

Hernia Repair

Coverage, Coding and Reimbursement Overview — Physician / Hospital Outpatient / ASC

2011 Edition† — All Reimbursement Amounts are Listed at National Medicare Rates



PHYSICIAN OVERVIEW

Physician rates effective January 1, 2011 through December 31, 2011.

COVERAGE

Medicare	Carrier LCD (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

NON-INGUINAL ^A	CODING	REIMBURSEMENT ^B
	CPT® Codes	Professional
Repair initial incisional or ventral hernia; reducible	49560	\$732
incarcerated or strangulated	49561	\$913
Repair recurrent incisional or ventral hernia; reducible	49565	\$753
incarcerated or strangulated	49566	\$923
Implantation of mesh or other prosthesis for open incisional or ventral hernia repair, or closure of debridement (use with 11004–11006, 49560–49566)	+49568	\$266
Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	43332 <i>New!</i>	\$1,183
with implantation of mesh or other prosthesis	43333 <i>New!</i>	\$1,285
Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	43334 <i>New!</i>	\$1,299
with implantation of mesh or other prosthesis	43335 <i>New!</i>	\$1,399
Repair, paraesophageal hiatal hernia (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	43336 <i>New!</i>	\$1,533
with implantation of mesh or other prosthesis	43337 <i>New!</i>	\$1,673
Repair diaphragmatic hernia	39503, 39540, 39541	\$6,046, \$868, \$941
Repair lumbar hernia	49540	\$662
Repair epigastric hernia	49570, 49572	\$404, \$501
Repair umbilical hernia	49580, 49582, 49585, 49587	\$319, \$468, \$432, \$511
Repair spigelian hernia	49590	\$559
Repair femoral hernia	49550, 49553, 49555, 49557	\$563, \$617, \$585, \$709
Repair of omphalocele	49600, 49605, 49606, 49610, 49611	\$719, \$4,916, \$1,115, \$675, \$547
Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty; without implantation of mesh	43281	\$1,575
with implantation of mesh	43282	\$1,770
Laparoscopy, surgical, esophageal lengthening procedure (eg., Collis gastroplasty or wedge gastroplasty)	43338	\$136
Laparoscopy, surgical, repair ventral, umbilical, spigelian, epigastric hernia (includes mesh insertion); reducible	49652	\$719
incarcerated or strangulated	49653	\$901
Laparoscopy, surgical, incisional hernia (includes mesh insertion); reducible	49654	\$827
incarcerated or strangulated	49655	\$995
Laparoscopy, surgical, recurrent incisional hernia (includes mesh insertion); reducible	49656	\$830
incarcerated or strangulated	49657	\$1,193
Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	49659	Carrier Determined
INGUINAL ^A	CODING	REIMBURSEMENT ^B
Repair, initial inguinal hernia, preterm infant to under five years; reducible	49491, 49495, 49500	\$772, \$395, \$376
incarcerated or strangulated	49492, 49496, 49501	\$936, \$603, \$589
Repair initial inguinal hernia, age five years or over; reducible	49505	\$507
incarcerated or strangulated	49507	\$624
Repair recurrent inguinal hernia, any age; reducible	49520	\$618
incarcerated or strangulated	49521	\$751
Repair inguinal hernia, sliding, any age	49525	\$560
Laparoscopy, surgical; repair initial inguinal hernia	49650	\$416
repair recurrent inguinal hernia	49651	\$542

^A Abbreviated CPT® Code descriptions. See CPT® codebook for full descriptions.

^B Conversion factor used for this Overview is \$33.9764, as published in CMS Change Request 7300.

HOSPITAL (FACILITY) OUTPATIENT OVERVIEW

Hospital Outpatient rates effective January 1, 2011 through December 31, 2011.

COVERAGE

Medicare	Fiscal Intermediary (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

CODING		REIMBURSEMENT		
Device Code ^a	HCPCS / CPT [®] Codes	Outpatient (OPPS)		
		APC	SI ^A	Rate
Mesh implantable (absorbable, non-absorbable)	C1781 ^B	—	N	—
NON-INGUINAL^C		REIMBURSEMENT		
Repair initial incisional or ventral hernia; reducible	49560	154	T	\$2,278
incarcerated or strangulated	49561	154	T	\$2,278
Repair recurrent incisional or ventral hernia; reducible	49565	154	T	\$2,278
incarcerated or strangulated	49566	154	T	\$2,278
Implantation of mesh or other prosthesis for open incisional or ventral hernia repair, or closure of debridement (use with 11004–11006, 49560–49566)	+49568	154	T	\$2,278
Repair paraesophageal hiatal hernia	43332, 43333, 43334, 43335, 43336, 43337	—	C	—
Repair diaphragmatic hernia	39503, 39540, 39541	—	C	—
Repair lumbar hernia	49540	154	T	\$2,278
Repair epigastric hernia	49570, 49572	154	T	\$2,278
Repair umbilical hernia	49580, 49582, 49585, 49587	154	T	\$2,278
Repair spigelian hernia	49590	154	T	\$2,278
Repair femoral hernia	49550, 49553, 49555, 49557	154	T	\$2,278
Repair of small omphalocele	49600	154	T	\$2,278
Repair of large omphalocele	49605, 49606, 49610, 49611	—	C	—
Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty; without implantation of mesh	43281	—	C	—
with implantation of mesh	43282	—	C	—
Laparoscopy, surgical, esophageal lengthening procedure (eg., Collis gastroplasty or wedge gastroplasty)	43338	—	C	—
Laparoscopy, surgical, repair ventral, umbilical, spigelian, epigastric hernia (includes mesh insertion); reducible	49652	132	T	\$4,897
incarcerated or strangulated	49653	132	T	\$4,897
Laparoscopy, surgical, incisional hernia (includes mesh insertion); reducible	49654	132	T	\$4,897
incarcerated or strangulated	49655	132	T	\$4,897
Laparoscopy, surgical, recurrent incisional hernia (includes mesh insertion); reducible	49656	132	T	\$4,897
incarcerated or strangulated	49657	132	T	\$4,897
Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	49659	130	T	\$2,662
INGUINAL^C		REIMBURSEMENT		
Repair, initial inguinal hernia, with or without hydrocelectomy	49491, 49495, 49500	154	T	\$2,278
incarcerated or strangulated	49492, 49496, 49501	154	T	\$2,278
Repair initial inguinal hernia, age five years or over; reducible	49505	154	T	\$2,278
incarcerated or strangulated	49507	154	T	\$2,278
Repair recurrent inguinal hernia, any age; reducible	49520	154	T	\$2,278
incarcerated or strangulated	49521	154	T	\$2,278
Repair inguinal hernia, sliding, any age	49525	154	T	\$2,278
Laparoscopy, surgical; repair initial inguinal hernia	49650	131	T	\$3,295
repair recurrent inguinal hernia	49651	131	T	\$3,295

^A Status Indicators: C—Inpatient Procedures; N—Items & Services Packaged into APC Rates; Q1—STVX-Packaged Codes; Q2—T-Packaged Codes; S—Significant Procedure, Not Discounted When Multiple; T—Significant Procedure, Multiple Reduction Applies

^B Used for Medicare outpatient claims.

^C Abbreviated CPT[®] Code descriptions. See CPT[®] codebook for full descriptions.

* Medicare OPPS billing instructions require the reporting of device C-codes for certain APCs. Refer to the CMS website: http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedures.asp

COVERAGE

Medicare	Carrier LCD (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

NON-INGUINAL^B	CODING	REIMBURSEMENT
	CPT[®] Code	Rate
Repair initial incisional or ventral hernia; reducible	49560	\$1,282
incarcerated or strangulated	49561	\$1,282
Repair recurrent incisional or ventral hernia; reducible	49565	\$1,282
incarcerated or strangulated	49566	\$1,282
Implantation of mesh or other prosthesis for open incisional or ventral hernia repair, or closure of debridement (use with 11004–11006, 49560–49566)	+49568	\$1,282
Repair paraesophageal hiatal hernia	43332, 43333, 43334, 43335, 43336, 43337	Non-covered
Repair diaphragmatic hernia	39503, 39540, 39541	Non-covered
Repair lumbar hernia	49540	\$1,282
Repair epigastric hernia	49570, 49572	\$1,282, \$1,282
Repair umbilical hernia	49580, 49582, 49585, 49587	\$1,282, \$1,282, \$1,282, \$1,282
Repair spigelian hernia	49590	\$1,282
Repair femoral hernia	49550, 49553, 49555, 49557	\$1,282, \$1,282, \$1,282, \$1,282
Repair of omphalocele	49600	\$1,282
Repair of omphalocele (other)	49605, 49606, 49610, 49611	Non-covered
Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty; without implantation of mesh	43281	Non-covered
with implantation of mesh	43282	Non-covered
Laparoscopy, surgical, esophageal lengthening procedure (eg., Collis gastroplasty or wedge gastroplasty)	43338	Non-covered
Laparoscopy, surgical, repair ventral, umbilical, spigelian, epigastric hernia (includes mesh insertion); reducible	49652	\$2,755
incarcerated or strangulated	49653	\$2,755
Laparoscopy, surgical, incisional hernia (includes mesh insertion); reducible	49654	\$2,755
incarcerated or strangulated	49655	\$2,755
Laparoscopy, surgical, recurrent incisional hernia (includes mesh insertion); reducible	49656	\$2,755
incarcerated or strangulated	49657	\$2,755
Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	49659	Non-covered

INGUINAL^B	CODING	REIMBURSEMENT
Repair, initial inguinal hernia, pre-term infant; reducible	49491	Non-covered
incarcerated or strangulated	49492	Non-covered
Repair initial inguinal hernia, full-term infant under age six months; reducible	49495	\$1,282
incarcerated or strangulated	49496	\$1,282
Repair initial inguinal hernia, age six months to under five years; reducible	49500	\$1,282
incarcerated or strangulated	49501	\$1,282
Repair initial inguinal hernia, age five years or older; reducible	49505	\$1,282
incarcerated or strangulated	49507	\$1,282
Repair recurrent inguinal hernia, any age; reducible	49520	\$1,282
incarcerated or strangulated	49521	\$1,282
Repair inguinal hernia, sliding, any age	49525	\$1,282
Laparoscopy, surgical; repair initial inguinal hernia	49650	\$1,854
repair recurrent inguinal hernia	49651	\$1,854

^A Refer to Addendum AA and BB of CMS - 1504FC for covered ASC procedures and current information, [www.cms.hhs.gov/ASCPayment/04F_\(ASC\).asp](http://www.cms.hhs.gov/ASCPayment/04F_(ASC).asp)
^B Abbreviated CPT[®] Code descriptions. See CPT[®] codebook for full descriptions.

TERMINOLOGY AND ACRONYMS

ABN: Advance Beneficiary Notice. A legal, written notice to a Medicare beneficiary from a physician or hospital informing the patient that the health service or item that the physician has prescribed is not or may not be a covered service under Medicare, and that the patient will be responsible for payment if denied.

Anesthesia Guidelines: The rules for coding and charging are complex. Variable circumstances can include duration, method of anesthesia / sedation, the physician or specialist administering services, and the site of service. Local Medicare Policies, and the AMA CPT® coding book, professional edition, should be consulted for questions regarding the proper coding and billing for anesthesia services.

APC: Ambulatory Payment Classification. These are numeric classifications used by Medicare to reimburse services performed in a hospital outpatient setting. An APC will contain multiple HCPCS Codes that are similar both clinically and in terms of resources used by the hospital. The APC rate is set prospectively by CMS based on historic claims data.

APC Status Indicator: Alpha characters are used to designate the APC payment calculation method. For multiple APCs on a single claim with Status Indicator "T" the first APC will be paid at 100% and all others at 50%. For all APCs with Status Indicator "S" each APC will be paid at 100%, no discounting.

ASC: Ambulatory Surgery Center. When used by Medicare, this designation describes a legal licensing status establishing a site of service distinct from a physician's office or hospital-based facility.

Bundled: Certain supplies / procedures provided by a physician as described by CPT® Codes / HCPCS Codes may be included ("Bundled") with another service for reimbursement purposes.

Carrier: A Medicare contractor responsible for physician and ASC medical policies, adjudication of claims and other administrative functions.

CC: Complications and Comorbidities. Patient conditions utilized as two of several factors in MS-DRG Groupers.

CCI: Correct Coding Initiative. A listing of CPT® Codes that are designated as comprehensive or component codes. If comprehensive and component codes are submitted on the same bill, only the comprehensive code will be paid unless a modifier is submitted. Medicare uses these as NCCI (National Correct Coding Initiative) edits.

CPT® Code: Current Procedural Terminology Code. These 5-digit numeric codes are the property of the American Medical Association and are used to describe physician services. Additionally, Medicare licenses these codes from the AMA and uses them to describe physician, hospital outpatient, ASC services, and other outpatient services.

DRG: Diagnosis Related Group. A numeric classification system used by Medicare and some commercial payers to reimburse for hospital inpatient services. The DRG is assigned by software that considers the ICD-9 procedure and diagnosis codes submitted on a claim.

DME: Durable Medical Equipment. Certified supplies, prosthetics, equipment, etc., provided to patients in other than a hospital inpatient setting.

DMERC: Durable Medical Equipment Regional Contractor. Medicare contractor that adjudicates claims for DME providers.

Facility / Non-Facility: For some physician procedures, the reimbursement is determined by the site of service. If the fee is designated as "Facility," the procedure is performed in a site of service other than a physician office. If the fee is designated as "Non-Facility," the procedure is performed in a physician office.

FI: Fiscal Intermediary. A Medicare contractor responsible for hospital inpatient and outpatient medical policies, adjudication of claims and other administrative functions.

HCPCS: Healthcare Common Procedure Coding System. The name of a coding system established by Medicare to describe services and supplies. The base (Level I) codes are CPT® Codes.

ICD-9: International Classification of Diseases. Numeric codes used by essentially all payers to describe diagnosis and procedures. The combination of procedure and diagnosis codes determines DRG assignment for inpatient reimbursement.

ICD-9 procedure 4-digit codes (e.g., 39.90 Insertion of non-drug-eluting peripheral vessel artery stent(s)) Abbrev: Px.

ICD-9 diagnosis 3, 4 or 5-digit codes (e.g., 586 Renal failure, unspecified) Abbrev: Dx.

Inpatient: The status used to describe a patient who has been admitted to the hospital. Usually involves multi-day stay.

IPPS: Inpatient Prospective Payment System. Medicare (CMS) per case (see "DRG" and "MS-DRG") methodology for hospital inpatient services.

LCD / LMRP: Local Coverage Determination / Local Medical Review Policy. The written policies produced by Medicare contractors applicable to geographic areas. A CMS national policy (see NCD) supersedes a LCD.

MCC: Major Complications and Comorbidities. Patient conditions utilized as two of several factors in MS-DRG Groupers. MCC are typically significant acute manifestations or advanced stages of chronic conditions that would result in higher resource utilization in the course of treatment.

MS-DRG: Medicare Severity Diagnosis Related Group. A numeric classification system effective October 1, 2007 used by Medicare to reimburse for hospital inpatient services. The MS-DRG is assigned by the combination of ICD-9 procedure codes, diagnosis codes and the presence or absence of MCC / CCs as derived from the medical record documentation. The MS-DRG system was designed to more accurately pay hospitals based on patient severity of illness.

Modifier: A 2-digit alphanumeric code that is appended to a CPT® Code for further specificity.

NCD: National Coverage Determination. The written policies from Medicare that have a national jurisdiction (supersedes any LCD).

Observation: Hospital outpatient services to monitor and assess a patient for determination of hospital admission or discharge.

OPPS: Outpatient Prospective Payment System. Medicare (CMS) per group (see "APC") methodology for hospital outpatient services.

Outpatient: A patient admitted to a hospital to receive treatment but not admitted as an inpatient (see "Observation").

Packaged: Certain supplies / procedures provided by a facility as described by CPT® Codes / HCPCS Codes may be included ("Packaged") with another service for reimbursement purposes.

Prospective: A predetermined reimbursement rate, regardless of the cost of that service.

Pro / Tech: Professional / Technical. For some diagnostic tests, the physician reimbursement is established in two components. The "Professional" component is for the physician supervision, interpretation and other personal service. The "Technical" component is for the equipment, supplies, staff and other costs related to the test.

S&I: Supervision and Interpretation. This term is sometimes used to differentiate the imaging service (professional reading / interpretation) from other components of the procedure, such as introduction and placement of catheters.

Unadjusted Rate: The prospective reimbursement rate before it is adjusted for local factors such as the wage index, graduate medical education, outlier cases, disproportionate share and other factors. This is sometimes called the "national average" rate. All Medicare reimbursement will have local adjustment factors.

RESOURCES

Suggested Resources: Coding and reimbursement is complex, specific to case documentation and variable by geographic location. Always consult current physician, hospital and ASC resources.

1. Medicare national (NCD) and local policies (LCD / LMRP): <http://www.cms.hhs.gov/mcd/search.asp>
2. CPT® Assistant, American Medical Association: <http://www.ama-assn.org>
3. Current Procedural Terminology CPT®, 2011, American Medical Association: <http://www.ama-assn.org>
4. ICD-9-CM 2011
5. Coding Terminology and Acronyms and additional resource: <http://goremedical.com/coding/>

† Disclaimer: The payment amounts listed in this guide are national averages. Actual payment will vary based on several factors including the site of the service, geographic location, patient population mix, and hospital teaching status. References to particular applications and procedures listed in this Coding Overview do not represent the appropriateness or market availability of any Gore Medical Product. The information contained in this Overview is provided for general information purposes only and should NOT be relied on for submission purposes. Consult your professional resources and the patient's insurer for situation-specific information.

Physicians and hospitals are responsible for selecting and reporting the code(s) that most accurately describe the procedure(s) performed, the products used and the patient's condition. The basis for accurate coding is clear and complete documentation in the medical record, precisely describing the procedures performed and products used.

Providers should follow coding guidelines from the patient's insurer, and should also review the complete coding authorities (e.g., CPT®, HCPCS, ICD-9-CM) used by the insurer.

The identification of a code in this Coding Overview should not be construed to guarantee coverage for a product or procedure, or payment in any particular amount.



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