2022 Ventral Hernia Reimbursement Fact Sheet

To comply with Medicare and third-party payor requirements, claim forms must indicate the most appropriate ICD-10 procedure(s) and diagnosis(s) applicable. Ventral hernia repair procedures are assigned to only the following Medicare ICD-10 procedure code for inpatient settings:

Finding the appropriate ICD-10-PCS Code[1]

STEP 1: Using the table below, select the appropriate codes from each column in the respective order.

Procedure Code	Body Part	Approach	Device	Qualifier
0WU: General Anatomical Region Supplement	F Abdominal Wall	0 Open	7 Autologous Tissue Substitute J Synthetic Substitute K Nonautologous Tissue Substitute	Z No Qualifier

STEP 2: Combine the code in the respective order from left to right. This is your ICD-10-PCS Code.

For example, the code for Supplement Abdominal Wall with Nonautologous Tissue Substitute, Open Approach (0WUF0KZ) would be created in the steps below:

Example: STEP 1: Procedure Code 0WU + Body Part F + Approach 0 + Device K + Qualifier Z = STEP 2: 0WUF0KZ

Coding & Payment

Surgeon CPT, APC, ASC, DRG & HCPCS Codes

SURGEON CPT CODE[2]	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT[3]	
	Incisional or Ventral Hernia	**Facility**	**Non-Facility**
49560	Repair initial incisional or ventral hernia; reducible	$ 763	N/A
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	$ 960	N/A
49565	Repair recurrent incisional or ventral hernia; reducible	$ 794	N/A
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	$ 968	N/A
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)	$ 273	N/A
	Debridement of Abdominal Wall		
11042	Debridement subcutaneous tissue (includes epidermis and dermis, if performed), first 20 sq cm or less	$ 61	$ 134
11043	Debridement muscle and/or fascia (includes epidermis and dermis, and subcutaneous tissue, if performed), first 20 sq cm or less	$ 156	$ 239
11045	Debridement subcutaneous tissue (includes epidermis and dermis, if performed), each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	$ 27	$ 42
11046	Debridement muscle and/or fascia (includes epidermis and dermis, and subcutaneous tissue, if performed), each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	$ 56	$ 75

Surgeon CPT, APC, ASC, DRG & HCPCS Codes (continued)

SURGEON CPT CODE[2]	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT[3]	
11004	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and peritoneum	$ 581	N/A
11005	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure	$ 794	N/A
11006	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, peritoneum and abdominal wall, with or without fascial closure	$ 716	N/A
	Component Separation		
15734	Muscle, myocutaneous, or fasciocutaneous flap, trunk	$ 1,540	N/A
	Abdominal Wall Repair (Utilized for Abdominal Wall Repair without the presence of a hernia)		
15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)	$ 219	$ 219

OUTPATIENT FACILITY

APC	APC Description	Status Indicator	NATIONAL AVERAGE MEDICARE PAYMENT[4]
5341	Abdominal/Peritoneal/Biliary & Related Procedures (CPT Codes: 49560,49561)	J1	$ 3,249
5052	Level 2 Skin Procedure (CPT Code 11042)	T	$ 353
5053	Level 2 Skin Procedure (CPT Code 11043)	T	$ 535
5361	Level 1 Laparoscopy & Related Services (CPT codes 49565, 49566)	J1	$ 5,168
5055	Level 5 Skin Procedures (CPT Code 15734)	T	$ 3,596

Ambulatory Surgery Center

CPT Code	Procedure Description	NATIONAL AVERAGE MEDICARE PAYMENT[5]
	Incisional or Ventral Hernia	
49560	Repair initial incisional or ventral hernia; reducible	$ 1,441
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	$ 1,441
49565	Repair recurrent incisional or ventral hernia; reducible	$ 2,363
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	$ 2,363
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)	Packaged
	Debridement of Abdominal Wall	
11042	Debridement subcutaneous tissue (includes epidermis and dermis, if performed), first 20 sq cm or less	$ 179
11043	Debridement muscle and/or fascia (includes epidermis and dermis, and subcutaneous tissue, if performed), first 20 sq cm or less	$ 271
11045	Debridement subcutaneous tissue (includes epidermis and dermis, if performed), each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	Packaged
11046	Debridement muscle and/or fascia (includes epidermis and dermis, and subcutaneous tissue, if performed), each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	Packaged
	Component Separation	
15734	Muscle, myocutaneous, or fasciocutaneous flap, trunk	$ 1,824
	Abdominal Wall Repair (Utilized for Abdominal Wall Repair without the presence of a hernia)	
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	Packaged

Surgeon CPT, APC, ASC, DRG & HCPCS Codes (continued)

Medicare reimburses inpatient hospital services based on the DRG associated with the principal diagnosis and procedures. Private payor reimbursement varies and is typically based on the contract negotiated between the provider and payor.

INPATIENT FACILITY

DRG	DESCRIPTION*	AVERAGE LENGTH OF STAY (DAYS)[6]	NATIONAL AVERAGE DRG PAYMENT[6]
353	Hernia procedures except inguinal and femoral with MCC	5.9	$ 19,947
354	Hernia procedures except inguinal and femoral with CC	3.6	$ 11,770
355	Hernia procedures except inguinal and femoral without CC/MCC	2.4	$ 8,970
907	Other O.R. procedures for injuries with MCC	6.8	$ 26,036
908	Other O.R. procedures for injuries with CC	3.9	$ 13,521
909	Other O.R. procedures for injuries without CC/MCC	2.4	$ 9,041
957	Other O.R. procedures for multiple significant trauma with MCC	9.1	$ 48,936
958	Other O.R. procedures for multiple significant trauma with CC	6.7	$ 27,734
959	Other O.R. procedures for multiple significant trauma without CC/MCC	4.2	$ 18,043
987	Nonextensive O.R. Procedure Unrelated to Principal Diagnoses with MCC	7.7	$ 21,602
988	Nonextensive O.R. Procedure Unrelated to Principal Diagnoses with CC	4.3	$ 11,253
989	Nonextensive O.R. Procedure Unrelated to Principal Diagnoses without MCC/CC	2.3	$ 7,409

*CC stands for Complications and Comorbidities while MCC refers to Major Complications and Comorbidities. These are a measure of the severity of an illness indicating additional diagnoses present on a case that MAY increase the expected resource consumption beyond that of the same case without a CC or MCC under the current Medicare definition. Whether a complication or comorbiditiy is classified as a CC or MCC is defined by Medicare.

HCPCS is the acronym for the Healthcare Common Procedure Coding System. These codes are frequently used to report supplies and services that are not assigned a Level II CPT code. In some instances, private payor and/or Medicare may provide additional reimbursement for some HCPCS codes. Facilities may use them to track device costs on the facility charge master or super bill. Currently there is no additional reimbursement for these codes and they are considered packaged and not separately reimbursable.

HCPCS[4]	HCPCS DESCRIPTION	NATIONAL AVERAGE MEDICARE PAYMENT[7]
C1781	Mesh (Implantable)	Carrier Priced

1. ICD-10 Procedural Coding System (ICD-10-PCS) is developed and maintained by the Centers for Medicare and Medicaid Services (CMS). 2. All Current Procedural Terminology (CPT) five digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2021 American Medical Association. 3. CY 2022 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B (CMS-1751-F, Vol 86, No. 221; November 19, 2021); Addendum B. All MPFS Fee Schedules calculated using CF of $33.5983 effective January 2022. 4. CY 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1753-F, Vol. 86, No. 218; November 16, 2021); Addendum B and Final ASC Addenda AA.. 5. CY 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1753-F, Vol. 86, No. 218; November 16, 2021); Addendum B and Final ASC Addenda AA. 6. Medicare Inpatient Prospective Payment System Final Rule [CMS-1752-F], Federal Register (Vol. 86, Issue 154), Friday, August 13, 2021; Final: National Average DRG Payment. 7. All Healthcare Common Procedure Coding System (HCPCS) Level II alpha-numeric codes, descriptions, instructions, guidelines and other material are copyright 2021 Centers for Medicare & Medicaid Services (CMS). All Rights Reserved.