Medical Policy Guidelines

Heel Injury – Prior Authorization Requirements

This medical policy provides guidelines for the prior authorization process of diagnostic and treatment services related to heel injuries. The policy aims to ensure appropriate medical necessity, effective utilization management, and evidence-based care for members presenting with heel pain or injury.

1. Coverage Criteria

• Persistent heel pain for at least 6 weeks despite conservative management (e.g., rest, ice, orthotics, physical therapy).

• Clinical documentation supports diagnosis such as plantar fasciitis, heel spur, or Achilles tendinopathy.

• Non-surgical treatments have been attempted and documented.

• Referral to orthopedic or podiatry specialist includes imaging results or relevant prior treatment notes.

2. Diagnostic Procedures Requiring Prior Authorization

Procedure	CPT Code	Authorization Required
MRI of Foot/Ankle (without contrast)	73718	Yes
MRI of Foot/Ankle (with contrast)	73719	Yes
CT Scan of Foot/Ankle	73700	Yes
Ultrasound of Foot/Ankle	76881	No
X-ray of Heel	73650	No

3. Non-Covered Services

The following services are considered experimental, investigational, or not medically necessary for heel injury management and will not be covered:

• Platelet-rich plasma (PRP) injections for plantar fasciitis.

• Extracorporeal shockwave therapy (ESWT) without supporting documentation of prior conservative therapy.

• Stem cell therapy for heel pain.

• Custom orthotics without prior assessment documentation.

4. Documentation Requirements

Providers must submit the following documentation to support prior authorization requests:

• Detailed clinical notes including onset, duration, and progression of symptoms.

• Documentation of conservative treatments attempted and their outcomes.

• Imaging reports or test results supporting diagnosis.

• Proposed treatment plan and rationale for advanced imaging or surgical intervention.

5. Medical Review Guidelines

All prior authorization requests will be reviewed by a medical director or qualified clinician. Requests not meeting the outlined criteria may be subject to denial with an opportunity for peer-to-peer review.

Note: This policy is subject to periodic review and update based on emerging clinical evidence and payer utilization trends.

Disclaimer

This medical policy is intended to provide guidance on prior authorization and coverage decisions. It does not replace clinical judgment or member benefit plan provisions. Final coverage determinations are based on member eligibility, benefits, and applicable regulations at the time of service.