Seven Common Questions in Foot and Ankle Coding

A previous article published in AAOS Now (“How to Avoid Common Mistakes When Coding Hand Procedures,” March 2019) identified common coding issues for hand procedures. This article presents seven coding conundrums and frequently asked questions pertaining to foot and ankle procedures.

1. Which Current Procedural Terminology (CPT) code should be used to report excision of an exostosis from the talus or calcaneus?

There are two CPT code sets that could be used to describe excision of an exostosis at those sites. Codes 28100–28103 describe “excision of bone cyst or benign tumor” and vary as to whether autograft or allograft is also used. Code 28120 describes “partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); talus or calcaneus.”

The conundrum arises because CPT includes different guidelines for exostosis removal from different anatomic areas. For the tibia and fibula, CPT directs “for exostosis excision, see 27635,” whereas at the phalanges, CPT directs “for partial excision of bossing or exostosis for phalanx in the foot, use 28124.” Code 27635 represents an excision or curettage code,
whereas code 28124 represents a partial excision code. There are no such instructions for the talus, calcaneus, other tarsals, or metatarsals. Additionally, a May 2011 edition of the American Medical Association (AMA) coding guidance publication “CPT Assistant” stated that code 28120 “is typically performed for an infection and not for an exostosis and only if a partial excision of the heel is performed.”

What is a foot and ankle coder to do? Consider the extent of excision work documented; if it is straightforward, then codes 28100–28103 may better reflect the service performed and the diagnosis present. If the work is extensive, 28120 may be used, but be aware that payers may deny the service based on diagnosis.

2. Why do insurance plans keep denying my second unit of calcaneal osteotomy?

Sometimes a physician may perform two separate osteotomy procedures on the calcaneus. The CPT code for calcaneal osteotomy, 28300, uses the word “osteotomy” in the singular not plural; thus, it would appear that two osteotomies should support two units of 28300 (osteotomy; calcaneus [e.g., Dwyer or Chambers type procedure], with or without internal fixation).

As a component of the National Correct Coding Initiative (NCCI), the Centers for Medicare & Medicaid Services (CMS) created a system of medically unlikely edits (MUEs). They are intended to prevent providers from incorrectly being paid for more units of service than make sense anatomically or would be common practice. Each CPT code is also assigned an MUE adjustment indicator (MAI), which describes the nature of the MUE. For example, phalanx fracture code 28525 (open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each) is assigned an MUE of three units and is assigned an MAI of “3: Date of Service Edit: Clinical.” This means that if more than three units of 28525 are submitted on a single date, only three will be paid. Because patients commonly have 12 phalanx bones in each foot “other than the great toe” that could be repaired (24 in both feet), those units in excess of three can be appealed.

Unfortunately, not all of the MAIs are able to be appealed. By comparison, code 28300 has an MAI of “2: Date of Service Edit: Policy,” and that type of
MAI is not eligible for appeal. Medicare isn’t the only payer following those guidelines. Many insurance plans use CMS MUEs during claims processing as well. When performing a double calcaneal osteotomy, consider appending a 22 modifier to indicate the necessary additional physician work.

3. Which code should we report for repair of an osteochondritis dissecans lesion of the talar dome using an allograft?

CPT code 28446 is used to describe repair of an osteochondritis dissecans lesion using autograft from the proximal tibia (open osteochondral autograft, talus [includes obtaining graft(s)]. Because there is no category I CPT code that describes the procedure using allograft, we must report the service using code 27899 (unlisted procedure, leg or ankle). Code 28446 could be used for comparison for physician work, but it is reasonable to expect a reduced payment because the work of harvesting the autograft is not required or performed.

4. If a physician documents reconstruction of both the anterior tibiofibular ligament (ATFL) and the calcaneofibular ligament (CFL), can we report two units of ligament repair? Is repair of the peroneal tendon(s) included in a modified Broström ligament reconstruction?

Modified Broström ligament reconstruction is commonly reported with CPT code 27698 (repair, secondary, disrupted ligament, ankle, collateral [e.g., Watson–Jones procedure]). Although a physician may document work at both the ATFL and the CFL, all of the work is included in one unit of code 27698.

If a physician additionally repairs the peroneal tendon(s) due to tearing, that work would be reportable with a flexor tendon repair code, either 27658 (repair, flexor tendon, leg; primary, without graft, each tendon) or 27659 (repair, flexor tendon, leg; secondary, with or without graft, each tendon). There is no NCCI edit between 27698 and 27658 or 27659 that should require the use of distinct services modifier 59. According to the AAOS Global Service Guidelines, if the peroneal tendon is not torn and repaired, but a portion of tendon is harvested for use as a graft during ligament reconstruction, harvesting and any associated suture reinforcement are not separately reportable with code 27698.
5. Our surgeon performed a crossover second toe repair utilizing a second metatarsal shortening osteotomy (28308). A capsulotomy was done to access the metatarsal for shortening. Can we code for the capsulotomy (28270)?

When a capsulotomy is performed for access to the metatarsal, it is not separately reportable. If the capsulotomy is performed to correct contracture in conjunction with the second metatarsal osteotomy because the osteotomy is extra-articular, it is separately reportable.

6. If a second toe extensor digitorum brevis tendon transfer was also performed to pull the second toe laterally and augment the deficient lateral tissue, can we code for the transfer? If so, can we use the tendon transfer codes for the ankle (27690 or 27691)?

It is acceptable to report a tendon transfer in conjunction with a shortening metatarsal osteotomy, but there are no codes for reporting tendon transfers in the toes.

In June 2016, “CPT Assistant” said that it is acceptable to use code 28285 when the tendon transfer is performed for hammertoe, claw toe, or crossover deformity correction. The AAOS Global Service Guidelines restrict reporting capsulotomy code 28270 in conjunction with code 28285 unless there is clear documentation of contracture at the metatarsophalangeal joint and it is correlated to a separate, supporting diagnosis.

7. If the operative note describes treatment of a Lisfranc dislocation using arthrodesis, is it required that a physician document placement of bone graft? How would we report dislocation treatment without arthrodesis?

Although in some cases arthrodesis CPT codes do require placement of bone graft (e.g., spine procedures), the AMA vignettes for codes 28730 (arthrodesis, midtarsal or tarsometatarsal, multiple or transverse) and 28740 (arthrodesis, midtarsal or tarsometatarsal, single joint) do not include bone graft placement as a required element. In the vignette for code 28740, arthrodesis is achieved through removal of the articular surfaces and placement of screws across the joint. For code 28730, a similar method is used, and the vignette states, “Bone graft is inserted as necessary.” If an arthrodesis is not performed for the treatment of a Lisfranc dislocation by removal of the articular surfaces with or without bone graft, consider using...
code 28615 (open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed).

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