

Clinical Practice Guideline: Bone Cortex Incision of the Foot

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Product: Specialty

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT Code 28005 to be medically necessary for the incision of the bone cortex of the foot **if used for the treatment of at least one of the following conditions:**

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

CPT CODES AND DESCRIPTIONS

CPT® Code	CPT® Code Description
28005	Incision, bone cortex (e.g., osteomyelitis or bone abscess), foot

BACKGROUND

Osteomyelitis is inflammation of the bone caused by an infecting organism. Although bone is normally resistant to bacterial colonization, events such as trauma or surgery, or presence of foreign bodies or prostheses may disrupt bony integrity and lead to the onset of bone infection. Osteomyelitis can also result from hematogenous spread after bacteremia.

Acute osteomyelitis presents with acute inflammatory cells, edema, vascular congestion, and small-vessel thrombosis. In early disease, infection extends into the surrounding soft tissue, which compromises the vascular supply to the bone, leading to interference with healing. Chronic osteomyelitis presents with pathologic findings of necrotic bone, formation of new bone, and polymorphonuclear leukocyte exudation, which is joined by large numbers of lymphocytes, histiocytes, and occasional plasma cells.

Following incision of the infected bone, samples can be sent for microbiological and histological assessment to aid subsequent management of osteomyelitis. In cases where

1 surgery is necessary, the surgeon may incise and drain the infection, and debride necrotic
2 tissue and bone.

3
4 Surgery is indicated to treat osteomyelitis when the patient has not responded to specific
5 antimicrobial treatment, if there is evidence of a persistent soft tissue abscess or
6 subperiosteal collection, or if concomitant joint infection is suspected. Debridement of
7 necrotic tissues, removal of foreign materials, and sometimes skin closure of chronic
8 unhealed wounds are necessary in some cases (Kishner et al., 2022).

9
10 The Infectious Disease Society of America (IDSA) guideline for the treatment of diabetic
11 foot infections (Lipsky et al., 2020) suggests that the most definitive way to diagnose
12 diabetic foot osteomyelitis is by the combined findings on bone culture and histology. The
13 IDSA also suggests sending a sample for culture and histopathology when bone is debrided
14 to treat osteomyelitis. For patients not undergoing bone debridement, clinicians should
15 consider obtaining a diagnostic bone biopsy when faced with specific circumstances, e.g.,
16 diagnostic uncertainty, inadequate culture information, failure of response to empiric
17 treatment.

18 19 **PRACTITIONER SCOPE AND TRAINING**

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

25
26 It is best practice for the practitioner to appropriately render services to a member only if
27 they are trained, equally skilled, and adequately competent to deliver a service compared
28 to others trained to perform the same procedure. If the service would be most competently
29 delivered by another health care practitioner who has more skill and training, it would be
30 best practice to refer the member to the more expert practitioner.

31
32 Best practice can be defined as a clinical, scientific, or professional technique, method, or
33 process that is typically evidence-based and consensus driven and is recognized by a
34 majority of professionals in a particular field as more effective at delivering a particular
35 outcome than any other practice (Joint Commission International Accreditation Standards
36 for Hospitals, 2020).

37
38 Depending on the practitioner's scope of practice, training, and experience, a member's
39 condition and/or symptoms during examination or the course of treatment may indicate the
40 need for referral to another practitioner or even emergency care. In such cases it is prudent
41 for the practitioner to refer the member for appropriate co-management (e.g., to their
42 primary care physician) or if immediate emergency care is warranted, to contact 911 as

1 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice
2 guideline for information.

4 **References**

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