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

2024 Medicare National Average Payments

Physician Reimbursement

CPT[1] Code*	CPT Code Descriptors	RVUs[A]	2024 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)	41.69	$1,388
23920	Disarticulation of shoulder	33.95	$1,130
23921	Disarticulation of shoulder; secondary closure or scar revision	14.47	$482
24900	Amputation, arm through humerus; with primary closure	22.47	$748
24920	Amputation, arm through humerus; open, circular (guillotine)	22.29	$742
24925	Amputation, arm through humerus; secondary closure or scar revision	17.42	$580
24930	Amputation, arm through humerus; re-amputation	23.49	$782
24931	Amputation, arm through humerus; with implant	28.16	$937
25900	Amputation, forearm, through radius and ulna;	21.83	$727
25905	Amputation, forearm, through radius and ulna; open, circular (guillotine)	21.38	$712
25907	Amputation, forearm, through radius and ulna; secondary closure or scar revision	18.79	$626
25909	Amputation, forearm, through radius and ulna; re-amputation	20.87	$695
25915	Krukenberg procedure	35.19	$1,171
25920	Disarticulation through wrist;	22.21	$739
25922	Disarticulation through wrist; secondary closure or scar revision	19.71	$656
25924	Disarticulation through wrist; re-amputation	21.70	$722
25927	Transmetacarpal amputation;	26.18	$872
25929	Transmetacarpal amputation; secondary closure or scar revision	18.31	$610
25931	Transmetacarpal amputation; re-amputation	24.25	$807
26910	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer	23.15	$771
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	21.40	$712
26952	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)	20.81	$693
27290	Interpelviabdominal amputation (hindquarter amputation)	48.82	$1,625
27295	Disarticulation of hip	37.94	$1,263
27590	Amputation, thigh, through femur, any level;	23.44	$780
27591	Amputation, thigh, through femur, any level; immediate fitting technique including first cast	29.14	$970
27592	Amputation, thigh, through femur, any level; open, circular (guillotine)	20.07	$668
27594	Amputation, thigh, through femur, any level; secondary closure or scar revision	15.22	$507
27596	Amputation, thigh, through femur, any level; re-amputation	21.33	$710
27598	Disarticulation at knee	20.79	$692
27880	Amputation, leg, through tibia and fibula;	26.84	$894
27881	Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast	25.21	$839
27882	Amputation, leg, through tibia and fibula; open, circular (guillotine)	17.70	$589
27884	Amputation, leg, through tibia and fibula; secondary closure or scar revision	17.39	$579
27886	Amputation, leg, through tibia and fibula; re-amputation	19.47	$648

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]	2024 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	17.12	$570
27889	Ankle disarticulation	19.18	$639
28800	Amputation, foot; midtarsal (e.g. Chopart type procedure)	15.88	$529
28805	Amputation, foot; transmetatarsal	21.17	$705
28810	Amputation, metatarsal, with toe, single	12.74	$424
28820	Amputation, toe; metatarsophalangeal joint	5.30	$176
28825	Amputation, toe; interphalangeal joint	5.17	$172
Excision of Neuroma Coding Examples			
28080	Excision, interdigital (Morton) neuroma, single, each	11.50	$383
64774	Excision of neuroma; cutaneous nerve, surgically identifiable	13.01	$433
64776	Excision of neuroma; digital nerve, 1 or both, same digit	12.31	$410
+64778	Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)	5.35	$178
64782	Excision of neuroma; hand or foot, except digital nerve	13.79	$459
+64783	Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)	6.38	$212
64784	Excision of neuroma; major peripheral nerve, except sciatic	21.89	$729
64786	Excision of neuroma; sciatic nerve	30.25	$1,007
+64787	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)	6.94	$231
64788	Excision of neurofibroma or neurolemmoma; cutaneous nerve	12.44	$414
64790	Excision of neurofibroma or neurolemmoma; major peripheral nerve	25.76	$858
64792	Excision of neurofibroma or neurolemmoma; extensive (including malignant type)	32.54	$1,083
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] 2024 Payment	ASC SI[C]	ASC[4] 2024 Payment
Nerve Procedure Coding Options						
64999	Level 1 Nerve Injections	5441	T	$282		Not Covered by Medicare in the ASC
Amputation Coding Examples						
23921	Level 4 Skin Procedures	5054	T	$1,739	A2	$946
24925	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
25907	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
25909	Level 4 Musculoskeletal Procedures	5114	J1	$6,823		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] 2024 Payment	ASC SI[C]	ASC[4] 2024 Payment
Amputation Coding Examples						
25922	Level 2 Musculoskeletal Procedures	5112	J1	$1,533	A2	$819
25929	Level 4 Skin Procedures	5054	T	$1,739	A2	$946
25931	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	G2	$1,519
26910	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
26951	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
26952	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
27594	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
27884	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
28805	Level 3 Musculoskeletal Procedures	5113	J1	$3,087		Not Covered by Medicare in the ASC
28810	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
28820	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
28825	Level 3 Musculoskeletal Procedures	5113	J1	$3,087	A2	$1,519
Excision of Neuroma Coding Examples						
28080	Level 2 Musculoskeletal Procedures	5112	J1	$1,533	A2	$819
64774	Level 1 Nerve Procedures	5431	J1	$1,842	A2	$898
64776	Level 1 Nerve Procedures	5431	J1	$1,842	A2	$898
+64778			N	Not Separately Paid	N1	Not Separately Paid
64782	Level 1 Nerve Procedures	5431	J1	$1,842	A2	$898
+64783			N	Not Separately Paid	N1	Not Separately Paid
64784	Level 1 Nerve Procedures	5431	J1	$1,842	A2	$898
64786	Level 2 Nerve Procedures	5432	J1	$6,354	A2	$3,013
+64787			N	Not Separately Paid	N1	Not Separately Paid
64788	Level 1 Nerve Procedures	5431	J1	$1,842	A2	$898
64790	Level 1 Nerve Procedures	5431	J1	$1,842	A2	$898
64792	Level 2 Nerve Procedures	5432	J1	$6,354	A2	$3,013
C7551	Exc neuroma w/ implnt nv end		E1		G2	$3,013
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

Outpatient Facility Payment – Hospital Outpatient Complexity Adjustment Payment

CMS has deemed that when certain combinations of CPT codes are billed together for a Hospital Outpatient admission that a complexity adjustment would be made to the payment, where the payable Hospital Outpatient Department APC would be reclassified to a higher paying Ambulatory Payment Classification (APC). The following table contains the combination of primary and secondary CPT codes and the resulting APC code assignment with the corresponding Medicare national average payment.

Primary CPT Code	Primary Descriptor	Primary APC Assignment	Secondary CPT Code	Secondary Descriptor	Secondary APC Assignment	Complexity Adjusted APC Assignment[3]	Complexity Adjusted APC Payment Rate[3]
64784	Excision of neuroma; major peripheral nerve, except sciatic	5431	64787	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)	N/A	5432	$6,353.57

B. HOPD Status Key: C = Inpatient only procedure; E1=Non-Covered items and services based on statutory exclusions. Not covered by any Medicare outpatient benefit category, not reasonable and necessary; 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 Payment – ASC Complexity Adjustment Payment

CMS has deemed that when certain combinations of CPT codes are billed together for an ambulatory surgery center (ASC) admission that a complexity adjustment would be made to the payment. If a combination of CPT codes are billed together with the designated HCPCS level II code, the payment will be modified. The following contains the combination of primary and secondary CPT codes, and the HCPCS level II code and corresponding assigned national Medicare average payment.

HCPCS and CPT Code Combination	Primary Descriptor	Payment Indicator[4]	Medicare National Average Payment[4]
C7551	Excision of major peripheral nerve neuroma, except sciatic, with implantation of nerve end into bone or muscle	G2	$3,013
64784	Excision of neuroma; major peripheral nerve, except sciatic	A2	N/A - Paid via the C7551 HCPCS code when all three codes in this table are billed together
64787	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)	N1	

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[0,3,4]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	2024[8] Payment
040	Peripheral, Cranial Nerve and Other Nervous System Procedures with MCC	$26,960
041	Peripheral, Cranial Nerve and Other Nervous System Procedures with CC or Peripheral Neurostimulator	$15,618
042	Peripheral, Cranial Nerve and Other Nervous System Procedures without CC/ MCC	$12,181
474	Amputation for Musculoskeletal System and Connective Tissue Disease with MCC	$30,126
475	Amputation for Musculoskeletal System and Connective Tissue Disease with CC	$15,016
476	Amputation for Musculoskeletal System and Connective Tissue Disease without CC/MCC	$8,240

* 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 2024 Professional Edition, ©2023 American Medical Association (AMA); CPT is a trademark of the AMA.
2. 2024 Medicare Physician Fee Schedule, www.cms.gov
3. 2024 Medicare Hospital Outpatient Prospective Payment System, www.cms.gov
4. 2024 Medicare ASC Payment Rates, www.cms.gov
5. 2024 HCPCS, www.cms.gov
6. 2024 ICD-10-PCS, www.cms.gov
7. 2024 ICD-10-CM, www.cms.gov
8. 2024 IPPS Final Rule, Medicare DRG payment rates determined based on a hospital base rate of $7,001.60

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