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MEDICAL POLICY – 7.01.600

Abdominal Wall Hernia Repair in Adults

Effective Date:	**Jan. 2, 2026**	RELATED MEDICAL POLICIES:
Last Revised:	Sep. 9, 2025	7.01.516 Bariatric Surgery
Replaces:	N/A	7.01.523 Panniculectomy and Excision of Redundant Skin

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

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Introduction

An abdominal wall hernia occurs when an organ or tissue pushes through a weakened area in the muscles of the abdomen. This can cause discomfort, especially during activities like lifting, bending, or coughing, and may interfere with daily life. In some cases, hernias can lead to serious complications if the trapped tissue loses its blood supply. Treatment often involves surgical repair, particularly for larger or more severe hernias. The most appropriate approach depends on the hernia's size, the person's overall health, and the risk of the hernia coming back. This policy describes when abdominal wall hernia repair may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Note: This policy only applies to individuals aged 19 and older

Procedure	Medical Necessity

• **Open hernia repair**
• **Laparoscopic hernia repair**
• **Robotic hernia repair**
	Initial (epigastric, incisional, ventral, umbilical, spigelian (See Related Information Section) hernia repair may be considered medically necessary when the following criteria are met:
	• Symptomatic hernia including ALL of the following:
	  ○ Pain or other functional impairment present for at least 6 weeks
	  ○ Conservative therapy failure over 4 weeks (NSAIDS, abdominal binders, lifestyle changes [weight loss or obesity counseling, increased fiber intake, avoid heavy or fatty foods, good posture, avoid heavy lifting, improve core strength, maintain regular bowel habits and avoid straining] adequate hydration, adjust sleep position to avoid pressure on hernia)
	
	Recurrent (epigastric, incisional, ventral, umbilical, spigelian) hernia repair may be considered medically necessary when ANY of the following criteria are met:
	• The prior hernia repair has failed as confirmed by recurrence by imaging or physical exam
	• Symptoms have returned or worsened as defined by any of the following:
	• Pain and/or functional impairment has returned or intensified over 4 weeks
	• A palpable bulge is located at or near the prior repair site
	
	Incarcerated or strangulated (See Related Information Section) (epigastric, incisional, ventral, umbilical, spigelian) hernia repair is considered medically necessary.
	
	All other abdominal hernia repair procedures not outlined in this policy are considered not medically necessary.

Procedure	Investigational
Investigational Procedures	**The following procedures, devices, or adjuncts related to abdominal wall hernia repair are considered investigational including but not limited to:**

Procedure	Investigational
	• Tissue-engineered mesh or stem cell-seeded implants • Enhanced-view totally extraperitoneal (eTEP) hernia repair technique • Robotic component separation (robotic TAR) • Use of custom 3D-printed mesh implants • (See Related Information Section)

Documentation Requirements

The patient's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- Office visit notes that contain the relevant history and physical related to the requested procedure.
- Age
- For **initial hernia repair** include documentation of **ALL** of the following:
  - Pain or bulge or functional impairment persisting for at least 6 weeks
  - Failure of conservative management (activity modification, analgesics, abdominal binder) for at least 4 weeks)
  - Defect size documentation by imaging or intraoperative measurement (less than 3cm, 3 to 10 cm, or greater than 10 cm)

- For **recurrent hernia repair** include documentation of **ANY** of the following:
  - Evidence of recurrency by imaging or physical exam to confirm fascial defect at previous repair site
  - Prior surgical history as evidenced by operative report or provider documentation of previous hernia repair

AND

- **All** of the following:
  - Pain or bulge persisting or functional impairment persisting at least 4 weeks
  - Failure of conservative management (activity modification, analgesics, abdominal binder) for at least 4 weeks)
  - Defect size documentation by imaging or intraoperative measurement (less than 3cm, 3 to 10 cm, or greater than 10 cm)

Coding

Code	Description
CPT	
49591	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., 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) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., 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) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., 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) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., 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) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., 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) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible
49659	Unlisted laparoscopy procedure, including hernioplasty, herniorrhaphy, and herniotomy
49999	Unlisted procedure, abdomen, peritoneum and omentum

Related Information

Definition of Terms

Physical functional impairment In this policy, physical functional impairment means either limitation from normal physical functioning or baseline level of functioning that may include, but is not limited to problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body part(s) or obstruction of an orifice. Physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairments or potential impairments.

Hernia Types

Epigastric hernia: Found between the ribcage and navel.

Incisional hernia: Occurs at a previous surgical site.

Incarcerated hernia: A hernia that cannot be pushed back into the abdomen (non-reducible hernia) where trapped tissue may lead to bowel obstruction or compromised blood flow.

Spigelian hernia: Forms along the lateral edge of the rectus abdominis muscle.

Strangulated hernia: A non-reducible hernia with compromised blood flow, causing tissue ischemia and risk of necrosis.

Umbilical hernia: Forms near the belly button.

Ventral hernia: Forms at in the anterior abdominal wall, often at the midline.

Investigational Hernia Repair Methods

Custom 3D-printed mesh implants: Patient-specific prosthetic mesh fabricated using additive manufacturing for tailored hernia repair.

Enhanced-view totally extraperitoneal (eTEP) technique: Advanced laparoscopic approach performed in the preperitoneal space for hernia repair.

Robotic component separation (robotic TAR): Robot-assisted transversus abdominis release to reconstruct complex abdominal wall defects.

Tissue-engineered mesh or stem cell-seeded implants: Biologic or cell-based materials designed to promote tissue regeneration in hernia repair.

Evidence Review

Description

Traditional open hernia repair method is suitable using an incision over the hernia site. Hernia may be pushed back or removed, and the abdominal wall is suited to reinforcement with sutures or mesh. Usually suited to larger or complex hernias. Laparoscopic hernia repair is a minimally invasive technique; this is preferred for smaller or recurrent hernias using small incisions and a camera. Mesh is required to reinforce the weakened areas, and the expected recovery time is shorter for laparoscopic hernia repair over traditional hernia open repair.

Hernia repair options are optimized to the type of hernia and individual's health and hernia surgical history. The best repair method depends on several important factors. These include an individual's overall health (age, medical history, and comorbidities) to determine which surgery type is safest. Less complex underlying health conditions may make individuals more suited to a laparoscopic (minimally invasive) hernia repair procedure. Smaller hernias may be suited to a simpler procedure, while larger or more complex hernias often require surgical mesh reinforcement to reduce the risk of recurrence. Following a previous hernia repair, precautions such as mesh placement or stronger sutures may be medically necessary. Additionally, incisional or lumbar hernias with a higher recurrence rate may need a stronger repair technique.

Background

A pre-surgical consultation is required to allow the surgeon to assess the individual's medical condition to recommend the safest, most effective approach to hernia repair. Some procedures use mesh reinforcement, others rely on direct suturing, and some involve laparoscopic techniques to minimize scarring and recovery time. Upon discussing the individual's symptoms, lifestyle, and medical history, the surgeon may customize the treatment plan to optimize the ensure the hernia repair outcome. Selecting the correct procedure type for hernia repair may result in faster healing, lower complications, and a stronger long-term hernia repair.

The hernia repair surgical approach depends on hernia type, size, and severity. Femoral hernias are typically repaired using open surgery or laparoscopic techniques. Mesh reinforcement is often used to reduce recurrence. Umbilical and epigastric hernias may be repaired without mesh if they are considered small. However, larger hernias often require reinforcement with synthetic

mesh for durability. Incisional hernias require complex repair due to prior surgical weakness. Mesh placement and laparoscopic options help reinforce the site and prevent recurrence. A Spigelian hernia has a deep location; therefore, minimally invasive laparoscopic surgery is preferred to minimize recovery time and risk. The right repair method depends on individual health factors, hernia size, and risk of recurrence. Surgical consultation helps determine the best approach for each individual.

Summary of Evidence

The medical necessity of surgical techniques for abdominal wall hernia repair is supported by rigorous, US based clinical evidence. Each technique has been evaluated through randomized controlled trials (RCTs) and systematic reviews that underscore its efficacy in specific patient populations. Open hernia repair remains essential for large, recurrent, or strangulated hernias. The Veterans Affairs Cooperative Study #456, a multicenter RCT involving 1,983 male patients at 14 US centers, demonstrated a lower recurrence rate with open mesh repair (4.9%) compared to laparoscopic mesh repair (10.1%) at two years.[1] A recent systematic review analyzing 2,926 patients further validated these findings, showing significantly reduced recurrence rates with mesh versus suture repair in small umbilical hernias.[2]

Laparoscopic repair is considered medically necessary in cases of bilateral, recurrent, or anatomically challenging hernias. A US based meta-analysis of 23 studies found that laparoscopic repair offers fewer short-term complications and faster recovery compared to open surgery, without compromising recurrence rates.[3] Similarly, Martins et al. (2024) conducted a systematic review of nine randomized trials and reported a 50% lower recurrence rate and a 70% reduction in surgical site infections with laparoscopy, reinforcing its value in selected patients.[4]

Robotic-assisted repair provides an effective and precise option for complex ventral and incisional hernias. A systematic review by Ye et al. (2021) of 25 US based studies concluded that robotic repairs were associated with fewer complications, shorter hospital stays, and reduced transfusion rates compared to open repair—though at a higher financial cost relative to laparoscopy.[5] Supporting these findings, a large comparative study by Kudsi et al. (2023) evaluated 1,284 patients (609 robotic, 675 open) and found significantly lower complication rates with robotic-assisted repair, including reduced complications (4.9% vs. 13.2%), fewer surgical site events (12.2% vs. 21.5%), and a markedly lower recurrence rate (2.8% vs. 8.9%).[6] Although robotic ventral hernia repair (RVHR) was associated with higher hospital costs, these were offset by lower post-discharge expenses, resulting in no significant difference in total cost of care.[6]

Table 1. Medically Necessary Surgical Techniques for Abdominal Wall Hernia Repair

Surgical Approach	Medical Necessity Criteria	Summary of Clinical Evidence	Outcomes Compared to Alternatives
Open Hernia Repair	Documented symptomatic hernia (pain, bulge, risk of incarceration); large or strangulated hernia; failure of minimally invasive repair.	Long-standing surgical standard. Studies demonstrate low recurrence when mesh is used. Endorsed by ACS and international hernia societies.[7,8]	Comparable recurrence rate to laparoscopy; longer recovery time.
Laparoscopic Hernia Repair	Reducible or bilateral inguinal hernias; recurrent hernia after prior open repair; desire for faster recovery or reduced pain; general anesthesia tolerated.	Cochrane reviews and RCTs show faster return to activity, lower wound complications, and improved cosmesis.[9,10]	Faster recovery; fewer wound complications vs open repair.
Robotic-Assisted Hernia Repair	Large, recurrent, or complex ventral/incisional hernias requiring enhanced visualization or deep plane dissection; surgeon expertise and device availability	Early studies show equivalent outcomes to laparoscopy with improved surgeon ergonomics. Long-term recurrence rates remain under investigation.[11]	Comparable results; may reduce technical complications.

Investigational methods lack sufficient evidence of safety, efficacy, and/or improved outcomes compared to established methods. Certain procedures, devices, and adjunctive techniques in abdominal wall hernia repair remain investigational based on current evidence, with no conclusive demonstration of improved outcomes over established standards of care.

Stem cell–seeded and tissue-engineered meshes are still confined to early-stage investigations and preclinical studies. Rajan et al. (2014) reported on optimized cell viability in scaffold models, but no clinical trials have yet validated the safety or efficacy of these technologies in human hernia repair.[12]

The enhanced view totally extraperitoneal (eTEP) hernia repair technique, while gaining popularity among minimally invasive surgeons, lacks high-quality comparative data. Most available studies, like the multicenter case series by Belyansky et al. (2018), describe technical

feasibility and short-term outcomes but do not offer randomized evidence comparing eTEP to traditional laparoscopic or open techniques.[13]

Similarly, robotic transversus abdominis release (TAR) has yet to demonstrate measurable clinical advantages over open or laparoscopic TAR. A recent systematic review and meta-analysis by Lima et al. (2024) found that robotic TAR was associated with longer operative times, higher direct costs, and no significant improvement in surgical site occurrence or recurrence when compared to open TAR across 10 US based studies.[14]

Custom 3D-printed mesh implants remain investigational as well, with limited peer-reviewed literature and no FDA-cleared applications for broad clinical use. In a recent review, Ahmed et al. (2024) concluded that while bioresorbable, patient-specific meshes offer theoretical advantages, current evidence is restricted to early clinical feasibility studies and lacks data on long-term outcomes or cost-effectiveness.[15]

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in **Table 2**.

Table 2. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT06710795	AFFIX: Post-market Study of MaxTack Motorized Fixation Device in Subjects Undergoing Ventral Hernia Repair [b]	110	2/15/2027
NCT04779918	Ventral or Inguinal Hernia, Robotically Repaired With OviTex Mesh [b]	160	12/30/2027
NCT06449378	Transorb Self-Gripping Resorbable Mesh in High-risk Subjects Undergoing Open Repair of Ventral Hernia [b]	163	6/30/2031
NCT05599750	Suture Repair vs Mesh Repair for Incisional Hernia	154	10/30/2031

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT05094089	Assessment of GORE SYNECOR Biomaterial in Focused Patient Populations and Long-Term Application (SYN 20-01) [b]	320	12/31/2028
NCT04578340	Long Term Outcomes Following Hernia Repair With Mesh [b]	4700	10/01/2026
NCT05472987	Robotic Versus Open Ventral Hernia Repair (ROVHR)	200	8/01/2025

NCT National Trial Number Table notes = Trial search on 6/20/25. [a]

[b] Industry sponsored trial.

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

Society of American Gastrointestinal and Endocsopic Surgeons (SAGES)

Guideline: *Guidelines for Laparoscopic Ventral Hernia Repair* Key Recommendations:[16]

- Laparoscopic repair is associated with fewer wound infections than open repair, with similar recurrence and pain outcomes.
- Patient selection should consider hernia size, prior surgeries, and surgeon experience.
- Mesh placement should ensure adequate overlap (typically 3–5 cm beyond defect margins) and secure fixation.
- Avoid laparoscopic repair in very small (<3 cm) or very large (>10 cm) defects unless surgeon is highly experienced.

- Postoperative care should include early ambulation and pain control; recurrence risk is influenced by mesh type and fixation method.

American College of Surgeons (ACS)

Guideline: *Hernia Repair and Complex Abdominal Wall Reconstruction* Key Recommendations per 2017 ACS Bulliten:[17]

- Mesh reinforcement is standard for most ventral and incisional hernias to reduce recurrence.
- Tailor surgical approach (open, laparoscopic, robotic) based on hernia complexity, patient anatomy, and surgeon expertise.
- Component separation techniques are appropriate for large or complex defects, especially with loss of domain.
- Documentation and coding must clearly reflect hernia type, size, and surgical method for accurate reimbursement.
- Patient education is emphasized, including risks, benefits, and recovery expectations.

European Hernia Society (EHS) & American Hernia Society (AHS)

Guideline: *Updated Guideline for Closure of Abdominal Wall Incisions* (2022) Key Recommendations: [18]

- Laparoscopic surgery is suggested when safe and feasible due to the decreased risk of both incisional hernia and surgical-site occurrences.
- Prefer non-midline incisions when feasible to reduce incisional hernia risk.
- For midline laparotomy closure, use continuous small-bites technique with slowly absorbable suture.
- Prophylactic mesh augmentation is recommended after elective midline laparotomy to reduce risk of incisional hernia.
- In laparoscopic surgery, close trocar sites ≥10 mm, especially at the umbilicus, to prevent port-site hernias.

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Hernia repair is a surgical procedure and therefore is not regulated by the FDA.

As of June 2025, the FDA has published a draft guidance regarding hernia mesh packaging and labeling recommendations for public comment. The rationale for publication of the document or public comment is to guide the FDA to finalize guidelines for safe and effective use of hernia mesh for hernia repair.[19]

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History

Date	Comments
10/01/25	New policy, approved September 9, 2025, effective for dates of service on or after January 2, 2026, following 90-day provider notification. Add to Surgery section. Open, laparoscopic, or robotic abdominal hernia repair is considered medically necessary when criteria are met.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.