Optum

Desk Reference

Coders' Desk Reference for ICD-10-PCS Procedures

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

optumcoding.com

Contents

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, 2021. (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 2022 edition will gradually be incorporated into future editions.

ICD-10-PCS Overview

ICD-10-PCS Code Structure

ICD-10-PCS has a multiaxial, 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 Ø–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 Ø 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 2023

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 Ø 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 Ø through 9 and the alphabet (except I and O because they are easily confused with the numbers 1 and Ø). 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 Ø in the Central Nervous body system specifies Brain and the body part value Ø 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

ICD-10-PCS Root Operation Definitions

Ø Medical and Surgical			
ICD-10-PCS Value		**Definition**	
Ø	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
		Example:	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	**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
Baffes	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.

Abdominoplasty

Body System

Anatomical Regions, General

PCS Root Operation

Alteration

Repair

Supplement

Root Operation Table

ØWØ Anatomical Regions, General, Alteration

ØWQ Anatomical Regions, General, Repair

ØWU Anatomical Regions, General, Supplement

Body Part

Abdominal Wall

Approach

Open

External (Repair, Stoma)

Device

Autologous Tissue Substitute (Alteration, Supplement)

Synthetic Substitute (Alteration, Supplement)

Nonautologous Tissue Substitute (Alteration, Supplement)

No Device (Alteration, Repair)

Qualifier

Stoma

No Qualifier

Description

An abdominoplasty is a repair of the abdominal wall, which is classified to the body system "General Anatomical Regions" in PCS. Anatomically, the abdominal wall is subdivided into two general regions: the anterolateral and the posterior abdominal wall. It is composed of three tissue layers: skin, superficial fascia, and muscle. Surgical procedures on the abdominal wall involve all three of these tissue layers. Abdominoplasty may be performed for either cosmetic or medical purposes.

Alteration

Alteration involves modifying an anatomic structure without affecting the function of the body part. The root operation Alteration identifies procedures that are cosmetic in nature. Use of this root operation requires diagnostic confirmation that the abdominoplasty is being performed to improve appearance.

Abdominoplasty performed for cosmetic reasons may also be referred to as a "tummy tuck." The procedure involves removing excess skin and underlying subcutaneous tissue and abdominal fat as well as tightening and restoring abdominal musculature. A cosmetic abdominoplasty may also involve reinforcement of the abdominal wall with biological or synthetic material, which is reported with the appropriate device value.

Focus Point

A cosmetic abdominoplasty (abdominal panniculectomy) that involves only the removal of excess skin, underlying subcutaneous tissue, and fat, without muscle tightening, is assigned a code from table ØJØ.

Repair

The root operation Repair involves restoring a body part, in this case the abdominal wall, to its normal anatomic structure and function. Repair is primarily used when an injury to the abdominal wall requires layered suture repair. Repair of the abdominal wall may also be required for stoma complications, such as a parastomal hernia. When the repair of the abdominal wall is focused on a stoma, the qualifier Stoma is reported.

Focus Point

Do not report the root operation Repair when mesh is used to reinforce a repair of the abdomen. See *the root operation Supplement.*

Supplement

When the abdominal wall is repaired and biological or synthetic material is used to reinforce or augment the repair, the correct root operation is Supplement. A common procedure classified to this root operation is the repair of a hernia involving the abdominal wall using mesh to reinforce the repair. Mesh may also be used in the repair of complex abdominal wall anomalies.

Focus Point

Do not report the root operation Supplement when biological or synthetic material is used but the objective of the procedure is solely cosmetic in nature. In this case, the correct root operation is Alteration and the biological or synthetic material used to reinforce the abdominal wall is captured using the appropriate device value. All methods, approaches, and devices used to improve appearance are coded as Alteration.

Coding Guidance

AHA: 2017, 3Q, 8; 2014, 4Q, 38

Herniorrhaphy, Paraesophageal (Diaphragmatic)

Body System

Respiratory System

PCS Root Operation

Repair

Supplement

Root Operation Table

ØBQ Respiratory System, Repair

ØBU Respiratory System, Supplement

Body Part

Diaphragm

Approach

Open

Percutaneous Endoscopic

Device

No Device (Repair)

Autologous Tissue Substitute (Supplement)

Synthetic Substitute (Supplement)

Nonautologous Tissue Substitute (Supplement)

Description

A paraesophageal herniorrhaphy is performed on patients with a paraesophageal hiatal hernia, which occurs when the gastroesophageal (GE) junction remains in its normal anatomic position but the upper part of the stomach pushes through an opening in the diaphragm, called the esophageal or diaphragmatic hiatus, and up into the chest next to the esophagus. The stomach cannot return to its normal anatomic position. This is different from a "sliding" hiatal hernia, in which the stomach may slide back into its normal place.

Repair

Under general anesthesia, using an Open abdominal approach, the physician makes an incision across the abdomen. The herniated stomach is returned to its appropriate position in the abdomen, and the hernia sac is cut away and removed. The enlarged opening in the diaphragm through which the esophagus passes is narrowed by placing sutures in the two pillars connecting the spinal column and the diaphragm. The physician may reform the stomach, cut the vagus nerve, or alter the size of the stomach-intestinal opening, as well. Drains are placed and the wound is sutured closed.

Alternatively, the Open approach may be thoracic or thoracoabdominal. The physician makes an incision across the chest, which may be extended into the upper abdomen. Tissues are dissected and the esophagus, diaphragm, and upper part of the stomach are exposed. The connective tissue is used to stitch folds or tucks into the diaphragm to restore it to its original position. Drains are placed, and the incision is closed with sutures or staples.

In a Percutaneous Endoscopic repair, the physician makes several tiny incisions through which the laparoscope and surgical instruments are inserted, which are used to reposition the herniated stomach and repair the hernia defect with direct sutures.

Supplement

Under general anesthesia, using an Open abdominal approach, the physician makes an incision across the abdomen. The herniated stomach is returned to its appropriate position in the abdomen, and the hernia sac is cut away and removed. The enlarged opening in the diaphragm through which the esophagus passes is narrowed by placing biologic or synthetic mesh in the defect. The physician may reform the stomach, cut the vagus nerve, or alter the size of the stomach-intestinal opening, as well. Drains are placed and the wound is sutured closed.

Alternatively, the Open approach may be thoracic or thoracoabdominal. The physician makes an incision across the chest, which may be extended into the upper abdomen. Tissues are dissected and the esophagus, diaphragm, and upper part of the stomach are exposed. The enlarged opening in the diaphragm through which the esophagus passes is narrowed by placing biologic or synthetic mesh in the defect. Drains are placed and the incision is closed with sutures or staples.

In a Percutaneous Endoscopic approach, the physician makes several tiny incisions through which the laparoscope and the surgical instruments are inserted, which are used to reposition the herniated stomach and repair the hernia defect with mesh.

Focus Point

The diaphragm is classified to the Respiratory body system in ICD-10-PCS.

Focus Point

Report concomitant Nissen fundoplication for gastroesophageal reflux as a separate procedure, using root operation Restriction.

Coding Guidance

AHA: 2014, 3Q, 28

Resection, Lymph Node

Body System
Lymphatic and Hemic Systems

PCS Root Operation
Resection

Root Operation Table
0 7 T Lymphatic and Hemic Systems, Resection

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
Percutaneous Endoscopic

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. Often, when a cancerous organ is excised, the regional lymph nodes also are excised to reduce or eradicate metastatic cells. In other cases, the lymphatic system itself may be the origin of the disease—for example in lymphoma—and the lymph nodes may be removed to reduce or eradicate the disease.

Lymph nodes exist along lymphatic chains that include lymphatic channels and the nodes. In Resection, an entire lymph node chain is removed. If the intent is to remove all of the lymph nodes in an area, this is also reported as Resection. The lymphatic resection may be performed alone or as part of a more extensive operation. Report the lymphatic resection code(s) in addition to the codes for separately reportable procedures.

In lymphadenectomy with an Open approach, the physician makes an incision in the skin overlying the lymphatic chain. The surrounding tissues, nerves, and blood vessels are dissected away, and the lymph nodes are visualized. One or more complete lymphatic chains are removed, and the wound is closed with sutures or staples.

In lymphadenectomy with a Percutaneous Endoscopic approach, the physician performs a laparoscopic resection of the lymphatic chain or chains. The physician places a trocar at the umbilicus into the abdominal or retroperitoneal space and insufflates the peritoneal or retroperitoneal space. The laparoscope is placed through the umbilical trocar, and additional trocars are placed in the insufflated cavity. The lymphatic chain or chains are identified, and the surrounding tissues, nerves, and blood vessels are dissected away so that the lymphatic tissue can be removed. The trocars are removed, and the incisions are closed.

Focus Point
Lymph node sampling, sentinel node biopsy, or "selective" lymph node removal, are reported as the root operation Excision. If a partial removal of a lymph node chain is done, it is coded as Excision. Lymph node dissection, resection, and radical or modified radical lymph node excision usually describe complete removal of a chain of lymphatic tissue, which is Resection. In radical procedures, everything within a designated anatomic boundary is resected.

Focus Point
Removal of one or more entire chains of lymph nodes plus one or more partial chains of lymph nodes or isolated lymph nodes of a single, named body part meets the definition of the root operation Resection of the single body part. Therefore, report only Resection without an additional code for Excision.

Focus Point
The neck is a structure dense with lymph nodes, which are classified by levels in the staging of squamous cell carcinoma. If the entire lymphatic chain of one level of the neck (right or left) is documented as removed, report this removal as Resection even though all lymphatic chains (levels) in the body part were not removed.

Coding Guidance
AHA: 2018, 1Q, 22; 2016, 2Q, 12; 2016, 1Q, 30; 2014, 3Q, 9

Whipple

Body System

Gastrointestinal System

Hepatobiliary System and Pancreas

PCS Root Operation

Excision

Resection

Root Operation Table

ØDB Gastrointestinal System, Excision
ØDT Gastrointestinal System, Resection
ØFB Hepatobiliary System and Pancreas, Excision
ØFT Hepatobiliary System and Pancreas, Resection

Body Part

Gallbladder
Pancreas
Common Bile Duct
Stomach
Duodenum
Jejunum

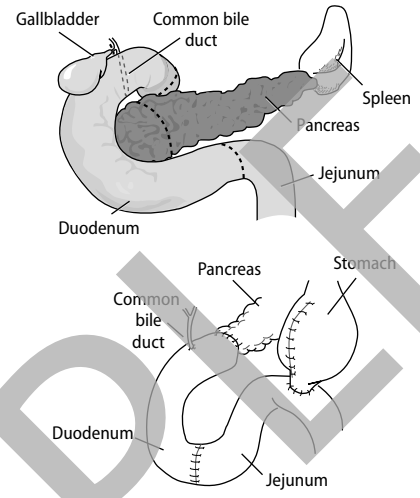
Approach

Open
Percutaneous Endoscopic

Description

A pancreaticoduodenectomy, also known as the Whipple procedure, involves excising multiple abdominal organs such as the head of the pancreas, duodenum, stomach pylorus, common bile duct, and often gallbladder and proximal jejunum. Anastomosis or reconstruction involves attaching the hepatic duct to the jejunum and the stomach to the jejunum. It is performed to treat pancreatic cancer in lieu of a total pancreatectomy.

The physician performs excision of the proximal pancreas, duodenum, distal bile duct, gallbladder, and distal stomach with reconstruction. Under general anesthesia, using an Open approach, the physician makes an abdominal incision and explores the abdomen. The duodenum, proximal pancreas, and bile duct are mobilized. The distal bile duct, distal stomach, and distal duodenum are divided. The pancreas is transected at the junction of the head and body, and the pancreatic head, duodenum, distal stomach, and distal bile duct are removed en bloc. The anatomy is reconstructed by performing sequential anastomoses between the proximal jejunum and the distal bile duct and distal stomach. The edge of the remaining distal pancreas is closed with sutures or staples. The incision is closed. The Whipple procedure can also be performed using a Percutaneous Endoscopic (laparoscopic) approach using several small incisions and a laparoscope.



Each of the organs removed is reported separately with root operation Excision (partial) or Resection (complete). Many Whipple procedures involve gallbladder resection and distal jejunum excision, which are also reported. Because there are different versions of the Whipple, such as the pyloric sparing Whipple, the operative report must be reviewed carefully to determine the correct body part values and approach to report.

Focus Point

Assign individual codes when the same procedure is performed on separate body parts. See *guideline B3.2a.*

Focus Point

Because the resection of the entire duodenum includes the ampulla of Vater, resection of the ampulla is not reported separately.

Focus Point

The remaining body parts are rerouted at the conclusion of a Whipple procedure, but Bypass is not the appropriate root operation as this is not the objective.

Focus Point

The anastomoses are considered inherent in the Excision and Resection procedures and are not coded separately. See *guideline B3.1b.*

Coding Guidance

AHA: 2019, 1Q, 3; 2014, 3Q, 32

Alphabetic Index

A