

# Hernia repair and complex abdominal wall reconstruction



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**T**he American College of Surgeons (ACS) Coding Hotline receives numerous queries about Current Procedural Terminology (CPT) coding for hernia repair and complex abdominal wall reconstruction.\* Similarly, participants at ACS Surgical Coding Workshops have expressed confusion regarding coding for these procedures. This column provides an update to a coding column published in the September 2011 issue of the *Bulletin*<sup>1</sup> in an effort to educate health care professionals and coding staff on proper coding for hernia repair and complex abdominal wall reconstruction.

## Hernia repair

Hernia repair includes isolation and dissection of the hernia sac, reduction of intraperitoneal contents, fascial repair, and soft tissue closure. In 1993, the ACS submitted a code change proposal to the

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American Medical Association CPT Editorial Panel to revise hernia coding in 1994 based on several variables, including the following:

- Type of hernia (inguinal, lumbar, femoral, incisional, ventral, epigastric, umbilical, spigelian)
- Patient age (infant, child, adult)
- Patient presentation (initial versus recurrent)
- Clinical presentation (reducible versus incarcerated or strangulated)
- Method of repair (open versus laparoscopic)

As identified in Table 1, page 53, only the codes for open repair of inguinal hernias (49491–49525) or umbilical hernias (49580–49587) have distinct codes based on the age of the patient. Until 1994, separate repair codes were used to report incarcerated hernias and strangulated hernias. These two patient presentations were combined in the 1994 CPT revision. Until 1994, separate codes were used

to report different approaches to hernia repair, such as an inguinal approach versus an anterior extraperitoneal approach (Henry) for a femoral hernia repair. Beginning in 1994, all open hernia repair codes were categorized as reducible or incarcerated/strangulated, except for the rare lumbar hernia repair (49540) or rare spigelian hernia repair (49590).

A hernia should be considered incarcerated if, at the time of the operation, it contains viscera that the surgeon must manually reduce. It should be considered strangulated if the incarcerated contents have evidence of ischemia due to compression of the vascular supply.

The 1994 CPT code set added only two codes for laparoscopic hernia repair (49650 and 49651). Laparoscopic hernia repair was developed as a technique long after open hernia repair. In 1994, when codes 49650 and 49651 were created, very few laparoscopic inguinal hernia repairs were performed for incarcerated hernias. Therefore, separate codes to report this

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TABLE 1. HERNIA REPAIR CODES AND 2017 MEDICARE RELATIVE VALUE UNITS (RVU)

CPT code	Descriptor	2017 work RVU	2017 total RVU
Open hernia repair			
49491	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible	12.53	22.65
49492	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated	15.43	27.70
49495	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible	6.20	10.93
49496	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated	9.42	15.67
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible	5.84	11.38
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated	9.36	17.51
49505	Repair initial inguinal hernia, age 5 years or older; reducible	7.96	15.04
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	9.09	16.91
49520	Repair recurrent inguinal hernia, any age; reducible	9.99	18.27
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	11.48	20.72
49525	Repair inguinal hernia, sliding, any age	8.93	16.56
49540	Repair lumbar hernia	10.74	19.47
49550	Repair initial femoral hernia, any age; reducible	8.99	16.63
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	9.92	18.23
49555	Repair recurrent femoral hernia; reducible	9.39	17.28
49557	Repair recurrent femoral hernia; incarcerated or strangulated	11.62	20.95
49560	Repair initial incisional or ventral hernia; reducible	11.92	21.34
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	15.38	26.91
49565	Repair recurrent incisional or ventral hernia; reducible	12.37	22.22
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	15.53	27.15
49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)	6.05	12.03
49572	Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated	7.87	14.91
49580	Repair umbilical hernia, younger than age 5 years; reducible	4.47	9.46
49582	Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated	7.13	13.34
49585	Repair umbilical hernia, age 5 years or older; reducible	6.59	12.85
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	7.08	13.72

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TABLE 1. HERNIA REPAIR CODES AND 2017 MEDICARE RVU (CONTINUED)

CPT code	Descriptor	2017 work RVU	2017 total RVU
49590	Repair spigelian hernia	8.90	16.55
<b>Laparoscopic hernia repair</b>			
49650	Laparoscopy, surgical; repair initial inguinal hernia	6.36	12.37
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	8.38	16.08
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	11.92	21.51
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	14.94	26.84
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	13.76	24.47
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	16.84	29.86
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	15.08	26.55
54   49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	22.11	38.24
<b>Additional codes related to hernia repair</b>			
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	19.86	37.95
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	5.96	12.16
+49568	Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) (Use 49568 in conjunction with 11004–11006, 49560–49566)	4.88	7.76
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	0.00*	0.00*
49999	Unlisted procedure, abdomen, peritoneum and omentum	0.00*	0.00*

\*Contractor priced codes do not have assigned RVUs.

work were not included in the ACS 1994 code change proposal. Also, no coding distinction was made regarding whether a laparoscopic inguinal hernia repair was performed transabdominal preperitoneally (commonly known as “TAPP”) or totally extraperitoneally (commonly known as “TEP”).<sup>2</sup> In 2009, after sufficient supporting literature was published, six

new laparoscopic hernia repair codes for ventral and incisional hernia repair (49652–49657) were added to the CPT code set.  
Hernia repair codes are not size-dependent. A 1 centimeter incarcerated initial incisional hernia is repaired with the same code (49561) as a 25 centimeter incarcerated initial incisional hernia, and both receive the same payment regardless of

the difference in operative time and effort. In addition, multiple hernias repaired in the same operative session through the same incision cannot be coded separately. Multiple holes in a “Swiss cheese” abdominal wall count as a single incisional hernia repair.<sup>2</sup>  
All open and laparoscopic hernia repairs are unilateral, with the exception of umbilical

**CODING TIP: ROBOTIC HERNIA REPAIR**

Robotic hernia repair is reported with a laparoscopic hernia repair code. It is incorrect to report modifier 22, *Increased procedural services*, for robotic assistance. It is also incorrect to report an unlisted laparoscopic procedure code unless no existing laparoscopic code describes the procedure. Although laparoscopic surgery is typically covered by third-party payors, including Medicare, no additional payment is made when a robotic surgical technique is used.

If your payor accepts Healthcare Common Procedure Coding System (HCPCS) Level II S-codes, you may report S2900, *Surgical techniques requiring use of robotic surgical system (List separately in addition to code for primary procedure)*, in addition to the primary laparoscopic procedure code. However, HCPCS S-codes are not payable under Medicare.

hernia repair (49580–49587). Modifier 50, *Bilateral procedure*, is used to report bilateral hernia repair in one of two ways, by line-item format or by bundled format, depending on a payor’s reporting preference. The following example shows both methods of reporting bilateral reducible inguinal hernia repair in an adult:

- *Line-item format:* Report 49505 and 49505-50 on separate claim lines and bill the full fee for each procedure/line.
- *Bundled format:* Report 49505-50 on one claim line and bill twice the full fee.

Medicare rules state that if a code is reported with modifier 50 or is reported twice on the same day by any other means, payment will be made based on 150 percent of the Medicare physician fee schedule (MPFS) amount for a single code. Most payors follow this rule.

**When and how to report implantation of mesh**

The use of mesh or other prosthesis is considered inherent to all laparoscopic hernia repairs

(49650–49657) and to some of the open hernia repair codes, including inguinal (49491–49525), lumbar (49540), femoral (49550–49557), epigastric (49570–49572), umbilical (49580–49587), and spigelian (49590). The use of mesh or other prosthesis is not inherent to the open repair of incisional or ventral hernias (49560–49566).

Code 49568, *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)*, may be reported only once in addition to the open incisional or ventral hernia repair code (49560–49566), as applicable. Medicare rules do not permit appending modifier 50 to code 49568 for bilateral hernia repair. Code 49568 includes the work of placing the mesh, independent of the size of mesh used. It is the facility’s responsibility to report the type and size of mesh used; the surgeon only reports code 49568.

Although the surgeon is compensated for the physician work related to placing the mesh, either as part of the payment for the hernia repair or separate payment for code 49568, the surgeon does not receive

compensation for the cost of the mesh. Like other supplies and equipment, mesh is reimbursed to the facility where the hernia repair is performed. Typical facility costs for prosthetic mesh range from less than \$50 for simple polypropylene mesh to more than \$200 for some of the proprietary contoured multilayer mesh hernia systems and more than \$2,000 for engineered, biologic products.<sup>2</sup> In comparison, the 2017 MPFS physician payment for the work of placing the mesh is \$278.

To be clear, code 49568 represents placement of any type of mesh or other prosthesis, whether synthetic, biologic, or otherwise and whether autograft, dermal graft, xenograft, or graft based on new technique or technology. It would be incorrect to report a code for application of a skin substitute graft (15271–15274) or code for implantation of a biologic implant for soft tissue reinforcement (15777) for mesh implantation in conjunction with a hernia repair code. Codes 15271–15274 are reported for the topical application of skin substitute grafts or, in the case of 15777, for placement of non-surface biological implants for

## CODING TIP: HYBRID LAPAROSCOPIC AND OPEN HERNIA REPAIR

Code 15734 is an open procedure. For more complicated laparoscopic hernia repair procedures that may include separation of components, report code 49659, *Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy*. For hernia repair procedures that are hybrid laparoscopic and open repairs, report the appropriate code for open hernia repair.

soft tissue reinforcement (for example, for sarcoma defects or breast reconstruction).

### Complex abdominal wall reconstruction

Large or complex abdominal wall hernias may require more than simple suture repair or repair with mesh. For these cases, a technique known as “component separation” (also known as the separation of parts operation) may be used to repair the hernia and reconstruct the abdominal wall defect. Component separation involves separating and creating musculofascial advancement flaps to facilitate closure of large midline hernia defects.

In one component separation technique, an anterior release mobilizes the entire rectus sheath toward the midline by incising the aponeurosis of the external oblique from the costal margin to the pubis. While protecting the neurovascular pedicles, the rectus flap is mobilized to bring the more medial tissues of the anterior abdominal wall toward the midline. The posterior or transversus abdominis release musculofascial flap is another method to perform mobilization of the rectus sheath. Using this method, the same rectus muscle is advanced to the midline through release of the transversus abdominis

in the posterior rectus plane while also preserving the neurovascular bundles.

The work related to the hernia repair is reported with the appropriate hernia repair code and the work related to the component separation procedure is reported with code 15734, *Muscle, myocutaneous, or fasciocutaneous flap, trunk*. Medicare guidelines do not allow use of modifier 50 (bilateral procedure) with 15734. Therefore, if both sides of the rectus sheath are mobilized, you would report one unit of 15734 plus a second unit of 15734 with modifier 59 appended (15734, 15734-59) and bill full fee for both procedures. Payor software will apply modifier 51 as appropriate and reduce payment based on the multiple procedure reduction rule. For clarity, code 15734 represents a musculofascial flap involving the mobilization of the rectus muscle whether performed with anterior or posterior release. Code 15734 can only be reported once for each side. It cannot be reported four times—once for each posterior and anterior side. Only one muscle flap is mobilized on each side.

### Additional coding considerations

The hernia repair codes and code 15734 include simple repair (12001–12007), intermediate

repair (12031–12037), and/or complex repair (13100–13102) of skin and subcutaneous tissues. These codes should not be reported separately when the procedures are performed in conjunction with a hernia repair. Also, codes for adjacent tissue transfer (14000–14302) may not be reported with a hernia repair, even if extensive mobilization of skin and adipose tissue is performed. *The Current Procedural Terminology 2017 Professional Edition* states: “Undermining alone of adjacent tissues to achieve closure, without additional incisions, does not constitute adjacent tissue transfer.”<sup>3</sup>

For removal of mesh that is infected or involved in an enterocutaneous fistula, report code 11008, *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection)* (List separately in addition to code for primary procedure), in addition to code 10180, *Incision and drainage, complex, postoperative wound infection*, or code 11005, *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection, abdominal wall*, as appropriate.

For removal of mesh that is not infected, report code

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CLINICAL CODING EXAMPLES

**CLINICAL SCENARIO:** Patient who had previous abdominal surgery with mesh implantation presents with a large reducible recurrent incisional hernia. After extensive lysis of adhesions and excision of subcutaneous scar tissue and previously implanted mesh, the incisional hernia is repaired using musculofascial flaps (right and left posterior rectus sheath TAR release, elevation of 400 sq cm subcutaneous flaps, implantation of mesh, and complex closure).

Code(s) reported	Descriptor	Work RVU	Total RVU
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	19.86	37.95
15734-59	Muscle, myocutaneous, or fasciocutaneous flap; trunk	19.86	37.95
49565	Repair recurrent incisional or ventral hernia; reducible	11.92	21.34
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	5.96	12.16
+49568	Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection ( <i>List separately in addition to code for the incisional or ventral hernia repair</i> )	4.88	7.76

**DISCUSSION:** This operation describes a hernia repair and component separation, with mobilization of both flaps. Modifier 59 is appended to the second instance of code 15734 to indicate it is a distinct and separate service. Modifier 51 could be appended to the second instance of 15734 and 49565 and 20680; however, most payors suggest not appending modifier 51 to any codes because coding software will automatically adjust payment for multiple procedures. Removal of prior mesh may be reported with 20680. The subcutaneous flaps and wound closure are inherent to the hernia repair and are not reported separately.

**CLINICAL SCENARIO:** Patient with significant weight loss presents with umbilical hernia and diastasis recti. The hernia is repaired and an abdominoplasty is performed.

Code(s) reported	Descriptor	Work RVU	Total RVU
49585	Repair umbilical hernia, age 5 years or older; reducible	6.59	12.85
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	0.00	0.00

**DISCUSSION:** The diastasis is not a hernia and repair involves simple plication. Code 49585 is reported for the hernia repair and code 17999 is reported for the additional work of plication. Code 17999 is contractor priced, and therefore, it is necessary to submit supporting documentation (eg, procedure report) along with the claim to provide an adequate description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. If abdominoplasty is the only procedure performed, report code only 17999.

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**CLINICAL SCENARIO:** A patient who previously underwent open left side inguinal hernia repair with mesh presents with a left side incarcerated recurrent inguinal hernia and a new reducible right inguinal hernia. At laparoscopy, both hernias are repaired with mesh.

Code(s) reported	Descriptor	Work RVU	Total RVU
49651-LT	Laparoscopy, surgical; repair recurrent inguinal hernia	8.38	16.08
49650-RT	Laparoscopy, surgical; repair initial inguinal hernia	6.36	12.37

**DISCUSSION:** Codes 49650 and 49651 do not differentiate between reducible and incarcerated/strangulated. Addition of modifiers for left and right side indicate distinct separate procedures.

**CLINICAL SCENARIO:** A patient undergoes repair of an incarcerated incisional hernia and omentectomy.

Code(s) reported	Descriptor	Work RVU	Total RVU
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	15.38	26.91

**DISCUSSION:** Resection of the piece of omentum contained within an incisional hernia is not reported as an omentectomy. Code 49255, *Omentectomy, epiploectomy, resection of omentum (separate procedure)*, describes removing the entire organ, starting at the greater curvature of the stomach, and is typically performed for malignancy. Code 49255 may only be reported as a “separate procedure.” In this instance, the omental resection was part of the hernia repair. If the additional work was extensive, modifier 22 may be appended to 49561, but supporting documentation (procedure report) must be submitted with the claim to provide an adequate description of the nature, extent, and need for the procedure, as well as the time, effort, and equipment necessary to provide the service.

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CLINICAL CODING EXAMPLES (CONTINUED)

**CLINICAL SCENARIO:** A patient had an umbilical hernia repair with mesh two years ago. She is having pain at the hernia repair site. At laparotomy, lysis of adhesions and mesh removal is performed.

Code(s) reported	Descriptor	Work RVU	Total RVU
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)	18.46	31.73
20680-59	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	5.96	12.16

**DISCUSSION:** In this case, it is acceptable to report the lysis of adhesions because it is the only work done. Removal of noninfected mesh is reported with 20680 and modifier 59 to indicate a distinct procedure. The umbilical defect will be closed incidentally as part of the laparotomy closure.

**CLINICAL SCENARIO:** A patient undergoing open cholecystectomy has a reducible umbilical hernia repaired during the same operative session. The cholecystectomy and hernia repair are performed through separate incisions.

Code(s) reported	Descriptor	Work RVU	Total RVU
47600	Cholecystectomy	17.48	30.90
49585-59	Repair umbilical hernia, age 5 years or older; reducible	6.59	12.85

**DISCUSSION:** If both procedures are performed through the same incision, the hernia repair would be inherent to the cholecystectomy and not separately reported. In this clinical scenario, the procedures are performed through separate incisions, and, therefore, both procedures may be reported. Modifier 59 is appended to the hernia repair to indicate a distinct procedure. If the cholecystectomy was performed laparoscopically, the port is typically placed through a hernia with subsequent closure of the hernia (port site). In this instance, only the laparoscopic cholecystectomy would be reported.

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**CLINICAL SCENARIO:** A patient presents with multiple incarcerated ventral hernia defects in a midline scar and a separate single incisional hernia at an old ostomy site. Repair is accomplished with mesh.

Code(s) reported	Descriptor	Work RVU	Total RVU
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	15.38	26.91
49561-59	Repair initial incisional or ventral hernia; incarcerated or strangulated	15.38	26.91
+49568	Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)	4.88	7.76

**DISCUSSION:** The current standard for this abdominal wall hernia repair would recommend the placement of mesh as opposed to primary repair. The tenet of repair for this clinical scenario describes a single piece of mesh that overlaps all the defects. Report code 49561 twice: once for the repair of multiple “Swiss-cheese” defects in the midline scar, and once for the repair of the defect at the old ostomy site. Modifier 59 is appended to the second instance of code 49561 to indicate a distinct procedure. If one piece of mesh were placed to cover all defects, then the add-on code 49568 also should be reported. It would be unusual for a surgeon to place two separate pieces of mesh for the reasons mentioned in this column.

However, if two distinct defects were repaired and separate pieces of mesh were implanted—for example, an incisional defect from previous flank incision and concomitant incisional defect for low suprapubic incision—then code 49561 and 49568 would each be reported twice and modifier 59 appended to the second instance of each code to indicate a distinct service. Modifier 51 could also be appended to the second instance of 49561, however, most payors suggest not appending modifier 51 to any codes because coding software will automatically adjust payment for multiple procedures. Modifier 51 is never reported to add-on codes and would not be appended to code 49568.

**CLINICAL SCENARIO:** A patient with a midline reducible incisional hernia undergoes a standard open Rives-Stoppa repair with retrorectus mesh.

Code(s) reported	Descriptor	Work RVU	Total RVU
49560	Repair initial incisional or ventral hernia; reducible	11.92	21.34
+49568	Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)	4.88	7.76

**DISCUSSION:** 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. It is incorrect to report 15734 for a standard Rives-Stoppa repair. Code 15734 may be reported only when musculofascial flaps are created by myofascial release.

20680, *Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate).*

Transversus abdominis plane (TAP) local anesthesia block (for example, abdominal plane block, rectus sheath block) is a procedure that is performed on patients who undergo abdominal and/or pelvic surgery for postoperative pain control and abdominal wall analgesia. The TAP block is a peripheral nerve block applied to anesthetize the sensory nerves of the anterior abdominal wall. The intention of this procedure is to allow the instilled local anesthesia to access multiple branches of several different nerves (for example, ilioinguinal, iliohypogastric, subcostal, intercostal) by using a single injection technique thereby providing a dermatomal sensory block over the six lower thoracic and first lumbar afferents.<sup>4</sup> Medicare global surgery rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure.<sup>5</sup> Therefore, a TAP block (64486–64489) may not be reported by a surgeon in conjunction with an abdominal operation, including hernia repair.

When reporting an unlisted code to describe a procedure or service (such as 49659,

*Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy*), it is necessary to submit supporting documentation (procedure report) along with the claim to provide an adequate description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service.

### ACS Coding Hotline

If you or your coding staff have questions, contact the ACS Coding Hotline at 800-ACS-7911 (800-227-7911). The hours of operation are 8:00 am–5:00 pm (Central), Monday–Friday, holidays excluded. ACS Fellows are given five free consultation units (CU) each calendar year. One CU covers a period of up to 10 minutes.

In addition, ACS Surgical Coding Workshop opportunities are available for surgeons and/or their coding staff. For more information or to sign up for one of the 2017 ACS Surgical Coding Workshops, visit [facs.org/advocacy/practmanagement/workshops](http://facs.org/advocacy/practmanagement/workshops). ♦

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