

Coders' Desk Reference for ICD-10-PCS Procedures

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

SAMPLE



2025

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Main Terms

The alphabetic index reflects the structure of the tables. The index:

- Is based on the value of the third character
- Contains common procedure terms
- Lists anatomic sites
- Uses device terms

The main terms in the alphabetic index are root operations, root procedure types, or common procedure names. The index provides at least the first three or four values of the code, and some entries may provide complete valid codes. However, the user should always consult the appropriate table to verify that the most appropriate valid code has been selected.

For the Medical and Surgical and related sections, the root operation values are used as main terms in the index. The subterms under the root operation main terms are body parts. For the Ancillary section of the code tables, the main terms in the index are the general type of procedure performed.

The second type of term in the index uses common procedure names, such as "appendectomy" or "fundoplication." These common terms are listed as main terms with a "see" reference noting the PCS root operations that are possible valid code tables based on the objective of the procedure.

Use Reference

The index also lists anatomic sites from the Body Part Key and device terms from the Device Key. These terms are listed with "use" references, which are additional references to the terms located in the appendix keys. The term provided is the body part value or device value to be selected when constructing a procedure code using the code tables. This type of index reference does not direct the user to another term in the index, but provides guidance regarding character value selection. Therefore, "use" references generally do not refer to specific valid code tables.

ICD-10-PCS Code Tables

ICD-10-PCS contains 17 sections of code tables organized by general type of procedure. Each table is composed of rows that specify the valid combinations of code values. In most sections of the coding system, the upper portion of each table contains a description of the first three characters of the procedure code. In the Medical and Surgical section, for example, the first three characters contain the name of the section, the body system, and the root operation performed. The four columns in the table specify the last four characters. In the Medical and Surgical section, they are labeled body part, approach, device and qualifier, respectively. Each row in the table specifies the valid combination of values for characters 4 through 7. All seven characters must be specified to form a valid code.

Note that the code must be constructed with a combination of values within the same row of the table. A combination of values from different rows of the same table will result in an invalid code.

How to Use Coders' Desk Reference for ICD-10-PCS Procedures

Coders' Desk Reference for ICD-10-PCS Procedures is divided into convenient sections for easy use. The basic format of the book provides clinical coding support with illustrations, narratives, and other resources that help the user work from the medical record. The book begins with special chapters that provide detailed information on coding guidelines and conventions relating to ICD-10-PCS procedure coding, as well as common abbreviations, acronyms, symbols, eponyms, and surgical terms found in the medical record. It then follows the organization of ICD-10-PCS, looking at procedures and their associated ICD-10-PCS root operation tables. Due to the significant expansion of the number of ICD-10-PCS codes, it is impossible to include a description of every procedure. Included are representative examples of procedures, organized by section and subsection.

List of Illustrations

This is a list of illustrations by procedure name with a cross-reference to the appropriate page.

ICD-10-PCS Official Guidelines for Coding and Reporting 2025

For the new coder, and even for the veteran, this chapter provides an overview and detailed instructions on ICD-10-PCS coding guidelines and conventions.

ICD-10-PCS Root Operation Definitions

This resource is a compilation of all root operations in the Medical and Surgical, Medical and Surgical-Related, and Ancillary sections as well as the New Technology section of the ICD-10-PCS manual. It provides a definition and in some cases a more detailed explanation of the root operation to better reflect its purpose or objective. Examples of related procedures may also be provided.

Abbreviations, Acronyms, and Symbols

The medical profession has its own shorthand for documentation. Here, acronyms, abbreviations, and symbols commonly seen on operative reports or medical charts are listed for easy reference.

Procedure Eponyms

In the medical record, procedures are often documented by their common name or eponym (such as Billroth's operation I). Eponyms honor the developer of a procedure or test but do little to clarify what the procedure is. ICD-10-PCS does not cross-reference

ICD-10-PCS Root Operation Definitions

0 Medical and Surgical			
ICD-10-PCS Value	Definition		
0	Alteration	Definition:	Modifying the anatomic structure of a body part without affecting the function of the body part
		Explanation:	Principal purpose is to improve appearance
		Examples:	Face lift, breast augmentation
1	Bypass	Definition:	Altering the route of passage of the contents of a tubular body part
		Explanation:	Rerouting contents of a body part to a downstream area of the normal route, to a similar route and body part, or to an abnormal route and dissimilar body part. Includes one or more anastomoses, with or without the use of a device.
		Examples:	Coronary artery bypass, colostomy formation
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:	All CHANGE procedures are coded using the approach EXTERNAL
		Examples:	Urinary catheter change, gastrostomy tube change
3	Control	Definition:	Stopping, or attempting to stop, postprocedural or other acute bleeding
		Explanation:	None
		Examples:	Control of post-prostatectomy hemorrhage, control of intracranial subdural hemorrhage, control of bleeding duodenal ulcer, control of retroperitoneal hemorrhage
4	Creation	Definition:	Putting in or on biological or synthetic material to form a new body part that to the extent possible replicates the anatomic structure or function of an absent body part
		Explanation:	Used for gender reassignment surgery and corrective procedures in individuals with congenital anomalies
		Examples:	Creation of vagina in a male, creation of right and left atrioventricular valve from common atrioventricular valve
5	Destruction	Definition:	Physical eradication of all or a portion of a body part by the direct use of energy, force, or a destructive agent
		Explanation:	None of the body part is physically taken out
		Examples:	Fulguration of rectal polyp, cautery of skin lesion
6	Detachment	Definition:	Cutting off all or a portion of the upper or lower extremities
		Explanation:	The body part value is the site of the detachment, with a qualifier if applicable to further specify the level where the extremity was detached
		Examples:	Below knee amputation, disarticulation of shoulder
7	Dilation	Definition:	Expanding an orifice or the lumen of a tubular body part
		Explanation:	The orifice can be a natural orifice or an artificially created orifice. Accomplished by stretching a tubular body part using intraluminal pressure or by cutting part of the orifice or wall of the tubular body part.
		Examples:	Percutaneous transluminal angioplasty, internal urethrotomy

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	0JJB Excision Subcutaneous Tissue and Fascia
Adams	Advancement of round ligament(s) of uterus	0US9 Reposition Uterus
Adams	Crushing of nasal septum	095M 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	Dacrycystotomy 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

Surgical Terms

A special language is spoken in the surgical suite and written in the medical charts documenting procedures. The following list includes many of the medical terms heard most often in the operating room.

ablation. Surgical removal or destruction of a part, using electrocautery, radiofrequency, laser, chemicals, or hot and cold liquids.

abrasion. Removal of layers of skin.

achalasia. Failure of the smooth muscles within the gastrointestinal tract to relax at points of junction; most commonly referring to the esophagogastric sphincter's failure to relax when swallowing.

acromioplasty. Repair of the part of the shoulder blade that connects to the deltoid muscles and clavicle.

advance. To move away from the starting point.

allograft. Transplanted tissue from the same species.

amputation. Removal of a limb or part of a limb.

analysis. Study of a body section or parts.

anastomosis. Surgically created connection between ducts, blood vessels, or bowel segments to allow flow from one to the other.

aneurysm. Circumscribed dilation or outpouching of an artery wall, often containing blood clots connecting directly with the lumen of the artery.

angioplasty. Reconstruction of a blood vessel.

antibody. Immunoglobulin or protective protein encoded within its building block sequence to interact only with its specific antigen.

antigen. Substance inducing sensitivity or triggering an immune response and the production of antibodies.

antrum. Chamber or cavity, typically with a small opening.

appliance. Device providing function to a body part.

arthrocentesis. Aspiration of fluid from a joint with needle.

arthrodesis. Surgical fixation of a joint.

arthroplasty. Restoration of a joint.

arthroscopy. Endoscopic examination of a joint.

arthrotomy. Surgical incision into a joint.

articulate. Comprised of separate segments joined together, allowing for movement of each part on the other.

aspiration. Drawing in or out by suction.

assay. Test of purity.

astragalectomy. Surgical excision of the talus (ankle) bone.

augmentation. Add to or increase the substance of a body site, usually performed as plastic reconstructive measures. Augmentation may involve the use of an implant or prosthesis, especially within soft tissue or grafting procedures, such as bone tissue.

autograft. Any tissue harvested from one anatomical site of a person and grafted to another anatomical site of the same person. Most commonly, blood vessels, skin, tendons, fascia, and bone are used as autografts.

avulse. Tear away from.

benign. Mild or nonmalignant in nature.

bioartificial. Comprising both living tissue or cells and synthetic materials.

biofeedback. Technique allowing the patient to control body function.

biometry. Statistical analysis of biological data.

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

blood type. Classification of blood by group.

bougie. Probe used to dilate or calibrate a body part.

bovine. Of or relating to cattle (cows).

brachytherapy. Radiotherapy proximate to the organ being treated.

bridge. Connection between two parts of an organ.

bronchoscopy. Visual inspection of the airway using a fiberoptic scope.

brush. Tool used to gather cell samples or clean body part.

burr. Drill used to cut and shape bone.

bursa. Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts.

bypass. 1) Auxiliary flow. 2) A surgically created pathway altering the route of passage of the contents of a tubular body part.

calculus. Concretion of calcium, cholesterol, salts, or other substances that forms in any part of the body.

cannula. Tube inserted to facilitate passage.

capsulorrhaphy. Suturing or repair of a joint capsule, most frequently done on the glenohumeral joint.

Closure, Left Atrial Appendage

Body System

Heart and Great Vessels

PCS Root Operation

Occlusion

Root Operation Table

02L Heart and Great Vessels, Occlusion

Body Part

Atrium, Left

Approach

Open

Percutaneous

Percutaneous Endoscopic

Device

Extraluminal Device

Intraluminal Device

No Device

Qualifier

Left Atrial Appendage

Description

The left atrial appendage (LAA), also called the left auricle, is a small pouch in the anterior left atrium. It is thought to accept excess blood volume when left atrial pressure is high. The LAA is anatomically insignificant, except for patients who have atrial fibrillation (AF). In AF, the right and left atria beat irregularly, and usually rapidly, although some patients in AF experience bradycardia. The erratic beats disrupt the normal flow of blood in the heart and may cause blood to pool in the LAA, where it may linger and form thrombi. As a result, patients with AF have a fivefold risk of stroke and usually undergo lifelong pharmacological therapy to prevent clot formation. For some patients, anticoagulant therapy is contraindicated, and occlusion of the left atrial appendage provides prophylaxis.

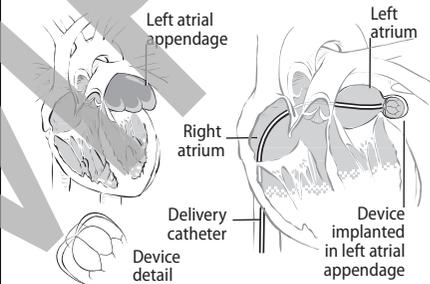
To surgically close the LAA, the surgeon uses a surgical stapler, clip, or suture to pull together the walls of the LAA to permanently close the opening from the left atrium. Occlusion may also be performed by inserting a device that blocks blood from entering the LAA. Cardiovascular surgeons routinely perform closure of the left atrial appendage during major cardiovascular procedures such as coronary artery bypass graft, mitral valve repair, and maze procedures. In patients with atrial fibrillation, prophylactic left atrial appendage removal or exclusion is recommended whenever the chest has been opened for another cardiovascular procedure to prevent future strokes.

Occlusion may be performed using an Open, Percutaneous, or Percutaneous Endoscopic approach.

The Watchman™ is an intraluminal device for percutaneous endovascular, transcatheter closure of the LAA. To implant the Watchman device, the physician places a catheter sheath into the femoral vein and advances it, under fluoroscopic guidance, to the right atrium. The physician then advances a transseptal puncture apparatus through the sheath to the right atrium, punctures the intra-atrial septum, and advances the Watchman device into the opening of the LAA in the left atrium. The device self-expands, sealing off the LAA.

The AtriClip® is an extraluminal device that is clamped on the LAA exterior, sealing the LAA from the rest of the left atrium. It may be placed using an Open approach or by accessing the heart through an incision between the ribs (mini-thoracotomy) using thoracoscopic assistance to view the operative site.

Alternatively, the physician may use sutures or staples to close the LAA, using an Open or Percutaneous Endoscopic approach. Sutures and staples are considered integral to the performance of the procedure and are not coded as devices.



Focus Point

Medical devices that occlude the LAA are an emerging technology, so watch for changes in status for FDA approval of new and existing devices. Use the ICD-10-PCS Device Key for guidance.

Focus Point

If a device is inserted with the intention that it will remain at the end of the procedure but for some reason (wrong size, complication, etc.) it must be removed before the conclusion of the operative episode, assign codes for both the insertion and removal of the device. See guideline B6.1a.

Harvest, Graft, Autologous Bone Marrow

See also Biopsy, Bone Marrow

See also Transplant, Bone Marrow (BMT) in the Medical and Surgical-Related section, Administration

Body System

Lymphatic and Hemic Systems

PCS Root Operation

Extraction

Root Operation Table

07D Lymphatic and Hemic Systems, Extraction

Body Part

Bone Marrow, Sternum

Bone Marrow, Iliac

Bone Marrow, Vertebral

Bone Marrow

Approach

Open

Percutaneous

Device

No Device

Qualifier

No Qualifier

Description

Bone marrow is a fatty substance within bone cavities that helps form blood cells and contains stem cells. Bone marrow may be harvested for transplantation into the bloodstream, to be used in combination with other graft materials for bone grafts or for injection into the muscles. An autologous transplant uses the patient's own bone marrow for the transplant. The harvested bone marrow is usually obtained from a large bone such as the iliac crest or sternum.

Once harvested, the bone marrow is processed with a centrifuge to remove blood and bone fragments and may be used immediately or cryopreserved for later transplantation. If cryopreserved, at the time of transplantation the bone marrow is thawed and infused into the bloodstream of the recipient through an intravenous catheter.

Bone marrow graft harvest procedures are routinely performed with a needle via a Percutaneous approach but can be performed using an Open approach.

With the patient under the appropriate anesthesia, the skin over the bone is first cleaned with an antiseptic solution. A local anesthetic is injected at the site, and the bone extraction needle is inserted into the marrow in the center of the bone using a Percutaneous approach. The needle is rotated to the right, to the left, withdrawn, and reinserted at a different angle. This procedure is repeated in an alternating clockwise/ counterclockwise motion until the holes in the needle contain sufficient bone marrow. Once the needle is in place, the stylet is removed by pulling it straight out, and a syringe is connected. The bone marrow is extracted through the needle with the syringe. Several bone punctures may be required to extract sufficient bone marrow for transplant. A bandage is applied to the collection sites. The specimen contains bone marrow whose structure has not been disturbed or destroyed.

During an Open procedure, the provider cuts through the skin and all other body layers such as fascia and muscle to expose the site of the procedure and obtains the bone marrow using drills, trephines, or a biopsy needle.

Focus Point

According to ICD-10-PCS guideline B3.4a, biopsy of bone marrow is coded to the root operation Extraction with the qualifier Diagnostic.

Focus Point

Bone marrow graft harvested from the local incision or operative site is not reported separately. However, if a separate incision in a different body part/location is required to harvest the graft, such as from the pelvis or iliac crest, this may be reported in addition to the primary procedure, according to ICD-10-PCS guideline B3.9.

Focus Point

The body part value T Bone Marrow is used to identify bone marrow extracted from other sites, such as the femur.

Coding Guidance

AHA: 2022, 1Q, 54; 2021, 4Q, 47; 2017, 4Q, 74; 2015, 1Q, 30; 2013, 4Q, 111

Joint Replacement, Hip (Total)

Body System

Lower Joints

PCS Root Operation

Replacement

Root Operation Table

ØSR Lower Joints, Replacement

Body Part

Hip Joint, Right

Hip Joint, Left

Approach

Open

Device

Synthetic Substitute, Metal

Synthetic Substitute, Metal on Polyethylene

Synthetic Substitute, Ceramic

Synthetic Substitute, Ceramic on Polyethylene

Synthetic Substitute, Oxidized Zirconium on Polyethylene

Synthetic Substitute

Articulating Spacer

Qualifier

Cemented

Uncemented

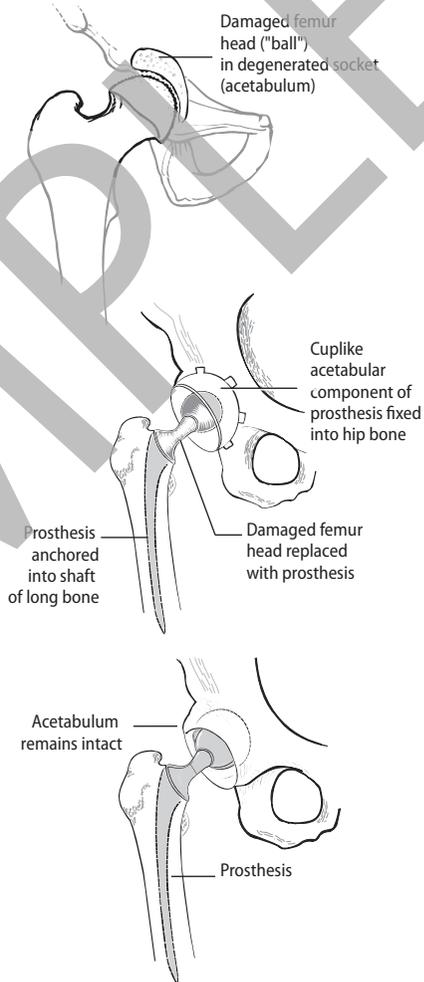
No Qualifier

Description

Hip replacement surgery is a reconstructive procedure performed on patients with painful hips due to osteoarthritis, rheumatoid arthritis, hip fracture, avascular necrosis/osteonecrosis, and bone tumors.

The physician performs a total reconstruction of the hip with replacement of both the femoral head and acetabulum by prosthesis. Under general anesthesia, the patient is placed in a lateral decubitus position (lying on the side), and prepped and draped. Using an Open approach, the physician makes an incision along the posterior aspect of the hip. The short external rotator muscles are released by incision from their insertion point on the femur, exposing the joint capsule. The physician incises the capsule and dislocates the hip posteriorly. The physician surgically removes the diseased femoral head with a reciprocating saw. The physician removes any osteophytes around the rim of the acetabulum with an osteotome. The acetabulum is reamed out with a power reamer, exposing both subchondral and cancellous bone, and the acetabular component is inserted. The femoral canal is then prepared using either a hand or a power reamer. The excised femoral head is measured with a caliper to determine the appropriate size for replacement. The physician prepares the femoral shaft by enlarging the canal with

a rasp and then selects the type of stem to be used. The stem is inserted and pounded into place in the femoral shaft with an impactor. The physician then repositions the femoral stem prosthesis. The physician may augment the area with an autograft or allograft. The autograft may be harvested from the excised femoral head. Donor bone (allograft) may be used instead. The physician places the bone graft into the canal and/or acetabulum. The hip is repositioned. The external rotator muscles are reattached. The incision is repaired in multiple layers with suction drains.



Focus Point

The root operation Replacement is reported for a total or partial hip arthroplasty and includes any explantation of the body part being replaced.

Tonsillectomy with Adenoidectomy

Body System

Mouth and Throat

PCS Root Operation

Destruction

Excision

Resection

Root Operation Table

ØC5 Mouth and Throat, Destruction

ØCB Mouth and Throat, Excision

ØCT Mouth and Throat, Resection

Body Part

Tonsils

Adenoids

Approach

External

Qualifier

Diagnostic

No Qualifier

Description

Tonsillectomy and adenoidectomy (T&A), the removal of both tonsils and adenoids, is a common and frequently performed procedure. It is often done to prevent recurrent infections, improve breathing, mitigate sleep apnea and snoring issues. In rare cases, a tonsillectomy and/or adenoidectomy may be performed to diagnose and/or remove neoplasms of the tonsils/adenoids.

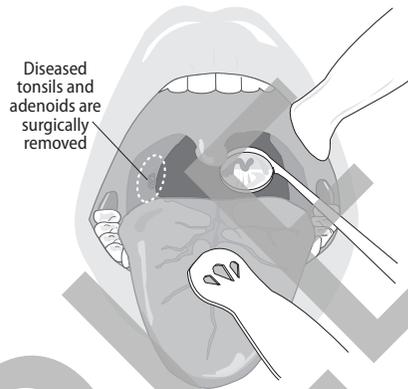
Destruction

Electrocautery (use of high frequency electrical current to produce heat) or laser ablation is used to eradicate the tonsils and adenoids via an External approach.

Excision

Using an External (intraoral) approach, the physician removes a portion of one or both tonsils by grasping the tonsil with a tonsil clamp and dissecting only the inflamed or diseased tonsil tissue. The tonsil tissue is removed, and bleeding vessels are clamped and tied. Bleeding may also be controlled using silver nitrate and gauze packing. Using a mirror or nasopharyngoscope for visualization, the physician

uses an adenotome or a curette and basket punch to excise a portion of one or both of the adenoids.



Resection

Using an External (intraoral) approach, the physician removes both tonsils completely by grasping each tonsil with a tonsil clamp and dissecting the capsule of the tonsil. The tonsils are removed, and bleeding vessels are clamped and tied. Bleeding may also be controlled using silver nitrate and gauze packing. Using a mirror or nasopharyngoscope for visualization, the physician uses an adenotome or a curette and basket punch to excise the adenoids.

Focus Point

If the tonsils and adenoids are removed for pathologic or histologic evaluation for diagnostic purposes, (e.g., neoplasm) the qualifier Diagnostic is used.

Focus Point

Two codes are needed, one for the removal of the tonsils and one for the removal of the adenoids. When both tonsils and/or adenoids are removed by either Excision or Resection, only one procedure is reported for each body part. Both the tonsils and adenoids are classified to single ICD-10-PCS body part values, without specific body parts for anatomical subdivisions. If any tonsil or adenoid tissue remains at the end of the procedure, report the root operation Excision rather than Resection. An Excision is coded when only part of the tonsil or adenoid is removed and there is a portion left behind.

Focus Point

An External approach is used on procedures within an orifice on structures that are visible without the aid of instrumentation. See guideline B5.3a.