

Medical Practice Coding Pro

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Grafts and flaps with complex hernia repair

Question: We're having discussions in our surgical practice on a couple of issues related to complex hernia repair. 1) My surgeon thinks he should be able to bill separately for placement of a xenograft during complex incisional hernia repair using dermal graft codes 15330-15331. I think the skin graft codes are not appropriate for hernias. Who's right? 2) When the surgeon does a component separation during the hernia repair, is it appropriate to report 15734?

Answer: To address your first question, both CPT and the American College of Surgeons (ACS) are pretty clear that it would not be appropriate to report an additional graft code when the surgeon places a xenograft mesh as part of an incisional hernia repair.

Here's what CPT states: "With the exception of the incisional or ventral hernia repairs (codes **49560-49566**), the use of mesh or other prostheses is not separately reported. Therefore, if the 'open hernia repair' is for an incisional or a ventral hernia repair, then it would be appropriate to separately report code **49568**, Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair). From a CPT coding perspective, xenograft mesh is a type of mesh prosthesis appropriately reported with code 49568" (CPT Assistant, June 2008).

ACS also warns you away from reporting the 15000 series codes for graft placement during hernia repair. "All codes in the 15000 series were specifically created for burn wounds, and fall within the skin substitute/integumentary section of the CPT Codebook," ACS states in the November 2009 *Bulletin of the American College of Surgeons*. "These codes are not intended to be used for abdominal wall fascial repair. More specifically, **15330**, Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children, and **15430**, Acellular xenograft implant first 10 sq cm or 1% body area of infants or children, are included in this skin substitute section and do not apply to reconstruction of the abdominal wall hernia."

Coding a flap for component separation

CPT does not address whether it would be appropriate to separately report component separation during complex hernia repair, but ACS states that this would be appropriate. "Some general surgeons now perform component separation of the abdominal wall, where the oblique or transversalis muscles are incised lateral to the hernia and the rectus muscles are mobilized toward the midline, to facilitate wound closure," the society states. "For this operation, the use of code **15734**, muscle, myocutaneous, or fasciocutaneous flap, trunk, would be appropriate."

ACS further advises its members to apply modifier **50** (bilateral procedure) to 15734 if performed on two sides of the body, and modifier **51** (multiple procedure) if performed through the same incision as the hernia repair.

You'll need to check payer policies to see how they handle these procedures. Two things to note:

- Medicare policy does not allow additional payment for 15734-50 – you'll only receive payment for one unit of the code, even with the modifier.
- Code 15734 pays \$1,315 (all fees par, not adjusted for locality), which is more than any of the incisional hernia repair codes, 49560-49568 (e.g., 49566 [repair recurrent incisional or ventral hernia; incarcerated or strangulated] pays \$906.70). Medicare policy directs you to append the 51 modifier to lesser-valued codes so the multi-procedure payment reduction will be applied to them. But if the primary reason for the surgery is the complex hernia and the flap procedure is supplemental, practices will need to decide whether that is truly appropriate.

OFFICIAL RESOURCES:

- ▶ *Bulletin of the American College of Surgeons*, November 2009: www.facs.org/ahp/pubs/tips/index.html
- ▶ *CPT Assistant*, June 2008

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