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Part B Insider (Multispecialty) Coding Alert

Hernia Coding: Mesh Coding Doesn't Have to Be Difficult--If You Follow These 4 Steps

Modifier 22 is the choice for difficult removal during hernia repair

Mesh placement may be common during hernia repair, but you can only bill separately for the procedure in a minority of cases. Make sure you know what they are.

1. Claim Placement With Incisional/Ventral Hernia

You may report separate placement of mesh (+49568, Implantation of mesh or other prosthesis for incisional or ventral hernia repair) only when the surgeon repairs an incisional or ventral hernia.

Get the specifics: Report 49568 with 49560 (Repair initial incisional or ventral hernia; reducible), 49561 (... incarcerated or strangulated), 49565 (Repair recurrent incisional or ventral hernia; reducible) and 49566 (... incarcerated or strangulated) when the surgeon documents mesh placement during the hernia repair.

2. Skip Separate Placement Code for All Others

For any hernia repairs not listed above--including epigastric, umbilical, spigelian and inguinal hernia repairs (49570-49651)--you should not separately report 49568, regardless of whether the surgeon places mesh during the repair. The National Correct Coding Initiative solidified this guideline within the past few years by bundling 49568 into all hernia repairs 49570-49651.

Example: If the operative report documents, "Repair of epigastric hernia [for instance, 49570, Repair epigastric hernia (e.g., preperitoneal fat); reducible (separate procedure)] with marlex mesh," the mesh isn't separately billable because you can only add 49568 to 49560, 49561, 49565 or 49566.

3. Removal + Repair = No Separate Payment

If the surgeon removes infected mesh placed during a previous hernia repair when making a recurrent hernia repair, you generally cannot code separately--or receive reimbursement--for the mesh removal.

Although you may be tempted to report an unlisted- procedure or foreign-body-removal code for mesh removal with recurrent repair, this is inappropriate.

Keep in mind that the surgeon is already getting paid more for using the "recurrent" code. The payer expects the recurrent repair to be more work than an initial repair due to scar tissue, adhesions and mesh issues.

Bottom line: Codes for recurrent repairs (for example, 49520, Repair recurrent inguinal hernia, any age; reducible) include as an integral component removal of mesh placed during a previous hernia repair.

Modifier 22 Provides an Option

When removing mesh requires truly extensive effort, you may be able to gain additional reimbursement by appending modifier 22 (Unusual procedural services) to the appropriate recurrent hernia repair code. But, be prepared to back your claim up with extensive documentation.

You just don't get extra money for mesh removal unless the physician really documents very well, and there are lots of problems beyond simply dissecting away the old mesh.

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Example: During recurrent inguinal repair on a 55-year-old patient, the surgeon must remove mesh placed during the previous repair. The area of the previous repair shows extensive scarring and infection, and the mesh removal requires 40 minutes longer than average to complete.

In this case, you can append modifier 22 to 49520. Include a full operative report and a cover letter describing precisely that the extra time was required to remove the mesh, along with a request for additional compensation.

4. Removal Only Means Unlisted Procedure

You can report mesh removal separately in some circumstances. Most coding experts recommend an unlisted-procedure code if you have mesh removal without repair of a new hernia--for example, when the patient has erosion of the skin over the mesh or some pain related to the implant.

For procedures of this type, you'll most likely report 49999 (Unlisted procedure, abdomen, peritoneum and omentum) with a diagnosis of 996.60 (Infection and inflammatory reaction due to unspecified device, implant and graft). You will have to provide the payer with complete documentation to describe the procedure.

One to avoid: CPT +11008 (Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection [list separately in addition to code for primary procedure]) seems perfect to describe removal of mesh, either with or without hernia repair. But 11008 is an add-on code for use with 11004-11006 only. These codes describe extensive debridement performed on high-risk patients for conditions such as Fournier's gangrene (608.83).

In other words: You should not report 11008 for removal of infected mesh only, or for mesh removal with any hernia repair.

5. Mesh Isn't the Only Hernia Prosthesis

In some cases, the surgeon uses AlloDerm instead of mesh for ventral hernia repair, and you may consider the AlloDerm to be a prosthesis. Therefore, you may report the placement separately using +49568.

Watch your claims: Remember, you may report 49568 separately only when the surgeon performs the incisional or ventral hernia procedures described by codes 49560-49566.

Consider, also, that you should not report mesh placement separately when using an unlisted-procedure code for endoscopic hernia repairs (49659, Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy). Instead, you should include full documentation with the claim that explains the surgeon also placed the mesh or other prosthetic.

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