Electrothermal Arthroscopy

Number: 0545

Policy

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.

Aetna considers electrothermal arthroscopy (also known as electrothermally-assisted capsule shift, and electrothermally-assisted capsulorrhaphy (ETAC)) of the joint capsule, ligaments, or tendons experimental and investigational for all indications, including any of the following because available scientific evidence does not permit conclusions concerning the long-term effects on health outcomes (not an all-inclusive list):

- Achilles injuries; or
- Adhesive capsulitis; or
- Ankle, hip, knee, or thumb instability; or
- Bankart lesions; or
- Bony avulsion of the capsule; or
- Deficient or thin capsule; or
- Frozen shoulder; or
- Glenohumeral joint (shoulder) instability; or
- Hill-Sachs lesions; or
- Humeral-side avulsion of the capsule; or
- Ligament tear and meniscal injury of the knee; or
- Multi-directional instability; or
- Temporomandibular joint dislocation; or
- Wrist injuries.

Policy History

Last Review 05/25/2017
Effective: 06/22/2001
Next Review: 05/24/2018

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes
Background
Thermal capsular shrinkage, also known as thermal capsulorrhaphy, is an arthroscopic procedure performed under general anesthesia that utilizes thermal energy/heat to shrink the tendons or ligaments of the synovial joint. Thermal capsulorrhaphy purportedly increases stability of the joint. It is theorized that when heat is applied to the tissue a molecular change occurs to the structure of collagen (the chief component of connective tissue, tendons and bones) causing the length of the collagen to shrink and tighten.

Examples of thermal capsular shrinkage devices include, but may not be limited to: ArthroCare system 2000 CAPS X ArthroWand; ORA-50 electrothermal system and accessories; VULCAN EAS electrothermal arthroscopy system and accessories; VAPR TC electrode for use with VAPR II electrosurgical system.

The shoulder joint is a ball and socket type of joint that permits a wide range of movement. Its bony structures include the humerus and the shallow cavity (the glenoid) of the shoulder blade, thus making it inherently unstable. A circle of ligaments, tendons, muscles and cartilage form a capsule around the joint to maintain stability. The glenoid labrum is the fibro-cartilage ring attached to the rim of the glenoid cavity, and acts to stabilize the humeral head inside the glenoid. The Bankart lesion is a specific injury to a part of the shoulder joint called the labrum.

Shoulder instability is defined as excessive movements of the shoulder that cause pain in daily activities or sporting activities. Dislocations occur when the head of the humerus completely pops out of the socket, and typically are the result of a complete dislocation with capsulo-labral avulsion, a tearing away of the labrum from the glenoid rim. The first few times this happens, it is usually with significant, high-energy trauma. After that, it can get easier and easier for the joint to dislocate. Most shoulder dislocations are anterior. Subluxation is the feeling that the shoulder slips slightly out of socket, then immediately comes back.
The cause of this instability varies. Sometimes it is the result of an abnormal, generalized hyperlaxity of the capsule usually caused by repetitive microtrauma, such as in overhead throwing sports, racquet sports, and swimming. It can also result from recurrent partial or full anterior dislocations of the shoulder. Aching, heaviness, or sharp pains associated with pathologic conditions of the rotator cuff, biceps, or labrum are common presenting complaints.

The main goal for any shoulder surgery is to stabilize the shoulder and maintain a full, pain-free range of motion. The multiplicity of procedures that address this problem have in common either blocking anterior displacement of the humerus and/or tightening the joint capsule. For long-term shoulder health, anatomic stabilization of the Bankart lesion is the first priority because it corrects uni-directional anterior subluxation/dislocation. The Bankart procedure involves a small incision (1 cm) into the shoulder, and a suturing of the labrum back to the glenoid. The Bankart repair reduces pain and can be performed without causing a significant loss of external rotation.

Anatomic re-attachment of the capsulo-labral complex alone may not successfully stabilize the gleno-humeral joint. It has been proposed that the higher recurrence rates seen in arthroscopic repairs that secure the capsulo-labral complex back to the glenoid rim may be the result of failure to treat the stretched-out capsule. Electrothermally-assisted capsulorrhaphy (ETAC), also known as electrothermal arthroscopy and electrothermally-assisted capsule shift, provides an easy approach to arthroscopically advance or tighten the capsule in conjunction with arthroscopic re-attachment procedures.

The ElectroThermal Arthroscopy System uses high-energy radiofrequency waves to heat the collagen fibers in the joint. This controlled thermal energy eventually causes contraction and firming up of the soft tissue in an effort to stabilize the joint. Initial success of this procedure appears to depend on proper patient selection, appropriate surgical technique, attention to the
rehabilitation program, and patient compliance. Monopolar electrothermal stabilization is technically easy to perform, and reported peri-operative complication rates have been low. Short-term, uncontrolled studies of electrothermal arthroscopy for shoulder instability have shown preservation of range of motion and more rapid post-operative recovery than with open procedures. Although results of short-term studies of electrothermal arthroscopy appear to equal or exceed other surgical procedures, longer-term clinical outcome studies with direct comparisons with open procedures are necessary to determine the effectiveness of electrothermal arthroscopy. Long-term follow-up is necessary to determine whether results for this procedure will deteriorate over time.

In this regard, a number of investigators have commented on the need for long-term follow-up studies of electrothermal arthroscopy for shoulder instability. Levine et al (2001) reported that the advances in thermal treatment of the capsule have made arthroscopic electrothermal capsulorrhaphy increasingly attractive as an alternative to the open approach for the primary treatment of multi-directional instability. However, the authors concluded that longer follow-ups will be necessary before definitive statements can be made regarding the arthroscopic techniques. Khan et al (2002) noted that monopolar electrothermal stabilization of the shoulder shows considerable promise as a treatment alternative in athletes and patients with recurrent instability. However, long-term follow-up is necessary to determine if results for this procedure deteriorate over time, especially in patients with multi-directional instability. Furthermore, Walton et al (2002) noted that “[g]ood results have been reported with this technique in recent short-term studies” but that “[f]urther long-term evaluations are necessary to evaluate the technique, indications, and results of this novel method of reducing capsular volume”. Levitz et al (2001) cautioned that it is not known how much the capsule should be shrunk or what long-term results will show.

Current evidence supporting the use of electrothermal arthroscopy for shoulder instability is limited to uncontrolled retrospective (Hovis et al, 2002; Lephart et al, 2002; Levitz et al,
2001; Lyons et al, 2001; Reinold et al, 2003; Joseph et al, 2003) and prospective case series, with variable results (Fitzgerald et al, 2002; Levy et al, 2000; Mishra et al, 2001; Savoie et al, 2000; Noonan et al, 2003; and Gieringer, 2003). Most of these studies are small and of short duration, although some mid-term results have been reported. There is a lack of adequate well-controlled long-term clinical studies of the effectiveness and durability of electrothermal arthroscopy, comparing outcomes of this procedure with established surgical methods of treating shoulder instability.

In a review of the literature on electrothermal arthroscopy, Gerber and Warner (2002) of the Harvard Shoulder Service have warned that “Currently, however, the indications for thermal capsulorrhaphy are defined poorly, clinical outcome has not been shown to be superior to conventional stabilization procedures, and long-term effects on joint biology and mechanics are not known. Based on a critical review of the literature and personal clinical experience, the authors conclude that additional experimental and clinical investigations are necessary to add this procedure to the accepted modalities applied for the treatment of shoulder instability”.

A technology assessment of electrothermal arthroscopy prepared for the Washington State Department of Labor and Industries (2003) concluded that, “[w]hile researchers have published their findings in peer-reviewed journals, the evidence comes primarily from case series studies with small study populations. Therefore, findings do not substantially show thermal shrinkage’s efficacy or effectiveness for the treatment of shoulder instability…”.

Recent studies by Enad et al (2004) as well as D’Alessandro et al (2004) indicated that the long-term outcome of electrothermal arthroscopy is unsatisfactory. Enad et al (2004) examined the effectiveness of arthroscopic electrothermal capsulorrhaphy for the treatment of instability in overhand athletes. Electrothermal capsulorrhaphy without labral repair was used to treat 20 symptomatic overhand athletes (15 baseball, 3 softball, and 2 volleyball). A total of 19 patients were evaluated at a mean of 23 months. Overall Rowe results were 10 excellent, 4 good, 2 fair,
and 3 poor, with a mean score of 82. The overall mean American Shoulder and Elbow Surgeons (ASES) score was 85.7 (mean pain score, 42.2; mean score for activities of daily living, 43.5). Two failures (10 %) required open shoulder stabilization. Ten athletes returned to their prior level of sport, 3 returned to a lower level, and 6 were unable to return to their sport. These preliminary results indicate that treatment of the overhand athlete with isolated electrothermal capsulorrhaphy is favorable but does not reproduce the success of open surgery. Overall recurrence and failure rates were high. Instability in overhand athletes may require something other than isolated electrothermal capsulorrhaphy to address laxity.

D'Alessandro et al (2004) reported a “high rate of unsatisfactory results” in a published prospective evaluations of the effectiveness of arthroscopic electrothermal capsulorrhaphy with 2 to 5 years follow-up. This non-randomized prospective study evaluated the indications and results of thermal capsulorrhaphy in 84 subjects with shoulder instability. Subjects underwent arthroscopic thermal capsulorrhaphy after initial assessment, radiographs, and failure of a minimum of 3 months of non-operative rehabilitation. Outcome measures included pain, recurrent instability, return to work/sports, and the ASES Shoulder Assessment score. After a median duration of follow-up of 38 months, overall results were excellent in 33 participants (39 %), satisfactory in 20 (24 %), and unsatisfactory in 31 (37 %). The authors concluded that “[t]he high rate of unsatisfactory overall results (37 %), documented with longer follow-up, is of great concern”. The authors cautioned that “[t]he enthusiasm for thermal capsulorrhaphy should be tempered until further studies document its efficacy”.

There is also a lack of evidence of the effectiveness of electrothermal arthroscopy for other joints, including knee, ankle and elbow. The most thoroughly studied indication for electrothermal arthroscopy, other than shoulder instability, is anterior cruciate ligament (ACL) laxity. Carter et al (2002) reported failure at an average of 4 months post-surgery in 11 of 18 patients with laxity of the ACL treated with electrothermal arthroscopy. Of the 7 patients with a good result, 6 were treated
for acute laxity. The investigators concluded “[e]ven with the short-term follow-up in our study, it is evident that thermal shrinkage using radiofrequency technology has limited application for patients with anterior cruciate ligament laxity. Although it may be useful in treating patients with an acutely injured native anterior cruciate ligament, further study is needed to see if the ligament stretches out over time or is at increased risk of reinjury.” Indelli and co-workers (2003) reported their experience using monopolar thermal repair on 28 consecutive knees with partial ACL tears. Based on measurements of ACL stability 2 or more years after surgery, the authors found the results to be comparable to experience with ACL re-constructions with allograft. The authors stated, however, that longer follow-up and the results of other studies will better define the selection, methods, and results of thermal repair of partial ACL tears. Oakes and McAllister (2003) stated that although the use of thermal energy to selectively shrink tissues may ultimately prove to be an invaluable tool, the lack of well-designed, randomized controlled studies to firmly establish its efficacy in the treatment of partial cruciate injuries mandates cautious use of this technique at this time. A technology assessment prepared for the Washington State Department of Labor and Industries (2003) concluded that there is inadequate evidence of the effectiveness of electrothermal arthroscopy for ACL laxity.

In a review on thermal modification of the lax ACL by means of radiofrequency, Lubowitz (2005) stated that results of shrinkage of a lax, intact native ACL using radiofrequency seems promising, but complications of catastrophic, spontaneous ACL rupture have been reported. The author noted that more research is needed to define treatment techniques, indications, and selection criteria for ACL thermal shrinkage using radiofrequency and to compare its outcomes with traditional ACL reconstructive surgery.

In a multi-center study, Smith and colleagues (2008) prospectively evaluated the mid-term results (beyond 2 years) of thermal shrinkage on both lax native ACL and lax re-constructions and determined the effectiveness of this procedure. A total of 64 patients underwent electrothermal shrinkage for a lax ACL, both native and previous re-constructions. They were followed-up
past 2 years with KT-1000 measurements. Failure criteria were subsequent operations for instability and KT-1000 measurements greater than 5 mm. Three patients were lost to follow-up. Among the 61 patients followed-up past 2 years, failure occurred in 31 (50.8%). The failure rate for lax grafts alone was 78.9%, and there was a failure rate of 38.1% for lax native ligaments. The authors concluded that electrothermal shrinkage of lax native or re-constructed ACLs is not an appropriate treatment.

Chloros et al (2008) reviewed the recent literature on arthoscopic treatment of distal radius fractures (DRFs), triangular fibro-cartilage complex injuries, inter-carpal ligament injuries, and ganglion cysts, including the use of electrothermal devices. A major advantage of arthroscopy in the treatment of DRFs is the accurate assessment of the status of the articular surfaces and the detection of concomitant injuries. Non-randomized studies of arthroscopically assisted reduction of DRFs show satisfactory results, but there is only 1 prospective randomized study showing the benefits of arthroscopy compared with open reduction-internal fixation. Wrist arthroscopy plays an important role as part of the treatment for DRFs; however, the treatment for each practitioner and each patient needs to be individualized. Wrist arthroscopy is the gold standard in the diagnosis and treatment of triangular fibro-cartilage complex injuries. Type 1A injuries may be successfully treated with debridement, whereas the repair of type 1B, 1C, and 1D injuries gives satisfactory results. For type 2 injuries, the arthroscopic wafer procedure is equally effective as ulnar shortening osteotomy but is associated with fewer complications in the ulnar positive wrist. With interosseous ligament injuries, arthroscopic visualization provides critical diagnostic value. Debridement and pinning in the acute setting of complete ligament tears are promising and proven. In the chronic patient, arthroscopy can guide re-constructive options based on cartilage integrity. The preliminary results of wrist arthroscopy using electrothermal devices are encouraging; however, complications have been reported, and therefore, their use is controversial. In dorsal wrist ganglia, arthroscopy has shown excellent results, a lower rate of recurrence, and no incidence of scapholunate interosseous ligament instability compared with open ganglionectomy. Arthroscopy in the treatment of volar
wrist ganglia has yielded encouraging preliminary results; however, further studies are warranted to evaluate the safety and effectiveness of arthroscopy.

Chu and colleagues (2009) examined if radiofrequency electrothermal treatment of thumb basal joint instability could produce clinical improvement and result in successful functional outcomes for patients. From August 2001 to April 2006, these researchers treated 17 thumbs with symptomatic thumb basal joint instability using arthroscopic electrothermal shrinkage of the volar ligaments and joint capsule with a monopolar radiofrequency probe. The sample included 11 men and 6 women with a mean age of 35.3 years (range of 20 to 60 years). All patients underwent regular clinical follow-up at a mean of 41 months (range of 24 to 80 months). Pain improved in all thumbs after surgery. Thumb pinch strength significantly improved in all thumbs after surgery (p < 0.01). All patients were satisfied with the results and returned to their pre-injury activities. The authors concluded that by use of the described method of arthroscopic electrothermal shrinkage of the volar ligaments and joint capsule in patients with symptomatic thumb basal joint instability, most patients had good subjective results and the pinch strength improved significantly in most patients. Of 17 thumbs, 16 had satisfactory subjective and functional stability at a minimum 2 years' follow-up. This was a small, non-controlled study; its findings need to be validated by well-designed studies.

Torres and McCain (2012) noted that acute temporomandibular joint dislocation is a common occurrence that is generally treated by conservative therapy. In some patients, this can become a chronic recurrent condition. This recurrent temporomandibular joint dislocation (RTD) can significantly decrease the patient's quality of life and require some form of surgical intervention for correction. These researchers examined the effectiveness of a minimally invasive alternative treatment for RTD using operative arthroscopy. A total of 11 patients treated for RTD between 2004 and 2010 were retrospectively analyzed. Electrothermal capsulorrhaphy was performed using a standard double puncture operative arthroscopy with a Ho:YAG laser and/or electrocautery. Post-operatively, the patients were monitored for
6 months to 6 years. Of the 11 subjects, 2 suffered a recurrence of temporomandibular dislocation and required open arthrotomy for correction. The other 9 patients had no signs of recurrence or any significant post-operative loss of function. The authors concluded that electrothermal capsulorrhaphy is an effective and minimally invasive method for the treatment of RTD. The findings of this small, non-controlled study need to be validated by well-designed studies.

The triangular fibro-cartilage complex (TFCC) is formed by the triangular fibro-cartilage discus, the radio-ulnar ligaments and the ulno-carpal ligaments. Garcia-Lopez et al (2012) evaluated the clinical and occupational outcomes of arthroscopic treatment with electrothermal shrinkage for TFCC tears. These researches retrospectively reviewed 162 patients. All patients had ulnar-sided wrist pain that limited their occupational and sporting activities. The surgical technique consisted of electrothermal collagen shrinkage of the TFCC. Pain relief, range of motion, complications, re-operation rate, time to return to work and workers' compensation claims were evaluated. Exclusion criteria were distal radioulnar joint instability and association of other wrist lesions. Complete pain relief was noted in 80.3 % of the patients, incomplete pain relief in 14.8 %, and only 4.9 % required re-operation because of pain-persistence. The average range of motion was over 90 % compared to the opposite hand. Worker's compensation claims were introduced by 20 patients, of which 6 did not return to their previous occupation. The authors concluded that electrodiathermy may be a useful option for arthroscopic treatment of TFCC tears in cases without distal radioulnar joint instability. The findings of this study need to be validated by well-designed studies.

Mohtadi et al (2014) noted that radiofrequency technology for shoulder instability was rapidly adopted despite limited clinical evidence and a poor understanding of its indications. Reports of serious adverse events followed, leading to its abandonment. These researchers presented findings from a multi-center randomized clinical trial evaluating the safety and effectiveness of ETAC compared with open inferior capsular shift (ICS) and reviewed the role of randomized trials in adopting new
technology. Patients (greater than 14 years) diagnosed with multi-directional instability or multi-directional laxity with antero-inferior instability and failed non-operative treatment were enrolled. Patients with bone lesions or labral, biceps anchor, or full-thickness rotator cuff tears were excluded intra-operatively. Outcomes included Western Ontario Shoulder Instability Index, function and recurrent instability at 2 years post-operatively, and surgical times. A total of 54 subjects (mean age of 23 years; 37 women) were randomized to ETAC (n = 28) or open ICS (n = 26). The groups were comparable at baseline, except for external rotation at the side. At 2 years post-operatively, there were no statistically or clinically significant differences between groups for the Western Ontario Shoulder Instability Index (p = 0.71), American Shoulder and Elbow Surgeons score (p = 0.43), Constant score (p = 0.43), and active range of motion. Recurrent instability was not statistically different (ETAC, 2; open, 4; p = 0.41).

Electrothermally-assisted capsulorrhaphy (23 minutes) was significantly shorter than open ICS (59 minutes) (p < 0.01) surgery. Three subjects (1 ETAC, 2 open) had stiff shoulders. The authors concluded that at 2 years post-operatively, quality of life and functional outcomes between groups were not clinically different; ETAC had fewer complications and episodes of recurrence compared with open surgery. They stated that this evidence reinforced the need to critically evaluate new technology before widespread clinical use.

UpToDate reviews on “Overview of surgical therapy of knee and hip osteoarthritis” (Mandl and Marin, 2015), “Synovectomy for inflammatory arthritis of the knee” (Wright, 2015) do not mention electrothermal arthroscopy/ETAC as a therapeutic option.

McRae and associates (2016) noted that ETAC was introduced as an adjunct to shoulder stabilization surgery to address capsular laxity in the treatment of traumatic anterior dislocation. No previous randomized controlled trial (RCT) has compared arthroscopic Bankart repair with ETAC of the medial gleno-humeral ligament and anterior band of the inferior gleno-humeral ligament versus undergoing arthroscopic Bankart repair alone. These investigators hypothesized that there would be no
difference in quality of life (QOL) between these 2 groups. Complication/failure rates were also compared. A total of 88 patients were randomly assigned to receive arthroscopic Bankart repair with \((n = 44)\) or without ETAC \((n = 44)\). Post-operative visits occurred at 3, 6, 12, and 24 months with WOSI, ASES, and Constant scores completed, and rates of dislocation/subluxation were determined. Data on 74 patients were analyzed, with the rest lost to follow-up. There were no differences between groups at any post-surgery time points for WOSI, ASES, or Constant scores (non-significant); 8 patients in the no-ETAC group and 7 in the ETAC group were considered failures (non-significant). The authors concluded that no benefits in patient-reported outcome or recurrence rates using ETAC were found. Mean WOSI scores 2 years post-surgery were virtually identical for the 2 groups; ETAC could not be shown to provide benefit or detriment when combined with arthroscopic labral repair for traumatic anterior instability of the shoulder.

UpToDate reviews on “Anterior cruciate ligament injury” (Friedberg, 2017) and “Meniscal injury of the knee” (Cardone and Jacobs, 2017) do not mention electrothermal arthroscopy as a therapeutic option.

<table>
<thead>
<tr>
<th>CPT Codes / HCPCS Codes / ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by &quot;+&quot;:</strong></td>
</tr>
<tr>
<td><strong>Other CPT codes related to the CPB:</strong></td>
</tr>
<tr>
<td>29804</td>
</tr>
<tr>
<td>29806 - 29828</td>
</tr>
<tr>
<td>29843 - 29847</td>
</tr>
<tr>
<td>29848</td>
</tr>
<tr>
<td>29861 - 29863</td>
</tr>
<tr>
<td>Code</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>29870 - 29887</td>
</tr>
<tr>
<td>29891 - 29899</td>
</tr>
<tr>
<td>29905</td>
</tr>
<tr>
<td>29906</td>
</tr>
<tr>
<td>29907</td>
</tr>
</tbody>
</table>

**HCPCS codes not covered for indications listed in the CPB:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2300</td>
<td>Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy</td>
</tr>
</tbody>
</table>

**ICD-10 codes not covered for indications listed in the CPB (not all-inclusive):**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M23.000 - M23.92</td>
<td>Internal derangement of knee</td>
</tr>
<tr>
<td>M24.00 - M25.9</td>
<td>Other specific joint derangements</td>
</tr>
<tr>
<td>M26.601 - M26.69</td>
<td>Temporomandibular joint disorders</td>
</tr>
<tr>
<td>M65.871 - M65.879</td>
<td>Other synovitis and tenosynovitis of ankle and foot</td>
</tr>
<tr>
<td>M75.00 - M75.02</td>
<td>Adhesive capsulitis of shoulder</td>
</tr>
<tr>
<td>M76.60 - M76.62</td>
<td>Achilles tendinitis</td>
</tr>
<tr>
<td>Numerous options</td>
<td>Sprains and strains of wrist [Codes not listed due to expanded specificity]</td>
</tr>
<tr>
<td>Numerous options</td>
<td>Sprains and strains of ankle and foot [Codes not listed due to expanded specificity]</td>
</tr>
<tr>
<td>Numerous options</td>
<td>Injury, elbow, forearm, and wrist [Codes not listed due to expanded specificity]</td>
</tr>
<tr>
<td>Numerous options</td>
<td>Injury, other and unspecified, knee, leg, ankle, and foot [Codes not listed due to expanded specificity]</td>
</tr>
<tr>
<td>S03.00x+ - S03.02x+</td>
<td>Dislocation of jaw</td>
</tr>
</tbody>
</table>
The above policy is based on the following references:


50. Washington State Department of Labor and Industries, Office of the Medical Director. Thermal shrinkage for the treatment of shoulder instability and anterior cruciate


66. Mandl LA, Marin GM. Overview of surgical therapy of knee and hip osteoarthritis. UpToDate [online serial]. Waltham, MA: UpToDate; reviewed April 2015.

67. Wright RJ. Synovectomy for inflammatory arthritis of the knee. UpToDate [online serial]. Waltham, MA: UpToDate; reviewed April 2015.


Copyright Aetna Inc. All rights reserved. Clinical Policy Bulletins are developed by Aetna to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Clinical Policy Bulletin contains only a partial, general description of plan or program benefits and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Treating providers are solely responsible for medical advice and treatment of members. This Clinical Policy Bulletin may be updated and therefore is subject to change.

Copyright © 2001-2017 Aetna Inc.
AETNA BETTER HEALTH® OF PENNSYLVANIA

Amendment to
Aetna Clinical Policy Bulletin Number: 0545 Electrothermal Arthroscopy

There are no amendments for Medicaid.