Medica Coverage Policy

MEDICA®

Policy Name:	**Electrothermal Therapy for Treatment of Joint Instability or Laxity of Ligaments**
Current Policy Effective Date:	11/1/2008

Product Application

The policy applies to all fully insured Medica Health Plans, Medica Insurance Company, and Medica Health Plans of Wisconsin products, unless a specific limitation or exception exists. For self-insured plans, consult individual plan sponsor benefit documents. If there is a discrepancy between a coverage policy and a self-insured benefit plan, the provisions of the benefit plan will govern. With respect to Medicare and Medicaid members, this policy will apply unless Medicare or Medicaid policies require different coverage.

Important Information - Please Read Before Using This Policy

Medica updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to Medica members. Medica also reserves the right to amend these policies without notice to contracted health care providers unless the amendment materially alters the policy. If the amendment materially alters the policy, Medica will disclose the change to contracted health care providers not less than 45 days prior to implementation of the policy. Medica's Coverage Policies contain general information only and do not guarantee coverage. Receipt of benefits is subject to all terms and conditions of the member's coverage document. Members should consult their Certificates of Coverage or Plan Documents/Summary Plan Descriptions, to review the provisions relating to a specific coverage determination. If there is a conflict between a Coverage Policy and the applicable coverage document, the coverage document will govern. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Medica's Provider Service Center toll free at 1-800-458-5512.

Medica's Coverage Policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

Coverage Policy

Electrothermal therapy for treatment of glenohumeral instability is investigative and therefore NOT COVERED.

Electrothermal therapy for shrinkage of the tendons and ligaments of the knee is investigative and therefore NOT COVERED.

Electrothermal therapy for treatment of instability or laxity of ligaments in other joints is investigative and therefore NOT COVERED. These joints include, but are not limited to, the ankle, elbow, hip, and wrist.

Description

Joint instability or laxity of ligaments may occur due to repetitive microtrauma to a the joint, such as repetitive motion or overextension, and traumatic injury. Treatments include medical management, physical rehabilitation, and arthroscopic or open repair of the ligaments, capsule, or other segments of the joint.

Electrothermal therapy, also referred to as thermal capsulorrhaphy or thermal shrinkage, uses nonablative heat (65-90 degrees centigrade) delivered to the capsule or ligament of a joint via a thermal catheter using radiofrequency or laser energy. After arthroscopic or percutaneous placement of the probe, it is moved along the periphery of the ligament or capsule. The goal of treatment is to re-stabilize the joint by shrinking and shortening stretched collagen fibers. It may be done as a stand-alone procedure or in conjunction with other surgery. Following electrothermal therapy, a rehabilitation period of three to six months is generally required. During rehabilitation, the joint is immobilized followed by a program of exercises.

Electrothermal therapy has been investigated to treat laxity in a number of joints including the knee, ankle, wrist, elbow, and hip. Use of this technology to improve stability of the glenohumeral joint of the shoulder has been the most widely researched.

FDA Approval
Electrothermal therapy is a procedure, and therefore is not regulated through the FDA approval process. The FDA has approved thermal probe systems for arthroscopic and general surgical use, including resection, ablation, excision of soft tissue, hemostasis of blood vessels, and coagulation of soft tissue.

Prior Authorization

Prior authorization is not applicable.

Coding Considerations

Use the current applicable CPT/HCPCS code(s).

Decision Date: 6/24/2008
Re-Review Date(s): 06/24/2008
06/28/2005

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