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

2025 medicare national average payments

physician reimbursement

CPT[1] code	CPT code descriptors	RVUs[A]	2025[2] payment
nerve procedure coding option			
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)	42.02	$1,359
23920	Disarticulation of Shoulder	34.22	$1,107
23921	Disarticulation of Shoulder; Secondary Closure or Scar Revision	14.58	$472
24900	Amputation, Arm Through Humerus; with Primary Closure	23.44	$758
24920	Amputation, Arm Through Humerus; Open, Circular (Guillotine)	22.50	$728
24925	Amputation, Arm Through Humerus; Secondary Closure or Scar Revision	17.59	$569
24930	Amputation, Arm Through Humerus; Re-amputation	23.70	$767
24931	Amputation, Arm Through Humerus; with Implant	28.41	$919
25900	Amputation, Forearm, Through Radius and Ulna	22.13	$716
25905	Amputation, Forearm, Through Radius and Ulna; Open, Circular (Guillotine)	21.55	$697
25907	Amputation, Forearm, Through Radius and Ulna; Secondary Closure or Scar Revision	18.95	$613
25909	Amputation, Forearm, Through Radius and Ulna; Re-amputation	21.08	$682
25915	Krukenberg Procedure	35.47	$1,147
25920	Disarticulation Through Wrist	22.34	$723
25922	Disarticulation Through Wrist; Secondary Closure or Scar Revision	19.78	$640
25924	Disarticulation Through Wrist; Re-amputation	21.80	$705
25927	Transmetacarpal Amputation	26.14	$846
25929	Transmetacarpal Amputation; Secondary Closure or Scar Revision	18.48	$598
25931	Transmetacarpal Amputation; Re-amputation	24.15	$781
26910	Amputation, Metacarpal, with Finger or Thumb (Ray Amputation), Single, with or without Interosseous Transfer	23.15	$749
26951	Amputation, Finger or Thumb, Primary or Secondary, Any Joint or Phalanx, Single, Including Neurectomies; with Direct Closure	21.39	$692
26952	Amputation, Finger or Thumb, Primary or Secondary, Any Joint or Phalanx, Single, Including Neurectomies; with Local Advancement Flaps (V-Y, Hood)	20.78	$672
27290	Interpelviabdominal Amputation (Hindquarter Amputation)	49.19	$1,591
27295	Disarticulation of Hip	37.99	$1,229
27590	Amputation, Thigh, Through Femur, Any Level	23.44	$758
27591	Amputation, Thigh, Through Femur, Any Level; Immediate Fitting Technique Including First Cast	29.41	$951
27592	Amputation, Thigh, Through Femur, Any Level; Open, Circular (Guillotine)	20.31	$657
27594	Amputation, Thigh, Through Femur, Any Level; Secondary Closure or Scar Revision	15.33	$496
27596	Amputation, Thigh, Through Femur, Any Level; Re-amputation	21.41	$693
27598	Disarticulation at Knee	20.98	$679
27880	Amputation, Leg, Through Tibia and Fibula	26.90	$870
27881	Amputation, Leg, Through Tibia and Fibula; with Immediate Fitting Technique Including Application of First Cast	24.90	$805
27882	Amputation, Leg, Through Tibia and Fibula; Open, Circular (Guillotine)	17.75	$574
27884	Amputation, Leg, Through Tibia and Fibula; Secondary Closure or Scar Revision	17.49	$566
27886	Amputation, Leg, Through Tibia and Fibula; Re-amputation	19.56	$633

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]	2025[2] payment
	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	17.19	$556
27889	Ankle Disarticulation	19.26	$623
28800	Amputation, Foot; Midtarsal (e.g. Chopart Type Procedure)	15.99	$517
28805	Amputation, Foot; Transmetatarsal	21.28	$688
28810	Amputation, Metatarsal, with Toe, Single	12.78	$413
28820	Amputation, Toe; Metatarsophalangeal Joint	5.33	$172
28825	Amputation, Toe; Interphalangeal Joint	5.20	$168
	excision of neuroma coding examples		
28080	Excision, Interdigital (Morton) Neuroma, Single, Each	11.70	$378
64774	Excision of Neuroma; Cutaneous Nerve, Surgically Identifiable	13.14	$425
64776	Excision of Neuroma; Digital Nerve, 1 or Both, Same Digit	12.32	$399
+64778	Excision of Neuroma; Digital Nerve, Each Additional Digit (List Separately in Addition to Code for Primary Procedure)	5.38	$174
64782	Excision of Neuroma; Hand or Foot, Except Digital Nerve	14.03	$454
+64783	Excision of Neuroma; Hand or Foot, Each Additional Nerve, Except Same Digit (List Separately in Addition to Code for Primary Procedure)	6.43	$208
64784	Excision of Neuroma; Major Peripheral Nerve, Except Sciatic	22.18	$717
64786	Excision of Neuroma; Sciatic Nerve	30.42	$984
+64787	Implantation of Nerve End Into Bone or Muscle (List Separately in Addition to Neuroma Excision)	7.03	$227
64788	Excision of Neurofibroma or Neurolemmoma; Cutaneous Nerve	12.50	$404
64790	Excision of Neurofibroma or Neurolemmoma; Major Peripheral Nerve	26.10	$844
64792	Excision of Neurofibroma or Neurolemmoma; Extensive (Including Malignant Type)	32.76	$1,060
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, and many amputation procedure codes are exclusive to the inpatient setting

CPT[1] code	APC description	HOPD APC	HOPD SI[B]	HOPD[3] 2025 payment	ASC SI[C]	ASC[4] 2025 payment
	nerve procedure coding options					
64999	Level 1 Nerve Injections	5441	T	$295		Not Covered by Medicare in the ASC
	amputation coding examples					
23921	Level 4 Skin Procedures	5054	T	$1,829	A2	$981
24925	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
25907	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
25909	Level 4 Musculoskeletal Procedures	5114	J1	$7,144		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; V = Clinic or Emergency Department Visit, paid under OPPS, separate APC payment.

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, and many amputation procedure codes are exclusive to the inpatient setting

CPT[1] code	APC description	HOPD APC	HOPD SI[B]	HOPD[3] 2025 payment	ASC SI[C]	ASC[4] 2025 payment
amputation coding examples						
25922	Level 2 Musculoskeletal Procedures	5112	J1	$1,600	A2	$838
25929	Level 4 Skin Procedures	5054	T	$1,829	A2	$981
25931	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	G2	$1,579
26910	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
26951	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
26952	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
27594	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
27884	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
28805	Level 3 Musculoskeletal Procedures	5113	J1	$3,245		Not Covered by Medicare in the ASC
28810	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
28820	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
28825	Level 3 Musculoskeletal Procedures	5113	J1	$3,245	A2	$1,579
excision of neuroma coding examples						
28080	Level 2 Musculoskeletal Procedures	5112	J1	$1,600	A2	$838
64774	Level 1 Nerve Procedures	5431	J1	$1,953	A2	$925
64776	Level 1 Nerve Procedures	5431	J1	$1,953	A2	$925
+64778			N	Not Separately Paid	N1	Not Separately Paid
64782	Level 1 Nerve Procedures	5431	J1	$1,953	A2	$925
+64783			N	Not Separately Paid	N1	Not Separately Paid
64784	Level 1 Nerve Procedures	5431	J1	$1,953	A2	$925
64786	Level 2 Nerve Procedures	5432	J1	$6,404	A2	$3,090
+64787			N	Not Separately Paid	N1	Not Separately Paid
64788	Level 1 Nerve Procedures	5431	J1	$1,953	A2	$925
64790	Level 1 Nerve Procedures	5431	J1	$1,953	A2	$925
64792	Level 2 Nerve Procedures	5432	J1	$6,404	A2	$3,090
C7551	Exc Neuroma with Implnt Nv End		E1		G2	$3,090
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	complexity adjusted APC payment rate
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	$6,404.07

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%)

hospital 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.

primary CPT code	primary descriptor	payment indicator	medicare national average payment
C7551	Excision of Major Peripheral Nerve Neuroma, Except Sciatic, with Implantation of Nerve End into Bone or Muscle	G2	$3,090
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	2025 payment
040	Peripheral, Cranial Nerve and Other Nervous System Procedures with MCC	$26,844
041	Peripheral, Cranial Nerve and Other Nervous System Procedures with CC or Peripheral Neurostimulator	$16,075
042	Peripheral, Cranial Nerve and Other Nervous System Procedures without CC/ MCC	$12,508
474	Amputation for Musculoskeletal System and Connective Tissue Disease with MCC	$31,916
475	Amputation for Musculoskeletal System and Connective Tissue Disease with CC	$15,352
476	Amputation for Musculoskeletal System and Connective Tissue Disease without CC/MCC	$8,277

* 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 2025 Professional Edition, ©2024 American Medical Association (AMA); CPT is a trademark of the AMA.
2. 2025 Medicare Physician Fee Schedule, www.cms.gov
3. 2025 Medicare Hospital Outpatient Prospective Payment System, www.cms.gov
4. 2025 Medicare ASC Payment Rates, www.cms.gov
5. 2025 HCPCS, www.cms.gov
6. 2025 ICD-10-PCS, www.cms.gov
7. 2025 ICD-10-CM, www.cms.gov
8. 2025 IPPS Final Rule, Medicare DRG payment rates determined based on a hospital base rate of $7,117.02

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