

1 **Clinical Practice Guideline: Plantar Fasciectomy/Fasciotomy**

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3 **Date of Implementation: May 21, 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®**
 10 Codes 28008, 28060, 28062, 28250, and 29893 to be medically necessary for the partial
 11 or radical removal of the plantar fascia upon meeting ALL of the following criteria:

- 12 1. Member has intractable plantar fasciitis; AND
 13 2. Pain interferes with activities of daily livings (ADLs); AND
 14 3. Imaging excludes other pathological etiologies of heel pain (i.e., arthritis,
 15 traumatic calcaneal stress fracture, bone lesions, infection); AND
 16 4. There has been a failure of six months (except where indicated) of conservative
 17 therapy which must include **AT LEAST 4** of the following:
 18 o NSAIDS (ineffective for 4 weeks or contraindicated); AND
 19 o Physical therapy (i.e., stretching, arch taping); AND
 20 o Activity modification; AND
 21 o Night splints (for more than 4 weeks); AND
 22 o Shoe insert (including heel lift, arch support, or orthotic); AND
 23 o Corticosteroid injection.

24

25 **CPT® Codes and Descriptions**

CPT® Code	CPT® Code Description
28008	Fasciotomy, foot and/or toe
28060	Fasciectomy, plantar fascia; partial (separate procedure)
28062	Fasciectomy, plantar fascia; radical (separate procedure)
28250	Division of plantar fascia and muscle (e.g., Steindler stripping) (separate procedure)
29893	Endoscopic plantar fasciotomy

26

27 **BACKGROUND**

28 **Plantar Fasciitis**

29 Plantar heel pain is the most prevalent condition presenting to foot and ankle specialists.
 30 There are many causes of this condition, but one of the most common is plantar fasciitis.
 31 Plantar fasciitis is caused by inflammation of the plantar fascia due to biomechanical

1 stress. Its symptoms are pain along the proximal plantar fascia and its attachment in the
2 area of the calcaneal tuberosity and may occur with or without concomitant presence of a
3 heel spur. Localized nerve entrapment of the medial calcaneal or muscular branch off the
4 lateral plantar nerve may also be a contributing factor.

5
6 Diagnosis of plantar fasciitis is based on patient history, risk factors, and physical
7 examination findings. The clinical presentation of plantar fasciitis is well recognized, but
8 there are no universally accepted diagnostic tests to verify the diagnosis of plantar
9 fasciitis. Although there is not a single treatment algorithm for this condition, more than
10 90% of cases can be resolved with non-surgical conservative care. It is helpful for
11 practitioners to attempt to tailor treatments to fit their patient’s activity and lifestyle/
12 employment requirements, with consideration of the patient’s chronicity and severity of
13 symptoms.

14
15 Because the primary cause of plantar fasciitis is mechanical overload and increased
16 tension in the fascia, it is important to address any biomechanical factors that might be
17 contributing. This includes taping or strapping, over-the-counter insoles, custom foot
18 orthoses, and BMI counseling to prevent recurrence. Patients in all stages of plantar
19 fasciitis are advised to avoid non-supportive shoes, including flipflops and ballet slippers.
20 It is important to support the medial longitudinal arch to reduce stress on the plantar
21 fascia. In addition, as tight hamstrings and equinus are common in patients with plantar
22 fasciitis, stretching is important in the treatment of plantar fasciitis. The type of stretching
23 protocol (home stretching, night splint, or physical therapy) will vary according to the
24 severity of the equinus and patient preference (Martin et al., 2014; Schneider et al.,
25 2018).

26
27 The American College of Foot and Ankle Surgeons released a consensus statement on the
28 treatment of plantar fasciitis concluding that plantar fasciotomy (open and endoscopic) is
29 a safe and effective option for chronic, refractory plantar fasciitis” was appropriate for
30 patients meeting criteria of chronic, refractory cases that have failed appropriate
31 conservative treatment for ≥ 6 months. The consensus of the panel was that release of the
32 plantar fascia by any method is a valid surgical procedure in the treatment of chronic
33 plantar fasciitis (Schneider et al., 2018).

34
35 Wheeler et al. (2014) reviewed case series of long-term outcomes of patients ($N=79$) who
36 underwent plantar fasciotomy surgery between 1993 and 2009. Patients self-reported an
37 average reduction in pain by visual analog scale of 79%, and 84% of patients were
38 satisfied with the surgical results.

39
40 Persistent pain may result if the surgeon does not release enough of the plantar fascia and
41 tight fibers remain. If the opening of the fibers is not maintained when the plantar fascia
42 is released, it can fibrose and reattach. Therefore, some surgeons take a small portion of

1 the plantar fascia and perform a plantar fasciectomy to avoid this possible complication.
2 Conversely, some surgeons employ immediate weightbearing postoperatively while
3 others utilize splinting and casting to help keep the fibers of the plantar fascia separated
4 (Butterworth, 2010).

5 6 **Plantar Fibromatosis**

7 Plantar fibromatosis, also known as Ledderhose’s disease, is a rare, benign,
8 hyperproliferation process of the plantar aponeurosis. It is characterized by local
9 proliferation of abnormal fibrous tissue in the plantar fascia. The plantar aponeurosis is
10 gradually replaced by locally invasive tissue and progresses to form thickened fascia and
11 nodules that range in size from 0.5 to 3 centimeters (English et al., 2012).

12
13 One should evaluate surgical intervention for the various forms of plantar fibromatosis on
14 a case-by-case basis. In a symptomatic case of plantar fibromatosis not relieved by
15 conservative measures such as physical therapy, activity modification, footwear
16 modifications, oral anti-inflammatories, corticosteroid injections, and orthotic insoles,
17 then excision or fasciectomy of the plantar fascia may be considered (Coughlin et al.,
18 2013; Veith et al., 2013).

19
20 Multiple plantar fibromas generally require more extensive excision of the entire fibrous
21 band of plantar fascia (known as a Steindler plantar fascial stripping) in order to ensure
22 complete removal and prevent recurrence. Steindler stripping entails detachment of the
23 plantar fascia from the calcaneus, and from medial to lateral abductor hallucis longus,
24 flexor digitorum brevis, and abductor digiti quinti. Plantar fibromatosis has an
25 increasingly favorable prognosis with complete radical excision of the plantar
26 aponeurosis; however, surgery should only be undertaken when palliative measures have
27 failed, and the tumor has progressed from its early stages.

28 29 **PRACTITIONER SCOPE AND TRAINING**

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

35
36 It is best practice for the practitioner to appropriately render services to a member only if
37 they are trained, equally skilled, and adequately competent to deliver a service compared
38 to others trained to perform the same procedure. If the service would be most
39 competently delivered by another health care practitioner who has more skill and
40 training, it would be best practice to refer the member to the more expert practitioner.

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

6
 7 Depending on the practitioner’s scope of practice, training, and experience, a member’s
 8 condition and/or symptoms during examination or the course of treatment may indicate
 9 the need for referral to another practitioner or even emergency care. In such cases it is
 10 prudent for the practitioner to refer the member for appropriate co-management (e.g., to
 11 their primary care physician) or if immediate emergency care is warranted, to contact 911
 12 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice
 13 guideline for information.

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