



Hammertoe, Claw Toe, or Mallet Toe Surgical Treatment with or without Fusion – Single Service

Clinical Guidelines for Medical Necessity Review

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Important Notices

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Guideline Information:

Specialty Area: Diseases & Disorders of the Musculoskeletal System

Guideline Name: Hammertoe, Claw Toe, or Mallet Toe Surgical Treatment with or without Fusion (Single Service)

Literature review current through: 4/5/2024

Document last updated: 4/12/2024

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

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Medical Necessity Criteria

Service: Hammertoe, Claw Toe, or Mallet Toe Surgical Treatment with or without Fusion

General Guidelines

- **Units, Frequency, & Duration:** None
- **Criteria for Subsequent Requests:** None
- **Recommended Clinical Approach:** Surgery may be appropriate for a hammertoe, claw toe, or mallet toe deformity that is not alleviated by conservative management. Surgical treatment may consist of arthrodesis, arthroplasty, amputation, or tendon release/transfer. Surgical repair for cosmetic purposes only is not recommended.¹⁻³
- **Exclusions:** None.

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**:

- ◆ Radiographic confirmation of hammertoe or mallet toe deformity³; **AND**
- ◆ The patient has **ANY** of the following clinical presentations or positive findings:
 - Pain; **OR**
 - Difficulty walking; **OR**
 - The toe bends downwards or appears clawlike; **OR**
 - Balance may be affected; **OR**
 - Inability to flex or wiggle toes; **OR**
 - Callosities on toe; **OR**
 - Crossing over of lesser toes; **AND**
- ◆ The patient has failed to show significant improvement in pain or disability due to symptoms despite conservative treatment for at least 3 months with **ALL** of the following¹⁻³:
 - Trial of **ANY** of the following:
 - Taping; **OR**
 - Splinting; **OR**

- Toe spacer; **OR**
- Toe sleeve; **OR**
- Padding; **AND**
- Shoe modifications⁴; **AND**
- Oral steroids, anti-inflammatory medications, or analgesics; **AND**
- **ANY** of the following:
 - Corticosteroid injection if medically appropriate; **OR**
 - Corticosteroid injection is contraindicated; **AND**
- ◆ The patient has **ANY** of the following⁵:
 - Bursitis; **OR**
 - Ankylosis of PIP or DIP; **OR**
 - Interdigital neuroma from the deformity; **OR**
 - Lateral MTP capsular tear caused by the deformity; **OR**
 - Subluxation or dislocation of the MTP joint from the deformity; **OR**
 - MTP plantar plate tear; **OR**
 - Synovitis/capsulitis of the MTP joint; **OR**
 - Ulceration at the apex of the deformity.

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**:

- ◆ There is poor circulation; **OR**
- ◆ The patient has an active, uncontrolled infection (does not apply to chronic infections that are managed).

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.

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 metatarsophalangeal joint drawer test assists in confirming sagittal and transverse instability and potential for plantar plate pathology.¹

Shirzad and colleagues performed a systematic review of the literature in 2011 regarding lesser toe deformities. The group stated that in mallet toe, good results had been reported with distal interphalangeal (DIP) joint resection arthroplasty or fusion with a 72% fusion rate in one study of 50 patients with 97% of patients reporting satisfactory pain relief. Flexor digitorum longus (FDL) tendon transfer study patients reported 90% satisfaction in correction of MTP joint instability or subluxation. Other studies in this area reported complete correction of subluxation in only 54% of patients, and in the largest published series of FDL tendon transfers, 34 of 38 patients were satisfied with the procedure. In proximal interphalangeal resection arthroplasty, fusion rates of 81 to 100% were reported, with additional studies reporting high success rates.²

Mizel and Yodlowski (1995) discuss disorders of the lesser metatarsophalangeal joints including, claw toe, hammer toe, plantar keratoses, 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.³

References

1. Thomas JL, Blitch EL, Chaney DM, et al. Diagnosis and treatment of forefoot disorders. Section 1: digital deformities. *J Foot Ankle Surg.* 2009;48(3):418.e1-418.e4189.
2. Shirzad, Khalid MD; Kiesau, Carter D. MD; DeOrio, James K. MD; Parekh, Selene G. MD, MBA. Lesser Toe Deformities. *American Academy of Orthopaedic Surgeon* 19(8):p 505-514, August 2011.
3. American College of Foot and Ankle Surgeons (ACFAS). ACFAS position statement on cosmetic surgery. <https://www.acfas.org>. Published February 2004. Updated February 2020.
4. Murphy GA. Lesser toe abnormalities. In: Azar, F, Beatty JH. *Campbell's Operative Orthopaedics*. 14th ed. Elsevier; 2021:4227-4283.e3.
5. Mizel MS, Yodlowski, ML. Disorders of the Lesser Metatarsophalangeal Joints. *Journal of the American Academy of Orthopaedic Surgeons* 3(3):p 166-173, May 1995.

Clinical Guideline Revision History/Information

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Review History	