Molina Clinical Policy
Foot Surgery: Lesser Toe Deformities (Hammer, Mallet, Claw Toe)
Policy No. 702

Last Approval: 02/12/2025
Next Review Due By: February 2026

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

This policy addresses the surgical treatment of lesser toe deformities (hammer toe, claw toe, and mallet toe) and applies to all three deformities, as their etiologies and treatments are similar.

A **hammertoe** is defined as a deformity in which the proximal interphalangeal joint (PIP) is in a flexed position. A **claw toe** deformity involves flexion at the PIP and distal interphalangeal joints (DIP) while the metatarsophalangeal (MTP) joint is in a neutral or extended position. A **mallet toe** involves only the DIP, which is in a flexed position (Malhotra et al. 2016).

Hammertoe, one of the most common forefoot deformities, is a deformity of the second, third, or fourth toes in which a flexion deformity develops at the PIP joint and causes the toe tip to be depressed downward (Mueller et al. 2018). The two types of hammertoes are flexible and rigid hammertoe. Flexible hammertoe is defined as hammertoe where the MTP (the first joint that connects the toe to the foot), PIP (the second joint that connects the toe to the foot), and the DIP joint (the last joint that connects the toe to the foot) can be returned to a neutral position with active manipulation or ankle plantar flexion. Rigid hammertoe is where the MTP, PIP, and DIP joints cannot be returned to a neutral position with active manipulation. Initially, a hammer toe is flexible, but if left untreated, it may become rigid. Treatments must address and evaluate the deformity at all joints of the affected digit including the PIP joint, MTP joint, and DIP joint (Goransson & Constant 2023).

Nonsurgical treatment options include wider-toed shoes, toe sleeves, padding, splints, taping, and orthotics. These modifications can be beneficial for managing forefoot disorders, however, none of these techniques are permanent solutions to the deformity and pain may persist with worsening deformity. Surgical intervention should be considered if functionality and pain do not improve. The goal of surgical treatment is to improve symptoms by restoring alignment and function and avoiding recurrence. The type of surgical treatment for a toe deformity is determined by the flexibility and severity of the deformity, as well as any associated pathology. Correction of both flexible and rigid deformities may necessitate single or multiple procedures. Flexible deformities are amenable to soft-tissue procedures, whereas rigid deformities require at least a component of the bony intervention.

1. **Flexible hammertoe** frequently requires a combination of soft tissue and bony procedures to achieve a satisfactory correction of the deformity. Surgical options include for flexible hammertoe include:
    - *Flexor tenotomy (tendon lengthening)* involves a small incision to release the tendon, allowing the toe to extend fully.
    - *Tendon transfer* involves a tendon on the bottom of the toe that is rerouted over the bent part of the toe, pulling it down into a straighter position.

2. **Rigid hammertoe** (cannot be treated with tenotomy or tendon transfer) requires PIP joint resection arthroplasty or PIP joint arthrodesis:
    - *PIP joint arthroplasty,* a common procedure for rigid hammertoes, is the surgical reconstruction or replacement of a painful, damaged joint due to degeneration (e.g., arthritis), trauma, or deformity. The end of one of the bones is removed to make room for the toe to straighten, followed by a pin or plate to stabilize

the bones while they heal. Arthroplasty at the DIP or PIP joint includes resection of half of the articular surface of the joint. This procedure may be performed with flexor tenotomy for flexible or semirigid deformities; however, flexor tenotomy is contraindicated as the sole procedure for rigid hammertoe deformities. A non-reducible, rigid hammertoe deformity is an osseous problem that requires more than just a tenotomy.

- *PIP joint arthrodesis,* or joint fusion surgery, is like arthroplasty in that both ends of the bones in the toe joint are cut and held together with a pin, allowing them to fuse together as they heal. Arthrodesis relieves joint pain and restores joint stability; however, joint motion is lost during the procedure.

RELATED POLICIES

MCP-700: Foot Surgery: Bunionectomy
MCP-701: Foot Surgery: Hallux Rigidus

COVERAGE POLICY

Surgical correction of a lesser toe deformity (hammertoe, claw toe, or mallet toe) OR repeat hammertoe surgical treatment due to documented failure of previous surgical procedure may be **considered medically necessary** when ALL the following criteria are met:

1. Member is ≥ 18 years old, or has documented evidence of skeletal maturity

2. Diagnosis of ONE of the following lesser toe deformities:
   a. **Hammertoe** based on ALL the following:
      i. Flexion deformity at proximal interphalangeal joint (PIP) joint
      ii. Normal or dorsiflexion at metatarsophalangeal (MTP) joint
      iii. Nonreducible deformity at PIP joint
   b. **Claw Toe** based on ALL the following:
      i. Plantarflexion at distal interphalangeal (DIP) joint
      ii. Dorsiflexion at MTP joint
      iii. Plantarflexion at PIP joint
      iv. Nonreducible deformity at PIP joint
   c. **Mallet Toe** based on ALL the following:
      i. Flexion deformity at DIP joint
      ii. Nonreducible deformity at DIP joint

3. Radiographic confirmation and interpretation of the affected foot (anterior/posterior and lateral views), indicating at least ONE of the following imaging findings:
   a. Flexion deformity at proximal interphalangeal (PIP) joint
   b. Joint subluxation or dislocation
   c. Joint space narrowing

4. Documentation of clinically significant symptoms resulting in persistent pain and functional limitation despite at least 6 months of conservative treatment, including but not limited to the following:
   a. Alternative or modified footwear (e.g., accommodative shoe with wide toe box and low heels)
   b. Protective cushions, taping, or adhesive devices or foot orthotics
   c. Oral medication (e.g., acetaminophen, NSAID) or corticosteroid injections
   d. Debridement or trimming of hyperkeratotic lesions (e.g., calluses)

5. Documentation of ANY of the following signs/symptoms directly attributable to a lesser toe deformity:
   a. Adventitious bursa on the lesser toe deformity
   b. Ankyloses of the DIP joint or PIP joint
   c. Interdigital neuroma caused by the deformity

d. Lateral MTP capsular tear caused by the deformity
e. Subluxation or dislocation of the MTP joint caused by the deformity
f. Synovitis/capsulitis of the MTP joint
g. Ulceration or skin breakdown caused by the deformity

6. Absence of ALL the following contraindications:
   a. Active infection of the foot or joint, unless correction of lesser toe deformity is necessary for found management (e.g., nonhealing ulcer over the medial prominence)
   b. Severe vascular insufficiency
   c. Poor wound healing

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results, and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Randomized Controlled Trials

Scheidt et al. (2022) conducted a randomized controlled trial to compare outcomes after lesser toe deformity correction with either proximal interphalangeal (PIP) joint arthrodesis or PIP joint resection arthroplasty. Thirty-seven patients (48 toes) were included in the study. The American Orthopedic Foot and Ankle Society score (AOFAS) osseous consolidation, pain measured by the visual analog scale (VAS), and other clinical outcomes were measured preoperatively and at 6 weeks and 6 months postoperative. At 6 months postoperative osseous consolidation was significantly higher for the arthrodesis group ($p = 0.001$). Pain was 0 for both the arthroplasty and the arthrodesis group at 6 months ($p = 0.669$) at 6 months postoperative. The AOFAS score was 83 and 80 for the arthroplasty and arthrodesis group, respectively ($p = 0.879$). Overall, both the PIP joint arthrodesis and PIP joint resection arthroplasty showed significant improvement at 6 months postoperatively with no differences in clinical outcomes.

Schrier et al. (2016) conducted a randomized controlled trial comparing proximal interphalangeal joint (PIPJ) resection and fusion to determine which provides superior clinical outcomes. The study included 55 patients (89 toes), with 26 patients (39 toes) in the resection group and 29 patients (50 toes) in the fusion group. Additional metatarsophalangeal joint (MTPJ) releases were performed when necessary. The study evaluated outcomes using the American Orthopaedic Foot & Ankle Society scale, the Foot Function Index subdivided into the pain subscale (section B) and activity limitation subscale (section C), and pain assessed via the visual analog scale. The results showed no significant differences between the groups in scores from 3 to 12 months post-operation (AOFAS, $p = 0.46$; FFI pain subscale, $p = 0.25$; FFI activity limitation subscale, $p = 0.90$; visual analog scale, $p = 0.71$). Complications, such as floating toes, malalignment, infection, and pseudarthrosis, occurred in both groups without significant differences in frequency. Both PIPJ resection and fusion produced comparable and favorable outcomes for pain and activity levels.

National/Specialty Organizations

The **American Orthopedic Foot & Ankle Society (AOFAS 2021)** issued the following recommendation on avoiding surgery for bunion or hammertoes:

"Foot surgery for cosmetic reasons is not supported by medical research. Symptoms such as pain and limitations of activity are the most common reasons to pursue bunion or hammertoe surgery. Patients having surgery for bunions and hammertoes are at risk for a wide range of complications such as nerve damage, infection, bone healing problems, and toe stiffness."

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
28285	Correction, hammertoe (e.g., interphalangeal fusion, partial or total phalangectomy)
28286	Correction, cock-up fifth toe, with plastic skin closure (e.g., Ruiz-Mora type procedure)
28010	Tenotomy, percutaneous, toe; single tendon
28011	Tenotomy, percutaneous, toe; multiple tendons
28232	Tenotomy, open, tendon flexor; toe, single tendon (separate procedure)
28234	Tenotomy, open, extensor, foot or toe, each tendon

HCPCS (Healthcare Common Procedure Coding System)

Code	Description
L8641	Metatarsal joint implant

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

02/12/2025 Policy reviewed. Clarified clinical indications by reorganizing criteria and removing E/I/U indications. Updated Summary of Medical Evidence and References. IRO Peer Review on January 2, 2025, by a practicing physician board-certified in Orthopedic Surgery.
04/10/2024 Policy reviewed, no changes to criteria. Updated Summary of Medical Evidence and References.
04/13/2023 New policy, replaces MCP-401: Foot Surgery. IRO Peer Review March 29, 2023, by a practicing, board-certified physician in Orthopedic Surgery.

REFERENCES

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2. Centers for Medicare and Medicaid Services (CMS). Medicare coverage database. Accessed December 14, 2024. https://www.cms.gov/medicare-coverage-database/search.aspx
3. Goransson M, Constant D. Hammertoe. [Updated 2023 May 23]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK559268/.
4. Malhotra K, Davda K, Singh D. The pathology and management of lesser toe deformities. EFORT Open Rev. 2016 Nov;1(11):409-419.
5. Mueller CM, Boden SA, Boden AL, et al. Complication rates and short-term outcomes after operative hammertoe correction in older patients. Foot Ankle Int. 2018 Jun;39(6):681-688.
6. Scheidt S, Nowak V, Mittag F, Götze M, Wülker N, Hofmann UK. Comparison of Lesser Toe Proximal Interphalangeal Joint Arthrodesis Versus Resection Arthroplasty: A Randomized Controlled Study. Orthopedics. 2022 Mar-Apr;45(2):86-90. doi: 10.3928/01477447-20220105-08. Epub 2022 Jan 12. PMID: 35021029.
7. Schrier JC, Keijsers NL, Matricali GA, et al. Lesser Toe PIP Joint Resection Versus PIP Joint Fusion: A Randomized Clinical Trial. Foot Ankle Int. 2016 Jun;37(6):569-75. doi: 10.1177/1071100716629776. Epub 2016 Feb 3. PMID: 26843544.

APPENDIX

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

Washington

For Medicaid, there is a language around foot care in the following Washington Administrative Codes: WAC 182-531-0150: Noncovered physician-related and health care professional services—General and administrative; and WAC 182-531-1300: Foot care services for clients twenty-one years of age and older. Per the WACs, routine foot care is considered a non-covered healthcare service unless the client meets conditions and criteria outlined in WAC 182-531-1300. If criteria are needed for medical necessity review in the case that the member has a qualifying condition, this MCP can be applied as a medical necessity tool.