Frequently Asked Questions

QUESTION	ANSWER
Is the hernia defect or the sac measured to determine the size for selecting the correct code?	The hernia **defect** is measured, not the sac.
Is the hernia defect measured using width or length?	The measurement will be the **maximal craniocaudal (vertical) or transverse (horizontal) distance between the outer margins** of the single defect or all defects repaired. Refer to the diagrams from the ACS webinar (slide 20) and the 2023 CPT code book for examples.
Is the hernia size measured before or after opening the hernia defect?	The measurement should be made **before** opening the defect because the fascia will typically retract, resulting in a falsely higher measurement.
How were the size cutoffs in the code descriptors determined?	An expert panel of surgeons from the ACS, SAGES, and ASCRS familiar with hernia repair reviewed the literature that supported the code change application. This literature included **comparison outcome data for different sized hernia repairs that helped inform the decision to use the three categories of size** in the code descriptors.
Do the inguinal, femoral, and lumbar hernia repair codes that are not changing still have a 90-day global period or will all hernia repair codes be changed to a 0-day global period?	Only the anterior abdominal hernia (i.e., epigastric, incisional, ventral, umbilical, spigelian) and parastomal hernia repair codes will have 0-day global period. **All other hernia repair codes, including inguinal, femoral, lumbar, and omphalocele, will continue to have a 90-day global period.**
When billing an unlisted code for a laparoscopic component separation procedure after an incisional hernia repair, is it correct to assume the unlisted code has a 90-day global?	Unlisted codes are contractor-priced codes for which Medicare Administrative Contractors (MAC) determine the global period. However, since it is likely that the unlisted code will be crosswalked to CPT code 15734, which has a 90-day global, **it is correct to assume that the MAC will likely consider the global for that procedure to be 90 days.**
If a general surgeon repairs a large incisional anterior abdominal hernia (0-day global), and then a plastic surgeon comes in to perform a complex component separation abdominal reconstruction (90-day global), is the global period for both surgeons 90 days?	If **each surgeon only reports their own code** for the operation they performed, then the global period would be different for each surgeon based on the code they reported. However, **if both surgeons report both codes,** either as co-surgeons or as assistant surgeons for one another, then the 90-day global would apply for both surgeons.
How do global periods apply for combined procedures—for example, what if one surgeon performs a procedure (i.e., ovarian tumor removal) and another surgeon repairs a large ventral hernia in combination? Does the 90-day global period apply to both procedures even though the hernia repair code has a 0-day global?	If **each surgeon only reports their own code** for the operation they performed, then the global period would be different for each surgeon based on the code they reported. However, **if both surgeons report both codes,** either as co-surgeons or as assistant surgeons for one another, then the 90-day global would apply for both surgeons.

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If two surgeons perform separate procedures—for example, Surgeon A performs a 90-day global hysterectomy and Surgeon B a 0-day global umbilical hernia repair—is Surgeon B's global bumped up to 90 days?	If **each surgeon only reports their own code** for the operation they performed, then the global period would be different for each surgeon. Surgeon A would follow 90-day global rules and Surgeon B would follow 0-day global rules. However, if **both surgeons report both codes**, either as co-surgeons or as assistant surgeons for one another, then the 90-day global would apply for both surgeons.
Will umbilical hernia repairs incident to a non-hernia laparoscopic procedure (e.g., laparoscopic cholecystectomy) still be disallowed?	Yes. A hernia repaired through an incision made to perform another procedure **is not separately reportable.** The repair is inherent to the repair of the incision for the other procedure.
If a surgeon repairs both a ventral hernia and an inguinal hernia, can the two repairs be reported separately? What will the global period be?	Yes, a ventral and inguinal hernia repair **can be separately reported** when performed during the same operative session. Because the inguinal hernia has a 90-day global period, that will be the global period for the entire operation, and E/Ms or other procedures cannot be separately reported during the global with the exception of procedures that require a return to the OR.
How should repair of an incarcerated parastomal hernia of 5 cm and a primary reducible ventral hernia of 8 cm that are separated by 6 cm of fascia be reported?	The parastomal hernia repair codes are distinctly different than the anterior abdominal hernia repair codes. Therefore, **both the parastomal and ventral hernia repairs would be separately reported and the amount of fascia between the hernias is not relevant to coding.** The coding guidance related to distance between distant hernias only applies if all hernias are anterior abdominal hernias (i.e., epigastric, incisional, ventral, umbilical, spigelian).
Is robotic or laparoscopic TAR or component separation reported with CPT code 15734?	CPT code 15734 describes an open procedure. **For more complicated laparoscopic hernia repair procedures that may include separation of components (e.g., TAR), report code CPT code 49659** (*Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy*).
The new hernia repair codes are for any approach (i.e., open, laparoscopic, robotic). Why can't the myocutaneous flap CPT code 15734 also apply to any approach?	The new anterior abdominal hernia code descriptors include terminology about any approach. **Only hernia codes were reviewed and changed at CPT** based on literature and level of evidence. Modification or revision of integumentary codes for myocutaneous flaps or other codes that may be reported for complex abdominal closure were not part of such hernia code review. Therefore, **the repair codes will continue to be reported based on current descriptors and global period assignment.**

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How is a Rives-Stoppa incisional hernia repair with retrorectus mesh reported?	Rives-Stoppa is an incisional hernia repair procedure in which mesh or other prosthesis is placed between the rectus abdominis muscle and the posterior sheath. All anterior abdominal hernia repair codes now include placement of mesh as inherent. Therefore, **only the appropriate hernia repair code is reported. Rives-Stoppa is not reported with CPT code 15734 or adjacent tissue transfer codes.**
When an anterior abdominal hernia repair is performed and the patient is discharged the next day, should the hernia repair be billed as inpatient or outpatient? Is CPT code 99238 for inpatient discharge only?	For 2023, the family of facility E/M codes have been revised to collapse inpatient and observation care services into a single code. Therefore, **if a patient is admitted to overnight observation after an anterior abdominal hernia repair and is examined and discharged the following day, CPT code 99238** (*Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter or code 99239 (more than 30 minutes on the date of encounter)*) **may be reported.**
What E/M code is reported on the day of discharge if the patient is discharged by a hospitalist and not by the surgeon? Do they both report a discharge management code?	For 0-day global codes, **only one physician may bill a discharge code** on the day or days after the procedure—either the physician who admitted and cared for the patient or the physician who assumed the care of the patient. **It would be atypical for a surgeon to transfer postoperative care after a hernia repair to a hospitalist.** This is no different than if the operation performed had a 90-day global (e.g., colectomy), where a hospitalist could not report a discharge day management code unless the surgeon formally transferred postoperative care to the hospitalist because 90-day global codes include all postoperative care, both in the facility and the office, for 90 days.
If a patient has an incisional hernia repair on Monday at 4pm and is admitted to observation, and the next morning the surgeon examines the patient at 8am and clears the patient for discharge, can the surgeon report an E/M?	If **documentation supports discharge day management on the day after surgery,** the surgeon should bill CPT code 99238 or 99239. For 2023, the discharge management codes are revised to indicate either inpatient or observation discharge management.
Can a non-admitting physician bill a discharge code (e.g., CPT code 99238)?	Only **one physician** may bill a discharge code on the day or days after the procedure—either the physician who admitted and cared for the patient or the physician who assumed the care of the patient. For example, if a hospitalist admits a patient and a surgeon takes the patient to the OR to repair a strangulated hernia, and that patient stays under the surgeon's care for two days before discharge, **the surgeon would report the discharge code.**

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If both a ventral hernia repair code and a parastomal hernia repair code are reported, should modifier 51 or 59 be appended to one of the codes?	The anterior abdominal hernia repair codes and parastomal hernia repair codes have an NCCI modifier indicator "1," which means an appropriate modifier is required to bypass the edit. **For these code pairs, the modifier would be 59.**
What E/M modifier is used for the decision for surgery for these new 0-day global hernia repair codes?	If the decision for surgery is made during an E/M visit on any day other than the day of surgery, no modifier is appended to the E/M code. However, **if the E/M service is performed on the day of surgery**—for example, if a surgeon is called into the emergency department to consult on a possible strangulated hernia and decides the patient needs to go to the OR—**then modifier 25 would be appended to the appropriate E/M code to indicate the surgeon performed a significant, separately identifiable E/M service.** Do not use modifier 57, which should only be appended to an E/M on the day of or on the day before a procedure with a 90-day global period.
When performing bilateral component separation after a ventral hernia repair, should modifiers LT and RT be appended to each instance of CPT code 15734?	According to **Medicare guidelines**, the bilateral procedure concept does not apply to CPT code 15734, so modifier 50 should not be reported. **However, private payors have different requirements for reporting**—some may require RT and LT reported and modifier 59 appended to one instance, or just modifier 59 reported once with no other modifiers. Others may require modifier 51 instead of 59. **You should verify and follow your payor's policy for reporting.**
Are the new suture/staple removal codes only reported postoperatively with E/M services after a 0-day global procedure, or can these codes be used at an office visit after other operations, such as a colectomy?	CPT codes 15853 and 15854 are "add-on" codes that must be reported with select E/M visit codes. **If you cannot report an E/M service—**for example, during a 90-day global period after a colectomy—**then you may not report these codes.**
The new anterior abdominal hernia repair codes include placement of mesh when performed. Does it matter where the mesh is placed (e.g., retrorectus, preperitoneal, intraperitoneal)?	The new code descriptors state that placement of mesh or other prosthesis is included when performed and not separately reportable. **There is no reference to where the mesh is placed.**
Can dressing changes at postoperative office visits be coded for the 0-day global hernia repair codes?	There are **no specific CPT codes for changing a postoperative wound dressing**, as this work is included in an E/M service.
Can the new suture/staple removal codes be reporting without also reporting an E/M code?	No. CPT codes 15853 and 15854 are "add-on" codes that **may only be reported in conjunction with E/M CPT codes** 99202-99205, 99211-99215, 99281-99285, 99341-99350.

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Does modifier 25 need to be added to the postoperative office visit code when the suture/staple removal code is reported?	No. CPT codes 15853 and 15854 are practice expense "add-on" codes that have to be reported with an E/M service, so **modifier 25 does not need to be applied.** Keep in mind that these codes may not be reported during the postoperative period of codes that have a 10-day or 90-day global.
Does modifier 25 need to be added to the postoperative office visit code when also reporting aspiration of a seroma one week after an incisional hernia repair?	Yes. If a separate and distinct E/M service was performed on the **same day** as aspiration of a seroma, **modifier 25 must be appended** to the E/M service.
Can the parastomal hernia repair code be separately reported in addition to the reversal of ostomy procedure codes (for example, if there is a parastomal hernia after a Hartmann's procedure that is reduced and repaired during ostomy reversal)?	The repair of a parastomal hernia is inherent to the repair/closure of the wound for the reversal of the ostomy and therefore **a hernia repair code would not be separately reportable**. However, if a significant amount of time and effort is required, **modifier 22 may be appended to the ostomy reversal procedure** and supporting documentation submitted for additional reimbursement.
What is the diagnosis code that would be reported with the postoperative E/M visits for a 0-day global hernia repair when the patient comes in for a wound assessment and staple removal?	Report the **primary hernia diagnosis code** that was used for the surgery **in addition to Z48.81** (*Encounter for surgical aftercare following surgery on specified body systems*) as a secondary code.