physician & facility coding & billing neuroma & post amputation pain guide

2022 Medicare National Average Payments

Physician Reimbursement

CPT[1] Code*	CPT Code Descriptors	RVUs[A]	2022 Payment[2]
	Nerve Procedure Coding Options		
64999 Or -22 modifier	Unlisted procedure, nervous system or Append -22 modifier (increased procedural services) to the CPT code used to describe the surgical amputation or excision of neuroma	n/a	Contractor Determined
Note: provider will need to submit an operative report or special note detailing the procedure to apply the Nerve Cap. Payers will determine payment amount based on the information the physician submits.			
	Amputation Coding Examples		
23900	Interthoracoscapular amputation (forequarter)	19.26	$667
23920	Disarticulation of shoulder	18.89	$654
23921	Disarticulation of shoulder; secondary closure or scar revision	15.61	$540
24900	Amputation, arm through humerus; with primary closure	20.95	$725
24920	Amputation, arm through humerus; open, circular (guillotine)	12.54	$434
24925	Amputation, arm through humerus; secondary closure or scar revision	5.25	$182
24930	Amputation, arm through humerus; re-amputation	5.10	$176
24931	Amputation, arm through humerus; with implant	19.26	$667
25900	Amputation, forearm, through radius and ulna;	18.89	$654
25905	Amputation, forearm, through radius and ulna; open, circular (guillotine)	15.61	$540
25907	Amputation, forearm, through radius and ulna; secondary closure or scar revision	20.95	$725
25909	Amputation, forearm, through radius and ulna; re-amputation	12.54	$434
25915	Krukenberg procedure	5.25	$182
25920	Disarticulation through wrist;	5.10	$176
25922	Disarticulation through wrist; secondary closure or scar revision	19.26	$667
25924	Disarticulation through wrist; re-amputation	18.89	$654
25927	Transmetacarpal amputation;	15.61	$540
25929	Transmetacarpal amputation; secondary closure or scar revision	20.95	$725
25931	Transmetacarpal amputation; re-amputation	12.54	$434
26910	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer	5.25	$182
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	5.10	$176
26952	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)	19.26	$667
27290	Interpelviabdominal amputation (hindquarter amputation)	18.89	$654
27295	Disarticulation of hip	15.61	$540
27590	Amputation, thigh, through femur, any level;	20.95	$725
27591	Amputation, thigh, through femur, any level; immediate fitting technique including first cast	12.54	$434
27592	Amputation, thigh, through femur, any level; open, circular (guillotine)	5.25	$182
27594	Amputation, thigh, through femur, any level; secondary closure or scar revision	5.10	$176
27596	Amputation, thigh, through femur, any level; re-amputation	19.26	$667
27598	Disarticulation at knee	18.89	$654
27880	Amputation, leg, through tibia and fibula;	15.61	$540
27881	Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast	20.95	$725
27882	Amputation, leg, through tibia and fibula; open, circular (guillotine)	12.54	$434
27884	Amputation, leg, through tibia and fibula; secondary closure or scar revision	5.25	$182
27886	Amputation, leg, through tibia and fibula; re-amputation	5.10	$176

A. Total RVU (Relative Value Unit) – Total includes work RVU, Practice Expense RVU and Malpractice RVU. Information presented herein reflects the Facility Setting

Physician Reimbursement

CPT[1] Code	CPT Code Descriptors	RVUs[A]	2022 Payment[2]
	Amputation Coding Examples		
27888	Amputation, ankle, through malleoli of tibia and fibula (e.g. Syme, Pirogoff type procedures), with plastic closure and resection of nerves	19.26	$667
27889	Ankle disarticulation	18.89	$654
28800	Amputation, foot; midtarsal (e.g. Chopart type procedure)	15.61	$540
28805	Amputation, foot; transmetatarsal	20.95	$725
28810	Amputation, metatarsal, with toe, single	12.54	$434
28820	Amputation, toe; metatarsophalangeal joint	5.25	$182
28825	Amputation, toe; interphalangeal joint	5.10	$176
	Excision of Neuroma Coding Examples		
28080	Excision, interdigital (Morton) neuroma, single, each	15.73	$544
64774	Excision of neuroma; cutaneous nerve, surgically identifiable	12.39	$429
64776	Excision of neuroma; digital nerve, 1 or both, same digit	11.66	$404
+64778	Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)	5.32	$184
64782	Excision of neuroma; hand or foot, except digital nerve	13.49	$467
+64783	Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)	6.36	$220
64784	Excision of neuroma; major peripheral nerve, except sciatic	21.58	$747
64786	Excision of neuroma; sciatic nerve	30.08	$1,041
+64787	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)	7.01	$243
64788	Excision of neurofibroma or neurolemmoma; cutaneous nerve	12.04	$417
64790	Excision of neurofibroma or neurolemmoma; major peripheral nerve	24.8	$861
64792	Excision of neurofibroma or neurolemmoma; extensive (including malignant type)	31.65	$1,095
Flap procedure CPT code options are not provided herein as multiple codes may be appropriate to describe the complete procedure. Review the operative note carefully to ensure all coding options are considered and then selected.*			

CPT/HCPCS Modifier Options*	
Modifier	Description
-22	Increased Procedural Service
-51	Multiple Procedures
-58	Staged or Related Procedure or Service by Same Physician or Other Qualified Healthcare Professional During the Postoperative Period
-59	Distinct Procedural Service
-XE	Separate Encounter
-XS	Separate Structure
-XP	Separate Practitioner
-XU	Unusual Non-Overlapping Service

Outpatient Facility Reimbursement – only CPT codes payable in an outpatient setting are listed below.

CPT[1] Code	APC Description	HOPD APC	HOPD SI[B]	HOPD[3] 2022 Payment	ASC SI[C]	ASC[4] 2022 Payment
	Nerve Procedure Coding Options					
64999	Level 1 Nerve Injections	5441	T	$267		Not Covered by Medicare in the ASC
	Amputation Coding Examples					
23921	Level 4 Skin Procedures	5054	T	$1,749	A2	$887
24925	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,362
25907	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,362
25909	Level 4 Musculoskeletal Procedures	5114	J1	$6,397		Not Covered by Medicare in the ASC

A. Total RVU (Relative Value Unit) – Total includes work RVU, Practice Expense RVU and Malpractice RVU. Information presented herein reflects the Facility Setting.
B. HOPD Status Key: C = Inpatient only procedure; J1 = Comprehensive APC rules apply; all covered Part B services are packaged into a single payment; N = No separate payment; payment is packaged into payment for other services; Q1 = Packaged APC payment if billed on the same date of service as an HCPCS code assigned status indicator S, T, V; S = Significant procedure, not discounted when multiple procedure performed; T = Procedure, discounted 50% when another procedure with a T status is billed.
C. ASC Status Key: A2, & G2: Payment based on OPPS relative payment rate and subject to the multiple procedure discount (50%);

Outpatient Facility Reimbursement – only CPT codes payable in an outpatient setting are listed below.

CPT[1] Code	APC Description	HOPD APC	HOPD SI[B]	HOPD[3] 2022 Payment	ASC SI[C]	ASC[4] 2022 Payment
Amputation Coding Examples						
25922	Level 2 Musculoskeletal Procedures	5112	J1	$1,423	A2	$742
25929	Level 4 Skin Procedures	5054	T	$1,749	A2	$887
25931	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	G2	$1,362
26910	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,36
26951	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,362
26952	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,362
27594	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,362
27884	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,362
28805	Level 3 Musculoskeletal Procedures	5113	J1	$2,892		Not Covered by Medicare in the ASC
28810	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,362
28820	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,362
28825	Level 3 Musculoskeletal Procedures	5113	J1	$2,892	A2	$1,362
Excision of Neuroma Coding Examples						
28080	Level 2 Musculoskeletal Procedures	5112	J1	$1,426	A2	$742
64774	Level 1 Nerve Procedures	5431	J1	$1,793	A2	$826
64776	Level 1 Nerve Procedures	5431	J1	$1,793	A2	$826
+64778				Not Separately Paid		Not Separately Paid
64782	Level 1 Nerve Procedures	5431	J1	$1,793	A2	$826
+64783				Not Separately Paid		Not Separately Paid
64784	Level 1 Nerve Procedures	5431	J1	$1,793	A2	$826
64786	Level 2 Nerve Procedures	5432	J1	$5,824	A2	$2,498
+64787				Not Separately Paid		Not Separately Paid
64788	Level 1 Nerve Procedures	5431	J1	$1,793	A2	$826
64790	Level 1 Nerve Procedures	5431	J1	$1,793	A2	$826
64792	Level 2 Nerve Procedures	5432	J1	$5,824	A2	$2,498
Flap procedure CPT code options are not provided herein as multiple codes may be appropriate to describe the complete procedure. Review the operative note carefully to ensure all coding options are considered and then selected.*						

HCPCS Level II Coding Options*	
HCPCS Code[5]	HCPCS Code Description
C9399	Unclassified drugs or biologicals
C1889	Implantable/insertable device, not otherwise classified

B. HOPD Status Key: C = Inpatient only procedure; J1 = Comprehensive APC rules apply; all covered Part B services are packaged into a single payment; N = No separate payment; payment is packaged into payment for other services; Q1 = Packaged APC payment if billed on the same date of service as an HCPCS code assigned status indicator S, T, V; S = Significant procedure, not discounted when multiple procedure performed; T = Procedure, discounted 50% when another procedure with a T status is billed

C. ASC Status Key: A2, & G2: Payment based on OPPS relative payment rate and subject to the multiple procedure discount (50%);

Inpatient Facility Reimbursement

ICD-10-PCS Hospital Procedure Code Examples* (code according to patient's medical records)	
ICD-10-PCS[6] Code	Procedure Description
Amputation Coding Examples	
0X6[0,1]0ZZ	Detachment at [Right, Left] Forequarter, Open Approach
0X6[2,3]0ZZ	Detachment at [Right, Left] Shoulder Region, Open Approach
0X6[B,C]0ZZ	Detachment at [Right, Left] Elbow Region, Open Approach
0X6[8,9]0Z[1,2,3]	Detachment at [Right, Left] Upper Arm, [High, Mid, Low], Open Approach
0X6[D,F]0Z[1,2,3]	Detachment at [Right, Left] Lower Arm, [High, Mid, Low], Open Approach
0X6[J,K]0Z[0,4,5,6,7,8,9,B,C,D,F]	Detachment at [Right, Left] Hand, [Complete, Complete 1st Ray, Complete 2nd Ray, Complete 3rd Ray, Complete 4th Ray, Complete 5th Ray, Partial 1st Ray, Partial 2nd Ray, Partial 3rd Ray, Partial 4th Ray, Partial 5th Ray], Open Approach
0X6[L,M]0Z[0,1,2,3]	Detachment at [Right, Left] Thumb, [Complete, High, Mid, Low], Open Approach
0X6[N,P]0Z[01,2,3]	Detachment at [Right, Left] Index Finger, [Complete, High, Mid, Low] Open Approach
0X6[Q,R]0Z[0,1,2,3]	Detachment at [Right, Left] Middle Finger, [Complete, High, Mid, Low] Open Approach
0X6[S,T]0Z[0,2,3,]	Detachment at [Right, Left] Ring Finger, [Complete, High, Mid, Low] Open Approach
0X6[V,W]0Z[0,1,2,3]	Detachment at [Right, Left] Little Finger, [Complete, High, Mid, Low] Open Approach
0Y6[2,3,4]0ZZ	Detachment at [Right, Left, Bilateral] Hindquarter, Open Approach
0Y6[7,8]0ZZ	Detachment at [Right, Left] Femoral Region, Open Approach
0Y6[F,G]0ZZ	Detachment at [Right, Left] Knee Region, Open Approach
0Y6[C,D]0Z[1,2,3]	Detachment at [Right, Left] Upper Leg, [High, Mid, Low] Open Approach
0Y6[H,J]0Z[1,2,3]	Detachment at [Right, Left] Lower Leg, [High, Mid, Low] Open Approach
0Y6[M,N]0Z[0,4,5,6,7,8,9,B,C,D,F]	Detachment at [Right, Left] Foot, [Complete, Complete 1st Ray, Complete 2nd Ray, Complete 3rd Ray, Complete 4th Ray, Complete 5th Ray, Partial 1st Ray, Partial 2nd Ray, Partial 3rd Ray, Partial 4th Ray, Partial 5th Ray], Open Approach
0Y6[P,Q]0Z[0,1,2,3]	Detachment at [Right, Left] 1st Toe, [Complete, High, Mid, Low], Open Approach
0Y6[R,S]0Z[0,1,2,3]	Detachment at [Right, Left] 2nd Toe, [Complete, High, Mid, Low], Open Approach
0Y6[T,U]0Z[0,1,2,3]	Detachment at [Right, Left] 3rd Toe, [Complete, High, Mid, Low], Open Approach
0Y6[V,W]0Z[0,1,2,3]	Detachment at [Right, Left] 4th Toe, [Complete, High, Mid, Low], Open Approach
0Y6[X,Y]0Z[0,1,2,3]	Detachment at [Right, Left] 5th Toe, [Complete, High, Mid, Low], Open Approach
Excision of Neuroma Coding Examples	
01B0[0,3,4]ZZ	Excision of Cervical Plexus, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01B1[0,3,4]ZZ	Excision of Cervical Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01B2[03,4]ZZ	Excision of Phrenic Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01B3[0,3,4]ZZ	Excision of Brachial Plexus, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01B4[0,3,4]ZZ	Excision of Ulnar Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01B5[0,3,4]ZZ	Excision of Median Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01B6[0,3,4]ZZ	Excision of Radial Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01B8[0,3,4]ZZ	Excision of Thoracic Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01B9[0,3,4]ZZ	Excision of Lumbar Plexus, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01BA[0,3,4]ZZ	Excision of Lumbosacral Plexus, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01BB[0,3,4ZZ	Excision of Lumbar Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01BC[0,3,4]ZZ	Excision of Pudendal Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01BD[0,3,4]ZZ	Excision of Femoral Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01BF[0,3,4]ZZ	Excision of Sciatic Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01BG[0,3,4]ZZ	Excision of Tibial Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01BH[0,3,4]ZZ	Excision of Peroneal Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01BQ[0,3,4]ZZ	Excision of Sacral Plexus, [Open, Percutaneous, Percutaneous Endoscopic] Approach
01BR[0,3,4]ZZ	Excision of Sacral Nerve, [Open, Percutaneous, Percutaneous Endoscopic] Approach
Flap procedure ICD-10-PCS code options are not provided herein as multiple codes may be appropriate to describe the complete procedure. Review the operative note carefully to ensure all coding options are considered and then selected.*	

Inpatient Facility Reimbursement

ICD-10-CM Diagnosis Code Examples* (code according to patient's medical records)	
ICD-10-CM[7] Code	Diagnosis Description
C40.00-C41.9	Malignant neoplasm of bone and articular cartilage
C45.0-C49.A9	Malignant neoplasm of mesothelial and soft tissue
D36.10-D36.17	Benign neoplasm of peripheral nerves and autonomic nervous system
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E13.52	Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene
G57.00-G57.03	Lesion of sciatic nerve
G57.20-G57.23	Lesion of femoral nerve
G57.30-G57.33	Lesion of lateral popliteal nerve
G57.40-G57.43	Lesion of medial popliteal nerve
G57.60-G57.63	Lesion of plantar nerve
G57.80-G57.83	Other specified mononeuropathies of lower limb
G57.90-G57.93	Unspecified mononeuropathy of lower limb
G56.10-G56.13	Other lesions of median nerve
G56.20-G56.23	Lesion of ulnar nerve
G56.30-G56.33	Lesion of radial nerve
G56.80-G56.83	Other specified mononeuropathies of upper limb
G56.90-G56.93	Unspecified mononeuropathies of upper limb
I96	Gangrene, not elsewhere classified
T87.30	Neuroma of amputation stump, unspecified extremity
T87.31	Neuroma of amputation stump, right upper extremity
T87.32	Neuroma of amputation stump, left upper extremity
T87.33	Neuroma of amputation stump, right lower extremity
T87.34	Neuroma of amputation stump, left lower extremity
S68.011A-S68.729S	Traumatic amputation of wrist, hand and fingers
S98.011A-S98.929S	Traumatic amputation of ankle and foot
S58.011A-S58.929S	Traumatic amputation of elbow and forearm
S78.011A-S78.929S	Traumatic amputation of hip and thigh
S88.011A-S88.929S	Traumatic amputation of lower leg
Flap procedure ICD-10-CM code options are not provided herein as multiple codes may be appropriate to describe the complete diagnosis. Review the operative note carefully to ensure all coding options are considered and then selected.*	

Inpatient Facility Reimbursement

MS-DRG	MS-DRG Description	2022[8] Payment
040	Peripheral, Cranial Nerve and Other Nervous System Procedures with MCC	$23,346
041	Peripheral, Cranial Nerve and Other Nervous System Procedures with CC or Peripheral Neurostimulator	$14,194
042	Peripheral, Cranial Nerve and Other Nervous System Procedures without CC/ MCC	$11,485
474	Amputation for Musculoskeletal System and Connective Tissue Disease with MCC	$24,622
475	Amputation for Musculoskeletal System and Connective Tissue Disease with CC	$13,267
476	Amputation for Musculoskeletal System and Connective Tissue Disease without CC/MCC	$7,009

* All codes referenced herein are examples only and may not be all-inclusive. Coding should be based on the medical record documentation and the code sets in effect at the time of service.

References:

1. CPT 2022 Professional Edition, ©2021 American Medical Association (AMA); CPT is a trademark of the AMA.
2. 2022 Medicare Physician Fee Schedule, www.cms.gov; Last accessed January 2022
3. 2022 Medicare Hospital Outpatient Prospective Payment System, www.cms.gov; Last accessed December 2021
4. 2022 Medicare ASC Payment Rates, www.cms.gov; Last accessed December 2021
5. 2022 HCPCS, www.cms.gov; Last accessed December 2021
6. 2022 ICD-10-PCS, www.cms.gov; Last accessed December 2021
7. 2022 ICD-10-CM, www.cms.gov; Last accessed December 2021
8. 2022 DRG Expert, Optum 360, LLC.

Disclaimer: The information is for educational purposes only and should not be construed as authoritative. The information is current as of January 2022 and is based upon publicly available source information. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third-party payors is solely responsible for the accuracy of the codes assigned to the services or items in the medical record. When making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Items and services that are billed to payors must be medically necessary and supported by appropriate documentation. It is important to remember that while a code may exist describing certain procedures and/or technologies, it does not guarantee payment by the payors.

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