Clinical Practice Guideline: **Heel Cord Lengthening or Shortening**

Date of Implementation: **August 20, 2015**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT Codes 27606, 27685, and 27686 to be medically necessary for heel cord lengthening or shortening **upon meeting 1 or more of the following criteria:**

1. Clubfoot (acquired clubfoot, ICD-10 codes M21.541 - M21.549) or other deformity (e.g., midfoot collapse (Congenital vertical talus deformity (ICD-10 Q66.80 - Q66.82)), lowering of arch (Congenital pes planus (ICD-10 Q66.50 – Q66.52))) that has failed to respond to nonoperative treatment, including **2 or more of the following**:
    - Serial casting
    - Bracing
    - Orthotics
    - Night splints
    - Physical therapy, including stretching program
2. Recurrent clubfoot after conservative treatment
3. Clubfoot or other deformity too severe or longstanding to use conservative treatment
4. Diabetic foot ulcers in patient with limited ankle dorsiflexion
5. Equinus deformity (Varus deformity, not elsewhere classified and congenital talipes equinovarus (M21.171 – M21.179, Q66.00-Q66.02))

CPT Codes and Descriptions

CPT Code	CPT Code Description
27606	Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each

BACKGROUND

Contracture of the gastrocnemius-soleus complex, often referred to as an equinus contracture, is a common clinical finding. Contracture of the gastrocnemius-soleus can be defined as less than 10 degrees of passive ankle dorsiflexion with the knee flexed and extended. Severe deformities are obvious and debilitating, such as clubfoot deformity and contracture following an untreated compartment syndrome of the leg. Other common contractures are seen in adults with neurologic impairment or following ankle trauma. Neuromuscular problems can lead to equinus contracture in children, especially in cerebral palsy. Percutaneous Achilles tenotomy and lengthening/shortening of the ankle tendon to treat conditions associated with limited ankle dorsiflexion are addressed within the context of this clinical practice guideline.

A course of conservative treatment as the first line of care for equinus deformity. If conservative measures fail to adequately reduce pain and improve function, then more invasive measures may be considered as treatment options.

Congenital talipes equinovarus, which is also known as clubfoot, is a common congenital orthopedic condition characterized by an excessively turned in foot (equinovarus) and high medial longitudinal arch (cavus). If left untreated it can result in long-term disability, deformity, and pain. Interventions can be conservative, such as splinting or stretching, or surgical. The Ponseti technique is currently the most widely implemented treatment with good long-term outcomes. This technique involves six to eight weeks of long leg plaster casts (toe to groin) with gentle manipulation around the talar head of the ankle joint. The long leg plaster casts are changed once a week. Most patients require an Achilles tenotomy to correct remaining equinus deformity (Bina et al., 2020).

Jaddue et al. (2010) carried out a study to compare open to percutaneous tendo-achilles lengthening (TAL) as treatment for equinus deformity in children with cerebral palsy (CP). Eighteen ambulatory spastic children (28 feet) with isolated primary fixed equinus deformity were randomized to these two methods and prospectively followed up 7 to 18 months postoperatively (mean 11 months). The study found that the percutaneous TAL gave shorter operative time, shorter hospitalization period, better active dorsal and plantarflexion abilities, better parent satisfaction, and lower complication rates. It was concluded that percutaneous TAL seemed to be superior to the open TAL regarding the studied parameters.

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)* policy for information.

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