

Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds

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[Instructions for Use](#)

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Related Policy
<ul style="list-style-type: none"> Lithotripsy for Salivary Stones

Coverage Rationale

Extracorporeal shock wave therapy (ESWT), whether low energy, high energy, or radial wave, is unproven and not medically necessary for any musculoskeletal or soft tissue indications due to insufficient evidence of efficacy.

Note: This policy does not address extracorporeal shock wave lithotripsy (ESWL) used for the treatment of:

- Gallstones
- Kidney stones
- Pancreatic stones
- Salivary stones

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified
0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound
0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy
28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia

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Description of Services

Extracorporeal shock wave therapy (ESWT) devices are similar to the lithotripters used for breaking up kidney stones in urology. They produce low- or high-energy pulses arising from acoustic energy, called shock waves, which can be focused and then propagated through water within body tissues. When focused on a boundary between tissues of differing densities, the shock wave is altered, and energy is emitted. The shock waves for orthopedic indications are the same as those used to break up kidney stones but have ten times less energy. Low energy defocused ESWT or soft focused acoustical wave pattern is used for wound healing.

Although the mechanism of therapeutic effect for ESWT has not been established, it has been proposed that shock waves may have a direct mechanical effect through the rapid buildup of positive pressure and/or a more indirect effect through the implosion of bubbles in the interstitial fluid. These forces may reduce transmission of pain signals from sensory nerves, cause calcium deposits to disintegrate, break down scar tissue, cause a transient inflammatory response, and/or stimulate tissue healing. (Hayes 2022)

Clinical Evidence

Achilles Tendinitis

Conclusive evidence recommending ESWT as a treatment for Achilles tendinopathy is lacking. Studies comparing high energy, single-treatment protocols with low energy, multiple-treatment protocols, and studies comparing various dosing intervals and energy flux densities are also needed to determine optimal treatment parameters. A standardized method to evaluate results may also be helpful. Published articles on ESWT for Achilles tendonitis have been limited to studies using animal models. There are no adequate prospective clinical studies demonstrating the effectiveness of ESWT for Achilles tendonitis.

Stania et al. (2023) conducted a systematic review and meta-analysis to determine the efficacy of ESWT as a monotherapy for Achilles tendinopathy. There were 373 articles identified from various countries, only six RCTs remained after inclusion criteria were met. The sample size was 157 participants in the experimental group and 187 participants in the control group. The results demonstrated the very low -quality evidence suggested that ESWT was no more effective in decreasing pain than any other conservative treatment (D: -0.8; 95% CI: -3.15, 1.56; $p > .5$). However, the heterogeneity of the studies included was high and no significant differences were found between the ESWT and control groups pooled scores. The authors concluded that despite high or medium methodological quality of the analyzed RCTs, an evidence rating was too low to allow conclusions. Therefore, no strong recommendations can be made for the use of ESWT in patients with Achilles tendinopathy. The limitations of the study include small sample size, short-term follow-up and low-quality evidence.

Feeney (2022) conducted a systematic review to evaluate the use of ESWT in the management of midportion Achilles tendinopathy. A search of databases [MEDLINE (PubMed), AMED, EMBASE, CINAHL, and CENTRAL] was performed with a total of 283 articles identified. Of these, seven randomized controlled trials (RCTs) were eligible for inclusion in the review. The mean sample size of the included studies was 57. Five studies diagnosed midportion Achilles tendinopathy based on history and physical examination while two confirmed the presence of Achilles tendinopathy by combining history and physical examination with ultrasound findings. Three studies utilized radial ESWT only, one study used a combination of radial and focused ESWT, one study compared radial and focused ESWT, and two studies used focused ESWT only. The length of follow-up ranged from three to 16 months. Overall, four of the seven RCTs included found a statistically significant improvement in outcome measures with the use of ESWT compared to control. The other three studies observed no statistically significant improvement in outcome measures with the use of ESWT compared to control, each did observe a significant improvement in the ESWT groups from baseline. The author concluded ESWT appeared to be safe and at least as effective as control in the management of Achilles tendinopathy. Additionally, the most effective intervention may be a combination of eccentric loading exercises with a course of ESWT. The author suggests that further high-quality studies with larger sample sizes and a combination of treatments are needed to determine the most effective treatment, dose, time between treatments, and frequency (Hz) of ESWT patients should receive.

In 2019, Stania et al. published results from a systematic review of research reports on ESWT in patients with Achilles tendinopathy to help practicing physiotherapists establish the most effective intervention parameters. A search was conducted using the following databases: PubMed, Scopus, EBSCOhost, and Web of Science. The papers were checked for relevant content and were included based on the following criteria: full-text article published in English and including comprehensive description of shock wave application. Twenty-two articles met the inclusion criteria. Most studies on the effectiveness of ESWT for Achilles tendinopathy included in this review were RCTs. Two case-control studies, a case series study, prospective audit, clinical trial protocol, and a pilot study were also considered. The majority were

prospective studies. Only a few authors presented the findings from retrospective observations. The two modalities of shock wave therapy used for Achilles tendinopathy are focused shock waves and radial shock waves. The authors concluded that the complexity of the biological response to shock waves, the high diversity of application methodologies, and the lack of objective measurements all prevent ESWT effectiveness for Achilles tendinopathy from being fully determined. There are knowledge gaps yet to be researched, and the results of experimental studies remain contradictory. The authors noted that there is a need for further multidirectional and multicenter, randomized controlled studies on the effectiveness of shock waves for Achilles tendinopathy that should fulfil the criteria for evidence-based medicine.

In 2017, the Washington State Health Care Authority conducted a Health Technology Assessment to review the evidence for the efficacy of ESWT for treating Achilles tendinopathy. Two small RCTs showed significant pain improvement while running or playing sports, but there was no difference between groups while working or using the stairs. One RCT reported significant improvement in function when comparing ESWT to sham. The strength of evidence for this indication was low and there was no evidence found on the intermediate or long-term outcomes.

Guidance from the National Institute for Health and Care Excellence (NICE) concluded that although the evidence on ESWT for refractory Achilles tendinopathy raises no major safety concerns, evidence on efficacy of the procedure is inconsistent. NICE encourages further research into ESWT for Achilles tendinopathy, which may include comparative data collection. Studies should clearly describe patient selection, treatment protocols, use of local anesthesia and the type and duration of energy applied. Studies should include validated outcome measures and have a minimum of one year of follow-up. (NICE, 2016)

Calcific Tendinitis of the Shoulder (Rotator Cuff)

Review of the recent clinical evidence suggests that, based on conflicting findings, high-energy ESWT is promising but not yet proven for improving pain and shoulder function in clinically significant ways for some patients with chronic calcific shoulder tendinitis; additional standardization of energy levels and treatment protocols are needed as well as additional data to address safety concerns and assess in which patient population benefits outweigh harm.

Xue et al. (2024) conducted a systematic review and meta-analysis on the effects of extracorporeal shock wave therapy (ESWT) for rotator cuff tendinopathy. A total of seventeen studies (n = 1131) from 2006-2023 were included in the review. The results showed that compared with the control group, ESWT for pain, function, range of movement (ROM) and external rotation were statistically significant, with a total effective rate (TER) (OR = 3.64, 95% CI 1.85, 7.14, p = 0.0002). However, ROM-Abduction (SMD = 0.72, 95% CI -0.22, 1.66, p = 0.13) was not statistically significant. The authors concluded ESWT may be a promising approach for the treatment of rotator cuff tendinopathy. Due to the limited quality and number of included trials, additional high-quality prospective clinical studies are needed to verify these conclusions. Limitations of the study include lack of random allocation and concealment methods leading to selection bias, and language limitations.

A Hayes Health Technology Assessment (2022, updated August 2023) evaluated the efficacy of ESWT for treating symptomatic calcific tendinitis of the shoulder when conservative therapies have failed. Twelve RCTs were included in the assessment. ESWT was associated with improvement in function from baseline and reduction of pain in some patients with calcific tendinitis of the shoulder. Evidence comparing ESWT with clinical alternatives yielded conflicting findings or was limited in quantity. Primary complications were pain or discomfort during or just after treatment, bruising, and swelling. Hayes noted the overall quality of evidence was low and while ESWT appears to be safe and effective, continued research is needed to determine optimal ESWT treatment parameters, clarify comparative benefit versus alternative treatments, and establish treatment durability. Follow-up beyond twelve months was also recommended.

According to the NICE guidance on the use of ESWT for calcific tendonitis of the shoulder, current evidence shows no major safety concerns in the short-term. However, evidence on efficacy is noted as inadequate. NICE recommends that ESWT for calcific tendinopathy in the shoulder should only be used in the context of research and further research should include RCTs comparing the procedure with current best practice. (NICE, 2022)

Shao et al. (2022) conducted a RCT to investigate the effect of ESWT on short-term functional and structural outcomes after rotator cuff repair. Two groups randomized to either the ESWT group (n = 19) or the control group (n = 19) participated in five weeks of advanced rehabilitation three months after rotator cuff repair. The ESWT group also received 2000 pulses of shockwave therapy once a week for five weeks. All individuals had clinical and magnetic resonance imaging (MRI) examinations at three months (baseline) and at six months (follow-up) after surgery. Thirty-two participants completed all assessments. Pain and function improved in both groups. At six months post repair, pain intensity was lower and American Shoulder and Elbow Surgeons form scores were higher in the ESWT group than in the control group (all p-values < 0.01). Signal/noise quotient near the suture anchor site decreased significantly from baseline to follow-up in the

ESWT group ($p = 0.008$) and was significantly lower than that in the control group ($p = 0.036$). Muscle atrophy and the fatty infiltration index did not differ between groups. The authors concluded radial ESWT reduced early shoulder pain and accelerated proximal supraspinatus tendon healing at the suture anchor site post rotator cuff repair. However, the authors note that in terms of functional outcomes at the short-term follow-up, radial ESWT does not appear to be superior to advanced rehabilitation. Limitations include small sample size, short follow-up period, and the study only included individuals with medium to large rotator cuff tears. The authors suggest further studies are needed to evaluate the correlation between energy flux density and biological effects.

Surace et al. (2020) reviewed thirty-two RCTs and controlled clinical trials involving 2281 participants with rotator cuff disease with or without calcific deposits. The primary comparison was shock wave therapy compared to placebo with a 3-month follow-up. The findings favored ESWT vs. placebo for pain levels [standardized mean difference (MD) -0.49 , 95% CI -0.88 to -0.11] and functional status (standardized MD 0.62 , 95% CI 0.13 to 1.11). The adverse events were more frequent with ESWT than placebo (relative risk 3.61 , 95%CI 2.00 to 6.52). The authors concluded there were very few clinically important benefits of ESWT and uncertainty regarding its safety based on the currently available low- to moderate-certainty evidence.

Testa et al. (2020) completed a systematic review of two electronic medical databases searching for studies on the use of ESWT therapy without surgical treatment with symptoms duration more than two months, and at least six months of follow-up for treating rotator cuff tendinopathy, subacromial impingement, and medial and lateral epicondylitis (LE). After screening 822 articles that met the initial criteria, 26 articles were selected that met their criteria after a full-text review. The authors concluded that ESWT is a safe and effective treatment of soft tissue diseases of the upper limbs. Even in the minority cases when unsatisfied results were recorded, high energy shockwaves were nevertheless suggested in prevision of surgical treatment. The authors however reported a moderate overall risk of bias that could have influenced their analysis.

Bannuru et al. (2014) conducted a systematic review ($n = 28$ RCTs/1307 subjects) of the evidence to assess the efficacy of ESWT in patients with calcific and non-calcific tendinitis. The outcome measures included pain, function and calcification resolution which was evaluated only in calcific tendinitis trials. High-energy ESWT was found to be statistically significantly better than placebo for both pain and function. The results for low-energy ESWT favored ESWT for function, while results for pain were inconclusive. The reduction in calcification was significantly greater after high-energy ESWT than after placebo treatment; results for low-energy ESWT were inconclusive. No significant benefit was found between ESWT and placebo for non-calcific tendinitis. The authors concluded that high-energy ESWT is effective for improving pain and shoulder function in chronic calcific shoulder tendinitis and can result in complete resolution of calcifications.

Verstraelen et al. (2014) conducted a systematic review and meta-analysis of RCTs across five electronic online databases to identify all RCTs that compared high-energy ESWT (> 0.28 mJ/mm²) with low-energy ESWT (< 0.09 mJ/mm²) in treating patients with calcifying rotator cuff tendinitis. The literature search originally identified 194 potentially relevant studies; 189 of which were screened out as they did not meet the criteria for the analysis. The total study population from five RCT's of low-versus high-energy ESWT consisted of 359 participants. All five RCTs showed greater improvement in functional outcome (Constant-Murley score) in patients treated with high-energy ESWT compared with patients treated with low-energy ESWT at three and six months. The three-month MD was 9.88 (95% CI, 9.04 – 10.72 , $p < 0.001$; 6-month data could not be pooled). Furthermore, high-energy ESWT more often resulted in complete resorption of the deposits at three months. The corresponding odds ratio was 3.40 (95% CI, 1.35 – 8.58) and $p = 0.009$ (6-month data could not be pooled). Based on the meta-analysis, the authors concluded that high-energy ESWT is more effective than low-energy ESWT in terms of functional outcome (Constant-Murley score) and radiographic resorption (chance of complete resorption) of the deposits after three months. However, there is still a need for high-quality RCTs to discover the exact dose-response relation. In the authors' opinion, this future research should focus on high-energy ESWT because current available evidence indicates that high-energy ESWT is more effective than low-energy ESWT regarding the functional and radiologic outcomes in the short term and midterm.

Clinical Practice Guidelines

Canadian Agency for Drugs and Technologies in Health (CADTH)

A 2016 report issued by the CADTH reviewed evidence on the effectiveness of shockwave therapy for pain associated with upper extremity orthopedic disorders including rotator cuff tendinopathy and epicondylitis. Evidence from four systematic reviews suggests that, in comparison with placebo, shockwave therapy using high energy is effective in reducing pain in calcific tendinitis of the shoulder. Evidence suggests that there is no significant benefit with ESWT compared to placebo or other treatments in case of non-calcific tendinitis of the shoulder. It should be noted however, that there is considerable overlap in the studies included in the four systematic reviews, hence findings are not mutually exclusive. The authors noted it appears that in general, the techniques for using SWT for all orthopedic disorders still need to be standardized. There appears to be a lack of consensus regarding the definitions for high and low energy SWT.

Other issues include determination of precise doses and optimal frequency of application, whether the shockwaves should be directed to the target area by radiological or ultrasound imaging, and whether local anesthetic injections should be used in the target area prior treatment to reduce pain. (CADTH, 2016)

Chronic Plantar Fasciitis (Including Plantar Fibromatosis and Plantar Nerve Lesion)

Evidence in the form of RCTs regarding the efficacy of ESWT for plantar fasciitis (PF) is conflicting and inconsistent.

In 2024 Cortés-Pérez et al. conducted a systematic review and meta-analysis comparing the efficacy of ESWT versus CS injections on pain, thickness of plantar fascia and foot function in patients with PF. Sixteen RCTs (n = 1121 participants) were included in the review with acute and chronic PF. The participants (ESWT 561; CS injections 560) were analyzed post-intervention from four to six weeks, and three, six and twelve months. Regarding pain intensity, the results demonstrated in the immediate post-evaluation, no differences were found between CS injections and ESWT. Differences favoring ESWT in reducing pain intensity were observed in three and six months. At three months high-intensity ESWT is the most indicated dose in reducing thickness of PF. On foot function, ESWT was favored over CS injections at three and six months. At one year follow-up no significant differences were shown between therapies. The authors concluded ESWT is a safe therapy. Findings suggest radial and high-intensity dose are the most adequate for improving pain and foot function. Limitations in the study include low level evidence, generalizability, methodology quality, risk of bias, inadequate concealment and heterogeneity.

A double-blind, RCT by Gezginaslan and Başar (2021) was performed to investigate the effect of density and number of sessions ESWT on pain, fatigue, disability, physical function, and quality of life in patients with PF. Between September 2019 and December 2019, a total of 94 patients with the diagnosis of PF were included in the study. All patients were randomly divided into three groups. Group 1 (n = 33) received a total of seven sessions of high-energy flux density (H-ESWT) (0.26 mJ/mm²), group 2 (n = 31) received a total of three sessions of H-ESWT (0.26 mJ/mm²), group 3 (n = 30) received total of seven sessions of low-energy flux density (< 0.08 mJ/mm²) with three days interval. At baseline and one month after the treatment, the VAS, Short Form-36, Foot Function Index (FFI), Functional Assessment of Chronic Illness Therapy (FACIT)-Fatigue Scale, and Six-Minute Walking Test (6MWT) scores were compared among the groups. Of the patients, 69 were females and 25 were males with a mean age of 45.0 ±8.43 (range, 25-67) years. There were no statistical differences in the age, sex, demographic characteristics, and baseline VAS, FFI, 6MWT, and FACIT scores between the groups (p > .05). However, there was a statistical decrease in the VAS, FACIT, and FFI scores in all groups after treatment compared to baseline, although only the 6MWT, and Short Form-36 subscale scores were statistically higher (p < .05). There was also a statistical difference in the scale scores in Group 1 versus Group 2 and in Group 2 versus Group 3. The authors concluded the study results suggest that H-ESWT for high number of sessions is more effective than LESWT for low number of sessions on pain, quality of life, physical function, fatigue, and disability in patients with PF. The short terms follow-up (one month) did not allow for assessment of intermediate and long-term outcomes. A small sample size (n = 94) makes it difficult to determine whether these conclusions can be generalized to a larger population. Further investigation is needed before clinical usefulness of this procedure is proven.

Asheghan et al. (2020) completed a RCT to compare the effectiveness of ultrasound-guided dextrose prolotherapy with radial extracorporeal shock wave therapy (ESWT) in the treatment of chronic PF. This RCT was conducted on 59 patients with chronic PF. The patients were randomly assigned into two groups receiving three sessions of radial ESWT (29 patients) vs. two sessions of ultrasound-guided intrafascial 2 cc dextrose 20% injection (30 patients). The following outcome measures were assessed before and then six weeks and 12 weeks after the treatments: pain intensity by VAS, daily life and exercise activities by Foot and Ankle Ability Measure (FAAM), and the plantar fascia thickness by ultrasonographic imaging. The VAS and FAAM scales showed improvements of pain and function in both study groups at six weeks and 12 weeks after the treatments. A reduction was noted for plantar fascia thickness at these intervals (all p < .05). The inter-group comparison revealed that except for the FAAM-sport subscale which favored ESWT, the interaction effects of group and time were not significant for other outcome measures. Dextrose prolotherapy has comparable efficacy to radial ESWT in reducing pain, daily-life functional limitation, and plantar fascia thickness in patients with PF. No serious adverse effects were observed in either group. The authors concluded that dextrose prolotherapy and ESWT have comparable outcomes, however, ESWT appears to be a good alternative choice due to lower costs and possible equal or better effectiveness in clinical practice. This study has several limitations. The authors were not able to completely blind the patients, most participants were female, and results may not be generalized to the male population, and there was no control group. Further studies with a larger sample size and long-term follow-up are needed.

A RCT by Cinar et al. (2020) was performed to determine whether a combination of ESWT with standard care (exercise and orthotic support) improves functional ability in patients with PF when compared to standard care alone. Participants with PF were randomly allocated into two groups: ESWT (n = 23), and control (n = 21). All participants received a home exercise program with orthotic support. In addition, ESWT group received 2000 shock waves with 0.02 mJ/mm² for three sessions. Functional outcomes were measured by function subscale of American Orthopedic Foot and Ankle Society

(AOFAS-F) score and 12 minutes walking test including walking speed, cadence. The scores were recorded at baseline, third week and third month after the treatment. Analysis was performed using repeated measures ANOVA, and an intention to treat approach using multiple imputations. Results showed that there was improvement in AOFAS-F total score and walking speed over three months in both groups ($p < 0.001$, $p = 0.04$ respectively); improvements in AOFAS-F were particularly in activity limitation ($p = 0.001$), walking distance ($p = 0.02$) and walking surface ($p = 0.02$). Groups were comparable with each other for both walking speed and AOFAS-F in any assessment time ($p > 0.05$). However, groups performed differently in cadence where there was an increase in cadence in ESWT group whereas a decline in control at the third month ($p = 0.07$). The results revealed that ESWT did not have an additive benefit over usual care to improve foot function and walking performance in patient with PF over three months post-treatment. There are limitations to this study. Gait function was not evaluated. A small sample size makes it difficult to decide whether these conclusions can be generalized to a larger population. The findings of this study need to be validated by well-designed studies.

Lai et al. (2018) published the results of a prospective RCT which evaluated and compared the therapeutic effects of ESWT and corticosteroid injections (CSI) in patients with chronic PF. The study also examined the correlation between plantar fascia thickness changes and clinical outcomes. Patients were included if they had more than two months without an injection and had been treated with conservative treatment for one month, without improvement before proceeding to ESWT or CSI treatment. Patients (110) were randomly assigned to receive ESWT or CSI. The authors summarized that ESWT was more efficient in reducing chronic fasciitis pain after 12 weeks than corticosteroid injection. Furthermore, the increase in plantar fascia thickness after ESWT, the more efficient the clinical outcome. However, further long-term studies with large patient populations are needed to validate the findings of this study.

Sun et al. (2017) performed a meta-analysis of RCTs ($n = 9$ studies/935 subjects) to compare the effectiveness of general ESWT, focused shock wave (FSW), and radial shock wave (RSW) to placebo for chronic PF. Limitations of the analysis include the lack of comparison to established treatment methods. The authors concluded that FSW may be associated with higher success rate and greater pain reduction compared to sham therapy in chronic PF patients. However, additional high-quality clinical trials and systemic reviews are needed to demonstrate the efficacy of ESWT (e.g., FSW, RSW therapies) and determine whether RSW therapy is an ideal alternative therapeutic method to conservative treatment and surgery.

Gollwitzer et al. (2015) published the results of a double-blind RCT involving 250 subjects with PF randomized to ESWT or placebo intervention and followed for 12 weeks post-treatment. The authors reported that the VAS composite score showed a significant difference in the reduction of heel pain in the ESWT group vs. the placebo group (69.2% vs. 34.5 %). They also stated that the ESWT group demonstrated significantly superior results on the Roles and Maudsley score, a subjective 4-point patient assessment of pain and limitations of activity. No test for the accuracy of the blinding was conducted.

In 2014, Yin and colleagues published a systematic review and meta-analysis of studies involving ESWT for PF. The authors included a total of seven studies that were either RCTs or quasi-RCTs involving subjects with PF of at least 6 months duration. The primary outcome was treatment success rate. Among the five studies included in the pooled analysis for low energy devices, the result indicated that low energy ESWT was more likely to lead to treatment success than control treatment. However, the authors noted significant heterogeneity in the definitions for treatment success across studies. The pooled analysis for high energy ESWT devices involved two studies, and no difference between the ESWT and control treatments was reported. This study is hampered by the heterogeneity of the definition of treatment success across studies, as well as the basic issues of the base studies themselves, which are addressed above.

Dizon et al. (2013) conducted a systematic review and meta-analysis of clinical trials (2002-2010) to evaluate the effectiveness of ESWT in treating chronic PF. Eleven studies were included in this review. The primary outcome measure of interest was overall pain in the morning and during activity. Compared to placebo control, ESWT was more effective in reducing morning pain. There was no difference between ESWT and control in decreasing overall pain; however moderate-intensity ESWT was more effective in decreasing overall activity pain. There was no significant difference in the effectiveness of decreasing activity pain. Both moderate-and high-intensity ESWT were more effective in improving functional outcome. Acknowledged study limitations include the lack of consistency in outcome measure, specified dose intensities and follow-up.

A 2009 guidance statement from NICE states that the current evidence on the efficacy of ESWT for refractory PF raises no major safety concerns; however, current evidence on its efficacy is inconsistent. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and audit or research. NICE encourages further research into ESWT for refractory PF in the form of clinical studies with clearly described patient selection and treatment protocols, including a description of local anesthesia use and the type of energy applied. (NICE, 2009b)

Clinical Practice Guidelines

American College of Foot and Ankle Surgeons (ACFAS)

In 2017 the ACFAS released a consensus statement for the diagnosis and treatment of adult acquired infracalcaneal heel pain. This document includes the statement, “Extracorporeal shockwave therapy (ESWT) is safe and effective in the treatment of plantar fasciitis.” A general observation across all studies was that approximately 70% of patients with chronic or subacute PF who underwent ESWT had experienced meaningful improvement in their heel pain at 12 weeks. ESWT, however, does not appear to be an effective first-line option for patients with acute PF. This consensus does not take into account the issues raised above regarding conflicting findings and potential bias in study results from questionable or lack of blinding, use of subjective and self-reported data, and the other methodological issues. (Schneider, 2017)

Canadian Agency for Drugs and Technologies in Health (CADTH)

A 2016 report issued by the CADTH reviewed evidence on the effectiveness of shockwave therapy for pain associated with lower extremity orthopedic disorders including PF. It was concluded that more evidence is needed to determine whether ESWT is more clinically effective than surgery for pain associated with lower extremity orthopedic disorders. (CADTH, 2016)

A technology assessment of RCTs evaluating the safety and efficacy of ESWT for the treatment of chronic PF was performed for the CADTH. Ho (2007) concluded “the lack of convergent findings from these randomized trials of ESWT for PF suggests uncertainty about its effectiveness. The evidence reviewed does not support the use of this technology for this condition.”

Delayed or Nonunion Fractures

Conclusive evidence recommending ESWT as an effective treatment for delayed or nonunion fractures is lacking.

The Cochrane Library published a systematic review and meta-analysis conducted by Searle et al. (2023) to assess the effects of low-intensity ultrasound (LIPUS), high-intensity focused ultrasound (HIFUS) and ESWT as part of the treatment of acute fractures in adults. The review included twenty-one studies (n = 1543 fractures) in 1517 participants, no studies tested HIFUS. The results showed very low-certainty evidence for the effect of LIPUS on HRQoL at up to one year after surgery for lower limb fractures (MD 0.06, 95% confidence interval (CI) -3.85 to 3.97, favors LIPUS; 3 studies, 393 participants). There was no difference in time to return to work after people had complete fractures of the upper and lower limbs (MD 1.96 days, 95% CI -2.13 to 6.04, favors control; 2 studies, 370 participants; low-certainty evidence). There is little or no difference in delayed union or non-union up to twelve months after surgery (RR 1.25, 95% CI 0.50 to 3.09, favors control; 7 studies, 746 participants; moderate-certainty evidence) nor any difference of skin irritation between groups. There was uncertainty whether ESWT reduces pain at twelve months after surgery in fractures of the lower limb (MD -0.62, 95% CI -0.97 to -0.27, favors ESWT); the difference between pain scores was not clinically important and evidence was low. The effect of ESWT on delayed or non-union at twelve months was low certainty of evidence (RR 0.56, 95% CI 0.15 to 2.01; 1 study, 57 participants). There were no treatment-related adverse events for ESWT. Data was not reported for HRQoL, functional recovery, time to return to normal activities, or time to fracture union. The authors concluded the effectiveness of ultrasound and shock wave therapy for acute fractures in terms of patient-reported outcomes was uncertain. Future studies of high quality evidence are needed. The limitations of the study include high risk of bias, small sample sizes, and inconsistencies in study findings.

A systematic review was completed by Kwok et al. (2022) to evaluate the use of ESWT in the treatment of foot and ankle fracture non-unions. Four databases were searched to identify relevant studies in the available literature. Eight studies were reviewed, demonstrating union rates of 65%-100% and 90-100% at three- and six-months following ESWT treatment, respectively. No major complications were seen in any of the studies. Minor complications included local soft tissue swelling, petechiae, bruising and pain. The authors concluded that the literature that is currently available is limited to case series of relatively small sample sizes, highlighting the need for a prospective, RCT to further investigate the efficacy of ESWT in the treatment of foot and ankle fracture non-unions.

In a systematic review by Willems et al (2019) evaluating ESWT for treatment of delayed or non-union fractures, the authors found that high quality RCTs are still needed to validate the efficacy and safety of this treatment. The review included 30 peer reviewed studies consisting of two RCTs and 28 prospective and retrospective cohort studies involving a total of 2027 delayed-unions and nonunions in adults. Delayed-unions treated with ESWT had a union rate of 86% (n = 314) while nonunions treated with ESWT had a 73% (n = 1782) overall union rate. The overall union rate of nonunions treated with surgery was 81% (n = 80). Although the results showed similar union rates between ESWT and surgery-treated patients, none of the ESWT group had adverse events that required further care while there were severe adverse events noted in the surgery group. The authors found a lot of heterogeneity within and between the studies such as

fractures of different bones, the use of different energy settings, number of treatments and number of shock waves applied with the ESWT and a lack of consensus as to when the biological endpoint is reached in which no further bone healing occurs. The authors concluded that high quality RCTs should be conducted on the effect of ESWT with homogeneous groups and shock wave parameters so that treatment recommendations can be made.

Elster, et al. (2010) conducted a study with one hundred ninety-two patients were treated with ESWT at a single referral trauma center for treatment for tibia nonunion. Nonunion was determined by radiographic or CT analysis at least six months following operative or nonoperative treatment, with at least three months of no radiographic changes. Fracture healing was determined by radiographic or CT analysis. At the time of last follow up, 138 of 172 (80.2%) patients demonstrated complete fracture healing. Mean time from first shock wave therapy to complete healing of the tibia nonunion was 4.8 months. Associated factors influencing fracture healing included number of orthopedic operations shock wave treatments and pulses delivered. Patients requiring multiple (more than one) shock wave treatments versus a single treatment had a significantly lower likelihood of fracture healing. This study concludes that high energy ESWT may be used successfully in the treatment of tibia nonunions. The reported healing rate of 80% and the large sample size gives this study relevance; however, limitations include retrospective design and lack of a control group using immobilization alone. Although this study evaluated nonunion of tibia fractures, there is potential for future investigation of ESWT in the treatment of fracture and arthrodesis nonunion in the foot and ankle.

Zelle et al. (2010) conducted a systematic review to evaluate the results of ESWT in the treatment of fractures and delayed unions/nonunions. Ten studies were included and involved 924 patients who underwent one to three treatment sessions. The overall union rate in patients with delayed union/nonunion was 76% and ranged from 41% to 85%. The authors concluded that while promising, ESWT for the treatment of fractures and delayed unions/nonunions requires further studies. Additional studies need to investigate how shock wave therapy compares with other treatment approaches and if different anatomic fracture locations demonstrate different success rates. In addition, the optimal treatment dose needs to be identified in further investigations.

A RCT by Cacchio et al. (2009) compared ESWT with surgical treatment in 126 patients with long-bone non-unions. Outcomes were measured using x-rays. Each group showed the same amount of healing at six, 12 and 24 months. The authors concluded that ESWT is as effective as surgery in stimulating union of long-bone hypertrophic non-unions. The study is limited by lack of blinding and a control group. Additional studies are needed to further validate the results.

Hammer Toe

A detailed search of the medical peer-reviewed literature did not identify any clinical studies that evaluated ESWT for the treatment of hammer toe.

Lateral Epicondylitis (Tennis Elbow)

Evidence in the form of RCT regarding the efficacy of ESWT for LE is conflicting and inconsistent.

Cetin et al. (2024) conducted a randomized prospective study comparing the clinical outcomes of patients with LE treated with local massage, corticosteroid (CS) injection, and ESWT. After exclusions the study included thirty-eight patients (Group 1/local massage 9; Group 2/CS injection 13; Group 3/ESWT: 16) who had not received any treatment for the LE in the last six months. All three groups were clinically evaluated using the Visual Analog Scale (VAS) Disabilities of the Arm, Shoulder, and Hand (DASH), and DASH-Work Model (DASH-WM) scores at the initial examination at the beginning of the study and at two-week, three-month, and six-month follow-up. The results demonstrated in Group 1, all three scores decreased significantly in the first two weeks, but no significant difference was observed in any of the scores at the six-month follow-up. Group 2 showed a significant decrease in all scores at two weeks, whereas no statistically significant decrease was observed in any of the scores at six months. However, a significant decrease was observed in VAS and DASH scores at three months. Group 3 showed statistically significant decreases in all scores throughout the follow-up period. The authors concluded ESWT was superior to both local massage and CS injection treatments throughout the study and at final follow-up. However, there are relatively few studies that show the superiority of these treatments over one another and there is still no consensus on a standard, effective method used for LE. Further studies on combined treatment modalities are needed on this subject. Limitations include small sample size, study design and short follow-up.

A systematic review and network meta-analysis by Liu et al. (2022) was completed to examine the efficacy of ESWT and injection therapies by synthesizing direct and indirect evidence for all pairs of competing therapies for LE. PubMed, EMBASE, and Web of Science databases were searched for all appropriate RCTs, assessing the effect of ESWT or injection therapies. The primary outcome was short-term (≤ 3 months) and medium-term (> 3 months but ≤ 12 months) pain, while the secondary outcomes were grip strength and patient-reported outcome measures. All outcomes were assessed using standardized mean differences (SMDs) with 95% confidence intervals and were ranked using surface under the cumulative ranking curve (SUCRA) probabilities to determine a hierarchy of treatments. Sensitivity analysis was

performed to eliminate potential therapeutic effects of normal saline (NS) and exclude trials that included patients with acute LE. Results: 40 RCTs were included to evaluate ESWT and five different injection therapies, including corticosteroids, autologous whole blood, platelet-rich plasma, botulinum toxin A (BoNT-A), and dextrose prolotherapy (DPT). DPT [-.78 (-1.34 to -.21)], ESWT [.57 (-.89 to -.25)], platelet-rich plasma [-.48 (-.85 to -.11)], and BoNT-A [-.43 (-.84 to -.02)] outperformed placebo for short-term pain relief; ESWT [-.44 (-.85 to -.04)] outperformed placebo for medium-term pain relief. DPT was ranked as the most optimal short-term and medium-term pain reliever (SUCRA, 87.3% and 98.6%, respectively). ESWT was ranked as the most optimal short-term and medium-term grip strength recovery (SUCRA; 79.4% and 86.4%, respectively). The authors concluded that DPT and ESWT were the best two treatment options for pain control and ESWT was the best treatment option for grip strength recovery. Corticosteroids were not recommended for the treatment of LE. More evidence is required to confirm the superiority in pain control of DPT among all these treatment options on LE. Limitations to the study included no standardized treatment protocol for each treatment, as well as no standardized protocols and treatment modalities in ESWT. The effectiveness of ESWT may change with the evolution of the times and advancement of machines. Further research with RCTs is needed to validate these findings.

Özmen et al. (2021) performed a comparison study to determine the clinical and sonographic effects of ultrasound (US) therapy, ESWT, and Kinesio taping (KT) in LE. A total of 40 patients with LE were included in the study. The patients were randomly assigned to three treatment groups: US (n = 13), ESWT (n = 14), and KT (n = 13) groups. The VAS scores decreased in all groups ($p < 0.05$). Grip strength increased after eight weeks in only the KT group ($p < 0.05$). The Patient-Rated Tennis Elbow Evaluation Scale scores significantly decreased after two weeks and after eight weeks in the US group and ESWT groups, and after eight weeks in the KT group ($p < 0.05$). Common extensor tendon (CET) thicknesses decreased after eight weeks in only the ESWT group ($p < 0.05$). The authors concluded that the US therapy, KT, and ESWT are effective in reducing pain and improving functionality. However, none of these treatment methods were found to be superior to others in reducing the pain and improving functionality. Limitations of the study include small sample size (40 patients) and short duration of follow-up. Also, there was no exercise intervention in addition to the treatment methods applied. Grip strength may be increased by strengthening the forearm muscles.

Atalay and Gezginaslan (2020) completed a RCT to evaluate the effectiveness of neural therapy (NT) versus ESWT in the treatment of LE. Between August 2018 and November 2018, 76 patients with LE (26 males, 50 females; mean age: 44, 8 ±9.5 years; range, 29–65 years) were randomly allocated to either NT or ESWT one session weekly for a total of three weeks. The subjective pain severity was evaluated using the VAS and Duruoz Hand Index (DHI) was used to assess the functional disability before and after treatment and at 12 weeks. When the before and after treatment and 12 weeks variances of values were compared between ESWT and NT groups, there were no differences in the VAS and DHI scores between the groups ($p > 0.05$) [VAS score at 12 weeks (effect size = 0, 18, 95% confidence interval {CI}: -0,358–1,619) or DHI score (effect size = 0, 13, 95 % CI: -7,627–4,390)]. However, within the groups, there were differences in VAS and DHI scores between before treatment and after treatment ($p < 0.05$), and between before treatment and at 12 weeks follow up ($p < 0.05$). No adverse events occurred in this study. The authors concluded that the results of this study showed that both ESWT and NT have similar effects in reducing pain and hand function in patients with LE. However, neither of two the treatment modalities showed superiority. There are some limitations to this study. The number of subjects in the study is small which could have decreased the power of the study. As there was no control group, the authors could not determine the effect of two therapeutic methods. The lack of blinding, qualitative data/feedback from patients, non-treatment group or routine care group, and long-term outcomes are the other limitations of the study. Further investigation with large-scale, prospective, long-term outcomes, placebo-controlled studies are needed.

In a systematic review and meta-analysis by Yao et al. (2020), the authors found that additional high quality RCTs are still needed to validate that ESWT safely and effectively relieves the pain and functional impairment from LE. The meta-analysis included 13 published RCTs that included 1035 patients, of which 501 patients received ESWT and 534 received other treatments. Due to the heterogeneity of the studies, the authors performed a pooled analysis of the data which they concluded showed significantly lower VAS scores (0 indicating no pain and 10 the worst pain) indicative of early recovery and significantly increased grip strength in the ESWT treatment group. There were also several limitations of the meta-analysis identified by the authors, including different ESWT instruments, treatment protocols, diagnostic criteria, and the fact that the majority of the studies were conducted in one country. The authors concluded that future RCTs should address these limitations.

Another systematic review and meta-analysis completed in 2020 by Yoon et al. focused on the effect of ESWT on LE for reducing pain and improving grip strength as well; however, the analysis also investigated the effects of ESWT according to the specific type applied, symptom duration and follow up duration. In this review, 12 studies with 1104 patients were included in the meta-analysis with ten of the 12 studies having also been included in the Yao systematic review and meta-analysis. This meta-analysis concluded that ESWT did not show clinically important improvement in pain reduction and grip strength although the authors did conclude that radical ESWT was more effective than focused ESWT and that patients with longer duration of symptoms had more improvement while the effects did not last beyond 24 weeks. Yoon et al. also noted the heterogeneity of the studies included in the review and the diversity of the treatment protocols, shock

wave devices and length of treatment among the studies. The authors recommended future studies on specific conditions and parameters to establish optimal protocol settings for ESWT for LE.

Aydin and Atiç (2018) performed a prospective RCT comparing the efficacy of ESWT to wrist-extensor splint (WES) application in the treatment of LE. Patients were included if they had been treated based on a diagnosis of unilateral LE. Patients were excluded if they had bilateral LE, carpal tunnel syndrome, cubital tunnel syndrome, previous elbow surgery, previous conservative and surgical treatment for LE, neurological deficits in the upper extremity, systemic disease, other diseases in the neck and shoulder region, lateral epicondylar tendon ruptures, tumors in the forearm and elbow, osteoporosis, and hemophilia. The patients were randomized into two groups. Group one received ESWT four times per week using the DolorClast device and group two received a wrist extensor splint. The primary outcomes measured were the effectiveness of ESWT compared to WES in decreasing pain, improving grip strength, increasing quality of life, and alleviating arm pain during daily life activities in the treatment of LE. Evaluation data were collected before and after treatment at weeks four, 12, and 24. In both groups there were significant improvements in decreasing pain, increasing grip strength and improving quality of life at four, 12, and 24 weeks compared to pretreatment values. However, there was no statistically significant difference between the two groups at the three time points. The authors noted limitations of the study were the small patient population and use of the patient-reported questionnaires.

Capan et al. (2016) conducted a double-blind, randomized, placebo-controlled trial in outpatient clinics of a medical faculty hospital. Fifty-six patients with LE were randomized to radial ESWT or sham radial ESWT groups. Both the patients and the outcome assessing investigator were blinded to group assignment. The radial ESWT was administered to the painful epicondyle at the elbow at each session at three once weekly sessions. Sham radial ESWT was applied without the contact of the applicator at the same area. Study patients were assessed at baseline and at one and three months after treatment using a VAS for pain, Roles and Maudsley scale and Patient-Rated Tennis Elbow Evaluation for pain and function. Grip strength of the affected extremity was also measured using a hand dynamometer. Both radial ESWT and sham radial ESWT groups showed a significant improvement in all outcome measures at post treatment follow-up points. Favorable absolute and percentage changes in assessments at one- and three-months post treatment did not show any significant difference between groups. The authors concluded radial ESWT does not seem to be more effective either in reducing pain or improving function or grip strength in patients with LE at least at three mos. after treatment when compared with sham radial ESWT.

Refractory Greater Trochanteric Pain Syndrome (GTPS)

There is insufficient quality evidence to conclude ESWT is effective for GTPS therefore, additional research involving larger, well-designed studies is needed to establish its safety and efficacy.

Harding et al. (2024) conducted a systematic review and meta-analysis to investigate the efficacy of shock wave therapy (SWT) on pain and function in the management of GTPS compared to alternative treatment interventions. The study included a total of 1221 participants of which 849 underwent SWT and post treatment follow-up ranged from one week to two years. The results demonstrated within RCTs, large treatment effects were identified across all follow-up timepoints for pain in SWT groups. Following SWT in non-RCTs, a large treatment effect for pain was consistently seen across all timepoints. Moderate-large functional treatment effects of SWT in RCTs were seen at all follow-up timepoints. Within non-RCTs SWT resulted in moderate treatments effects in all time points. The authors concluded although moderate strength evidence was found, SWT was not significantly beneficial compared to control for pain or function over time. Further robust RCTs investigating the impact of optimal treatment protocols of SWT on acute versus chronic would be beneficial for optimizing patient care. Limitations in the study include methodological heterogeneity, risk of bias, and lack of standardization.

The ECRI Institute published an Executive Summary on the use of ESWT for chronic lateral hip pain / GTPS with a focus on the safety and efficacy of ESWT used with or in place of physical therapy, pain medication, and other non-surgical treatments. The review included one systematic review (n = 295) of controlled studies and two RCTs (n = 103 and n = 50) that were not included in the systematic review. The Executive Summary concluded that the evidence is inconclusive due to limited data available and the high risk of bias from the studies reviewed because of lack of randomization or complete blinding, small size, high attrition, and single-center focus. Other published data that were not included in the review were excluded because the risk of bias was higher and because there were too few patients per treatment. ECRI Institute recommended large, multi-centered studies to validate available data and to assess long term outcomes related to pain recurrence and retreatment. (ECRI 2020)

Ramon et al (2020) completed a randomized, multicenter clinical trial with 103 participants with chronic GTPS. The participants were divided into two groups, both of which were treated with three weekly sessions of focused extracorporeal shockwave treatment (F-ESWT) with the test group (n = 53) receiving an energy flux density (EFD) of 0.20 mJ/mm² and the control group (n = 50) receiving the lowest EFD of the device (0.01 mJ/mm²) using the same brand of

device. Each participant was assessed at baseline and one, two, three, and six months after the last session by clinicians blinded to the group allocation. The authors concluded that F-ESWT and a specific home exercise program is safe and effective for GTPS, with a success rate of 86.8% at two months after treatment that was maintained until the end of the six-month follow-up. Limitations identified by the authors included a lack of follow-up beyond six months, a lack of exact data on participants' compliance with the home exercise protocol, the imbalance of participation by women (n = 74) to men (n = 29) in a sample size of only 103, which may not detect important differences in responses to the intervention between the sexes and that the control group received some albeit the lowest dose of ESWT so it could be considered a quasi-placebo group. The authors recommend further high-quality RCTs to confirm the long-lasting effectiveness of F-ESWT for GTPS.

In 2015, Mani-Babu et al. reported results of a systematic review and meta-analysis of studies evaluating ESWT for lower limb tendinopathies, including GTPS. The review included 13 studies providing sufficient data to compute effect size calculations. The energy level, number of impulses, number of sessions, and use of a local anesthetic varied between studies. The authors concluded that there was limited to moderate evidence to support ESWT as an effective intervention and should be considered for GTPS when other nonoperative treatments have failed.

Tenosynovitis of the Foot or Ankle

A detailed search of the medical peer-reviewed literature did not identify any clinical studies that evaluated ESWT for the treatment of tenosynovitis of the foot or ankle.

Tibialis Tendonitis

A detailed search of the medical peer-reviewed literature did not identify any clinical studies that evaluated ESWT for the treatment of tibialis tendonitis.

Wounds

ESWT mechanisms of action for wound healing are not fully elucidated in the literature. The current understanding is that the mechanical effects of the shock waves on cells trigger biological responses that enhance tissue perfusion and angiogenesis.

Hitchman et al. (2023) conducted a systematic review aimed at the role of ESWT in diabetic foot ulcer (DFU) healing and the impact of different ESWT doses. In total six RCTs published between 2009 and 2019 were analyzed. The primary outcome of the study was time to healing. The results demonstrated time to ulcer healing was probably shorter in patients treated with ESWT compared to standard ulcer care alone. Patients treated with ESWT were more likely to heal at twenty weeks post-ESWT compared with those treated with standard ulcer care alone. The authors concluded ESWT remains a promising new treatment but the translation into routine clinical practice is still limited by the low certainty of evidence surrounding its effectiveness, case selection and optimum dose. Future trials are necessary and must be conducted in a scientific rigorous way to prevent wasting of resources and improve DFU care. Limitations in the study include risk of bias, small sample size and heterogeneity.

The ECRI Institute published a Clinical Evidence Assessment on the dermaPACE System in 2020 that focused on how the device compares with standard of care and other chronic wound treatments. ECRI concluded that the evidence is somewhat favorable when comparing dermaPACE with standard of care alone as it appears to improve complete DFU healing rates at 24-week follow-up and decreases time to wound closure. ECRI based their recommendation on two low-quality RCTs (n = 206, n = 130) that were multi-centered and double blinded based on pooled data from the same study participants. ECRI also reviewed a third RCT from a single-center, open-label study (n = 77; 84 ulcers) that compared dermaPACE with hyperbaric oxygen therapy in patients with chronic DFUs and reported rates of complete wound closure, improved healing, unchanged ulcers, and adverse events. They did not find any published studies that evaluated the effectiveness of dermaPACE for treating chronic wound types other than DFUs. dermaPACE has been granted De Novo clearance by the FDA only for treating DFUs at this time although it is intended to treat chronic wounds more broadly.

Huang et al. (2020) performed a systematic review and meta-analysis of eight RCTs (n = 339) to assess the safety and efficacy of ESWT on the healing of DFUs. The authors concluded that ESWT was associated with a greater reduction of the wound surface area, an increase of re-epithelialization and more patients with complete cure at the end of treatment. All the included studies were conducted by different medical centers in different countries with varied treatment protocols for treatment strength, frequency and duration. Patient ages ranged from 56.2 to 67.8 years. The control groups in the studies also received various treatments with standard wound care in six RCTs and hyperbaric oxygen therapy (HBOT) in two studies. The authors also found that ESWT was more effective than HBOT for treating DFUs. Limitations identified by the authors include the application of ESWT only to DFU wounds, the small number of included studies in the meta-analysis (< 10) and that cost effectiveness was not reviewed.

In a systematic review and meta-analysis, Zhang et al. (2018) examined the effects of ESWT and conventional wound therapy (CWT) for acute and chronic soft tissue wounds. A total of ten RCTs involving 473 patients were included in this systematic review and meta-analysis. The meta-analysis showed that ESWT statistically significantly increased the healing rate of acute and chronic soft tissue wounds 2.73-fold (OR = 3.73, 95 % CI: 2.30 to 6.04, $p < 0.001$) and improved wound-healing area percentage by 30.45 % (SMD = 30.45; 95 % CI: 23.79 to 37.12; $p < 0.001$). ESWT reduced wound-healing time by 3 days (SMD = -2.86, 95 % CI: -3.78 to -1.95, $p < 0.001$) for acute soft tissue wounds and 19 days (SMD = -19.11, 95 % CI: -23.74 to -14.47, $p < 0.001$) for chronic soft tissue wounds and the risk of wound infection by 53 % (OR = 0.47, 95 % CI: 0.24 to 0.92, $p = 0.03$) when compared with CWT alone. Serious adverse effects were not reported. The authors concluded that ESWT showed better therapeutic effects on acute and chronic soft tissue wounds compared with CWT alone. However, the authors noted that higher-quality and well-controlled RCTs are needed to further evaluate the role of ESWT for acute and chronic soft tissue wounds.

Omar et al. (2017) performed a systematic review of ten databases for clinical trials about ESWT in the management of chronic wound of lower extremity (CWLE). These were published between 2000 and 2016. A total of 11 studies with 925 patients were found. Expert therapists assessed the methodological qualities of the selected studies using the Physiotherapy Evidence Database (PEDro) scale and categorized each study according to Sackett's levels of evidence. Eight studies were categorized as level II; two studies were categorized as level III and one study was categorized as level V. In conclusion, this review demonstrated mild to moderate evidence to support the use of ESWT as an adjuvant therapy with a standardized wound care program. However, it is difficult to draw firm conclusions about the efficacy of ESWT. So, future research with high methodological quality is required to assess the efficacy and cost-effectiveness of this relatively new physical therapy application.

In a phase II RCT, Ottomann et al. (2011) evaluated shock wave effects in burn wounds. A predefined cohort of 50 patients (6 with incomplete data or lost to follow-up) with acute second-degree burns were randomly to receive standard therapy (burn wound debridement/topical antiseptic therapy) with ($n = 22$) or without ($n = 22$) defocused ESWT applied once to the study burn, after debridement. Randomization sequence was computer-generated, and patients were blinded to treatment allocation. Mean time to complete ($\geq 95\%$) epithelialization (CE) for patients that did and did not undergo ESWT was 9.6 ± 1.7 and 12.5 ± 2.2 days, respectively. The authors concluded that the application of a single defocused shock wave treatment to the superficial second-degree burn wound after debridement/topical antiseptic therapy significantly accelerated epithelialization. However, they also indicated that this finding warrants confirmation in a larger phase III trial.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The FDA has classified extracorporeal shock wave therapy (ESWT) products as class III devices through the premarket approval program (PMA) under the product code NBN (generator, shock-wave, for pain relief).

Devices used for extracorporeal shock wave therapy are extensive. Refer to the following website for more information and search by product name in device name section: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed May 31, 2024)

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The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [2024T0269HH]

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Policy History/Revision Information

Date	Summary of Changes
10/01/2024	<p data-bbox="337 205 584 237">Applicable Codes</p> <ul data-bbox="337 237 672 268" style="list-style-type: none"><li data-bbox="337 237 672 268">• Added CPT code 0864T <p data-bbox="337 268 664 300">Supporting Information</p> <ul data-bbox="337 300 1445 365" style="list-style-type: none"><li data-bbox="337 300 1445 331">• Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information<li data-bbox="337 331 992 365">• Archived previous policy version SURGERY 021.33

Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

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