

Clinical Practice Guideline: Foot/Toe Soft Tissue Tumor Excision

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GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT® codes 28039, 28041, 28043, and 28045 to be medically necessary for the excision of a soft tissue tumor of the foot or toe **if used for the treatment of at least 1 of the following conditions:**

- Neoplasm of unspecified behavior of bone, soft tissue, and skin (D49.2)
- Malignant neoplasm of peripheral nerves and soft tissue of lower limb (C47.20 - C47.22, C49.20 - C49.22)
- Benign neoplasm, lipoma, fibroma, cystic lesions (D17.20, D21.9, D17.23-D17.24, D17.30, and D17.39)

CPT® Code	CPT® Code Description
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater
28041	Excision, tumor, soft tissue of foot or toe, subfascial (e.g., intramuscular); 1.5 cm or greater
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm
28045	Excision, tumor, soft tissue of foot or toe, subfascial (e.g., intramuscular) less than 1.5 cm

BACKGROUND

CPT® codes 28039, 28041, 28043, and 28045 reference the excision of soft tissue tumors of the foot or toe. The excision of subcutaneous soft connective tumors is described by CPT® codes 28039 and 28043. This involves the marginal resection of tumors confined to subcutaneous tissue below the skin, but above the deep fascia. Resection described by CPT® codes 28041 and 28045 involve more extensive subfascial excisions (e.g., intramuscular) of the foot or toe.

Soft tissue tumors constitute a large and heterogeneous group of neoplasms. Most soft tissue tumors of various histogenetic types are classified as either benign or malignant;

1 however, many are of an intermediate nature, which typically implies aggressive local
2 behavior with a low-to-moderate propensity for metastasis. It is much more common for a
3 soft-tissue mass or lump to be benign rather than malignant.

4
5 Benign soft tissue tumors are classified as follows into three stages based on latent, active
6 and local aggressive growth. Stage one includes lesions that are latent or inactive (static)
7 and usually have no clinical symptoms. Examples include lipoma, ganglionic cyst and
8 fibroma. Stage two lesions are actively growing and are associated with clinical symptoms.
9 Examples include xanthoma, glomus tumor, neurilemoma and neurofibroma. Stage three
10 lesions are locally aggressive, histologically immature and show progressive growth that
11 is not limited by normal anatomic boundaries. Examples include hemangioma and plantar
12 fibromatosis.

13
14 Soft tissue sarcomas (malignant) are graded into low-grade (Stage I) and high-grade (Stage
15 II) tumors based on histologic appearance coupled with diagnostic imaging characteristic
16 and anatomical location. Sarcomas with the presence of distant metastasis are considered
17 Stage III tumors. If a malignant sarcoma is suspected, a referral to a musculoskeletal
18 oncologist is strongly recommended.

19
20 Lipomas may occur in the soft tissue, muscle, tendon sheaths or bone. The mass is soft,
21 non-tender, mobile and usually asymptomatic unless it compresses neural structures. Most
22 lipomas of the foot are slow growing, located in the subcutaneous tissue and are usually
23 solitary.

24
25 Plantar fibromatosis usually presents as a solitary lesion or multiple nodules, often
26 occurring along the medial and central band of the plantar fascia. These lesions are
27 typically unilateral, are firm and fixed to the plantar fascia. When patients are weight
28 bearing, the lesions may produce discomfort due to the irregular contour of the plantar
29 surface in the arch of the foot. However, most lesions are asymptomatic. These lesions
30 usually have slow growth that stops once they reach a size of approximately 3 cm.

31
32 Hemangiomas are benign vascular tumors that are believed to represent hamartomatous
33 malformations of normal vascular tissues or benign neoplasms. Most are soft, compressible
34 and subcutaneous in location. Tumors can be of the cavernous, capillary or mixed type
35 with the port-wine capillary hemangiomas being most common in the foot. One may also
36 see hemangiomas in conjunction with dyschondroplasia, also known as Maffucci's
37 syndrome.

38
39 Neurilemoma is a benign tumor of nerve sheath origin (Schwann cell) with a peak
40 incidence in the fourth and fifth decades of life. There is no predilection to either gender.
41 The tumor is usually solitary, less than 2 cm, well-encapsulated and on the surface of a

1 peripheral nerve. Patients will present with a painful nodule associated with a Tinel’s sign
2 in the distribution of the affected nerve.

3
4 Biopsy is an essential component of the preoperative diagnostic work-up and should be
5 carried out in every case in which malignancy is suspected. Moreover, this is the only way
6 to establish whether a soft tissue tumor is malignant, and this confirmation is a prerequisite
7 for any neoadjuvant therapy (Katenkamp, K. & Katenkamp, D., 2009).

8
9 A multidisciplinary approach in the treatment of soft tissue sarcomas is required to
10 determine the optimal treatment for patients with this disease. The treatment team includes
11 the surgeon, radiation oncologist, medical oncologist, and pathologist. The main goal of
12 treatment is to control the local and distant spread of the tumor while maintaining, as best
13 as possible, function and quality of life. This requires adequate resection of the tumor
14 through a properly planned surgery. If the sarcoma has not spread, surgery is done to
15 remove the tumor and any surrounding tissues that could potentially be affected by the
16 cancer.

17
18 There is a dearth of literature on the soft-tissue sarcoma of the foot. Research by Latt et al.
19 (2010) carried out a review of cases of soft-tissue sarcoma of the foot treated in a
20 specialized musculoskeletal oncology practice over a 15-year period to gain insight into
21 the presentation, treatments, and outcomes for this rare disease. The surgical management
22 consisted of resection in nine patients, resection and arthrodesis in four patients, and
23 amputation in three patients. Limb salvage was usually possible, but it required accepting
24 marginal resections, relying on free tissue transfer to obtain coverage and using radiation
25 therapy to obtain local control. The researchers concluded that this combination of surgical
26 procedures provided an acceptable local control rate and very good functional outcomes.
27 (Latt et al., 2010).

28 29 **PRACTITIONER SCOPE AND TRAINING**

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

35
36 It is best practice for the practitioner to appropriately render services to a member only if
37 they are trained, equally skilled, and adequately competent to deliver a service compared
38 to others trained to perform the same procedure. If the service would be most competently
39 delivered by another health care practitioner who has more skill and training, it would be
40 best practice to refer the member to the more expert practitioner.

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

6
 7 Depending on the practitioner’s scope of practice, training, and experience, a member’s
 8 condition and/or symptoms during examination or the course of treatment may indicate the
 9 need for referral to another practitioner or even emergency care. In such cases it is prudent
 10 for the practitioner to refer the member for appropriate co-management (e.g., to their
 11 primary care physician) or if immediate emergency care is warranted, to contact 911 as
 12 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* policy for
 13 information.

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