

NOTE: This policy has been revised. The revised policy will be effective December 1, 2021. To view the revised policy, [click here](#).

Medical Policy Manual

Surgery, Policy No. 12.03

Ventral Hernia Repair

Effective: June 1, 2020

Next Review: May 2021

Last Review: April 2020

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

Ventral hernias occur in the abdomen and 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.

MEDICAL POLICY CRITERIA

- I. Surgical repair of a ventral hernia may be considered **medically necessary** in symptomatic patients when there is documentation that one or more of the following Criteria are met:
 - A. Hernia associated pain; or
 - B. Bowel obstruction or strangulation; or
 - C. Incarceration; or
 - D. Thinning of the overlying skin; or
 - E. Loss of abdominal domain (see Policy Guidelines).
- II. Surgical repair of ventral hernias using the component separation technique (CST) may be considered **medically necessary** for the following indications (see Policy Guidelines):

- A. Initial repair is for a large (defined as width greater than or equal to 10 cm) abdominal wall defect that cannot be closed primarily; or
- B. Repair is for a recurrent ventral hernia.
- III. Surgical repair of ventral hernias is considered **not medically necessary** when Criterion I. is not met.
- IV. Surgical repair of ventral hernias using the component separation technique (CST) is considered **not medically necessary** when Criterion II. is not met.
- V. Surgical repair of asymptomatic ventral hernias, including ventral hernias found incidentally during surgery, is considered **not medically necessary**.
- 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]
- A defect width greater than or equal to 10 cm is classified as a large hernia.^[2]

LIST OF INFORMATION NEEDED FOR REVIEW

SUBMISSION OF DOCUMENTATION

It is critical that the list of information below is submitted for review to determine if the 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 and description of associated functional physical impairment if applicable
- Diagnostic testing results as applicable to request and associated policy criteria
- Photographs as applicable to request and associated policy criteria
- Documentation of stable weight loss as applicable to associated criteria
- If the component separation technique is being performed, specify if the surgical repair is for an initial or recurrent hernia and for initial repairs, indicate the size of the hernia in centimeters.

CROSS REFERENCES

1. [Cosmetic and Reconstructive Surgery](#), Surgery, Policy No. 12

BACKGROUND

Ventral 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, Umbilical, Lumbar 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] 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.

Note:

- CPT states, “select the name of the procedure or service that accurately identifies the service performed”; therefore, an abdominal wall hernia with a specific CPT code (i.e. **epigastric, umbilical, spigelian, or lumbar** hernia repair) should not be coded as a ventral hernia repair.
- A ventral hernia at the site of a prior surgery is considered an incisional hernia.

SUMMARY

There is enough evidence to show that the surgical repair of a ventral hernia improves health outcomes for symptomatic patients meeting criteria. Therefore, 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, complicated ventral hernias and is not typically used for the initial surgical approach to

ventral hernia repair of less than 10 cm in width. Therefore, surgical repair of recurrent or very large (greater than or equal to 10 cm in width) ventral hernias using the component separation technique may be considered medically necessary. Surgical repair of initial ventral hernias less than 10 cm in width using the component separation technique is considered not medically necessary.

There is not sufficient evidence that surgical repair of asymptomatic ventral hernias improves health outcomes. Therefore, surgical repair of asymptomatic ventral 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 Aug;13(4):407-14. PMID: 19495920

CODES

Codes	Number	Description
CPT	15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
	49560	Repair initial incisional or ventral hernia; reducible
	49565	Repair recurrent incisional or ventral hernia; reducible
	49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
	49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
	49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
HCPCS	None	

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