Molina Clinical Policy
Plantar Fasciitis Release Surgery
Policy No. 402

Last Approval: 02/11/2026
Next Review Due By: February 2027

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 (Lim et al. 2016).

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 that can aggravate the condition, and short-term use of nonsteroidal anti-inflammatory drugs (NSAIDs). For patients with severe pain, glucocorticoid injections of the plantar region may be considered; however, they typically do not offer sustained benefit. For chronic plantar fasciitis, alternative modalities such as extracorporeal shock wave therapy (ESWT), platelet-rich plasma injections, cryoablation, and other interventions may be considered but are not supported by high-quality evidence. Most cases of chronic plantar fasciitis resolve over time without the need for invasive intervention (Buchbinder 2025).

Plantar fasciitis surgery should only be considered for intractable pain which has not responded to at least 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 and may be less painful with fewer complications and a quicker recovery time in comparison (Buchbinder 2025; DynaMed 2025).

RELATED POLICIES

MCP-338: Plantar Fasciitis Treatments

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
2. Member is ≥ 18 years old

3. Exclusion of all 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) confirmed via imaging
    a. **Exception:** 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

4. Documentation of clinically significant heel pain and functional impairment interfering with activities of daily living despite at least 6 months of conservative management including, but not limited to, the following:
    a. Physical therapy
    b. Activity modification
    c. Night splints (at least ≥ 4 weeks)
    d. Foot orthotics (e.g., shoe inserts, heel lifts, footgear modifications, corrective splinting)
    e. Oral medications (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs]) or corticosteroid injections
    f. Home stretching program
    g. Taping

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 to 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.

Randomized Controlled Trials
Johannsen et al. (2020) conducted a randomized controlled trial to compare operative treatment with supervised non-operative rehabilitation for plantar fasciitis. Thirty patients were assigned to either a non-operative group (corticosteroid injections and strength training) or a surgical group (endoscopic partial fasciotomy and heel spur removal followed by the same strength training program). Primary outcomes, including the Foot Function Index (FFI) and Visual Analog Scale (VAS) for pain, were assessed at baseline and 3-, 6-, 12-, and 24-months post-treatment. Both groups showed significant improvement over time. At 12 months post-treatment, the surgical group had significantly better FFI scores ($p = 0.033$), but the difference was not significant at 24 months ($p = 0.06$). VAS pain scores at 24 months were significantly better in the surgical group ($p = 0.001$). The study concluded that operative treatment offers significant benefits compared to rehabilitation alone for managing plantar fasciitis.

Systematic Reviews and Meta-Analyses
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. Nayer 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 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.

National and Specialty Organizations

The **American College of Foot and Ankle Surgeons (ACFAS)** *2010 clinical practice guideline* indicates that the first-line treatment options for plantar heel pain associated with plantar fasciitis are patient-directed treatments (e.g., foot padding and strapping, therapeutic orthotic insoles, corticosteroid injections, activity limitations, oral anti-inflammatories, weight loss, and Achilles and plantar fascia stretching) for a period of at least six weeks. Second-line treatment options include continuation of tier one treatments with consideration for additional therapies, such as prescription physical therapy, use of night splints to maintain an extended length of plantar fascia and gastrocsoleus complex, prescription orthotic devices, immobilization, and subsequent injections. Third-line treatment options include continuation of tier 1 and 2 treatment programs with consideration of surgical plantar fasciotomy using a recognized technique (e.g., endoscopic, in-step, or a minimally invasive technique). The ACFAS also recommends that extracorporeal shock wave therapy (ESWT) may be considered as an alternative to traditional surgical approaches for recalcitrant plantar heel pain based on fair evidence consistent with Level III or IV studies (Thomas et al. 2010).

The **ACFAS** *2017 clinical consensus statement on the diagnosis and treatment of adult acquired infracalcaneal heel pain* lists plantar fasciotomy (both open and endoscopic approaches) as a safe and effective treatment option for chronic, refractory plantar fasciitis. The consensus statement also notes that the appropriate treatment of plantar fasciitis requires sufficient understanding of the patient's chronicity of symptoms, and that stretching and biomechanical support are also both safe and effective treatment options. In most cases, infracalcaneal pain is a soft tissue-related disorder and calcaneal spurring is most likely not a causative factor. While radiographs can help rule out other causes of pain and should be ordered for refractory pain not responsive to conservative treatment, the routine use of radiographs is not necessary for initial diagnosis. Advanced imaging has its greatest utility for patients "in whom conservative treatment has failed and when historical or clinical symptoms are present that suggest another plausible etiology" (Schneider et al. 2017).

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	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 (e.g., Steindler stripping) (separate procedure)
29893	Endoscopic plantar fasciotomy

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

02/11/2026	Policy reviewed. No changes to coverage criteria.
02/12/2025	Policy reviewed. Updated Summary of Medical Evidence and References. Clarified clinical indications by reorganizing criteria.
04/10/2024	Policy reviewed. Added to coverage criteria: examples of baseline imaging, use of oral steroids and use of night splints for at least 4 weeks. Removed coverage criteria of ≥ 6 months for physical therapy, activity modification and foot orthotics. Updated references. IRO Peer Review on February 13, 2024, by a practicing physician board-certified in Podiatry.
04/13/2023	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.
04/13/2022	Policy reviewed, no changes to criteria, updated references.
04/05/2021	New policy. IRO Peer Review on March 18, 2021, by a practicing physician board-certified in Orthopaedic Surgery.

REFERENCES

1. Arshad Z, Aslam A, Razzaq MA, Bhatia M. Gastrocnemius Release in the Management of Chronic Plantar Fasciitis: A Systematic Review. Foot Ankle Int. 2022 Apr;43(4):568-575. doi: 10.1177/10711007211052290. Epub 2021 Nov 12. PMID: 34766860; PMCID: PMC8996295.
2. Buchbinder, R. Plantar fasciitis. Updated April 24, 2025. Literature review current through December 2025. Accessed January 2, 2026. https://www.uptodate.com.
3. DynaMed. Plantar fasciitis. EBSCO Information Services. Updated February 3, 2025. Accessed January 2, 2026. https://www.dynamed.com.
4. Johannsen F, Konradsen L, Herzog R, et al. Endoscopic fasciotomy for plantar fasciitis provides superior results when compared to a controlled non-operative treatment protocol: a randomized controlled trial. Knee Surg Sports Traumatol Arthrosc. 2020 Oct;28(10):3301-3308. doi: 10.1007/s00167-020-05855-3. Epub 2020 Jan 31. PMID: 32006073.
5. Lim AT, How CH, Tan B. Management of plantar fasciitis in the outpatient setting. Singapore Med J. 2016 Apr;57(4):168-70; quiz 171. doi: 10.11622/smedj.2016069. PMID: 27075037; PMCID: PMC4853481.
6. Nayar SK, Alcock H, Vemulapalli K. Surgical treatment options for plantar fasciitis and their effectiveness: a systematic review and network meta-analysis. Arch Orthop Trauma Surg. 2023 Aug;143(8):4641-4651. doi: 10.1007/s00402-022-04739-0. Epub 2023 Jan 3. PMID: 36596990.
7. Schneider HP, Baca JM, Carpenter BB, Dayton PD, Fleischer AE, Sachs BD. American College of Foot and Ankle Surgeons Clinical Consensus Statement: Diagnosis and Treatment of Adult Acquired Infracalcaneal Heel Pain. J Foot Ankle Surg. 2018 Mar-Apr;57(2):370-381. doi: 10.1053/j.jfas.2017.10.018. Accessed January 5, 2026.
8. Thomas JL, Christensen JC, Kravitz SR, et al. American College of Foot and Ankle Surgeons heel pain committee. The diagnosis and treatment of heel pain: a clinical practice guideline-revision 2010. J Foot Ankle Surg. 2010 May-Jun;49(3 Suppl):S1-19. doi: 10.1053/j.jfas.2010.01.001. PMID: 20439021.
9. Ward L, Mercer NP, Azam MT, et al. Outcomes of endoscopic treatment for plantar fasciitis: A systematic review. Foot Ankle Spec. 2022 Nov 7:19386400221129167. doi: 10.1177/19386400221129167. Epub ahead of print. PMID: 36342049.