

1 **Clinical Practice Guideline: Calcaneal Osteotomy**

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3 **Date of Implementation: July 16, 2015**

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5 **Product: Specialty**

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8 **GUIDELINES**

9 American Specialty Health – Specialty (ASH) considers services consisting of CPT Code  
10 28300 to be medically necessary for calcaneal deformity correction **upon meeting ALL of**  
11 **the following criteria:**

- 12  
13 1. When supported by **1 or more of the following diagnoses:**

14

ICD-10 Code	ICD-10 Code Description
M21.071 - M21.079	Valgus deformity, not elsewhere classified, ankle
M21.171 - M21.179	Varus deformity, not elsewhere classified, ankle
M21.371 - M21.379	Foot drop
M21.531 - M21.539	Acquired clawfoot
M21.541 - M21.549	Acquired clubfoot
M21.6X1 - M21.6X9	Other acquired deformities of foot
M21.961 - M21.969	Unspecified acquired deformity of lower leg
M67.971 - M67.979, M67.98 - M67.99,	Unspecified disorder of synovium and tendon of lower leg, ankle and foot, other sites, and multiple sites
M71.871 – M71.879, M71.88, M71.89	Other specified bursopathies, ankle and foot, other sites, and multiple sites
Q66.00 - Q66.02	Congenital talipes equinovarus
Q66.10 - Q66.12, Q66.30 - Q66.32	Congenital talipes calcaneovarus and other congenital varus deformities of feet
Q66.211 - Q66.219, Q66.221 - Q66.229	Congenital metatarsus primus varus - adductus
Q66.40 - Q66.42	Congenital talipes calcaneovalgus, foot
Q66.50 - Q66.52	Congenital pes planus, foot
Q66.6	Other congenital valgus deformities of feet
Q66.70 - Q66.72	Congenital pes cavus, foot
Q66.80 - Q66.82	Congenital vertical talus deformity, foot

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Q66.89	Other specified congenital deformities of feet
Q66.90 - Q66.92	Congenital deformity of feet, unspecified

- 1 2. Failure of **at least 1 of the following** non-operative treatments with persistent pain
- 2 and dysfunction
- 3 ○ Orthotics/bracing
- 4 ○ Activity modification

5

6 **CPT CODES AND DESCRIPTIONS**

CPT® Code	CPT® Code Description
28300	Osteotomy; calcaneus (e.g., Dwyer or Chambers type procedure), with or without internal fixation

7

8 **BACKGROUND**

9 The calcaneus can be realigned to achieve a different orientation, which can correct many  
 10 different deformities and functional limitations. For example, pes cavus and pes planus are  
 11 deformities that can be addressed with calcaneal realignment to relieve pain, improve  
 12 alignment, and gait.

13

14 A course of conservative treatment is the first line of care for foot and ankle deformity. If  
 15 conservative measures fail to adequately reduce pain and improve function, then surgical  
 16 procedures may be considered as treatment options. Appropriate surgical management is  
 17 determined based upon degree of deformity and individualized patient needs (Heaver et  
 18 al., 2020).

19

20 Calcaneal osteotomy is an extra-articular, joint-sparing procedure that is used in the  
 21 correction of significant foot and ankle deformities. For example, both varus and valgus  
 22 deformities often require calcaneal deformities for correct alignment. Multiple options for  
 23 osteotomies include translational, closing wedge (Dwyer), and rotational type osteotomies  
 24 (Evans, Z-osteotomy). Although a large number of calcaneal osteotomies have been  
 25 described in the literature, there are a few principal ones that tend to be more commonly  
 26 used than others. The Dwyer osteotomy is commonly used for frontal plane deformity of  
 27 varus in the cavus foot. Whereas the Evans osteotomy is often performed for realignment  
 28 of the adolescent valgus foot, but it is also used during adult flatfoot repairs (Mahan, 2003).

29

30 Cavus foot deformity, most commonly the result of first-ray plantar flexion, is frequently  
 31 encountered by the foot and ankle specialist. The Dwyer calcaneal osteotomy is a useful  
 32 adjunctive procedure to address the heel varus component of the cavus foot deformity,  
 33 especially in the presence of concomitant peroneal tendon pathology. The lateralizing heel  
 34 osteotomy using a wedge resection can effectively reduce future stress on the repaired  
 35 peroneal tendons (Boffeli et al., 2012).

1 Infection and the presence of open wounds are absolute contraindications for the calcaneal  
 2 osteotomy. The potential complications associated with calcaneal osteotomies are nerve  
 3 and tendon injury, failure of the bone fragments to heal together, loss of correction of the  
 4 deformity, painful hardware and infection. Careful review of indications and  
 5 contraindications for the procedure, with meticulous surgical technique, should be  
 6 followed to avoid complications and to achieve optimal outcomes.

## 7 8 **PRACTITIONER SCOPE AND TRAINING**

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

14  
 15 It is best practice for the practitioner to appropriately render services to a member only if  
 16 they are trained, equally skilled, and adequately competent to deliver a service compared  
 17 to others trained to perform the same procedure. If the service would be most competently  
 18 delivered by another health care practitioner who has more skill and training, it would be  
 19 best practice to refer the member to the more expert practitioner.

20  
 21 Best practice can be defined as a clinical, scientific, or professional technique, method, or  
 22 process that is typically evidence-based and consensus driven and is recognized by a  
 23 majority of professionals in a particular field as more effective at delivering a particular  
 24 outcome than any other practice (Joint Commission International Accreditation Standards  
 25 for Hospitals, 2020).

26  
 27 Depending on the practitioner’s scope of practice, training, and experience, a member’s  
 28 condition and/or symptoms during examination or the course of treatment may indicate the  
 29 need for referral to another practitioner or even emergency care. In such cases it is prudent  
 30 for the practitioner to refer the member for appropriate co-management (e.g., to their  
 31 primary care physician) or if immediate emergency care is warranted, to contact 911 as  
 32 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice  
 33 guideline for information.

## 34 35 **References**

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