



MASSACHUSETTS

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Medical Policy

Thermal Capsulorrhaphy as a Treatment of Joint Instability

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Policy Number: 591

BCBSA Reference Number: 7.01.82A (For Plan internal use only)

NCD/LCD: N/A

Related Policies

None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Thermal capsulorrhaphy as a treatment of joint instability, including but not limited to the shoulder, knee, and elbow, is **NOT MEDICALLY NECESSARY**.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	This is not a covered service.
Commercial PPO and Indemnity	This is not a covered service.
Medicare HMO Blue SM	This is not a covered service.
Medicare PPO Blue SM	This is not a covered service.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.
The following codes are included below for informational purposes only; this is not an all-inclusive list.

The following HCPCS code is considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

HCPCS Codes

HCPCS codes:	Code Description
S2300	Arthroscopy, shoulder, surgical; with thermally induced capsulorrhaphy

Description

Shoulder instability may arise from a single traumatic event (i.e., subluxation or dislocation), repeated microtrauma, or constitutional ligamentous laxity, resulting in deformation and/or damage in the glenohumeral capsule and ligaments. If instability persists, either activity modifications or surgical treatment may be considered. Surgery consists of inspection of the shoulder joint with repair, reattachment, or tightening of the labrum, ligaments, or capsule, performed either with sutures or sutures attached to absorbable tacks or anchors. While arthroscopic approaches have been investigated over the past decade, their success has been controversial due to a higher rate of recurrent instability compared with open techniques, thought to be related in part to the lack of restoration of capsular tension.

Thermal capsulorrhaphy has been proposed as a technically simpler arthroscopic technique for tightening the capsule and ligaments. The technique is based on the observation that the use of nonablative levels of radiofrequency thermal energy can alter the collagen in the glenohumeral ligaments and/or capsule, resulting in their shrinkage and a decrease in capsular volume, both thought to restore capsular tension. Thermal capsulorrhaphy may be used in conjunction with arthroscopic repair of torn ligaments or other structures. In addition, thermal capsulorrhaphy has also been investigated as an arthroscopic treatment of glenohumeral laxity, as a sole arthroscopic treatment, and in patients with congenital ligamentous laxity, such as Ehlers-Danlos or Marfan's syndrome.

Examples of thermal capsulorrhaphy devices for the treatment of joint instability include Oratec ORA-50 Monopolar RF Generator and Arthrocare. All thermal capsulorrhaphy devices for the treatment of joint instability are considered not medically necessary regardless of the commercial name, the manufacturer or FDA approval status.

Summary

The literature on thermal capsulorrhaphy either alone or in combination or in combination with other arthroscopic procedures, for shoulder instability is limited to small studies with conflicting findings. Literature on thermal capsulorrhaphy for joints other than the shoulder is limited.

Since the literature does not support use of thermal capsulorrhaphy alone, or in combination with other arthroscopic procedures, this procedure is considered not medically necessary.

Policy History

Date	Action
3/2020	Policy updated with literature review through March 1, 2020, no references added. Policy statements unchanged.
8/2016	Clarified coding information.
7/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
8/2013	Annual policy review. New references added.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
6/2011	Reviewed - Medical Policy Group – Orthopedics, Rehabilitation and Rheumatology.

	No changes to policy statements.
11/1/2010	New policy effective 11/1/2010 describing ongoing non-coverage.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

References

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