

<b>2.01.16</b>		<b>Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions</b>	
<b>Original Policy Date:</b>	September 12, 2008	<b>Effective Date:</b>	March 1, 2024
<b>Section:</b>	2.0 Medicine	<b>Page:</b>	Page 1 of 31

## Policy Statement

- I. Use of platelet-rich plasma (PRP) (i.e., autologous blood-derived preparations) is considered **investigational** for the treatment of acute or chronic wounds, including surgical wounds and nonhealing ulcers and certain other non-orthopedic conditions.

**NOTE:** Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

## Policy Guidelines

**Note:** Please refer to the Rationale section of this policy for the non-orthopedic conditions and to Blue Shield of California's Medication Policy: REGRANEX (becaplermin, topical) for coverage criteria.

### Platelet-Rich Plasma (i.e., Autologous Blood-Derived Preparations)

#### Coding

There is a CPT category III code for injections of platelet-rich plasma (PRP):

- **0232T:** Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed

The instructions issued with the code state that it is not to be reported with codes 20550, 20551, 20600-20610, 76942, 77002, 77012, 77021, or 86965. Code 0232T includes the harvesting and preparation of the PRP.

For situations other than injection (when 0232T would be reported), no specific CPT codes describe the preparation of autologous blood-derived products, but the following CPT code can be used:

- **86999:** Unlisted transfusion medicine procedure

The American Medical Association's Department of Coding instructs that placement of PRP into an operative site is an inclusive component of the operative procedure performed and not separately reported.

**Effective July 1, 2023,** the following HCPCS code has been **revised**:

- **G0460:** Autologous platelet rich plasma (PRP) or other blood-derived product for nondiabetic chronic wounds/ulcers (includes, as applicable: administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)

**Effective July 1, 2023,** the following HCPCS code has been **revised**:

- **G0465:** Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes, as applicable: administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)

The following HCPCS code represents other human platelet-derived growth factor preparations used to promote wound healing:

- **S9055:** Procuren or other growth factor preparation to promote wound healing

The following HCPCS code represents becaplermin:

- **S0157:** Becaplermin gel 0.01%, 0.5 gm

**Note:** Requests for specific drugs related to this or other policies should be addressed to Pharmacy services as for all other medications. In the event of a policy conflict related to medications, the Pharmacy medication policy will be followed.

## Description

The use of blood-derived growth factors, including recombinant platelet-derived growth factors (PDGFs) and platelet-rich plasma (PRP), has been suggested as a treatment for wounds or other miscellaneous non-orthopedic conditions, including but not limited to, diabetic ulcers, pressure ulcers, venous stasis ulcers, and surgical and traumatic wounds.

## Related Policies

- Bioengineered Skin and Soft Tissue Substitutes
- Electrostimulation and Electromagnetic Therapy for Treating Wounds
- Negative Pressure Wound Therapy in the Outpatient Setting
- Noncontact Ultrasound Treatment for Wounds
- Orthopedic Applications of Platelet-Rich Plasma

## 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

### Platelet-Rich Plasma

The FDA 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. Blood products such as PRP are included in these regulations.

Under these regulations, certain products including blood products such as PRP are exempt and therefore, do not follow the traditional FDA regulatory pathway. To date, the FDA has not attempted to regulate activated PRP.<sup>2</sup>

Numerous PRP preparation systems have been cleared for marketing by the FDA through the 510(k) process. These devices are intended to concentrate patient plasma at the point of care during bone grafting procedures. The use of different devices and procedures can lead to variable concentrations of active platelets and associated proteins, increasing variability between studies of clinical efficacy.

## Rationale

### Background

#### Wound Healing Treatment

A variety of growth factors have been found to play a role in wound healing, including platelet-derived growth factor (PDGF), epidermal growth factor, fibroblast growth factors, transforming growth factors, and insulin-like growth factors. Autologous platelets are a rich source of PDGF, transforming growth factors (that function as a mitogen for fibroblasts, smooth muscle cells, and osteoblasts), and vascular endothelial growth factors. Recombinant PDGF also has been extensively investigated for clinical use in wound healing.

Autologous platelet concentrate suspended in plasma, also known as platelet-rich plasma (PRP), can be prepared from samples of centrifuged autologous blood. Exposure to a solution of thrombin and calcium chloride degranulates platelets (releasing various growth factors) and results in the polymerization of fibrin from fibrinogen, creating a platelet gel. The platelet gel can then be applied to wounds or may be used as an adjunct to surgery to promote hemostasis and accelerate healing. In the operating room setting, PRP has been investigated as an adjunct to a variety of periodontal, reconstructive, and orthopedic procedures. For example, bone morphogenetic proteins are a transforming growth factor, and thus PRP has been used in conjunction with bone-replacement grafting (using either autologous grafts or bovine-derived xenograft) in periodontal and maxillofacial surgeries.

PRP is distinguished from fibrin glues or sealants, which have been used for many years as a surgical adjunct to promote local hemostasis at incision sites. Fibrin glue is created from platelet-poor plasma and consists primarily of fibrinogen. Commercial fibrin glues are created from pooled homologous human donors; Tisseel® (Baxter International) and Hemaseel® (Haemacure Corp.) are examples of commercially available fibrin sealants. Autologous fibrin sealants can also be created from platelet-poor plasma. This evidence review does not address the use of fibrin sealants.

#### Wound Closure Outcomes

This review addresses the use of recombinant PDGF products and PRP for non-orthopedic indications, which include a number of wound closure-related indications.

For this review, the primary endpoints of interest for the study of wound closure are as follows, consistent with guidance from the U.S. Food and Drug Administration (FDA) for the industry in developing products for the treatment of chronic cutaneous ulcer and burn wounds<sup>1</sup>:

- Incidence of complete wound closure;
- Time to complete wound closure (reflecting accelerated wound closure);
- Incidence of complete wound closure following surgical wound closure;
- Pain control.

#### Literature Review

The platelet-rich plasma (PRP) portion of this evidence review on the platelet-derived wound healing formulae was originally based on a 1992 TEC Assessment that primarily focused on the Procuren process.<sup>3</sup> This preparation method is no longer commercially available. Currently, a large number of devices are available for the preparation of PRP or PRP gel. The amount and mixture of growth factors produced by different cell-separating systems vary, and it is unknown whether platelet activation before an injection is necessary.<sup>4,5,6,7,8</sup>

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, and ability to function<sup>3,4</sup>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, 2 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.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

### **Recombinant Platelet-Derived Growth Factor for Diabetic Lower-Extremity Ulcers Clinical Context and Therapy Purpose**

The purpose of recombinant platelet-derived growth factor (PDGF) is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with diabetic lower-extremity ulcers.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with diabetic lower-extremity ulcers.

#### ***Interventions***

The therapy being considered is recombinant PDGF.

#### ***Comparators***

Comparators of interest include standard wound care.

#### ***Outcomes***

The general outcomes of interest are symptoms, change in disease status, morbid events, quality of life (QOL), and treatment-related morbidity.

Follow-up at 20 weeks is of interest for recombinant PDGF to monitor relevant outcomes.

### **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 events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.

- Studies with duplicative or overlapping populations were excluded.

### Review of Evidence

The portion of this evidence review on the use of recombinant PDGF (becaplermin gel) was informed by a 1999 TEC Assessment, which found that the evidence supported the conclusion that becaplermin gel, in conjunction with good wound care, improves the health outcomes of patients with chronic neuropathic diabetic ulcers that met the patient selection criteria defined therein.<sup>9</sup> Becaplermin gel plus good wound care resulted in a 43% complete wound closure rate, compared with 28% for patients treated with good wound care alone. Becaplermin gel also appeared to reduce the average time to complete wound closure.

### Systematic Reviews

A 2014 systematic review identified 6 RCTs (N=992 patients) that compared recombinant PDGFs with placebo or standard care.<sup>10</sup> There was a combined odds ratio of 1.53 (95% confidence interval [CI], 1.14 to 2.04; p=.004) favoring recombinant PDGF for complete healing rate.

Sridharan et al (2018) conducted a systematic review and meta-analysis of RCTs on topical growth factors compared with standard of care in patients with diabetic foot ulcers (DFUs). The primary outcome of concern was complete healing and the second outcome of concern was the existence of adverse events. Rankogram was generated based on the surface under the cumulative ranking curve. In total, 26 studies with 2088 participants and 1018 adverse events were included. The pooled odds ratio estimates for recombinant human epidermal growth factor (rhEGF), autologous-PRP, and recombinant human platelet-derived growth factor were 5.7 [95% CI, 3.34 to 10.37], 2.65 [95% CI, 1.65 to 4.54], and 1.97 [95% CI, 1.54 to 2.55] respectively. The surface under the cumulative ranking curve for rhEGF was 0.95; sensitivity analysis did not reveal significant changes from pooled estimates and rankogram. With regard to adverse events, no differences were observed for the overall risk of adverse events between the growth factors; however, the growth factors were observed to lower the risk of lower limb amputations compared to standard of care. The results lead the authors to conclude that rhEGF, recombinant human platelet-derived growth factor, and autologous PRP significantly improved the healing rate when used as adjuvants to the standard of care. Compared to other growth factors, rhEGF performed better. The limitations of this study include the following: the strength of most of the outcomes assessed was low, and the findings may not be applicable for DFU with infection or osteomyelitis.<sup>11</sup>

**Table 1. Systematic Reviews of Trials Assessing Recombinant Platelet-Derived Growth Factor for Diabetic Lower-Extremity Ulcers**

Study (Year)	Literature Search	Studies	Participants	N	Design	Results
Sridharan et al (2018)	Dec 2016	RCTs	Patients with diabetic lower-extremity ulcers treated with platelet-derived growth factor	2088	RCTs	Pooled analysis estimated rhEGF, PRP, rhPDGF

PRP: autologous platelet-rich plasma; RCT: Randomized Controlled Trial; rhEGF: recombinant epidermal growth factor; rhPDGF: recombinant human platelet-derived growth factor.

### Retrospective Studies

A 2005 industry-sponsored study assessed the effectiveness of recombinant PDGF for diabetic neuropathic foot ulcers in actual clinical practice.<sup>12</sup> Among a cohort of 24,898 patients in wound care centers, those subjects whose wounds did not heal over an 8-week observation period were eligible for the study and were retrospectively assessed over 20 weeks or until they healed. Any subject with an open wound who was lost to follow-up was considered unhealed. Of the nearly 25000 patients treated for foot ulcers, 2394 (9.6%) received recombinant PDGF. A propensity score method with

covariates to statistically model treatment selection was used to adjust for selection bias; results were stratified by 5 propensity score groups. Overall, the rate of healing was 26.5% in the control group and 33.5% in patients treated with recombinant PDGF. The relative risk (RR), controlling for the propensity to receive PDGF, was 1.32 (95% CI, 1.22 to 1.38) for healing and 0.65 (95% CI, 0.54 to 0.78) for amputation (6.4% in controls vs. 4.9% in the PDGF group). The analysis also indicated those who received PDGF were more likely to be younger, male, and have older wounds—factors not known to affect wound healing. These results support the clinical utility of recombinant PDGF for treatment of diabetic neuropathic foot ulcers in actual clinical practice.

### **Section Summary: Recombinant Platelet-Derived Growth Factor for Diabetic Lower-Extremity Ulcers**

Published evidence includes an industry-sponsored study and 2 systematic reviews that showed an improvement in treatment over control for tested outcome measures.

### **Recombinant Platelet-Derived Growth Factor for Pressure Ulcers Clinical Context and Therapy Purpose**

The purpose of recombinant PDGF is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with pressure ulcers.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with pressure ulcers.

#### ***Interventions***

The therapy being considered is recombinant PDGF.

#### ***Comparators***

Comparators of interest include standard wound care.

#### ***Outcomes***

The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity.

Though not completely standardized, follow-up for pressure ulcer symptoms would typically occur in the months after starting treatment.

### **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 events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

### **Review of Evidence**

#### **Randomized Controlled Trials**

Rees et al (1999) conducted an RCT focusing on the use of becaplermin gel as a treatment for pressure ulcers.<sup>15</sup> Patient selection criteria included full-thickness ulcers and an anatomic location where pressure could be offloaded during treatment. This latter patient selection criterion might have limited the number of patients with pressure ulcers who would have been considered candidates for becaplermin therapy. Patients were randomized to 1 of 4 parallel treatment groups and received either a placebo or 1 of 3 dosages of becaplermin. All patients received a standardized program of

good wound care. In the 2 groups treated with the once-daily dosage (becaplermin 0.01% or 0.03%), the incidence of complete healing was significantly improved compared with the placebo group. There was no difference in outcome between the 0.01% and 0.03% groups, suggesting there is no clinical benefit in increasing the potency above 0.01%. A third group received becaplermin 0.01% twice daily. That group did not report improved outcomes compared with placebo, a finding that is unexplained.

### **Section Summary: Recombinant Platelet-Derived Growth Factor for Pressure Ulcers**

Published evidence includes a multicenter, double-blind RCT that showed an improvement in treatment over control for tested outcome measures.

### **Recombinant Platelet-Derived Growth Factor for Venous Stasis Leg Ulcers**

#### **Clinical Context and Therapy Purpose**

The purpose of recombinant PDGF is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with venous stasis leg ulcers.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with venous stasis leg ulcers.

#### ***Interventions***

The therapy being considered is recombinant PDGF.

#### ***Comparators***

Comparators of interest include standard wound care.

#### ***Outcomes***

The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity.

Though not completely standardized, follow-up for venous stasis leg ulcer symptoms would typically occur in the months after starting treatment.

### **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 events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

### **Review of Evidence**

#### **Randomized Controlled Trials**

Senet et al (2011) in France, published a multicenter, double-blind RCT of becaplermin gel for venous leg ulcers.<sup>14</sup> There was no significant difference between the becaplermin (n=28) and control hydrogel (n=31) groups for any of the outcome measures, which included complete closure rates after 8 and 12 weeks, changed ulcer area, and changed ulcer-related pain and QOL.

### **Section Summary: Recombinant Platelet-Derived Growth Factor for Venous Stasis Leg Ulcers**

Published evidence includes a multicenter, double-blind RCT that showed no difference between treatment and control for tested outcome measures.

## Recombinant Platelet-Derived Growth Factor for Acute Surgical or Traumatic Wounds

### Clinical Context and Therapy Purpose

The purpose of recombinant PDGF is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with acute surgical or traumatic wounds. The following PICO was used to select literature to inform this review.

### *Populations*

The relevant population of interest is individuals with acute surgical or traumatic wounds.

### *Interventions*

The therapy being considered is recombinant PDGFs.

### *Comparators*

Comparators of interest include standard wound care.

### *Outcomes*

The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity.

Though not completely standardized, follow-up for acute surgical or traumatic wound symptoms would typically occur in the months after starting treatment.

### 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 events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

### Review of Evidence

Topical recombinant PDGF has also been investigated for repair of work-related fingertip injuries. A 2005 prospective controlled trial alternately assigned 50 patients (fingertip wound area  $\geq 1.5$  cm, with or without phalangeal exposure) to daily treatment with PDGF (n=25) or surgical reconstruction (n=25).<sup>15</sup> Statistical analysis showed that baseline characteristics of the 2 groups were similar for patient age, wound area (2.2 to 2.4 cm), and distribution of fingertip injuries across the digits. Assessment by an independent physician showed that, compared with the surgical intervention, treatment with recombinant PDGF resulted in faster return to work (10 days vs. 38 days) and wound healing (25 days vs. 35 days), less functional impairment (10% vs. 22%), and less need for physical therapy (20% vs. 56%), respectively. Fingertips treated with PDGF were also reported to have satisfactory aesthetic results, while surgically treated fingertips were shorter and often unsightly. These results, if confirmed in additional RCTs, could lead to improvement in health outcomes for patients with fingertip injuries. However, this trial was limited by its small sample size, method of randomization, and potential for investigator bias (although examining physicians were blinded to treatment allocation, actual treatment might have been obvious).

### Adverse Events

Growth factors cause cells to divide more rapidly. For this reason, the manufacturer of Regranex continued to monitor studies that started before its approval (in December 1997) for any evidence of adverse events, such as increased numbers of cancers. In a long-term safety study completed in 2001, more deaths from cancer occurred among patients who used Regranex than in those who did not. A subsequent study was performed using a health insurance database that covered the period



from January 1998 through June 2003. This trial identified 2 groups of patients with similar diagnoses, drug use, and use of health services: 1 group used Regranex, and the other group did not.

Results showed there were more deaths from cancer among patients who were given 3 or more prescriptions for Regranex than deaths for those not treated with Regranex. No single type of cancer was identified; deaths from all types of cancer were observed. In 2008, the U.S. Food and Drug Administration concluded that the increased risk of death from cancer in patients who used 3 or more tubes of Regranex was 5 times higher compared with those who did not use Regranex, prompting the manufacturer to add a black box warning to the labeling for Regranex. The risk of new cancers among Regranex users was not increased compared with nonusers, although the duration of follow-up of patients in this study was not long enough to detect new cancers.

### **Section Summary: Recombinant Platelet-Derived Growth Factor for Acute Surgical or Traumatic Wounds**

Published evidence includes nonrandomized controlled trials reporting satisfactory aesthetic results. Larger RCTs are required to confirm and expound on these results.

### **Platelet-Rich Plasma for Chronic Wounds**

#### **Clinical Context and Therapy Purpose**

The purpose of PRP is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with chronic wounds

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with chronic wounds.

#### ***Interventions***

The therapy being considered is PRP.

#### ***Comparators***

Comparators of interest include standard wound care.

#### ***Outcomes***

The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity.

Though not completely standardized, follow-up for chronic wound symptoms would typically occur in the months after starting treatment.

### **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 events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

## Review of Evidence

### Diabetic Foot Ulcers

#### Systematic Reviews

A number of systematic reviews of the evidence on PRP have been published.<sup>16,17,18,19,20,21,22,23</sup> These reviews are heterogeneous in whether they pooled data from studies reflecting a variety of wound types<sup>16,17,24,18,25</sup> or focused on specific wound types, primarily diabetic foot ulcers.<sup>19,20,21,22</sup> Results from the reviews that pooled data from a variety of wound types<sup>16,17,24,18,25</sup> are not discussed herein as their design precludes drawing conclusions about the applicability of the review findings to specific wound types. As the majority of the RCTs included in the systematic reviews were published post-2014, herein are summarized those systematic reviews that focused on specific wound types with search dates that extend to at least 2015.<sup>21,22,23</sup>

Three recent systematic reviews have evaluated studies of PRP for individuals with diabetic foot ulcers.<sup>21,22,23</sup> Table 2 provides a crosswalk of the studies included in the systematic reviews.

**Table 2. Comparison of Trials of Platelet-Rich Plasma in Individuals with Diabetic Foot Ulcers Included in Systematic Reviews**

Primary Study (Year)	Li 2019 <sup>21</sup>	Qu 2021 <sup>22</sup>	Deng 2023 <sup>23</sup>
Ahmed 2017 <sup>26</sup>			

In their meta-analysis, Li et al (2019) assessed the efficacy and safety of autologous platelet-rich gel for topical treatment of diabetic chronic cutaneous ulcers<sup>21</sup>. Their analysis included 15 RCTs with 829 patients. Results indicated that autologous platelet-rich gel had a significant positive effect on healing rate, shorter healing time, and lower risk of infection than conventional treatment. Autologous platelet-rich gel also had a significantly lower incidence of infection when compared with conventional treatment (odds ratio [OR]=0.34; 95% CI: 0.15 to 0.77; p=.009). This meta-analysis was limited by a high or unclear risk of bias among the trials, which may indicate the trials were underpowered. Also, some studies had small sample sizes and limited outcome information. Further, 7 of the included trials are available only in the Chinese language. Finally, most of the trials were 8 to 12 weeks long and others only 2 to 5 weeks, making it difficult to analyze the relationship of time of observation to ulcer healing.

The Agency for Healthcare Research and Quality (AHRQ) (2020) published a Technology Assessment on Platelet-Rich Plasma for Wound Care in the Medicare Population. This Technology Assessment was requested by the Centers for Medicare & Medicaid Services to inform reconsideration of a National Coverage Decision on autologous blood-derived products for chronic non-healing wounds.<sup>61</sup> This Technology Assessment evaluates evidence in lower extremity diabetic ulcers, lower extremity venous ulcers and pressure ulcers. Separate meta-analyses were conducted for each wound type. Here the focus is on findings for lower extremity diabetic ulcers and those for the other populations are discussed below. Risk of bias of individual studies was assessed using the Cochrane Collaboration's Risk of Bias 2 tool and rated high in 8 RCTs (57.14%), moderate in 6 RCTs (42.86%) and high in the 1 observational study (100%). Strength of the body of evidence was rated based on the Evidence-based Practice Center methods guide. The findings of this Technology Assessment indicated that there is moderate-strength evidence that PRP modestly increases complete wound closure (see meta-analysis results in Table 4 below) and low-strength evidence that PRP may shorten time to wound closure (meta-analysis not feasible). However, due to risk of bias and severe imprecision, evidence is insufficient to draw conclusions about other important outcomes, including wound infection, amputation, pain reduction, and wound recurrence. Important limitations of the literature were described as "inadequate description of offloading and wound care procedures, wound characteristics, PRP formulation techniques, concentration and volume; inadequate length of follow-up, and lack of stratification by comorbidities and other patient characteristics, such as diabetes control, vascular perfusion, and under representation of older adults."

A meta-analysis by Deng et al (2023) assessed 22 RCTs (N=1559) to determine the safety and efficacy of PRP to treat diabetic foot ulcers.<sup>23</sup> Results indicated PRP significantly increased the overall healing rate of diabetic foot ulcers compared with standard treatment (risk ratio [RR]=1.42; 95% CI: 1.30 to 1.56; p<.001; I<sup>2</sup>=55%). PRP increased the complete wound healing time of diabetic foot ulcers compared to conventional treatment (mean difference [MD]=-3.13; 95% CI: -5.86 to -0.39; p<.001; I<sup>2</sup>=97.5%) and resulted in a greater reduction in diabetic foot ulcer area (MD=1.02; 95% CI: 0.51 to 1.53; p<.001; I<sup>2</sup>=36%). The rate of amputation, reported by 3 trials, significantly reduced risk for the autologous PRP group (RR=0.35; 95% CI, 0.15 to 0.83; p<.001; I<sup>2</sup>=0%). Four studies reported adverse events, and pooled analysis revealed a similar rate of events between the PRP and control groups (RR=0.96; 95% CI, 0.57 to 1.61; p>0.05; 35%). The authors reported no significant publication bias was detected by funnel plot analysis; however, a sensitivity analysis suggested that the pooled outcome assessment for time to wound healing may be affected by considerable inter-study variability. The low number of high-quality of studies available on PRP for diabetic foot ulcers and the low number of studies reporting some outcomes of interest were limitations of this meta-analysis.

**Table 3. Characteristics of Key Systematic Reviews with Meta-Analyses in Individuals with Diabetic Foot Ulcers**

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Li (2019) <sup>21</sup> .	2004-2017	15	Patients with diabetic chronic cutaneous wounds/ulcers that do	N=829 (14-117)	RCTs	NR

Study	Dates	Trials	Participants	N (Range)	Design	Duration
			not show signs of healing in 4 weeks			
Qu (2021) <sup>22</sup>	Inception- 2020	14	Adults with lower extremity diabetic ulcers, lower extremity venous ulcers, or pressure ulcers in any location, or a mix of these 3 etiologies	N=1,096 (range NR)	RCTs	Median = 6 wk (range, none to 11 months)
Deng (2023) <sup>23</sup>	Inception- 2023	22	Adults with diabetic foot ulcers	N=1559	RCTs	NR

NR: not reported; RCT: randomized controlled trial; wk: week(s); y: year(s).

**Table 4. Results of Key Systematic Reviews with Meta-Analyses in Individuals with Diabetic Foot Ulcers**

Study	Healing Rate	Healing Time	Complete Wound Healing	Risk of Infection	Wound complications	Pain Reduction	Recurrence
<b>Li (2019)<sup>21</sup></b>							
RR	1.39						
MD		-9.18					
OR				0.34			
95% CI	1.29 to 1.50	-11.32 to -7.05		0.15 to 0.77			
P-value	<.001	<.001		.009			
<b>Qu (2021)<sup>22</sup></b>							
RR			1.20	0.77			2.09
WMD						-1.10 <sup>a</sup>	
95% CI			1.09 to 1.32	0.54 to 1.11		-1.81 to -0.39	0.31 to 13.93
P-value							
<b>Deng (2023)<sup>23</sup></b>							
RR	1.42				.096		
MD		-3.13					
95% CI	1.30 to 1.56	-5.86 to -0.39			0.57 to 1.61		
P-value	<.001	<.001			.203		

<sup>a</sup>Visual Analog Scale

CI: confidence interval; MD: mean difference; OR: odds ratio; RR: risk ratio; WMD: weighted mean difference; Z: indicates overall effect.

### Randomized Controlled Trials

Key characteristics and results of several RCTs of diabetic foot ulcers published subsequent to the AHRQ review (2020) are summarized in Tables 5 and 6 below.

One RCT of PRP dressing with total-contact casting compared to standard saline dressing for diabetic foot ulcers (Gupta et al [2021])<sup>62</sup> did not find significant differences in rates of ulcer area reduction or absolute ulcer area reduction between groups over the 6-week study period. Another RCT of PRP versus standard wound care found accelerated rates of ulcer area reduction and decreased incidence of wound infections with PRP treatment; however, the difference in the percentage of healed surface between groups lost statistical significance at 6, 7, or 8 weeks of follow-up and it is unclear whether complete wound healing was achieved in either group.<sup>36</sup>

**Table 5. Summary of Key RCT Characteristics**

Study	Countries	Sites	Dates	Participants	Intervention	Control
Gupta et al (2021) <sup>62</sup>	India	1	2016 to 2018	Individuals with diabetes mellitus	Autologous intralesional PRP	Saline dressing (n=30)

Study	Countries	Sites	Dates	Participants	Intervention	Control
				with noninfected diabetic foot ulcers with total ulcer area of 20 cm <sup>2</sup> or less on the plantar surface	therapy with total contact casting (n=30)	
Hossam et al (2022) <sup>36</sup> ,	Egypt	1	2018	Individuals with type 1 or 2 diabetes with non-ischemic revascularized chronic diabetic foot ulcers of more than 6 months duration with no clinical signs of infection, Wagner grade 1 or 2, and ASA physical status class 2	Autologous intralesional CaCl <sub>2</sub> -activated PRP therapy (injection and/or gel) with saline gauze (n=40)	Standard wound care with moist dressing with or without collagenase ointment (n=40)

ASA: American Society of Anesthesiologists; PRP: platelet-rich plasma; RCT: randomized controlled trial.

Table 6. Summary of Key RCT Results

Study	Complete Healing	Percentage of Healed Surface Area <sup>a</sup>	Complete Healing Time	Pain	Quality of Life	Infection	Recurrence
Gupta et al (2021) <sup>62</sup> ,	NR	6 weeks: 85.98% vs 81.72%; p=NR	NR	NR	NR	NR	NR
Hossam et al (2022) <sup>36</sup> ,	95% vs 77.8% <sup>b</sup> ; p<.001	1 week: 23.1% vs 0%; p=.002 5 weeks: 89.2% vs 60.1%; p<.001 8 weeks: 96.7% vs 95.5%; p=.529	NR	NR	NR	PRP: 4 (10%) Control: 18 (45%) with 4 resulting in amputation p<.001	NR

NR: not reported; PRP: platelet-rich plasma; RCT: randomized controlled trial.

<sup>a</sup> Percentage of healed surface area in treatment vs. control groups.

<sup>b</sup> Proportion of patients with complete healing in treatment (n=38) vs. control groups (n=28) at 6 and 9 weeks, respectively.

Study relevance, design, and conduct limitations are summarized below in Tables 9 and 10.

### Other Chronic Wound Types

The AHRQ (2020) Technology Assessment on Platelet-Rich Plasma for Wound Care in the Medicare Population described above also evaluated evidence on use of PRP in individuals with lower extremity venous ulcers and individuals with pressure ulcers.<sup>63</sup>

For individuals with lower extremity venous ulcers, the evidence included 8 RCTs and 3 observational studies (total N=615). The majority compared PRP to management without PRP. Risk of bias was described as moderate due to randomization and outcome measurement limitations. There were no significant differences between PRP versus management without PRP in complete wound closure (RR=1.49; 95% CI: 0.72 to 3.06; 5 studies, N=250; *I*<sup>2</sup>=29.4%), wound recurrence (RR=0.38; 95% CI: 0.09 to 1.57), wound infection (RR=0.79; 95% CI: 0.22 to 2.81), or quality of life as measured by the Chronic

Lower Limb Venous Insufficiency Questionnaire (weighted mean difference [WMD]=10.99; 95%CI: -50.5 to 72.5). For the outcomes time to complete wound closure and pain, meta-analysis of 2 studies was not possible due to insufficient data and findings were mixed between studies on both outcomes. The strength of evidence was rated as 'insufficient' to draw conclusions on all outcomes. Oliveira et al (2020) also conducted a meta-analysis of cost and effectiveness of studies of PRP for venous ulcers.<sup>64</sup> Based on fewer studies identified from searches only through July 2018, although their findings indicated greater reductions in wound area for PRP, findings were consistent with the AHRQ review in finding no significant difference in complete wound closure (RR=2.54; 95% CI, 0.42 to 15.30; 4 studies, N=156; I<sup>2</sup>=69%).

For individuals with pressure ulcers, the AHRQ Technology Assessment (2020)<sup>22</sup> included 1 RCT and 1 comparative observational study (total N not reported). The comparator was serum physiological dressing in the RCT and saline dressing in the observational study. Risk of bias of the primary studies was described as moderate, due to limitations in the randomization process and outcome measurement, deviations from intended interventions, and selective outcome reporting. Although both studies found that PRP significantly reduced wound size (strength of evidence=insufficient), neither study evaluated other important outcomes, such as complete wound closure.

A meta-analysis by Fang et al (2023) pooled data from 6 studies on patients treated for lower extremity venous ulcers with PRP.<sup>65</sup> A total of 294 patients were included, with 148 patients in the PRP group and 146 in the control group. PRP was found to have a greater reduction in elliptical area at the end of treatment compared to the control group (Mean difference [MD], -1.19; 95% CI, -1.8 to -.058; P=.0001) with a moderate quality of evidence. The healing rate also favored PRP over the control group (RR=5.73; 95% CI, 3.29 to 9.99; P<.00001) with a moderate quality to the evidence base. The authors suggest there may be publication bias in the calculation of these pooled estimates according to Egger's test.

### Randomized Controlled Trials

Two RCTs of PRP for chronic wounds (Saha et al [2020])<sup>66,67</sup> were identified as published subsequent to the AHRQ review (2020).<sup>22</sup> Key characteristics and results of selected RCTs are reported in Tables 7 and 8 below.

Saha et al.'s analyses included 91.5% (n=108) of randomized individuals. Participants were mostly males in their late 40s with trophic ulcer duration of 13.4 months. Reduction in ulcer surface area, the primary outcome, was significantly greater for the PRP group from the first week (38.96% vs 12.46%; p<.001) through the fifth (and last) week of follow-up (91.10% vs 79.77%; p<.001). However, healing time and recurrence were not reported and there was no significant difference in complete healing rate.

Shehab et al (2023) conducted an RCT of adjunct PRP in addition to compression therapy in individuals with post-phlebotic venous ulcers.<sup>67</sup> Forty patients were randomized 1:1 to either PRP and compression therapy or placebo. The median number of treatments was 6 (range 3 to 6). Both participants and outcome assessors were blinded to treatment allocation. The median ulcer surface area, the primary outcome, was significantly lower for the PRP group (4 cm<sup>2</sup> vs 10 cm<sup>2</sup>; p=.036) as well as the median volume of ulcers (1 cm<sup>3</sup> vs 3 cm<sup>3</sup>; p=.008). This translated to individuals in the PRP group experiencing a larger drop in ulcer area (74% vs 40%; p=.008) and volume (81% vs 48%; p=.013) compared to placebo. Differences in VAS pain scores were observed in favor of the PRP group at both the 3-month and 6-month follow-ups. Nine patients in the PRP group had complete wound healing, but the authors did not report the rate of complete healing in the control group, and healing time and recurrence were not reported.

**Table 7. Summary of Key RCT Characteristics**

Study	Countries	Sites	Dates	Participants	Intervention	Control
Saha et al (2020) <sup>66</sup> ,	Iran	1	2016 to 2018	Individuals with clinically diagnosed trophic ulcers due to leprosy	Autologous PRP therapy with total contact casting (n=59)	Only total contact casting (n=59)
Shehab et al (2023) <sup>67</sup> ,	Egypt	1	2019 to 2020	Adults with chronic post-phlebotic lower limb venous ulcers	Autologous PRP therapy with compression therapy (n=20)	Placebo plus compression therapy (n=20)

PRP: platelet-rich plasma; RCT: randomized controlled trial.

**Table 8. Summary of Key RCT Results**

Study	Complete Healing	Healing Time	Pain	Quality of Life	Infection	Recurrence
Saha et al (2020) <sup>66</sup> ,	22 (39.29%) vs 11 (21.15%); p NR	NR	NR	NR	0 vs 0; p=.773	NR
Shehab et al (2023) <sup>67</sup> ,	9 (45%) vs NR	NR	BL: 6.5 vs 6.4; p=.43 3 mos: 1 vs 4.5; p<.0001 6 mos: 0.5 vs 2.2; p<.0001	NR	NR	NR

NR: not reported; RCT: randomized controlled trial.

<sup>a</sup> Percentage of healed surface area in study and control groups at 6 weeks.

Tables 9 and 10 summarize the relevance and design and conduct limitations of selected RCTs.

**Table 9. Study Relevance Limitations**

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Duration of Follow-up <sup>e</sup>
Saha et al (2020) <sup>66</sup> ,	4. Single site in Iran	4. Short duration of treatment; 8 weeks		1. Recurrence, quality of life not addressed 5. Clinical significance of difference in wound surface area not prespecified	1. 4 weeks follow-up post-treatment insufficient to assess long-term efficacy
Gupta et al (2021) <sup>62</sup> ,	4. Single site in India	4. Short duration of treatment; 6 weeks	3. Total-contact casting not used in control group	1. Complete wound healing, recurrence, quality of life not addressed 5. Clinical significance of difference in wound surface area not prespecified	1. 6 week study period insufficient to assess long-term efficacy
Hossam et al (2022) <sup>36</sup> ,	4. Single site in Egypt	1. Frequency and type of PRP treatment (injection and/or gel) not standardized		1. Complete wound healing, recurrence, quality of life not addressed 5. Primary outcome differences and timepoints were not prespecified	1. 8 week study period insufficient to assess long-term efficacy

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Duration of Follow-up <sup>e</sup>
Shehab et al (2023) <sup>67</sup> ,	4. Single site in Egypt	4. Short duration of treatment; 8 weeks 1. Frequency and type of PRP treatment (injection and/or gel) not standardized 4. Short duration of treatment; 6 weeks	1. Placebo treatment not clearly defined	1. Recurrence, quality of life not addressed	

PRP: platelet-rich plasma.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

<sup>b</sup> Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

<sup>c</sup> Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

<sup>d</sup> Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.

<sup>e</sup> Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

**Table 10. Study Design and Conduct Limitations**

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
Saha et al (2020) <sup>66</sup> , Gupta et al (2021) <sup>62</sup> ,		1-3. Blinding not described			1. Power calculations not reported	3. Confidence intervals and/or p values not reported
Hossam et al (2022) <sup>36</sup> ,		1-3. Blinding not described		1. High loss to follow-up or missing data; reasons for and extent of missingness unclear at all timepoints	1. Power calculations not reported	3. Confidence intervals not reported
Shehab et al (2023) <sup>67</sup> ,					1. Power calculations not reported	4. Complete healing rate not reported for the control group

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment



unclear; 4. Inadequate control for selection bias.

<sup>b</sup> Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

<sup>c</sup> Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

<sup>d</sup> Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

<sup>e</sup> Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

<sup>f</sup> Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

### Section Summary: Platelet-Rich Plasma for Chronic Wounds

The evidence for autologous PRP for a variety of chronic wounds includes systematic reviews, RCTs, which have been summarized in several systematic reviews, and nonrandomized trials. In meta-analyses of individuals with lower extremity diabetic ulcers, PRP demonstrated an improvement over the control groups in complete wound closure and healing time, but moderate to high risk of bias and imprecision preclude drawing conclusions on other important outcomes such as recurrence, infection, amputation, and quality of life. In individuals with venous ulcers, PRP did not demonstrate an improvement over the control groups in complete wound closure, recurrence, wound infection or quality of life, although imprecision likely precluded identifying differences on these outcomes. In individuals with pressure ulcers, although PRP reduced wound size, other important outcomes such as complete wound closure were not measured. Overall, the studies are small and of low quality, and the results should be interpreted with caution.

### Platelet-Rich Plasma for Acute Surgical or Traumatic Wounds

#### Clinical Context and Therapy Purpose

The purpose of PRP is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with acute surgical or traumatic wounds.

The following PICO was used to select literature to inform this review.

#### *Populations*

The relevant population of interest is individuals with acute surgical or traumatic wounds.

#### *Interventions*

The therapy being considered is PRP.

#### *Comparators*

Comparators of interest include standard wound care.

#### *Outcomes*

The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity.

Though not completely standardized, follow-up for acute surgical or traumatic wound symptoms would typically occur in the months after starting treatment.

### 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 events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

## Review of Evidence

### Surgical Wounds

#### Aortic Arch Repair

Zhou et al (2015) reported on a double-blind RCT with 80 patients that assessed the effect of PRP on the amount of blood transfused in the perioperative period for elective ascending and transverse aortic arch repair.<sup>68</sup> An anesthesiologist prepared the PRP so that the surgeon was unaware of the treatment group. The volume of PRP transfused was 726 mL and led to a reduction in transfusion rates for red blood cells, frozen plasma, cryoprecipitate, and platelets by 34% to 70% ( $p < .02$ ). Hospital length of stay was also reduced (9.4 days vs. 12.7 days). There was no difference in mortality between the 2 groups (1 patient in each group) and no significant differences in postoperative complications or other outcome measures. Corroboration of the effect of PRP on perioperative blood transfusion is needed.

#### Sternotomy Wounds

Serraino et al (2015) reported on a large series with historical controls that assessed the occurrence of deep sternal wound infections in patients who underwent cardiac surgery either with (2010 to 2012, 422 consecutive patients) or without (2007 to 2009, 671 consecutive patients) application of PRP.<sup>69</sup> The 2 groups were comparable at baseline. At the end of cardiac surgery, PRP gel was applied to the sternum before the closure of subcutaneous tissue. Rates of both deep and superficial wound infections were reduced in the patients treated with PRP (deep: 0.2% vs. 1.5%; superficial: 0.5% vs. 2.8%). Interpretation of these results is limited by likely differences in treatments over time. RCTs are needed to evaluate this potential use of PRP.

Zhu et al (2023) published a meta-analysis of the effect of PRP on sternal wound healing.<sup>70</sup> Eleven studies with a total of 8961 cardiac surgery patients were included. Patients were either treated with PRP ( $n=3663$ ) or control therapies ( $n=5298$ ), with sample sizes ranging from 44 to 2000 participants. PRP was found to have a significantly lower rate of sternal wound infection (Odds ratio [OR], 0.11; 95% CI, 0.03 to 0.34;  $p < .001$ ;  $I^2$ , 0%), deep sternal wound infection (OR, 0.29; 95% CI, 0.16 to 0.51;  $p < .001$ ;  $I^2$ , 32%) and superficial sternal wound infection (OR, 0.20; 95% CI, 0.13 to 0.33;  $p < .001$ ;  $I^2$ , 0%) compared to patients in the control cardiac surgery groups. All pooled estimates at no to low heterogeneity (0% to 32%). The poor quality of included studies, heterogeneous PRP preparations, and heterogeneous cardiac surgeries limit the interpretation of the results.

#### Otolaryngology

El-Anwar et al (2016) reported on an RCT that evaluated PRP in 44 children (age range, 12 to 23 months) undergoing repair of a complete cleft palate.<sup>71</sup> Speech and velopharyngeal valve movement on follow-up were evaluated by 3 judges who "usually assessed every patient blindly," physical examination, video nasoendoscopy, and audio recording of audio perceptual assessment. At 6 months, PRP-treated patients had better nasality grade on audio perceptual assessment ( $p = .024$ ) and better velopharyngeal closure on endoscopy ( $p = .016$ ).

A 2008 double-blind RCT assessed the efficacy of PRP following tonsillectomy in 70 children (age range, 4 to 15 years).<sup>72</sup> PRP was placed into the tonsil beds of half of the children, where it was directly visible. To compare pain symptoms and recovery, a daily diary was completed by the patient or a family member for 10 days after surgery. A FACES Pain Scale was used for children ages 4 to 7 years, while a numeric pain rating scale was used for children older than 7 years. Diaries from 83% of patients showed no differences in pain, medication doses, activity, and days eating solid foods between the 2 conditions.

### Other Surgical Wounds

A 2011 Norwegian trial of PRP applied to saphenous vein harvest sites after wound closure found no differences in the incidence of wound infection or cosmetic result.<sup>73</sup>

Alamdari et al (2018) published a clinical trial evaluating the efficacy of pleurodesis with a combination of PRP and fibrin glue compared with surgical intervention. The study population consisted of 52 esophageal cancer patients with postoperative chylothorax who did not respond to conservative management. Each member of the population was consecutively and randomly allocated to either a PRP fibrin glue pleurodesis arm or a surgical thoracic duct ligation arm. Twenty-six in each arm were treated with their respective interventions. The patients were distributed into the intervention arms in a way that made each group similar in terms of tumor size and patient demographics. This distribution procedure was not described. All patients (26) in the PRP treatment arm and 20 (76.9%) in the surgery arm were successfully treated ( $p=.009$ ). Seven patients (26.92%) of the PRP required a second application of the PRP fibrin glue after a week. The mean length of hospital stay was higher in the surgery group ( $53.50 \pm 16.662$  days) than the PRP group ( $36.04 \pm 8.224$  days;  $p < .001$ ). The study was limited due to the fact the procedure for randomization was not described and, thus, its efficacy cannot be evaluated.<sup>27</sup>

Mohamadi et al (2019) reported on an RCT of 110 participants in Tehran that evaluated the efficacy of PRP gel in wound healing time following pilonidal sinus surgery.<sup>74</sup> Each group included 55 participants. Follow-up duration was 9 weeks. In the treatment group, PRP was both injected into the wound weekly, as well as applied to the wound surface and covered with latex. In the control group, wound dressing was described as "classic", but no other details were provided. Little to no detail was provided about specific outcome assessment methods (*i.e.*, "pain duration was inquired from participants"). All patients completed the study and were included in the outcome assessments. PRP significantly shortened mean healing time (4.8 vs 8.7 weeks;  $p < .001$ ), pain duration (1.3 vs 3.4 weeks;  $p < .001$ ), and antibiotic consumption duration (0.57 vs 1.74 weeks;  $p < .001$ ). This RCT also performed regression analyses to evaluate the correlation between different factors in wound healing activity. Significant negative associations were found between healing time and wound volume and pain duration and angiogenesis. Notable limitations of this study included unclearly defined wound dressing in the comparator group, unblinded and poorly defined outcome assessment, short-term follow-up and lack of assessment of other important health outcomes.

Slaninka et al (2020) published an RCT that evaluated PRP in 24 individuals in the Czech Republic who had undergone dermo-epidermal skin grafts taken from the thigh area.<sup>75</sup> Indications for skin grafts were primarily hard-to-heal lower leg wounds. PRP was applied to 1 thigh and covered with Vaseline-impregnated, open-weave gauze and gauze. The control was the other thigh, which was also covered with open-weave gauze and gauze, but without PRP. Of the 24 included individuals, 3 (12.5%) were excluded after developing infections. The infections were described as first occurring on the non-PRP wound and only subsequently occurring on the PRP wound after several days. PRP significantly shortened median healing time (14 days vs 18 days;  $p=.026$ ). No other outcomes were reported. Notable limitations of the RCT include its small sample size and that it did not address important health outcomes and harms.

Wang et al (2023) published a meta-analysis

### Traumatic Wounds

Kazakos et al (2009) reported on a prospective RCT that evaluated treatment of acute traumatic wounds (open fractures, closed fractures with skin necrosis, friction burns) with platelet gel in 59 consecutive patients (27 PRP, 32 controls).<sup>76</sup> Conventional treatment consisted of topical washing and cleaning of the wounds, removal of the necrotic tissue, and dressing in petroleum jelly gauze every 2 days. In all patients with open tibial fractures, an external fixation system was applied. PRP gel was applied to the wounds after surgical debridement and placement of the external fixation system. The time needed for preparation and application of the PRP gel was 52 minutes. After that, PRP gel was

applied to the wounds once weekly in the outpatient clinic until there was adequate tissue regeneration (mean, 21 days) sufficient to undergo reconstructive plastic surgery. Control patients receiving conventional treatment required a mean of 41 days for adequate tissue regeneration. Pain scores were significantly lower in PRP-treated patients at 2 and 3 weeks (visual analog scale score, 58 PRP vs. 80 controls). Although these results are encouraging, additional study with a larger number of patients is needed.

Marck et al (2016) reported on a randomized, double-blind, within-patient-controlled study in patients with deep dermal to full-thickness burns undergoing split-skin graft, comparing PRP with usual care.<sup>77</sup> The study randomized 52 patients, 50 of whom received the allocated PRP intervention. There were no significant differences in short-term (5 to 7 days) rates in graft take in the intervention and control areas on each patient. At 3, 6, and 12 months, there were no significant differences in skin appearance or epithelialization scores.

Yeung et al (2018) performed a prospective RCT to test the efficacy of lyophilized platelet-rich plasma powder (LPRP) on the healing rate of wounds in patients with deep, second-degree burn injuries in comparison with a control group using a placebo. LPRP was dissolved in a solution and applied on deep second-degree burn wounds once per day for 4 consecutive days. Twenty-seven patients with deep second-degree burns were recruited and then those that met eligibility criteria were randomized into 2 groups. The LPRP group received the intervention (n=15) and the control group received a placebo application (n=12). A concentration of  $1.0 \times 10^7$  platelets/cm<sup>2</sup> (wound area) was sprayed on the wound evenly. Function was assessed by the percentage of wound closure and bacteria picking out rate at weeks 2 and 3. The mean burn area of control for the LPRP was  $75.65 \pm 50.72$  cm<sup>2</sup> and  $99.73 \pm 70.17$  cm<sup>2</sup> (p=.0013), respectively. In the control group, the original wound area was 25.49 cm<sup>2</sup> at baseline, 23.79 cm<sup>2</sup> (6.67% healed) at week 2, and 4.34 cm<sup>2</sup> (86.40% healed) at week 3. In the LPRP group, the original wound area was 84.36 cm<sup>2</sup>, followed by 23.96 cm<sup>2</sup> (71.59% healed) at week 2, and 0.63 cm<sup>2</sup> (99.24% healed) at week 3. The wound closure rate at week 2 in the LPRP group reached nearly 80% and was greater than 90% by week 3, showing a significant difference (p<.05). Alternatively, in the control group, the wound closure rates were 60% and 80% in 2 and 3 weeks, respectively. The postoperative infection rate in the LPRP (26.67%) was lower than the control group (33.33%). Neither was significant, statistically. One limitation of this study is that the powder is made by an independent lab and dissolved in a specified amount of water. This provides an opportunity for accidental error-this may also be the case with some liquid PRP.<sup>78</sup>

Huang et al (2021) published a meta-analysis of 8 RCTs representing 539 patients with burn wounds.<sup>79</sup> The healing rate of burn wounds was improved with PRP (OR, 4.43; 95% CI, 2.13 to 9.22), yielding a significantly shorter wound healing time (OR, -4.23; 95% CI, -5.48 to -2.98) compared to conventional dressings for both superficial and deep burn groups. Incidence of adverse events, pain scores, and scar scores was also all improved in the PRP treatment group. Interpretation of results is limited by risks of bias arising from lack of blinding, small study size, heterogeneous PRP preparations, and short follow-up durations.

Imam et al (2023) published a meta-analysis of 13 comparative studies, including 808 individuals with burn wounds who were treated with PRP (n=413) or standard wound therapy (n=395) with sample sizes ranging from 25 to 100 individuals.<sup>80</sup> PRP had a shorter healing time than compared to standard therapy (Mean difference [MD], -5.80; 95% CI, -7.73 to -3.88; p<.001) as well as a higher healing rate (OR, 3.14; 95% CI, 2.05 to 4.8; p<.001) although these pooled estimates had substantial ( $I^2=93\%$ ) and moderate heterogeneity ( $I^2=42\%$ ), respectively. Individuals treated with PRP also had a higher percentage of graft take area (MD, 4.39; 95% CI, 1.51 to 7.26; p<.001) and higher percent of area healed (MD, 12.67; 95% CI, 9.79 to 15.55, p<.001) compared to standard therapy for burn wounds with a low level of heterogeneity. No differences were observed in the graft take ratio or infection rates which showed low heterogeneity across studies in the pooled estimates. Interpretation of results is limited by risks of bias arising from low overall study quality, small study sizes, heterogeneous

PRP preparations, limited number of studies included for some comparisons, and short follow-up durations.

### **Section Summary: Platelet-Rich Plasma for Acute Surgical or Traumatic Wounds**

The evidence for autologous PRP for a variety of acute surgical or traumatic wounds includes systematic reviews and RCTs. For a variety of other conditions, studies have either not demonstrated a benefit or have demonstrated small benefits in studies with methodologic limitations.

### **Supplemental Information**

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

### **Practice Guidelines and Position Statements**

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

#### **American College of Physicians**

In 2015, the American College of Physicians (ACP) published guidelines on treatment of pressure ulcers.<sup>81</sup> The guidelines noted that "although low-quality evidence suggests that dressings containing PDGF [platelet-derived growth factors] promote healing, ACP supports the use of other dressings such as hydrocolloid and foam dressings, which are effective at promoting healing and cost less than PDGF dressings." A search of the ACP website on December 1, 2020 found that this 2015 guideline is now listed as inactive.

#### **Association for the Advancement of Wound Care**

The Association for the Advancement of Wound Care developed guideline recommendations for the management of pressure ulcers (2010)<sup>82</sup>, and venous ulcers (2015)<sup>83</sup>:

- Pressure ulcer: "Growth factors are not indicated for PU [pressure ulcers] at this time." (level C evidence - no randomized controlled trials (RCTs) available comparing growth factors with A-level dressings)<sup>82</sup>.
- Venous ulcer: "Platelet-derived growth factor has shown no significant effects on VU [venous ulcer healing or recurrence]." (level A evidence)<sup>83</sup>.

#### **National Institute for Health and Care Excellence**

In 2019, the National Institute for Health and Care Excellence updated its guidance on the prevention and management of diabetic foot problems.<sup>84</sup> The guidance stated that neither autologous platelet-rich plasma gel nor platelet-derived growth factors should be offered in the treatment of diabetic foot ulcers.

#### **U.S. Preventive Services Task Force Recommendations**

Not applicable.

#### **Medicare National Coverage**

In 2012, the Centers for Medicare & Medicaid Services (CMS) revised its national coverage decision on autologous blood-derived products for chronic non-healing wounds.<sup>85,86</sup> This revision replaces prior noncoverage decisions.<sup>87,88</sup>

The Centers for Medicare & Medicaid Services covers autologous PRP only for patients who have chronic non-healing diabetic, pressure, and/or venous wounds and when all of the following conditions are met: "The patient is enrolled in a clinical research study that addresses the following questions using validated and reliable methods of evaluation...

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

"Prospectively, do Medicare beneficiaries that have chronic non-healing diabetic, venous and/or pressure wounds who receive well-defined optimal usual care, along with PRP therapy, experience clinically significant health outcomes compared to patients who receive well-defined optimal usual care for chronic non-healing diabetic, venous and/or pressure wounds as indicated by addressing at least 1 of the following:

- Complete wound healing?
- Ability to return to previous function and resumption of normal activities?
- Reduction of wound size or healing trajectory which results in the patient's ability to return to previous function and resumption of normal activities?"

In response to a formal request from Nuo Therapeutics on May 9, 2019, CMS began a fourth reconsideration of its national coverage decision.<sup>61</sup> To inform this reconsideration, the Mayo Evidence-based Practice Center performed a technology assessment that was published by Qu et al (2020) and its results are described above in the Rationale section.<sup>89</sup> Following their review of this evidence, on December 21, 2020, CMS posted a Proposed Decision Memorandum that proposes to expand its 2012 Coverage with Evidence Development decision to cover any use of autologous PRP "...for the treatment of chronic non-healing diabetic wounds under section 1862(a)(1)(A) of the Social Security Act (the Act)."<sup>88</sup> This decision is based on the evidence described above that is sufficient "...to demonstrate that patients with diabetic ulcers who are treated with autologous PRP have better outcomes (complete wound healing) when compared to patients who receive standard care." CMS additionally noted that a limitation of the evidence is that "None of these studies addressed whether or not PRP affected a patient's ability to return to previous function and resumption of normal activities, or resulted in reduction of wound size or healing trajectory as an intermediary towards a formal endpoint of a patient's ability to return to previous function and resumption of normal activities."

For other chronic non-healing wounds, "CMS proposes that coverage of autologous PRP for the treatment of all other chronic non-healing wounds will be determined by local Medicare Administrative Contractors (MACs) under section 1862(a)(1)(A) of the Act."

In April 2021, CMS published an updated decision memo following the fourth reconsideration of the national coverage analysis stating that CMS will "cover autologous platelet-rich plasma (PRP) for the treatment of chronic non-healing diabetic wounds under section 1862(a)(1)(A) of the Social Security Act (the Act) for a duration of 20 weeks, when prepared by devices whose FDA cleared indications include the management of exuding cutaneous wounds, such as diabetic ulcers. Coverage of autologous PRP for the treatment of chronic non-healing diabetic wounds beyond 20 weeks will be determined by local Medicare Administrative Contractors (MACs).

Coverage of autologous PRP for the treatment of all other chronic non-healing wounds will be determined by local Medicare Administrative Contractors (MACs) under section 1862(a)(1)(A) of the Act."<sup>90</sup>

### Ongoing and Unpublished Clinical Trials

Some larger studies that might influence this review are listed in Table 9.

**Table 9. Summary of Key Trials**

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT05979584	Platelet Rich Plasma VS Platelet Fibrin Plasma in Treatment of Diabetes Foot Ulcer: a Randomized Controlled Trial	56	Dec 2024

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT02312596 <sup>a</sup>	A Prospective, Randomized Clinical Trial of PRP Concepts Fibrin Bio-Matrix in Non-Healing Diabetic Foot Ulcers	200	Dec 2021
NCT02312570 <sup>a</sup>	A Prospective, Randomized Clinical Trial of PRP Concepts Fibrin Bio-Matrix in Chronic Non-Healing Pressure Ulcers	200	Dec 2021
NCT02307448 <sup>a</sup>	Effectiveness of Autologous Platelet Rich Plasma in the Treatment of Chronic Non-Healing Wounds	80	Dec 2022
NCT02402374 <sup>a</sup>	Randomized, Placebo-controlled, Blind-assessor Study to Evaluate the Safety and Efficacy of Autologous Platelet Rich Plasma Gel Prepared With the RegenKit-BCT Plus Family of Kits for the Treatment of Diabetic Foot Ulcer	192	Dec 2020 (unknown)
<b>Unpublished</b>			
NCT02071979 <sup>a</sup>	Registry Trial of the Effectiveness of Platelet Rich Plasma for Chronic Non-Healing Wounds (CMS)	1500	Jan 2018 (terminated; updated 01/18)

NCT: national clinical trial; PRP: autologous platelet-rich plasma.

<sup>a</sup> Denotes industry-sponsored or cosponsored trial.

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## Documentation for Clinical Review

- No records required

## 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.*

*The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.*

Type	Code	Description
CPT®	0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed
	86999	Unlisted transfusion medicine procedure
HCPCS	G0460	Autologous platelet rich plasma (PRP) or other blood-derived product for nondiabetic chronic wounds/ulcers (includes, as applicable: administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment) <b>(Code revision effective 7/1/2023)</b>
	G0465	Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes, as applicable: administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment) <b>(Code revision effective 7/1/2023)</b>
	P9020	Platelet rich plasma, each unit

Type	Code	Description
	S0157	Becaplermin gel 0.01%, 0.5 gm
	S9055	Procuren or other growth factor preparation to promote wound healing

## Policy History

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

Effective Date	Action
09/12/2008	BCBSA Medical Policy adoption 2.01.16. References updated. Coding update.
12/13/2010	Coding Update
07/01/2011	Policy title change from Recombinant and Autologous Platelet-Derived Growth Factors as a Primary Treatment of Wound Healing and Other Miscellaneous Conditions in the Outpatient Setting without position change
06/13/2012	Coding Update
06/28/2013	Coding Update
05/01/2016	Policy title change from Recombinant and Autologous Platelet-Derived Growth Factors as a Treatment of Wound Healing and Other Non-Orthopedic Conditions. Policy revision without position change.
03/01/2017	Policy revision without position change
03/01/2018	Policy revision without position change
03/01/2019	Policy revision without position change
03/01/2020	Coding Update
05/01/2020	Annual review. No change to policy statement. Literature review updated.
03/01/2021	Annual review. No change to policy statement. Policy guidelines and literature updated. Coding update.
03/01/2022	Annual review. No change to policy statement. Literature review updated. Coding update.
03/01/2023	Annual review. No change to policy statement. Policy guidelines and literature review updated.
08/01/2023	Coding update.
03/01/2024	Annual review. Policy statement, guidelines and literature review updated.

## Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

**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 and Feedback (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 at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: [MedPolicy@blueshieldca.com](mailto:MedPolicy@blueshieldca.com)

*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.*

**Appendix A**

POLICY STATEMENT	
BEFORE	AFTER
<p><b>Red font: Verbiage removed</b></p>	
<p><b>Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions 2.01.16</b></p> <p><b>Policy Statement:</b></p> <ol style="list-style-type: none"> <li>I. Use of platelet-rich plasma (PRP) (i.e., autologous blood-derived preparations) is considered <b>investigational</b> for the treatment of acute or chronic wounds, including surgical wounds and nonhealing ulcers and certain other non-orthopedic conditions.</li> </ol> <p><b>Note:</b> Please refer to the Rationale section of this policy for the non-orthopedic conditions and to Blue Shield of California’s Medication Policy: <b>REGANEX</b> (becaplermin, topical) for coverage criteria.</p>	<p><b>Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions 2.01.16</b></p> <p><b>Policy Statement:</b></p> <ol style="list-style-type: none"> <li>I. Use of platelet-rich plasma (PRP) (i.e., autologous blood-derived preparations) is considered <b>investigational</b> for the treatment of acute or chronic wounds, including surgical wounds and nonhealing ulcers and certain other non-orthopedic conditions.</li> </ol>