Medical Policy:
Foot Surgery-Bunion/Hammertoe/
Metatarsophalangeal Joint
(Commercial)

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<th>POLICY NUMBER</th>
<th>EFFECTIVE DATE</th>
<th>APPROVED BY</th>
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<td>01/01/2020</td>
<td>MPC (Medical Policy Committee)</td>
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**Related Medical Guideline**
Cosmetic Surgery Procedures

**Definitions**

| Hallux valgus (HV) deformity (aka bunion) | Painful bony bump that develops on the inside of the foot at the big toe joint. Pressure on the joint causes the big toe to lean toward the second toe. Over time, the normal structure of the bone changes, resulting in the bunion bump. The deformity gradually increases causing pain when wearing shoes and walking. |
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#### Foot Surgery-Bunion/Hammertoe/Metatarsophalangeal Joint(Commercial)

<table>
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<tr>
<th>Condition</th>
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<td>Hallux rigidus (aka stiff big toe)</td>
<td>A deformity in the joint located at the base of the big toe. It causes pain and stiffness in the big toe and, over time, bending the toe becomes more and more difficult. This condition can cause discomfort and even disability, since this important toe is used to walk, lean, climb and even stand. Hallux Rigidus is a progressive condition in which foot mobility decreases over time. In its primary phases, the mobility of the big toe is only somewhat limited (&quot;Hallux Limitus&quot;); however, with progression, the range of motion of the toe decreases until it reaches the final state of &quot;Rigidus,&quot; which is when the toe remains stiff or as &quot;frozen.&quot;</td>
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<tr>
<td>Bunionette (tailor’s bunion)</td>
<td>Painful bony prominences that occur over the lateral aspect of the fifth (little toe) metatarsophalangeal (MTP) joint</td>
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<td>Hammertoe</td>
<td>A contracture (bending) deformity of one or both joints of the second, third, fourth, or fifth (little) toes. This abnormal bending can put pressure on the toe when wearing shoes, causing problems to develop. Hammertoes usually start out as mild deformities and get progressively worse over time. In the earlier stages, hammertoes are flexible, and the symptoms can often be managed with noninvasive measures. But if left untreated, hammertoes can become more rigid and will not respond to nonsurgical treatment.</td>
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### Guideline

A. **Bunionectomy**

B. **Hammertoe Repair**

C. **Metatarsophalangeal Joint Surgical Correction**

D. **Metatarsophalangeal Joint Replacement**

A. **Bunionectomy (Bunionette, Simple and Bony Correction)**

**General Criteria**

1. Skeletal maturity
2. Symptoms of pain and walking difficulty unresponsive to ≥ 6 months of conservative therapy (≥ 2 must be applicable):
   a. Change in footwear
   b. Padding or orthotics (shoe inserts)
   c. Nonsteroidal anti-inflammatory drugs (NSAIDS)
   d. Local injections to the first metatarsophalangeal joint (e.g., local anesthesia or steroid)

**Bunionette**

Considered medically necessary when the General Criteria above are met with radiologic imaging confirmation of a MTP joint of at least 16 degrees and an Intermetatarsal angle (IMA) of at least 10 degrees

**Simple Bunionectomy (e.g., modified McBride, Silver Procedure)**

Considered medically necessary when the **General Criteria** above are met with radiologic imaging confirmation of a hallux valgus angle (HVA) of at least 15 degrees and one:
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1. Presence of diabetes and ulcers or infection originating from the bunion
2. Foot pain limiting everyday activity (walking, wearing reasonable shoes)
3. Chronic big toe inflammation and swelling that does not improve with rest and medications
4. Toe deformity that causes drifting in of the big toe toward smaller toes
5. Toe stiffness that causes inability to bend and straighten the big toe

**Bony Correction Bunionectomy (e.g., Akin, Chevron, Keller, Lapidus, Mitchell, proximal metatarsal osteotomy procedures, etc.)**
Considered medically necessary when the General Criteria above are met and both:
1. Radiologic imaging confirmation of a hallux valgus angle (HVA) of at least 30 degrees
2. Intermetatarsal angle (IMA) of at least 13 degrees and one:
   i. Significant foot pain that limits everyday activities (walking, wearing reasonable shoes)
   ii. Chronic big toe inflammation and swelling that does not improve with rest or medications
   iii. Toe deformity that causes a drifting in of the big toe toward smaller toes
   iv. Toe stiffness that causes inability to bend and straighten the big toe

**Limitations/Exclusions**
A bilateral bunionectomy done at the same time generally not considered medically necessary unless extenuating circumstances are present
Bony correction bunionectomy is considered experimental, investigational or unproven for all of the following:
- Foot ulcer(s) secondary to peripheral vascular disease
- Gangrene of the foot, ankle or lower leg
- Non-ambulatory members (unless surgery is to relieve ulceration due to prominence)
- Open blisters, pressure sores, and skin ulceration overlying the bunion when the bunion is not the cause of the skin lesion (bony correction may lead to osteomyelitis)
- Poor tissues at the operative site due to excessive scarring and multiple closely placed previous incisions
- Severe vascular insufficiency significantly impairing foot-circulation (e.g., absent foot pulses, intermittent claudication, ankle/arm ratio < 0.6)
- Cosmetic appearance of the foot

**B. Hammertoe Repair (i.e., surgical correction of hammertoe, claw toe, or mallet toe)**
Hammertoe repair is considered medically necessary for members ≥ 18 years of age (or skeletally mature) when ≥ 1 of the following clinical indications is applicable:
1. Adventitious bursitis on the dorsal surface of the hammertoe
2. Ankylosis of the distal interphalangeal (DIP) joint or proximal interphalangeal (PIP) joint
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3. Inter-digital neuroma caused by the deformity
4. Lateral metatarsophalangeal (MTP) capsular tear caused by the deformity
5. Painful nail conditions secondary to persistent trauma
6. Presence of co-existing or causative conditions (e.g., tendon contracture) that need repair
7. Subluxation or dislocation of the MTP joint
8. Synovitis/capsulitis of the MTP joint
9. Ulceration of the apices

Documentation should detail all:

1. Radiographic confirmation of deformity (i.e., interpretation and report of anterior/posterior and lateral views of the affected foot)
2. Skeletal maturity (epiphyseal closure)
3. Symptoms unresponsive to ≥ 3 months of conservative management directed by a healthcare professional (≥ 2 must be applicable):
   i. Corticosteroid injections
   ii. Debridement of associated hyperkeratotic lesions (e.g., corns, calluses)
   iii. Foot orthotics (e.g., adaptive footwear such as shoe inserts, footgear modifications, corrective splinting)/orthopedic shoes (i.e., wide/deep toe box) (Note: benefit exclusions may apply)
   iv. Oral analgesics and/or nonsteroidal anti-inflammatory drugs (NSAIDs)
   v. Protective padding
   vi. Taping or adhesive devices

Repeat hammer toe surgery is considered medically necessary following failure of a previous surgical procedure.

Limitations/Exclusions
Fixation implants are considered experimental, investigational or unproven (e.g., Acumed Hammertoe Fusion Set, BME Hammerlock Implant, CannuLink Intramedullary Fusion Device, CrossTie Intraosseous Fixation System, Futura Flexible Digital Implant, Futura LMP Lesser Phalangeal Joint Implant, HammerFix IP Fusion System, Integra Hammertoe Implant, OsteoMed Interflex IPG System, Pro-Toe Hammertoe Implant, Smart Toe, StayFuse Fusion Device, ToeGrip Device, Two-Step Hammer Toe Implant, th Weil-Carver Hammertoe Implant and the Wright Cann Phalinx System)

C. Metatarsophalangeal (MTP) Joint — Surgical Correction
Surgical correction (e.g., arthrodesis, cheilectomy, Keller procedure [resection arthroplasty]) of the first MTP joint (e.g., hallux rigidus) is considered medically necessary in skeletally mature members with osteoarthritis (OA).

Documentation should detail all:
1. Skeletal maturity (epiphyseal closure)
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2. Radiologic confirmation of OA as evidenced by any:
   i. Cysts in the metatarsal head
   ii. Loss of cartilage between bones
   iii. Mild to moderate bony proliferative pathology

3. Symptoms unresponsive to ≥ 6 months of conservative management directed by a healthcare professional (≥ 2 must be applicable):
   i. Alternative or modified footwear
   ii. Corticosteroid injections
   iii. Debridement of associated hyperkeratotic lesions (e.g., corns, calluses)
   iv. Foot orthotics (e.g., adaptive footwear such as shoe inserts, footwear modifications, corrective splinting) (Note: benefit exclusions may apply)
   v. Oral analgesics or nonsteroidal anti-inflammatory drugs (NSAIDS)
   vi. Protective cushions/pads
   vii. Taping or adhesive devices

D. Metatarsophalangeal (MTP) Joint — Replacement

Partial or total replacement of the first MTP (hallux rigidus) joint is considered medically necessary for disabling arthritis by either hemiarthroplasty or total prosthetic replacement arthroplasty with silastic or metallic implants.

Limitations/Exclusions

The following services are considered experimental, investigational or unproven:

- MTP joint replacement for joints other than the first MTP joint
- Ceramic implants (e.g., Moje prosthesis)
- Synthetic implants (e.g., Arthrex metatarsal phalangeal joint implant, Cartiva Synthetic Cartilage Implant, METIS prosthesis, OsteoMed ReFlexion 1st MTP Implant System and the ToeFit-Plus prosthesis)
- Interpositional arthroplasty with biologic spacers for hallux rigidus, degenerative arthritis, and other indications involving the MTP joints

Applicable Coding

To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy

Applicable CPT and Diagnosis Codes

References


Gazdag A, Cracchiolo A. Surgical treatment of patients with painful instability of the second metatarsophalangeal joint. Foot Ankle Int. 1998;19:137-143.


Alvine F, Garvin KL. Peg and dowel fusion of the proximal interphalangeal joint. Foot Ankle. 1980;1:90-94.


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Baumhauer JF, Singh D, Glazebrook M, et al; for and on behalf of the Cartiva MOTION Study Group. Correlation of hallux rigidus grade with motion, VAS pain, intraoperative cartilage loss, and treatment...
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Specialty-matched clinical peer review.

Revision history

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