

OHIO Medicaid: Molina will not apply age restrictions in relation to EPSDT(Rule 5160-1-14 | Healthчек: early and periodic screening, diagnostic, and treatment (EPSDT) covered services.) and no time constraints to be applied for length of conservative treatment requirements.

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

Plantar fasciitis is defined as the inflammation of the plantar fascia, the thick band of connective tissue that connects the heel bone to the base of the toes. Degeneration and inflammation of the plantar fascia caused by repetitive micro trauma leads to chronic heel pain. The characteristic symptom of plantar fasciitis is heel pain, which is usually localized to the plantar medial aspect of the heel. Pain is typically worse in the morning or after a rest period but improves with movement. A diagnosis of plantar fasciitis is usually made based on clinical history and physical examination. Plantar fasciitis is primarily treated medically and up to 95% of patients have symptom resolution within 12 to 18 months. Current medical management of plantar fasciitis includes stretching exercises of the foot and calf, avoiding the use of flat shoes and barefoot walking, using prefabricated, over-the-counter silicone heel shoe inserts, limiting physical activities such as running, jumping, dancing, etc. that can aggravate the condition, short term use of nonsteroidal anti-inflammatory drugs (NSAIDs), and injection of the plantar region with glucocorticoids and a local anesthetic. Extracorporeal Shock Wave Therapy (ESWT) may be considered as an alternative to surgical treatment. Surgery should only be considered for intractable pain which has not responded to 6–12 months of conservative medical treatment. Open and endoscopic partial plantar fascial release are the most common surgical interventions utilized for the treatment of plantar fasciitis when all other medical management has failed. The open procedure enables the first branch of the lateral plantar nerve to be directly decompressed if necessary and this cannot be done using an endoscopic approach. The endoscopic procedure is less invasive, less painful, has fewer complications, and has a quicker recovery time in comparison to the open procedure.

COVERAGE POLICY

Plantar fascial release surgery (open or endoscopic) **may be considered medically necessary** when **ALL** the following criteria are met:

1. Diagnosis of plantar fasciitis; **AND**
2. Age 18 or older; **AND**
3. Baseline imaging to include other pathological etiologies of heel pain (e.g., Achilles tendinopathy, arthritis, heel fat pad atrophy, tarsal tunnel syndrome, calcaneal stress fracture, bone lesions, heel spur or infection)*
**Heel spurs are typically an incidental finding due to a higher incidence of heel spurs in patients with plantar fasciitis. However, there is no direct correlation between the presence of heel spurs and plantar fascial pain. Heel spurs do not negate the medical necessity of plantar fascial release surgery and may be treated in conjunction with plantar fascial release surgery if clinically indicated.*

AND

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4. Significant heel pain and functional impairment interfering with activities of daily living that persist after at least 6 months of applicable conservative management that includes, but is not limited to, **ALL** the following:
 - a. Physical therapy \geq 6 months; **AND**
 - b. Activity modification \geq 6 months; **AND**
 - c. Night splints \geq 4 weeks; **AND**
 - d. Foot orthotics (e.g., shoe inserts, heel lifts, footwear modifications, corrective splinting) \geq 6 months; **AND**
 - e. Oral analgesics or NSAIDS unless contraindicated or not tolerated; **AND**
 - f. Corticosteroid injections unless contraindicated or not tolerated; **AND**
 - g. Home stretching program; **AND**
 - h. Taping.

Note: For coverage policy on minimally invasive therapies for plantar fasciitis, please reference Molina Clinical Policy No. 338: Plantar Fasciitis Treatments.

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

The peer reviewed medical literature has an abundance of low-moderate quality evidence for the use of open and endoscopic partial plantar fascial release as a treatment for intractable plantar fasciitis that has not responded to conservative treatment. Most of the evidence consists of case series, non-randomized clinical studies, and retrospective reviews. Despite the lack of robust studies, plantar fascial release surgical treatment has become the standard of care for intractable pain lasting 6-12 months that has failed medical management.

There is an abundance of good quality evidence in the peer reviewed literature for the use of conservative medical therapy as a first- and second-line treatment for plantar fasciitis. There are several randomized controlled trials, retrospective reviews, case series and professional society guidelines. First line treatments include stretching exercises, ice, activity modification, weight loss in obesity, footwear modifications, arch taping, nonsteroidal anti-inflammatory medications and shock-absorbing shoe inserts or orthoses. Second line therapy includes night splints, steroidal anti-inflammatory injections, and casting.

Nayar et al. (2023) completed a systematic review and network meta-analysis to determine the effectiveness of surgical treatment options for plantar fasciitis unresponsive to non-operative management options. A total of 17 studies were included with a total of 865 patients. The surgical options included in the review included open and endoscopic plantar fasciotomy, gastrocnemius release, radiofrequency microtenotomy and dry needling. All the surgical interventions resulted in improved visual analog scale (VAS) scores and American Orthopedic Foot and Ankle Society (AOFAS) scores. There were also no major complications noted with any of the surgeries. Nayar et al. (2023) noted that additional large randomized controlled trials are needed to determine long-term outcomes and a management algorithm as current evidence is uncertain regarding best surgical intervention.

Arshad et al. (2022) completed a systematic review to summarize the outcomes of gastrocnemius recession in the treatment of plantar fasciitis. A total of 6 studies were included in the review with a total of 118 patients. All studies reported excellent outcomes with significant postoperative improvements in VAS, AOFAS, 36-item short form health survey, and foot and ankle ability measure scores. An overall pooled complication rate of 8.5% was noted in the 5 studies that reported complications. Arshad et al. (2022) found that gastrocnemius recession is associated with greater postoperative improvement when compared to plantar fasciotomy and conservative stretching exercises.

Ward et al. (2022) completed a systematic review on the clinical outcomes and postoperative complications of endoscopic plantar fascia release at mid-term and long-term follow-up. A total of 26 studies were included in the review

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with a total of 978 patients. Of the 26 included studies, 18 measured preoperative and postoperative AOFAS scores. The mean preoperative AOFAS score was 55.66 ± 10.3 and the mean postoperative score was 89.6 ± 5.2 out of 100. A total of 88 out of 994 patients reported complications for a complication rate of 8.9%. Ward et al. (2022) found that although endoscopic plantar fascia release provides good clinical outcomes, there is a moderately high complication rate. Thus, endoscopic plantar fascia release should only be considered following failure of conservative management.

The **American College of Foot and Ankle Surgeons (ACFAS)** practice guideline indicates that first line treatment options for plantar heel pain associated with plantar fasciitis (e.g., foot padding and strapping, therapeutic orthotic insoles, cortisone injections, and Achilles and plantar fascia stretching) for a period of six weeks (Thomas, 2010). Second line treatment options include continuation of tier one treatments, with consideration for additional therapies, including use of night splints to maintain an extended length of plantar fascia and gastrocnemius complex. ACFAS also recommends that ESWT may be considered as an alternative to traditional surgical approaches for recalcitrant plantar heel pain.

AOFAS (2021) recommendations state to try at least 6 months of non-operative care (e.g., first- and second-line treatments) before performing surgery for plantar fasciitis.

For a list of peer-reviewed studies used in the development and update of this policy, please see the References.

CODING & BILLING INFORMATION

CPT Codes

CPT	Description
28008	Fasciotomy, foot and/or toe
28060	Fasciectomy, plantar fascia; partial (separate procedure)
28062	Fasciectomy, plantar fascia; radical (separate procedure)
28119	Ostectomy, calcaneus; for spur, with or without plantar fascial release
28250	Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)
29893	Endoscopic plantar fasciotomy

HCPCS Codes – N/A

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

4/13/2023	Policy reviewed. Revised coverage criteria #3 from “exclude” to “include” and added note on heel spurs, Updated Overview, Summary of Medical Evidence, Coding & Billing, and References.
4/13/2022	Policy reviewed, no changes to criteria, updated references.
4/5/2021	New policy.

REFERENCES

Government Agency

- Centers for Medicare and Medicaid Services (CMS). Medicare coverage database. Accessed March 8, 2023. <https://www.cms.gov/medicare-coverage-database/search.aspx>.

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Peer Reviewed Publications

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APPENDIX

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