Clinical Practice Guideline: **Ostectomy for Tailor's Bunion**

Date of Implementation: **June 18, 2015**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT Code 28110 to be medically necessary for the treatment of Tailor's bunion **upon meeting ALL of the following criteria:**

1. When supported by a diagnosis of other acquired deformities of foot (Tailor's bunion) (M21.621- M21.622)
2. Symptomatic bunion (5th metatarsal) **indicated by 1 or more of the following**:
   - Ulceration at fifth metatarsophalangeal joint
   - Difficulty walking because of pain at fifth metatarsophalangeal joint
   - Inability to accommodate or modify footwear to control pain
3. Failure of **at least 2 of the following** non-operative treatments
   - Padding
   - Orthotics
   - Shoe modification
   - Activity modification
   - Injection

CPT CODES AND DESCRIPTIONS

CPT Code	Description
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)

BACKGROUND

Tailor's bunion (also called bunionette) involves deformity of the fifth metatarsophalangeal (MTP) joint, typically involves deformity with lateral prominence of the fifth metatarsal head. Structural causes of this deformity may include a prominent lateral condyle, a plantarflexed fifth metatarsal, a splay foot deformity, lateral bowing of the fifth metatarsal, a combination of these deformities, or hypertrophy of the soft tissues over the lateral aspect of the metatarsal head.

The patient with a tailor's bunion may or may not have pain related to the deformity. The most common presentation of bunionette deformity is pain associated with lateral pressure with footwear. There also may be a history of localized swelling and/or callus formation.

The clinical examination of a patient with a tailor's bunion will reveal a lateral or plantar-lateral prominence of the fifth metatarsal head. Tenderness on palpation of the lateral and/or plantar-lateral fifth metatarsal head may be associated with an overlying adventitial bursa or hyperkeratotic lesion.

Radiographic findings may be helpful in the assessment of the exact nature of the deformity and contributory structural pathology. Radiographic evaluation includes anteroposterior, oblique, and lateral views of the weight-bearing foot. Common measurements obtained using the AP view include metatarsal head width, IMA, and fifth metatarsophalangeal angle (MTPA). Average normal IMA has historically been considered to be 6.5°, with angles >8° defined as abnormal. Fifth MTPA is measured by the degree of divergence of the fifth toe from the long axis of the metatarsal shaft. The MTPA measures on average 10.2° to 14° in normal feet but 16° in feet with symptomatic bunionette deformities (Shi et al., 2018).

Conservative care is the first line of treatment for foot and toe deformity. Conservative treatment for tailor's bunion may include wide shoes, custom accommodative orthotics, nonsteroidal anti-inflammatory medications, and barrier pads to alleviate pain. Skincare with callous shaving of keratosis also can temporarily relieve pressure. The use of localized injections to address concomitant metatarsophalangeal joint (MTPJ) synovitis has been studied, with moderate, short-term, and sustained improvement in less than one-third of the patients at 2-year follow-up (Shi et al., 2018; Morawe & Schmieschek, 2018).

Surgical treatment is indicated for patients experiencing pain due to bunionette deformity who have failed nonsurgical care and patients who are not candidates for nonsurgical care. The goal of surgical treatment is to decrease the prominence of the fifth metatarsal laterally. Selection of the surgical procedure is based on the physical evaluation and radiographic assessment. Surgical correction to alleviate the pain at the bone prominence varies from exostectomy to differing types of osteotomies. Resection of the fifth metatarsal head, which entails removal of a portion of the bone, for treatment of tailor's bunion is generally indicated for salvage conditions or in the presence of unreconstructable deformities (Ajis et al., 2005; Shi et al., 2018).

Excision of the fifth metatarsal head, resection of the distal half of the metatarsal, and fifth ray resection have all been used to treat a bunionette deformity but are not appropriate in the initial treatment of symptomatic conditions. Therefore, these procedures are used as a salvage procedures for infection, ulceration, or severe deformity. Situations in which these procedures may be appropriate include severe osteopenia, extensive degenerative joint changes, chronic ulceration, previous failed surgery, or poor medical health (DiDomenico et al., 2013).

PRACTITIONER SCOPE AND TRAINING

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

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

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

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

References

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