2019 Targeted Muscle Reinnervation Reimbursement Guide

Checkpoint Stimulator and Locator

Checkpoint is a hand held, single use device that assists surgeons in locating and identifying nerves and evaluating nerve and muscle excitability in surgical procedures.

CPT Coding and Payment in the OPPS Setting

There is no separate CPT code to report the use of the Checkpoint® Stimulator & Locator. The CPT codes provided below represent the more commonly reported procedures in which the Checkpoint Stimulator & Locator would be used in targeted muscle reinnervation. Modifier-22, Increased Procedural Service, may be appended when the physician documents the work associated with use of the Checkpoint Stimulator & Locator. This work is above that described by the primary procedure code.

CPT	Description	Hospital Outpatient			Physician
		SI	APC	Payment	MPFS
Procedures Associated with Targeted Muscle Reinnervation					
64708	Neuroplasty, major peripheral nerve, arm or leg, open; other than specified	J1	5431	$1,631.48	$519.68
64874	Suture of nerve; requiring extensive mobilization, or transposition of nerve (List separately in addition to code for nerve suture; CPT 64831 - 64865)	N	N/A	Packaged	$182.36
64905	Nerve pedicle transfer; first stage	J1	5432	$4,566.06	$1,062.07
Amputation Procedures					
23900	Interthoracoscapular amputation (forequarter)	C	N/A	N/A	$1,440.48
23920	Disarticulation of shoulder;	C	N/A	N/A	$1,170.19
23921	Disarticulation of shoulder; secondary closure or scar revision	T	5054	$1,548.96	$485.45
24900	Amputation, arm through humerus; with primary closure	C	N/A	N/A	$764.39
24920	Amputation, arm through humerus; open, circular (guillotine)	C	N/A	N/A	$762.59
24925	Amputation, arm through humerus; secondary closure or scar revision	J1	5113	$2,623.34	$587.80
24930	Amputation, arm through humerus; re-amputation	C	N/A	N/A	$801.87
24931	Amputation, arm through humerus; with implant	C	N/A	N/A	$970.89
24935	Amputation, arm through humerus; with implant; Stump elongation, upper extremity	J1	5114	$5,699.59	$1,211.99
25900	Amputation, forearm, through radius and ulna;	C	N/A	N/A	$737.00
25905	Amputation, forearm, through radius and ulna; open, circular (guillotine)	C	N/A	N/A	$724.03
25907	Amputation, forearm, through radius and ulna; secondary closure or scar revision	J1	5113	$2,623.34	$630.68
25909	Amputation, forearm, through radius and ulna; re-amputation	J1	5113	$2,623.34	$708.53
25915	Krukenberg procedure	C	N/A	N/A	$1,219.20
25920	Disarticulation through wrist;	C	N/A	N/A	$727.99
25922	Disarticulation through wrist; secondary closure or scar revision	J1	5112	$1,1313.34	$639.33
25924	Disarticulation through wrist; re-amputation	C	N/A	N/A	$700.60
25927	Transmetacarpal amputation;	C	N/A	N/A	$834.67

CPT	Description	Hospital Outpatient			Physician
		SI	APC	Payment	MPFS
25929	Transmetacarpal amputation; secondary closure or scar revision	T	5054	$1,548.96	$619.51
25931	Transmetacarpal amputation; re-amputation	J1	5113	$2,623.34	$768.71
27290	Interpelviabdominal amputation (hindquarter amputation)	C	N/A	N/A	$1,690.59
27295	Disarticulation of hip	C	N/A	N/A	$1,310.38
27590	Amputation, thigh, through femur, any level;	C	N/A	N/A	$827.10
27591	Amputation, thigh, through femur, any level; immediate fitting technique including first cast	C	N/A	N/A	$1,002.25
27592	Amputation, thigh, through femur, any level; open, circular (guillotine)	C	N/A	N/A	$708.17
27594	Amputation, thigh, through femur, any level; secondary closure or scar revision	J1	5113	$2,623.34	$526.89
27596	Amputation, thigh, through femur, any level; re-amputation	C	N/A	N/A	$747.09
27598	Disarticulation at knee	C	N/A	N/A	$739.16
27880	Amputation, leg, through tibia and fibula;	C	N/A	N/A	$947.83
27881	Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast	C	N/A	N/A	$897.37
27882	Amputation, leg, through tibia and fibula; open, circular (guillotine)	C	N/A	N/A	$619.87
27884	Amputation, leg, through tibia and fibula; secondary closure or scar revision	J1	5113	$2,623.34	$591.76
27886	Amputation, leg, through tibia and fibula; re-amputation	C	N/A	N/A	$680.78
27888	Amputation, ankle, through malleoli of tibia and fibula (eg, Syme, Pirogoff type procedures), with plastic closure and resection of nerves	C	N/A	N/A	$686.91
27889	Ankle disarticulation	J1	5114	$5,699.59	$671.77

Status Indicators:

- **C** – Inpatient procedure only; see DRG section of this guide.
- **J1** - Indicates that the procedure has been assigned to a comprehensive APC which will result in the packaging of all other procedures appearing on the same claim (except services with a status indicator of F, G, H, L, & U). When more than one procedure assigned to a C-APC appear on the same claim, CMS assigns one "J1" service as the primary service for the claim based on CMS' cost-based ranking of primary services. If the reported "J1" services on a claim map to different C-APCs, CMS designates the "J1" service assigned to the C-APC with the highest comprehensive geometric mean cost as the primary service for that claim.
- **N** = Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
- **T** - Paid under OPPS; separate APC payment. Multiple procedure discount applies.

Notes

- MPFS rates provided are the national facility average for CY 2019.
- With the exception of CPT 64874, all procedures listed above are subject to standard payment adjustment rules for multiple procedure discounts. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Payment is based on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. No payment adjustment rules for multiple procedures apply to CPT 64874.

Inpatient Diagnostic Related Groups*

DRG	Description	Payment
040	Peripheral/Cranial Nerve and Other Nervous System Procedures with MCC	$23,666.28
041	Peripheral/Cranial Nerve and Other Nervous System Procedures with CC or Peripheral	$14,208.68
042	Peripheral/Cranial Nerve and Other Nervous System Procedures without CC/MCC	$11,275.25
239	Amputation for Circulatory System Disorders Except Upper Limb and Toe with MCC	$28,372.18
240	Amputation for Circulatory System Disorders Except Upper Limb and Toe with CC	$16,537.23
241	Amputation for Circulatory System Disorders Except Upper Limb and Toe without CC/MC	$9,615.44
255	Upper Limb and Toe Amputation for Circulatory System Disorders with MCC	$15,304.58
256	Upper Limb and Toe Amputation for Circulatory System Disorders with CC	$10,535.41
257	Upper Limb and Toe Amputation for Circulatory System Disorders without CC/MCC	$6,784.43
474	Amputation for Musculoskeletal System and Connective Tissue Disorders with MCC	$22,864.39
475	Amputation for Musculoskeletal System and Connective Tissue Disorders with CC	$12,945.90
476	Amputation for Musculoskeletal System and Connective Tissue Disorders without CC/MCC	$6,932.64
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	$18,568.16
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	$11,358.99
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures without MCC/CC	$8,319.53
616	Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders with MCC	$24,913.39
617	Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders with CC	$12,492.84
618	Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders without CC/MCC	$6,984.45
907	Other O.R. Procedures for Injuries with MCC	$25,400.79
908	Other O.R. Procedures for Injuries with CC	$12,006.05
909	Other O.R. Procedures for Injuries without CC/MCC	$7,985.15
957	Other O.R. Procedures for Multiple Significant Trauma with MCC	$45,778.78
958	Other O.R. Procedures for Multiple Significant Trauma with CC	$25,182.09
959	Other O.R. Procedures for Multiple Significant Trauma without CC/MCC	$14,764.76

*DRGs are assigned using the principal and additional diagnoses; the principal procedure and additional procedures; sex, and discharge status. The DRGs provided represent the most likely assignments for a patient admitted for an amputation procedure that involved targeted muscle reinnervation. The payment rate provided represents the national average for CY 2019.

References:

- Hospital Outpatient Prospective Payment Final Rule with Comment and Final CY2019 Payment Rates (CMS-1695-FC); Addendum B and ASC Addenda.
- CY 2019 Revision to Payment Policies under the Physician's Fee Schedule and Other Revisions to Part B (CMS-1693-F); Addendum B. All MPFS Fee Schedules calculated using CF of $36.0391 effective January 1, 2019.
- DRG values calculated using a base rate of $5565.30 and Capital Standard Payment of $459.41. The national average hospital Medicare base rate is an average of the sum of four categories: Hospital Submitted Quality Data and is a Meaningful EHR User, Hospital Did NOT Submit Quality Data and is a Meaningful EHR User, Hospital Submitted Quality Data and is NOT a Meaningful EHR User, Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User. This information is provided as a benchmark reference only. There is no official publication of the average hospital base rate; therefore, the national average payments provided are approximate. Actual reimbursement will vary by geographic region, status as a teaching facility, share of low-income patients, status of submitting quality data, status as a meaningful electronic health user, participation in the Hospital Value-Based Purchasing (VBP), and Hospital Readmissions Reduction Program (HRRP). Calculations were based on data provided in FY 2019 IPPS Final Rule CN (Tables 1A, 1D, and 5).
- ICD-10-CM Expert for Physicians 2019, ©2018 Optum360, LLC. All rights reserved
- ICD-10-PCS 2019, ©2018 Optum360, LLC. All rights reserved