2011 Procedures Adult Criteria

Plantar Fascial Release, Endoscopic/Open[1*RIN, 2]

CLIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name		ID#	Phone#
	Signature		Date	

ICD-9-CM: 83.14

INDICATIONS (choose one and see below)

☐ 100 Plantar fasciitis
☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Plantar fasciitis **[All]**[3]
- ☐ 110 Plantar foot/heel pain interferes with ADLs[4, 5]
- ☐ 120 Tender at plantar fascial origin by PE[6]
- ☐ 130 X-ray **[One]**[7]
  - ☐ 131 Normal
  - ☐ 132 Heel spur[8]
- ☐ 140 Continued pain **after** Rx **[All]**
  - ☐ 141 NSAID **[One]**[9]
    - ☐ -1 Rx ≥ 4 wks
    - ☐ -2 Contraindicated/not tolerated[10]
  - ☐ 142 PT ≥ 6 mos[11]
  - ☐ 143 Activity modification ≥ 6 mos
  - ☐ 144 Night splints ≥ 4 wks[12]
  - ☐ 145 Shoe insert **[One]**[13]
    - ☐ -1 Heel lift ≥ 6 mos
    - ☐ -2 Arch support ≥ 6 mos
    - ☐ -3 Orthotic ≥ 6 mos[14]
  - ☐ 146 Corticosteroids **[One]**
    - ☐ -1 Injection[15]
    - ☐ -2 Phonophoresis/iontophoresis[16]

Notes

(1)-RIN:
For criteria covering extracorporeal shock wave therapy for plantar fasciitis, see the "Plantar Fasciitis, Extracorporeal Shock Wave Therapy (ESWT)" criteria subset.

(2)
Surgical intervention for the treatment of plantar fasciitis is rare, since approximately 90% of cases resolve with nonsurgical therapy (Hammer et al., Foot Ankle Int 2003; 24(11): 823-828). Open and endoscopic partial plantar fascial release are the most common surgical interventions utilized for the treatment of plantar fasciitis. The open procedure enables the first branch of the lateral plantar nerve to be directly decompressed if necessary, while the endoscopic approach does not (Williams and Brage, Clin Sports Med 2004; 23(1): 123-144). The endoscopic procedure may be the better alternative for treating plantar fasciitis, since it is less invasive, less painful, has fewer complications, and a quicker recovery time in comparison to the open procedure (Boyle and Slater, Foot Ankle Int 2003; 24(2): 176-179). The American Orthopaedic Foot and Ankle Society Position Statement on Endoscopic and Open Heel Surgery does not recommend endoscopic plantar fascial release if fascial pain coexists with nerve compression (Buchbinder, N Engl J Med 2004; 350(21): 2159-2166).

(3)-DEF:
Plantar fasciitis is a common cause of heel pain thought to be caused by an overloading of the plantar fascia resulting in inflammation, degeneration, microtears, and fibrosis at the fascia origin. Other factors contributing to the development of the tendinopathy included genetic make-up and inefficient lower extremity biomechanics and musculoskeletal function (Kountouris and Cook, Best Pract Res Clin Rheumatol 2007; 21(2): 295-316).

(4)
The pain of plantar fasciitis is most pronounced at the insertion site of the plantar fascia (Rompe et al., J Bone Joint Surg Am 2002; 84-A(3): 335-341). It is frequently worse when initiating ambulation, subsides with walking, but often returns with prolonged weight-bearing. Athletes, overweight individuals, and individuals who spend a prolonged amount of time on their feet are at increased risk for developing this condition (Williams and Brage, Clin Sports Med 2004; 23(1): 123-144).

(5)
Activities of daily living (ADLs) are frequently divided into those simple activities relating to basic self-care and those that involve more complex interactions with others and the environment (called instrumental activities of daily living or IADLs). This criterion includes both types of activity. Whether a condition is of sufficient severity to interfere with ADLs or IADLs is somewhat subjective. There should be an indication that symptoms impede the patient's ability to effectively work, shop, manage at home, care for family members, or tend to personal hygiene.

(6)
The plantar fascial insertion is located at the medial tubercle of the calcaneus.

(7)
The x-ray is performed to exclude other pathological etiologies of the heel pain, such as arthritis, traumatic calcaneal stress fracture, bone lesions, or infection (Buchbinder, N Engl J Med 2004; 350(21): 2159-2166).

(8)
While a heel spur may be present, it is not the cause of the symptoms nor is it pathognomonic for the diagnosis of plantar fasciitis (Williams and Brage, Clin Sports Med 2004; 23(1): 123-144; Lee et al., Foot Ankle Int 2003; 24(12): 927-930).

(9)-POL:
NSAIDs are preferred for the treatment of this condition because of their anti-inflammatory effect. It is a matter of local medical policy whether to accept acetaminophen or other analgesics as alternatives for NSAIDs.

(10)
Contraindications to NSAIDs may be absolute (e.g., pregnancy, history of allergic reaction) or relative (e.g., anticoagulant use, history of PUD).

(11)
PT interventions and modalities that can be effective for treating plantar fasciitis include stretching exercises, and ice or heat application (Buchbinder et al., JAMA 2002; 288(11): 1364-1372; Ogden et al., Foot Ankle Int 2002; 23(4): 301-308). Non weight-bearing stretching exercises which specifically address the plantar fascia provide good outcomes in relation to pain, function, and patient satisfaction (DiGiovanni et al., J Bone Joint Surg Am 2003; 85-A(7): 1270-1277). This criterion includes exercise therapy by provider instruction to the patient, as well as supervised training through formal PT.

(12)

Night splints hold the plantar fascia and Achilles tendon in a lengthened position overnight so that they can be stretched more effectively.

(13)
Since pathophysiologic findings support the theory that plantar fasciitis is the result of chronic overload of the plantar fascia, the principle behind shoe modification (e.g., heel lifts, arch support, orthotics) is to decrease loading and stress on the plantar fascia by supporting the arch, controlling pronation, and absorbing shock (Williams and Brage, Clin Sports Med 2004; 23(1): 123-144).

(14)
Off-the-shelf or custom-fitted orthotics distribute pressure evenly across the foot and reduce strain on the fascia during standing and ambulation. A randomized, controlled study to determine if foot orthoses were effective in reducing the pain of plantar fasciitis showed significant pain reduction and compliance compared to the use of night splints alone (Roos et al., Foot Ankle Int 2006; 27(8): 606-611). Another study evaluating orthotic devices found more favorable short-term effects with regard to pain and function for the group assigned to wear orthoses when compared to those wearing sham devices (Landorf et al., Arch Intern Med 2006; 166(12): 1305-1310).

(15)
Corticosteroid injections for the treatment of plantar fasciitis may provide short-term pain relief and are most beneficial when administered early in the course of the disease (Rompe, Sports Med Arthrosc 2009; 17(2): 100-104; Toomey, Foot Ankle Clin 2009; 14(2): 229-245). An increased risk of rupture of the plantar fascia, as well as atrophy of the fat pad covering the heel, needs to be considered when corticosteroid injection is proposed; the data to support injection and subsequent rupture, however, are limited and inconclusive (Glazer, Phys Sportsmed 2009; 37(2): 74-79; Buchbinder, N Engl J Med 2004; 350(21): 2159-2166).

(16)-DEF:
Phonophoresis utilizes ultrasound to deliver medication through the skin. Iontophoresis uses electrical currents to deliver ions of a medication into the tissues.