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2023 Billing and Coding Guide

Hernia procedures

Overview

This guide is intended to aid providers in appropriate procedure code selection for Hernia procedures. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the CPT®[1] code.

Instructions for use:

- Full code descriptions and details of code reporting requirements and/or guidance, can be found in the section labeled coding.
- Physician, Hospital Outpatient, and/or Ambulatory Surgery Center (ASC) rates, can be found in the section labeled reimbursement.
- Details surrounding specialized coding and reimbursement information can be found in the corresponding appendices, FAQ sections, and indicated in footnotes.
- This document is not all-inclusive, nor does it replace advice from your coding and compliance departments and/or CPT®[1] coding manuals.

2023 updates

New anterior abdominal hernia repair codes

The American Medical Association (AMA) CPT®[1] Code updates for 2023 include the deletion of hernia repair codes 49560-49590 and 49652-49657. In place of the deleted codes, the AMA added 12 new codes that describe hernia repair by any surgical approach and include the insertion of mesh or other prosthesis when performed. The new CPT®[1] codes for 2023 are categorized based on: whether the hernia is **initial** or **recurrent**, **reducible** or **incarcerated/strangulated**, and the **repair size**. Providers do not need to change how inguinal, lumbar, and/or femoral hernia repair is reported. Additionally, the new codes incorporate three separate size distinctions:

- **< 3 cm**
- **3 cm – 10 cm**
- **> 10 cm**

New add-on code

Creation of a new add-on code for removal of total or near total non-infected mesh to be reported with all abdominal hernia repair codes.

CPT®[1] code	Description
Mesh Removal	
+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 (eg, open, laparoscopic, robotic)

NOTE: Providers may report 11008 (Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) List separately in addition to code for primary procedure.[2]

2023 updates

Global period considerations

Medicare payment for most surgical procedures covers both the procedure and post-operative visits occurring within a global period of either 010 or 090 days following the procedure. For 2023, the new abdominal repair CPT®[1] codes have a 000 day global and as a result, providers are now able to separately report pre and post operative E/M codes and receive reimbursement.

There were no changes in the global for inguinal or femoral hernia repair which have 90 days.

NCCI edits

New NCCI edits have been developed for the new abdominal hernia codes. Be aware that some NCCI edits appear to have inconsistencies with CPT®[1] guidance.[3] Providers should develop a strategy for how to manage. For further questions and/or information surrounding NCCI edits, please consult your Medtronic Reimbursement Support personnel.

2023 Abdominal hernia repair coding crosswalk

			2022 Old CPT®[1] code	2023 < 3 cm New CPT®[1] code	2023 3-10 cm New CPT®[1] code	2023 > 10 cm New CPT®[1] code
Laparoscopic Incisional Ventral Hernia	Initial	Reducible	49654	49591	49593	49595
		Incarcerated Strangulated	49655	49592	49594	49696
	Recurrent	Reducible	49656	49613	49615	49517
		Incarcerated Strangulated	49657	49614	49516	49518

			2022 Old CPT®[1] code	2023 < 3 cm New CPT®[1] code	2023 3-10 cm New CPT®[1] code	2023 > 10 cm New CPT®[1] code
Laparoscopic Hernia (Other)	Initial	Reducible	49652	49591	49593	49595
		Incarcerated Strangulated		49592	49594	49596
	Recurrent	Reducible	49653	49613	49615	49617
		Incarcerated Strangulated		49614	49616	49618

2023 Abdominal open hernia repair coding crosswalk

			2022	2023	2023	2023
				< 3 cm	3-10 cm	>10 cm
			Old CPT®[1] code	New CPT®[1] code	New CPT®1 code	New CPT®[1] code
Open Incisional Ventral	Initial	Reducible	49560	49591	49593	49595
		Incarcerated Strangulated	49561	49592	49594	49596
	Recurrent	Reducible	49565	49613	49615	49617
		Incarcerated Strangulated	49566	49614	49616	49618

			2022	2023	2023	2023
				<3 cm	3-10 cm	>10 cm
			Old CPT®[1] code	New CPT®[1] code	New CPT®[1] code	New CPT®[1] code
Open Umbilical Hernia	Initial (< 5 Years)	Reducible	49580	49591	49593	49595
		Incarcerated Strangulated	49582	49592	49594	49596
	Recurrent (> 5 Years)	Reducible	49585	49613	49615	49617
		Incarcerated Strangulated	49587	49614	49616	49618

2023 Abdominal open hernia repair coding crosswalk

			2022	2023	2023	2023
				< 3 cm	3-10 cm	> 10 cm
			Old CPT®[1] code	New CPT®[1] code	New CPT®[1] code	New CPT®[1] code
Open Epigastric Hernia	Initial	Reducible	49570	49591	49593	49595
		Incarcerated Strangulated	49572	49592	49594	49596
	Recurrent	Reducible	49570	49613	49615	49617
		Incarcerated Strangulated	49572	49614	49616	49618

			2022	2023	2023	2023
				< 3 cm	3-10 cm	> 10 cm
			Old CPT®[1] code	New CPT®[1] code	New CPT®[1] code	New CPT®[1] code
Open Spigelian Hernia	Initial	Reducible	49590	49591	49513	49595
		Incarcerated Strangulated		49592	49594	49596
	Recurrent	Reducible	49590	49613	49615	49517
		Incarcerated Strangulated		49614	49516	49518

Coding

The coding information below does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes must be supported by clear documentation within the medical record.

- HCPCS[4] II codes
- CPT®[1] procedure codes
- ICD-10-PCS[5] codes
- Coding appendix

HCPS[4] II codes

Level II HCPCS[4] codes are primarily used to report supplies, drugs and implants that are not reported by a CPT®[1] code. HCPCS codes are reported by the physician, hospital or DME provider that purchased the item, device, or supply. Different payers have different payment methods for these items.

C-codes are a series of HCPCS codes that facilities reimbursed under the Medicare Outpatient Prospective Payment System (OPPS) are required to report for eligible items and services. Medicare assigns C codes to specific devices eligible for pass-through payment. Every year, in the OPPS rule, Medicare publishes a list of CPT®[1] and HCPCS codes that are designated as device-intensive procedures. When reporting procedures on this list, facilities should capture both the CPT®[1] code representing the procedure performed and the C-code representing the device used. Although C-codes only affect Medicare outpatient reimbursement, facilities may also want to report C-codes on inpatient claims if the device is not used exclusively for inpatient procedures. Medicare tracks this information and uses it in its rate-setting process. Non-OPPS facilities may report C- codes at their discretion.

HCPCS II S-codes cannot be reported to Medicare. They are used only by non-Medicare payers, which cover and price them according to their own policies and provider contracts.

HCPCS[4] code	Description
C1781	Mesh (implantable)
C9364	Porcine implant, Permacol™, per square centimeter
A4649	Surgical supply; miscellaneous
S2900	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)

CPT®[1] procedure codes

CPT®[1] code	Description
Abdominal hernia, initial	
Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s);	
49591	Less than 3 cm, reducible
49592	Less than 3 cm, incarcerated or strangulated
49593	3 cm to 10 cm, reducible
49594	3 cm to 10 cm, incarcerated or strangulated
49595	Greater than 10 cm, reducible
49596	Greater than 10 cm, incarcerated or strangulated
Abdominal hernia, recurrent	
Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s);	
49613	Less than 3 cm, reducible
49614	Less than 3 cm, incarcerated or strangulated
49615	3 cm to 10 cm, reducible
49616	3 cm to 10 cm, incarcerated of strangulated
49617	Greater than 10 cm, reducible
49618	Greater than 10 cm, incarcerated or strangulated

CPT®[1] procedure codes

CPT®[1] code	Description
Component separation	
15734	Muscle, myocutaneous or fasciocutaneous flap; trunk
Diaphragmic hernia	
39501	Repair, laceration of diaphragm, any approach
39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic
Enterolysis	
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)
44180	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion)
Femoral hernia	
49550	Repair initial femoral hernia, any age; reducible
49553	Repair initial femoral hernia, any age; incarcerated or strangulated
49555	Repair recurrent femoral hernia; reducible
49557	Repair recurrent femoral hernia; incarcerated or strangulated

CPT®[1] procedure codes

CPT®[1] code	Description
Inguinal hernia	
49492	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated
49495	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible
49496	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated
49505	Repair initial inguinal hernia, age 5 years or older; reducible
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated
49520	Repair recurrent inguinal hernia, any age; reducible
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated
49525	Repair inguinal hernia, sliding, any age
49650	Laparoscopy, surgical; repair initial inguinal hernia
49651	Laparoscopy, surgical; repair recurrent inguinal hernia

CPT®[1] procedure codes

CPT®[1] code	Description
Mesh removal	
+11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)
+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) (List separately in addition to code for primary procedure)
Paracolostomy hernia	
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)
Paraoesophageal hernia	
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg nissen, toupet procedures)
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis

CPT®[1] procedure codes

CPT®[1] code	Description
Parastomal hernia	
49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible
49622	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated
Unlisted hernia	
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy

ICD-10-PCS[5] codes

ICD-10-PCS[5] procedure codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly used ICD-10-PCS procedure codes, however codes listed below are not exhaustive as other codes may apply.

ICD-10-PCS[5] code	Description
Abdominal wall repair	
0WQF4ZZ	Repair Abdominal Wall, Percutaneous Endoscopic Approach
0WQF0ZZ	Repair Abdominal Wall, Open Approach
0WUF4KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0WUF4JZ	Supplement Abdominal Wall with Synthetic Substitute, Percutaneous Endoscopic Approach
0WUF0JZ	Supplement Abdominal Wall with Synthetic Substitute, Open Approach
0YU64KZ	Supplement Left Inguinal Region with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0YUE0JZ	Supplement Bilateral Femoral Region with Synthetic Substitute, Open Approach
0BUT4KZ	Supplement Diaphragm with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
Component separation	
0KNK4ZZ	Release Right Abdomen Muscle, Percutaneous Endoscopic Approach
0KNL4ZZ	Release Left Abdomen Muscle, Percutaneous Endoscopic Approach
0KNK0ZZ	Release Right Abdomen Muscle, Open Approach
0KNL0ZZ	Release Left Abdomen Muscle, Open Approach
Adhesiolysis	
0DN84ZZ	Release Small Intestine, Percutaneous Endoscopic Approach

Coding appendix

Add-on CPT®[1] codes

An Add-on Code is a CPT®[1] code that describes a service that is performed in conjunction with the primary service by the same practitioner. All codes in an encounter should be reported even if they are packaged under the OPPS and only paid to the healthcare professional.

Modifiers

Modifiers are used to supplement the information or adjust the care description to provide extra details concerning a procedure or service. Modifiers help further describe a procedure code without changing its definition. Modifiers are appended to CPT®[1] codes. A list of modifiers can be found in the CPT®[1] book.[2]

NCCI edits

The Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding, with the overall goal of reducing improper payments of Medicare Part B and Medicaid claims. Providers should consider NCCI edits when submitting claims.[3]

Coding appendix

Unlisted codes

Unlisted codes do not have established RVUs under Medicare's Physician Payment System and are typically priced by the contractor after review and individual consideration.

Unlisted CPT®[1] codes do not carry a rate assignment from Medicare in the physician office setting. Payment may be available on a case-by-case basis with submission of medical records.

Reimbursement

This section provides 2023 Medicare unadjusted national average allowable rates for physician, hospital outpatient, and ambulatory surgery settings. CPT®[1] code descriptions in this section have been shortened to the consumer-friendly version per AMA guidelines.[6]

Providers may choose to perform multiple procedures during the same encounter. When this occurs, providers must report all procedures and the payment may be subject to packaging rules, multiple procedure reduction, complexity adjustments, or multiple endoscopy reductions.

- Physician[7], Hospital Outpatient[8] and Ambulatory Surgery[8] national unadjusted reimbursement rates
- Inpatient[9] national unadjusted reimbursement rates
- Reimbursement appendix

Reimbursement

Physician, Hospital Outpatient, and Ambulatory Surgery national unadjusted reimbursement rates

		Physician[7]			Hospital Outpatient[8]			Ambulatory Surgery[8]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Abdominal hernia, initial									
49591	Less than 3 cm; reducible	5.96	NA	$346	5341	J1	$3,542†	G2	$1,666
49592	Less than 3 cm; incarcerated or strangulated	8.46	NA	$481	5361	J1	$5,212†	G2	$2,498
49593	Between 3 cm and 10 cm; reducible	10.26	NA	$579	5341	J1	$3,542†	G2	$1,666
49594	Between 3 cm and 10 cm; incarcerated or strangulated	13.46	NA	$754	5361	J1	$5,212†	G2	$2,498
49595	Greater than 10 cm; reducible	13.94	NA	$778	5341	J1	$3,542†	G2	$1,666
49596	Greater than 10 cm; incarcerated or strangulated	18.67	NA	$1,034	NA	C	NA	NA	NA
Abdominal hernia, recurrent									
49613	Less than 3 cm; reducible	7.42	NA	$426	5341	J1	$3,542†	G2	$1,666
49614	Less than 3 cm; incarcerated or strangulated	10.25	NA	$578	5361	J1	$5,212†	G2	$2,498
49615	Between 3 cm and 10 cm; reducible	11.46	NA	$646	5341	J1	$3,542†	G2	$1,666
49616	Between 3 cm and 10 cm; incarcerated or strangulated	15.55	NA	$868	NA	C	NA	NA	NA
49617	Greater than 10 cm; reducible	16.03	NA	$894	NA	C	NA	NA	NA
49618	Greater than 10 cm; incarcerated or strangulated	22.67	NA	$1,252	NA	C	NA	NA	NA

Please refer to page 27 for footnotes

Reimbursement

Physician, Hospital Outpatient, and Ambulatory Surgery national unadjusted reimbursement rates

		Physician[7]			Hospital Outpatient[8]			Ambulatory Surgery[8]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Component separation									
15734	Creation of muscle graft to trunk	23.00	NA	$1,517	5055	T	$3,253	A2	$1,694
Diaphragmic hernia									
39501	Repair of muscle tissue separating chest and abdominal cavities	13.98	NA	$856	NA	C	NA	NA	NA
39503	Repair of congenital defect of muscle separating chest and abdominal cavitites, neonate	108.91	NA	$5,781	NA	C	NA	NA	NA
39541	Repair of chronic injury to muscle separating chest and abdominal cavitites	15.75	NA	$941	NA	C	NA	NA	NA
Enterolysis									
44005	Release of intestinal scar tissue	18.46	NA	$1,103	NA	C	NA	NA	NA
44180	Release of small bowel scar tissue using an endoscope	15.27	NA	$931	5361	J1	$5,212†	NA	NA
Femoral hernia									
49550	Repair of femoral groin hernia	8.99	NA	$588	5341	J1	$3,542†	A2	$1,666
49553	Repair of trapped femoral groin hernia	9.92	NA	$644	5341	J1	$3,542†	A2	$1,666

Please refer to page 27 for footnotes

Reimbursement

Physician, Hospital Outpatient, and Ambulatory Surgery national unadjusted reimbursement rates

		Physician[7]			Hospital Outpatient[8]			Ambulatory Surgery[8]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Femoral hernia									
49555	Repair of recurrent femoral groin hernia	9.39	NA	$616	5341	J1	$3,542†	A2	$1,666
49557	Repair of trapped recurrent femoral groin hernia	11.62	NA	$736	5341	J1	$3,542†	A2	$1,666
Inguinal hernia									
49492	Repair of trapped groin hernia in preterm infant younger than 37 weeks gestation performed from birth to 50 weeks postconception	15.43	NA	$974	5341	J1	$3,542†	NA	NA
49495	Repair of groin hernia in full term infant younger than 6 months or preterm infant older than 50 weeks of age postconception and younger than 6 months at the time of surgery	6.20	NA	$417	5341	J1	$3,542†	A2	$1,666
49496	Repair of trapped groin hernia in full term infant younger than 6 months or preterm infant older than 50 weeks postconception and younger than 6 months at time of surgery	9.42	NA	$626	5341	J1	$3,542†	A2	$1,666
49500	Repair of groin hernia (6 months to younger than 5 years)	5.84	NA	$425	5341	J1	$3,542†	A2	$1,666
49501	Repair of trapped groin hernia (6 months to younger than 5 years)	9.36	NA	$618	5341	J1	$3,542†	A2	$1,666

Please refer to page 27 for footnotes

Reimbursement

Physician, Hospital Outpatient, and Ambulatory Surgery national unadjusted reimbursement rates

		Physician[7]			Hospital Outpatient[8]			Ambulatory Surgery[8]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Inguinal hernia									
49505	Repair of groin hernia (5 years or older)	7.96	NA	$532	5341	J1	$3,542†	A2	$1,666
49507	Repair of trapped groin hernia (5 years or older)	9.09	NA	$598	5341	J1	$3,542†	A2	$1,666
49520	Repair of groin hernia that is not trapped	9.99	NA	$644	5341	J1	$3,542†	A2	$1,666
49521	Repair of trapped or strangulated groin hernia	11.48	NA	$729	5341	J1	$3,542†	A2	$1,666
49525	Repair of sliding groin hernia	8.93	NA	$584	5341	J1	$3,542†	A2	$1,666
49650	Repair of groin hernia using an endoscope	6.36	NA	$441	5361	J1	$5,212†	A2	$2,498
49651	Repair of recurrent groin hernia using an endoscope	8.38	NA	$575	5361	J1	$5,212†	A2	$2,498

Please refer to page 27 for footnotes

Reimbursement

Physician, Hospital Outpatient, and Ambulatory Surgery national unadjusted reimbursement rates

		Physician[7]			Hospital Outpatient[8]			Ambulatory Surgery[8]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Mesh removal									
+11008	Removal of infected artificial material or mesh from abdomen	5.00	NA	$274	NA	C	NA	NA	NA
+49623	Removal of mesh at same time as hernia repair	3.75	NA	$199	NA	N	NA	NA	NA
Paracolostomy hernia									
44346	Revision of opening from large bowel to skin with repair of hernia	19.63	NA	$1,193	NA	C	NA	NA	NA
Paraoesophageal hernia									
43280	Strengthening of muscle between esophagus and stomach by wrapping part of stomach around esophagus using an endoscope	18.10	NA	$1,090	5362	J1	$9,087†	NA	NA
43281	Repair of hernia of muscle at esophagus and stomach using an endoscope	26.60	NA	$1,552	5362	J1	$9,087†	NA	NA
43282	Repair of hernia of muscle at esophagus and stomach with implantation of mesh using an endoscope	30.10	NA	$1,746	5362	J1	$9,087†	NA	NA

Please refer to page 27 for footnotes

Reimbursement

Physician, Hospital Outpatient, and Ambulatory Surgery national unadjusted reimbursement rates

		Physician[7]			Hospital Outpatient[8]			Ambulatory Surgery[8]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Paraoesophageal hernia									
43332	Repair of paraesophageal hernia through abdomen	19.62	NA	$1,157	NA	C	NA	NA	NA
43333	Repair of paraesophageal hernia with mesh implant through abdomen	21.46	NA	$1,267	NA	C	NA	NA	NA
43334	Repair of paraesophageal hernia through chest	22.12	NA	$1,241	NA	C	NA	NA	NA
Parastomal hernia									
49621	Repair of sliding hernia next to stoma	13.70	NA	$749	NA	C	NA	NA	NA
49622	Repair of entrapped hernia next to stoma	17.06	NA	$924	NA	C	NA	NA	NA
Unlisted hernia									
49659	Other repair of hernia using an endoscope	Carrier priced			5361	J1	$5,212†	NA	NA

Please refer to page 27 for footnotes

Reimbursement

Inpatient[9] national unadjusted reimbursement rates

Under Medicare's MS-DRG[9] methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG[9] has a relative weight that is then converted to a flat payment amount. Only one MS-DRG[9] is assigned for each inpatient stay, regardless of the number of procedures performed. MS-DRGs shown are those typically assigned to the following scenarios when the patient is admitted specifically for the procedure.

Below are commonly used DRGs, however codes listed below are not exhaustive as other codes may apply.

MS-DRG[9]	Description	Rate
Repair of Diaphragmatic Hernia (Hiatal Hernia, Paraesophagael Hernia)		
326	Stomach, Esophageal And Duodenal Procedures W MCC	$35,112
327	Stomach, Esophageal And Duodenal Procedures W CC	$17,569
328	Stomach, Esophageal And Duodenal Procedures W/O CC/MCC	$11,371
Adhesiolysis		
335	Peritoneal Adhesiolysis W MCC	$25,269
336	Peritoneal Adhesiolysis W CC	$14,590
337	Peritoneal Adhesiolysis W/O CC/MCC	$10,807
Hernia Repair – Inguinal, Femoral		
350	Inguinal and Femoral Hernia Procedures W MCC	$16,168
351	Inguinal and Femoral Hernia Procedures W CC	$10,085
352	Inguinal and Femoral Hernia Procedures W/O CC/MCC	$7,560
Hernia Repair – Other (Epigastric, Incisional/Ventral, Lumbar, Parastomal, Spigelian, Umbilical)		
353	Hernia Procedure Except Inguinal and Femoral W MCC	$19,672
354	Hernia Procedure Except Inguinal and Femoral W CC	$12,018
355	Hernia Procedure Except Inguinal and Femoral W CC/MCC	$9,413

MCC: Major Complications and/or Comorbidities **CC: Complications and/or Comorbidities**

Footnotes

Can add "see appendix for further explanation"

NA	Indicates that there is no established Medicare allowable in this site of care
+	Add-on codes are always listed in addition to the primary procedure code
†	Comprehensive APCs (C-APCs)
¶	Device intensive
§	Packaged Payment, see Status Indicators in Reimbursement appendix
||	Modifier, see definitions in Reimbursement appendix
RVU	Indicates Relative Value Unit

Reimbursement appendix

Carrier priced

Carrier priced codes are not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis.

Complexity adjustment

The complexity adjustments were implemented by CMS to provide for a payment adjustment when two or more high-cost procedures are performed and paid under Medicare's Hospital Outpatient Comprehensive APC system. To qualify, claims with certain code combinations must meet specific thresholds for both cost and frequency. When these thresholds are met, the code combinations qualify for reassignment to the next highest paying APC.

Comprehensive APC

In the Outpatient Prospective Payment System, a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. Comprehensive APCs (or C-APCs) are identified by HCPCS with assigned status indicator = J1 or J2. All other Medicare Part B services provided at the same surgical encounter are packaged with the primary service.

Reimbursement appendix

Inpatient Only (IPO) List

CMS can define procedures and services for which payment under the outpatient prospective payment system (OPPS) is inappropriate. Services designated as “inpatient only” are not appropriate to be furnished in a hospital outpatient department. Generally, inpatient only procedures are surgical services that require inpatient care because of the nature of the procedure.

Status Indicator

In the Hospital Outpatient, Status Indicator (SI) shows how a code is handled for payment purposes: C= Inpatient procedures, not paid under OPPS; J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; S = procedure or service not discounted when multiple procedure; Additional details can be found in Addendum D1 of the OPPS rule

Work Relative Value Unit (RVU)

The Work RVU is a unit of measure that describes the work associated with a physician’s procedural services and is factored into the total physician payment. Work RVU is one of three total components on which physician payment is based: physician work RVU, practice expense RVU, and medical malpractice RVU.[7]

Reimbursement appendix

Payment Indicator

In the ASC, the Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; A2 = surgical procedure, payment based on hospital outpatient rate adjusted for ASC; G2 = surgical procedure, non-office based, payment based on hospital outpatient rate adjusted for ASC.

w/MCC, w/CC or w/o CC/MCC

In the inpatient setting, w/MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs w/MCC have at least one major secondary complication or comorbidity. Similarly, w/CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs w/CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs w/o CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.

Frequently asked questions

01

Can I bill separately for the implantation of the mesh?

Prior to 2023, an add-on code was reported on the claim when mesh was inserted in open procedures using CPT®[1] code +49658 – Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection. Effective January 1, 2023, CPT®[1] code +49568 was deleted. The new CPT®[1] codes for abdominal hernia repair include the physician work associated with the implantation of mesh

02

How do you code if both reducible and incarcerated/strangulated hernias are repaired during the same encounter?

All hernias are reported as if they were incarcerated/strangulated.

Frequently asked questions

03

How do I code a procedure that was robotically assisted?

When coding for robotic-assisted procedures in the outpatient setting or the professional fee, the CPT®[1] code that accurately describes the surgical procedure via laparoscopic approach should be used. There are no designated CPT®[1] codes or modifiers to report the use of robotic assistance. Some commercial payers may allow the use of HCPCS code S2900 to report robotic assistance. S codes should not be used when billing services to Medicare. When coding inpatient facility services, robotic assistance indexes to ICD-10-PCS code table 8E0.[5]

04

What do the changes in Global Period mean for Abdominal Hernia Repair procedures

Medicare payment for most surgical procedures covers both the procedure and post-operative visits occurring within a global period of either 010 or 090 days following the procedure. The new abdominal repair CPT®[1] codes have a 000 day global period and as a result, providers are now able to separately report pre and post operative E/M codes and receive reimbursement. There were no changes in the global periods for inguinal or femoral hernia repair.

Frequently asked questions

05

What is a common scenario where modifier 50 is utilized/appended?

Modifier 50 is reported when bilateral procedures are performed on both sides of the body. Modifier 50 should not be appended to midline procedures such as abdominal hernias. Modifier 50 can be used with inguinal or femoral hernias when both the right and left side are surgically repaired.

06

How do you report a repair of an inguinal, femoral or lumbar and an anterior abdominal hernia performed in the same operative session?

Both procedures may be reported when performed in the same operative session by appending modifier 59. Please reference the 2023 CPT®[1] book for more information.[2]

Resources

Medtronic Reimbursement Support is available to assist you with your coding and reimbursement questions. If your coding or reimbursement questions were not answered in this guide, please check out these additional resources:

Visit our website: https://www.medtronic.com/covidien/en-us/support/reimbursement.html

Email us: rs.MedtronicMedicalSurgicalReimbursement@medtronic.com

Ask us about our Quick Reference Guide for CY2023 Abdominal Hernia code changes.

References

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