

1 **Clinical Practice Guideline: Cock-Up Fifth Toe Correction**

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3 **Date of Implementation: October 15, 2015**

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5 **Product: Specialty**

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8 **GUIDELINES**

9 American Specialty Health – Specialty (ASH) considers services consisting of CPT Code
 10 28286 to be medically necessary for correction of cock-up fifth toe deformity **upon**
 11 **meeting ALL of the following criteria:**

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1. Presence of cock-up fifth toe deformity
2. Persistent pain and dysfunction
3. Failure of **at least 3 of the following** non-operative treatments:
 - Adhesive devices
 - Corrective splinting
 - Footwear modification
 - Padding
 - Manipulation
 - Non-steroidal anti-inflammatory drugs (NSAIDs)
 - Orthoses
 - Protective padding
 - Removal of any corns or calluses

26 **CPT CODES AND DESCRIPTIONS**

CPT® Code	CPT® Code Description
28286	Correction, cock-up fifth toe, with plastic skin closure (e.g., Ruiz-Mora type procedure)

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27 **BACKGROUND**

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CPT code 28286 describes surgical procedures for the correction of cock-up fifth toe with removal of the proximal phalanx and plastic skin closure to pull the toe into alignment.

Fifth toe positional problems typically cause irritation with various forms of footgear. The position of the toe can cause irritation against the toe box of the shoe causing pain and callus formation. Although deformities can be congenital, the greatest numbers of deformities are the result of developmental problems. These are commonly related to biomechanics and shoe type.

There are three varieties of deformity which occur at the fifth metatarsophalangeal joint of the fifth toe: a cock-up deformity, a plantar flexion deformity, and an overlapping

1 deformity. The cock-up deformity is most commonly seen in older patients. The typical
2 presentation is a dorsiflexed and adducted fifth toe. A hyperkeratotic lesion is often seen
3 overlying the proximal interphalangeal joint of the fifth toe. With an adducted deformity,
4 hyperkeratotic tissue can develop in the web space and become macerated creating a soft
5 corn (heloma molle).

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7 Non-surgical treatment is the initial treatment choice for the symptomatic cock-up fifth toe
8 deformity. It can be treated conservatively with shoe modifications or proper foot
9 maintenance; however, structural deformities of the toe often require surgical correction.
10 If standard non-operative options fail to improve functional limitation and relieve pain,
11 surgical correction is the definitive treatment.

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13 Cock-up deformity of the fifth toe often consists of a fixed hammertoe deformity coupled
14 with a hyperextension deformity of the metatarsophalangeal joint in which the base of the
15 proximal phalanx articulates with the metatarsal articular surface at almost a 90° angle.
16 While a soft tissue release of the metatarsophalangeal joint contracture combined with a
17 hammertoe repair of the fifth toe will often suffice for mild-to-moderate deformities,
18 frequently the fixed nature of a severe deformity requires significant osseous
19 decompression to successfully realign the digit. With a severe cock-up deformity, resection
20 arthroplasty may be considered (Coughlin et al. 2013).

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22 Phalangectomy of the proximal phalanx can be beneficial for the treatment of cock-up fifth
23 toe deformity. One of the main complications following this procedure is instability of the
24 fifth toe. Iatrogenic fifth toe instability can be corrected by syndactylization procedure.
25 Alternatively, subtotal resection of the proximal phalanx may be undertaken to avoid fifth
26 toe instability. The Ruiz-Mora procedure as modified by Janecki and Wilde (subtotal
27 resection of the proximal phalanx) is the preferred procedure (Coughlin et al., 2013).

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29 Complications of the Ruiz-Mora procedure include instability of the toe, fourth digit
30 hammertoe formation, callus formation, and bunionette deformity (Schroeder, 2022). A
31 frank preoperative discussion with the patient is important to both define the patient's
32 expectations and educate him or her regarding the possibility of complications.

33 34 **PRACTITIONER SCOPE AND TRAINING**

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

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41 It is best practice for the practitioner to appropriately render services to a member only if
42 they are trained, equally skilled, and adequately competent to deliver a service compared
43 to others trained to perform the same procedure. If the service would be most competently

1 delivered by another health care practitioner who has more skill and training, it would be
2 best practice to refer the member to the more expert practitioner.

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

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10 Depending on the practitioner’s scope of practice, training, and experience, a member’s
11 condition and/or symptoms during examination or the course of treatment may indicate the
12 need for referral to another practitioner or even emergency care. In such cases it is prudent
13 for the practitioner to refer the member for appropriate co-management (e.g., to their
14 primary care physician) or if immediate emergency care is warranted, to contact 911 as
15 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* policy for
16 information.

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