Regence

Medical Policy Manual Surgery, Policy No. 12.03

Anterior Abdominal Wall (Including Incisional) Hernia Repair

Effective: August 1, 2026

Next Review: May 2027
Last Review: June 2026

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Anterior abdominal hernias develop when a portion of the lining of the peritoneum pushes through a weak area of the abdominal wall fascia. This results in a protrusion which can be filled with intra-abdominal fat or intestine. An incisional hernia is a protrusion of tissue that forms in a prior surgical incision in the abdomen.

MEDICAL POLICY CRITERIA

Notes:

- Epigastric, incisional, and spigelian hernias do not have specific ICD-10 codes and are reported by the non-specific ventral hernia codes K43.2 and K43.9.
- Umbilical hernia is reported by code K42.9.
- An incarcerated hernia is defined as: a hernia in which the intraperitoneal contents are trapped or twisted within the hernia sac.
- An anterior abdominal wall hernia at the site of a prior surgery is considered an incisional hernia.
- Clinical documentation to support criteria is required (See Required Documentation)

Medically Necessary

I. Surgical repair of an anterior abdominal wall (including incisional) hernia may be considered **medically necessary** in symptomatic patients when there is documentation that one or more of the following Criteria is met:

   A. Hernia associated pain of documented severity to interfere with activities of daily living (see Policy Guidelines); or

   B. Incarceration; or

   C. Thinning of the overlying skin; or

   D. Loss of abdominal domain (see Policy Guidelines).

II. Surgical repair using the component separation technique (CST) may be considered **medically necessary** for a large (defined as width greater than or equal to 10 cm) midline anterior abdominal wall (including incisional) hernia (see Policy Guidelines).

Not Medically Necessary

III. Surgical repair of an anterior abdominal wall (including incisional) hernia is considered **not medically necessary** when Criterion I. is not met.

IV. Surgical repair of an abdominal wall defect, including an anterior abdominal or incisional hernia, using the component separation technique (CST) is considered **not medically necessary** when Criterion II. is not met.

V. Surgical repair of an asymptomatic anterior abdominal wall (including incisional) hernia found incidentally during surgery is considered **not medically necessary**.

Cosmetic

VI. Surgical repair of diastasis recti is considered **cosmetic**.

VII. Abdominoplasty and related procedures, including but not limited to fascial plication, surgical imbrication, and tightening of lax fascia, are considered **cosmetic**.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

- Loss of abdominal domain is defined as 50% of the abdominal viscera reside outside the abdominal cavity.[1]
- The component separation technique (CST) is based on subcutaneous lateral dissection, fasciotomy lateral to the rectus abdominis muscle, and dissection on the plane between external and internal oblique muscles with medial advancement of the block that includes the rectus muscle and its fascia. This release allows for medial advancement of the fascia and closure of up to 20 cm-wide defects in the midline area. Extraperitoneal or retrorectus placement of mesh or preparation for placement of mesh is not considered CST.
- Activities of Daily Living (ADLs) definition: ADLs are defined as feeding, bathing, dressing, grooming, meal preparation, household chores, and occupational tasks that are required as a daily part of job functioning.

REQUIRED DOCUMENTATION

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- History and physical/chart notes
- Current symptomology related to the hernia.
- Documentation of the impact of hernia related pain on physical ability and activity (including the specific activity and how it is impeded).
- Diagnostic testing results as applicable to request and associated policy criteria
- Photographs as applicable to request and associated policy criteria
- If the component separation technique is being performed, documentation of the location and size of the hernia in centimeters.

CROSS REFERENCES

1. Cosmetic and Reconstructive Surgery, Surgery, Policy No. 12
2. Correct Coding Guidelines, Reimbursement Policy, Administrative, Policy No. 129

BACKGROUND

Abdominal wall hernias are usually acquired when pressure is applied to an area of the abdomen which is weakened. They can occur spontaneously, known as a primary hernia, or at the site of a previous surgical incision, known as an incisional hernia.

Abdominal wall hernias (epigastric, incisional, ventral, umbilical, and spigelian) are defined by their anatomical location. Patients who are obese, older, under-weight, pregnant, have ascites or other factors which increase intra-abdominal pressure may be predisposed to developing abdominal hernias. Most hernias are acquired; however, the occurrence of umbilical hernias in infants is considered a congenital defect which usually resolves before the age of two. Children with persistent symptoms may require surgical repair.

Diastasis recti is defined as increased distance between the right and left rectus abdominis muscles that is created by the stretching of the collagen sheath (the linea alba) connecting the two rectus abdominis muscles. Diastasis recti is not considered a hernia as there is no fascial defect.

In general, small, asymptomatic hernias do not require surgical repair. Adults with larger symptomatic hernias should be considered for ventral hernia repair. Over time, hernia symptoms may develop and include pain, bowel obstruction, incarceration, thinning of the overlying skin, strangulation, and displacement of abdominal contents into the hernia itself, known as loss of abdominal domain.

LOSS OF ABDOMINAL DOMAIN

Loss of abdominal domain is defined as 50% of the abdominal viscera reside outside the abdominal cavity.[1]

COMPONENT SEPARATION TECHNIQUE

The component separation technique (CST) is a surgical method that may be used to repair large, complicated ventral hernias using a rectus abdominis muscle advancement flap. A

defect width greater than or equal to 10 cm is classified as a large hernia by the European Hernia Society.[2] This surgical technique is based on subcutaneous lateral dissection, fasciotomy lateral to the rectus abdominis muscle, and dissection on the plane between external and internal oblique muscles with medial advancement of the block that includes the rectus muscle and its fascia. This release allows for medial advancement of the fascia and closure of up to 20 cm-wide defects in the midline area. Mesh reinforcement is often used in recurrent repairs where the abdominal defect is too large and there is a large amount of tension on the CST repair. CST is not typically used as an initial surgical approach for small primary ventral hernia repairs.

SUMMARY

Medically Necessary

Surgical repair of a ventral hernia may be considered medically necessary in symptomatic patients when policy criteria are met.

The component separation technique is a method that may be used to repair large (greater than 10 centimeters) midline ventral hernias. Therefore, surgical repair of large (greater than or equal to 10 centimeters in width) midline ventral or incisional hernias using the component separation technique may be considered medically necessary.

Not Medically Necessary

Surgical repair of an abdominal wall defect, including but not limited to ventral or incisional hernias that are less than 10 centimeters in width using the component separation technique is considered not medically necessary.

Cosmetic

Surgical repair of asymptomatic ventral (including incisional) hernias is considered not medically necessary. Surgical repair of diastasis recti, abdominoplasty, and related procedures, including but not limited to fascial plication, surgical imbrication, and tightening of lax fascia, are considered cosmetic.

REFERENCES

1. Mancini GaL, Hien. *Loss of Abdominal Domain: Definition and Treatment Strategies*, 2016, pp. 361-370.
2. Muysoms FE, Miserez M, Berrevoet F, et al. Classification of primary and incisional abdominal wall hernias. *Hernia : the journal of hernias and abdominal wall surgery.* 2009;13(4):407-14. PMID: 19495920

CODES

Notes:

- Laparoscopic (including robotic) or open ventral (including incisional) hernia repair may be reported with CPT codes listed below depending on the size of defect and the indication.
- The separation component (CST) is reported with CPT code 15734 when performed open. When performed by laparoscopic technique, it is reported by unlisted CPT code 49659 with reference to CPT code 15734.

Codes	Number	Description
CPT	15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
	49591	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
	49593	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible
	49595	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible
	49613	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
	49615	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible
	49617	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible
	49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible
	49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy
HCPCS	C7565	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s) less than 3 cm, reducible with removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair

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