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MEDICAL POLICY – 7.01.165

Radiofrequency Coblation Tenotomy for Musculoskeletal Conditions

BCBSA Ref. Policy:	7.01.165
Effective Date:	Mar. 1, 2025
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Replaces:	N/A

RELATED MEDICAL POLICIES:

6.01.527 Diagnosis and Treatment of Sacroiliac Joint Pain

Select a hyperlink below to be directed to that section.

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Introduction

Radiofrequency coblation is a minimally invasive technology that can be used in surgeries that treat musculoskeletal conditions. Using a fluid that conducts electricity (saline), radiofrequency (RF) energy is delivered through a surgical wand to remove soft tissue in precise locations. The low temperature and highly controlled delivery of the RF energy helps prevent damage to surrounding tissue. The goal of RF coblation is to relieve pain and restore function. Radiofrequency coblation in surgeries of the tendon and other musculoskeletal conditions is unproven (investigational). More studies are needed to see if this technology improves health outcomes.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Treatment	Investigational
Radiofrequency coblation tenotomy	**Radiofrequency coblation tenotomy (e.g., TOPAZ EZ Microdebrider Coblation Wand) is considered investigational as a treatment for musculoskeletal conditions, including but not limited to the following conditions:** • Achilles tendinopathy • Lateral epicondylitis • Patellar tendinopathy • Plantar fasciitis • Shoulder or rotator cuff tendinopathy • Wrist tendinopathy

Coding

Note: There is no specific code for radiofrequency coblation tenotomy or the TOPAZ EZ Microdebrider Coblation Wand which is a device and not a procedure. Code selection will depend on the service performed and the specific anatomy involved, and the definitive procedure performed.

Related Information

N/A

Evidence Review

Description

Radiofrequency (RF) coblation is being evaluated for the treatment of plantar fasciitis, lateral epicondylitis, and various musculoskeletal tendinopathies. When utilized for tenotomy, bipolar RF energy is directed into the tendon to generate a controlled, low-temperature field of ionizing

particles that break organic bonds, ablating or debriding target tissue with the goal of relieving pain and restoring function.

Background

Radiofrequency Coblation

Radiofrequency (RF) coblation uses bipolar low-frequency energy in an electrically conductive fluid (e.g., saline) to generate a high-density plasma field around the energy source. This creates a low-temperature field of ionizing particles that break organic bonds within the target tissue. Coblation technology is used in a variety of surgical procedures, particularly related to otolaryngology and orthopedics. The proposed advantage of coblation is that the procedure provides for controlled and highly localized ablation, resulting in minimal damage to surrounding tissue. RF coblation was also found to exhibit several properties that may make it an attractive option for addressing the underlying pathophysiology of chronic tendinopathies, namely increased angiogenesis, reduction of inflammatory responses, and increased expression of growth factors.[1] RF coblation surgical wands are utilized by orthopedic surgeons in minimally invasive arthroscopic procedures to facilitate soft tissue debridement, subacromial decompression, meniscal removal and sculpting, or tendon debridement.

The use of coblation technology for disc nucleoplasty and sacroiliac joint pain is addressed in separate medical policies. See **Related medical policies**.

Tendinopathy

Tendinopathy is a clinical pain syndrome characterized by tendon thickening due to proliferation and chronic irritation of neovascular repair tissue with a history of repetitive tendon loading. This condition commonly results from overuse and has a high incidence rate in athletes and laborers. Clinical history should clarify predisposing training or activity and assess the level of functioning. Biomechanical abnormalities during activity should be identified and corrected. Standard treatment may, therefore, consist of biomechanical modification, activity modification, physical therapy (e.g., heavy load resistance training), and nonsteroidal anti-inflammatory medication. For chronic tendinopathies, glucocorticoids should only be used in select cases (e.g., rotator cuff tendinopathy). Surgical consultation following six months of a well-designed physical therapy program with adjunct medical treatments can be considered if there is no improvement in pain or function.[2] Validated, and reliable functional assessment scores should

be utilized by the clinician to grade symptoms and assess individual function. Examples of suitable scales include the Victoria Institute of Sport Assessment for Achilles tendinopathy.[3] Surgical approaches may involve incisions to the paratendon and removal of adhesions and degenerate tissue. Longitudinal incisions may be made in the tendon to promote a repair response. This latter strategy has also been delivered via minimally invasive arthroscopic approaches.[4,5] These approaches may also address the debridement of the neovascular supply to the tendon surface. Collectively, a prolonged recovery duration to accommodate tendon healing may be required with these interventions.

Plantar Fasciitis

Plantar fasciitis is a musculoskeletal condition characterized by pain in the plantar region of the foot that worsens upon initiation of walking and with local point tenderness elicited during a clinical examination. Radiographic and ultrasonographic studies are not typically indicated for primary diagnosis but may be useful in ruling out alternative causes and visualizing the thickening of the plantar fascia. Initial standard therapy may consist of stretching exercises, orthotics, activity and lifestyle modification, nonsteroidal anti-inflammatory drugs, splints or casts, and glucocorticoid injections. The vast majority of individuals improve without surgery. Surgery is generally considered a last line of therapy and is reserved for individuals who do not respond to at least 6 to 12 months of initial, nonsurgical therapy. Surgical approaches include variations of open or endoscopic, partial or complete, plantar fascia release which may or may not include calcaneal spur resection, excision of abnormal tissue, and nerve decompression. The use of RF microtenotomy during open or percutaneous surgery has been explored alone or in combination with plantar fasciotomy.[6]

Plantar fasciitis is one of the most common causes of foot and heel pain in adults. It is estimated to be responsible for approximately 1 million patient medical visits per year in the US.[7] The peak incidence of the condition in the general population occurs between ages 40 and 60. There is a higher incidence rate among runners with a younger age of onset. The etiology of plantar fasciitis is poorly understood and may be multifactorial in nature. Contributing risk factors may include obesity, prolonged standing or activity, flat feet, and reduced ankle dorsiflexion.[8,9] Plantar fasciitis has been reported in association with fluoride use for the treatment of osteoporosis.[10] Differential sources of foot and heel pain may include Achilles tendinopathy, stress fractures due to osteoporosis, rheumatoid arthritis, peripheral neuropathies associated with diabetes, extrinsic factors (e.g., inappropriate footwear), aging, and structural disorders.

Lateral Epicondylitis

Lateral epicondylitis, also known as tennis elbow, represents chronic tendinosis of the myotendinous group of the lateral epicondyle characterized by pain and disability. The incidence in the general population may approach 1 to 3%.[11] Risk factors include smoking, obesity, forceful activity, and repetitive activity for at least 2 hours daily. Lateral epicondylitis is characterized by injury to the extensor carpi radialis brevis or extensor digitorum communis muscles. The condition is diagnosed through findings of localized tenderness and pain with clinical examination. Initial conservative management includes modification of activity and biomechanics, counterforce bracing or splinting, nonsteroidal anti-inflammatory drugs, and physical therapy.[12] Surgical referral is typically reserved for individuals with severe symptoms that do not improve despite compliance with an appropriately designed physical therapy program for at least six months.

Summary of Evidence

For individuals with plantar fasciitis who receive RF coblation tenotomy, the evidence includes nonrandomized, comparative cohort studies, a systematic review of these studies, and case series. The relevant outcomes are symptoms, functional outcomes, quality of life (QOL), medication use, and treatment-related morbidity. The trials reported improved pain and functional scores over 3-12 months, with improved outcomes with open versus percutaneous approaches. However, open RF coblation microtenotomy was associated with a higher incidence of postoperative persistent pain (9.1%) compared to endoscopic plantar fasciotomy (0%) in 1 study, with a separate study reporting a complication rate of 33% when both interventions were used in combination. A higher number of postoperative pain recurrences at 6 and 12 months were also reported with open RF coblation microtenotomy compared to endoscopic plantar fasciotomy. The durability of this intervention is unknown as no studies have reported long-term outcomes beyond 12 months. Studies are limited by small sample sizes, heterogeneity in surgical technique (open, percutaneous, endoscopic), missing data and/or inappropriate exclusions, lack of randomization, unclear blinding practices for individual outcome assessments, and poor statistical reporting. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with lateral epicondylitis who receive RF coblation tenotomy, the evidence includes small randomized controlled trials (RCTs). The relevant outcomes are symptoms, functional outcomes, QOL, medication use, and treatment-related morbidity. The trials compared RF microtenotomy to open or arthroscopic elbow release surgery. Clinically

meaningful improvements in pain and functional scores were noted for all treatment arms, with no significant differences between groups through 1 to 7 years of follow-up. For disability assessments in 1 study, open release surgery met the threshold for a clinically meaningful improvement over RF microtenotomy at 1 year, though this mean difference was not statistically significant. Studies were generally underpowered or demonstrated inconsistent delivery and unclear blinding of outcome assessments and inappropriate handling of missing or crossover data. No studies featuring RF coblation tenotomy for the treatment of wrist tendinopathy were identified. The evidence is insufficient to determine that the technology results in an improvement in net health outcomes.

For individuals with Achilles tendinopathy who receive RF coblation tenotomy, the evidence includes small, single-blinded RCTs. The relevant outcomes are symptoms, functional outcomes, QOL, medication use, and treatment-related morbidity. One trial did not demonstrate an added benefit for RF microdebridement compared to surgical decompression. Pain and functional outcomes improved in both groups but were not statistically different at a 6-month follow-up. The study was limited by a control group that showed significantly less severe symptom scores at baseline that did not fully meet the 2-point threshold for a clinically meaningful difference in pain score reduction. The other small RCT demonstrated potential benefits in pain and quality of life for RF microtenotomy (ArthroCare) compared with physical therapy at 2 years. However, conclusions cannot be drawn based on these findings due to numerous notable study limitations. Larger, adequately controlled studies with longer follow-up durations are lacking. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with shoulder or rotator cuff tendinopathy who receive RF coblation tenotomy, the evidence includes small RCTs. The relevant outcomes are symptoms, functional outcomes, QOL, medication use, and treatment-related morbidity. Trials did not demonstrate an added benefit for RF microdebridement compared to arthroscopic subacromial decompression surgery. Pain and functional outcomes improved in both groups but were not statistically different through 1 to 2 years follow-up. Neither study prespecified a clinically meaningful difference in outcome measures nor were harms assessed throughout their course. The loss to follow-up in 1 study was 18.7%. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with patellar tendinopathy who receive RF coblation tenotomy, the evidence includes one small RCT. The relevant outcomes are symptoms, functional outcomes, QOL, medication use, and treatment-related morbidity. The trial did not demonstrate an added benefit for RF microdebridement compared to mechanical debridement in individuals with chondral lesions and patellar tendinopathy. The study lacked reporting with validated pain

measures over time and reported a higher incidence of crepitus in individuals undergoing RF microdebridement. Furthermore, the study only enrolled female participants, limiting the broader applicability of these findings. Larger studies with validated pain and functional outcome measures are required to adequately assess the technology. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in **Table 1**.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT03854682	Surgical or Non-surgical Treatment of Plantar Fasciitis - A Randomized Clinical Trial	70	Jun 2025 (recruiting)
Unpublished			
NCT02304952	Eccentric Exercise or Radiofrequent Microtenotomy as Treatment of Chronic Lateral Epicondylalgia - a Randomized Controlled Trial	100	Sep 2018 (unknown)
NCT02275689	Alternative Treatment of Rotator Cuff Tendinopathy	34	Dec 2016 (completed)
NCT00534781[a]	Radiofrequency-based Plasma Microdebridement Compared to Surgical Microdebridement for Treating Achilles Tendinosis: A Prospective, Randomized, Controlled Multi-Center Study	60	Sep 2010 (completed)
NCT00189592[a]	Plantar Fasciosis Treatment Using Coblation Prospective, Double-Blind, Randomized Controlled Study	45	Jun 2008 (completed)

NCT: national clinical trial. [a] Denotes industry-sponsored or cosponsored trial.

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American College of Foot and Ankle Surgeons

In 2017, the American College of Foot and Ankle Surgeons published a clinical consensus statement on the diagnosis and treatment of adult acquired infracalcaneal heel pain based upon the best available evidence in the literature.[30] The panel determined that the following statement was uncertain – that is – neither appropriate nor inappropriate:

> "Other surgical techniques (e.g., ultrasonic debridement using a microtip device, cryosurgery, and bipolar radiofrequency ablation) are safe and effective options for chronic, refractory plantar fasciitis."

American College of Occupational and Environmental Medicine

In 2013, the American College of Occupational and Environmental Medicine updated their treatment guidelines for lateral epicondylitis as a result of a systematic review of the literature.[31] Surgery is recommended for cases inadequately responsive to multiple evidence-based treatments (Level of Evidence: I, insufficient evidence). Microtenotomy is also recommended (Level of Evidence: C, limited evidence base).

Medicare National Coverage

The Centers for Medicare & Medicaid Services have determined that thermal intradiscal procedures, including percutaneous (or plasma) disc decompression or coblation, are not reasonable and necessary for the treatment of low back pain. Therefore, thermal intradiscal procedures, which include procedures that "employ the use of a radiofrequency energy source

or electrothermal energy to apply or create heat and/or disruption within the disc for the treatment of low back pain, are noncovered."[32]

The Centers for Medicare & Medicaid Services have not published a national coverage decision on radiofrequency coblation tenotomy for the musculoskeletal conditions addressed in this policy.

Regulatory Status

In 2014, the TOPAZ EZ Microdebrider Coblation Wand with Integrated Finger Switch, an electrosurgical cutting and coagulation device (ArthroCare Corporation, K140521), was cleared for marketing by the US Food and Drug Administration (FDA) through the 510(k) process, on the basis of an earlier predicate device (ArthroCare Topaz Wand, K080282, 2008). The surgical wands are indicated for debridement, resection, ablation, and coagulation of soft tissue and hemostasis of blood vessels in arthroscopic and orthopedic procedures, including fasciotomy, synovectomy, tenotomy, and capsulotomy of the foot and tenotomy of the knee, wrist, elbow, ankle, shoulder, and rotator cuff. FDA product code: GEI.

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History

Date	Comments
03/01/21	New policy, approved February 9, 2021. Policy created with literature review through November 3, 2020. Radiofrequency coblation tenotomy is considered investigational as a treatment for musculoskeletal conditions under specified indications.
07/01/21	Related Policies updated; removed policy 7.01.93 as it has been archived.
11/01/21	Related Policies updated; removed policy 6.01.23 as it has been deleted.
03/01/22	Annual Review, approved February 7, 2022. Policy updated with literature review through October 20, 2021; no references added. Policy statements unchanged.
03/01/23	Annual Review, approved February 6, 2023. Policy updated with literature review through September 19, 2022; references added. Policy statements unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization.
03/01/24	Annual Review, approved February 12, 2024. Policy updated with literature review through November 3, 2023; references added. Policy statements unchanged.

Date	Comments
03/01/25	Annual Review, approved February 10, 2025. Policy updated with literature review through November 3, 2023; references added. Policy statements unchanged.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.