Clinical Practice Guideline: **Repair of Dislocating Peroneal (Fibularis) Tendons**

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Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers procedures consisting of CPT Codes 27675 and 27676 to be medically necessary for the repair of dislocating peroneal tendons **upon meeting ALL of the following conditions**:

1. Diagnosis of **at least 1 of the following** conditions:
   - Peroneal tendinitis and other enthesopathy of foot (ICD-10 codes M76.70 - M76.72, M77.50 - M77.52)
   - Abscess of tendon sheath or bursa, bursopathies, synovial hypertrophy, and other specified disorders of synovium and tendon of lower leg, ankle and foot, other site and multiple sites (ICD-10 codes M65.061 - M65.079, M65.08, M67.261 - M67.279, M67.28 - M67.29, M67.871 - M67.879, M67.88 - M67.89, M71.071 - M71.079, M71.08 - M71.09, M71.80, M71.871 - M71.879, M71.88 - M71.89)
   - Bursopathy and unspecified disorder of synovium and tendon of lower leg, ankle and foot, other, and multiple sites (ICD-10 codes, M67.961 - M67.979, M67.98 - M67.99, M71.9)
2. Lateral ankle pain, swelling and ecchymosis for at least 6 months
3. Posterior tenderness along the peroneal tendons
4. Pain and weakness with active ankle dorsiflexion and external rotation
5. Lateral tenderness, no medial tenderness
6. Ankle Circumduction Test: positive
7. Failure of **at least 2 of the following** non-operative treatments:
   - Physical therapy
   - Orthotics/bracing
   - Immobilization
   - Activity modification
   - Exercise program
   - Shoe modifications

CPT CODES AND DESCRIPTIONS

CPT®Code	**CPT®Code** Description
27675	Repair, dislocating peroneal tendons; without fibular osteotomy
27676	Repair, dislocating peroneal tendons; with fibular osteotomy

BACKGROUND

CPT code 27675 describes procedures for the repair of dislocating peroneal tendons. For peroneal tendon repair using fibular osteotomy procedures to deepen the peroneal groove, report CPT code 27676.

Peroneal tendon dislocation or subluxation from the retrofibular groove is a rare cause of ankle pain and disability. Subluxation of the peroneal tendons involves disruption of the superior peroneal retinaculum, typically occurring with avulsion of the retinaculum from its fibular insertion. The most common mechanism is forceful dorsiflexion of the ankle, hindfoot inversion with contraction of the peroneals causing disruption of the superior peroneal retinaculum. A convex retromalleolar groove and a varus heel are risk factors causing instability, and tendon pathology (Davda et al., 2017)..

The acute injury often remains unrecognized or is misdiagnosed as an ankle sprain. Untreated or undiagnosed acute injury predisposes a patient to chronic peroneal dislocation and/or potential peroneal tendon tear. If diagnosed early, certain acute peroneal dislocations can be manually reduced and held in a reduced position for a 4-6 week period of immobilization. However, peroneal dislocations often require surgery (Davda et al., 2017).

To diagnose a peroneal tendon injury, the foot and ankle surgeon will examine the foot and look for pain, instability, swelling, warmth, and weakness on the outer side of the ankle. Circumduction of the ankle may demonstrate dislocation of the tendons with eversion and dorsiflexion and spontaneous relocation with plantarflexion and inversion. Magnetic resonance imaging (MRI) is useful for preoperative planning as other pathology (peroneus brevis tear, low lying musculotendinous junction, fibular sulcus) may also need to be addressed concomitantly with repair of the subluxation or dislocating tendons (Easley & Wiesel, 2011). MRI is the standard imaging method for evaluating tendon disorders. It provides detailed multiplanar imaging without ionizing radiation, and its excellent soft-tissue contrast allows superior visualization of peroneal tenosynovitis and midsubstance or subtle longitudinal tears, grading of injuries of the superior peroneal retinaculum, diagnosis of ligamentous disorders, and determination of the morphology of the retromalleolar groove (Heckman et al., 2008).

The primary indication for treating these disorders is pain. Nonsurgical treatment is currently the first line of treatment for peroneal tendon dislocation and subluxation. Nonsurgical treatment options include immobilization, medications, physical therapy, and bracing. Conservative treatment may render recurrent instability in patients. Some researchers advocate for early surgical intervention for cases of acute peroneal tendon instability when considering the high rate of failure within the young, active patient population (Bahad & Kene, 2020). Failure of conservative measures is an indication for operative intervention. Operative treatment is frequently required for chronic peroneal

tendon dislocation. Surgical options consist of rerouting of tendons, soft tissue repairs and reconstruction of the retinaculum, and bony procedures to deepen the peroneal groove (Heckman et al., 2008).

Operative treatment for peroneal subluxation typically consists of anatomic repair or reconstruction of the superior peroneal retinaculum with or without deepening of the retromalleolar groove. Cho et al. (2014) carried out a prospective study to compare the operative outcome between retinaculum repair with and without fibular groove deepening for the treatment of recurrent traumatic peroneal tendon dislocation in young, active patients (N=29). Thirteen patients were treated by the superior peroneal retinaculum repair with fibular groove deepening (group A) and 16 patients by superior peroneal retinaculum repair alone (group B) and outcomes were evaluated with the American Orthopaedic Foot and Ankle Society (AOFAS) ankle-hindfoot score, visual analog scale (VAS) score for pain, and overall patient satisfaction measures with a minimum follow-up period of 12 months postoperatively. The mean AOFAS score improved significantly from 59.3 points preoperatively to 92.2 points at the final follow-up in group A and from 58.5 points preoperatively to 91.3 points at the final follow-up in group B. Mean VAS score also improved significantly from 5.0 points preoperatively to 1.0 points at the final follow-up in group A and from 4.9 points preoperatively to 1.2 points at the final follow-up in group B. Improvements in AOFAS and VAS scores at the final follow-up were not significantly different between the 2 groups. The authors concluded that isolated retinaculum repair, when compared with retinaculum repair with fibular groove deepening, was a faster and simpler technique, but both techniques had good outcomes for the treatment of recurrent traumatic peroneal tendon dislocation.

Several studies evaluate the results of surgical treatment of peroneal retinaculum in athletic populations. The Ankle and Foot Associates (ESSKA-AFAS) of the European Society of Sports traumatology, Knee Surgery and Arthroscopy (ESSKA) conducted a systematic review of peroneal tendon injuries in the active population and released a consensus statement on the optimal management of peroneal tendon pathologies (van Dijk et al., 2018). The ESSKA-AFAS concluded that treatment of peroneal tendon dislocation should be based on whether it is an acute or chronic injury and whether the patient is an athlete. The panel further concluded that the non-athlete with an acute dislocation may be offered conservative management but should be warned that there is a 50% chance of recurrent dislocation. In case of unsuccessful conservative management or chronic instability, surgical intervention is advised. Surgery in non-athletes with acute peroneal instability consists of reduction of the tendons into the retrofibular groove and repair of the SPR. Surgery is recommended for elite athletes having sustained either acute or chronic dislocation. There was agreement that surgical treatment in athletes should routinely include groove deepening, regardless of other possible treatments.

In a study of isolated subluxation repair, subluxation repair plus peroneus brevis tendon repair, or subluxation repair plus lateral ankle stabilization, Saxena & Ewen (2010) measured the AOFAS score and average time to return to activity of athletic patients with symptomatic subluxating peroneal tendons (*N*=31). As a group, the average time to return to activity was 3.2 +/- 0.8 months with a postoperative AOFAS score of 97.0 +/- 5.3. Patients with tendon tears were older in age (P < .01) and took longer to return to activity than the rest of the cohort (P = .02). There were a total of 4 patients with postoperative complications, although all were able to return to sports. The patients with peroneal subluxation in this study were able to return to their sport in approximately 3 months.

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)* clinical practice guideline for information.

References

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