Osteochondral Allografting

Fresh osteochondral allografting may be considered medically necessary as a technique to repair any of the following:

- Full-thickness chondral defects of the knee caused by acute or repetitive trauma when other cartilage repair techniques (e.g., microfracture, osteochondral autografting or autologous chondrocyte implantation) would be inadequate due to lesion size, location, or depth
- Large (area greater than 1.5 cm²) or cystic (volume greater than 3.0 cm³) osteochondral lesions of the talus when autografting would be inadequate due to lesion size, depth, or location
- Revision surgery after failed prior marrow stimulation for large (area greater than 1.5 cm²) or cystic (volume greater than 3.0 cm³) osteochondral lesions of the talus when autografting would be inadequate due to lesion size, depth or location.

Osteochondral allografting for all other joints is considered investigational.

Osteochondral Autografting

Osteochondral autografting, using one or more cores of osteochondral tissue, may be considered medically necessary for any of the following:

- For the treatment of symptomatic full-thickness cartilage defects of the knee caused by acute or repetitive trauma in patients who have had an inadequate response to a prior surgical procedure, when all of the following have been met:
  - Adolescent patients should be skeletally mature with documented closure of growth plates (e.g., 15 years or older). Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (e.g., 55 years or younger)
  - Focal, full-thickness (grade III or IV) unipolar lesions on the weight-bearing surface of the femoral condyles, trochlea, or patella that are between 1 and 2.5 cm² in size
  - Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less), and normal-appearing hyaline cartilage surrounding the border of the defect
  - Normal knee biomechanics or alignment and stability achieved concurrently with osteochondral grafting
- Large (area greater than 1.5 cm²) or cystic (volume greater than 3.0 cm³) osteochondral lesions of the talus
- Revision surgery after failed marrow stimulation for osteochondral lesion of the talus

Osteochondral autografting for all other joints and any indications other than those listed above is considered investigational.

Allogeneic/Autologous Minced Cartilage

Treatment of focal articular cartilage lesions is considered investigational with either of the following:

- Allogeneic minced or particulated cartilage
- Autologous minced or particulated cartilage

Treatment of focal articular cartilage lesions with decellularized osteochondral allograft plugs (e.g., Chondrofix) is considered investigational.
Treatment of focal articular cartilage lesions with reduced osteochondral allograft discs (e.g., ProChondrix, Cartiform) is considered investigational.

**Policy Guidelines**

If débridement is the only prior surgical treatment, consideration should be given to marrow-stimulating techniques before osteochondral grafting is performed, particularly for lesions less than 1.5 cm² in area or 3.0 cm³ in volume.

Severe obesity (e.g., body mass index greater than 35 kg/m²) may affect outcomes due to the increased stress on weight-bearing surfaces of the joint.

Misalignment and instability of the joint are contraindications. Therefore, additional procedures, such as repair of ligaments or tendons or creation of an osteotomy for realignment of the joint, may be performed at the same time. In addition, meniscal allograft transplantation may be performed in combination, either concurrently or sequentially, with osteochondral allografting or osteochondral autografting.

**Outerbridge Classification System**

The characterization of cartilage is as follows:

- **Grade 0** - normal cartilage
- **Grade I** - softening with swelling
- **Grade II** - a partial-thickness defect with fissures on the surface that do not reach subchondral bone or exceed 1.5 cm² in diameter
- **Grade III** - fissuring to the level of subchondral bone in an area with a diameter of more than 1.5 cm²
- **Grade IV** - subchondral bone exposed

**Coding**

The following CPT codes are specific to these procedures:

- **27415**: Osteochondral allograft, knee, open
- **27416**: Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft[s])
- **28446**: Open osteochondral autograft, talus (includes obtaining graft[s])
- **29866**: Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g., mosaicplasty) (includes harvesting of the autograft[s])
- **29867**: Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)

There is no CPT code specific to osteochondral allograft of the talus.

**Description**

Osteochondral grafts are used to repair full-thickness chondral defects involving a joint. In the case of osteochondral autografts, one or more small osteochondral plugs are harvested from non-weight-bearing sites, usually from the knee, and press fit into a prepared site in the lesion. Osteochondral allografts are typically used for larger lesions. Autologous or allogeneic minced cartilage, decellularized osteochondral allograft plugs, and reduced osteochondral allograft discs are also being evaluated as a treatment of articular cartilage lesions.

**Related Policies**

- Meniscal Allografts and Other Meniscal Implants
- Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions
Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

The U.S. Food and Drug Administration regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research, under Code of Federal Regulation, title 21, parts 1270 and 1271. Osteochondral grafts are included in these regulations.

DeNovo® ET Live Chondral Engineered Tissue Graft (Neocartilage) is marketed by ISTO Technologies outside of the United States. The Food and Drug Administration approved ISTO’s investigational new drug application for Neocartilage in 2006, which allowed ISTO to pursue phase 3 clinical trials of the product in human subjects. However, ISTO’s clinical trial for Neocartilage was terminated due to poor enrolment as of August 31, 2017.

Rationale

Background

Articular Cartilage Lesions

Damaged articular cartilage can be associated with pain, loss of function, and disability, and can lead to debilitating osteoarthritis over time. These manifestations can severely impair an individual’s activities of daily living and quality of life. The vast majority of osteochondral lesions occur in the knee with the talar dome and capitulum being the next most frequent sites. The most common locations of lesions are the medial femoral condyle (69%), followed by the weight-bearing portion of the lateral femoral condyle (15%), the patella (5%), and trochlear fossa. Talar lesions are reported to be about 4% of osteochondral lesions.

Treatment

There are two main goals of conventional therapy for patients who have significant focal defects of the articular cartilage: symptom relief and articular surface restoration.

First, there are procedures intended primarily to achieve symptomatic relief: débridement (removal of debris and diseased cartilage) and rehabilitation. Second, there are procedures intended to restore the articular surface. Treatments may be targeted to the focal cartilage lesion, and most such treatments induce local bleeding, fibrin clot formation, and resultant fibrocartilage growth. These marrow stimulation procedures include microfracture, abrasion arthroplasty, and drilling, all of which are considered standard therapies.

Microfracture

Microfracture is an arthroscopic procedure in which a small pick creates a network of holes at the base of the articular cartilage lesion, allowing blood into the injured area to form clots and subsequent fibrocartilage growth. Efficacy of the microfracture technique for articular cartilage lesions of the knee was examined by Mitrofever et al (2009) in a systematic review. Twenty-eight studies (total n=3122 patients) were selected; 6 studies were randomized controlled trials.
Microfracture was found to improve knee function in all studies during the first 24 months after the procedure but the reports on durability were conflicting. A prospective longitudinal study of 110 patients by Solheim et al (2016) found that, at a mean of 12 years (range, 10-14 years) after microfracture, 45.5% of patients had poor outcomes, including 43 patients who required additional surgery. The size of the lesion has also been shown to affect outcomes following marrow stimulation procedures.

**Abrasion and Drilling**
Abrasion and drilling are techniques to remove damaged cartilage. Instead of a drill, high speed burs are used in the abrasion procedure.

Fibrocartilage is generally considered to be less durable and mechanically inferior to the original articular cartilage. Thus, various strategies for chondral resurfacing with hyaline cartilage have been investigated. Alternatively, treatments of very extensive and severe cartilage defects may resort to complete replacement of the articular surface either by osteochondral allotransplant or artificial knee replacement.

**Osteochondral Grafting**
Autologous or allogeneic grafts of osteochondral or chondral tissue have been proposed as treatment alternatives for patients who have clinically significant, symptomatic, focal defects of the articular cartilage. It is hypothesized that the implanted graft’s chondrocytes retain features of hyaline cartilage that is similar in composition and property to the original articulating surface of the joint. If true, the restoration of a hyaline cartilage surface might restore the integrity of the joint surface and promote long-term tissue repair, thereby improving function and delaying or preventing further deterioration.

Both fresh and cryopreserved allogeneic osteochondral grafts have been used with some success. However, cryopreservation decreases the viability of cartilage cells and fresh allografts may be difficult to obtain and create concerns regarding infectious diseases. As a result, autologous osteochondral grafts have been investigated as an option to increase the survival rate of the grafted cartilage and to eliminate the risk of disease transmission. Autologous grafts are limited by the small number of donor sites; thus, allografts are typically used for larger lesions. In an effort to extend the amount of the available donor tissue, investigators have used multiple, small osteochondral cores harvested from non-weight-bearing sites in the knee for treatment of full-thickness chondral defects. Several systems are available for performing this procedure: the Mosaicplasty System (Smith & Nephew), the OATS (Osteochondral Autograft Transfer System; Arthrex), and the COR and COR2 systems (DePuy Mitek). Although mosaicplasty and autologous osteochondral transplantation (AOT) may use different instrumentation, the underlying mode of repair is similar (i.e., use of multiple osteochondral cores harvested from a non-weight-bearing region of the femoral condyle and autografted into the chondral defect). These terms have been used interchangeably to describe the procedure.

Preparation of the chondral lesion involves débridement and preparation of recipient tunnels. Multiple individual osteochondral cores are harvested from the donor site, typically from a peripheral non-weight-bearing area of the femoral condyle. Donor plugs range from 6 to 10 mm in diameter. The grafts are press fit into the lesion in a mosaic-like fashion into the same-sized tunnels. The resultant surface consists of transplanted hyaline articular cartilage and fibrocartilage, which is thought to provide “grouting” between the individual autografts. Mosaicplasty or AOT may be performed with either an open approach or arthroscopically. Osteochondral autografting has also been investigated as a treatment of unstable osteochondritis dissecans lesions using multiple dowel grafts to secure the fragment. While osteochondral autografting is primarily performed on the femoral condyles of the knee, osteochondral grafts have been used to repair chondral defects of the patella, tibia, and ankle. With osteochondral autografting, the harvesting and transplantation can be performed during the same surgical procedure. Technical limitations of osteochondral autografting are difficulty in restoring concave or convex articular surfaces, the incongruity of articular surfaces that can
alter joint contact pressures, short-term fixation strength and load-bearing capacity, donor-site morbidity, and lack of peripheral integration with peripheral chondrocyte death.

Reddy et al (2007) evaluated donor-site morbidity in 11 of 15 patients who had undergone graft harvest from the knee (mean, 2.9 plugs) for treatment of osteochondral lesions of the talus. At an average 47-month follow-up (range, 7-77 months), 5 patients were rated as having an excellent Lysholm Knee Scale score (95-100 points), 2 as good (84-94 points), and 4 as poor (≤64 points). The reported knee problems were instability in daily activities, pain after walking one mile or more, slight limp, and difficulty squatting. Hangody et al (2001) reported that some patients had slight or moderate complaints with physical activity during the first postoperative year but there was no long-term donor-site pain in a series of 36 patients evaluated 2 to 7 years after AOT.

Filling defects with minced or particulated articular cartilage (autologous or allogeneic) is another single-stage procedure being investigated for cartilage repair. The Cartilage Autograft Implantation System (Johnson & Johnson) harvests cartilage and disperses chondrocytes on a scaffold in a single-stage treatment. The Reveille Cartilage Processor (Exactech Biologics) has a high-speed blade and sieve to cut autologous cartilage into small particles for implantation. BioCartilage (Arthrex) consists of a micronized allogeneic cartilage matrix that is intended to provide a scaffold for microfracture. DeNovo NT Graft (Natural Tissue Graft) is produced by ISTO Technologies and distributed by Zimmer. DeNovo NT consists of manually minced cartilage tissue pieces obtained from juvenile allograft donor joints. The tissue fragments are mixed intraoperatively with fibrin glue before implantation in the prepared lesion. It is thought that mincing the tissue helps both with cell migration from the extracellular matrix and with fixation.

A minimally processed osteochondral allograft (Chondrofix; Zimmer) is now available. Chondrofix is composed of decellularized hyaline cartilage and cancellous bone; it can be used “off the shelf” with pre-cut cylinders (7-15 mm). Multiple cylinders may be used to fill a larger defect in a manner similar to AOT or mosaicplasty.

ProChondrix (AlloSource) and Cartiform (Arthrex) are wafer-thin allografts where the bony portion of the allograft is reduced. The discs are laser etched or porated and contain hyaline cartilage with chondrocytes, growth factors, and extracellular matrix proteins. ProChondrix is available in dimensions from 7 to 20 mm and is stored fresh for a maximum of 28 days. Cartiform is cut to the desired size and shape and is stored frozen for a maximum of two years. The osteochondral discs are typically inserted after microfracture and secured in place with fibrin glue and/or sutures.

Autologous chondrocyte implantation is another method of cartilage repair involving the harvesting of normal chondrocytes from normal non-weight-bearing articular surfaces, which are then cultured and expanded in vitro and implanted back into the chondral defect. Autologous chondrocyte implantation techniques are discussed in Blue Shield of California Medical Policy: Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions.

**Literature Review**

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function— including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the
intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Osteochondral Autografts and Allografts to Treat Focal Articular Cartilage Lesions
Clinical Context and Therapy Purpose
The purpose of autografts and allografts in patients with focal articular cartilage lesions is to provide a treatment option that is an alternative to or an improvement on existing therapies. The question addressed in this evidence review is: Does the use of autografts or allografts improve the net health outcomes in patients with focal articular cartilage lesions compared with standard treatment such as marrow stimulation?

The following PICOTS were used to select literature to inform this review.

Patients
The relevant populations of interest are patients with:
- Full-thickness articular cartilage lesions of the knee
- Full-thickness articular cartilage lesions of the ankle <1.5 cm²
- Full-thickness articular cartilage lesions of the ankle >1.5 cm² or cystic (>3.0 cm²) lesions of the ankle
- Full-thickness articular cartilage lesions of the elbow
- Full-thickness articular cartilage lesions of the shoulder

Interventions
The therapies being considered include:
- Osteochondral autograft: The injured area of cartilage and underlying bone are removed and replaced with a graft of cartilage and bone harvested from another area. It is hypothesized that the implanted graft’s chondrocytes retain features of hyaline cartilage that is similar in composition and property to the original articulating surface of the joint, thereby restoring the hyaline cartilage surface.
- Fresh osteochondral allograft: The technique is the same as described above; however, the graft of cartilage and bone is obtained from a tissue donor.
- Autologous or allogeneic minced or particulated articular cartilage: Pieces of cartilage are mechanically minced into 1-2 mm pieces, allowing chondrocytes to be released from the extracellular matrix, migrate to surrounding tissues, and form a new cartilage-tissue matrix.
- Decellularized osteochondral allograft plugs: Allografts undergo a procedure which extracts lipids. The graft is then inactivated and sterilized in order to extend shelf life.
- Reduced osteochondral allograft discs: The discs are laser etched and contain hyaline cartilage with chondrocytes, growth factors, and extracellular matrix proteins.

Comparators
To restore articular surface, standard therapies of marrow stimulation currently in use include microfracture, abrasion arthroplasty, and drilling. Microfracture involves debridement of the damaged area and puncturing of the underlying bone to allow bleeding of the bone, stimulating the formation of new joint surface cartilage.

Outcomes
The general outcomes of interest are improvements in symptoms and QOL. Symptom improvements in the knee can be detected using the Lysholm Knee Scale, which consists of
eight items: pain, instability, locking, swelling, limp, stair climbing, squatting, and need for support. There are several symptom measurements for the ankle, such as the Foot and Ankle Ability Measures, in which the patient indicates their ability to perform various walking activities on a scale from "no difficulty" to "unable to do", as well as the American Orthopaedic Foot & Ankle Society Score, and the Foot and Ankle Outcome Score. Quality of life can be measured using the Short-Form (36-item or 12-item).

Study Selection Criteria
Methodologically credible studies were selected using the following principles:
- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse effects, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Osteochondral Autograft for Articular Cartilage Lesions of the Knee
The evidence on AOT for articular cartilage lesions of the knee includes systematic reviews and a number of RCTs that have compared outcomes from AOT with marrow stimulation or autologous chondrocyte implantation (ACI).

Systematic Reviews
A Cochrane review by Gracitelli et al (2016) evaluated surgical interventions (microfracture, drilling, AOT, allograft transplantation) for the treatment of isolated cartilage defects of the knee in adults. Three RCTs selected compared AOT with microfracture for isolated cartilage defects. The evidence was considered of very low quality with high or unclear risk of bias.

In a systematic review by Magnussen et al (2008), at short-term follow-up, neither of the "advanced" cartilage repair techniques (osteochondral transplantation or autologous chondrocyte transplantation) showed superior outcomes compared with traditional abrasive techniques. Based on evidence from five RCTs and a prospective comparative trial, reviewers concluded that no single technique produced superior clinical results for treatment of articular cartilage defects, however, "any differences in outcome based on the formation of articular rather than fibrocartilage in the defect may be quite subtle and only reveal themselves after many years of follow-up. Similarly, complications such as donor-site morbidity in AOT may be late in their presentation and thus not be detected at short follow-up."

However, in a mid-term meta-analysis that included 5 RCTs, Pareek et al (2016) found that Tegner Activity Scale scores were higher, and failure rates lower with AOT than with microfracture. In subgroup analysis, activity scores were higher in the subset of patients treated with AOT who had lesions greater than 3 cm² at mid-term follow-up.

In a systematic review, Harris et al (2011) evaluated whether outcomes from cartilage repair or restoration techniques remained successful if combined with meniscal allograft. Six level IV studies (case series) with 110 patients were included in the review. Patients underwent meniscal allograft transplantation with ACI (n=73), osteochondral allograft (n=20), AOT (n=17), or microfracture (n=3). All studies showed improved clinical outcomes at final follow-up compared with the preoperative condition. Outcomes were also compared with historical outcomes of each procedure performed in isolation. Four of the six studies found outcomes equivalent to procedures performed in isolation, suggesting that the combined procedures did not result in poorer outcomes.

Observational Studies
While observational studies do not provide evidence of efficacy or comparative efficacy, they may provide information about the durability of any observed improvements and potential...
impacts of patient selection factors. Observational studies have reported longer term outcomes and an impact of sex, age, and size and location of the lesion.

Hangody et al (2008), who first reported use of the mosaicplasty technique in humans in 1992, has coauthored a number of summaries and case series. Based on their experience with this procedure, Hangody et al (2008) considered the optimal indications to be lesions 1 to 4 cm² in diameter, patients 50 years of age or younger (due to decreased repair capacity with aging), and correction of instability, malalignment, and meniscal or ligamental tears. Solheim et al (2010, 2013) reported 5- to 9-year (n=69) and 10- to 14-year (n=73) follow-up from patients treated for articular cartilage defects 1 to 5 cm² in area. The Lysholm Knee Scale scores and visual analog scale (VAS) scores for pain improved at mid-term follow-up and long-term follow-up. However, a poor outcome, defined as a Lysholm Knee Scale score of 64 or less or subsequent knee replacement, was observed in 40% of the patients by 10 to 14 years. Factors associated with a poor outcome in this series were patient age (≥40 years at the time of surgery), female sex, and articular cartilage defects of 3 cm² or more.

The importance of concomitant realignment procedures is addressed by other studies. Marcacci et al (2007) described a 7-year follow-up for 30 patients treated with AOT for symptomatic grade III to IV chondral lesions (average, 1.9 cm; range, 1.0-2.5 cm). Nineteen patients received other procedures (anterior cruciate ligament reconstruction, meniscectomy, medial collateral ligament repair) at the same time. Magnetic resonance imaging (MRI) at 7 years showed complete bone integration in 96% of patients, complete integration of the grafted cartilage in 75% of cases, complete filling of the cartilage defect in 63%, and congruency of the articular surface in “some” patients.

Other publications have reported on improved outcomes following AOT for patellar lesions. For example, a prospective study by Astur et al (2014) analyzed 33 patients with symptomatic patellar lesions (diameter, 1-2.5 cm) treated with AOT. At a minimum 2-year follow-up (range, 24-54 months), all patients were reported to have significant improvements in functional scores, as measured by the Lysholm Knee Scale, Kujala, and Fulkerson scores and the 36-item Short-Form Health Survey QOL score. In a series of 22 patients (mean lesion size, 1.6 cm²), Nho et al (2008) reported that both the International Knee Documentation Committee Subjective Knee Evaluation Form (IKDC) and the activity of daily living scores increased significantly from preoperatively to 29-month follow-up following patellar resurfacing.

Section Summary: AOT for Articular Cartilage Lesions of the Knee
Several systematic reviews of RCTs have evaluated AOT for cartilage repair of the knee in the short- and mid-term. The RCTs are not high-quality, and not all reviews found a benefit compared with abrasion techniques. However, compared with abrasion techniques (e.g., microfracture, drilling), there is evidence that AOT decreases failure rates and improves outcomes in patients with medium-size lesions (e.g., 2-6 cm²) when measured at longer follow-up. This is believed to be due to better durability of the natural hyaline cartilage compared with the fibrocartilage that is obtained with abrasion techniques. Factors shown to affect success in observational studies are younger male patients with lesions smaller than 3 cm². Thus, there is a relatively narrow range of lesion size for which AOT is most effective. In addition, the best results have been observed with lesions on the femoral condyles, although treatment of trochlea and patella lesions also improves outcomes. Correction of malalignment is important for the success of the procedure.

FRESH Osteochondral Allograft for Articular Cartilage Lesions of the Knee Systematic Reviews
The Cochrane review by Gracitelli et al (2016) on surgical interventions (microfracture, drilling, mosaicplasty, and allograft transplantation) for treating cartilage defects of the knees did not identify any RCTs on fresh allograft transplantation.
A systematic review by De Caro et al (2015) included 11 articles that had at least 10 patients and were published in the previous 5 years. Articles included a total of 374 knees in 358 patients treated with fresh osteochondral allografting. The size of the lesions ranged from 1 to 27 cm². Different outcome measures were used but overall results showed improvement in objective and subjective clinical scores, a high rate of return to some level of sport or active duty, and graft survival rates of 82% at 10 years and 66% at 20 years. Although bony integration was usually achieved, cartilage integration was limited. In a review of indications, techniques, and outcomes.

Chui et al (2015) stated that fresh osteochondral allografting would be indicated for lesions greater than 2 cm² for which other techniques such as microfracture, AOT, and ACI are inadequate due to lesion size, location, or depth. Reviewers also considered fresh osteochondral allografting to be a salvage procedure for previously failed restoration treatments of the knee.

Observational Studies

Nielsen et al (2017) identified 149 knees in 142 patients who had participated in a sport or recreational activity before a cartilage injury. Following treatment with one or more osteochondral allografts (mean size, 8.2 cm²), 112 (75.2%) patients had returned to the sport. Allograft survival was 91% at 5 years and 89% at 10 years; 14 knees (9.4%) were considered failures.

Fresh osteochondral allografting for patellar cartilage injury was reported by Gracitelli et al (2015). Of 28 knees (27 patients) that had osteochondral transplantation, 8 (28.6%) were considered failures and 9 (45%) required further surgery. Allograft survival was estimated to be 78.1% at 10 years and 55.8% at 15 years. The mean follow-up duration was 9.7 years (range, 1.8-30.1 years) for the 20 (71.4%) knees with intact grafts.

Section Summary: Fresh Osteochondral Allograft for Articular Cartilage Lesions of the Knee

The evidence on fresh osteochondral allografts for articular cartilage lesions of the knee includes case series and systematic reviews of case series. Due to the lack of alternatives, this fresh allograft procedure may be considered as a salvage operation in younger patients for full-thickness chondral defects of the knee caused by acute or repetitive trauma when other cartilage repair techniques (e.g., microfracture, AOT, ACI) would be inadequate due to lesion size, location, or depth.

Osteochondral Autograft for Articular Cartilage Lesions of the Ankle

AOT for Articular Cartilage Lesions of the Ankle less than 1.5 cm²

Osteochondral lesions of the talus are typically associated with an ankle sprain or fracture but comprise a relatively small proportion of lesions (<4%) compared with cartilage lesions of the knee joint. Therefore, RCTs on AOT for talar lesions may be limited. One RCT with 32 patients, case series, and a systematic review of these studies have been identified on AOT for lesions of the talus.

Zengerink et al (2010) published a systematic review on treatment of osteochondral lesions of the talus. Fifty-one nonrandomized and 1 randomized trial (Gobbi et al [2006]; described below) were included. Studies described a variety of lesion sizes, some cystic, some as primary treatment, and some after a failed arthroscopic procedure, with follow-up of at least six months. Success rates averaged 85% for bone marrow stimulation, 87% for osteochondral autografting, and 76% for ACI. Because of the high cost of ACI and the knee morbidity seen with AOT, reviewers concluded that bone marrow stimulation is the treatment of choice for primary osteochondral talar lesions. However, the analysis was not conducted to assess the relation between lesion characteristics and success rates, limiting interpretation of these results.
Subsection Summary: AOT for Articular Cartilage Lesions of the Ankle less than 1.5 cm²
For the use of AOT for repair of articular cartilage lesions of the ankle that are less than 1.5 cm² in area, a systematic review found similar improvements in outcomes following microfracture and AOT. However, given the success of marrow stimulation procedures for smaller lesions (<1.5 cm²) and the increase in donor-site morbidity with graft harvest from the knee, current evidence does not support the use of AOT as a primary treatment for smaller ankle lesions.

The following sections review the evidence for lesions that have failed a prior arthroscopic procedure, and for larger lesions, defined as at least 1.5 cm² in size. This size threshold is derived from studies that have determined bone marrow stimulation procedures for articular cartilage lesions of the talus that are at least 1.5 cm² in area have lower success rates than for those for smaller lesions. For lesions less than 1.5 cm² in size, multiple studies have shown high success rates with marrow stimulation alone. Because of the increase in morbidity with AOT, marrow stimulation would be the most appropriate treatment for small primary lesions. Of the relatively small number of talar osteochondral lesions, about 20% will be considered too large for marrow stimulation. This series reported by Choi et al (2009) also estimated that failure rate following marrow stimulation was 10.5% for lesions less than 1.5 cm²; whereas 80% of lesions at least 1.5 cm² failed after a marrow stimulation procedure.

AOT for the Primary Treatment of Large (>1.5 cm²) or Cystic Articular (>3.0 cm³) Cartilage Lesions of the Ankle

Randomized Controlled Trials
The single RCT identified on AOT for articular cartilage lesions of the talus is by Gobbi et al (2006). The study included 32 patients (33 ankles) with large (mean, 4 cm²; range, 1-8 cm²) lesions randomized to chondroplasty (n=11 ankles), microfracture (n=10 ankles), or AOT (n=12 ankles). Assessment at 24-month follow-up showed similar improvements for the 3 treatment groups, as measured by the American Orthopaedic Foot and Ankle Society (AOFAS) Ankle-Hindfoot Scale score (mean baseline scores ranging 31 to 37 and mean 24-month scores ranging from 83 to 85). An AOFAS score of 90-100 is considered excellent, 80-89 is good, 70-79 is fair, <70 is poor). The Subjective Assessment Numeric Evaluation scores also improved significantly in all treatment groups, from baseline scores of 35 to 36 to 24-month scores of 78 to 82. Complication rates were also similar. Postoperative pain, measured by numeric pain intensity scores, was greater following AOT (5.25) than after chondroplasty (3.3) or microfracture (3.4). Although authors reported following subjects through a mean of 53 months (range, 24-199 months), durability results after 24 months were not reported. Thus, any potential differences between hyaline and fibrocartilage at longer term follow-up cannot be determined from this study.

Observational Studies
Hangody et al (2008) reviewed the records of 1097 mosaicplasties for the knee and ankle in a single institution. Ninety-eight of the mosaicplasties were for the treatment of talus lesions. Based on an evaluation of clinical scores, good-to-excellent results were reported for 93% of the talar procedures. Durable results were available for 36 patients, with a mean 4.2-year period (range, 2-7 years) of follow-up. In this subset of the population, the average size of the grafts was 1 cm², and an average of three osteochondral cores (range, 1-6 cm²) were used. According to the Hanover ankle evaluation, 28 (78%) experienced excellent results, 6 (17%) experienced good results, and 2 (5%) experienced moderate results.

Haleem et al (2014) reported on a minimum 5-year follow-up for AOT for larger lesions of the talus. Fourteen patients who had a double-plug graft for a larger lesion (mean, 208 mm²) were matched by age and sex to a cohort of 28 patients who had a single-plug graft for a smaller osteochondral lesion (mean, 74 mm²). Both groups had significant improvements in the Foot and Ankle Outcome Score (FAOS) and 12-Item Short-Form Health Survey scores, with no significant difference between the single-plug and double-plug groups. In the single-plug group, FAOS improved from 51.6 at baseline to 87.1 at final follow-up, while in the double-plug group the FAOS improved from 49.5 to 86.2.
Shimozono et al (2018) conducted a retrospective analysis comparing patients receiving AOT (n=25) with patients receiving osteochondral allografts (n=16) for lesions of the ankle. Patients in the autograft group had significantly better outcomes as measured by the Foot and Ankle Outcome Score, the Magnetic Resonance Observation of Cartilage Repair Tissue score, and the 12-item Short-Form Health Survey. The rate of secondary procedures was also higher in the allograft group (25%) compared with the autograft group (0%).

Subsection Summary: AOT for the Primary Treatment of Large (>1.5 cm²) or Cystic Articular (>3.0 cm³) Cartilage Lesions of the Ankle

The evidence on AOT for the treatment of large or cystic articular cartilage lesions includes an RCT that found similar efficacy results for AOT, marrow stimulation, and chondroplasty at two-year follow-up. Longer term results were not reported in this RCT. However, several observational studies with longer term follow-up (four to five years) have shown favorable results for patients with large or cystic lesions receiving AOT. Limitations of the published evidence preclude determining the effects of the technology on health outcomes. Evidence reported through clinical input supports that this use provides a clinically meaningful improvement in net health outcomes and is consistent with generally accepted medical practice. Studies on the standard treatment for ankle lesions (marrow stimulation), have reported positive outcomes for patients with small lesions of the ankle (<1.5 cm²) but have generally reported high failure rates for patients with large (>1.5 cm²) lesions. Because the standard treatment has been shown to be less effective on larger lesions, there is support in the clinical community for AOT in patients with large lesions of the ankle. Further details from clinical input are included in the Clinical Input section and the Appendix.

Osteochondral Autograft for Treatment of Osteochondral Lesions of the Ankle that have Failed a Prior Marrow Stimulation Procedure

Nonrandomized Comparative Trials

Yoon et al (2014) compared outcomes for 22 patients who underwent AOT with outcomes for 22 patients who underwent repeat arthroscopy using marrow stimulation after failed treatment of osteochondral lesions of the talus. The treatment was selected by the patient after discussion with the surgeon about the risks and benefits of the two procedures, including possible nonunion of the osteotomy site, donor-site morbidity, and the recovery period. The study included consecutive patients who met study criteria and had failed primary marrow stimulation. Exclusion criteria were diffuse arthritic changes or diffuse fibrillated articular cartilage or axial malalignment or chronic ankle instability. These 44 patients were among 399 patients who received arthroscopic marrow stimulation during the study period, indicating that, for about 90% of patients, primary marrow stimulation was effective. The two groups were comparable at baseline. Independent and blinded evaluation showed an excellent or good outcome on AOFAS scores (≥80) in 19 (86.4%) patients treated with AOT compared with 12 (54.5%) patients who received repeat marrow stimulation (p=0.021). All patients showed initial improvement in VAS and AOFAS scores after 6 months, but over a mean follow-up of 50 months, only 7 (31.8%) in the repeat marrow stimulation group achieved excellent or good results, and 14 (63.6%) of this group underwent further revisions. For patients with large lesions who were treated with repeat microfracture, 100% underwent a subsequent procedure. Conversely, a significantly higher proportion of the group treated with AOT (18 [81.8%]) achieved excellent or good results over a mean follow-up of 48 months, and none required further revisions.

Imhoff et al (2011) retrospectively evaluated 26 AOT procedures (25 patients) of the talus at a mean follow-up of 7 years (range, 53-124 months); 9 had failed a prior marrow stimulation procedure. Two additional patients had undergone a revision procedure and were not included in the follow-up data. The lesion size was less than 3 cm², and an average of 1.5 cylinders was grafted. From baseline to follow-up, for all 26 ankles combined, AOFAS scores improved from 50 to 78 points (p<0.01), Tegner Activity Scale scores from 3.1 to 3.7 (p<0.05), and VAS scores for pain from 7.8 to 1.5 (p<0.01). However, in an analysis between patients undergoing surgery for the first time and patients undergoing revision surgery, outcomes were
significantly worse in patients who had undergone a prior marrow stimulation procedure (see Table 1).

### Table 1. Results at 7-Year Follow-Up

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>AOFAS Score (SD)</th>
<th>Tegner Activity Scale Score (SD)</th>
<th>VAS Score (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat procedure</td>
<td>62.0 (16.4)</td>
<td>2.0 (1.9)</td>
<td>3 (3.2)</td>
</tr>
<tr>
<td>Initial procedure</td>
<td>87.0 (15.0)</td>
<td>4.6 (2.2)</td>
<td>0.6 (1.1)</td>
</tr>
<tr>
<td>p</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

Adapted from Imhoff et al (2011).31
AOFAS: American Orthopaedic Foot & Ankle Society; VAS: visual analog scale; SD: standard deviation.

### Observational Studies

AOT for osteochondritis dissecans (OCD) was reported by Hangody et al (2001) for 36 consecutive patients.6 Most patients had previous surgical interventions and presented with stage III or IV lesions (completely detached or displaced fragment). The average size of the defect was 1 cm, and the average number of grafts per patients was three (range, 1-6). At a mean follow-up of 4.2 years, ankle function measured using the Hannover scoring system showed good-to-excellent results in 34 (94%) cases. Examination by radiograph, computed tomography, and MRI showed incorporation into the recipient bed and congruency of the articular surface.

Kreuz et al (2006) reported on outcomes from a prospective series of 35 patients who underwent osteochondral grafting from the ipsilateral talar articular facet following failed bone marrow stimulation.32 Mean lesion diameter was 6.3 mm. At a mean follow-up of 49 months (range, 33-77 months), the AOFAS Ankle-Hindfoot Scale score had improved from 54.5 points (range, 47-60 points) to 89.9 points (range, 80-100 points).

Georgiannos et al (2016) reported on 5- to 7-year follow-up for a prospective cohort of 46 patients who had failed a prior marrow stimulation procedure.33 Osteochondral plugs, which ranged from 4.75 to 8 mm in diameter, were taken from the talar facet. A temporary block of bone was removed to provide access to the talar dome. At a median follow-up of 5.5 years (range, 52-75 months), AOFAS score had improved from 55 to 90, and the median VAS score improved from 52/100 to 91. All grafts had incorporated and osteotomy sites healed, although five patients underwent subsequent surgery for osteophytes.

### Subsection Summary: AOT for Articular Cartilage Lesions of the Ankle that have Failed a Prior Marrow Stimulation Procedure

The evidence for AOT in patients with articular cartilage lesions of the talus that have failed a prior marrow stimulation procedure includes two nonrandomized comparative trials and several case series. One nonrandomized comparative study has suggested improved outcomes with AOT compared with repeat marrow stimulation. Another study compared outcomes among patients receiving AOT as a first treatment with patients receiving AOT as a revision treatment. The study found improvements in both groups compared to baseline measures; however, larger improvements were seen in the group receiving AOT as a first treatment compared with those receiving AOT as a revision procedure. Case series have consistently indicated good-to-excellent results of AOT at mid-term follow-up. The published evidence supports a meaningful improvement in the net health outcome. Evidence reported through clinical input further supports that this use provides a clinically meaningful improvement in net health outcome and is consistent with generally accepted medical practice. Further details from clinical input are included in the Clinical Input section and the Appendix.

### Fresh Osteochondral Allograft for Articular Cartilage Lesions of the Ankle

Use of AOT is limited by the number of cores that can be taken from the non-weight-bearing part of the talus or ipsilateral knee. AOT may also be inadequate due to lesion depth or location, such as on the talar shoulder. For osteochondral lesions for which AOT would be inadequate due to lesion size, depth, or location, the use of fresh osteochondral allografts has been investigated. Use of fresh allografts for defects of the talus has been reported mainly in case series and a
systematic review of these series. Due to the relatively rare occurrence of this condition, most series have fewer than 20 patients. One RCT was identified that compared AOT with allograft plugs for recurrent cartilage lesions.

Systematic Reviews
Diniz et al. (2019) conducted a systematic review on the use of allografts for 10 foot and ankle indications. A total of 107 studies were identified, 12 of which related to osteochondral lesions of the ankle (n=125 patients). No meta-analyses were conducted. Summary descriptions were not presented separately by lesion size. Eleven of the studies were considered level IV evidence and one study was level V evidence. Within these studies, 6 minor complications and 9 major complications were reported, for an overall complication rate of 12%. The authors concluded that osteochondral allografts for lesions of the ankle can be considered in larger defects that are not amenable to bone marrow stimulation or when donor site morbidity is of concern (grade: C).

In addition to the failure rate of AOT, van Dijk (2017) noted that an osteochondral allograft can compromise a future arthrodesis or arthroplasty by the failure of bony ingrowth because the bulk of the graft will consist of dead bone.

Primary Full-Thickness Articular Cartilage Lesions of the Ankle less than 1.5 cm²
The literature on fresh allograft for the treatment of small lesions of the ankle is very limited because this treatment is considered only when there are no other options available to delay arthrodesis or arthroplasty. Because microfracture is effective as a primary treatment in lesions less than 1.5 cm² and AOT is effective as a revision procedure, use of allograft for small lesions has not been reported. Note that other allograft products, such as minced juvenile cartilage and reduced allograft discs, are described in other sections.

Large (Area >1.5 cm²) or Cystic (Volume >3.0 cm³) Cartilage Lesions of the Ankle
In a systematic review, VanTienderen et al. (2017) included 5 studies with a total of 90 patients (91 ankles) who received a fresh osteochondral allograft for large or cystic osteochondral lesions of the talus. Studies selected reported at least one outcome of interest, including AOFAS score, Foot Functional Index score, VAS score, reoperation rate, or rate of allograft collapse. The mean lesion volume was 3.7 cm³ (range, 1.0-10.9 cm³) and the number of prior procedures ranged from 1 to 4. At a mean follow-up of 45 months (range, 6-91 months), mean AOFAS scores of the combined studies improved from 48 to 80 and mean VAS scores of the combined studies improved from 7.1 to 2.7. However, some failures occurred: 23 (25.3%) patients required at least 1 reoperation and 12 (13.2%) patients were considered failures, defined as postoperative graft nonunion or resorption or persistence of symptoms leading to arthrodesis or arthroplasty.

Ahmad and Jones (2016) conducted an RCT comparing AOT with fresh allograft plugs for the treatment of large (area >1.5 cm², n=9) or recurrent (volume >3.0 cm³; n=27) cartilage lesions of the talus. The majority of the study participants had recurrent osteochondral lesions. Only five patients with large primary osteochondral lesions were in the autograft treatment group and four patients with large primary osteochondral lesions were in the allograft treatment group. Subgroup analyses on these patients with primary lesions was not conducted.

Revision of Large (Area >1.5 cm²) or Cystic (Volume >3.0 cm³) Osteochondral Lesions of the Ankle
Randomized Controlled Trial
The study by Ahmad and Jones (2016; discussed above) included 9 large and 27 recurrent osteochondral lesions of the talus. Most patients had failed a prior microfracture. The study randomized 20 patients to AOT and 20 patients to plugs taken from a size-matched donor talus. Four patients from the allograft group had significant damage to the shoulder of the talar dome. These four received a hemi-talus allograft and were subsequently excluded from the study. Comparative analyses combined the patients with primary and recurrent lesions. Foot and Ankle Ability Measures and VAS scores were similar in the two groups. In the autograft group, the mean
Foot and Ankle Ability Measures score increased from 55.2 to 80.7, and the mean VAS score decreased from 7.8 to 2.7 at final follow-up. These outcomes were reported as being lower than those reported for the autograft group but the differences were not statistically significant. However, more patients in the allograft group had graft nonunion (3/16 [18.8%] patients vs the autograft group (2/20 [10%] patients), consistent with the systematic review by Van Tienderen et al (2017; described above).

Observational Study
Gaul et al (2019) presented a case series of 19 patients (20 ankles) who received osteochondral allografts for osteochondral lesions of the ankle, 19 of which had prior surgical procedures (drilling, osteotomy, microfracture). Five of the 20 ankles required further surgery, 3 of which were considered allograft failures. The mean time to failure was 3.5 years. Of the 17 nonfailed ankles, median follow-up was 9.7 years. Mean Olerud-Molander Ankle Score improved significantly following the procedure. Of the 15 patients who answered the follow-up survey, 14 reported less pain and better function.

Section Summary: Fresh Osteochondral Allograft for Articular Cartilage Lesions of the Ankle
The evidence on osteochondral allografts for articular cartilage lesions of the ankle includes an RCT, case series, and a systematic review of case series.

There is little evidence on fresh osteochondral allografts for the primary treatment of full-thickness articular cartilage lesions of the ankle less than 1.5 cm². Because microfracture is effective as a primary treatment in lesions less than 1.5 cm², AOT is typically considered as a revision procedure. Due to the high failure rate of allografts, use of allografts for small primary cartilage lesions is not appropriate.

The evidence for fresh osteochondral allografts for the treatment of large (area >1.5 cm²) or cystic (volume >3.0 cm³) osteochondral lesions of the ankle includes a small number of patients in an RCT, case series, and a systematic review of case series. The majority of patients in the RCT were patients with revision osteochondral lesions, so conclusions about the few patients with primary lesions could not be made. The systematic review of case series reported improvements in ankle scores and decreases in pain scores, though 25% of patients needed additional surgery and 13% experienced either graft nonunion, resorption, or symptom persistence. Also, the use of allografts may have a negative impact on any future arthroplasty or arthrodesis. Limitations of the published evidence preclude determining the effects of the technology on health outcomes. Evidence reported through clinical input supports that the use provides a clinically meaningful improvement in net health outcome and is consistent with generally accepted medical practice. For particularly large lesions, marrow stimulation techniques have been found to be ineffective and obtaining an adequate volume of autograft may cause significant morbidity. For these reasons, osteochondral allografts may be a considered option for large lesions of the ankle. Further details from clinical input are included in the Clinical Input section and the Appendix.

The evidence on fresh osteochondral allografts for revision of large (area >1.5 cm²) or cystic (volume >3.0 cm³) osteochondral lesions of the ankle includes an RCT which compared outcomes between patients receiving autografts vs allografts. Most of the patients had failed a prior microfracture. The RCT found that outcomes were statistically similar with osteochondral allografts compared with autografts. However, failure rates due to nonunion were higher in patients in the allograft group compared with patients in the autograft group. Limitations of the published evidence preclude determining the effects of the technology on health outcomes. Evidence reported through clinical input supports that the use provides a clinically meaningful improvement in net health outcome and is consistent with generally accepted medical practice. For particularly large lesions, marrow stimulation techniques have been found to be ineffective and obtaining an adequate volume of autograft may cause significant morbidity. For these reasons, osteochondral allografts may be a considered option for revision of large lesions.
Osteochondral Autograft for articular cartilage Lesions of the Elbow

Systematic Reviews

A systematic review by Westermann et al (2016) included 24 case series (total n=492 patients) that assessed return to sports after operative treatment (AOT[n=164], microfracture and débridement [n=236], and fixation [n=92]) for OCD of the capitulum. The most common primary sport was baseball (371/464) followed by gymnastics (35/464). Quality of the evidence was assessed using the Grading of Recommendations Assessment, Development, and Evaluation system. None of the studies were randomized or controlled, mostly level four evidence, retrospective, and from single institutions. The overall return to sports rate was 86% at a mean 5.6 months. Average lesion size was similar for the different treatments among eight studies with information available. Among all 24 studies, patients were more likely to return to their preoperative sport at any level after AOT (0.95; 95% confidence interval [CI], 0.89 to 0.99) compared with débridement and microfracture (0.62; 95% CI, 0.46 to 0.77; p<0.001) or fixation with pins, wires, or screws (0.72; 95% CI, 0.51 to 0.89; p=0.01). Grafts were taken from the lateral femoral condyle or ribs. The percentages returning to their preoperative sport at their previous level were 94% (AOT), 71% (microfracture and débridement), and 64% (fixation). Adverse events from the surgical procedures are rare; however, patients considering AOT need to consider donor site morbidity.

Kirsch et al (2017) conducted a systematic review of the literature through July 2016 of case series evaluating return to play after AOT for the treatment of OCD of the capitellum. Seven case series (n=126) met the inclusion criteria and were rated as moderate quality using the Methodological Index for Non-Randomized Studies. A total of 119 (94%) of the patients undergoing AOTs successfully returned to competitive sports. The mean time to unrestricted return was 5.6 months (range 3 to 14 months).

Observational Study

Sato et al (2018) presented a case series of 72 patients receiving AOT for advanced (stage III and IV) OCD of the humeral capitellum in young athletes, who were followed for at least 3 years. The Timmerman and Andrews clinical rating score, which incorporates subjective measures (such as pain, swelling, and activity level) and objective measures (such as flexion and arc of elbow motion) improved significantly from 101 to 190 following the procedure. Seventy of the patients returned to their sport without restrictions by 5.8 months. Subsequent surgeries included additional grafting (n=2), delayed medial ligament reconstruction (n=1), and arthroscopic removal of loose bodies (n=2).

Donor-Site Morbidity

Bexkens et al (2017) conducted a meta-analysis of case series that assessed donor-site morbidity after AOT for OCD of the capitellum. Reviewers included 11 studies with 190 patients (range, 11-33 patients per series); most patients were adolescents. Grafts were harvested from the femoral condyle in eight studies and from the costal-osteochondral junction in three studies. With donor-site morbidity defined as persistent symptoms of at least 1 year or that required intervention, morbidity was reported in 10 (7.8%) of 128 patients from the knee-to-elbow group and 1 (1.6%) of 62 in the rib-to-elbow group. A limitation of this meta-analysis was its incomplete assessment and reporting of outcomes for the donor site in the primary publications.

Section Summary: AOT for Articular Cartilage Lesions of the Elbow

OCD of the elbow typically occurs in patients who play baseball or do gymnastics. The literature on AOT for advanced OCD of the elbow consists of case series, primarily from Europe and Asia, and systematic reviews of case series. Although the meta-analysis suggested a benefit of AOT compared with débridement or fixation, additional prospective comparative studies are needed to determine the effects of the procedure with greater certainty.
Osteochondral Autograft for Articular Cartilage Lesions of Shoulder
A European study by Kircher et al (2009) reported on 9-year follow-up after AOT for cartilage defects of the shoulder in 7 patients. One additional patient was reported to have had donor-site morbidity at the knee and chose not to return for follow-up. All plugs showed full integration with the surrounding bone, and six of seven patients showed a congruent joint surface. The Constant score improved from 76 points preoperatively to 90 points at 33 months and remained at 91 points at the 9-year follow-up. Subscores for pain and activities of daily living showed significant improvement at 33-month follow-up, with a very slight nonsignificant decline at 9-year follow-up. None of the patients required additional shoulder surgery.

Section Summary: AOT for Articular Cartilage Lesions of Shoulder
The evidence on osteochondral autografting for the shoulder is very limited and therefore does not allow conclusions about the efficacy of this treatment.

Minced or Particulated Cartilage for Articular Cartilage lesions

Autologous Minced Cartilage
Cole et al (2011) reported on a multicenter trial with 29 patients (of 582 screened) randomized in a 1:2 ratio to microfracture or Cartilage Autograft Implantation System (CAIS). In the single-stage CAIS procedure, autologous hyaline cartilage was harvested, minced, affixed to a synthetic absorbable scaffold, and fixed on the lesion site with absorbable staples. At baseline, there were no significant differences between groups in the duration of symptoms, International Cartilage Repair Society grade, and area and depth of the chondral defect. There was a difference in the sex and work status of the two groups. At three-week and six-month follow-ups, there were no significant differences in outcomes between the two groups, but at later follow-up, there were differences reported. The IKDC Form score was significantly higher in the CAIS group compared with the microfracture group at both 12 (73.9 vs 57.8) and 24 (83.0 vs 59.5) months. All subdomains of the Knee injury and Osteoarthritis Outcome Score symptoms and stiffness, pain, activities of daily living, sports and recreation, knee-related QOL were significantly increased at 24 months in the CAIS group compared with microfracture patients. Qualitative analysis of MRI at 3 weeks and 6, 12, and 24 months showed no differences in the fill of the graft bed, tissue integration, or presence of subchondral cysts. Adverse events were similar for the groups.

Allogeneic Juvenile Minced Cartilage
Knee
Evidence on the efficacy of DeNovo NTs is limited to case reports and small case series. The largest series identified was an industry-sponsored prospective study by Farr et al (2014), which included 25 patients with cartilage lesions of the femoral condyle or trochlea. Patients had symptomatic, focal, contained chondral lesions of the femoral condyles or trochlea with defect areas ranging between 1 cm² and 5 cm² (mean, 2.7 cm²; range 1.2-4.6 cm²). Mean number of prior surgeries was 1.1, with 18 patients reporting prior débridement and/or microfracture. Patients returned for follow-up at 3, 6, 12, 18, and 24 months for radiographs, IKDC examination, and completion of questionnaires. Outcomes included the Knee injury and Osteoarthritis Outcome Score, IKDC, Marx Activity Scale, and 100-mm VAS score for pain. IKDC score improved over the 24 months of follow-up. At 24 months, IKDC score had improved from 45.7 preoperatively to 73.6 of 100. There were also significant improvements in Knee injury and Osteoarthritis Outcome Score subscores (p < 0.001) and VAS pain score (from 43.7/100 at baseline to 11.1 at 24 months, p < 0.001). MRI showed a mean lesion fill of 109.7% with mild graft hypertrophy identified in 20.7% of patients. Of 11 elective second-look arthroscopies at 24 months, 2 grafts (18%) showed either partial or complete delamination. Histology from eight patients with biopsy showed a mixture of hyaline and fibrocartilage; areas with hyaline cartilage varied across sections. There was good integration with the surrounding native cartilage.

A study by Tompkins et al (2013) included 13 patients (15 knees) who received particulated juvenile allograft to the patella. Ten of the 15 knees underwent concomitant procedures, limiting interpretation of functional outcomes. Cartilage repair, assessed at a mean of 28.8
months, was reported to be nearly normal in 73% of knees while 27% of knees had evidence of graft hypertrophy.

**Ankle**

One proposed advantage of particulated articular cartilage for osteochondral lesions of the talus is that it is not always necessary to perform an osteotomy to access the lesion. At this time, use of DeNovo NT for the talus has been reported in case reports, small case series, and a systematic review of these studies.

Saltzman et al (2017) reported on a descriptive systematic review of the published case reports and case series.47, Included were data on 33 ankles from 2 case reports, a series of 7 patients by Bleazey and Brigido (2012)48, and a series of 24 ankles by Coetzee et al (2013),49, described next.

A preliminary report by Coetzee et al (2013),49, described 24 ankles (23 patients) with osteochondral lesions of the talus (mean lesion size, 125 mm²) that were treated with DeNovo NT. Fourteen (58%) of the ankles had failed at least 1 prior bone marrow stimulation procedure. At an average follow-up of 16.2 months, 78% of ankles had good-to-excellent scores on the AOFAS Ankle-Hindfoot Scale score, with a final mean VAS score of 24 out of 100. However, 18 (76%) ankles had at least 1 concomitant procedure (hardware removal and treatment for impingement, synovitis, instability, osteophytes, malalignment), limiting interpretation of the functional results. One treatment failure was caused by partial graft delamination.

In addition to their systematic review of the literature, Saltzman et al (2017) also reported on 6 patients who had been treated at their institution with particulated juvenile articular cartilage for articular cartilage lesions of the talus.47, Lesion size ranged from 96 to 308 mm². Two of the six patients underwent a medial malleolar osteotomy to access the lesion. Implantation procedures included débridement, marrow stimulation, and fixation of the particulated cartilage with fibrin glue. At a mean 13-month follow-up, all 6 patients reported subjective improvements in pain and function. However, for all three patients who had MRI between three months and two years postoperatively, there was persistent subchondral edema and nonuniform chondral surface.

Dekker et al (2018) conducted a retrospective review of patients receiving particulated juvenile cartilage allograft transplantation for osteochondral lesions of the talus (n=15).50, Twelve of the 15 patients had undergone a prior microfracture procedure and 3 patients received the transplant as a primary procedure. A successful procedure was defined as improvement in pain and no subsequent cartilage procedures. After at least 1 year follow-up, 9 (60%) cases were considered successful, with 3 patients needing additional cartilage procedures and 3 reporting continued pain. Predictors of failure were larger lesions and male sex.

DiSandis et al (2018) reported on a series of 46 patients receiving particulated juvenile cartilage allograft transplantation and autologous bone marrow aspirate concentration for osteochondral lesions of the talus.51, Only 24 patients had pre- and post-FAOS and 12-item Short-Form Health Survey data. Almost all subscale scores were significantly improved after the procedure; however, MRI showed inhomogeneous repair tissue structure, persistent bone marrow edema, and moderately hyperintense tissue.

**Section Summary: Minced or Particulated Cartilage for Articular Cartilage Lesions**

The evidence on autologous minced or particulated cartilage includes a small RCT from 2011. The evidence on allogeneic minced cartilage includes case reports and case series. The case series have suggested an improvement in outcomes compared with baseline but there is also evidence of subchondral edema, nonuniform chondral surface, graft hypertrophy, and delamination. For articular cartilage lesions of the knee, further evidence, preferably from RCTs, is needed to evaluate the effect on health outcomes compared with other available procedures. For articular cartilage lesions of the ankle, there are few treatment options and, in the largest case series, over half of the patients had failed prior marrow stimulation. However, the concomitant procedures performed in that study limited interpretation of its results.
Randomized comparisons with microfracture in patients who have not received prior treatment would permit greater certainty about the effectiveness of this procedure.

**Decellularized Osteochondral Allograft**

Case series have suggested high failure rates for decellularized osteochondral allograft plugs (Chondrofix). A review of records for 32 patients treated by Farr et al (2016) identified failure in 23 (72%) patients when failure was defined as structural damage of the graft identified by MRI or arthroscopy, or any reoperation resulting in the removal of the allograft. Johnson et al (2017) examined records from an institutional registry of 34 patients who, following discussion of alternative cartilage repair options, chose treatment with a decellularized osteochondral allograft plug. Patient-reported outcomes along with MRI results were recorded at six months, one year, and two years by independent observers. At a mean follow-up of 15.5 months (range, 6-24 months), 10 (29%) patients required revision surgery with removal of the implant. Failure rates were higher for females and larger lesions (hazard ratio, 1.9 per 1 cm² increase; 95% CI, 1.2 to 3.1; p=0.005).

**Section Summary: Decellularized Osteochondral Allograft**

The evidence on decellularized osteochondral allograft plugs has reported delamination of the implants and high failure rates.

**Reduced Osteochondral Allograft Discs**

The evidence on reduced osteochondral allograft discs is limited to case reports and very small case series with two to three patients.

**Section Summary: Reduced Osteochondral Allograft Discs**

The evidence on reduced osteochondral allograft discs consists only of small case series and is insufficient to draw conclusions about treatment efficacy.

**Summary of Evidence**

The following conclusions are based on a review of the evidence, including but not limited to published evidence and clinical expert opinion, solicited via Blue Cross Blue Shield Association Clinical Input Process.

**Knee Lesions**

For individuals who have full-thickness articular cartilage lesions of the knee who receive an AOT, the evidence includes RCTs, systematic reviews of RCTs, and longer term observational studies. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. Several systematic reviews have evaluated AOT for cartilage repair in the short- and mid-term. Compared with abrasion techniques (e.g., microfracture, drilling), there is evidence that AOT decreases failure rates and improves outcomes in patients with medium-size lesions (e.g., 2-6 cm²) when measured at longer follow-up. This is believed to be due to the higher durability of hyaline cartilage compared with fibrocartilage from abrasion techniques. There appears to be a relatively narrow range of lesion size for which AOT is most effective. The best results have also been observed with lesions on the femoral condyles, although treatment of lesions on the trochlea and patella may also improve outcomes. Correction of malalignment is important for the success of the procedure. The evidence suggests that AOT may be considered an option for moderate-sized symptomatic full-thickness chondral lesions of the femoral condyle, trochlea, or patella. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have full-thickness articular cartilage lesions of the knee who autografting would be inadequate due to lesion size, location, or depth who receive a fresh osteochondral allograft, the evidence includes case series. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. Due to the lack of alternatives, this procedure may be considered a salvage operation in younger patients for full-thickness chondral defects of the knee caused by acute or repetitive trauma when other cartilage repair techniques (e.g.,
microfracture, AOT, ACI) would be inadequate due to lesion size, location, or depth. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Ankle Lesions**
For individuals who have primary full-thickness articular cartilage lesions of the ankle less than 1.5 cm² who receive an AOT, the evidence includes observational studies and a systematic review of these studies. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. A systematic review found similar improvements in outcomes following microfracture and AOT. Given the success of marrow stimulation procedures for smaller lesions (<1.5 cm²) and the increase in donor-site morbidity with graft harvest from the knee, current evidence does not support the use of AOT as a primary treatment for smaller articular cartilage lesions of the ankle. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have large (area >1.5 cm²) or cystic (volume >3.0 cm³) full-thickness articular cartilage lesions of the ankle who receive an AOT, the evidence includes an RCT and several observational studies. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. An RCT in patients with large lesions found similar efficacy for AOT, marrow stimulation, and arthroplasty at two-year follow-up. Longer term results were not reported in the RCT. However, observational studies with longer term follow-up (four to five years) have shown favorable results for patients with large or cystic lesions receiving AOT. Limitations of the published evidence preclude determining the effects of the technology on health outcomes. Evidence reported through clinical input supports that the use provides a clinically meaningful improvement in net health outcome and is consistent with generally accepted medical practice. Studies on the standard treatment for ankle lesions, marrow stimulation, have reported positive outcomes for patients with small lesions of the ankle (<1.5 cm²) but have generally reported high failure rates for patients with large (>1.5 cm²) lesions. Because the standard treatment has been shown to be less effective on larger lesions, there is support in the clinical community for AOT in patients with large lesions of the ankle. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have osteochondral lesions of the ankle that have failed primary treatment who receive an AOT, the evidence includes two nonrandomized comparative trials and several case series. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. The best evidence for revision AOT comes from a nonrandomized comparative study that found better outcomes with AOT than with repeat marrow stimulation. This finding is supported by case series that have indicated good-to-excellent results at mid-term and longer term follow-up with revision AOT. The published evidence supports a meaningful improvement in the net health outcome. Evidence reported through clinical input further supports that this use provides a clinically meaningful improvement in net health outcome and is consistent with generally accepted medical practice. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have primary full-thickness articular cartilage lesions of the ankle less than 1.5 cm² who receive a fresh osteochondral allograft, there is little evidence. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. Because microfracture is effective as a primary treatment for lesions less than 1.5 cm² and AOT is effective as a revision procedure, use of allograft for small primary cartilage lesions has not been reported. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have large (area >1.5 cm²) or cystic (volume >3.0 cm³) cartilage lesions of the ankle when autografting would be inadequate who receive a fresh osteochondral allograft, the evidence includes a small number of patients in an RCT, case series, and a systematic
review of case series. The relevant outcomes are symptoms, functional outcomes, QOL, and
treatment-related morbidity. The majority of patients in the RCT were patients with revision
osteoarticular lesions, so conclusions about the few patients with primary lesions could not be
made. The systematic review of case series reported improvements in ankle scores and
decreases in pain scores, though 25% of patients needed additional surgery and 13%
experienced either graft nonunion, resorption, or symptom persistence. Limitations of the
published evidence preclude determining the effects of the technology on health outcomes.
Evidence reported through clinical input supports that the use provides a clinically meaningful
improvement in net health outcome and is consistent with generally accepted medical
practice. For particularly large lesions, marrow stimulation techniques have been found to be
ineffective and obtaining an adequate volume of autograft may cause significant morbidity. For
these reasons, osteochondral allografts may be a considered option for large lesions of the
ankle. The evidence is sufficient to determine that the technology results in a meaningful
improvement in the net health outcome.

For individuals who have revision osteochondral lesions of the ankle when autografting would
be inadequate who receive a fresh osteochondral allograft, the evidence includes an RCT. The
relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity.
Most of the patients in the RCT had failed a prior microfracture. The RCT found that outcomes
were statistically similar with osteochondral allografts compared with autografts. However, failure
rates due to nonunion were higher in patients in the allograft group compared with patients in
the autograft group. Limitations of the published evidence preclude determining the effects of
the technology on health outcomes. Evidence reported through clinical input supports that the
use provides a clinically meaningful improvement in net health outcome and is consistent with
generally accepted medical practice. For particularly large lesions, marrow stimulation
 techniques have been found to be ineffective and obtaining an adequate volume of autograft
may cause significant morbidity. For these reasons, osteochondral allografts may be a
considered option for revision of large lesions of the ankle. The evidence is sufficient to
determine that the technology results in a meaningful improvement in the net health outcome.

**Elbow Lesions**
For individuals who have full-thickness articular cartilage lesions of the elbow who receive an
osteochondral autograft, the evidence includes a meta-analysis of case series. The relevant
outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. OCD of
the elbow typically occurs in patients who play baseball or do gymnastics. The literature on
osteochondral autografts for advanced OCD of the elbow consists of small case series, primarily
from Europe and Asia, and a systematic review of case series. Although the meta-analysis
suggested a benefit of osteochondral autographs compared with débridement or fixation, RCTs
are needed to determine the effects of the procedure with greater certainty. The evidence is
insufficient to determine the effects of the technology on health outcomes.

**Shoulder Lesions**
For individuals who have full-thickness articular cartilage lesions of the shoulder who receive an
AOT, the evidence includes a case series. The relevant outcomes are symptoms, functional
outcomes, QOL, and treatment-related morbidity. Evidence on AOT for the shoulder is very
limited. The evidence is insufficient to determine the effects of the technology on health
outcomes.

**Knee, Ankle, Elbow, or Shoulder Lesions**
For individuals who have full-thickness articular cartilage lesions of the knee, ankle, elbow, or
shoulder who receive autologous or allogeneic minced or particulated articular cartilage, the
evidence includes a small RCT and small case series. The relevant outcomes are symptoms,
functional outcomes, QOL, and treatment-related morbidity. The evidence on autologous
minced cartilage includes a small RCT. The evidence on allogeneic juvenile minced cartilage
includes a few small case series. The case series have suggested an improvement in outcomes
compared with preoperative measures but there is also evidence of subchondral edema,
nonhomogeneous surface, graft hypertrophy, and delamination. For articular cartilage lesions of the knee, further evidence, preferably from RCTs, is needed to evaluate the effect on health outcomes compared with other procedures. There are fewer options for articular cartilage lesions of the ankle. However, further study in a larger number of patients is needed to assess the short- and long-term effectiveness of this technology. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have full-thickness articular cartilage lesions of the knee, ankle, elbow, or shoulder who receive decellularized osteochondral allograft plugs or reduced osteochondral allograft discs, the evidence includes small case series. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. The case series on decellularized osteochondral allograft plugs reported delamination of the implants, and high failure rates. Evidence on reduced osteochondral allograft discs consists only of case reports and very small case series. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Clinical Input**

**Objective**
Clinical input is sought to determine whether the use of osteochondral autografts improves the net health outcome when used to treat focal articular cartilage lesions in the ankle and elbow.

**Respondents**
Clinical input was provided by the following specialty societies and physician members identified by a clinical health system:
- American Academy of Orthopaedic Surgeons (AAOS) and American Orthopaedic Foot and Ankle Society (AOFAS)
- Anonymous, Orthopedic Surgery (Catholic Health Initiatives [CHI])

Clinical input provided by the specialty society at an aggregate level is attributed to the specialty society. Clinical input provided by a physician member designated by the specialty society or health system is attributed to the individual physician and is not a statement from the specialty society or health system. Specialty society and physician respondents participating in the Blue Cross Blue Shield Association Evidence Street® clinical input process provide a review, input, and feedback on topics being evaluated by Evidence Street. However, participation in the clinical input process by a specialty society and/or physician member designated by the specialty society or health system does not imply an endorsement or explicit agreement with the Evidence Opinion published by Blue Cross Blue Shield Association or Blue Shield of California.
Clinical Input Responses

Figure 1:

<table>
<thead>
<tr>
<th>Clinical Indication</th>
<th>Respondent</th>
<th>Identified by</th>
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<tbody>
<tr>
<td>Lesion size &gt; 150mm²</td>
<td>AAOS/AOFAS</td>
<td></td>
</tr>
<tr>
<td>Large cystic lesions</td>
<td>AAOS/AOFAS</td>
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</tr>
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<td>Autograft transplantation in revision osteochondral lesion of the talus</td>
<td>AAOS/AOFAS</td>
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<tr>
<td>Allograft transplantation in revision osteochondral lesion of the talus</td>
<td>AAOS/AOFAS</td>
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<td>CHI</td>
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<tr>
<td>Failed microfracture</td>
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<td>CHI</td>
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Confidence Level that Evidence Supports Improved Health Outcomes

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Confidence Level that Clinical Use is in Accordance with Generally Accepted Medical Practice

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Additional Comments

Ankle

- “Osteochondral autografts are appropriate for primary treatment of osteochondral lesions of the talus with a surface area > 150mm².” (AAOS/AOFAS)
- “Both osteochondral autograft and allograft transplantations are valid treatment options in revision situations.” (AAOS/AOFAS)
- “Osteochondral allografts have been shown to be useful for primary treatment of large, cystic osteochondral lesions of the talus. In large cystic lesions, as defined by surface area >150mm² or volume >3000mm³, arthroscopic marrow stimulation techniques are unreliable and obtaining an adequate volume of autograft carries the risk of significant morbidity.” (AAOS/AOFAS)
- “While the use of autograft has a trend for superior results for graft healing, donor site morbidity with chronic knee pain can be a cause of concern ranging from 0-26% of patients. However, osteochondral fresh allograft may be the only option in certain cases with extraordinary large lesions or when the lesions involve shoulder region of the talus. Overall, both osteochondral autograft and allograft transplantation have a definitive role in the treatment of uncommon but disabling recurrent osteochondral lesions of the talus.” (AAOS/AOFAS)
- “An attempt to treat a patient with an osteochondral autograft gives patients an opportunity to decrease pain and improve function and avoid a potentially greater morbid procedure such as a fusion or total ankle arthroplasty, which may be inappropriate in a younger patient.” (Anonymous - CHI)

Elbow

- “Large OCD [osteocondritis dissecans] lesions of the capitellum may benefit from osteochondral autografts in patients failing non-operative treatment or debridement/microfracture.” (Anonymous - CHI)
Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2017 Input

In response to requests from Blue Cross Blue Shield Association, clinical input on osteochondral autografts improves for treating focal articular cartilage lesions in the ankle and elbow was received from 3 respondents, including 2 specialty society-level response and 1 physician from 1 health systems in 2017. Evidence from clinical input is integrated within the Rationale section summaries and the Summary of Evidence.

2011 Input

In response to requests from Blue Cross Blue Shield Association, input was received from 3 academic medical centers in 2011. Input generally agreed with the stated criteria for osteochondral grafting, except the following: input was mixed on the requirement for an adequate response to a prior surgical procedure, the size of the lesion, and the requirement for an absence of meniscal pathology. Input was also mixed on the investigational status of osteochondral grafts in other joints, including the patellar and talar joints, and for the use of autologous minced cartilage.

2008 Input

In response to requests from Blue Cross Blue Shield Association, input was received from 1 physician specialty society and 3 academic medical centers in 2008. All reviewers agreed that osteochondral autografts and allografts are considered reasonable for patients with full-thickness chondral defects who meet specific criteria.

Practice Guidelines and Position Statements

Ankle

American Orthopaedic Foot and Ankle Society

The American Orthopaedic Foot and Ankle Society (2018) issued a position statement on the use of osteochondral transplantation for the treatment of osteochondral lesions of the talus. In the statement, the Society "endorses the use of osteochondral autograft and allograft transplantation for the treatment of osteochondral lesion of the talus, especially large diameter lesions, cystic lesions, and those that have failed previous surgical treatment. AOFAS does not consider these procedures to be experimental in a patient population that has failed nonoperative management."

International Consensus Group on Cartilage Repair of the Ankle

The International Consensus Group on Cartilage Repair of the Ankle (2017) convened to review the best available evidence and develop consensus statements to guide management of patients needing cartilage repair of the ankle. The Consensus Group, consisting of 75 experts from 25 countries, acknowledged that evidence in the field of cartilage repair of the ankle is both low-quality and at low-levels. One topic addressed by the Consensus Group was the use of osteochondral allografts. Through a process based on the Delphi method of achieving consensus, the following recommendations were issued:

- Osteochondral allograft plugs may be preferred over autografts in the following conditions: lesions >1.5 cm; knee osteoarthritis; history of knee infection; patients expressing concern of donor site morbidity of the knee. (grade of evidence: prospective cohort study)
- The source of osteochondral allograft plugs for the ankle should come from the ankle, not the knee. (grade of evidence: basic science)
• There is an absence of clinical evidence and clinical experience for the use of decellularized osteochondral allograft plugs.
• The preferred type of allograft for the ankle is fresh, nonfrozen. (grade of evidence: basic science)

Elbow
American Academy of Orthopaedic Surgeons
In 2010 guidelines, which remain available on the American Academy of Orthopaedic Surgeons website in 2018, on the diagnosis and treatment of osteochondritis dissecans, the Academy was unable to recommend for or against a specific cartilage repair technique in symptomatic skeletally immature or mature patients with an unsalvageable osteochondritis dissecans lesion. 56, 57

A 2010 Academy review of articular cartilage restoration methods stated that “osteochondral autografting is generally used for smaller focal lesions of the femoral condyle no greater than 1.5 to 2 cm.” 58

Knee
The National Institute for Health and Care Excellence (2018) issued a new guidance, mosaicplasty for symptomatic articular cartilage defects of the knee (IPG607). 59 The guidance states that the evidence for safety and efficacy of mosaicplasty for knee cartilage defects is adequate to support the use of the procedure.

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 2.

Table 2. Summary of Key Trials

<table>
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<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
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<td>NCT01347892a</td>
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<td>Sep 2019</td>
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<td>NCT01329445a</td>
<td>Post Market, Longitudinal Data Collection Study of DeNovo NT for Articular Cartilage Defects of the Knee</td>
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<tr>
<td>NCT01670617a</td>
<td>A Stratified, Post-Market Study of DeNovo NT for the Treatment of Femoral and Patellar Articular Cartilage Lesions of the Knee</td>
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<td>Dec 2021</td>
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</table>

NCT: national clinical trial.

References


Documentation for Clinical Review

Please provide the following documentation (if when requested):

- History and physical and/or consultation notes including:
  - Description of the knee structure (e.g., articular cartilage defects [including grade] and surrounding articular cartilage degenerative changes)
  - Knee biomechanics (i.e., stability and alignment) on physical exam
  - Documented closure of growth plates (if applicable)
  - Reason patient is not a candidate for total knee arthroplasty
  - Prior treatment (surgical and non-surgical) and patient response(s)
  - Reason for requested procedure and planned treatment

- Progress notes specific to the condition and request (if applicable)

- Diagnostic radiology reports (including Outerbridge classification)

Post Service

- Operative report(s)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

MN/IE

The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.
Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions

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<td>27416</td>
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Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

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<td>BCBSA Medical Policy adoption</td>
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<td>07/14/2014</td>
<td>Policy title change from Osteochondral Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions</td>
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</table>

Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.
Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.