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## Procedural Eponyms

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<th>Eponym</th>
<th>Description</th>
<th>ICD-10-PCS Table Reference</th>
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</thead>
</table>
| Madlener | Tubal ligation | **0UL5** Occlusion Fallopian Tube, Right  
**0UL6** Occlusion Fallopian Tube, Left  
**0UL7** Occlusion Fallopian Tubes, Bilateral |
| Magnuson (-Stack) | Arthroplasty for recurrent shoulder dislocation | **0RSJ** Reposition Shoulder Joint, Right  
**0RSK** Reposition Shoulder Joint, Left |
| Malmström’s | Vacuum extraction | **10D0** Extraction Products of Conception |
| Malmström’s | Vacuum extraction with episiotomy | **10D0** Extraction Products of Conception  
**0W8N** Division Perineum, Female |
| Manchester (-Donald) (-Fothergill) | Uterine suspension | **0US9** Reposition Uterus |
| Mankwold | Cervical os repair | **0UVC** Restriction Cervix |
| Marshall-Marchetti (-Krantz) | Retropubic urethral suspension | **0TSD** Reposition Urethra |
| Master | Stress test (two-step) | **4A02** Measurement Cardiac  
**4A12** Monitoring Cardiac |
| Matas | Aneurysmorrhaphy | **02V** Restriction Heart and Great Vessels  
**03V** Restriction Upper Arteries  
**04V** Restriction Lower Arteries |
| Mayo | Bunionectomy | **0STP** Resection Toe Phalangeal Joint, Right  
**0STQ** Resection Toe Phalangeal Joint, Left |
| Mayo | Umbilical herniorrhaphy | **0WQF** Repair Abdominal Wall |
| Mayo | Vaginal hysterectomy | **0UT9** Resection Uterus  
**0UTC** Resection Cervix |
| Maze/Cox-Maze | Ablation or destruction of heart tissue | **02S8** Destruction Conduction Mechanism |
| Mazet | Knee disarticulation | **0Y6F** Detach Knee Region, Right  
**0Y6G** Detach Knee Region, Left |
| McBride | Bunionectomy with soft tissue correction | **0QBN** Excision Metatarsal, Right  
**0QBP** Excision Metatarsal, Left  
**0MQS** Repair Foot Bursa and Ligament, Right  
**0MQT** Repair Foot Bursa and Ligament, Left |
| McBurney | Repair inguinal hernia | **0YQS** Repair Inguinal Region, Right  
**0YQ6** Repair Inguinal Region, Left |
| McCall | Enterocele repair | **0UQF** Repair Cul-de-sac  
**0UUF** Supplement Cul-de-sac |
Spinal Tap/Lumbar Puncture

Root operation table(s) (PCS Root Operation and Body System)

009 Drainage, Central Nervous System

Body Part(s)
Spinal Canal

Approach
Percutaneous

Device(s)
Drainage Device
No Device

Qualifier(s)
Diagnostic
No Qualifier

Description
The spinal column and brain are encased in a sheath called the meninges. Within the meninges flows the cerebrospinal fluid (CSF), which circulates between the spine and brain, acting as a cushion for and supplying nutrients.

A spinal tap or lumbar puncture can be a diagnostic and/or therapeutic procedure. For diagnostic assessment of the brain or spinal column, CSF may be aspirated for pathological examination. Often, the physician is looking for infective agents (indicating meningitis or encephalitis) or blood (indicating intracranial or spinal injury). Alternately, CSF may be aspirated for therapeutic reasons, for example, to lower intracranial pressure (ICP).

The lumbar region of the spine is the usual site for spinal tap. Lumbar puncture (LP) is preferred due to the anatomical structure of the lumbar spine.

For LP, the patient is usually seated, leaning forward, but may be lying on one side with the knees drawn up to the chest, with the back flexed to widen the spaces between the vertebrae. The L3 and L4 vertebrae are located and local anesthesia is administered. The lumbar puncture needle is inserted. In diagnostic cases, CSF is drawn through the needle into a syringe. In therapeutic cases, a catheter may be inserted and the fluid emptied into a reservoir. Pressure reading is performed with a manometer. When the tap is completed, the needle is removed and the wound is dressed. In many cases, the patient lies prone to prevent fluid leakage.

Occasionally, in a therapeutic lumbar puncture, serial or repeated drainage may need to be performed. In these cases, to avoid the need for repeated punctures, a lumbar drainage catheter is left in place until it is no longer needed. Multiple pressure measurements may be obtained, depending on the type of drainage needed: draining a specified level or volume, or to keep a specific pressure. If the drainage device remains at the conclusion of the lumbar puncture procedure, report Drainage Device. If all catheters and tubes are removed at the conclusion of the procedure, report No Device.

For both diagnostic and therapeutic spinal tap, the appropriate root operation is Drainage, which involves taking or letting out fluids and/or gases from a body part. The approach is Percutaneous, as the instrumentation (needle or catheter) is inserted through the skin and other body layers in order to reach the site of the procedure (spinal canal). For a diagnostic spinal tap, report the qualifier Diagnostic, and for a therapeutic tap report No Qualifier.

Focus Point
ICD-10-PCS, code assignment is dependent on the objective of the procedure (therapeutic or diagnostic). If a spinal tap (lumbar puncture) is documented as both therapeutic and diagnostic, both the procedures may be reported, according to ICD-10-PCS Multiple Procedures Guideline B3.4b. However, specimens are routinely sent to pathology for study without necessarily being considered diagnostic. If the documentation is unclear, query the physician.

Focus Point
Fluid is drained from the spinal canal in a spinal tap. Therefore, the correct body part is Spinal Canal, not the Spinal Cord.

Focus Point
Documentation of a “dry” tap means no CSF was obtained, but the procedure was complete. The intent of the procedure was to obtain fluid; the fact that no fluid was obtained does not preclude reporting the procedure. Code the full procedure.

Coding Guidance
AHA: 2014, Q1, 8
Thyroidectomy

Root operation table(s) (PCS Root Operation and Body System)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0GB</td>
<td>Excision, Endocrine System</td>
</tr>
<tr>
<td>0GT</td>
<td>Resection, Endocrine System</td>
</tr>
</tbody>
</table>

Body Part(s)
- Thyroid Gland Lobe, Left
- Thyroid Gland Lobe, Right
- Thyroid Gland

Approach
- Open
- Percutaneous Endoscopic

Qualifier(s)
- Diagnostic
- No Qualifier

Description
Thyroidectomy describes the removal of all or part of the thyroid gland. As an endocrine organ, the thyroid gland manufactures hormones and secretes them into the bloodstream. These hormones regulate metabolic functions including heart rate, digestion, and body temperature. The average thyroid gland is approximately the size of a business card, with a half-inch thickness. The thyroid gland wraps around the trachea at the level of the fifth cervical vertebra. It is divided into two lobes that are connected by a small band, the isthmus.

Thyroidectomy may be indicated if the patient has a malignancy or if a benign disorder causes symptoms. Symptoms of a benign disorder include dysphagia, dyspnea or vocal changes related to compression of the esophagus, trachea, or larynx due to thyroid hyperplasia. Hypersecretion of hormones also can cause metabolic symptoms and may lead to thyroidectomy, as in the case of refractory Graves’ disease.

In an Open approach, the physician directly exposes the thyroid via a transverse cervical incision in the skin. The platysma muscles are divided and the strap muscles are separated in the midline. The thyroid lobe to be excised is isolated and vessels serving the lobe are ligated. The isthmus is severed. The parathyroid glands are preserved. The thyroid tissue is divided in the midline of the isthmus over the anterior trachea. The thyroid lobe is resected, or a portion is excised. When the excision or resection is complete, the muscles are re-approximated and the skin incision is closed.

In a Percutaneous Endoscopic approach, the physician makes a small incision and dissects through the platysma and strap muscles until the superior pole of the thyroid is located, at which point the endoscope is inserted and minimally invasive video-assisted thyroidectomy (MIVAT) is performed using endoscopic dissector and aspirator tools. The thyroid tissue to be excised is isolated and the vessels serving the lobe are ligated. The isthmus is severed. The parathyroid glands are preserved, and the thyroid tissue is cut and aspirated. When the excision or resection is complete, the instruments are removed and the muscles are re-approximated. The skin incision is closed.

Excision
If only a portion of the thyroid gland lobe is removed (Thyroid Gland Lobe, Right or Thyroid Gland Lobe, Left), the root operation is Excision. Excision may be performed for therapeutic and/or diagnostic purposes. Thyroid gland excision for diagnostic purposes is reported with the qualifier Diagnostic.

Resection
Resection, which involves removal of all of a body part, is reported for the removal of the entire lobe of the thyroid gland (Thyroid Gland Lobe, Right or Thyroid Gland Lobe, Left) or the entire thyroid gland.
Focus Point
ICD-10-PCS code assignment is dependent on the objective of the procedure (therapeutic or diagnostic). If a thyroid gland excision is documented as both therapeutic and diagnostic, both the biopsy (diagnostic) and the more definitive (therapeutic) treatment may be reported, according to ICD-10-PCS Multiple Procedures Guideline B3.4b. However, surgical specimens are routinely sent to pathology for study without necessarily being considered diagnostic. If the documentation is unclear, query the physician.

Focus Point
Resection includes all of a body part, or any subdivision of the body part that has its own body part value. Removal of all of one of the body parts of the thyroid (right or left lobe) is reported as Resection of the lobe. If both the right and left thyroid lobes are removed, report Resection of Thyroid. See ICD-10-PCS Guideline B3.8.

Focus Point
ICD-10-PCS classifies two body parts for the thyroid gland in the Excision table: "Thyroid Gland Lobe, Right" and "Thyroid Gland Lobe, Left." The Resection table also includes the body part Thyroid Gland. The thyroid gland also contains the isthmus, a small band of tissue that joins the right and left lobes. In less than a third of the population, there is a third "lobe" of the thyroid gland called the pyramidal. It is very small, and arises from the medial anterior aspect of the isthmus. Excision or Resection of the pyramidal lobe or the isthmus would be reported as an Excision of the Thyroid Gland Lobe, Right or Thyroid Gland Lobe, Left, according to its laterality.
Tracheostomy

**Root operation table(s) (PCS Root Operation and Body System)**

<table>
<thead>
<tr>
<th>Root Operation Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0B1</td>
<td>Bypass, Respiratory System</td>
</tr>
</tbody>
</table>

**Body Part(s)**

Trachea

**Approach (Optional Field)**

Open

Percutaneous

**Device(s) (Optional Field)**

Tracheostomy Device

**Qualifier(s) (Optional Field)**

Cutaneous

**Description**

In respiration, air is inhaled through the nose or mouth and carried into the trachea leading to the bronchial tubes for an oxygen exchange in the lungs. In tracheostomy, a stoma is surgically created as an air conduit for the trachea to the exterior through an incision in the skin of the neck. In this way, the cervical trachea and oropharynx are bypassed and air can pass directly through the stoma and into the distal trachea for respiration.

A tracheostomy may be performed on a patient who is on mechanical ventilation long term or one who has suffered trauma or neurological damage. In some cases, infection or malignancy may lead to tracheostomy.

In an Open approach, the physician creates a tracheostomy by making a horizontal neck incision and dissecting the muscles to expose and visualize the trachea. The thyroid isthmus is cut if necessary. The trachea is incised and an airway is inserted. After bleeding is controlled, a stoma is created by suturing the skin to the tissue layers. This may be a planned or an emergency procedure.

The physician creates a tracheostomy by inserting a needle using a Percutaneous approach through the skin of the neck and into the trachea. A cannula is threaded over the needle. The cannula is secured with sutures. One type of percutaneous tracheostomy is percutaneous transtracheal jet ventilation (PTJV). In PTJV, a catheter is inserted through the cricothyroid membrane. The catheter is attached to a high-pressure oxygen supply.

Percutaneous dilatational tracheostomy (PDT) is typically performed at the bedside as opposed to a tracheostomy done in the operating room using the traditional open surgical approach. Percutaneous dilatational tracheostomy involves making an incision in the skin over the tracheal cartilage and inserting a needle and guide wire into the trachea. The physician uses a dilator to enlarge the opening and then inserts a standard tracheostomy tube. Bronchoscopy may be performed synchronously in order to visualize and confirm the placement of the needle, guide wire, and dilator.

Regardless of the approach, report tracheostomy tube insertion Tracheostomy Device and the qualifier Cutaneous to show that the root operation Bypass is performed from the trachea to the skin.

**Focus Point**

Tracheostomy is defined as a permanent or semi-permanent airway established into the trachea through the skin of a patient’s neck, while tracheotomy is defined as a temporary incision into the trachea. Report a code from root operation table 0B1 when tracheostomy is performed (Bypass). Report a code from root operation table 0B9 when tracheotomy is performed (Drainage).

**Focus Point**

Review documentation of the tracheostomy procedure carefully. Do not report a new tracheostomy insertion procedure when the tracheostomy tube is only being replaced or changed. Report instead code 0B21XFZ Change tracheostomy device in trachea, external approach.

**Focus Point**

If a laryngoscope or bronchoscope is used only to confirm the placement of a percutaneous tracheostomy, do not code the endoscopic guidance (inspection) separately. Inspection of a body part(s) performed in order to achieve the objective of a procedure is not coded separately. See ICD-10-PCS Guideline B3.11a.

**Coding Guidance**

AHA: 2014, Q4, 3