If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Texas may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Hernia Repair

Policy Number: CPCP012

Version: 1.0

Clinical Payment and Coding Policy Committee Approval Date: August 19, 2025

Plan Effective Date: November 25, 2025

Description

This policy addresses billing and coding for hernia repair procedures/services. This policy is not intended to impact care decisions or medical practice. Providers (i.e., facilities, physicians, and other qualified health care professionals) are expected to exercise independent medical judgement in providing care to members.

Reimbursement Information

The Plan reserves the right to request supporting documentation. Providers are responsible for accurately, completely, and legibly documenting services performed. Appropriate coding is the key to minimizing delays in claim(s) processing. Ensure revenue codes and procedure codes reflect the diagnosis and services rendered. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

The following table provides information for hernia procedures and is not an all-encompassing code list. The inclusion of a code below does not guarantee it is a covered service or eligible for reimbursement. Exclusions may apply under benefit plans or other plan documents.

Hernia Type	Additional Information	Associated Codes
Anterior Abdominal (Includes epigastric, incisional, spigelian, umbilical, and ventral)	Some codes describe the repair of an anterior abdominal hernia (epigastric, incisional, spigelian, umbilical, ventral) by different approaches and size. Other codes describe whether it was incarcerated or strangulated. Add-on CPT code +49623 can be used in conjunction with 49591-49618.	49591, 49592, 49593, 49594, 49595, 49596, 49613, 49614, 49615, 49616, 49617, 49618, +49623 Additional coding may be submitted with an umbilical hernia repair, e.g., 51500 for an excision of urachal cyst or sinus.
Diaphragmatic	Some codes describe the repair for a neonate vs. a non-neonate and the complexity.	39503, 39540, 39541
Femoral	Some codes describe the repair with specific criteria for the initial or reoccurrence. Other codes describe whether it was incarcerated or strangulated.	49550, 49553, 49555, 49557

Hiatal (Paraesophageal)	Some codes describe the repair with specific criteria with or without the implantation of mesh or other prosthesis. Other codes describe if the procedure was performed by laparoscopy.	43280, 43281, 43282, 43327, 43328, 43332, 43333, 43334, 43335, 43336, 43337
Inguinal	Some codes describe the repair with specific criteria for age of the member or reoccurrence. Other codes describe whether it was incarcerated, strangulated, or performed by laparoscopy.	49491, 49492, 49495, 49496, 49500, 49501, 49505, 49507, 49520, 49521, 49525, 49650, 49651, 54640 Additional coding may be submitted with an inguinal hernia repair, e.g., 55540 for an excision of varicocele or ligation of spermatic veins for varicocele.
Lumbar	CPT code 49540 describes the repair of a lumbar hernia.	49540
Omphalocele	Some codes describe the repair size of the omphalocele hernia. Other codes describe the stage. CPT code 49606 describes the removal of prosthesis, final reduction and closure, in the operating room.	49600, 49605, 49606, 49610, 49611
Parastomal	CPT code 49621 is used for the repair of a reducible parastomal hernia, while CPT code 49622 is reported for an incarcerated or strangulated parastomal hernia. Add-on CPT code +49623 can be used in conjunction with 49621 and/or 49622.	49621, 49622, +49623

If an **unlisted or miscellaneous code(s)** is submitted on a claim, supporting documentation must be submitted. Unlisted procedure codes (e.g., 39599, 43289, 44238, 49659, 49999, etc.) must only be used when the overall procedure and outcome of the procedure are not adequately described by an existing procedure code.

Hybrid laparoscopic and open repairs during a hernia repair procedure should include the applicable code for the open hernia repair.

Preoperative Testing

For information on preoperative testing rendered to a member on the date of admission and up to three calendar days preceding the date of admission, refer to *CPCP038 Outpatient Services Prior to an Inpatient Admission*.

Bariatric Surgery Billed with Hernia Repair

Providers should refer to the member's benefit coverage and/or exclusions for bariatric surgery and any complications that are related to bariatric surgery. Hiatal hernia repair codes may be considered integral or mutually exclusive if they are billed on the same date of service with the following bariatric codes, including, but not limited to: 43999, 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, and 43848.

Additional References

Clinical Payment and Coding Policy

CPCP035 Unlisted/Not Otherwise Classified (NOC) Coding Policy
CPCP038 Outpatient Services Prior to an Inpatient Admission

References

Policy Update History

Approval Date	Description
02/23/2018	New Policy
02/22/2019	Annual Review
05/29/2020	Annual review, Updated Disclaimer, References, Policy language
06/18/2021	Annual Review
04/22/2022	Annual Review
05/03/2023	Annual Review
06/28/2024	Annual Review
08/19/2025	Annual Review; Grammatical and formatting updates; Hernia Type table, Description column removed; Reference updated.