinus. There is no sinus body part in the 097 Dilation, Ear, Nose and Sinus table.

Focus Point

If balloon sinuplasty procedures are performed on more than one designated sinus body part, a procedure code for each body part is reported separately using all appropriate body part values, according to guideline B4.3.

Coding Guidance

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