



Cohere Medical Policy – Bunionette Surgical Treatments

Clinical Policy for Medical Necessity Review

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Important Notices

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Policy Information:

Specialty Area: Musculoskeletal Care

Policy Name: Cohere Medical Policy - Bunionette Surgical Treatments

Type: ☒ Adult (18+ yo) | ☒ Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Bunionette Surgical Treatments

Cohere Health takes an evidence-based approach to reviewing imaging and procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity.

Documentation must include a recent and detailed history, physical examination related to the onset or change in symptoms, relevant lab results, prior imaging, and details of previous treatments. Advanced imaging or procedures should be requested after a clinical evaluation by the treating provider, which may include referral to a specialist.

- When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations, unless otherwise directed by the health plan.
- Requests submitted without clinical documentation, or those that do not align with the provided clinical information—such as mismatched procedure, laterality, body part, or CPT code—may be denied for lack of medical necessity due to insufficient or inconsistent clinical information.
- When there are multiple diagnostic or therapeutic procedures requested simultaneously or within the past three months, each will be reviewed independently. Clinical documentation must clearly justify all of the following:
 - The medical necessity of each individual request
 - Why prior imaging or procedures were inconclusive, or why additional/follow-up studies are needed
 - How the results will impact patient management or treatment decisions
- Requests involving adjacent or contiguous body parts may be considered not medically necessary if the documentation demonstrates that the patient's primary symptoms can be adequately assessed with a single study or procedure.

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. 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 findings³⁻⁹:
 - 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 following³⁻⁹:
 - 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 degrees; **OR**
 - Fifth MTP angle greater than 15 degrees; **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 healing¹⁰; **OR**
- Presence of active or untreated infection at the surgical site (may be necessary for a diabetic ulcer correction).¹¹

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

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 postoperative 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

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 on the surgical technique to be used and on the perioperative protocol.⁴

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

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 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. Minimally invasive surgical techniques have increased in popularity in recent years, with positive study outcomes.¹²

Thomas et al. (2009) developed a Clinical Practice Guideline for the American College of Foot and Ankle Surgeons for the 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 the potential for plantar plate pathology.⁵

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Policy Revision History/Information

Original Date: April 12, 2024		
Review History		
Version 2	09/20/2024	Updated language regarding conservative treatment.
Version 3	07/24/2025	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. Reference added to support bunionette surgical treatments in pediatric and adolescent populations.