# Americas Hernia Society Hernia Coding Advisory

**Approved January 27, 2023**

## Introduction

Current Procedural Terminology (CPT) codes for ventral hernia repair were developed more than a decade ago and had not undergone significant revision. The Centers for Medicare and Medicaid Services (CMS) noted that ventral hernia procedures were performed more frequently in the outpatient setting. Although the Resource based Relative Value Utilization Committee of the AMA (RUC) recommended that the value of the hernia codes remain whole, CMS disagreed and intended to implement a 23-hour rule for these procedures, thus reducing wRVU value associated with the procedures. As the CPT code set is designed to represent the typical patient, the CMS proposed changes would have resulted in underpayment to surgeons for those patients requiring inpatient care. Due to the heterogeneity of hernia repairs in which some require inpatient hospitalization, a coalition of surgical representatives created a series of new hernia codes that better represented the work of hernia repair moving forward.

As the work of hernia repair has evolved significantly due to advances in surgical techniques, codes were created that were agnostic to approach (i.e., laparoscopic, robotic, open) and instead were based upon hernia characteristics (Table 1). This allows surgeons to choose the most appropriate technique for repair without impacting the reimbursement associated with the hernia repair approach. Additionally, the codes were created as zero-day global procedures to allow for coding and billing for all visits in the postoperative setting, inpatient and outpatient. This change in coding strategy allows surgeons to code and receive reimbursement for the work performed not only in the operating room, but in the postoperative setting using E&M codes.

### Inguinal, femoral, and lumbar hernias

The updated CPT codes do not have any specific changes for inguinal, femoral, or lumbar hernia CPT codes. These codes will continue to have a 90-day global period.

### Component separation

The CPT codes 15734 (used for open component separation techniques) and 49659 (used for laparoscopic/robotic component separation) continue to exist and can be used in conjunction with the updated CPT codes for ventral hernia repair. CPT codes 15734 and 49569 are associated with a 90-day global period, so if these codes are used, one cannot use E&M codes for postoperative care and instead the postoperative global period code 99024 should be used.

### Zero-day global period

The new CPT codes for anterior abdominal hernia, parastomal hernia and placement of mesh/ prosthesis for delayed abdominal closure are subject to zero-day global period. Therefore, postoperative care encounters both inpatient (i.e. subsequent in-hospital care and discharge) and outpatient (E/M codes for established patients) are now billable. It is important to note that when the new zero-day global period codes are performed in conjunction with 90-day global period codes, the postoperative care encounters will be included with the 90 day global codes and cannot be billed separately. Examples of this situation include both open and minimally invasive component separation and when anterior abdominal hernia and inguinal hernia repairs are performed concomitantly.

**Ventral**

As of January 2023, there is no differentiation in CPT ventral hernia coding based upon surgical approach (open, laparoscopic, robotic, hybrid). Furthermore, all ***anterior abdominal hernia repairs*** are coded similarly independent of type: epigastric, incisional, ventral, umbilical, and spigelian hernias. Lastly, placement of mesh is considered inherent to all ventral hernia repairs and is not coded separately. Unique CPT codes are assigned to anterior abdominal hernia repair based on three hernia characteristics: defect size, primary versus recurrent hernia and reducible versus obstruction/gangrene status. The new codes are all subject to the zero-day global period rule. The new 2023 anterior abdominal hernia CPT codes are summarized in Table 2.

**Parastomal**

Parastomal hernias now have unique CPT codes. Two codes were created: reducible and incarcerated. The parastomal hernia CPT codes do not differentiate between primary versus recurrent hernias and mesh placement is considered inherent to parastomal hernia repairs. The parastomal hernia codes may be utilized in conjunction with other anterior abdominal hernia codes but are subject to 50% multiple procedure discount when multiple hernias are repaired concomitantly. The new parastomal hernia repair CPT codes are subject to the zero-day global period rule.

**Other New Codes**

A CPT code for removal of previously placed surgical mesh was created in 2023 to account for the additional time and complexity required. This add-on code is utilized in addition to the recurrent incisional hernia codes when total or near-total mesh excision is performed. Previously, the removal of prior mesh was considered inherent to a recurrent hernia repair.

A CPT code for implantation of absorbable mesh for delayed abdominal closure in the setting of infection was added to create a mechanism to code for mesh following debridement due to infection.

There are also two codes for clinic work to offset practice expenses for suture or staple removal. These codes can be added to an E&M code. Although these codes have no associated work relative value unit assignment, they were created to capture the practice expense associated with these activities.

**Measuring Hernia Defects**

Defect size corresponds to the maximal length or width of a defect, or the maximal length or width of an oval that encircles the perimeter of all defects repaired. It is essential to measure hernia defect size in greater dimension during the hernia repair procedure and to document the defect dimensions in the operative note.

**Single Hernia**

For measuring the defect, use the maximal distance of the hernia defect, either in the craniocaudal or transverse distance.

**Multiple Hernias**

The size to report is the total length or width of all the hernias repaired. Multiple hernias with >10 cm intact fascia between should be measured as remote hernias.

**Remote Hernias**

If hernias are fixed concurrently with more than 10 cm of intact fascia between defects the sum of the greater dimension of each defect is used to calculate the total defect size to report even if the greater dimensions are in different planes (e.g. one horizontal and the other vertical).

**Table 1: Summary of 2023 coding changes.**

| Prior to 2023 | Starting in January 2023 |
|---|---|
| CPT codes for inguinal, femoral and lumbar hernias and code for creation of trunk flap and unlisted laparoscopic hernia code | No changes. These codes remain subject to a 90-day global period. |
| Anterior abdominal hernia varies based on type (umbilical, epigastric, ventral, incisional, spigelian) | All anterior abdominal hernias are coded similarly based upon unique hernia characteristics (size, reducibility, primary/recurrent) |
| Mesh implantation code can be added to open ventral/incisional codes | Mesh implantation is considered inherent with all anterior abdominal hernia and NOT coded separately |
| Parastomal hernias are considered incisional hernia | Parastomal hernias have separate codes that may be coded concomitant to other ventral hernias |
| Anterior abdominal hernia coding varies based on approach (open vs laparoscopic) | Anterior abdominal hernia coding does not change based upon technique |
| Anterior abdominal hernia coding does not include hernia defect size | Anterior abdominal hernia coding varies based on hernia defect size (<3cm, 3-10 cm, >10 cm) |
| Anterior abdominal hernia coding varies based on reducible vs. incarcerated/strangulated | New unique codes for reducible and incarcerated hernias stratified by size and primary vs. recurrent |
| Anterior abdominal hernia coding varies based on primary versus recurrent | Unique codes based upon primary vs recurrent stratified further based upon size and reducibility |
| Mesh removal code only applies to infected mesh | Mesh removal code added for non-infected mesh for total or near total removal in the setting of redo ventral hernia repair |
| 90-day global period for anterior abdominal hernia repair | 0-day global period for the new anterior abdominal hernia repair |

**Table 2: 2023 Anterior Abdominal Hernia CPT CODES**

*Repair of anterior abdominal hernia(s), (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh*

| CPT Code | Description | 2023 wRVU | Global period |
|---|---|---|---|
| **Initial hernia** | | | |
| 49591 | total length of defect(s) is **less than 3 cm, reducible** | 5.96 | none |
| 49592 | total length of defect(s) is **less than 3 cm, incarcerated or strangulated** | 8.46 | none |
| 49593 | total length of defect(s) is **3 cm to 10 cm, reducible** | 10.26 | none |
| 49594 | total length of defect(s) is **3 cm to 10 cm, incarcerated or strangulated** | 13.46 | none |
| 49595 | total length of defect(s) is **greater than 10 cm, reducible** | 13.94 | none |
| 49596 | total length of defect(s) is **greater than 10 cm, incarcerated or strangulated** | 18.67 | none |
| **Recurrent hernia** | | | |
| 49613 | total length of defect(s) is **less than 3 cm, reducible** | 7.42 | none |
| 49614 | total length of defect(s) is **less than 3 cm, incarcerated or strangulated** | 10.25 | none |
| 49615 | total length of defect(s) is **3 to 10 cm, reducible** | 11.46 | none |
| 49616 | total length of defect(s) is **3 to 10 cm, incarcerated or strangulated** | 15.55 | none |
| 49617 | total length of defect(s) is **greater than 10 cm, reducible** | 16.03 | none |
| 49618 | total length of defect(s) is **greater than 10 cm, incarcerated or strangulated** | 22.67 | none |
| | | | |
| **Parastomal hernias** | | | |
| 49621 | Repair of parastomal hernia, any approach (ie. open, laparoscopic, robotic), initial or recurrent, including implantation of mesh; **reducible** | 13.70 | none |
| 49622 | Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh; **incarcerated or strangulated** | 17.06 | none |
| | | | |
| **Other New Codes** | | | |
| 15778 | Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma | 7.05 | none |
| 49623 | Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) | 2.61 | ZZZ |
| 15853 | Removal of sutures or staples not requiring anesthesia (List separately in addition to E/M code) | 0.00* | ZZZ |
| 15854 | Removal of sutures and staples not requiring anesthesia (List separately in addition to E/M code) | 0.00* | ZZZ |

- While no work relative value units are assigned, there is practice expense relative value unit assignment