Clinical Practice Guideline: **Partial Excision of Foot or Ankle Bone**

Date of Implementation: **May 21, 2015**

Product: **Specialty**

GUIDELINES

A. American Specialty Health – Specialty (ASH) does not require prior authorization for procedures consisting of CPT Code 28120 and CPT Code 28122 provided that they are used for the treatment of the following conditions:

ICD-10 Codes and Descriptions That Support Medical Necessity

Code	Description
M86.071 - M86.079	Acute hematogenous osteomyelitis, ankle and foot
M86.171 - M86.179	Other acute osteomyelitis, ankle and foot
M86.271 - M86.279	Subacute osteomyelitis, ankle and foot
M86.371 - M86.379	Chronic multifocal osteomyelitis, ankle and foot
M86.471 - M86.479	Chronic osteomyelitis with draining sinus, ankle and foot
M86.571 - M86.579	Other chronic hematogenous osteomyelitis, ankle and foot
M86.671 - M86.679	Other chronic osteomyelitis, ankle and foot
M86.8X7	Other osteomyelitis, ankle and foot
M86.9	Osteomyelitis, unspecified
M90.871 - M90.879	Osteopathy in diseases classified elsewhere, ankle and foot

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B. ASH does not require prior authorization for procedures consisting of CPT Code 28124 and CPT Code 28126 provided that they are used for the treatment of the following conditions:

ICD-10 Codes and Descriptions That Support Medical Necessity

Code	Description
M86.071 - M86.079	Acute hematogenous osteomyelitis, ankle and foot
M86.171 - M86.179	Other acute osteomyelitis, ankle and foot
M86.271 - M86.279	Subacute osteomyelitis, ankle and foot
M86.371 - M86.379	Chronic multifocal osteomyelitis, ankle and foot
M86.471 - M86.479	Chronic osteomyelitis with draining sinus, ankle and foot
M86.571 - M86.579	Other chronic hematogenous osteomyelitis, ankle and foot
M86.671 - M86.679	Other chronic osteomyelitis, ankle and foot
M86.8X7	Other osteomyelitis, ankle and foot
M86.9	Osteomyelitis, unspecified
M90.871 - M90.879	Osteopathy in diseases classified elsewhere, ankle and foot

For the following diagnoses, medical necessity approval is contingent upon meeting the criteria listed below:

Code	Description
M20.40 - M20.42	Other hammer toe(s) (acquired)
M20.5X1 - M20.5X9	Other deformities of toe(s) acquired (including claw toe)
M20.60 - M20.62	Acquired deformities of toe(s), unspecified,

The following criteria must have tried at least 3 of the following and failed:

- Immobilization,
- Rest
- Use of nonsteroidal anti-inflammatory drugs (NSAIDs),
- Modifying footwear,
- Orthotics, and/or
- Physical therapy
- Padding

CPT CODES AND DESCRIPTIONS

CPT Code	Description
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); talus or calcaneus
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing) phalanx of toe
28126	Resection, partial or complete, phalangeal base, each toe

BACKGROUND

CPT codes 28120-28124 refer to partial excision of bone of the talus, calcaneus, tarsal, metatarsal or phalanges. These codes describe some specific types of excisions such as craterization or saucerization (excavation of tissue to form a shallow depression, performed in wound treatment to facilitate drainage from infected areas), sequestrectomy (a piece of necrotic bone that is surgical removed) or diaphysectomy (partial or complete removal of the shaft of a long bone). CPT code 28126 refers to a complete resection of the base of the phalange and is similar to CPT code 28124 from a medical necessity standpoint but is a more invasive procedure.

Osteomyelitis

Infections of the foot are a common source of morbidity, disability, and potential limb loss. However, appropriate diagnosis and treatment of foot infections can be challenging. The

thin, soft tissue envelope, the limited muscular attachments and occasionally the poor vascular perfusion from high energy trauma, diabetes, smoking or peripheral vascular disease makes the ankle and the foot more vulnerable to infection after open wounds or ankle/foot surgery (Malizos et al., 2010). Direct blunt trauma or open wounds of the distal tibia, the ankle joint and the foot may frequently lead to tissue loss and subsequent bacterial colonization. Resistant microorganisms can further complicate the problem, particularly in systemically compromised hosts.

Successful treatment is dependent on factors such as etiology; vascular, neurologic, and immune status; and the identity of the invading organism. Wide surgical debridement, skeletal stabilization and administration of antibiotics selected after pathogen susceptibility tests, supplemented by local antibiotic delivery in high dosage are the main steps to eradicate sepsis. However, the reconstruction of the resulting skeletal and soft tissue defects is often complex. In contrast to the more proximal segments of the leg, the availability of soft tissue for the coverage of full thickness defects with local or regional flaps is limited. Reconstruction of skeletal defects can be accomplished with bone grafting. However, large defects require complex reconstructive procedures, such as distraction osteogenesis, vascularized bone grafting or transfer of free flaps.

Toe or ray amputations, and more extensive amputative procedures in cases of diffuse osteomyelitis, can be a limb and life-saving procedure in a certain group of frail patients. Osteomyelitis is best managed by a multidisciplinary team of appropriately qualified specialists. It requires accurate diagnosis and optimization of host defenses, appropriate anti-infective therapy, and often bone debridement and reconstructive surgery (Rao et al., 2011).

Foot infections are a common and serious problem in persons with diabetes. Diabetic foot infections (DFIs) typically begin in a wound, most often a neuropathic ulceration. Empiric antibiotic therapy can be narrowly targeted at aerobic gram-positive cocci in many acutely infected patients, but those at risk for infection with antibiotic-resistant organisms or with chronic, previously treated, or severe infections usually require broader spectrum regimens. Osteomyelitis occurs in many diabetic patients with a foot wound and can be difficult to diagnose (optimally defined by bone culture and histology) and treat (often requiring surgical debridement or resection, and/or prolonged antibiotic therapy). Lipsky et al. (2020) released a clinical guideline outlining recommended care for diabetic patients with osteomyelitis based on a review of the leading clinical evidence and expert consensus. The authors recommended treatment with antibiotic therapy without surgical resection of bone in a patient with diabetes and uncomplicated forefoot osteomyelitis, for whom there is no other indication for surgical treatment. However, urgent evaluation of the need for surgery as well as intensive post-operative medical and surgical follow-up was recommended for patients with probable diabetic foot osteomyelitis with concomitant soft tissue infection.

Exostosis

An exostosis can be defined as a cartilage-capped bony projection on external surface of a bone (with marrow cavity) continuous with underlying bone.

A subungual exostosis is an osteocartilaginous, benign bone tumor that affects the distal phalanges of the toes and may be associated with multiple hereditary exostoses. The pathogenesis of the subungual exostosis is unclear, although trauma, infection, tumor, hereditary abnormality, or activation of a cartilaginous cyst have been suggested as possible etiologies for this condition. The most common presentation is that of several months of pain, erythema, and deformity of the nail bed. Conservative care consists of the use of high-box shoes and podiatric care. However, surgical intervention, when performed correctly, is the most appropriate treatment for these deformities (Garcia Carmona et al., 2009).

Toe Deformities

Lesser toe deformities are caused by alterations in normal anatomy that create an imbalance between the intrinsic and extrinsic muscles. Causes include improper shoe wear, trauma, genetics, inflammatory arthritis, and neuromuscular and metabolic diseases. Typical deformities include mallet toe, hammer toe, claw toe, curly toe, and crossover toe. Nonsurgical management focuses on relieving pressure and correcting deformity with various appliances. Surgical management is reserved for patients who fail nonsurgical treatment (DiPreta, 2014).

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

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