Bio-Engineered Skin and Soft Tissue Substitutes

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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.

**Description**

Bio-engineered skin and soft tissue substitutes may be derived from human tissue (autologous or allogeneic), non-human tissue (xenographic), synthetic materials, or a composite of these materials. Bio-engineered skin and soft tissue substitutes are being evaluated for a variety of conditions, including breast reconstruction and to aid healing of lower extremity ulcers and
severe burns. Acellular dermal matrix products are also being evaluated in the repair of a variety of soft tissues.

Policy

The following bio-engineered skin or soft tissue substitutes may be considered medically necessary when one of the following exists:

- Breast reconstructive surgery, post-mastectomy using allogeneic acellular dermal matrix (ADM) products* (i.e., AlloDerm®, AlloMax™, DermaMatrix™, FlexHD®, GraftJacket®)
- Chronic, non-infected, full-thickness lower extremity ulcers due to diabetes:
  - Apligraf®**
  - Dermagraft®**
- Chronic, non-infected, partial- or full-thickness lower extremity skin ulcers due to venous insufficiency which has not adequately responded following a one month period of conventional ulcer therapy:
  - Apligraf®**
  - Oasis™ Wound Matrix***
- Dystrophic epidermolysis bullosa:
  - OrCel™ (for the treatment of mitten-hand deformity when standard wound therapy has failed and when provided in accordance with the Humanitarian Device Exemption [HDE] specifications of the United States Food and Drug Administration [FDA])****
- Second- and third-degree burns:
  - Epicel® (for the treatment of deep dermal or full-thickness burns comprising a total body surface area of greater than or equal to 30% when provided in accordance with the HDE specifications of the FDA)****
  - TransCyte™**
  - Integra Dermal Regeneration Template™**

* Banked human tissue.
** FDA PMA approved.
*** FDA 510(k) cleared.
**** FDA-approved under a humanitarian device exemption (HDE).

All other applications of the above listed bio-engineered skin and soft tissue substitutes are considered investigational.

All other bio-engineered skin and soft tissue substitutes not listed above are considered investigational including, but not limited to, the following:

- ACell® UBM Hydanted Wound Dressing
- ACell® UBM Lyophilized Wound Dressing
• AlloPatch HD™
• AlloSkin™
• AlloSkin™ RT
• Amniofix®
• Aongen™ Collagen Matrix
• ArthroFlex™ (FlexGraft)
• Atlas Wound Matrix
• Avagen Wound Dressing
• Avaulta Plus™
• Biobrane®
• BioDfence/BioDfactor
• CelleraRX®
• Collagen Sponge (Innocoll)
• Collagen Wound Dressing (Oasis Research)
• Collaguard®
• CollaSorb™
• CollaWound™
• Collexa®
• Collieva®
• Conexa™
• Coreleader Colla-Pad
• CorMatrix®
• CRXa™
• Cymetra®
• Dermadapt™ Wound Dressing
• DressSkin
• Durepair Regeneration Matrix®
• Endoform Dermal Template™
• ENDURAgen™
• Epifix®
• Excellagen
• E-Z Derm™
• FortaDerm™ Wound Dressing
• GammaGraft
• Grafix® CORE
• Grafix® PRIME
• GraftJacket® Regenerative Tissue Matrix
• GraftJacket® Xpress, injectable
• HA Absorbent Wound Dressing
• Helicoll
• Hyalomatrix® (Laserskin®)
• Hyalomatrix® PA
Policy Guideline

CPT codes 15040 to 15278 are reported for the application of skin replacements and skin substitutes.

CPT codes 15040 to 15261 are specific to autografts and tissue-cultured autografts.
CPT codes 15271 to 15278 are specific to skin substitute grafts.

The add-on CPT code 15777 (implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) is specific for the use of these materials as an implant (list separately in addition to code for the primary procedure).

The HCPCS codes for these products that are used in outpatient and office settings are listed in the Coding Section of the policy. There are also HCPCS modifiers to indicate whether the skin substitute is or is not used as a graft (i.e., surface use versus use as an implant):

- JC: Skin substitute used as a graft
- JD: Skin substitute not used as a graft

**Internal Information**

There is an MD Determination Form for this Medical Policy. It can be found on the following Web page:
http://myworkpath.com/healthcareservices/MedicalOperations/PSR_Determination_Pages.htm

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<td>o Previous treatment plan and response</td>
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<td>o Specific diagnosis requiring skin or soft tissue substitute</td>
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**Post Service**

- Procedure report(s)
- Skin or soft tissue substitute invoice (if applicable)

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.
Prior Authorization Requirements

This service (or procedure) is considered **medically necessary** in certain instances and **investigational** in others (refer to policy for details).

For instances when the indication is **medically necessary**, clinical evidence is required to determine **medical necessity**.

For instances when the indication is **investigational**, you may submit additional information to the Prior Authorization Department.

Within five days before the actual date of service, the Provider MUST confirm with Blue Shield of California / Blue Shield of California Life & Health Insurance Company (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 also be directed to the Prior Authorization Department. Please call 1-800-541-6652 or visit the Provider Portal www.blueshieldca.com/provider.

Evidence Basis for the Policy

**Rationale**

**Background**

Bio-engineered skin and soft tissue substitutes may be either acellular or cellular. Acellular products (i.e., cadaveric human dermis with cellular material removed) contain a matrix or scaffold composed of materials such as collagen, hyaluronic acid, and fibronectin. Cellular products contain living cells such as fibroblasts and keratinocytes within a matrix. The cells contained within the matrix may be autologous, allogeneic, or derived from other species (e.g., bovine, porcine). Skin substitutes may also be composed of dermal cells, epidermal cells, or a combination of dermal and epidermal cells, and may provide growth factors to stimulate healing. Tissue-engineered skin substitutes can be used as either temporary or permanent wound coverings.

There are a large number of potential applications for artificial skin and soft tissue products. One large category is non-healing wounds, which potentially encompasses diabetic neuropathic ulcers, vascular insufficiency ulcers, and pressure ulcers. A substantial minority of such wounds do not heal adequately with standard wound care, leading to prolonged morbidity and increased
risk of mortality. Non-healing lower extremity wounds represent an ongoing risk for infection, sepsis, limb amputation and death. Bio-engineered skin and soft tissue substitutes have the potential to improve rates of healing and reduce secondary complications.

Other situations in which bio-engineered skin products might substitute for living skin grafts include certain postsurgical states such as breast reconstruction, in which skin coverage is inadequate for the procedure performed, or for surgical wounds in patients with compromised ability to heal. Second- and third-degree burns are another situation where artificial skin products may substitute for autografts or allografts. Certain primary dermatologic conditions that involve large areas of skin breakdown, such as bullous diseases, may also be conditions in which artificial skin products can be considered as substitutes for skin grafts. Acellular dermal matrix (ADM) products are also being evaluated in the repair of other soft tissues including rotator cuff repair, following oral and facial surgery, hernias, and a variety of other conditions.

**Regulatory Status**

There are a large number of artificial skin products that are commercially available or in development. The following summary of commercially available skin substitutes describes those products that have substantial relevant evidence on efficacy. Information on other artificial skin and soft tissue substitutes that are available in the U.S. may be found in a 2012 Technology Assessment from the Agency for Healthcare Research and Quality (Synder et al., 2012).

**Acellular Dermal Matrix**

Allograft ADM products derived from donated human skin tissue are supplied by U.S. AATB-compliant tissue banks using the standards of the American Association of Tissue Banks (AATB) and U.S. Food and Drug Administration's (FDA) guidelines. The processing removes the cellular components (i.e., epidermis and all viable dermal cells) that can lead to rejection and infection. Acellular dermal matrix products from human skin tissue are regarded as minimally processed and not significantly changed in structure from the natural material; the FDA classifies it as banked human tissue and therefore does not require FDA approval.

- **AlloDerm®** (LifeCell Corporation, Branchburg, NJ) is an ADM (allograft) tissue-replacement product that is created from native human skin and processed so that the basement membrane and cellular matrix remain intact. An injectable micronized form of AlloDerm (Cymetra) is also available.
- **AlloMax™ Surgical Graft** (Bard Davol Inc., Murray Hill, NJ) is an acellular non-cross-linked human dermis allograft. It is classified as banked human tissue and does not require FDA approval (AlloMax™ was previously marketed as NeoForm™).
- **DermaMatrix** (Synthes) is an ADM (allograft) derived from donated human skin tissue. DermaMatrix Acellular Dermis is processed by the Musculoskeletal Transplant Foundation® (MTF®).
- **GraftJacket® Regenerative Tissue Matrix** (Kinetic Concepts Inc., (KCI), San Antonio, TX) is an acellular regenerative tissue matrix processed from screened donated human skin supplied from U.S. tissue banks. The allograft is processed minimally to remove the epidermal and dermal cells while preserving dermal structure.
• PriMatrix™ (TEI Biosciences Inc., Boston, MA) is a xenogeneic ADM processed from fetal bovine dermis. It is indicated through the U.S. Food and Drug Administration's (FDA) 510(k) process for partial and full-thickness wounds; diabetic, pressure, and venous stasis ulcers; surgical wounds; and tunneling, draining, and traumatic wounds.

Amniotic Membrane

Amniotic membrane is harvested immediately after birth, cleaned, sterilized, and either fresh frozen or dehydrated. Human amniotic membrane is considered to be minimally processed and not significantly changed in structure from the natural material; FDA classifies it as banked human tissue and therefore, it does not require FDA approval. EpiFix® and Amniofix® (both from MiMedix) are commercially available sources of dehydrated human amniotic membrane. EpiFix® is provided in sheets and Amniofix® is an injectable form of micronized amniotic membrane. Other amniotic membrane products are AmnioClear® (Musculoskeletal Transplant Foundation®), AmnioGraft® (Bio-Tissue), and BioDfense™ and BioDDryFlex® (both from BioD).

Collagen Scaffold

OASIS™ Wound Matrix (Cook Biotech Inc., West Lafayette, IN) is a xenographic collagen scaffold derived from porcine small intestinal mucosa. It was cleared by the FDA's 510(k) process in 2000 for the management of partial and full-thickness wounds including pressure ulcers, venous ulcers, diabetic ulcers, chronic vascular ulcers, tunneled undermined wounds, surgical wounds, trauma wounds, and draining wounds.

Living Cell Therapy

• Apligraf® (Organogenesis Inc., Canton, MA) is a bilayered cell therapy composed of an epidermal layer of living human keratinocytes and a dermal layer of living human fibroblasts. Apligraf is supplied as needed, in 1 size, with a shelf-life of 10 days. It was FDA approved in 1998 for use in conjunction with compression therapy for the treatment of non-infected, partial and full-thickness skin ulcers due to venous insufficiency and in 2001 for full-thickness neuropathic diabetic lower extremity ulcers non-responsive to standard wound therapy.

• Dermagraft® (formerly Advanced Biohealing Inc., Westport, CT, no Organogenesis) is composed of cryopreserved human-derived fibroblasts and collagen derived from newborn human foreskin and cultured on a bioabsorbable mesh. Dermagraft® has been approved by the FDA for repair of diabetic foot ulcers.

• Epicel® (Genzyme Biosurgery, Cambridge, MA) is a cultured epithelial autograft and is FDA approved under a humanitarian device exemption (HDE) for the treatment of deep dermal or full-thickness burns comprising a total body surface area of greater than or equal to 30%. It may be used in conjunction with split-thickness autografts or alone in patients for whom split-thickness autografts may not be an option due to the severity and extent of their burns.

• OrCel™ (Forticell Bioscience Inc., New York, NY) (formerly called Composite Cultured Skin) is an absorbable allogeneic bilayered cellular matrix, made of bovine collagen, in which human dermal cells have been cultured. It was approved by FDA premarket
approval (PMA) for healing donor site wounds in burn victims and under a humanitarian device exemption (HDE) for use in patients with recessive dystrophic epidermolysis bullosa undergoing hand reconstruction surgery to close and heal wounds created by the surgery, including those at donor sites.

**Biosynthetic**

- **Biobrane®/Biobrane-L** (Smith & Nephew Inc., Memphis TN) is a biosynthetic wound dressing constructed of a silicon film with a nylon fabric partially imbedded into the film. The fabric creates a complex three-dimensional structure of trilfament thread which chemically binds collagen. A blood/sera clot in the nylon matrix, adheres the dressing to the wound until epithelialization occurs.

- **Integra® Dermal Regeneration Template** (Integra LifeSciences, Plainsboro, NJ) is a bovine, collagen/glycosaminoglycan dermal replacement covered by a silicone temporary epidermal substitute. It is FDA approved for use in postexcisional treatment of life-threatening full-thickness or deep partial-thickness thermal injury where sufficient autograft is not available at the time of excision or not desirable because of the physiological condition of the patient. Integra® Matrix Wound Dressing and Integra® meshed Bilayer Wound Matrix are substantially equivalent skin substitutes that are FDA 510(k) approved for other indications.

- **TransCyte™** (Advanced BioHealing Inc., Westport, CT) consists of human dermal fibroblasts grown on nylon mesh, combined with a synthetic epidermal layer and was approved by the FDA in 1997. TransCyte™ is intended to be used as a temporary covering over burns until autografting is possible. It can also be used as a temporary covering for some burn wounds that heal without autografting.

**Literature Review**

The following is a summary of the key literature to date.

**Breast Reconstruction**

*AlloDerm*

**Systematic Reviews:** Two systematic reviews from 2012 found an increased rate of complications with ADM-assisted breast reconstruction (Ho et al., 2012; Kim et al., 2012). One meta-analysis of 16 retrospective studies found a higher likelihood of seroma (pooled odds ratio [OR]: 3.9; 95% CI: 2.4 to 6.2), infection (pooled OR: 2.7; 95% CI: 1.1 to 6.4) and reconstructive failure (pooled OR: 3.0; 95% CI: 1.3 to 6.8) when compared to breast reconstruction using traditional musculofascial flaps (Ho et al., 2012). Another meta-analysis that compared 19 studies using ADM (n = 2,037) with 35 studies using submuscular reconstruction (n = 12,847) found an increased risk of total complications (relative risk [RR]: 2.05; 95% CI: 1.55 to 2.70), seroma (RR: 2.73; 95% CI: 1.67 to 4.46), infection (RR: 2.47; 95% CI: 1.71 to 3.57), and reconstructive failure (RR: 2.80; 95% CI: 1.76-4.45) with ADM (Kim et al., 2012). These meta-analyses are limited by the poor quality of included studies and significant heterogeneity.

**Randomized Controlled Trials (RCTs):** In 2012, McCarthy et al. reported a multicenter blinded randomized controlled trial of AlloDerm in two-stage expander/implant reconstruction. Seventy patients were randomized to Alloderm ADM-assisted tissue expander/implant reconstruction or
to submuscular tissue expander/implant placement. There were no significant differences between the groups in the primary outcomes of immediate postoperative pain (54.6 AlloDerm and 42.8 control on a 100-point visual analog score) or pain during the expansion phase (17.0 AlloDerm and 4.6 control), or in the secondary outcome of rate of tissue expansion (91 days AlloDerm and 108 days control) and patient-reported physical well-being. There was no significant difference in adverse events, although the total number of adverse events was small. Phase 2 of the study will evaluate long-term outcomes.

**Controlled Studies:** Preminger and colleagues (2008) evaluated the impact of Alloderm® on expansion rates in immediate tissue expander/implant reconstruction in a retrospective matched cohort study. Forty-five patients underwent reconstruction with Alloderm® while 45 received standard reconstruction. Subjects were matched for expander size (+/-100 milliliter (mL), history of irradiation, and indication for mastectomy. There were no significant differences in initial filling volume, mean number of postoperative expansions, mean rate of postoperative tissue expansion, or in the incidence of postoperative complications. Aesthetic outcomes were not addressed. In 2008, Colwell and Breuing reported on 10 patients who had mastopexy with dermal slings, five patients were given cadaveric (Alloderm®) and five were given autologous tissue. Patients maintained projection and breast base width after 6 months to 3 years.

**Uncontrolled Studies:** A number of case series have also demonstrated that this approach can provide tissue coverage of implants and tissue expanders (Salzberg, 2006; Breuing & Colwell, 2007). AlloDerm has been reported in nipple reconstructive surgery in a case series on 30 nipple reconstructive procedures performed at 1 institution (Garramone & Lam, 2007). Use of AlloDerm has also been reported in a small series (n=3) to correct breast implant-related problems (malposition, symmastia, and rippling) (Baxter, 2003).

**Other:** Liu et al. (2011) reported postoperative complications in breast reconstruction with (n = 266) or without (n = 204) AlloDerm. Radiation therapy, body mass index (BMI), intraoperative use of tumescent solution, and medical comorbidities were similar between the two groups, but there were twice as many smokers and the implants were larger in the AlloDerm group. There was a trend for a higher rate of major infections that required prosthesis removal in the AlloDerm group (4.9% vs. 2.5%, p = 0.172) and a statistically significant increase in overall wound infection rate (6.8% versus 2.5%). The overall surgical complication rate was significantly higher in the AlloDerm group (19.5% vs. 12.3%). Multivariate analysis indicated that the use of ADM, smoking, higher BMI, higher initial volume, and bigger implant size were associated with a higher overall surgical complication rate. This study was limited by the retrospective analysis and differences between groups at baseline.

Bindingnavele et al., (2007) reviewed charts of 41 patients (65 breasts) who had staged breast reconstruction with acellular cadaveric dermis to report postoperative complication rates. Rates for wound infection, expander removal, hematoma, and seroma were 3.1%, 1.5%, 1.5%, and 4.6%, respectively. The authors concluded that based on low rates of complications and good cosmetic outcomes, the technology should be in the repertoire of plastic surgeons, and follow-up was required to evaluate long-term outcomes.
**AlloDerm versus DermaMatrix or FlexHD**

A 2013 retrospective review by Liu et al. compared complication rates following breast reconstruction with AlloDerm or FlexHD in 382 consecutive women (547 breasts). Eighty-one percent of the sample were immediate reconstructions; 165 used AlloDerm, and 97 used FlexHD. Mean follow-up was 6.4 months. Compared with breast reconstruction without use of AlloDerm or FlexHD, ADM had a higher rate of delayed healing (20.2% vs 10.3%), although this finding might be related to differences in fill volumes. In univariate analysis, there were no significant differences in complications (return to the operating room, surgical site infection, seroma, hematoma, delayed healing, or implant loss) between AlloDerm and FlexHD. In multivariate analysis, there were no significant differences between AlloDerm or FlexHD for the return to the operating room, surgical site infection, seroma, or delayed healing. Independent risk factors for implant loss included the use of FlexHD, single-stage reconstruction, and smoking.

Another retrospective review from 2013 compared complication rates following use of AlloDerm (n=136) or FlexHD (n=233) in a consecutive series of 255 patients (369 breasts) (Seth et al., 2013). Total complication rates for the two products were similar (19.1% for AlloDerm and 19.3% for FlexHD). Analysis by type of complication showed no significant difference between the two, and regression analysis controlling for differences in baseline measures found that the type of ADM was not a risk factor for any complication.

Brooke et al. (2012) conducted a retrospective review of complication rates when AlloDerm (n=49), DermaMatrix (n=110), or FlexHD (n=62) was used for tissue expander breast reconstruction. (15) Clinically significant complications were defined as cellulitis, abscess, seroma, expander leak or puncture, skin necrosis, wound dehiscence, or hematoma. The total clinically significant complication rate was 22% with AlloDerm, 15% with DermaMatrix, and 16% with FlexHD (not significantly different). Infectious complication rates for the 3 products were the same at 10%. When compared with breast reconstruction without an ADM (n=64), there was no significant difference in the total complication rate (17% vs 11%), but there was a trend toward a higher incidence of infectious complications (10% vs 2%, p=0.09).

This small amount of evidence from retrospective comparative studies does not show any difference in outcomes among different types of ADM products.

**Interpositional Graft after Parotidectomy**

**AlloDerm**

In 2003, Sinha et al. reported the use of AlloDerm acellular human dermal matrix as an interpositional physical barrier to prevent the development of Frey syndrome (gustatory sweating) after parotidectomy. Thirty patients were divided into three groups; it was not described if the assignments were randomized. One group underwent superficial parotidectomy with reconstruction of the defect with AlloDerm, a second group had superficial parotidectomy without placement of an interpositional barrier, and the third group underwent deep-plane rhytidectomy without disruption of the parotid fascia. At minimum one-year follow-up, there was a subjective incidence of Frey syndrome in one patient treated with AlloDerm and five patients in the second group. The objective incidence of Frey syndrome, measured with the Minor starch-iodine test, was two patients treated with AlloDerm and eight patients in the second group. None of the patients in the third group who underwent deep-plane rhytidectomy without
disruption of the parotid fascia had subjective or objective Frey syndrome. There were no adverse effects.

A 2008 publication from Asia compared use of allogeneic ADM (RENOV) in 168 patients who had superficial or partial parotidectomy (Ye et al., 2008). Sixty-four patients received an ADM and 104 patients had superficial or partial parotidectomy alone. The size of the graft depended on the amount of tissue required to restore the normal facial contour. The method of assignment to the two groups was not described. At a median follow-up of 16 months (range, 11 to 27 months), the subjective incidence of Frey syndrome was 2% in the ADM group compared with 61% in controls. Objective assessment, performed in 30 patients randomly selected from each group, found an incidence of Frey syndrome in two patients (7%) treated with ADM and 24 patients (80%) in the control group. One patient in the ADM group and 18 patients in the control group developed a parotid fistula.

**DermaMatrix**

DermaMatrix is an ADM that differs from AlloDerm in several ways; it can be stored at room temperature (versus refrigerated), it has a shelf-life of three years (versus two years), and it can be rehydrated in three minutes (versus 30 minutes).

Athavale et al. (2011) evaluated complications of AlloDerm and DermaMatrix in a retrospective review of 100 patients treated between 2001 and 2009 at a single U.S. institution. Exclusion criteria for the study included presence of malignancy on final surgical pathology report, incomplete medical records, previous history of radiation therapy to the head and neck region, and additional procedures to the region of the parotid gland. Initially, only AlloDerm was used; this changed to a 20/80 ratio of AlloDerm/DermaMatrix due to more readily available stock of DermaMatrix. Complications were defined as any outcome that required procedural intervention for resolution (seroma/sialocele formation, infected fluid collection, and/or serosanguinous fluid collection). The authors identified eight complications in 31 DermaMatrix implants (26%) compared with five complications in 69 AlloDerm implants (7%). The complication rate did not differ for total parotidectomies but was higher for DermaMatrix compared to AlloDerm for subtotal parotidectomies (37% versus 8%). Nearly half of all complications were seroma/sialocele formation.

Double-blind RCTs with longer follow-up are needed to evaluate this procedure.

**Tendon Repair**

**GraftJacket**

In 2012, Barber et al. reported an industry-sponsored multi-center randomized controlled trial of augmentation with GraftJacket acellular human dermal matrix for arthroscopic repair of large (>3 centimeter (cm)) rotator cuff tears involving two tendons. Twenty-two patients were randomized to GraftJacket augmentation and 20 patients were randomized to no augmentation. At a mean follow-up of 24 months (range, 12 to 38 months) the American Shoulder and Elbow Surgeons (ASES) score improved from 48.5 to 98.9 in the GraftJacket group and from 46.0 to 94.8 in the control group (p = 0.035). The Constant score improved from 41 to 91.9 in the GraftJacket group and from 45.8 to 85.3 in the control group (p = 0.008). The University of California, Los Angeles score was not significantly different between the groups.
enhanced magnetic resonance imaging (MRI) scans showed intact cuffs in 85% of repairs in the GraftJacket group and 40% of repairs in the control group. However, no correlation was found between MRI findings and clinical outcomes. Rotator cuff retears occurred in three patients (14%) in the GraftJacket group and nine patients (45%) in the control group. Although these results were promising, additional study with a larger number of patients is needed.

**Fistula Repair**

**Acellular Dermal Matrix**

A study from Asia compared a xenogeneic ADM (J-I type, J.Y. Life Tissue Engineering Co., China) with endorectal advancement flap (ERAF) for the treatment of complex anorectal fistula in a randomized study with 90 consecutive patients (ba-bai-ke-re et al., 2010). Follow-up was performed at two days, 2, 4, 6, 12 weeks, and five months after surgery. Success was defined as closure of all external opening, absence of drainage without further intervention, and absence of abscess formation. Success was observed in 82.2% of the ADM group. Fistula recurred in two (4.45%) patients in the ADM group compared with 13 (28.89%) patients in the ERAF group. Healing time was reduced (7.5 versus 24.5 days) and quality of life was rated higher in the ADM group (85.9 versus 65.3). No significant difference was observed in the incontinence and anal deformity rate between the two groups. This product is not cleared for marketing in the United States, although the manufacturing process was reported to be similar to the Surgisis® AFPTM (anal fistula plug) (Cook® Biotech Inc., West Lafayette, IN).

**Surgical Repair of Hernias**

A 2011 systematic review included 30 level III and level IV articles on ADM for abdominal wall reconstruction (Zhong et al., 2011). No RCTs or high-quality comparative studies (level I or II) were identified. Examples of the level III studies are described next.

**AlloDerm**

Gupta et al. (2006) compared the efficacy and complications associated with the use of AlloDerm® and Surgisis® bioactive mesh (Cook® Biotech Incorporated, West Lafayette, IN) in 74 patients who underwent ventral hernia repair. The first 41 procedures were performed using Surgisis® Gold 8-ply mesh formed from porcine small intestine sub-mucosa, and the remaining 33 patients had ventral hernia repair with AlloDerm. Patients were seen seven to 10 days after discharge from the hospital and at six weeks. Any signs of wound infection, diastasis, hernia recurrence, changes in bowel habits, and seroma formation were evaluated. The use of the AlloDerm mesh resulted in eight hernia recurrences (24%). Fifteen of the AlloDerm patients (45%) developed a diastasis or bulging at the repair site. Seroma formation was only a problem in two patients.

In 2007, Espinosa-de-los-Monteros and colleagues retrospectively reviewed 39 abdominal wall reconstructions with AlloDerm performed in 37 patients and compared them with 39 randomly selected cases. They reported a significant decrease in recurrence rates when human cadaveric acellular dermis was added as an overlay to primary closure plus rectus muscle advancement and imbrication in patients with medium-sized hernias. However, no differences were observed when adding human cadaveric acellular dermis as an overlay to patients with large-size hernias treated with underlay mesh.
A 2013 study by Bochicchio and colleagues compared AlloDerm with FlexHD for complicated hernia surgery. From 2005 to 2007, AlloDerm was used to repair large (>200 cm²) symptomatic complicated ventral hernia that resulted from trauma or emergency surgery (n=55). From 2008 to 2010, FlexHD was used to repair large complicated ventral hernia in patients meeting the same criteria (n=40). The two groups were comparable at baseline. At 1-year follow-up, all of the AlloDerm patients were diagnosed with hernia recurrence (abdominal laxity, functional recurrence, or true recurrence) requiring a second repair. Eleven patients (31%) in the FlexHD group required a second repair. This comparative study is limited by the use of nonconcurrent comparisons, which is prone to selection bias and does not control for temporal trends in outcomes.

The limited evidence available at this time does not support the use of AlloDerm in hernia repair.

**Oral Surgery**

**AlloDerm**

In 2008, Novaes and de Barros described three randomized trials from their research group that examined use of ADM in root coverage therapy and alveolar ridge augmentation. Two trials used ADM in both the study and control groups and are not described here. A third trial compared ADM with subepithelial connective tissue graft in 30 gingival recessions (nine patients). At six months post surgery, the ADM showed recession reduction of 1.83 millimeters (mm) while subepithelial connective tissue graft showed recession reduction of 2.10 mm; these were not significantly different.

A non-randomized cohort study compared Alloderm with the gold standard of split thickness skin grafts in 34 patients who underwent oral cavity reconstruction following surgical removal of tumors (Girod et al., 2009). Patients were enrolled after surgical treatment for evaluation at a tertiary care center and divided into two cohorts according to the reconstruction method used, which was based on surgeon preference. Twenty-two patients had been treated with Alloderm, and 12 had been treated with split thickness skin grafts. The location of the grafts (AlloDerm versus autograft) were on the tongue (54% versus 25%), floor of mouth (9% versus 50%), tongue and floor of mouth (23% versus 8%), buccal (9% versus 0%), or other (5% versus 17%). More patients in the AlloDerm group were treated with radiation therapy (45% versus 17%), and the graft failure rate was higher (14% versus 0%). Radiation therapy had a significantly negative impact for both groups. Histology on a subset of the patients showed increased inflammation, fibrosis, and elastic fibers with split thickness skin grafts. Functional status and quality of life were generally similar in the two groups. Interpretation of these results is limited by the differences between the groups at baseline.

**Laryngoplasty**

There are several reports with short-term follow-up of micronized AlloDerm (Cymetra) injection for laryngoplasty. In 2005, Milstein et al. reported mean 11.2 month follow-up (range, 1 to 35 months) of Cymetra injection in 20 patients with unilateral vocal-fold paralysis. Pre- and post-operative digital voice samples and video stroboscopy were rated on a four-point scale by a panel of three voice experts who were blinded to the pre- or post-operative status. Compared with preoperative measures, Cymetra improved voice quality (from 3.23 to 1.65), glottal closure
(from 3.21 to 1.42), and degree of vocal-fold bowing (from 2.38 to 1.36). Quality-of-life measures and patients' self-perceptions of vocal quality were also improved. In five patients (25%), the effect was temporary, and in eight patients (40%) who had follow-up of one year or longer, the improvement was maintained. Longer-term study in a larger number of patients is needed to determine the durability of this procedure and to evaluate the safety of repeat injections.

**Tympanoplasty**

Vos et al. (2005) reported a retrospective non-randomized comparison of AlloDerm versus native tissue grafts for type I tympanoplasty. Included in the study were 108 patients (25 AlloDerm, 53 fascia reconstruction, and 30 fascia plus cartilage reconstruction) treated between 2001 and 2004. One surgeon had performed 96% of the AlloDerm tympanoplasties. Operative time was reduced in the AlloDerm group (82 minutes for AlloDerm, 114 minutes for fascial cases, and 140 minutes for fascia plus cartilage). There was no significant difference in the success rate of the graft (88% for AlloDerm, 89% for fascia grafts, 96.7% for cartilage plus fascia). There was no significant difference in hearing between the groups at follow-up (time not specified). Longer-term controlled study in a larger number of patients is needed to determine the durability of this procedure.

**Diabetic Lower Extremity Ulcers**

**Apligraf**

In 2001, Veves and colleagues reported on a randomized prospective study on the effectiveness of Graftskin (Apligraf), a living skin equivalent, in treating non-infected non-ischemic chronic plantar diabetic foot ulcers. The study involved 24 centers in the United States, 208 patients were randomly assigned to ulcer treatment either with Graftskin (112 patients) or saline-moistened gauze (96 patients, control group). Standard state-of-the-art adjunctive therapy, including extensive surgical debridement and adequate foot off-loading, was provided in both groups. Graftskin was applied at the beginning of the study and weekly thereafter for a maximum of four weeks (maximum of five applications) or earlier if complete healing occurred. At the 12-week follow-up visit, 63 (56%) Graftskin-treated patients achieved complete wound healing compared with 36 (38%) in the control group (p = 0.0042). The Kaplan-Meier median time to complete closure was 65 days for Graftskin, significantly lower than the 90 days observed in the control group (p = 0.0026). The rate of adverse reactions was similar between the two groups with the exception of osteomyelitis and lower-limb amputations, both of which were less frequent in the Graftskin group. The authors concluded application of Graftskin for a maximum of four weeks resulted in a higher healing rate when compared with state-of-the-art treatment and was not associated with any significant side effects. This study was reviewed in a 2001 Blue Cross Blue Shield Association Technology Evaluation Center (TEC) Assessment, which concluded Apligraf (graftskin), in conjunction with good local wound care, met the TEC criteria for the treatment of diabetic ulcers that failed to respond to conservative management.

In 2010, Steinberg and colleagues reported on a study of 72 subjects from Europe and Australia that assessed the safety and efficacy of Apligraf in the treatment of non-infected diabetic foot ulcers. The design and patient population of this study were similar to the 208-subject U.S. study (described above) which led to FDA approval of Apligraf for the treatment of diabetic foot
ulcers. For these studies, subjects with a non-infected neuropathic diabetic foot ulcer present for at least two weeks were enrolled in these prospective, multicenter, randomized, controlled, open-label studies comparing Apligraf use in conjunction with standard therapy (sharp debridement, standard wound care, and off-loading) against standard therapy alone. Pooling of data was performed because of the similarity and consistency of the two studies. Efficacy and safety results were consistent across studies independent of mean ulcer duration that was significantly longer in the European study (21 months, compared to 10 months in the U.S. study). Reported adverse events by 12 weeks were comparable across treatment groups in the two studies. Efficacy measures demonstrated superiority of Apligraf treatment over control treated groups in both studies. Combining the data from both studies, 55.2% (80 of 145) of Apligraf subjects had complete wound closure by 12 weeks, compared to 34.3% (46 of 134) of control subjects ($p = 0.0005$), and Apligraf subjects had a significantly shorter time to complete wound closure ($p = 0.0004$). The authors concluded both the European Union and U.S. studies exhibited superior efficacy and comparable safety for subjects treated with Apligraf compared to control subjects, and the studies provided evidence of the benefit of Apligraf in treating diabetic foot ulcers.

In 2010, Kirsner and colleagues reported on analysis of 2,517 patients with diabetic neuropathic foot ulcers who were treated between 2001 and 2004. The study was a retrospective analysis using a wound-care database; the patients received advanced biological therapy (i.e., Apligraf (446 patients), Regranex, or Procuren. In this study, advanced biological therapy was used, on average, within 28 days from the first wound clinic visit and associated with a median time to healing of 100 days. Wounds treated with engineered skin (Apligraf) as the first advanced biological therapy were 31.2% more likely to heal than wounds first treated with topical recombinant growth factor ($p < 0.001$), and 40.0% more likely to heal than those first treated with platelet releasate ($p = 0.01$). Wound size, wound grade, duration of wound, and time to initiation of advanced biological therapy affected the time to healing.

**Dermagraft**

A pivotal multicenter FDA-regulated trial randomized 314 patients with chronic diabetic ulcers to Dermagraft or control (Marston et al., 2003). Over the course of the 12-week study patients received up to eight applications of Dermagraft. All patients received pressure-reducing footwear and were encouraged to stay off their study foot as much as possible. At 12 weeks, the median percent wound closure for the Dermagraft group was 91% compared to 78% for the control group. Ulcers treated with Dermagraft closed significantly faster than ulcers treated with conventional therapy. No serious adverse events were attributed to Dermagraft. Ulcer infections developed in 10.4% of the Dermagraft patients compared to 17.9% of the control patients. Together, there was a lower rate of infection, cellulitis, and osteomyelitis in the Dermagraft-treated group (19% versus 32.5%).

**GraftJacket Regenerative Tissue Matrix**

Brigido et al. (2004) reported a small ($n = 40$) randomized pilot study of GraftJacket compared with conventional treatment for chronic non-healing diabetic foot ulcers. Control patients received conventional therapy with debridement, wound gel with gauze dressing, and off-loading. GraftJacket patients received surgical application of the scaffold using skin staples or sutures and moistened compressive dressing. A second graft application was necessary after the
initial application for all patients in the GraftJacket group. Preliminary one month results showed that after a single treatment, ulcers treated with GraftJacket healed at a faster rate than conventional treatment. There were significantly greater decreases in wound length (51% versus 15%), width (50% versus 23%), area (73% versus 34%) and depth (89% versus 25%). All of the grafts incorporated into the host tissue.

In 2009, Reyzelman et al. reported an industry-sponsored multicenter randomized study that compared a single application of GraftJacket versus standard of care in 86 patients with diabetic foot ulcers. Offloading was performed using a removable cast walker. Ulcer size at presentation was 3.6 square cm/sq cm in the GraftJacket group and 5.1 cm² in the control group. Eight patients, six in the study group and two in the control group, did not complete the trial. At 12 weeks, complete healing was observed in 69.6% of the GraftJacket group and 46.2% of controls. After adjusting for ulcer size at presentation, a statistically significant difference in non-healing rate was calculated, with odds of healing two times higher in the study group. Mean healing time was 5.7 weeks versus 6.8 weeks for the control group. The authors did not report if this difference was statistically significant. The median time to healing was 4.5 weeks for GraftJacket (range, 1 to 12 weeks) and seven weeks for control (range, 2 to 12 weeks). Kaplan-Meier survivorship analysis for time to complete healing at 12 weeks showed a significantly lower non-healing rate for the study group (30.4%) compared with the control group (53.9%). The authors commented that a single application of GraftJacket, as used in this study, is often sufficient for complete healing. This study was limited by the small study population, differences in ulcer size at baseline, and the difference in the percentage of patients censored in each group. Questions also remained about whether the difference in mean time to healing was statistically or clinically significant. Additional trials with a larger number of subjects are needed to evaluate if GraftJacket Regenerative Tissue Matrix improves health outcomes in this population.

**EpiFix Amniotic Membrane**

In 2013, Zelen et al. reported an industry-sponsored, nonblinded, RCT comparing use of EpiFix (n=13) with standard of care (SOC; moist wound therapy, n=12) for diabetic foot ulcers of at least 4 weeks’ duration. EpiFix was applied every 2 weeks if the wound had not healed, with weekly dressing changes comprised of nonadherent dressing, moisture retentive dressing, and a compression dressing. Standard moist wound dressing was changed daily. After 4 weeks of treatment, EpiFix treated wounds had reduced in size by a mean of 97.1% compared with 32.0% for the SOC group. Healing rate, defined as complete epithelialization of the open area of the wound, was 77% for EpiFix compared with 0% for SOC. After 6 weeks of treatment, wounds were reduced by 98.4% with EpiFix treatment compared with 1.8% for standard care. The healing rate was 92% with EpiFix compared with 8% with standard treatment alone. Results of this small study are encouraging, but preliminary. Confirmation of these results in a larger trial is needed.

**Oasis™ Wound Matrix**

Niezgoda and colleagues (2005) compared healing rates at 12 weeks for full-thickness diabetic foot ulcers treated with Oasis Wound Matrix, an acellular wound care product, versus Regranex Gel. This was an industry-sponsored randomized controlled multicenter trial conducted at nine outpatient wound care clinics and involved 73 patients with at least one diabetic foot ulcer.
Patients were randomized to receive either Oasis Wound Matrix (n = 37) or Regranex Gel (n = 36) and a secondary dressing. Wounds were cleansed and debrided, if needed, at a weekly visit. The maximum treatment period for each patient was 12 weeks. After 12 weeks of treatment, 18 (49%) Oasis-treated patients had complete wound closure compared with 10 (28%) Regranex-treated patients. Oasis treatment met the non-inferiority margin, but did not demonstrate that healing in the Oasis group was statistically superior (p = 0.055). Post-hoc subgroup analysis showed no significant difference in incidence of healing in patients with type 1 diabetes (33% versus 25%) but a significant improvement in patients with type 2 diabetes (63% versus 29%). There was also an increased healing of plantar ulcers in the Oasis group (52% versus 14%). These post-hoc findings were considered hypothesis generating. Additional studies with larger number of subjects are needed to evaluate the effect of Oasis treatment in comparison with the current standard of care.

**PriMatrix**

In 2011, Karr published a retrospective comparison of PriMatrix (a xenograft fetal bovine dermal collagen matrix) and Apligraf in 40 diabetic foot ulcers. The first 20 diabetic foot ulcers matching the inclusion and exclusion criteria for each graft were compared. Included were diabetic foot ulcers of four weeks' duration, at least 1 cm² in depth to subcutaneous tissue, healthy tissue at the ulcer, adequate arterial perfusion to heal, and able to off-load the diabetic ulcer. The products were placed on the wound with clean technique, overlapping the edges of the wound, and secured with sutures or staples. The time to complete healing for PriMatrix was 38 days with 1.5 applications compared to 87 days with two applications for Apligraf. Although promising, additional study with a larger number of subjects is needed to evaluate the effect of PriMatrix treatment in comparison with the current standard of care.

**Lower Extremity Ulcers Due to Venous Insufficiency**

**Apligraf**

Apligraf is a living cell therapy composed of living human keratinocytes and fibroblasts. Falanga and colleagues (1998) reported a multicenter randomized trial of Apligraf (human skin equivalent). A total of 293 patients with venous insufficiency and clinical signs of venous ulceration were randomized to compression therapy alone or compression therapy and treatment with Apligraf. Apligraf was applied up to a maximum of five (mean 3.3 times per patient during the initial three weeks. The primary endpoints were the percentage of patients with complete healing by six months after initiation of treatment and the time required for complete healing. At six months' follow-up, the percentage of patients healed was increased with Apligraf (63% versus 49%) and the median time to complete wound closure was reduced (61 days versus 181 days). Treatment with Apligraf was found to be superior to compression therapy in healing larger (> 1000 millimeter squared (mm²)) and deeper ulcers and ulcers of more than six months' duration. There were no symptoms or signs of rejection and the occurrence of adverse events were similar in both groups. This study was reviewed in a 2001 TEC Assessment, which concluded Apligraf (graftskin), in conjunction with good local wound care, met the TEC criteria for the treatment of venous ulcers that failed to respond to conservative management.
Dermagraft

Dermagraft is a living cell therapy composed of cryopreserved human fibroblasts cultured on a bioabsorbable mesh. Dermagraft has been approved by FDA for repair of diabetic foot ulcers. Use of Dermagraft for venous ulcers is an off-label indication. In 2013, Harding et al. reported an open-label multicenter RCT that compared Dermagraft plus compression therapy (n=186) versus compression therapy alone (n=180). The study had numerous inclusion/exclusion criteria that restricted the study population to patients who had nonhealing ulcers with compression therapy but had capacity to heal. Intention-to-treat analysis revealed no significant difference between the 2 groups in the primary outcome measure, the proportion of patients with completely healed ulcers by 12 weeks (34% Dermagraft vs 31% control). Prespecified subgroup analysis revealed a significant improvement in the percent of ulcers healed for ulcers of 12 months or less in duration (52% vs 37%) and for ulcers of 10 cm or less (47% vs 39%). There were no significant differences in the secondary outcomes of time to healing, complete healing by week 24, and percent reduction in ulcer area.

Oasis™ Wound Matrix

Oasis Wound Matrix is a xenogeneic collagen scaffold derived from porcine small intestinal mucosa. In 2005, Mostow et al. reported an industry-sponsored multicenter (12 sites) randomized trial comparing weekly treatment with Oasis Wound Matrix versus standard of care in 120 patients with chronic ulcers due to venous insufficiency who were not adequately responding to conventional therapy. Healing was assessed weekly for up to 12 weeks, with follow-up performed after six months to assess recurrence. After 12 weeks of treatment, there was significant improvement in the percentage of wounds healed in the Oasis group (55% versus 34%). After adjusting for baseline ulcer size, patients in the Oasis group were three times more likely to achieve healing than those in the standard care group. Patients in the standard care group whose wounds did not heal by the 12th week were given the option to cross over to Oasis treatment. None of the healed patients treated with Oasis wound matrix and seen for the six-month follow-up experienced ulcer recurrence.

A research group in Europe described two comparative studies of the Oasis matrix for mixed arterial venous and venous ulcers. In a 2007 quasi-randomized study, Romanelli et al. compared the efficacy of two extracellular matrix-based products, Oasis and Hyaloskin® (extracellular matrix with hyaluronic acid). A total of 54 patients with mixed arterial/venous leg ulcers were assigned to the two arms based on order of entry into the study; 50 patients completed the study. Patients were followed up twice a week and the dressings were changed more than once a week only if necessary. After 16 weeks of treatment, complete wound closure was achieved in 82.6% of Oasis-treated ulcers compared with 46.2% of Hyaloskin-treated ulcers. Oasis treatment significantly increased the time to dressing change (mean of 6.4 versus 2.4 days), reduced pain on a 10 point scale (3.7 vs. 6.2) and improved patient comfort (2.5 vs. 6.7).

In a 2010 trial, Romanelli et al. compared Oasis with a moist wound dressing in 23 patients with mixed arterial/venous ulcers and 27 patients with venous ulcers. The study was described as randomized, but the method of randomization was not described. After the eight-week study period, patients were followed up monthly for six months to assess wound closure. Complete wound closure was achieved in 80% of the Oasis-treated ulcers at eight weeks compared to 65%
of the standard of care group. On average, Oasis-treated ulcers achieved complete healing in 5.4 weeks as compared with 8.3 weeks for the standard of care group. Treatment with Oasis also increased the time to dressing change (5.2 days versus 2.1 days) and the percentage of granulation tissue formed (65% vs. 38%).

PriMatrix

PriMatrix is a xenogeneic ADM. In 2011, Karr published a retrospective comparison of PriMatrix and Apligraf in 28 venous stasis ulcers. The first 14 venous stasis ulcers matching the inclusion and exclusion criteria for each graft were compared. Included were venous stasis ulcers of 4 weeks' duration, at least 1 cm² in depth to subcutaneous tissue, healthy tissue at the ulcer, adequate arterial perfusion to heal, and able to tolerate compression therapy. The products were placed on the wound with clean technique, overlapping the edges of the wound, and secured with sutures or staples. The time to complete healing for PriMatrix was 32 days with 1.3 applications compared to 63 days with 1.7 applications for Apligraf. Although promising, additional study with a larger number of subjects is needed to evaluate the effect of PriMatrix treatment in comparison with the current standard of care.

Section Summary

Randomized-controlled trials have demonstrated the efficacy of Apligraf and Oasis Wound Matrix over the standard of care. Use of these products may be considered medically necessary for lower-extremity ulcers due to venous insufficiency. In a moderately large RCT, Dermagraft was not shown to be more effective than controls in the primary or secondary end points for the entire population and was slightly more effective than controls (an 8%-15% increase in healing) only in subgroups of patients with ulcer duration of 12 months or less or size of 10 cm or less. Additional study with a larger number of subjects is needed to evaluate the effect of PriMatrix treatment in comparison with the current standard of care.

Dystrophic Epidermolysis Bullosa

Dermagraft had been FDA approved in 2002 by a HDE for the treatment of dystrophic epidermolysis bullosa. The manufacturer has since withdrawn Demagraft from HDE status.

OrCel was approved by a HDE for use in patients with dystrophic epidermolysis bullosa undergoing hand reconstruction surgery to close and heal wounds created by the surgery, including those at donor sites. As this is a rare disorder, it is unlikely there will be randomized controlled trials to evaluate whether Dermagraft or OrCel improve health outcomes for this condition.

In 2003, Fivenson et al. reported the off-label use of Apligraf in five patients with recessive dystrophic epidermolysis bullosa who underwent syndactyly release.

Dermagraft, OrCel, and Apligraf are all living cell therapies. Apligraf is a bi-layered cell therapy composed of living human keratinocytes and fibroblasts, while OrCel is a bi-layered cellular matrix made of bovine collagen in which human dermal cells (fibroblasts and keratinocytes) have been cultured. Dermgraft is composed of cryopreserved human-derived fibroblasts and collagen on a bioabsorbable mesh.
Ocular Burns

A Cochrane review evaluated the evidence on amniotic membrane transplantation (AMT) for acute ocular burns (Clare et al., 2012). Included in the review was a single randomized controlled trial from India of 68 patients with acute ocular burns who were randomized to treatment with AMT and medical therapy or medical therapy alone. In the subset of 36 patients with moderate ocular burns who were treated within 7 days, 13/20 (65.0%) of control eyes and 14/16 (87.5%) of AMT-treated eyes had complete epithelialization by 21 days. There was a trend (p=0.09) toward a reduced risk ratio of failure of epitheliazation in the treatment group. Mean LogMAR [logarithm of the minimum angle of resolution] final visual acuities were 0.06 in the treatment group and 0.38 in the control group. In the subset of patients with severe ocular burns treated within 7 days, 1/17 (5.9%) of AMT-treated eyes and 1/15 (6.7%) control eyes were epithelialized by day 21. Final visual acuity was 1.77 logMAR in the treated eyes and 1.64 in the control group (not significantly different). The risk of bias was considered to be high because of differences between the groups at baseline and because outcome assessors could not be masked to treatment. The review determined that conclusive evidence supporting the treatment of acute ocular surface burns with AMT is lacking. It should also be noted that the amniotic membrane used in this study was fresh frozen and is not commercially available.

Non-Ocular Burns

Biomembrane

A small (n=46) quasirandomized trial compared treatment with amniotic membrane (Biomembrane) versus polyurethane membrane (Tegaderm) for patients with second- or third-degree burns covering less than 50% total body surface area (Adly et al., 2010). Treatment with amniotic membrane significantly reduced occurrence of infection (4.3%) compared with treatment with polyurethane (13.0%). Pain during dressing was reduced in the group treated with amniotic membrane (43.5% vs 60.9%), while the frequency of healing within the 11- to 20-day follow-up was greater (47.8% vs 39.1%). It was not reported if the evaluators in this quasirandomized study were blinded to treatment condition. In addition, this study did not have a control group treated with medical therapy alone.

Epicel

Epicel was FDA approved under a HDE for the treatment of deep dermal or full-thickness burns comprising a total body surface area of greater than or equal to 30%. It is unlikely there will be randomized controlled trials to evaluate whether Epicel will improve health outcomes for this condition. One case series described the treatment of 30 severely burned patients with Epicel (Carsin et al., 2000). The cultured epithelial autografts were applied to a mean 37% of total body surface area. Epicel achieved permanent coverage of a mean 26% of total body surface area, an area greater than that covered by conventional autografts (a mean 25%). Survival was 90% in these severely burned patients.

EpiFix

Although several small trials from the Middle East and Asia have evaluated locally harvested and processed amniotic membrane, no RCTs were identified with the commercially available EpiFix amniotic membrane.
**Integra Dermal Regeneration Template**

A 2013 study compared Integra versus split-thickness skin graft or viscose cellulose sponge (Cellonex), using three test sites of 10 cm x 5 cm on each of 10 burn patients (Lagus et al., 2013). The surrounding burn area was covered with meshed autograft. Biopsies were taken from each site on days 3, 7, 14, and 21, and at 3 months and 12 months. The tissue samples were stained and examined for markers of inflammation and proliferation. The Vancouver Scar Scale was used for scar assessment. At 12-month follow-up, the three methods resulted in similar clinical appearance, along with similar histologic and immunohistochemic findings.

Branski et al. (2007) reported a randomized trial of Integra compared with a standard autograft-allograft technique in 20 children with an average burn size of 73% total body surface area (71% full-thickness burns). Once vascularized (about 14 to 21 days) the Silastic epidermis was stripped and replaced with thin (0.05 mm to 0.13 mm) epidermal autograft. There were no significant differences between the Integra group and controls in burn size (70% versus 74% total body surface area), mortality (40% versus 30%), and length of stay (41 days versus 39 days). Long-term follow-up revealed a significant increase in bone mineral content and density (24 months) and improved scarring in terms of height, thickness, vascularity, and pigmentation (12 months and 18 to 24 months) in the Integra group. No differences were observed between the groups in the time to the first reconstructive procedure, cumulative reconstructive procedures required during two years, and the cumulative operating room time required for these procedures. The authors concluded Integra could be used for immediate wound coverage in children with severe burns without the associated risks of cadaver skin.

In 2003, Heimback and colleagues reported a multicenter (13 U.S. burn care facilities) postapproval study involving 222 burn injury patients (36.5% total body surface area, range 1% to 95%) who were treated with Integra® Dermal Regeneration Template. Within two to three weeks, the dermal layer regenerated, and a thin epidermal autograft was placed. The incidence of infection was 16.3%. Mean take rate (absence of graft failure) of Integra was 76.2%; the median take rate was 98%. The mean take rate of epidermal autograft placed over Integra was 87.7%; the median take rate was 95%.

**OrCel**

There is limited evidence to support the efficacy of OrCel compared to the standard of care for the treatment of split-thickness donor sites. Still et al. (2003) examined the safety and efficacy of bilayered OrCel to facilitate wound closure of split-thickness donor sites in 82 severely burned patients. Each patient had two designated donor sites randomized to receive a single treatment of either OrCel or the standard dressing (Biobrane-L). The healing time for OrCel sites was significantly shorter than for sites treated with a standard dressing, enabling earlier recropping. OrCel sites also exhibited a non-significant trend for reduced scarring. Additional studies are needed to evaluate the effect of this product on health outcomes.

**TransCyte**

In 2001, Lukish et al. compared 20 consecutive cases of pediatric burns greater than 7% total body surface area that underwent wound closure with TransCyte with the previous 20 consecutive burn cases greater than 7% total body surface area that received standard therapy.
Standard therapy consisted of application of antimicrobial ointments and hydrodebridement. Only one child in the TransCyte group required autografting (5%) compared with seven children in the standard therapy group (35%). Children treated with TransCyte had a statistically significant decreased length of stay compared with those receiving standard therapy, 5.9 days versus 13.8 days, respectively.

Amani et al. (2006) compared results from 110 consecutive patients with deep partial-thickness burns who were treated with Transcyte with data from the American Burn Association Patient Registry. Significant differences were found in patients who were treated with dermabrasion and Transcyte compared to the population in the Registry. Patients with 0% to 19.9% total body surface area burns treated with dermabrasion and Transcyte had length of stay of 6.1 days versus 9.0 days (p < 0.001). Those with 20% to 39.9% total body surface area burn had lengths of stay of 17.5 days versus 25.5 days. Patients who had 40% to 59.9% total body surface area burns had lengths of stay of 31 days versus 44.6 days. The authors found this new method of managing patients with partial-thickness burns to be more efficacious and significantly reduced length of stay compared to traditional management.

**Traumatic Wounds**

Use of Integra Dermal Regeneration Template has been reported in small case series (<20 patients) for the treatment of severe wounds with exposed bone, joint and/or tendon (Helgeson et al., 2007; Taras et al., 2010; Weigert et al., 2011). No controlled trials were identified.

**Other Indications**

In addition to indications reviewed above, off-label uses of bio-engineered skin substitutes have included surgical wounds, pressure ulcers, split-thickness skin donor sites, inflammatory ulcers such as pyoderma gangrenosum and vasculitis, scleroderma digital ulcers, post-keloid removal wounds, genetic conditions, and variety of other conditions (Lazic & Falanga, 2011). In addition, products that have been FDA approved/cleared for one indication (e.g., lower extremity ulcers) have been used off-label in place of other FDA approved/cleared products (e.g., for burns) (Saffle, 2009). No controlled trials were identified for these indications. Therefore, they are considered investigational.

**Clinical Input Obtained Through 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.

**2008**

In response to requests Blue Cross Blue Shield Association (BCBSA) for input on use of AlloDerm in breast reconstruction surgery, input was received from one physician specialty society (two physicians) and one academic medical center while this policy was under review in 2008. All reviewers indicated that this procedure should be available for use during breast reconstruction surgery.
2011

In response to requests from BCBSA, input was received from three physician specialty societies and two academic medical centers while this policy was under review in 2011. A majority of reviewers supported the indications and products as described in this policy. Clinical input was requested regarding the use of an interpositional spacer after parotidectomy. Support for this indication was mixed. Some reviewers suggested use of other products and/or additional indications; however, the input on these products/indications was not uniform. The reviewers provided references for the additional indications; these were subsequently reviewed.

2014

In response to requests from BCBSA, input was received from three physician specialty societies and four academic medical centers while this policy was under review in 2014. In addition to questions on medical necessity for different indications, input was specifically requested on the equivalency of products within the different categories (eg, ADM, living cell therapy, xenogenic collagen scaffold, and amniotic membrane). Five reviewers addressed the use of ADM products for breast reconstruction, and most considered the various ADM products (AlloDerm, AlloMax, DermaMatrix, FlexHD, and GraftJacket) to have similar outcomes when used for breast reconstructive surgery, although differences in firmness and stretch of the products were noted. Six reviewers addressed questions on bio-engineered skin and soft tissue substitutes for diabetic and venous lower-extremity ulcers. Responses were mixed, although a majority of reviewers considered living cell therapies to be equivalent for these indications. A majority of reviewers did not consider xenogenic ADM products (eg, PriMatrix) or amniotic membrane (eg, EpiFix) to be medically necessary for any indication.

Practice Guidelines and Position Statements

Review of the literature for 2013 guidelines from the American Society of Plastic Surgeons (ASPS) found that evidence suggests that the use of ADM, although increasingly common in postmastectomy expander/implant breast reconstruction, can result in increased risk of complications in the presence of certain risk factors. The ASPS notes that cellular dermal matrix is currently used to increase soft tissue coverage, support the implant pocket, improve contour and reduce pain with expansion. However, evidence to support these improved surgical outcomes are limited. Some evidence suggests that use of ADM is associated with increased postoperative complications, specifically related to infection and seroma. Overall, the ASPS found that evidence on ADM products in postmastectomy expander/implant breast reconstruction is varied and conflicting, and gave a Grade C recommendation based on level III evidence that surgeons should evaluate each clinical case individually and objectively determine the use of ADM.

In 2006, the ASPS endorsed guidelines from the Wound Healing Society on the treatment of arterial insufficiency ulcers (Hopf et al., 2006). The Guidelines stated that extracellular matrix replacement therapy appeared to be promising for mixed ulcers and may have a role as an adjuvant agent in arterial ulcers, but further study was required. (Level IIIC). “Despite the existence of animal studies, case series, and a small number of random control trials to support biomaterial use for pressure ulcers, diabetic ulcers, and venous ulcers; there are no studies
specifically on arterial ulcers. Therefore, studies in arterial ulcers must be conducted before the recommendation can be made.”

The ASPS endorsed guidelines from the Wound Healing Society on the treatment of venous ulcers in 2006 (Robson et al., 2006). The guidelines stated that various skin substitutes or biologically active dressings were emerging that provided temporary wound closure and served as a source of stimuli (e.g., growth factors) for healing of venous ulcers. Guideline number 7b.1 stated that there was evidence that a bilayered artificial skin (biologically active dressing), used in conjunction with compression bandaging, increased the chance of healing a venous ulcer compared with compression and a simple dressing (Level I).

The ASPS also endorsed guidelines from the Wound Healing Society on the treatment of diabetic ulcers in 2006 (Steed et al., 2006). The guidelines stated that healthy living skin cells assisted in healing diabetic foot ulcers by releasing therapeutic amounts of growth factors, cytokines, and other proteins that stimulated the wound bed. Guideline number 7.2.2 stated that living skin equivalents may be of benefit in healing diabetic foot ulcers (Level I).

The 2007 guidelines from the ASPS on chronic wounds of the lower extremity stated that maintaining a moist environment, while simultaneously removing soluble factors detrimental to wound healing might logically provide optimal conditions for wound healing (ASPS, 2007). Classic dressings include gauze, foam, hydrocolloid, and hydrogels. Fluid-handling mechanisms include absorption, gelling, retention and vapor transmission. Bioactive dressings include topical antimicrobials, bioengineered composite skin equivalent, bilaminar dermal regeneration template, and recombinant human growth factor.

The 2011 Guidance from the United Kingdom's National Institute for Health and Clinical Excellence recommends not to use dermal or skin substitutes for the inpatient management of diabetic foot problems, unless part of a clinical trial.

The 2006 guidelines on diabetic foot disorders from the American College of Foot and Ankle Surgeons (ACFAS) state that bioengineered tissues have been shown to significantly increase complete wound closure in venous and diabetic foot ulcers (Frykberg et al., 2006). Tissue-engineered skin substitutes can function both as biologic dressings and as delivery systems for growth factors and extracellular matrix components through the activity of live human fibroblasts contained in their dermal elements. Currently, two bioengineered tissues have been approved to treat diabetic foot ulcers in the U.S.: Apligraf™ (Organogenesis Inc., Canton, MA), and Dermgraft™ (Smith & Nephew, Inc., London, UK); both have demonstrated efficacy in randomized, controlled trials. Apligraf™ has been shown to significantly reduce the time to complete wound closure in venous and diabetic ulcers. Dermgraft™ is no longer available in the United States. Regenerative tissue matrix (GraftJacket™ by Wright, Arlington, TN) is a new therapy used in diabetic foot ulcers, although it had not undergone any RCTs at the time of this guideline. This allograft skin is minimally processed to remove epidermal and dermal cells while preserving the bioactive components and structure of dermis. This results in a framework that supports cellular repopulation and vascularization. Oasis™ composed of structural cellular components and growth factors utilized to promote natural tissue remodeling, recently completed a randomized trial that showed non-inferiority to becaplermin gel in the healing of diabetic foot ulcers. Integra™ dermal regeneration template, a collagen-chondroitin sponge overlaid with
silicone originally developed for burns has been shown to be ideally suited to chronic and pathologic wounds.

The 2012 guidelines from the Infectious Diseases Society of America (IDSA) state that for selected diabetic foot wounds that are slow to heal, clinicians might consider using bioengineered skin equivalents (weak recommendation, moderate evidence) growth factors (weak, moderate), granulocyte colony-stimulating factors (weak, moderate), hyperbaric oxygen therapy (strong, moderate), or negative pressure wound therapy (weak, low) (Lipsky et al, 2012). It is emphasized that none of these measures have been shown to improve resolution of infection and that they are expensive, not universally available, may require consultation with experts, and reports supporting their utility are mostly flawed.

A 2012 Technology Assessment from the Agency for Healthcare Research and Quality does not make a formal recommendation for bioengineered skin and soft tissue substitutes (Snyder et al., 2012). The Assessment notes that autologous tissue grafting is an invasive and painful procedure and often the extent of damaged skin is too large to be covered by autologous tissue graft alone. A variety of skin substitutes and alternatives are designed to replace the damaged epithelial and dermal layers of skin and many of the conditions and biological factors needed in the healing process may be provided by the substitute skin products.

**Medicare National Coverage**

Centers for Medicare and Medicaid Services (CMS) has issued the following national coverage determination: Porcine (pig) skin dressings are covered, if reasonable and necessary for the individual patient as an occlusive dressing for burns, donor sites of a homograft, and decubiti and other ulcers.

Beginning in 2014, CMS will not distinguish between different skin substitutes and will classify them as either high cost or low cost. CMS will package skin substitutes of the same class into the associated surgical procedures for hospital outpatient departments and ambulatory surgical centers. A separate payment might be made if the item is furnished on a different date of service as the primary service.

**Summary**

Bio-engineered skin and soft tissue substitutes are being evaluated for a variety of conditions. Overall, the number of bio-engineered skin and soft-tissue substitutes is large, but the evidence is limited for any specific product. Relatively few products have been compared with the standard of care, and then only for some indications. A few comparative trials have been identified for use in lower extremity ulcers (diabetic or venous) and for treatment of burns. In these trials, there is a roughly 15% to 20% increase in the rate of healing. Several other products/indications are supported by either clinical input or by an FDA HDE.

**Breast Reconstruction**

Given the extensive data from controlled cohorts and case series, as well as the clinical input obtained about the usefulness of this procedure in providing inferolateral support for breast reconstruction, use of allogeneic ADM products (ie, AlloDerm, AlloMax, DermaMatrix, FlexHD, GraftJacket) may be considered medically necessary in breast reconstruction when
there is insufficient tissue expander or implant coverage by the pectoralis major muscle and additional coverage is required; when there is viable but compromised or thin postmastectomy skin flaps that are at risk of dehiscence or necrosis, or when the inframammary fold and lateral mammary folds have been undermined during mastectomy and re-establishment of these landmarks is needed.

Interpositional Graft after Parotidectomy

Two lower quality controlled trials were identified that demonstrated a reduction in the incidence of Frey syndrome with use of an interpositional ADM graft. Neither study described the method of group assignment or blinding of patients and assessors. In addition, clinical input regarding the use of an interpositional spacer after parotidectomy was not uniform. Therefore, bio-engineered skin and soft tissue substitutes are considered investigational to fill in contour defects and prevent Frey syndrome after parotidectomy.

Tendon Repair

One small RCT was identified that found improved outcomes with GraftJacket acellular human dermal matrix for rotator cuff repair. Although these results are promising, additional study with a larger number of subjects is needed. Therefore, this use is considered investigational.

Fistula Repair

One RCT was identified that used an ADM product that has not been cleared for marketing in the U.S. Therefore, the use of this product for fistula repair is considered investigational.

Surgical Repair of Hernias

The limited evidence available does not support the efficacy of any tissue-engineered skin substitute for surgical repair of hernias. Therefore, this use is considered investigational.

Oral Surgery

Use of acellular human dermal matrix (AlloDerm) has been reported for root coverage therapy and oral cavity reconstruction following surgical removal of tumors. Although AlloDerm may possibly result in less scar contracture, results to date have not shown an improvement over the standard of care. Therefore, this use is considered investigational.

Laryngoplasty

The effect of micronized AlloDerm (Cymetra) in laryngoplasty has been reported in case series. Longer-term controlled study in a larger number of patients is needed to determine the durability of this procedure and to evaluate the safety of repeat injections.

Tympanoplasty

AlloDerm has been compared with native tissue grafts in a non-RCT. There was no significant difference in the success rate of the graft (88% for AlloDerm, 89% for fascia grafts, 96.7% for cartilage plus fascia), and there was no significant difference in hearing between the groups at follow-up. Longer-term controlled study in a larger number of patients is needed to determine the durability of this procedure.
**Diabetic Lower Extremity Ulcers**

Randomized controlled trials have demonstrated the efficacy of Apligraf and Dermagraft over the standard of care. Use of these products may be considered medically necessary for the treatment of diabetic lower extremity ulcers. Additional study with a larger number of subjects is needed to evaluate the effect of PriMatrix treatment in comparison with the current standard of care.

**Lower Extremity Ulcers due to Venous Insufficiency**

Randomized controlled trials have demonstrated the efficacy of Apligraf and Oasis Wound Matrix over the standard of care. Use of these products may be considered medically necessary for lower extremity ulcers due to venous insufficiency. In a large RCT (Harding et al., 2013), Dermagraft was not shown to be more effective than controls in the primary or secondary end points for the entire population, and was slightly more effective than controls (an 8%-15% increase in healing) only in subgroups of patients with ulcer duration of 12 months or less or size of 10 cm or less. Additional study with a larger number of subjects is needed to evaluate the effect of PriMatrix treatment in comparison with the current standard of care.

**Dystrophic Epidermolysis Bullosa**

OrCel have received approval via a HDE. As this is a rare disorder and it is unlikely that there will be RCTs, OraCel is considered medically necessary for this indication.

**Ocular Burns**

Evidence is insufficient to evaluate the efficacy of human amniotic membrane for ocular burns. This is considered investigational.

**Non-Ocular Burns**

Epicel is FDA-approved under a HDE for the treatment of deep dermal or full-thickness burns comprising a total body surface area of greater than or equal to 30%. This treatment may be considered medically necessary according to the HDE indications.

Comparative studies have demonstrated improved outcomes for Integra Dermal Regeneration Template and Transcyte for the treatment of burns; therefore, these are considered medically necessary.

**Traumatic Wounds**

Use of Integra Dermal Regeneration Template has been reported in small case series (<20 patients) for the treatment of severe wounds with exposed bone, joint, and/or tendon. Controlled trials are needed to evaluate this product/indication.

All other uses of the bio-engineered skin and soft-tissue substitutes are considered investigational.
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)) prohibit 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.

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

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### Medical Policy: Bio-Engineered Skin and Soft Tissue Substitutes

**Original Policy Date:** 10/7/2011  
**Effective Date:** 1/30/2015

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<td>FortaDerm, and FortaDerm Antimicrobial, any type, per sq cm</td>
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<td>Acellular pericardial tissue matrix of non-human origin (veritas), per square centimeter</td>
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<td>Q4107</td>
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<td>Q4129</td>
<td>Unite biomatrix, per square centimeter</td>
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<td>Strattice tm, per square centimeter</td>
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<td>Q4131</td>
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<td>Q4137</td>
<td>Amnioexcel or BioDExcel, per square centimeter</td>
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<td>Biodfence Dryflex, per square centimeter</td>
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<td>Amnioband or guardian, per sq cm</td>
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<td>V2790</td>
<td>Amniotic membrane for surgical reconstruction, per procedure</td>
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**ICD9 Procedure**

- None

**ICD9 Diagnosis**

- All Diagnoses
### Definitions

**Allogeneic** - Products obtained from another individual, other than the patient themselves.

**Autologous** - Products obtained from the same individual.

**Epidermolysis bullosa** - A group of inherited disorders in which skin blisters develop in response to minor injury. Skin grafting for denuded or ulcerated areas of the skin may be necessary.

**Xenographic** - Products derived from non-human sources (i.e., bovine, porcine).

### Index / Cross Reference of Related BSC Medical Policies

The following Medical Policies share diagnoses and/or are equivalent BSC Medical Policies:

- Autologous Platelet-Rich Plasma
- Reconstructive Services

### Key / Related Searchable Words

- Acellular dermal matrix
- Acellular tissue matrix
- ADM
- Amniotic membrane
- Artificial skin
- Bioengineered skin
- Skin substitutes
- Tissue engineered skin

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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.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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<tr>
<th>Effective Date</th>
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<tbody>
<tr>
<td>10/7/2011</td>
<td>Policy title change from Allograft Use in Breast Reconstructive Surgery with adoption of BCBSA Medical Policy</td>
<td>Medical Policy Committee</td>
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<tr>
<td>3/13/2012</td>
<td>Coding Update</td>
<td>Administrative Review</td>
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<tr>
<td>7/6/2012</td>
<td>Policy title change from Tissue-Engineered Skin Substitutes with position change</td>
<td>Medical Policy Committee</td>
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<tr>
<td>10/5/2012</td>
<td>Policy revision with position change</td>
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<td>2/22/2013</td>
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<td>3/29/2013</td>
<td>Policy revision with position change</td>
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<td>1/30/2015</td>
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The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.