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

Last Approval: 02/11/2026
Next Review Due By: February 2027

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

Lesser toe deformities (e.g., hammertoe, mallet, and claw toe) can require treatment. A hammertoe is defined as a deformity in which the proximal interphalangeal joint (PIP) is in a flexed position with or without hyperextension of the metatarsophalangeal (MTP) joint but with a neutral or hyperextended distal interphalangeal (DIP) joint. A claw toe deformity involves flexion at the PIP and DIP joints while the MTP joint is in a hyperextended position. A mallet toe involves only the DIP, which is in a flexed position (Malhotra et al. 2017).

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 of the toe that connects the toe to the foot), PIP (the second joint of the toe), and the DIP joint (the last joint of the toe) 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 bony intervention. Examples of possible surgeries for lesser toe deformities include, but are not limited to, the following:

- *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.
- *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 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 surgical treatment* due to documented failure of previous surgical procedure may be **considered medically necessary** when ALL the following criteria are met with accompanying documentation:

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

2. Diagnosis of ONE of the following lesser toe deformities with radiographic confirmation and interpretation via weight-bearing anterior/posterior and lateral views of the affected foot demonstrating joint changes (e.g., joint narrowing, flexion deformity, subluxation, dislocation):
   a. **Hammertoe** based on ALL the following:
      i. Flexion deformity at proximal interphalangeal joint (PIP) joint
      ii. Normal or dorsiflexion at metatarsophalangeal (MTP) 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. **Mallet Toe** based on flexion deformity at DIP joint

3. Clinically significant symptoms resulting in persistent pain and functional limitation despite at least six (6) months of provider directed conservative treatment (e.g., alternative or modified footwear, protective cushions or taping, foot orthotics, pharmacotherapy, and/or debridement or trimming of hyperkeratotic lesions)

4. At least ONE 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

5. Documentation of adequate lower extremity vascular perfusion (e.g., strong, palpable pedal pulses)

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
Weigang et al. (2025) conducted a randomized controlled trial (RCT) to compare the outcomes of minimally invasive surgery (MIS) with open surgery (OS) in the treatment of lesser toe deformities (e.g., hammer, claw, mallet, and curly).

A total of 100 adult patients with one or more lesser toe deformities were randomized evenly between groups. Follow-up occurred at 18 months and included clinical, functional, and radiographic assessments, and patient-reported outcomes using the Foot Function Index Germany (FFI-D) and satisfaction surveys. Results showed that both surgical techniques produced similar improvements in function outcomes, measured by the FFI-D, with significant postoperative improvement in both groups (mean FFI-D reduction of 59.5 in the MIS group and 48.2 in the OS group; $p < 0.001$) and nonsignificant difference between groups. Radiographic evidence also found similar success between both groups, with 2 cases of recurrence in each group. Bone healing complications were significantly more frequent in the OS group, with the MIS group achieving 100% osseous consolidation while the OS group had 6 non-unions ($p = 0.013$) and 2 partial consolidations ($p = 0.029$). Regarding adverse events, the OS group experienced more wound healing problems (7 cases in OS vs. 1 in MIS, $p = 0.029$) and more superficial infections (5 cases in OS vs. 0 in MIS, $p = 0.023$). Wire complications differed significantly between groups ($p = 0.03$), with 4 cases of wire migration in the MIS group and 3 cases of wire deformation in the OS group. One case of transient ischemia occurred in the OS group but resolved without toe loss. Other complications such as neuropathic pain, arthrofibrosis, and shoe conflict occurred at low and similar rates between groups. Study limitations include the single-center design, relatively short follow-up duration of 18 months, and the absence of a secondary validated functional outcome measure beyond the FFI-D. The authors concluded that both MIS and OS are safe and effective treatment options for lesser toe deformities. MIS offers equivalent clinical outcomes to OS with a lower risk of short-term complications like bone and soft tissue healing.

Askø Andersen (2024) conducted RCT substudy to evaluate the effect of flexor tendon tenotomy on plantar pressure in patients with diabetic hammertoe deformities. Participants were drawn from a multicenter RCT conducted by Askø Andersen (2022), which evaluated the effects of needle flexor tendon tenotomy for treating diabetic hammertoe. The original study (n = 95) found needle tenotomy to be effective and safe for treating and preventing ulcers associated with the diabetic hammertoe deformity. In this substudy, 22 participants were randomized to flexor tendon tenotomy plus standard non-surgical care and 23 were randomized to standard non-surgical care alone (n = 45). Both flexible and rigid hammertoes were included and the median number of toes treated per participant was 5. The primary outcome was change in peak plantar pressure, which was assessed at baseline and 3 months following tenotomy. At baseline visit, the average peak plantar pressure for the toe regions of the foot was 205.6 kilopascals (kPa) for the intervention group and 187.5 kPa for the control ($p=0.95$). At the follow-up visit, the average pressure was 61.3 kPa for the intervention group and 171.3 kPa for the control ($p < 0.0001$). The authors concluded that flexor tendon tenotomy of the diabetic hammer toe significantly reduces plantar pressure, which likely explains the positive effects of tenotomy treatment on diabetic foot ulcers.

Scheidt et al. (2022) conducted a RCT 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 RCT comparing PIP joint 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 (MTP) joint releases were performed when necessary. The study evaluated outcomes using the AOFAS, the Foot Function Index (FFI) subdivided into the pain subscale (section B) and activity limitation subscale (section C), and pain assessed via the VAS. 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, $p = 0.90$; VAS, $p = 0.71$). Complications, such as floating toes, malalignment, infection, and pseudarthrosis, occurred in both groups without significant differences in frequency. Both PIP joint resection and fusion produced comparable and favorable outcomes for pain and activity levels.

Systematic Reviews and Meta-Analyses

Scott et al. (2016) performed a systematic review to evaluate the effectiveness of percutaneous flexor tenotomy for the correction of flexible claw and hammer toe for healing and preventing the recurrence of diabetic toe ulcers. The review included 5 case series for a total of 163 patients undergoing 250 flexor tenotomy procedures. The studies

generally reported high ulcer healing rates, ranging from 92 to 100% healed within 2 months. Ulcer recurrence rates ranged from 0% to 18% with a median follow-up period of 22 months. Recurrences and non-healing ulcers were more common in complex ulcer grades like Wagner Grade 2 lesions or University of Texas Grade 3B lesions, which also showed longer healing times. In general, complication rates were low with few infections or new deformities reported across studies. However, ulcers that developed on adjacent toes due to redistributed pressure, or transfer ulcers, were noted across multiple studies. For example, of the 38 tenotomies performed by Van Netten et al. (2013), 8 developed transfer ulcers that healed and did not recur. While adverse events and ulcer recurrence were low, the authors warned this should be interpreted cautiously due to deficiencies in reporting and lack of sufficient follow-up protocols. Limitations include non-randomized study designs, small sample sizes, lack of control groups, heterogeneous surgical techniques, and inconsistent follow-up protocols. The authors concluded that more definitive research is needed to determine whether flexor tenotomy is a safe and effect treatment option for people with or at risk of developing diabetic toe ulcers.

National/Specialty Organizations

The **American Orthopedic Foot & Ankle Society (AOFAS)** issued a position statement on *cosmetic foot and ankle surgery*, which was endorsed by the **American Academy of Orthopaedic Surgeons (AAOS)**. The AOFAS notes that hammertoe surgery is a common procedure for symptomatic feet that do not respond to non-operative treatment. While operative care has been shown to improve pain and function, toe surgery can lead to complications such as stiffness, swelling, persistent pain, non-union, recurrent deformity, and toe necrosis in rare cases. There is no literature to support operations in an asymptomatic foot, and the literature demonstrates only benefits for patients with pain and/or some degree of functional limitation. Furthermore, studies have shown that foot shape is a poor predictor of function, and a "distinction should be made between cosmesis as a component of surgery and cosmesis as the primary goal." Operative procedures carry inherent risks which should be carefully considered prior to embarking on potentially unnecessary surgery. The AOFAS does not recommend the practice of cosmetic foot and ankle surgery and there lacks medical evidence on the safety and efficacy of such procedures (AOFAS 2021).

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

02/11/2026 Policy revised. Replaced list of required conservative treatments with broader language to allow for provider directed management. Removed nonreducible deformity from diagnostic criteria for hammer, claw and mallet toe. Revised radiographic diagnostic criteria. Replaced general contraindications with documentation of adequate lower limb perfusion. IRO peer reviewed on January 20, 2026 by a practicing physician board certified in orthopedic surgery.

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.

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