



If a conflict arises between a Clinical Payment and Coding Policy (“CPCP”) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. “Plan documents” include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSNM may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSNM has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (“HIPAA”) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (“UB”) Editor, American Medical Association (“AMA”), Current Procedural Terminology (“CPT®”), CPT® Assistant, Healthcare Common Procedure Coding System (“HCPCS”), ICD-10 CM and PCS, National Drug Codes (“NDC”), Diagnosis Related Group (“DRG”) guidelines, Centers for Medicare and Medicaid Services (“CMS”) National Correct Coding Initiative (“NCCI”) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Hernia Repair

Policy Number: CPCP012

Version: 1.0

Clinical Payment and Coding Policy Committee Approval Date: May 3, 2023

Plan Effective Date: May 15, 2023

Description:

This policy addresses coding and reimbursement for hernia repair procedures/services. This policy is not intended to impact care decisions or medical practice. Health care providers (i.e., facilities, physicians, and other qualified health care professionals (QHP)) are expected to exercise independent medical judgement in providing care to members.

The Plan reserves the right to request supporting documentation. Providers are responsible for accurately, completely, and legibly documenting services performed. Additionally, appropriate coding is the key to minimizing delays in claim(s) processing. Please ensure revenue codes and procedure codes reflect the diagnosis and services rendered. Failure to adhere to coding and

billing policies may impact claims processing and reimbursement. Claims may be reviewed on a case-by-case basis.

Reimbursement Information:

The following is not an all-encompassing coding list. The inclusion of a code below does not guarantee it is a covered service or eligible for reimbursement. Exclusions may apply under benefit plans or other plan documents.

Hernia Type	Description	Additional Information	Associated Codes
<p>Anterior Abdominal</p> <p>(Includes epigastric, incisional, spigelian, umbilical, and ventral)</p>	<p>Epigastric- Small in size, 5 cm to 6 cm. A type of hernia in the epigastric region of the abdominal wall. Typically, above the belly button and just below the sternum of your rib cage.</p> <p>Incisional- Occurs at the area of a prior operation due to a weakening of the abdominal wall.</p> <p>Spigelian- Hernia through the Spigelian fascia, defect in the lateral abdominal wall. This is also called a lateral ventral hernia. (At a very high risk for strangulation.)</p> <p>Umbilical- Occurs when part of the intestine protrudes through the umbilical opening in the abdominal muscles.</p> <p>Ventral- Bulge of tissues through a weakness within the abdominal wall muscles.</p>	<p>Some codes describe the repair of an anterior abdominal hernia (epigastric, incisional, spigelian, umbilical, ventral) by different approaches and size. Other codes describe whether it was incarcerated or strangulated.</p> <p>Add-on CPT code +49623 can be used in conjunction with 49591.</p>	<p>49591, 49592, 49593, 49594, 49595, 49596, 49613, 49614, 49615, 49616, 49617, 49618, +49623</p> <p>51500 is applicable for umbilical hernia repair.</p>
<p>Diaphragmatic</p>	<p>A birth defect in which there is an abnormal opening in the diaphragm.</p>	<p>Some codes describe the type of the diaphragmatic hernia (congenital or traumatic), while others</p>	<p>39501, 39503, 39540, 39541, 39545, 39560,</p>

	In rare instances there can be late onset or diagnosis of diaphragmatic hernias that may be related to a trauma or other cause.	describe the surgical approach or complexity.	39561, 39599, 44238
Femoral	Uncommon hernia that appears as a painful lump in the inner upper part of the thigh or groin that can often be pushed back in	Some codes describe the repair with specific criteria for the initial or reoccurrence. Other codes describe whether it was incarcerated or strangulated.	49550, 49553, 49555, 49557
Hiatal	Protrusion of the upper part of the stomach into the thorax through a tear or weakness in the diaphragm.	Some codes describe the repair with specific criteria with or without the implantation of mesh or other prosthesis.	43280, 43281, 43282, 43289, 43327, 43328, 43332, 43333, 43334, 43335, 43336, 43337
Inguinal	Occurs when tissue protrudes through a weak spot in the abdominal muscles/groin area.	Some codes describe the repair with specific criteria for age of the member or reoccurrence. Other codes describe whether it was incarcerated or strangulated.	49491, 49492, 49495, 49496, 49500, 49501, 49505, 49507, 49520, 49521, 49525, 49650, 49651, 54640, 55540
Lumbar	Occurs when there is protrusion through the lumbar triangle. There are two lumbar triangles, which lie between the bottom of the 12 th (last) rib and the hipbone and are situated around the back of the body.	CPT code 49540 describes the repair of a lumbar hernia.	49540
Omphalocele	A birth defect of the central portion of the anterior abdomen in which the herniated organs (intestines and sometimes other abdominal organs, i.e., liver) are covered by a thin membrane.	Some codes describe the repair size of the omphalocele hernia. Other codes describe the stage. CPT code 49606 describes the removal of prosthesis, final reduction, and closure, in the operating room.	49600, 49605, 49606, 49610, 49611

Parastomal	Occurs when part of the intestine sticks out through a stoma. A stoma is a surgically made opening in the stomach, small bowel, or colon that allows the member to pass waste into a bag.	CPT code 49621 is used for the repair of a reducible parastomal hernia, while CPT code 49622 is reported for an incarcerated or strangulated parastomal hernia. Add-on CPT code +49623 can be used in conjunction with 49622.	49621, 49622, +49623
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If unlisted or misc. codes are submitted on a claim, supporting documentation must be submitted. Unlisted procedure codes must only be used when the overall procedure and outcome of the procedure are not adequately described by an existing procedure code.

Hybrid laparoscopic and open repairs during a hernia repair procedure should include the applicable code for the open hernia repair.

Preoperative Testing

For information on preoperative testing rendered to a member on the date of admission and up to three calendar days preceding the date of admission, refer to **CPCP038 Outpatient Services Prior to an Inpatient Admission**.

Bariatric Surgery Billed with Hernia Repair

Providers should check the member's benefit coverage and/or exclusions for bariatric surgery and complications related to bariatric surgery. Hiatal hernia repair codes may be considered integral or mutually exclusive if billed on the same date of service with the following bariatric codes, including, but not limited to: 43999, 43659, 43770, 43771, 43772, 43773, 43774, and 43775.

Additional References:

Clinical Payment and Coding Policies:

CPCPLAB012 Pre-Operative Testing

CPCP035 Unlisted/Not Otherwise Classified (NOC) Coding Policy

CPCP038 Outpatient Services Prior to an Inpatient Admission

References:

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Policy Update History:

Approval Date	Description
02/23/2018	New Policy
02/22/2019	Annual review
05/29/2020	Annual review, Updated Disclaimer, References, Policy language
06/18/2021	Annual Review
04/22/2022	Annual Review
05/03/2023	Annual Review