Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Hernia Coding: These 3 FAQs Lead You on the Right Hernia Coding Track

Hint: Double the mesh may not equal double the reimbursement.

If your practice performs hernia consultations or repairs, you could probably benefit from a few quick pointers that can make your coding life a little easier. Today we've got the answers to three commonly-asked hernia coding questions.

Double Your Money With Double Mesh?

Question 1: I'm coding a laparoscopic inguinal hernia repair (right side). The surgeon repaired the hernia with mesh. He also documented the following: The dissection was carried out, reducing the indirect hernia and separating the round ligament from the iliac vessels. A small femoral hernia was also discovered and reduced. This was containing fatty tissue. A double mesh repair was performed using 2 separate polypropylene mesh patch prostheses. The first mesh was cut with a lateral slit inserted in position covering all the hernia orifices. The second was then placed overtop."

Answer: Begin with the code for the inguinal hernia repair, 49650 (Laparoscopy, surgical; repair initial inguinal hernia). Because the surgeon used the same mesh to cover all orifices (including the newly discovered femoral hernia), no other code is necessary.

Consideration: If correcting the femoral hernia had required a separate piece of mesh, you could potentially submit a separate code for that repair. CPT® does not include a code for laparoscopic femoral hernia repair, so your only choice would be 49659 (Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy).

Know Strangulation Status

Question 2: Our surgeon carried out an open umbilical hernia repair for a 65-year-old patient. The tissue removed was identified as a portion of incarcerated omentum and fibroadipose tissue compatible with a hernia sac. What are the correct procedure and diagnosis codes?

Answer: The correct diagnosis code is 552.1 (Umbilical hernia with obstruction). Because the surgeon removed a portion of incarcerated omentum, you know that the hernia involved an obstruction.

Also, there is no mention of gangrene. For those reasons, you would not report either of the following diagnosis codes:

- 551.1 □ Umbilical hernia with gangrene
- 553.1 □ Umbilical hernia without obstruction or gangrene.

The incarcerated omentum also provides a valuable clue for selecting the procedure code. You should report 49587 (Repair umbilical hernia, age 5 years or older; incarcerated or strangulated). This is the correct code for an open (not laparoscopic) umbilical hernia repair.

Slide into Sliding Hernia Repair Code Accuracy

Question 3: Our surgeon performed a laparotomy to expose the hiatus, and mobilized the gastroesophageal (GE) junction, reducing it into the abdomen. To accomplish reducing the GE junction 3 cm or more below the hiatus, the surgeon performed an esophageal lengthening procedure. The surgeon then narrowed the enlarged hiatus and constructed the fundoplication by "wrapping" and suturing the fundus over the GE junction. How should we report this?

Answer: You should code the case as 43327 (Esophagogastric fundoplasty partial or complete; laparotomy). You'll also

need to list +43338 (Esophageal lengthening procedure [e.g., Collis gastroplasty or wedge gastroplasty] [List separately in addition to code for primary procedure]) for the esophageal lengthening.

Here's why: You should report Type I hiatal hernia repair with simple fundoplasty codes 43327 and 43328 (...thoracotomy), according to CPT® Assistant, Feb. 2012. "Type I [repair] would not be reported with the paraesophageal repair codes," the article states.

Surprise: More than 95 percent of hiatal hernias are classified as "sliding." Those are Type I hiatal hernias, and because they're so common, they represent the majority of hiatal hernia repairs. That means you'll use the "fundoplasty" codes, not the (esophageal) "hiatal hernia" codes for most of your surgeon's hiatal hernia repair.