Policy: MP233
Section: Medical Benefit Policy
Subject: Injectable Blood Products for Orthopedic Conditions

I. Policy: Injectable Blood Products for Orthopedic Conditions

II. Purpose/Objective:
To provide a policy of coverage regarding Injectable Blood Products for Orthopedic Conditions

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**DESCRIPTION:** Autologous platelet-derived growth factors (APDGF), also referred to as platelet gel or platelet-rich plasma, have been proposed for use in the treatment of chronic wounds (e.g., lower extremity wounds), tendonitis, joint capsular injuries, soft tissue trauma (e.g., tendon and ligament ruptures), and muscle injuries and disorders. Bone marrow-derived mesenchymal stem cells have been proposed as a regenerative treatment for injuries to cartilage and bones.

**FOR MEDICARE BUSINESS SEGMENT:**
Per Decision Memo CAG-00190R3, CMS covers autologous platelet-rich plasma (PRP) only for patients who have chronic non-healing diabetic, pressure, and/or venous wounds and when the beneficiary is enrolled in a clinical research study that addresses the following questions using validated and reliable methods of evaluation.

The clinical research study must meet specified requirements to assess the effect of PRP for the treatment of chronic non-healing diabetic, pressure, and/or venous wounds.

A listing of approved studies can be found at: [https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Autologous-Platelet-rich-Plasma-PRP.html](https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Autologous-Platelet-rich-Plasma-PRP.html)

**EXCLUSIONS:** The Plan does NOT provide coverage for Autologous Platelet-Derived Growth Factor for any indication including but not limited to chronic non-healing wounds, Epicondylitis, Plantar Fasciitis, Dupuytren’s Contracture, bone healing and fusion, tendinopathy and sinus surgery because it is considered experimental, investigational or unproven. The Geisinger Technology Assessment Committee evaluated this technology and concluded that there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this technology on health outcomes when compared to established other tests or technologies.

The Plan does NOT provide coverage for bone marrow plasma or bone marrow-derived mesenchymal stem cell injection for any orthopedic condition because it is considered experimental, investigational or unproven. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this technology on health outcomes when compared to established other tests or technologies.

**Note:** A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

**CODING ASSOCIATED WITH:** Autologous Platelet-Derived Growth Factor

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.*

- P9020 Platelet rich plasma, each unit
- S9055 Procuren or other growth factor preparation to promote wound healing
- 0232T Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed
- G0460 Autologous platelet rich plasma for ulcers
- 38206 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
- 38230 Bone marrow harvesting for transplantation; allogeneic
- 38232 Bone marrow harvesting for transplantation; autologous


**LINE OF BUSINESS:**
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

**REFERENCES:**


Centeno CJ, Schultz JR, et al., Safety and complications reporting on the re-implantation of culture-expanded mesenchymal stem cells using autologous platelet lysate technique, Current Stem Cell Research and Therapy, 2010 (5)


This policy will be revised as necessary and reviewed no less than annually.

Devised: 06/2009

Revised: 6/10 (exclusion lang/refs), 9/16 (Title, Description, Exclusion); 11/16 (Add CMS CED provision)

Reviewed: 6/11, 6/12, 6/13, 6/14, 5/15, 6/16