Cohere Medicare Advantage Policy - Bunionette Surgical Treatments

Clinical Guidelines for Medical Necessity Review

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Important Notices

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Other Notices:

Guideline Information:

Specialty Area: Disorders of the Musculoskeletal System
Guideline Name: Cohere Medicare Advantage Policy - Bunionette Surgical Treatments

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Type: [**X**] Adult (18+ yo) | [_] Pediatric (0-17yo)

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Medical Necessity Criteria

Service: Bunionette Surgical Treatments

Benefit Category

Not applicable.

Recommended Clinical Approach

Bunionette is a deformity of the fifth metatarsal bone at the base of the little toe where it meets the metatarsal head.[1] Bunionette is usually caused by constraining footwear. Women are more likely to develop this deformity.[2] It is sometimes referred to as a "tailor's bunion".[3] There is a prominence of the fifth metatarsal head projecting laterally. Although the occurrence is not as common as bunions, they are similar in symptoms and causes. Initial treatment may include shoewear modification, padding, or shaving of the callus. Surgical treatment may include resection of the lateral aspect of the fifth metatarsal head or an osteotomy.

Evaluation of Clinical Benefits and Potential Harms

Cohere Health uses the criteria below to ensure consistency in reviewing the conditions to be met for coverage of bunionette surgical treatments. This process helps to prevent both incorrect denials and inappropriate approvals of medically unnecessary services. Specifically, limiting incorrect approvals reduces the risks associated with unnecessary procedures, such as complications from surgery, infections, and prolonged recovery times.

The potential clinical harms of using these criteria may include:

- Inadequate management of bunionette conditions: This can lead to complications like the progression of the foot deformity, worsening pain, and reduced mobility. These deformities can progress to open wounds, chronic calluses, or corns. Improper or delayed management of bunionette deformities can result in significant pain and disability, often necessitating more complex interventions later. According to Coughlin et al., inadequate management can result in severe pain and functional limitations.[1]
- Risks with inappropriate surgical procedures: These include infection, bleeding requiring a transfusion, injury to neurovascular structures,

anesthetic risk, chronic swelling, stiffness, and the need for repeat or additional procedures due to hardware failure, malunion, or nonunion. Post-surgical complications such as poor wound healing, nerve injury, and recurrence of the bunionette are also reported. Boffeli et al. highlight the significant risks associated with improper surgical techniques, including higher rates of infection and hardware complications.[2] Studies have reported complication rates of up to 50% for traditional open digital surgeries, commonly including pain, infection, neurovascular compromise, and delayed healing.[3]

- Adverse effects from delayed or denied treatment: This can worsen patient outcomes, such as an increased risk of worsening foot deformity resulting in chronic pain and disability. Delayed surgical intervention can lead to the progression of the deformity, making it more difficult to manage and increasing the risk of complications. Trnka et al. emphasize that delays in treatment can exacerbate deformities and lead to more challenging surgical corrections.[4]
- Increased healthcare costs and complications: This can result from the inappropriate use of emergency services and additional treatments. Unaddressed or improperly managed bunionettes can escalate healthcare costs due to the need for more extensive and emergency interventions later in life. According to Smith, escalating untreated bunionettes can lead to substantial increases in healthcare costs and resource utilization.[2,5]

The clinical benefits of using these criteria include:

- Improved patient outcomes: Ensuring timely and appropriate access to necessary surgical treatments for managing bunionette conditions. A systematic review reports that the success of nonsurgical treatment of symptomatic bunionettes is limited, and surgical intervention often yields better outcomes. Cooper et al. report that surgical interventions, such as metatarsal head resection, significantly improve patient outcomes.[6]
- Reduction in complications and adverse effects: Proper use of surgical criteria helps to avoid unnecessary interventions and their associated risks. Effective surgical intervention, such as distal chevron osteotomy or subcapital oblique osteotomy, has an overall success rate of 93%. Martijn et al. demonstrate the high success rates and low complication rates associated with well-planned surgical interventions.[7]

- Enhanced overall patient satisfaction and healthcare experience: Ensuring that bunionette surgery is used appropriately leads to better patient outcomes and higher satisfaction rates due to effective treatment and reduced complications. According to Trnka et al., appropriate surgical management leads to high levels of patient satisfaction and improved quality of life.[4]

This policy includes provisions for expedited reviews and flexibility in urgent cases to mitigate risks of delayed access. Evidence-based criteria are employed to prevent inappropriate denials, ensuring that patients receive medically necessary care. The criteria aim to balance the need for effective treatment with the minimization of potential harms, providing numerous clinical benefits in helping avoid unnecessary complications from inappropriate care.

In addition, the use of these criteria is likely to decrease inappropriate denials by creating a consistent set of review criteria, thereby supporting optimal patient outcomes and efficient healthcare utilization.

Medical Necessity Criteria

Indications

➔ **Bunionette surgical treatments** are considered appropriate if **ALL** of the following are **TRUE**[8-12]:

- ◆ The patient has **ANY** of the following positive findings:
  - Pain and swelling at the site of the lateral prominence of the fifth metatarsal head; **OR**
  - Callus formation laterally; **AND**
- ◆ Failure of conservative management (e.g., shoe modification, splinting, padding, rest, analgesics, physical therapy, oral or injectable corticosteroids) must be documented for a period of greater than 3 months. Documentation should include detailed evidence of the measures taken, rather than solely a physician's statement; **AND**
- ◆ Radiographic confirmation of **ANY** of the following.[9]
  - Bony prominence of the 5th metatarsal head; **OR**
  - 4th/5th IM angle greater than 9 degrees; **OR**
  - 5th MTP angle greater than 15 degrees.

Non-Indications

➔ **Bunionette surgical treatments** are not considered appropriate if **ANY** of the following is **TRUE**:

- ◆ Inadequate blood supply that could prevent healing; **OR**
- ◆ The patient has not reached skeletal maturity; **OR**
- ◆ Presence of active infection, untreated infection at the surgical site (may be necessary for a diabetic ulcer correction).

Level of Care Criteria

Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each

Medical Evidence

Thomas et al. (2009) developed a Clinical Practice Guideline for the American College of Foot and Ankle Surgeons for diagnosis and treatment of forefoot disorders: digital deformities. The guideline consists of multiple pathways which include digital deformities, central metatarsalgia, Morton's neuroma, tailor's bunion and trauma. They state that trauma may be an etiology of digital deformity; however, congenital or acquired deformities are more common. Examinations are generally performed sitting or standing, and gait analysis is stated to be beneficial. Regarding clinical maneuvers, the push-up test is effective at determining whether the deformity can be reduced. The metaphalangeal joint drawer test assists in confirming sagittal and transverse instability and potential for plantar plate pathology.[5]

In a 2019 systematic review, Cooper, Granadillo and Coughlin state that the literature is limited regarding the success of nonsurgical treatment of bunionettes that are symptomatic. These treatments include shoe wear modification and padding. Corticosteroid injections were shown in studies to have positive effects for up to two years. From a surgical perspective, the group stated that metatarsal head resection is typically resolved for unhealthy patients as poor outcomes such as transfer metatarsalgia, and painful fifth toe deformity have been reported. Type I bunionette deformities are often successfully corrected with distal chevron osteotomy or subcapital oblique osteotomy. Minimally invasive surgical techniques are increasing in popularity in recent years with positive study outcomes.[4]

Michels and colleagues (2021) conducted a survey study of 50 orthopedic surgeons with specific experience in percutaneous bunionette correction. A 92% response rate was obtained, and condylectomy was found to be rarely used while percutaneous oblique osteotomy was performed in almost all procedures. 95.7% were single osteotomies, 66.2-72.7% were complete, and 73.9% were performed with a Shannon long burr. 63.0% of respondents confirmed that the location of the osteotomy was dependent upon the deformity. It was concluded that there is some consensus in the surgical technique to be used and in the perioperative protocol.[3]

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Clinical Guideline Revision History/Information

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