

Medical Necessity Guideline: Umbilical Herniorrhaphy - Children < 5 Years of Age and Adults	Creation Date: 09/01/2007	Review Date: 05/23/2023	Effective Date: 09/01/2007
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PURPOSE:

To define the indications and required documentation for Umbilical Hernia repair.

DEFINITIONS:

Umbilical hernia - an outward bulging (protrusion) of the lining of the abdomen or part of the abdominal organ(s) through the area around the belly button ⁽⁴⁾.

GUIDELINE:

1. Repair of umbilical hernia is considered medically necessary, regardless of the member's age, if it is incarcerated or strangulated.
2. Children (under 18 years of age) - Repair of umbilical hernia is medically necessary for the following conditions:
 - The hernia has not closed by age 5 ^(1, 3).
 - The hernia is larger than 2 cm ⁽³⁾.
3. Adults (18 years of age and older) - Repair of umbilical hernia is medically necessary for the following conditions:
 - The hernia is progressively increasing in size ⁽⁵⁾
 - The hernia defect is greater than 1 cm ⁽⁶⁾
 - There is pain at the hernia site ^(1, 5, 6)
 - There is overlying skin ulceration or thinning ^(1, 6)
 - There is a rupture of the hernia ⁽⁶⁾
 - There is uncontrollable ascites ⁽¹⁾

Required Documentation:

DHP requires the following documentation to assess medical necessity for this procedure:

- In a child, current clinic note describing the course or progression of the hernia with age, if the size of the hernia is greater than 2 cm, and reducibility.
- In an adult, current clinic note describing the course or progression of the hernia, if the size of the hernia is greater than 1 cm, reducibility, if the overlying skin has thinning or ulceration, and if the underlying condition of the patient is resulting in persisting ascites.

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BACKGROUND:

Children:

Umbilical hernias are common in infants. The soft swelling over the belly button often bulges when the baby sits up, cries, or strains. However, the bulge may be flat when the infant lies on the back and is quiet. Umbilical hernias are usually painless. Most hernias in children heal on their own ⁽⁴⁾.

Holcomb and Ashcraft's Pediatric Surgery ⁽²⁾ states the following prognostic statistics: "Several studies have demonstrated spontaneous resolution rates of >90% of hernias by 1 year of age. One study found that 50% of hernias at age 4–5 years will close by age 11. Another study suggests that hernias with fascial defects greater than 1.5 cm are unlikely to close by age 6 years. In contrast, other series conclude that even large defects may spontaneously resolve without an operation. The primary danger associated with observation is the possibility of incarceration or strangulation. Studies have shown these complications to be quite rare, with an incidence of less than 1%. Patients with small fascial defects (0.5–1.5 cm in diameter) appear more prone to incarceration."

The book chapter by Chung in Sabiston Textbook of Surgery ⁽³⁾ states that "Enlarging umbilical hernia over time, in particular with a large skin proboscis more than 3 cm or a significantly large umbilical fascial defect (>2 cm), is unlikely to resolve spontaneously; therefore, surgical repair should be considered at an early age."

Discussion: Based on a review of authoritative textbooks and online resources ^(1, 2, 3, 4), it appears reasonable for the medical necessity cut-off age (other than incarceration or strangulation) to be 5 years for children or for the size cut-off to be a 2 cm fascial defect.

Adults:

Umbilical hernias are fairly common in adults. They are seen more in overweight people and in women, especially after pregnancy. They tend to get bigger over time.

Smaller hernias with no symptoms sometimes can be watched. Surgery may pose greater risks for patients with serious medical problems. Without surgery, there is a risk that some fat or part of the intestine will get stuck (incarcerated) in the hernia and become impossible to push back in. This is usually painful. If the blood supply to this area is cut off (strangulation), urgent surgery is needed. Nausea and vomiting may be experienced, and the bulging area may turn blue or a darker color.

To avoid this problem, surgeons often recommend repairing the umbilical hernia in adults. Surgery is also used for hernias that are getting larger or are painful. Surgery secures the weakened abdominal wall tissue (fascia) and closes any holes ⁽⁵⁾.

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Benjamin et. al., in Sabiston Textbook of Surgery ⁽¹⁾ state that “Small asymptomatic umbilical hernias barely detectable on examination need not be repaired. Adults who have symptoms, a large hernia, incarceration, thinning of the overlying skin, or uncontrollable ascites should have a hernia repair.”

Based on a review of authoritative textbooks and online resources ^(1, 5, 6) it appears that, in adults, other than for the smallest (<1 cm) of hernias, repair is indicated because they inevitably tend to grow larger and cause symptoms.

PROVIDER CLAIMS CODES:

ICD - 10	
K 42.0	Umbilical hernia with obstruction, without gangrene
K 42.1	Umbilical hernia with gangrene
K 42.9	Umbilical hernia without obstruction or gangrene

CPT	
49591	Repair of anterior abdominal hernia, further by initial or recurrent hernia, further by total defect size and by reducible or incarcerated/strangulated.
49592	Repair of anterior abdominal hernia, any approach, initial
49593	Repair of anterior abdominal hernia, any approach, initial
49594	Repair of anterior abdominal hernia, any approach, initial
49595	Repair of anterior abdominal hernia, any approach, initial
49596	Repair of anterior abdominal hernia, any approach, initial
49613	Repair of anterior abdominal hernia, any approach, recurrent
49614	Repair of anterior abdominal hernia, any approach, recurrent
49615	Repair of anterior abdominal hernia, any approach, recurrent
49616	Repair of anterior abdominal hernia, any approach, recurrent
49617	Repair of anterior abdominal hernia, any approach, recurrent
49618	Repair of anterior abdominal hernia, any approach, recurrent

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DOCUMENT HISTORY:

DHP Committee that Approved	<i>Review Approval Date (last 5 years)</i>					
Medical Director	06/13/2019	06/22/2020	06/10/2021	05/24/2022	06/07/2022	05/23/2023
CMO	11/21/2018	06/13/2019	06/22/2020	06/10/2021	06/07/2022	06/06/2023
Medical Policy Workgroup <i>Effective 2022</i>					06/07/2022	06/06/2023
Medical Management <i>Retired December 2020</i>	11/21/2018	06/13/2019	06/22/2020			
Utilization Management & Appeals <i>Effective January 2021</i>				06/10/2021	06/21/2022	06/20/2023
Utilization Management Behavioral Health <i>Retired December 2020</i>	02/28/2019	08/22/2019	06/22/2020			
Provider Advisory Committee (PAC) <i>Effective 2022</i>					6/17/2022	06/09/2023
Clinical Management Committee <i>Effective March 2021</i>				06/17/2021	06/24/2022 & 08/23/2022	07/20/2023
Quality Management <i>Retired 2020</i>	04/16/2019	10/22/2019	06/26/2020			
Executive Quality Committee <i>Effective 2021</i>				08/04/2021	06/28/2022	07/25/2023

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<i>Document Owner</i>	<i>Organization</i>	<i>Department</i>
Dr. Fred McCurdy, Medical Director	Driscoll Health Plan	Utilization Management

<i>Review/Revision Date</i>	<i>Review/Revision Information, etc.</i>
03/17/2014, 09/01/2015, 11/28/2016, 11/28/2017	No Change
11/15/2018	Added new reference
11/30/2019	Changed to new format, added reference and process. No change in benefit guideline
05/14/2020	New language and citations (Dr. Akhtar) – adds codes
06/02/2020	Dr. Serrao comments addressed
06/16/2020	Additional editing/formatting
05/22/2021	Added update reference Sabiston Textbook of Surgery and replaced quote in guideline – verified current references – Dr. Akhtar
05/09/2022	Initial review by Dr. Thomas Morris
05/24/2022	Final editing and review by Dr. Fred McCurdy
05/04/2023	Updated 2023 CPT codes added
05/23/2023	Reviewed by Drs Thomas Morris and Fred McCurdy

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