List of surgical terms

Essentially all medical terms, mostly Latin and Greek, can be combined to name a surgery. Here is a list of commonly used pre- and suffixes:

Prefixes

- *angio-* : related to blood vessels
- *arthr-* : related to a joint
- *bi-* : two
- *colono-* : related to large intestine colon
- *cysto-* : related to the Urinary bladder
- *cholecysto – related to the gall bladder*
- *encephal-* : related to the brain
- *gastr-* : related to stomach
- *hepat-* : related to the liver

. *lamino-* : related to vertebrae intervertebral disc

- *lapar-* : related to the abdominal cavity
- *lobo-* : related to a lobe (of the brain or lungs)
- *mammo-* and *masto-*: related to the breast
- *myelo – spinal cord or bone marrow*
- *myo-* : related to muscle tissue
- *nephro-* : related to the kidney or Renal
- *colpo-* : related to the vagina

    - *hyster-* : related to the uterus

- *oophoro* : related to the ovary
- *salpingo- fallopian tubes*
- *orchid-* : related to the testicle
- *balano - Penis*
- *vas-* : related to a duct, usually the vas deferens

Suffixes

- *-centesis* : surgical puncture
- *-desis* : fusion of two parts into one, stabilization
- *-ectomy* : surgical removal *(see List of -ectomies)*. The term 'resection' is also used, especially when referring to a tumor.Partially removal is excision
- *-opsy* : looking at
- *-oscopy* : viewing of, normally with a scope
- *-ostomy* or *-stomy* : surgically creating a hole (a new "mouth" or "stoma")
- *-otomy* or *-tomy* : surgical incision *(see List of -otomies)*

- *-pexy* : to fix or secure
- *-plasty* : to modify or reshape (sometimes entails replacement with a prosthesis)
- *-rrhapy* : to strengthen, usually with suture

[edit]List of surgical procedures

Medical Term Meaning

A

Acromegaly ---Enlargement of the extremities
Adenoid---- Resembling a gland
Afebrile------ Without fever
Anesthesia -----Without feeling or sensation
Arteriosclerosis ------Hardening of the arteries
Phlebosclerosis ------- Hardening of the veins

B

Blepharoptosis----- Downward /displacement of the eyelids
Bradycardia----- Slow heartbeat

C

Cardiovascular -----Pertaining to the heart and vessels
Cerebroma ----Tumor of the brain
Chondritis------ Inflammation of the cartilage
Chondromalacia----- Softening of the cartilage
Cyanosis. ---- Condition of blueness
Cystitis ------Inflammation of the Urinary bladder
Cholecystitis --- Inflammation of the gall bladder

D

Dentalgia/Odontalgia---- Toothache/pain
Dermatophytosis ----Condition of fungus of the skin
Duodenal ----Pertaining to the first part of small intestine
Dyspnea---- Difficult breathing

E

Encephalitis ----Inflammation of the brain
Endocarditis -----Inflammation within the heart
Endometritis ----Inflammation within the uterus
Erythrocyte ----Red cell

Medical Term Meaning

G

Gastroenteritis ---Inflammation of the stomach and intestine
Glossitis--- Inflammation of the tongue
Glucosuria ---Sugar in the urine

H

Hematemesis .--Vomiting of blood
Hematoma ---Tumor filled with blood

Hematuria--- Blood in the urine
Hepatic ---Pertaining to the liver
Hepatitis ----Inflammation of the liver
Hepatosplenomegaly -----Enlargement of the liver and spleen
Hydrophobia --Fear of water
Hyperemesis .---Excessive vomiting
Hypertension--- High blood pressure
Hypertrophy--- Excessive size (growth) of the tissue /organ
Hyperplasia – increasing no of cells in the tissue /organ
Hypotension ---Low blood pressure

I

Intercostal ----Between the ribs
Intra-Abdominal---- Inside the abdomen

K

Keratitis ----Inflammation of the cornea

L

Lipoma ---Fatty tumor

Medical Term Meaning

M

Monocyte ---Single or one cell
Myalgia--- Pain in the muscle
Myospasm ---Involuntary contraction of a muscle

N

Necrosis ----Condition of dead tissue
Nephrolithiasis ----Condition of stones in the kidney
Nephromegaly ----- Enlargement of the kidney
Nocturia--- Night urine

O

Oliguria--- Scant urine
Osteoarthritis ----Inflammation of the bones and joints
Otoscopic ---Pertaining to examination of the ear

P

Pericarditis -----Inflammation around the heart
Polyneuritis -----Inflammation of many nerves
Polyphagia---- Excessive eating
Postpartum--- After birth until 6 weeks period
Pyogenic---- Producing pus

R

Rhinitis ------Inflammation of the nose
Rhinorrhea --- Flow or discharge or runny nose

S

Salpingitis ----Inflammation of the fallopian tubes

Medical Term Meaning

T

Tachycardia ---Fast/Rapid heartbeat
Thrombophlebitis--- Inflammation of a vein with a blood clot

Operations or Procedures Meaning

Adenectomy ----Removal of a gland

Arthrocentesis---- Puncture of a joint for removal of fluid

Arthrodesis -----Surgical fixation of a joint

Cheiloplasty ---Plastic operation upon the lip

Cholecystectomy--- Removal of the gallbladder

Colostomy ---surgical creating hole into the colon

Gastrectomy ---Removal of the stomach

Glossorrhaphy ---Suture/ repair of the tongue

Herniorrhaphy ---Suture /repair of a hernia

Hysterectomy ---Removal of the uterus

Laparotomy ---- Incision into the abdominal wall

Laryngoscopy---- Examination of the larynx with an instrument

Nephrectomy ---Removal of a kidney

Orchiopexy----- Fixation of the testes

Otoplasty ----Plastic repair of the ears

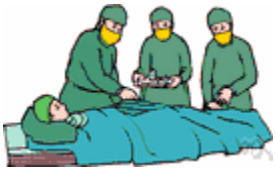
Rhinoplasty--- Plastic repair of the nose

Thoracentesis ---Puncture of the thorax

Tympanoplasty ----Plastic repair of the eardrum

List of surgical procedures

Noun 1. **surgical operation - a medical procedure involving an incision with instruments; performed to repair damage or arrest disease in a living body; "they will schedule the operation as soon as an operating room is available"**



surgical procedure, surgical process, surgery, operation

catheterisation, catheterization - the operation of introducing a catheter into the body

ablation, cutting out, extirpation, excision - surgical removal of a body part or tissue

amputation - a surgical removal of all or part of a limb

angioplasty - an operation to repair a damaged blood vessel or unblock a coronary artery

arthroplasty - surgical reconstruction or replacement of a malformed or degenerated joint

arthroscopy - a minimally invasive operation to repair a damaged joint; the surgeon examines the joint with an arthroscope while making repairs through a small incision

brain surgery - any surgical procedure involving the brain

castration - surgical removal of the testes or ovaries (usually to inhibit hormone secretion in cases of breast cancer in women or prostate cancer in men); "bilateral castration results in sterilization"

cauterisation, cauterization, cautery - the act of coagulating blood and destroying tissue with a hot iron or caustic agent or by freezing

chemosurgery - use of chemical to destroy diseased or malignant tissue; used in treatment of skin cancer

craniotomy - a surgical opening through the skull

cryosurgery - the use of extreme cold (usually liquid nitrogen) to destroy unwanted tissue (warts or cataracts or skin cancers)

curettage, curettement - surgery to remove tissue or growths from a bodily cavity (as the uterus) by scraping with a curette

debridement - surgical removal of foreign material and dead tissue from a wound in order to prevent infection and promote healing

decortication - removal of the outer covering of an organ or part

D and C, dilatation and curettage, dilation and curettage - a surgical procedure usually performed under local anesthesia in which the cervix is dilated and the endometrial lining of the uterus is scraped with a curet; performed to obtain tissue samples or to stop prolonged bleeding or to remove small tumors or to remove fragments of placenta after childbirth or as a method of abortion

electrosurgery - surgery performed with electrical devices (as in electrocautery)

enterostomy, enterotomy - surgical operation that creates a permanent opening through the abdominal wall into the intestine

enucleation - surgical removal of something without cutting into it; "the enucleation of the tumor"

wrong-site surgery - a surgical operation performed on the wrong part of the body

evisceration - surgical removal of an organ (or the contents of an organ) from a patient

exenteration - surgical removal of the organs within a body cavity (as those of the pelvis)

eye operation

, eye surgery - any surgical procedure involving the eyes

fenestration - surgical procedure that creates a new fenestra to the cochlea in order to restore hearing lost because of osteosclerosis

gastrectomy - surgical removal of all or part of the stomach

gastroenterostomy - surgical creation of an opening between the stomach

wall and the small intestines; performed when the normal opening has been eliminated

gastrostomy - surgical creation of an opening through the abdominal wall into the stomach (as for gastrolavage)

heart surgery - any surgical procedure involving the heart

haemorrhoidectomy, hemorrhoidectomy - surgical procedure for tying hemorrhoids and excising them

haemostasia, haemostasis, hemostasia, hemostasis - surgical procedure of stopping the flow of blood (as with a hemostat)

hysterotomy - surgical incision into the uterus (as in cesarean section)

implantation - a surgical procedure that places something in the human body; "the implantation of radioactive pellets in the prostate gland"

surgical incision, incision, section - the cutting of or into body tissues or organs (especially by a surgeon as part of an operation)

intestinal bypass - surgical operation that shortens the small intestine; used in treating obesity

jejunostomy - surgical creation of an opening between the jejunum and the anterior abdominal wall; will allow artificial feeding

major surgery - any surgical procedure that involves anesthesia or respiratory assistance

microsurgery - surgery using operating microscopes and miniaturized precision instruments to perform intricate procedures on very small structures

Team lead

. Distribution & Monitoring of workload.
2. Provide leadership and focus to the project teams. Responsible for the productivity, quality and overall performance of the projects.
3. Guiding the team in handling & resolution of work related problems, understanding & interpretation of Issues and decision making. Guiding coders in difficult coding scenarios.
4. Updating the production reports, client updates, MIS etc
5. Proving feedback to the coders.
6. Acknowledgement emails, Correspondence and call with clients etc..
7. Preparing, maintaining and updating Process Instructions and other documents.
8. Training and coaching coders.
9. Participate in Pilots and Developmental training programs. Learn and implement new client systems.

10. Monitor progress of trainee coders until they are fully productive and attend quality benchmark.
11. Co-ordinate and organize training for trainee coders as well as for existing members of the team based on the projects requirement.
12. Escalate and follow up for resolution of all issues that affect work.
13. Interaction with the clients & taking feedback from clients and formulating Strategies to meet the clients specific needs and expectations.
14. Proactively identify coding issues and communicate to client changes in coding guidelines and coding updates.

CPT 30901: When chemical cautery, silver nitrate, topical lidocaine, topical epinephrine or adrenaline or cocaine with electrocautery only is used to stop the epistaxis.

CPT 30903: If any packing material is used to stop the expistaxis.

Some examples of packing materials are:

Nasal tampons: Merocel or Doyle sponge

Vaseline gauze (placed using Bayonet forceps with nasal speculum)

Prefabricated nasal sponge or or ribbon gauze

Nasal Rocket or Rocket pack: Rhino Rocket or Rapid Rhino

Absorbable Gelatin foam: Gelfoam

Oxidized Cellulose: Surgicel

Nasal balloon / hemostatic nasal balloon / epistaxis balloon

285.21 Anemia in chronic kidney disease, or anemia in ESRD

15945 Excision, ischial pressure ulcer, with skin flap closure; with ostectomy

707.04 Pressure ulcer, hip-----WHICH REQUIRES 2 CODES

707.24 Pressure ulcer stage IV

Merocel: 

Rhinorocket / Rapidrhino: 

Nasal balloon: 


Ping pong

We want to capture encounters that appear to be 'Provider Issues' in all of the scenarios described below:

1. The providers are 'Ping Ponging' the deficiencies back to each other using the "Not My Patient" Addendum and it can clearly be seen by the record that the physician saw the patient.
2. A single provider is involved in the care and states that they did not see the patient.
3. A provider resolves his deficiency but does not provide you with the information needed to code. For example, if the provider states "YES" he did perform and Exam or HPI but did not give you any elements for the documented deficiency.

Regarding #3 as it relates to EKGs, if we have sent a chart back to a provider for an EKG interp and he states 'YES' that he performed and EKG but does not provide any further interpretations on the addendum, the coder will NOT code those AS IS at this time (i.e. we will not code the chart and assign stat code 28). Rather, for the time being, you should send the chart to the Coding Hold Queue with a sticky note on the CCD (EPF Provider Issue) and email Jessi and I to log the encounter on the Provider Issues Log (as described in the process in the email below).

The following process should be followed by the coder:

- The chart should be thoroughly researched to make sure the initial coder sent the deficient chart back to the correct provider.
- If after thorough research you determine that the chart cannot be corrected/coded you should leave the deficiency reason on the encounter in TES (DO NOT reflag the deficiency reason in TES – which will cause the deficiency to be redisplayed to the provider - and DO NOT make the encounter Nonbillable in TES or Onbase).
- A sticky must be placed on the CCD (done so by right clicking on the CCD and selecting 'Notes' then 'Add Note' and reference in the note "EPF Provider Issue". You should then send the chart to the **EDCP-Coding Hold Queue**.
- Finally, email Jessi and I the chart information (Facility, Onbase ID#, Acct#, Pt. Name, DOS, Deficient Provider, Deficiency Reason and a brief description of the issue). We will log this information for you.

Attestation on ROS, Exam
MLP in Critical care

Baseline

Account: 8700402

While you are correct in that there is not a complete attestation, with **the physician's initials (LAP) behind the ROS and Exam** parts of the record, we know that this is the MD's documentation – **therefore, we know that the MD had face to face time with the patient**. In the absence of a complete attestation, evidence/documentation of a physician's face to face time with a patient will suffice as a complete attestation and we can bill only for the MD.

HPI

Please review the below information that was sent to all SG providers regarding documentation in the **History of Present Illness (HPI)** section. This will assist coders with the appropriate counting of HPI elements.

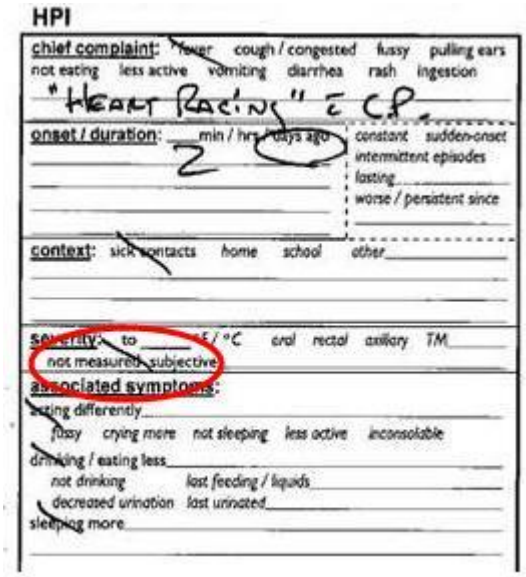
As a reminder, it is now acceptable to count backslashes through individual elements that the physicians have addressed and are negative. This is most applicable in the **Context** section, **Modifying Factors**sectionand the **Associated Signs and Symptoms** section. However, this is**NOTACCEPTABLE**for the **Severity** section in the HPI (See example #4 below under "Not Acceptable").

We have received many inquiries among all domains about what is and is not acceptable in the HPI section in recent weeks; so we are also including some examples of acceptable documentation and unacceptable documentation in these sections. Please review the below lists and contact Jessi and I with any questions.

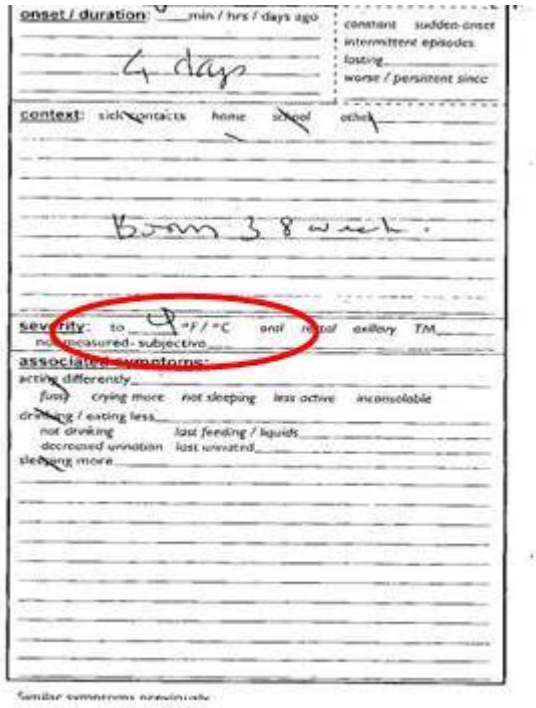
Not Acceptable:

1. On the Pediatric Illness T-sheet, under the Severity section, a slash through "not measured" (See **example A below**)
2. On the Pediatric Illness T-sheet, under the Severity section, Ø (zero with a backslash) in the temperature section (See **example B below**)
3. Circling the section header (such as "onset", "severity", etc. – see **example C below**)
4. In the severity section, back-slashing through "mild", "moderate", or "severe" (note that backslash indicates a negative value. Thus a circle would be an acceptable convention to be used instead to indicate the chief complaint was mild, moderate, or severe)
5. Drawing a dash through the blank lines in any section within the HPI section (See **example D below**)

Example A:


HPI
chief complaint: fever cough / congested fussy pulling ears
not eating less active vomiting diarrhea rash ingestion
"HEART RACING" & CP
onset / duration: min / hrs days ago
2
constant sudden-onset
intermittent episodes
lasting
worse / persistent since
context: sick contacts home school other
severity: to °F / °C oral rectal axillary TM
not measured subjective
associated symptoms:
eating differently
fussy crying more not sleeping less active inconsolable
drinking / eating less
not drinking last feeding / liquids
decreased urination last urinated
sleeping more

Example B:


onset / duration: ___min / hrs / days ago
4 days
constant sudden-onset
intermittent episodes
lasting
worse / persistent since
context: sick contacts home school other
born 38 week.
severity: to ___°F / °C oral rectal axillary TM
not measured- subjective
associated symptoms:
acting differently
fussy crying more not sleeping less active inconsolable
drinking / eating less
not drinking last feeding / liquids
decreased urination last urinated
sleeping more

Example C:

chief complaint: shortness of breath (hx of: asthma / COPD / CHF)

onset / duration: ____ min / hrs / days ago

continues in ED
gone now better
intermittent
worse

initiating event: upper respiratory illness out of meds
sports / exercise aspiration / choking allergy to:
exposure: smoke / mold other

context:

Double-click to zoom

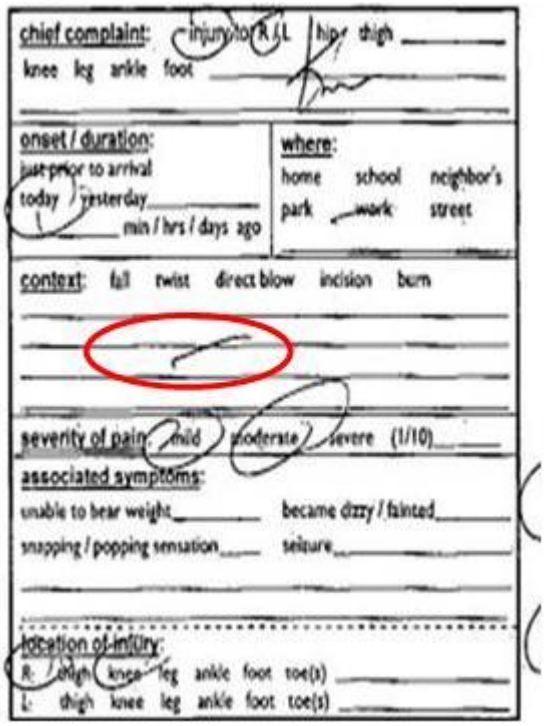
severity:
mild moderate severe
(1/10)

exacerbated by:
exertion laying flat coughing

associated symptoms:
fever / chills
sweating
chest pain / discomfort
left / right / central
pain / heaviness / tightness
painful breathing
constant / intermittent
duration
radiation back / jaw / arm
cough bloody / productive

heart racing
leg / calf pain
ankle / leg swelling
dizziness
light-headedness
anxiety
tingling hands / face
muscle spasms hands / feet

Example D:



chief complaint: injury to R / L hip thigh
knee leg ankle foot

onset / duration:
just prior to arrival
today / yesterday
min / hrs / days ago

where:
home school neighbor's
park work street

context: fall twist direct blow incision burn

severity of pain: mild moderate severe (1/10)

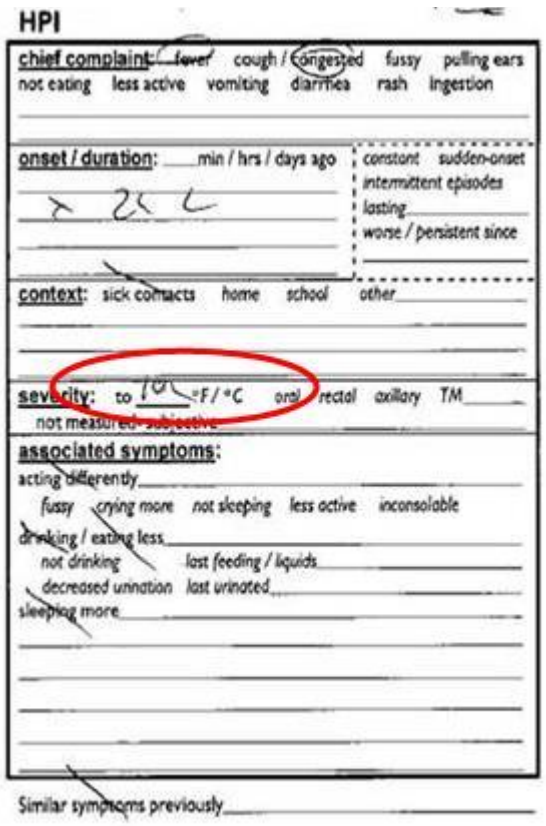
associated symptoms:
unable to bear weight
became dizzy / fainted
snapping / popping sensation
seizure

location of injury:
R: thigh knee leg ankle foot toe(s)
L: thigh knee leg ankle foot toe(s)

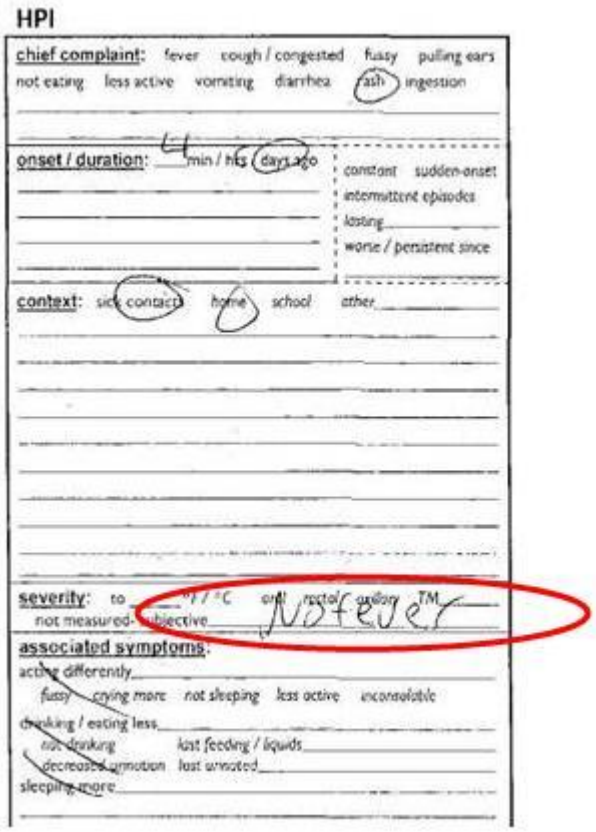
Acceptable:

1. On the Pediatric Illness T-sheet, under the Severity section, documentation of the following is acceptable:
1. The exact temperature documented in the temperature blank (see **example A** below)
2. "No fever" (must be documented in the severity section) (see **example B** below)
3. "Temperature Normal" (must be documented in the severity section)
2. In the severity section, **circling** "mild", "moderate", or "severe".

Example A:



Example B:



HPI

chief complaint: fever cough / congested fussy pulling ears
not eating less active vomiting diarrhea rash ingestion

onset / duration: ___ min / hrs days ago
constant sudden-onset
intermittent episodes
lasting
worse / persistent since

context: sick contacts home school other

severity: to ___ °F / °C oral rectal axillary TM
not measured objective Not febrile

associated symptoms:
acting differently
fussy crying more not sleeping less active inconsolable
drinking / eating less
not drinking last feeding / liquids
decreased urination last urinated
sleeping more

MID LEVEL CC TIME MISSING

Hello,

We have additional clarifications regarding charts where an MLP was involved in the care and the case meets the CDR for CC assignment but there is no critical care indicated on the record. The information below was from the February 23rd meeting notes:

- ***Midlevels with Critical Care***
  - *The following was listed on the October agenda*
    - *When making charts deficient for a Critical Care Deficiency, if a MLP (mid level provider) is participating in care on a patient who is critical it is likely that the critical care is being performed by the physician and not the MLP. Those critical care deficiency reasons should be routed to the MD rather than the MLP.*
  - *Also send back for "MLP Complete Attestation Required" since we are sending back to the ERMD instead of the midlevel.*
  - *If the chart returns with no attestation and the provider indicated critical care on the addendum, Code the chart to the appropriate E&M level (likely a 99285) and assign to both the Midlevel and the ERMD.*

We will definitely continue to send these back to the supervising physician for Critical Care Time Missing and MLP Complete Attestation Required. Below are various scenarios on how these may come back to us in the Coder Deficiency Rework Queue(#1 below is repeated from the agenda. #'s 2, 3 and 4 are new direction):

1. The physician indicates critical care time on the addendum but does not provide a complete attestation. **OUTCOME:** *Bill appropriate E/M (not critical care) and enter the MLP as Rendering provider and supervising physician as Attending provider(bill to both).*
2. The physician indicates critical care time on the addendum and the visit has a complete attestation. **OUTCOME:** *Bill appropriate critical care codes on the encounter and assign only the supervising physician as Rendering and Attending Provider. Complete Midlevel screen to capture midlevel involvement (bill to MD only).*
3. The physician completely attests to MLP services but requests on the addendum that the Critical Care deficiency be routed to the MLP involved in the care. **OUTCOME:** *Since the attestation is complete, it is acceptable at that time (by the physician's direction) to send the critical care deficiencyto the MLPto document the critical care time. If the MLP resolves the deficiency and documents critical care time, bill appropriate critical care codes on the encounter and assign only the supervising physician as Rendering and Attending Provider. If the MLP does not provide critical*

care time, bill appropriate E/M code (not critical care) and assign only the supervising physician as Rendering and Attending Provider. Complete Midlevel screen to capture midlevel involvement (bill to MD only).

4. The physician does not provide a complete attestation for MLP services and requests on the addendum that the Critical Care deficiency be routed to the MLP involved in the care. **OUTCOME:** *Since the attestation is incomplete, you will NOT send the critical care deficiency to the MLP. You should bill appropriate E/M code (not critical care) and enter the MLP as Rendering provider and supervising physician as Attending provider(bill to both).*

LEASE PROVIDER

It has come to our attention that Children's Legacy now has "leased providers" – these are Mid Level Providers (NP's). We will not do anything different in the assignment of these providers, however, these providers are not currently in TES. **The coders will need to make these encounters deficient following the "pending physician number" deficiency policy.** I have included the excerpt below from the EPF training manual.

The 4 providers are:

Lisa Thompson
Brooke Torbert
Lauren Knapp
Myna Laughlin

1. Making a new encounter deficient:

Review chart in Onbase. If found to be deficient you will assign the appropriate providers on the 'RndPhy, 'Att/SupPhy' and 'MidLevel'(if appropriate) fields on the Main Screen. You WILL NOT assign CPT or ICD-9 codes and you will not place documentation deficiency reason codes (i.e. 21, 22, 23, 30, 35) on the encounter. Rather, you will code 12DEF on the Procedure 1 field and mark 'Cd Cmp' in TES. Next you will place the appropriate deficiency reason on the encounter.

EXCEPTIONS:
Charts deficient for "PENDING PHYSICIAN NUMBER" are generally coded completely. However, if a chart is deficient for Pending Physician Number as well as other reasons (Missing ROS, Missing Exam, etc), please do not code the chart. Follow the normal deficiency process by only listing 12DEF in CPT code 1 position. Even though there are other provider deficiencies, you will only be able to make the chart deficient for Pending Physician Number. Make a note on the chart in Onbase indicating that chart is deficient for other reasons and move the chart to the coder deficiency queue. This will eliminate confusion on Records Management when adding in providers and deleting the Pending Physician Number Deficiency.
Restated, The only time the chart will be made deficient, coded and moved to the Coding Processed Queue is when Pending Physician Number is the only deficiency reason assigned.
? Also when a midlevel is involved in care, please fill out the co-signature/attestation boxes on the mid level screen before making the chart deficient for Pending Physician Number.

PAPER CHART

Please remember when coding an electronic/dictated facility if you notice that the provider is referencing the paper chart ("see paper chart") and any documentation elements are missing from the record, then the chart needs to be made **deficient for "EDRC-additional documentation requested" with comments of "please provide paper chart as provider is referencing this document" . Don't make the chart deficient for a provider deficiency.** We are seeing this specifically for our EPIC facilities, however, you may see this at other electronic/dictated facilities when their computer systems are down.