

CPT Codes 64774, 64787	
Diagnosis Code	Diagnosis Code Description
G57.92	Unspecified mononeuropathy of left lower limb
G57.93	Unspecified mononeuropathy of bilateral lower limbs

1 Exclusions:

2 The neuroma excision codes included herein are not allowed for the treatment of Morton’s
 3 neuroma. Refer to ASH clinical practice guideline Interdigital Excision and Nerve
 4 Implantation for Morton’s Neuroma (CPG 214-S) for the treatment of Morton’s neuroma.

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6 **CPT CODES AND DESCRIPTIONS**

CPT® Code	CPT® Code Description
64774	Excision of neuroma; cutaneous nerve, surgically identifiable
64776	Excision of neuroma; digital nerve, 1 or both, same digit
64778	Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)
64782	Excision of neuroma; hand or foot, except digital nerve
64783	Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)
64787	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)

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8 **BACKGROUND**

9 CPT codes 64774, 64776, 64778, 64782, and 64783 describe procedures consisting of
 10 excision of neuroma from a nerve of the ankle or foot. Procedures consisting of 64774
 11 involve excision of the neuroma in the subcutaneous tissue. In 64776, the practitioner
 12 incises the skin over the digital nerve and excises the neuroma. CPT code 64778 is reported
 13 for each additional neuroma of a separate digit. In 64782, the practitioner excises the
 14 neuroma of a peripheral nerve (except digital nerve) of the foot. CPT code 64783 is
 15 reported for each additional neuroma of the foot. Procedures that require implantation of
 16 nerve end into bone or bone are described by CPT code 64787.

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18 Neuromas of the ankle and foot can occur as a result of injury to the nerve due to trauma
 19 or surgical intervention. The resulting neuroma may cause distal pain along the course of
 20 the nerve and is therefore considered a type of peripheral neuropathy.

1 Nonsurgical care is the first line of treatment for painful neuromas. Surgical treatment is
2 recommended for recalcitrant neuromas which have not responded to nonsurgical care. The
3 goal of surgical treatment is to remove the neuroma without creating a new one. Surgical
4 treatment for painful neuromas of the cutaneous nerves of the foot and ankle consists of
5 resection with possible translocation of the nerve stump to a nearby muscle or vein.
6 Frequently, there are several branches of the nerve that are affected, with one in a separate
7 fibrous tunnel which may be easily overlooked. It is important to address both branches
8 under these circumstances.

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10 The superficial peroneal (fibular) nerve may be injured at the ankle or at the dorsum of the
11 foot leading to a subsequent neuroma, which may be treated by resection and relocation of
12 the nerve into the midportion of the anterior or lateral muscle compartment or
13 decompression by fasciotomy. Neuromas of the calcaneal nerve, commonly due to plantar
14 fasciotomy and tarsal tunnel decompression surgical intervention, can be resected and
15 translocated proximally into the closest muscle. Neuromas of the sural and saphenous
16 nerves can be resected and translocated between the gastrocnemius/soleus muscle or into
17 the leg as proximal as possible, respectively.

18
19 Currently, there is a paucity of high-quality statistical studies evaluating treatment of
20 peripheral neuromas of the ankle and foot. However, the most accepted evidence shows
21 support for neuroma resection and burial of the nerve stump into a tissue bed, typically
22 muscle, which protects the stump and helps the avoid the formation of a new neuroma
23 (Gould, 2011; Stokvis & Coert, 2011). Poppler et al. (2018) carried out a meta-analysis to
24 examine the efficacy of the surgical treatment of painful neuromas. Overall, the data
25 suggested that most patients with a painful neuroma, after careful selection as surgical
26 candidates, will have a meaningful decrease in pain with excision and transposition surgical
27 intervention (81% [95% CI: 75–86]) with the most consistent results compared to other
28 treatment groups, albeit with a high degree of heterogeneity amongst all studies.

30 **PRACTITIONER SCOPE AND TRAINING**

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

36
37 It is best practice for the practitioner to appropriately render services to a member only if
38 they are trained, equally skilled, and adequately competent to deliver a service compared
39 to others trained to perform the same procedure. If the service would be most competently
40 delivered by another health care practitioner who has more skill and training, it would be
41 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).

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 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)* clinical practice
 13 guideline for information.

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