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2024 Billing and Coding Guide

Hernia repair procedures

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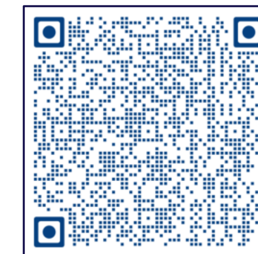
Overview

This guide is intended to aid providers in appropriate procedure code selection for Hernia procedures. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the CPT®[1] code.

Instructions for use:

- New tools and updates can be found in the New for 2024 section.
- Code descriptions and details of code reporting requirements and/or guidance, as well as Physician, Hospital Outpatient, and/or Ambulatory Surgery Center (ASC) rates, can be found in the Coding & Reimbursement section.
- Details surrounding specialized coding and reimbursement information can be found in the FAQ and resources section.
- This document is not all-inclusive, nor does it replace advice from your coding and compliance departments and/or CPT®[1] coding manuals.



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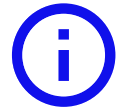
New for 2024

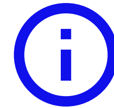


New Tool

Medtronic C-Code Finder

Launching January 2024, we will have a new tool specifically designed to access applicable commonly used C-codes as it relates to Medtronic products. Medicare provides C-codes, a type of HCPCS[3] II code, for hospital use in billing Medicare for some medical devices and supplies in the hospital outpatient setting. The C-code finder can be accessed at www.medtronic.com/c-code or by clicking the C-code button.

C-code Finder



Hernia defect measurement

Abdominal Hernia Best Practice Considerations for Documentation

Detailed documentation and coding are necessary for reimbursement and will directly influence whether a payer approves a patient claim for payment. It is important to include:

- **Indication for the procedure**
- **Procedure performed**
- **Hernia location**
- **Hernia length in centimeters**
- **Previous repair performed**
- **Mesh used/location**

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Coding & reimbursement

This section provides Medicare unadjusted national average allowable rates for physician, hospital outpatient, ambulatory and hospital inpatient settings. The coding information in this section does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes must be supported by clear documentation within the medical record.

Providers may choose to perform multiple procedures during the same encounter. When this occurs, providers must report all procedures and the payment may be subject to packaging rules, multiple procedure reduction, complexity adjustments, or multiple endoscopy reductions.

- HCPCS[2] II codes
- CPT®[1] procedure codes and Physician[3], Hospital outpatient[4] and Ambulatory surgery center[4] reimbursement rates
- Inpatient[5] national unadjusted reimbursement rates and ICD-10 PCS[6] codes

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HCPCS[2] II codes

C-code Finder

Level II HCPCS[2] codes are primarily used to report supplies, drugs and implants that are not reported by a CPT®[1] code. HCPCS codes are reported by the physician, hospital or DME provider that purchased the item, device, or supply. Different payers have different payment methods for these items.

C-codes are a series of HCPCS codes that facilities reimbursed under the Medicare Outpatient Prospective Payment System (OPPS) are required to report for eligible items and services. Medicare assigns C-codes to specific devices eligible for pass-through payment. Every year, in the OPPS rule, Medicare publishes a list of CPT®[1] and HCPCS codes that are designated as device-intensive procedures. When reporting procedures on this list, facilities should capture both the CPT®[1] code representing the procedure performed and the C-code representing the device used. Although C-codes only affect Medicare outpatient reimbursement, facilities may also want to report C-codes on inpatient claims if the device is not used exclusively for inpatient procedures. Medicare tracks this information and uses it in its rate-setting process. Non-OPPS facilities may report C- codes at their discretion.

HCPCS II S-codes cannot be reported to Medicare. They are used only by non-Medicare payers, which cover and price them according to their own policies and provider contracts.

HCPCS[2] code	Description
C1781	Mesh (implantable)
C9364	Porcine implant, Permacol™, per square centimeter
A4649	Surgical supply; miscellaneous
S2900	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)

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CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[4]	
Abdominal hernia repair, initial										
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);										
49591	Less than 3 cm; reducible	000	5.96	NA	$336	5341	J1	$3,296†	G2	$1,622
49592	Less than 3 cm; incarcerated or strangulated	000	8.46	NA	$466	5361	J1	$5,498†	G2	$2,705
49593	3 cm to 10 cm, reducible	000	10.26	NA	$562	5341	J1	$3,296†	G2	$1,622
49594	3 cm to 10 cm, incarcerated or strangulated	000	13.46	NA	$731	5361	J1	$5,498†	G2	$2,705
49595	Greater than 10 cm, reducible	000	13.94	NA	$755	5341	J1	$3,296†	G2	$1,622
49596	Greater than 10 cm, incarcerated or strangulated	000	18.67	NA	$1,002	NA	C	NA	NA	NA

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		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Abdominal hernia repair, recurrent										
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);										
49613	Less than 3 cm; reducible	000	7.42	NA	$414	5341	J1	$3,296†	G2	$1,622
49614	Less than 3 cm; incarcerated or strangulated	000	10.25	NA	$560	5361	J1	$5,498†	G2	$2,705
49615	3 cm to 10 cm, reducible	000	11.46	NA	$626	5341	J1	$3,296†	G2	$1,622
49616	3 cm to 10 cm, incarcerated or strangulated	000	15.55	NA	$841	Inpatient only				
49617	Greater than 10 cm, reducible	000	16.03	NA	$867	Inpatient only				
49618	Greater than 10 cm, incarcerated or strangulated	000	22.67	NA	$1,214	Inpatient only				

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		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Component separation										
15734	Muscle, myocutaneous or fasciocutaneous flap; trunk	000	22.67	NA	$1,214	5055	T	$3,418	A2	$1,861
Diaphragmic hernia repair										
39501	Repair, laceration of diaphragm, any approach	090	13.98	NA	$837	Inpatient only				
39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	090	108.91	NA	$5,599	Inpatient only				
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	090	15.75	NA	$913	Inpatient only				
Enterolysis										
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)	090	18.46	NA	$1,071	Inpatient only				
44180	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)	090	15.27	NA	$904	5361	J1	$5,498†	NA	NA
Femoral hernia repair										
49550	Repair initial femoral hernia, any age; reducible	090	8.99	NA	$572	5341	J1	$3,296†	A2	$1,622

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		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Femoral hernia repair										
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	090	9.92	NA	$625	5341	J1	$3,296†	A2	$1,622
49555	Repair recurrent femoral hernia; reducible	090	9.39	NA	$599	5341	J1	$3,296†	A2	$1,622
49557	Repair recurrent femoral hernia; incarcerated or strangulated	090	11.62	NA	$714	5341	J1	$3,296†	A2	$1,622
Inguinal hernia repair										
49492	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated	090	15.43	NA	$947	5341	J1	$3,296†	NA	NA
49495	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible	090	6.20	NA	$405	5341	J1	$3,296†	A2	$1,622
49496	Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated	090	9.42	NA	$610	5341	J1	$3,296†	A2	$1,622

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		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Inguinal hernia repair										
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible	090	5.84	NA	$414	5342	J1	$7,208†	A2	$3,722
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated	090	9.36	NA	$601	5341	J1	$3,296†	A2	$1,622
49505	Repair initial inguinal hernia, age 5 years or older; reducible	090	7.96	NA	$518	5341	J1	$3,296†	A2	$1,622
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	090	9.09	NA	$582	5341	J1	$3,296†	A2	$1,622
49520	Repair recurrent inguinal hernia, any age; reducible	090	9.99	NA	$627	5341	J1	$3,296†	A2	$1,622
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	090	11.48	NA	$708	5342	J1	$7,208†	A2	$3,722
49525	Repair inguinal hernia, sliding, any age	090	8.93	NA	$568	5341	J1	$3,296†	A2	$1,622
49650	Laparoscopy, surgical; repair initial inguinal hernia	090	6.36	NA	$430	5361	J1	$5,498†	A2	$2,705
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	090	8.38	NA	$561	5361	J1	$5,498†	A2	$2,705

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		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Mesh removal										
+11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	ZZZ	5.00	NA	$265	Inpatient only				
+49623	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, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)	ZZZ	3.75	NA	$193	NA	N	NA	NA	NA
Paracolostomy hernia repair										
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	090	19.63	NA	$1,159	Inpatient only				
Paraesophageal hernia repair										
43280	Laparoscopy, surgical, esophagogastic fundoplasty (eg, Nissen, Toupet procedures)	090	18.10	NA	$1,058	5362	J1	$9,808†	NA	NA
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	090	26.60	NA	$1,504	5362	J1	$9,808†	NA	NA

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		Physician[3]				Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Paraesophageal hernia repair										
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	090	30.10	NA	$1,694	5362	J1	$9,808†	NA	NA
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	090	19.62	NA	$1,125	Inpatient only				
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	090	21.46	NA	$1,233	Inpatient only				
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	090	22.12	NA	$1,202	Inpatient only				
Parastomal hernia repair										
49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible	000	13.70	NA	$727	Inpatient only				
49622	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated	000	17.06	NA	$896	Inpatient only				
Unlisted hernia repair										
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	YYY	Carrier priced			5361	J1	$5,498†	NA	NA

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Inpatient[5] national unadjusted reimbursement rates

Under Medicare's MS-DRG[5] methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. MS-DRGs shown are those typically assigned to the following scenarios when the patient is admitted specifically for the procedure.

Below are commonly used DRGs, however codes listed below are not exhaustive as other codes may apply.

MS-DRG[5]	Description	Rate
Repair of Diaphragmatic Hernia (Hiatal Hernia, Paraesophageal Hernia)		
326	Stomach, Esophageal And Duodenal Procedures W MCC	$35,561
327	Stomach, Esophageal And Duodenal Procedures W CC	$17,486
328	Stomach, Esophageal And Duodenal Procedures W/O CC/MCC	$11,184
Adhesiolysis		
335	Peritoneal Adhesiolysis W MCC	$25,031
336	Peritoneal Adhesiolysis W CC	$14,740
337	Peritoneal Adhesiolysis W/O CC/MCC	$10,477
Hernia Repair – Inguinal, Femoral		
350	Inguinal and Femoral Hernia Procedures W MCC	$16,804
351	Inguinal and Femoral Hernia Procedures W CC	$10,192
352	Inguinal and Femoral Hernia Procedures W/O CC/MCC	$7,765
Hernia Repair – Other (Epigastric, Incisional/Ventral, Lumbar, Parastomal, Spigelian, Umbilical)		
353	Hernia Procedures Except Inguinal and Femoral W MCC	$20,475
354	Hernia Procedures Except Inguinal and Femoral W CC	$12,027
355	Hernia Procedures Except Inguinal and Femoral W CC/MCC	$9,540

MCC: Major Complications and/or Comorbidities **CC: Complications and/or Comorbidities**

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ICD-10-PCS[6] procedure codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly used ICD-10-PCS procedure codes, however codes listed below are not exhaustive as other codes may apply.

ICD-10-PCS[6] code	Description
Epigastric, Incisional, Ventral, Lumbar, Parastomal, Spigelian, and Umbilical Hernia Repair	
0WQF4ZZ	Repair Abdominal Wall, Percutaneous Endoscopic Approach
0WQF0ZZ	Repair Abdominal Wall, Open Approach
0WUF4KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0WUF4JZ	Supplement Abdominal Wall with Synthetic Substitute, Percutaneous Endoscopic Approach
0WUF0JZ	Supplement Abdominal Wall with Synthetic Substitute, Open Approach
Inguinal and Femoral Hernia Repair	
0YQA0ZZ	Repair Bilateral Inguinal Region, Open Approach
0YU64KZ	Supplement Left Inguinal Region with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0YUE0JZ	Supplement Bilateral Femoral Region with Synthetic Substitute, Open Approach
Component separation	
0KNK4ZZ	Release Right Abdomen Muscle, Percutaneous Endoscopic Approach
0KNL4ZZ	Release Left Abdomen Muscle, Percutaneous Endoscopic Approach
0KNK0ZZ	Release Right Abdomen Muscle, Open Approach
0KNL0ZZ	Release Left Abdomen Muscle, Open Approach

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ICD-10-PCS[6] code	Description
Repair of Diaphragmatic Hernia (Hiatal Hernia, Paraesophageal Hernia)	
0BQT4ZZ	Repair Diaphragm, Percutaneous Endoscopic Approach
0BUT07Z	Supplement Diaphragm with Autologous Tissue Substitute, Open Approach
0BUT0JZ	Supplement Diaphragm with Synthetic Substitute, Open Approach
0BUT4KZ	Supplement Diaphragm with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
Mesh removal	
0WPF0JZ	Removal of Synthetic Substitute from Abdominal Wall, Open Approach
0WPF3JZ	Removal of Synthetic Substitute from Abdominal Wall, Percutaneous Approach
Enterolysis	
0DN84ZZ	Release Small Intestine, Percutaneous Endoscopic Approach

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Frequently asked questions

Can I bill separately for the implantation of the mesh?

Prior to 2023, an add-on code was reported on the claim when mesh was inserted in open procedures using CPT®[1] code +49658 – Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection. Effective January 1, 2023, CPT®[1] code +49568 was deleted. The new CPT®[1] codes for abdominal hernia repair include the physician work associated with the implantation of mesh

How do you code if both reducible and incarcerated/strangulated hernias are repaired during the same encounter?

All hernias are reported as if they were incarcerated/strangulated.

How do I code a procedure that was robotically assisted?

When coding for robotic-assisted procedures in the outpatient setting or the professional fee, the CPT®[1] code that accurately describes the surgical procedure via laparoscopic approach should be used. There are no designated CPT®[1] codes or modifiers to report the use of robotic assistance. Some commercial payers may allow the use of HCPCS code S2900 to report robotic assistance. S codes should not be used when billing services to Medicare. When coding inpatient facility services, robotic assistance indexes to ICD-10-PCS code table 8E0.[6]

What do the changes in Global Period mean for Abdominal Hernia Repair procedures?

Medicare payment for most surgical procedures covers both the procedure and post-operative visits occurring within a global period of either 010 or 090 days following the procedure. The new abdominal repair CPT®[1] codes have a 000 day global period and as a result, providers are now able to separately report pre and post operative E/M codes and receive reimbursement. There were no changes in the global periods for inguinal or femoral hernia repair.

What is a common scenario where modifier 50 is utilized/appended?

Modifier 50 is reported when bilateral procedures are performed on both sides of the body. Modifier 50 should not be appended to midline procedures such as abdominal hernias. Modifier 50 can be used with inguinal or femoral hernias when both the right and left side are surgically repaired.

How do you report a repair of an inguinal, femoral or lumbar and an anterior abdominal hernia performed in the same operative session?

Both procedures may be reported when performed in the same operative session by appending modifier 59. Please reference the 2023 CPT®[1] book for more information.[7]

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Appendix

Term	Footnote	Definition
Add-on CPT®[1] codes	+	An Add-on Code (AOC) is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An AOC is rarely eligible for payment if it's the only procedure reported by a practitioner.
Carrier priced		Carrier priced codes are not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis.
Complexity adjustment		The complexity adjustments were implemented by CMS to provide for a payment adjustment when two or more high-cost procedures are performed and paid under Medicare's Hospital Outpatient Comprehensive APC system. To qualify, claims with certain code combinations must meet specific thresholds for both cost and frequency. When these thresholds are met, the code combinations qualify for reassignment to the next highest paying APC.
Comprehensive APC	†	Under its comprehensive APC (C-APC) policy, CMS makes payment for certain costly primary services and all other items and services reported on the hospital outpatient department claim, which CMS considers integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a complete comprehensive service.
Device intensive[8]	¶	Definition/symbol - The "device intensive" status is assigned to all surgical procedures with an individual HCPCS code-level device offset of greater than 40%. Device intensive procedures are identified in Addendum AA with a payment indicator of XX.
Inpatient only (IPO) list		CMS can define procedures and services for which payment under the outpatient prospective payment system (OPPS) is inappropriate. These codes have a status indicator of "C". Services designated as "inpatient only" are not appropriate to be furnished in a hospital outpatient department. Generally, inpatient only procedures are surgical services that require inpatient care because of the nature of the procedure
Modifiers[7]	‖	Modifiers are used to supplement the information or adjust the care description to provide extra details concerning a procedure or service. Modifiers help further describe a procedure code without changing its definition. Modifiers are appended to CPT®[1] codes. List of modifiers can be found in the CPT®[1] book.
Multiple endoscopy rule[9]	††	The multiple endoscopy rule requires that you always bundle diagnostic endoscopy with any surgical endoscopy within the same family. The multiple endoscopy rule applies only when the physician performs two or more endoscopies in the same family.
Packaged payment	§	Under OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.
Payment indicator		CMS uses payment indicators to identify each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services' costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment (72 FR 67189-67190)
Status indicator		In the Hospital Outpatient, Status Indicator (SI) shows how a code is handled for payment purposes: C= Inpatient procedures, not paid under OPPS; J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; S = procedure or service not discounted when multiple procedure; Additional details can be found in Addendum D1 of the OPPS rule
Unlisted codes		Unlisted codes do not have established RVUs under Medicare's Physician Payment System and are typically priced by the contractor after review and individual consideration. Unlisted CPT®[1] codes do not carry a rate assignment from Medicare in the physician office setting. Payment may be available on a case-by-case basis with submission of medical records.
Work relative value unit (RVU)		The Work RVU is a unit of measure that describes the work associated with a physician's procedural services and is factored into the total physician payment. Work RVU is one of three total components on which physician payment is based: physician work RVU, practice expense RVU, and medical malpractice RVU.[7]
w/MCC, w/CC or w/o CC/MCC		In the inpatient setting, w/MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs w/MCC have at least one major secondary complication or comorbidity. Similarly, w/CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs w/CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs w/o CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.

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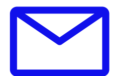
Resources

C-code Finder

Medtronic Reimbursement Support is available to assist you with your coding and reimbursement questions. If your coding or reimbursement questions were not answered in this guide, please check out these additional resources:

Visit our website: https://www.medtronic.com/covidien/en-us/support/reimbursement.html



Email us: rs.MedtronicMedicalSurgicalReimbursement@medtronic.com

Ask us about our Quick Reference Guide for CY2023 Abdominal Hernia code changes.

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References

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