

1 **Clinical Practice Guideline:** **Radical Resection and Biopsy of Malignant Tumors**
2 **of the Foot or Toe**

3
4 **Date of Implementation:** **December 18, 2015**

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6 **Product:** **Specialty**
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9 **GUIDELINES**

- 10 A. American Specialty Health – Specialty (ASH) considers services consisting of CPT
11 Codes 28046 and 28047 to be medically necessary for the radical resection of malignant
12 tumors of the foot or toe upon confirmation of the diagnosis of a cancerous lesion(s).
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- 14 B. ASH considers services consisting of CPT Code 10004-10012 and 10021 may be
15 appropriate aspiration procedures to be used for the biopsy of a suspected malignant
16 lesion(s).
17
- 18 1. CPT Code 10021 is an appropriate aspiration procedure for palpable lesions. CPT
19 Code 10005-10012 may be necessary for image-guided fine needle aspiration for
20 lesions that are difficult to palpate or non-palpable. Image guidance is used to
21 identify the exact location of the area to be sampled in these situations. An example
22 would be if the lesion is near vital structures such as major arteries and nerves. If a
23 lesion cannot be visualized or palpated, imaging guidance will limit damage to
24 other tissues, pain and the possibility of spreading the lesion.
 - 25 2. Fine needle aspiration (FNA) (CPT codes 10021, 10005-10012) should not be
26 reported with another biopsy code for the same lesion unless one specimen is
27 inadequate for diagnosis. For example, an FNA specimen is usually examined for
28 adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis,
29 it is not necessary to obtain an additional biopsy specimen. However, if the
30 specimen is not adequate and another type of biopsy (e.g., needle, open) is
31 subsequently performed at the same patient encounter, the other biopsy procedure
32 may also be reported with an NCCI-associated modifier.
 - 33 3. One biopsy may be billed per mass, lesion or nodule regardless of the number of
34 samples obtained. If multiple separate masses, lesions or nodules are biopsied, it is
35 important to provide the specific location of each to support reporting one biopsy
36 per separate mass, lesion or nodule.

1 **CPT CODES AND DESCRIPTIONS**

CPT® Code	CPT® Code Description
10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)
10007	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion
10008	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)
10009	Fine needle aspiration biopsy, including CT guidance; first lesion
10010	Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)
10011	Fine needle aspiration biopsy, including MR guidance; first lesion
10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)
10021	Fine needle aspiration biopsy; without imaging guidance; first lesion
28046	Radical resection of tumor (e.g., sarcoma), soft tissue of foot or toe; less than 3 cm
28047	Radical resection of tumor (e.g., sarcoma), soft tissue of foot or toe; 3 cm or greater

CPG 263 Revision 8 - S

Radical Resection and Biopsy of Malignant Tumors of the Foot or Toe

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To CQT for review 07/10/2023

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To QOC for review and approval 08/17/2023

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BACKGROUND

CPT code 28046 and 28047 describes radical excision of a malignant soft tissue tumor (i.e., sarcoma) from the foot or toe; area less than 3 cm and 3 cm or greater, respectively. The tumor and any adjacent tissue that may be affected by the spread of the neoplasm are also excised and large resections may be needed. The type and stage of the lesion determine the extent of the tumor margin resection area. Additionally, muscle or fascia may also need to be repaired.

Soft tissue tumors of the foot are not uncommon in the foot specialist's practice. Chondrosarcoma is the most usual malignant tumor of the foot in patients over the age of 40. Synovial sarcoma is the most frequent histological diagnosis in soft tissues. Epithelioid sarcoma or clear cell sarcoma, involve more frequently the foot and ankle than other sites. The classic local treatment of malignant conditions of the foot and ankle was below-knee amputation at different levels. Currently, with the development of adjuvant therapies, some patients may benefit from conservative surgery or partial amputation after multidisciplinary team discussions (Mascard et al., 2017).

Although masses are usually seen early with early symptoms due to compact anatomy with thin soft tissue coverage (e.g., pain on weight-bearing), diagnosis is often delayed. Diagnostic errors are more common than in other regions, since malignancy is often not considered. Furthermore, delayed diagnosis can result in under treatment or overtreatment with serious consequences. Suspicion is warranted in investigating any foot mass, especially including those that have a seemingly slow rate of growth. A detailed history of risk factors, prior malignancy, and metastatic disease especially in patients older than 50 years should raise the index of suspicion toward malignancy. Additionally, pre-existing painless masses that suddenly start growing should be followed by further diagnostic measures to rule out neoplasia. In any mass with suspected malignancy, indeterminate behavior, or if the diagnosis cannot be specified to one single entity, a biopsy must be obtained. Biopsy samples may be obtained by fine needle aspiration (FNA). An FNA sample is either a cellular sample or fluid sample; samples are subsequently sent to pathology for cytologic evaluation. Fine needle cytologic and fluid aspiration biopsies are reported using CPT codes, 10004 and 10021, fine needle aspiration without imaging guidance, or 10005-10012, fine needle aspiration with imaging guidance.

Adequate resection of any tumor is necessary for local tumor control and survival. No compromise in resection margins should be tolerated in tumors in which recurrence is associated with decreased survival. Notably, reoperations have a statistically worse prognosis, since the extension of the original tumor cannot be determined by the surgeon who is doing the revision. Wide resection is defined as removal of tumor surrounded on all sides with healthy tissue, and this type of resection is adequate for most malignant tumors. Alternatively, radical resection includes resection of the entire anatomic compartment (metatarsals are the only compartmental boundaries). Recurrence free survival after wide

1 and radical resection is similar for most malignant cases; however radical resection is often
 2 associated with severe functional impairment. Wide resection is typically the resection of
 3 choice in most malignant tumors. However, due to the smaller anatomic situation at the
 4 foot with only limited boundaries, radical resection – which is often equivalent with (ray)
 5 amputation – is more common at the foot than at other areas. Furthermore, adjuvant
 6 treatment options such as radiotherapy and chemotherapy may significantly improve
 7 function and survival after treatment of malignant tumors.

9 **PRACTITIONER SCOPE AND TRAINING**

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

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

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

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

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