

1 **Clinical Practice Guideline: Metatarsophalangeal and Interphalangeal Joint**
 2 **Capsulotomy**

4 **Date of Implementation: July 16, 2015**

6 **Product: Specialty**

9 GUIDELINES

10 American Specialty Health – Specialty (ASH) considers services consisting of CPT Code
 11 28270 and 28272 to be medically necessary for treatment of toe deformities **upon meeting**
 12 **ALL of the following criteria:**

- 13 1. Diagnosis of other hammer toe(s) acquired or other deformities of toe(s) (acquired)
 14 (ICD-10 codes M20.40 - M20.42 or M20.5X1 - M20.5X9) or contracture, foot
 15 (ICD-10 codes M24.574 - M24.576)
- 16 2. Must have failure of **at least 3 of the following** non- operative treatments with
 17 residual pain that limits function significantly:
 - 18 ○ Shoe modification
 - 19 ○ Orthoses/taping/splinting
 - 20 ○ Padding
 - 21 ○ Activity adjustments

22
 23 This procedure may be approved with other hammertoe procedure or release of foot
 24 contracture of involved joints in conjunction with hammertoe or by itself.

26 CPT CODES AND DESCRIPTIONS

CPT® Code	CPT® Code Description
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)
28272	Capsulotomy; interphalangeal joint, each joint (separate procedure)

28 BACKGROUND

29 Lesser toe (i.e., toes two through five) deformities are among the most common digital
 30 pathologies encountered by foot and ankle surgeons. These deformities may be either
 31 congenital or acquired, with the incidence of digital deformities greater among females
 32 than males in almost all age groups. The typical lesser toe deformities include hammer toe,
 33 claw toe, and mallet toe which may be associated with pain, stiffness, and footwear
 34 restrictions, and can often cause severe, debilitating symptoms. Hammer toe, mallet toe,
 35 crossover toe, and claw toe are technically different; however, they behave and look

1 similar. Lesser toe deformities may involve the metatarsophalangeal (MTP) or
2 interphalangeal (IP) joints of single or multiple digits.

3
4 The etiologies of lesser toe deformities include neuromuscular diseases and peripheral
5 neuropathies such as Charcot-Marie-Tooth disease, connective tissue diseases,
6 inflammatory arthritides, traumatic injuries, compartment syndrome, congenital
7 anomalies, and iatrogenic causes. Anatomic factors and constricting footwear may also
8 play a role in lesser toe deformities.

9
10 Hammertoes, claw toes, and mallet toes are common lesser toe deformities that are often
11 painful, and limit function and shoe wear selection. Hammertoe deformity primarily
12 comprises flexion contracture/deformity of the proximal interphalangeal (PIP) joint of the
13 toe, with hyperextension of the metatarsophalangeal (MTP) and distal interphalangeal
14 (DIP) joints. It is often combined with a hallux valgus deformity. Claw toe is defined by
15 flexion of both the PIP and DIP joints and hyperextension of the MTP joint, resembling a
16 claw. Claw toe represents an imbalance between the intrinsic and extrinsic muscle units
17 controlling the positioning of the toe. Mallet toe is defined by a flexion deformity at the
18 distal interphalangeal (DIP) joint. The proximal interphalangeal (PIP) joint and the MTP
19 joints are in a neutral position.

20
21 There also are separate and distinct digital deformities involving the second toe and fifth
22 toe. When an extension contracture is combined with medial deviation (subluxation) at the
23 level of the second MPJ, a “crossover” second toe deformity results. This deformity often
24 is combined with a hallux valgus deformity. Adduction or abduction digital deformities
25 may involve all lesser MTP joints or, in some cases, divergent digital contractures are seen.
26 Fifth toe pathology may include deformity in multiple planes (adductovarus deformity), or
27 significant overlap of the fifth toe over the fourth toe may be seen (Clinical Practice
28 Guideline Forefoot Disorders Panel, et al., 2009).

29
30 Nonsurgical treatment is the initial treatment choice for the symptomatic digital deformity.
31 Among the various nonsurgical treatment options, orthotic devices or shoe insole
32 modifications using a metatarsal pad may offer relief of excessive metatarsal head
33 pressures. Taping to reduce and splint flexible deformities may be performed in the setting
34 of an early crossover second toe deformity. Additionally, footwear changes such as a wider
35 and/or deeper toe box may be used to accommodate the deformity and decrease shoe
36 pressure over osseous prominences (Malhotra et al., 2017).

37
38 Should nonsurgical treatments deem unsuccessful for the management of pain and
39 functional limitations associated with digital deformities, then surgery may be considered
40 as a treatment option. The indications for surgery are significant pain and impairment,
41 which may include difficulty with footwear. Improving cosmetic appearance is not an
42 indication. Surgeons should carefully tailor surgical intervention to patient specific

1 pathology. Furthermore, most patients who undergo digital deformity correction have joint
2 stiffness at one or more levels, and must understand that this stiffness may persist even
3 after successful. If there is a previous failed surgery of the digits, further surgery may or
4 may not be advisable, and has the potential of creating a flair or floppy toe, or a dysvascular
5 digit. Contraindications include infection, neuropathy, and a dysvascular foot (Kitaoka,
6 2013)

7
8 Surgical treatment of digital deformities includes a spectrum of soft tissue and osseous
9 procedures. The degree and flexibility of the deformity along with any associated
10 pathology determine the surgical procedure(s) to be performed. Digital joint capsulotomy
11 is a soft-tissue procedure which involves the cutting, or release, of the joint capsule. The
12 surgeon cuts the tendons on the sides of the toe in order to properly realign the toe. A joint
13 capsule is inserted on the interior side of the toe to adjust the alignment.

14
15 The purpose of surgical treatment is to restore normal alignment of the joints and to restore
16 the balance between the flexors, extensors and intrinsics. Capsulotomy is a surgical option,
17 either as an isolated procedure or in conjunction with other procedures, for correction of
18 lesser toe deformities (Malhotra et al., 2017).

19 20 **PRACTITIONER SCOPE AND TRAINING**

21 Practitioners should practice only in the areas in which they are competent based on their
22 education, training and experience. Levels of education, experience, and proficiency may
23 vary among individual practitioners. It is ethically and legally incumbent on a practitioner
24 to determine where they have the knowledge and skills necessary to perform such services
25 and whether the services are within their scope of practice.

26
27 It is best practice for the practitioner to appropriately render services to a member only if
28 they are trained, equally skilled, and adequately competent to deliver a service compared
29 to others trained to perform the same procedure. If the service would be most competently
30 delivered by another health care practitioner who has more skill and training, it would be
31 best practice to refer the member to the more expert practitioner.

32
33 Best practice can be defined as a clinical, scientific, or professional technique, method, or
34 process that is typically evidence-based and consensus driven and is recognized by a
35 majority of professionals in a particular field as more effective at delivering a particular
36 outcome than any other practice (Joint Commission International Accreditation Standards
37 for Hospitals, 2020).

38
39 Depending on the practitioner's scope of practice, training, and experience, a member's
40 condition and/or symptoms during examination or the course of treatment may indicate the
41 need for referral to another practitioner or even emergency care. In such cases it is prudent
42 for the practitioner to refer the member for appropriate co-management (e.g., to their

1 primary care physician) or if immediate emergency care is warranted, to contact 911 as
 2 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice
 3 guideline for information.

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