Driscoll Health Plan
Medical Necessity Guideline

Medical Necessity Guideline: Pes Planus (Flat Feet/Valgus Deformity) and Orthotics	**Creation Date:** 3/14/2014	**Review Date:** 10/10/2023	**Effective Date:** 12/13/2023

PURPOSE:

To detail the authorization requirements for Orthotics Pes Planus (Flat Feet/Valgus deformity) and related conditions

DEFINITIONS:

Pes Planus (Flat foot) - The clinical diagnosis of flat foot is based on a valgus position of the heel and poor formation of the arch.

GUIDELINE:

Orthotic

A University of California at Berkeley Laboratory (UCBL) removable foot insert will be considered for prior authorization with documentation that the device is required to correct or treat at least one of the following conditions: [2]

- A valgus deformity and significant congenital pes planus with pain.
- A structural problem that results in significant pes planus, such as Down syndrome.
- Acute plantar fasciitis.

Non-covered Orthotic Services:[1]

- Tired feet
- Fatigued feet
- Non-severe bow legs
- Valgus deformity of the foot (except as outlined in the orthotic section – see above)
- Pes planus (flat feet) (except when there is a coexisting medical condition outlined in the Texas Medicaid Provider Procedures Manual [2])

Required Documentation: [(5)]

- Clear description of the term "flat feet" including age and whether physiologic/developmental as in early childhood, flexible-flat foot, or true pes planus.
- The use of the term "acquired pes planus" or other "acquired" condition must be explained in detail – including the causative mechanism or condition.
- Documentation of the description and the qualification of pain associated with the diagnosis. The use of "painful feet" alone is considered inadequate to meet this standard.

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- Attestation and description of previous failed education and 6-month trials of over-the-counter Orthotics and compliance with purchase and use of appropriate non-prescription footwear.

BACKGROUND:

Natural history of Pes Planus (Flat Foot)

Pes planus is common in infants and children. It usually resolves by the time a person is an adolescent. Therefore, pes planus is typically described as physiologic because it is common and usually doesn't cause symptoms (i.e., the foot is typically flexible and without pain). In addition, there are no functional consequences to the foot being "flat".

Infants are usually born with flexible, flat feet and a very large fat pad on the bottom of the foot that obscures the medial plantar arch. During the first decade of life, this medial longitudinal arch develops along with the foot's bones, muscles, and ligaments, and by age 2, a medial arch will be visible when the child is sitting. When the child stands (bears weight), this medical arch will frequently disappear, giving the appearance of flat feet. This usually resolves by the time the child is ten (10), but flat feet may persist into adolescence and adulthood. There is debate in the medical community as to whether this should be considered a normal variant or a deformity that leads to deformity requiring intervention. If there are no symptoms, most physicians would agree that this is a normal variant of foot shape that will persist throughout the person's lifetime. In rare instances, however, pes planus can become painful, and the foot may lose flexibility. This is frequently the first sign of some underlying foot pathology (e.g., arthritis, neuromuscular disease, or tarsal coalition) [3].

Definition of Pes Planus

Despite being common, there is no standard definition for pes planus. Furthermore, there are no extensive, prospective studies that compare the natural history of pes planus throughout the growth and development, comparing the response to various treatments. The available literature does not elucidate which patients are at risk for developing pain and disability as young adults. Current evidence suggests that it is safe and appropriate to observe an asymptomatic child with flat feet. Orthotics, although generally unproven to alter the course of flexible flatfoot, may provide relief of pain when pain is present. A general pediatrician needs to know when a referral to an orthopedic specialist is indicated, and which treatments may be offered to the patient. [4]

Epidemiology of Pes Planus

Numerous cross-sectional epidemiologic studies have shown that pes planus is the normal shape of the foot in the first few years of life. In children tow (2) years or younger, 97% have pes planus when the heel-to-arch width ratio defines it. This prevalence declines dramatically with

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increasing age such that only 4% of children have pes planus by age 10. This supports the belief that most pediatric pes planus resolves spontaneously throughout the first decade of life. A study analyzing footprints in >800 patients found a similar trend, with 54% of 3-year-old children having flat feet. The prevalence then decreased to 26% by the time the children reached age 6. This data suggests that the time between ages 3 to 6 years may be a critical time period for the development of the medial longitudinal arch. Of note, this same study looked at footprints in people 80 years of age and discovered that pes planus is a normal adult finding. [5]

Intervention in Pes Planus

Arch supports have long been advocated with very little evidence of benefit. Short-term positive results in the reduction of symptoms have been variably shown. However, no long-term follow-up studies have led many authors to conclude that treating children with physiologic pes planus is ineffective. It has also been posited that these treatments are uncomfortable and embarrassing for the child. One prospective study was conducted to determine if flexible pes planus could be influenced by corrective shoes and inserts and concluded that wearing corrective shoes or inserts for three (3) years did not influence the course of flexible flatfoot in children. Many other studies have discovered similar inability of custom foot orthotics or specialized shoes to be ineffective in treating pediatric flatfoot. Furthermore, other studies have shown no radiologic improvement with the use of arch supports/custom foot orthotics. [6]

Current Approach to Managing Pes Planus in Children

Although the natural history of the flexible flatfoot remains unknown, there is little evidence to suggest that this condition results in long-term problems or disability. As such, treatment is reserved for a small subset of patients who develop symptoms. Patients may complain of hindfoot pain, abnormal shoe wear, or fatigue after long walking. These patients may benefit from a nonprescription orthosis, such as a medial arch support. Severe cases, often associated with an underlying connective tissue disorder such as Ehlers-Danlos syndrome or Down syndrome, may benefit from a custom orthosis such as the UCBL (University of California Biomechanics Laboratory) orthosis to better control the hindfoot and prevent collapse of the arch. Although an orthosis may relieve symptoms, there is no evidence to suggest any permanent change in the foot's shape or alignment of the tarsal bones. [7, 8]

PROVIDER CLAIMS CODES:

ICD 10	
M21.4	Flatfoot (acquired)
M21.40	Flatfoot (acquired) unspecified foot
M21.41	Flatfoot (acquired) right foot
M21.42	Flatfoot (acquired) left foot
M21.6	Acquired deformities of foot

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Q66.5	Congenital pes planus
Q66.50	Congenital pes planus unspecified foot
Q66.51	Congenital pes planus right foot
Q66.52	Congenital pes planus left foot
Q66.6	Valgus deformities of feet

CPT	
L3000	Foot, insert, removable, molded to patient model, 'ucb' type, berkeley shell, each
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each
L3020	Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each
L1907	Ankle orthosis, supramalleolar with straps, with or without interface/pads, custom fabricated

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REFERENCES:

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2. Texas Medicaid Provider Procedures Manual (Current Edition); Durable Medical Equipment, Medical Supplies, and Nutritional Substances Handbook; Section 2.2.19.2.3 (Foot Orthoses)
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Corpus Christi, Texas 78415
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DOCUMENT HISTORY:

DHP Committee that Approved	*Review Approval Date (last 5 years)*					
Medical Director	05/23/2022	06/07/2022	05/23/2023	10/10/2023		
CMO	06/10/2021	06/07/2022	06/06/2023	12/13/2023		
Medical Policy Workgroup *Effective 2022*		06/07/2022	06/06/2023	12/13/2023		
Utilization Management & Appeals *Effective January 2021*	06/10/2021	06/21/2022	06/20/2023	12/13/2023		
Provider Advisory Committee (PAC) *Effective 2022*		06/17/2022	06/09/2023	12/13/2023		
Clinical Management Committee *Effective March 2021*	06/17/2021	06/24/2022 & 08/23/2022	07/20/2023	01/24/2024		
Executive Quality Committee *Effective 2021*	08/04/2021	06/28/2022	07/25/2023	01/30/2024		

Document Owner	***Organization***	***Department***
Dr. Fred McCurdy, Medical Director	Driscoll Health Plan	Utilization Management

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Review/Revision Date	*Review/Revision Information, etc.*
6/1/2015	No change
6/1/2016	No change
12/1/2017	No change
11/16/2018	No change
11/15/2019	Update references and conversion to new format by Tom Morris, MD; addition of process. No substantive change to benefit guideline content
05/12/2020	Added/updated new codes and new references
06/16/2020	Dr. Serrao's style recommendations added and modified, Add new source
05/21/2021	Updated, 2 new references, codes verified by Dr. Brendel
05/20/2022	Reviewed and updated, Dr. Albert Gest
05/23/2022	Reviewed and edited, Dr. Fred McCurdy
05/23/2023	Reviewed by Drs. Noorullah Akthar and Fred McCurdy; no changes
10/10/2023	Clarification of Non-Covered Orthotics services and Background revisions.

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