Cohere Medicare Advantage Policy - Bunionette Surgical Treatments

Clinical Policy for Medical Necessity Review

Version: 3
Revision Date: June 26, 2025

Important Notices

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Other Notices:

Policy Information:

Specialty Area: Disorders of the Musculoskeletal System
Policy Name: Cohere Medicare Advantage Policy - Bunionette Surgical Treatments
Type: [**X**] Adult (18+ years of age) | [**X**] Pediatric (0-17 years of age)

Table of Contents

Medical Necessity Criteria

Service: Bunionette Surgical Treatments

Related CMS Documents

Please refer to the CMS Medicare Coverage Database for the most current applicable CMS National Coverage.

- There are no applicable NCDs or LCDs for bunionette surgical treatments.

Description

Bunionette (or tailor's bunion) is a deformity of the fifth metatarsal bone where the little toe meets the metatarsal head, in which the fifth metatarsal head projects laterally. The bony bump may cause pain, swelling, and difficulty wearing shoes. During a bunionette surgical procedure, the doctor may remove part of the bone, realign the bone of the little toe, or both. Small screws or pins may be used to hold the bone in the new position while it heals. This surgery aims to correct the deformity, reduce pain, and improve function.[1–4]

Medical Necessity Criteria

Indications

Bunionette surgical treatments are considered appropriate if **ALL** of the following are **TRUE**:

- The patient has **ANY** of the following positive exam findings[3-8]:
  - Pain and swelling at the site of the lateral prominence of the fifth metatarsal head; **OR**
  - Lateral callus formation; **AND**
- Failure of conservative management for greater than 3 months, including **ALL** of the following[3-8]:
  - Anti-inflammatory medications, non-opioid analgesics, or prescription medications (e.g., oral steroids, neuropathic pain medications) if not contraindicated; **AND**
  - Shoe modifications; **AND**

    - Padding or callus shaving; **AND**
- Radiographic confirmation of **ANY** of the following[3,5]:
    - Bony prominence of the fifth metatarsal head; **OR**
    - Fourth/fifth intermetatarsal (IM) angle greater than 9°; **OR**
    - Fifth metatarsophalangeal (MTP) angle greater than 15°; **OR**
    - Congenital bowing.

Non-Indications

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

- Inadequate blood supply that could prevent healing[9]; **OR**
- Presence of active or untreated infection at the surgical site (may be necessary for a diabetic ulcer correction).[10]

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

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's 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 may include:

- Adverse effects from delayed or denied treatment, such as progression of foot deformities, functional limitations, worsening pain, and reduced mobility. These deformities can progress to transfer metatarsalgia, recurrence, wound complications, significant pain, and disability, often necessitating more complex interventions in the future.[1]

The clinical benefits of using these criteria include:

- Improved patient outcomes for bunionette surgical treatments, resulting in better long-term outcomes. In a systematic review of 28 studies, Martijn et al. reported overall success rates of 100% for proximal osteotomies and 92% for both distal and diaphyseal osteotomies.[2]
- Maintenance of rigorous patient safety standards aligned to best available evidence. For example, patients with inadequate blood supply that would prevent healing who undergo surgical treatments of the toe or foot are at risk for wound hypoxia and possible limb loss due to limited blood flow.[9] Also, patients with an active, untreated infection at the surgical site who undergo surgical treatments of the toe or foot are at risk for deep infection resulting in nonunion, limb loss, and increased mortality.[10,11]
- Appropriate allocation of healthcare resources at the individual beneficiary and population levels.

Medical Evidence

Cooper et al. (2023) performed a systematic literature review regarding the success rate of nonsurgical treatment of symptomatic bunionettes. These treatments include shoe wear modification, conservative treatment, and padding. Corticosteroid injections were shown in studies to have positive effects for up to two years. Metatarsal head resection is typically reserved 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.[12]

A systematic literature review and meta-analysis (Coll and Beech, 2021) looked at four retrospective case series published between 2000 and 2021, which reported outcomes for 68 procedures. Across all studies, scarf osteotomy showed statistically significant improvements in radiographic measurements (e.g., reduction in the fourth/fifth intermetatarsal angle) and in clinical outcomes (e.g., improved pain relief and patient function, measured by the AOFAS [American Orthopaedic Foot & Ankle Society] score). Surgical techniques were fairly consistent across studies and typically involved shifting and fixing the bone to correct the deformity, with most patients able to bear weight shortly after surgery. However, there was variation in post-operative protocols, and the ideal timeline for weight-bearing remains undefined. Despite positive clinical outcomes, the included studies were rated low quality due to their nature (case series), small sample sizes, inconsistent follow-up, and potential bias, as assessed by the Coleman Methodology Score and the Cochrane risk of bias tool.[3]

Nunes et al. (2020) conducted a retrospective case series of 18 patients who underwent bunionette percutaneous surgical treatment. The primary outcomes measured were functional outcomes and pain levels using the American Orthopaedic Foot and Ankle Society (AOFAS) scale and the visual analogue pain scale (VAS) preoperatively and at the last follow-up. Secondary outcomes included complications, time to radiographic consolidation, and satisfaction rate. Authors reported that AOFAS scores increased from 49.6 to 92.4 and the VAS decreased from 7.7 to 1.2. A common

complication reported was the formation of a hypertrophic bone callus in the third postoperative month in three operated feet. Overall, it was concluded that percutaneous osteotomy of the fifth metatarsal without the use of hardware is a safe, reproducible technique and presents good clinical and radiographic results for the treatment of bunionette.[8]

Martijn et al. (2018) performed a systematic literature review and meta-analysis to determine which type of fifth metatarsal osteotomy offers the best correction for bunionette deformities while minimizing complications and maximizing patient satisfaction. The study reviewed 28 clinical studies, covering 733 feet treated with different types of osteotomies (proximal, diaphyseal, or distal). All three types of osteotomies significantly improved the intermetatarsal angle (IMA) and metatarsophalangeal angle (MPA) and achieved generally high patient satisfaction. Proximal osteotomies achieved the greatest corrections in both angles but also had the highest rate of complications. Diaphyseal osteotomies offered good angle correction but had the highest revision surgery rates. Distal osteotomies, while correcting the deformity less dramatically, had the fewest complications and were the most frequently used in the included studies. The authors noted significant heterogeneity across the studies in surgical technique and reporting quality. While all osteotomy types can effectively correct bunionette deformities, the choice should depend on the severity of the deformity and the patient's risk tolerance.[2]

References

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Clinical Guideline Revision History/Information

Original Date: May 24, 2024		
Review History		
Version 2	06/12/2024	422.101 Disclaimer added
Version 3	06/26/2025	Annual review. No changes to procedure codes. Updated conservative care language to include 3 months of: anti-inflammatory medications, non-opioid analgesics, or prescription medications; shoe modifications; and padding or callus shaving." Added "congenital bowing" to one of the possible radiographic findings. Removed "the patient must have reached skeletal maturity" from the non-indications.

		Literature review - Description, Harms and Benefits, and Medical Evidence section updated (including references).