Clinical Practice Guideline: **Lower Extremity Tendon Lesion Excision**

Date of Implementation: **November 19, 2015**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT Codes 27630, 28090 and 28092 to be medically necessary for the excision of lesions of the ankle, foot, or toe tendons **upon meeting ALL of the following criteria:**

1. Failure of **AT LEAST 1** of the following non-operative treatments:
   - Physical therapy
   - Injections
   - Medications
   - Orthotics
2. Diagnosis of the following conditions: bursal cysts and ganglions (ICD-10 codes M67.471 - M67.479, M67.48 – M67.49, M71.371 - M71.379, M71.38 – M71.39) and/or bursitis and infective bursitis of the ankle and foot, and multiple sites (ICD-10 codes M71.171 - M71.179, M71.18 – M71.19, M71.571 - M71.579, M71.58)

CPT CODES AND DESCRIPTIONS

CPT® Code	CPT® Code Description
27630	Excision of lesion of tendon sheath or capsule (e.g., cyst or ganglion), leg and/or ankle
28090	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); foot
28092	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); toe(s), each

BACKGROUND

Cysts

Cysts have a similar histology and characteristics with loosely formed degenerative connective tissue and a viscous, jellylike component. Cyst recurrence is common, and the rate of recurrence symptomatic cysts may be decreased using surgical methods.

Ganglion cysts are cystic lesions originating from the joint capsule or tendon sheath. The ganglion is the product of mucoid degeneration in the area of the joint capsule or tendon sheath and can remain stable, wax and wane in size, or may spontaneously rupture and

resolve. They are distinguished from synovial cysts by the lack of communication with a joint cavity or the synovial membrane. Ganglion cysts are among the most common soft tissue lesions in the ankle and foot region, most frequently located around the ankle or at the dorsum of the foot. Ganglion cyst can present in the foot in locations other than the dorsum and could have extensions into the plantar aspect.

Plain films are usually of little benefit for the diagnosis of ganglion cysts, unless underlying arthritic changes are seen in the joint adjacent to the lesion. Ultrasound and MRI of the ganglion cysts indicate characteristic features; however, these modalities are often unnecessary to make the diagnosis. A history of waxing and waning size, location over a joint or tendon, and transillumination on physical examination may establish the diagnosis without requiring advanced imaging. Aspiration, with identification of the typical mucinous fluid, may also be used to diagnose the lesion, however most ganglion cysts recur after aspiration (Coughlin et al., 2013).

Various conservative management options are recommended as a first line of treatment for ganglion cysts on the foot. Most ganglion cysts are treated with reassurance and observation. The American College of Foot and Ankle Surgeons recommends monitoring the ganglion without treatment, shoe modifications including padding, and aspiration and injection as possible conservative treatments. If conservative treatment fails to relieve pain and functional disability, symptomatic lesions are treated with marginal excision of the entire cyst and surrounding degenerative joint capsule or tendon sheath.

Cysts may recur or a new cyst may develop. Ahn et al. (2010) analyzed the clinical results of 53 patients who underwent surgical excision for symptomatic or recurrent ganglion cysts of the foot and ankle for more than 24 months after excision (the mean duration of follow-up was 3.7 years) and tried to elucidate the prognostic factors. There were three (5.7%) cases of recurrence, all of which originated from the tendon sheath. In the case of ganglion cysts originating from the tendon sheath, careful attention should be paid to locate satellite masses to avoid recurrence.

Digital mucous cysts (DMC) are solitary, clear, or flesh-colored nodules that develop on the dorsal digits between the distal interphalangeal joint and the proximal nail fold. Digital mucous cysts are benign ganglion cysts of the digits, typically located at the distal interphalangeal joints or in the proximal nail fold. These cystic nodules or pupules can occur periungally or over the distal interphalangeal joint. The most common type generally arises from the interphalangeal joint of the toe by herniation of the tendon sheath or joint lining. Alternatively, they may result from localized fibroblastic proliferation near the proximal nail fold and is not connected to the joint space or tendon sheath. These lesions are usually asymptomatic although when the cysts become larger, more associated problems arise. Usually, the larger lesions become painful secondary to shoe pressure.

Most DMCs, especially the ganglion type, occur over an osteoarthritic joint. Recalcitrant and recurring cysts may reflect the extent of permanent damage of the distal interphalangeal (DIP) joint. Other concerns after treatment include decreased range of motion and occasional pain and swelling of the digit. Recurrence is lowest following surgery, but rates still vary depending on the technique used. Typically, with more aggressive dissection of the DMC, recurrences are fewer, but nail deformities are greater. (Li et al., 2010).

Bursitis

The intermetatarsal bursa is a naturally occurring synovium-lined cavity between the metatarsal heads containing a small amount of lubricating fluid, located immediately dorsal to the deep transverse metatarsal ligament. Bursitis describes an inflammation of the bursa that forms in response to physical irritation or repetitive mechanical load to a specific area of the body. Common locations in the foot include the plantar forefoot beneath the second toe, and the 5th metatarsal head.

Conservative treatment for intermetatarsal bursitis includes use of wider shoes, a rocker bar, and injection of the area with a steroid and local anesthetic combination. Surgical excision of the bursa may be helpful for recalcitrant bursitis.

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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