Cohere Medicare Advantage Policy - Hammertoe, Claw Toe, Or Mallet Toe Surgical Treatment With Or Without Fusion

Clinical Policy for Medical Necessity Review

Version: 3
Revision Date: May 22, 2025

Important Notices

Notices & Disclaimers:

GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.

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Other Notices:

Policy Information:

Specialty Area: Musculoskeletal Care
Policy Name: Cohere Medicare Advantage - Hammertoe, Claw Toe, Or Mallet Toe Surgical Treatment With Or Without Fusion
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Hammertoe, Claw Toe, Or Mallet Toe Surgical Treatment With Or Without Fusion

Related CMS Documents

There are no applicable NCDs and/or LCDs for hammertoe, claw toe, or mallet toe surgical treatment with or without fusion.

Description

Surgical treatment may be appropriate for a hammertoe, claw toe, or mallet toe deformity that is not alleviated by conservative management. Options include tenotomy, tenotomy of toe tendon; incision to lengthen the toe tendon; interphalangeal fusion; partial or total phalangectomy; osteotomy; or reconstruction.[1-4]

Medical Necessity Criteria

Indications

Hammertoe, claw toe, or mallet toe surgical treatment with or without fusion is considered appropriate if **ALL** of the following are **TRUE**[3,4,6]:

- **ANY** of the following clinical presentations or positive findings:
  - Pain[2]; **OR**
  - Swelling or redness[5]; **OR**
  - Difficulty walking[5]; **OR**
  - The toe bends downwards or appears clawlike[2]; **OR**
  - Balance may be affected[2]; **OR**
  - Inability to flex or wiggle toes[5]; **OR**
  - Callosities on toe[5]; **OR**
  - Crossing over of lesser toes[2]; **AND**
- **ANY** of the following conditions[2]:
  - Bursitis; **OR**
  - Ankylosis of proximal interphalangeal (PIP) joint; **OR**
  - Ankylosis of distal interphalangeal (DIP); **OR**

- Adventitious bursa due to deformity; **OR**
- Interdigital neuroma from the deformity; **OR**
- Lateral metatarsophalangeal (MTP) capsular tear caused by the deformity; **OR**
- Subluxation or dislocation of the MTP joint from the deformity; **OR**
- MTP plantar plate tear with documented exam findings consistent with plantar plate tear[7]; **OR**
- Synovitis/capsulitis of the MTP joint; **OR**
- Ulceration at the apex of the deformity; **OR**
- Painful nail conditions secondary to persistent trauma; **OR**
- Presence of co-existing or causative conditions (e.g., tendon contracture) that need repair; **AND**

- Failure of conservative management for greater than 3 months, including **ALL** of the following:
  - Shoe modification; **AND**
  - Splint or padding; **AND**
  - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
  - Physical therapy, including a physician-directed home exercise program; **AND**
  - **ANY** of the following:
    - Corticosteroid injection if medically appropriate; **OR**
    - Documentation that corticosteroid injection is contraindicated; **AND**
- Radiographic confirmation of hammertoe, claw toe, or mallet toe deformity.[3]

Non-Indications

Hammertoe, claw toe, or mallet toe surgical treatment with or without fusion is not considered appropriate if **ANY** of the following is **TRUE**:

- Poor circulation that could affect surgical healing; **OR**
- The patient has an active, uncontrolled infection (does not apply to chronic infections that are managed); **OR**
- Poorly controlled diabetes mellitus (DM).[8]

Level of Care Criteria

Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
28010	Tenotomy of toe tendon, accessed through the skin
28232	Incision to lengthen toe tendon, open procedure
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)
28286	Correction, cock-up fifth toe, with plastic closure
28308	Osteotomy, with or without lengthening, shortening, or angular correction, metatarsal; other than first metatarsal
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe
28313	Reconstruction of soft tissue angular deformity of toe
28899	Unlisted procedure of foot and toes

Disclaimer: S Codes are non-covered per CMS guidelines due to their experimental or investigational nature.

Evaluation of Clinical Harms and Benefits

Clinical determinations for Medicare Advantage beneficiaries are made in accordance with 42 CFR 422.101 guidance outlining CMS' required approach to decision hierarchy in the setting of NCDs/LCDs identified as being "not fully established". When clinical coverage criteria are "not fully established" Medicare Advantage organizations are instructed to create publicly accessible clinical coverage criteria based on widely-accepted clinical guidelines and/or scientific studies backed by a robust clinical evidence base. Clinical coverage criteria provided by Cohere Health in this manner include coverage rationale and risk/benefit analysis.

The potential clinical harms of using these criteria for hammertoe, claw toe, or mallet toe surgical treatment with or without fusion may include:

- Adverse effects from delayed or denied treatment include progression of the deformity, worsening pain, and reduced mobility. Untreated mallet toe deformities can lead to painful corns and calluses. Risks with inappropriate surgical procedures include infection, bleeding, injury to neurovascular structures, anesthetic risk, and the need for repeat or additional procedures due to hardware failure, malunion, or nonunion. Dang and Couglin (2020) reported a postoperative success rate following mallet toe surgery of 86%; dissatisfaction was attributed to toe misalignment following surgery.[9]

The clinical benefits of using these criteria for hammertoe, claw toe, or mallet toe surgical treatment with or without fusion may include:

- Improved patient selection and ensuring timely and appropriate access to manage toe deformities. Shirzad et al. (2011) report good outcomes with distal interphalangeal (DIP) joint resection, arthroplasty, or fusion, with 97% of patients reporting satisfactory pain relief.[1] In addition, reduced complications and adverse effects from unnecessary procedures are reported.

Medical Evidence

Bobrov et al. (2024) performed a prospective cohort study to evaluate surgical procedures in patients with severe instability of lesser metatarsal joints as well as to analyze the efficacy of the combined triple Weil osteotomy and plantar plate repair. The 113 patients (117 feet) were assigned to groups - the first group had Weil osteotomy with plantar plate repair, while the second group had combined Weil osteotomy and proximal interphalangeal joint K-wire arthrodesis. Group 1 demonstrated improved American Orthopedic Foot and Ankle Society (AOFAS) scores, reduced pain, and eliminated hyperkeratosis in 84.7% of study participants. Group 2 also demonstrated an improvement of 52.4%. The authors concluded that Weil osteotomy with plantar plate repair demonstrated greater results.[10]

de Jesús et al. (2024) conducted a systematic review on surgical procedures for claw toe deformity to improve foot mechanics. Kinematic evaluation methods were also explored. Sixteen articles were reviewed that related to arthrodesis of the proximal and distal interphalangeal joints; plantar plate tenodesis and release of collateral ligaments; tendon transfer; flexor digitorum brevis tenotomy and a proximal interphalangeal joint arthrolysis; and partial phalanx osteotomy to treat claw toe deformity. Findings include[11]:

- StayFuse™ device for interphalangeal joint arthrodesis to maintain proximal interphalangeal joint (PIPJ) alignment;
- Radiolucent and nitinol intramedullary implants for arthrodesis to minimize deformity of the PIPJ;
- The Stainsby procedure has proven safety and efficacy for claw toe deformities;
- Cobb–Stainsby arthroplasty had high rates of patient satisfaction.

Additional studies are needed that focus on postoperative effects, including the structural mechanics of the foot (e.g., stability, plantar pressure distribution, foot mechanics, gait, etc.).[11]

Baker et al. (2022) performed a systematic review and meta-analysis on the treatment of lesser metatarsophalangeal (MTP) joint instability with plantar plate repair. While there are several surgical options, a direct dorsal approach to repair the plantar plate is preferred. Twelve studies that included 537 plantar plate tears were analyzed with respect to postoperative Visual Analogue Scale (VAS) pain and AOFAS scores. At 2-year follow-up, patients who underwent a direct dorsal approach reported improved pain levels. The authors noted that research with long-term comparison groups is needed to address successful patient outcomes further.[12]

Mizel and Yodlowski (1995) discuss disorders of the lesser metatarso-phalangeal joints, including claw toe, hammer toe, plantar keratosis, Freiberg's infraction ,and cock-up fifth toe. Claw toe often results from hyperextension at the metatarsophalangeal joint with flexion deformities at the interphalangeal joints. Along with hammer toe, these conditions are usually acquired and progressive, often involving multiple toes. Freiberg's infraction patients present with pain at the metatarsophalangeal (MTP) joint that is usually exacerbated by activity. Magnetic resonance imaging results often appear as suspected avascular necrosis.[13]

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Clinical Guideline Revision History/Information

Original Date: May 24, 2024		
Review History		
Version 2	06/10/2024	422.101 Disclaimer added
Version 3	05/22/2025	Annual review. Added indication for ankylosis of distal interphalangeal or (DIP). Added indication for adventitious bursa on the hammertoe. Added indication for painful nail conditions secondary to persistent trauma. Added indication for the presence of co-existing or causative conditions (e.g., tendon contracture) that need repair. Literature review - Medical Evidence section updated (Bobrov et al., 2024; de Jesús et al., 2024; Baker et al., 2022).