

**Clinical Practice Guideline: Reconstruction of Posterior Tibial Tendon**

**Date of Implementation: June 18, 2015**

**Product: Specialty**

**GUIDELINES**

American Specialty Health – Specialty (ASH) considers procedures consisting of CPT® Code 28238 to be medically necessary for the reconstruction of the posterior tibial tendon with excision of accessory tarsal navicular bone **upon meeting ALL of the following conditions:**

1. Diagnosis of **at least 1 of the following** conditions with the presence of accessory navicular bone:
  - Ruptured posterior tibial tendon
  - Posterior tibial tendon dysfunction
  - Posterior tibial tendonitis
  - Adult flat foot
2. Failure of **at least 3 of the following** non-operative treatments with continued pain and dysfunction:
  - Physical therapy
  - Orthotics/bracing
  - Immobilization
  - Activity modification
  - Medications
  - Shoe modifications

**CPT® Codes and Descriptions**

CPT® Code	CPT® Code Description
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (e.g., Kidner type procedure)

**BACKGROUND**

Accessory bones are common skeletal variations in the human foot and ankle. Accessory naviculars are developmental in nature and originate from a secondary ossification center of the navicular bone. Most accessory bones are asymptomatic, yet a small portion can cause painful symptoms. Symptomatic accessory tarsal navicular is most commonly seen with a type II accessory navicular and is thought to be the result of altered biomechanics, presenting as shoe irritation and pain localizing to the navicular bone. Clinical symptoms may be attributed to tension and repetitive shearing stress at the synchondrosis from the

1 posterior tibial tendon, causing disruption of the synchondrosis, posterior tibial  
2 tenosynovitis and even osteonecrosis. Imaging may demonstrate degenerative changes at  
3 the synchondrosis and navicular tubercle, within the adjacent soft tissues and in the  
4 posterior tibial tendon.

5  
6 Nonsurgical treatment for accessory navicular syndrome includes immobilization,  
7 medications, physical therapy, and orthotics. If non-surgical treatment fails to relieve the  
8 symptoms of accessory navicular syndrome, surgery may be appropriate. Surgery may  
9 involve removing the accessory bone as this extra bone is not needed for normal foot  
10 function, reshaping the area, and repairing the posterior tibial tendon to improve its  
11 function.

12  
13 There are multiple surgical treatment options for symptomatic accessory naviculars  
14 described in the literature. They vary from simple excision to excision and rerouting of the  
15 posterior tibial tendon under the navicular, excision and restoring the continuity of the  
16 posterior tibial tendon, percutaneous drilling, or arthrodesis of the accessory ossicle  
17 (Leonard & Fortin, 2010).

18  
19 The Kidner procedure is the most common surgical treatment for accessory navicular bones  
20 that cause pain. This procedure is a surgery to treat a painful accessory navicular through  
21 reconstruction of the posterior tibial tendon with excision of the accessory navicular bone.

22  
23 Additionally, for the correction of symptomatic flexible flatfeet with minimal deformity,  
24 adjunctive soft tissue procedures can be considered. This may include the Kidner posterior  
25 tibial tendon advancement soft tissue procedure (Lee et al., 2005; Tao et al., 2019).  
26 Posterior tibial tendon dysfunction is the most common cause of the adult acquired flatfoot.  
27 Dysfunction of the posterior tibial tendon is typically a progressive, unilateral condition  
28 caused by pathologic changes within the tendon. The deformity is usually progressive and  
29 results in a flexible to rigid flatfoot, depending on the stage of the condition. Giorgini et al.  
30 (2010) carried out a review of the literature to determine the efficacy of the modified  
31 Kidner-Cobb procedure for symptomatic pes planovalgus or Mueller stage II posterior  
32 tibial tendon dysfunction (50 feet in 39 patients). All patients visually demonstrated  
33 postoperative elevation of the medial longitudinal arch height. The results of this review  
34 indicated that the modified Kidner-Cobb procedure is a useful treatment option for patients  
35 with symptomatic flexible flatfoot with stage II posterior tibial tendon dysfunction.

## 36 37 **PRACTITIONER SCOPE AND TRAINING**

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

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

6  
 7 Best practice can be defined as a clinical, scientific, or professional technique, method, or  
 8 process that is typically evidence-based and consensus driven and is recognized by a  
 9 majority of professionals in a particular field as more effective at delivering a particular  
 10 outcome than any other practice (Joint Commission International Accreditation Standards  
 11 for Hospitals, 2020).

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

## 20 21 **References**

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