Medical Coverage Policy | Orthopedic Applications of Platelet-Rich Plasma

EFFECTIVE DATE: 10|01|2023
POLICY LAST REVIEWED: 05|07|2025

OVERVIEW
The use of platelet-rich plasma has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of platelet-rich plasma has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
Medicare Advantage Plans
Use of platelet-rich plasma is not covered for all orthopedic indications as the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Commercial Products
Use of platelet-rich plasma is not medically necessary for all orthopedic indications as the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

COVERAGE
Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable not medically necessary/not covered benefits/coverage.

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

Autologous platelet concentrate suspended in plasma, also known as platelet-rich plasma, can be prepared from samples of centrifuged autologous blood. Exposure to a solution of thrombin and calcium chloride degranulates platelets, releasing the various growth factors. The polymerization of fibrin from fibrinogen creates a platelet gel, which can then be used as an adjunct to surgery with the intent of promoting hemostasis and accelerating healing. In the operating room setting, platelet-rich plasma has been investigated as an adjunct to various periodontal, reconstructive, and orthopedic procedures. For example, bone morphogenetic proteins are a type of transforming growth factor, and thus platelet-rich plasma has been used in conjunction with bone-replacement grafting (using either autologous grafts or bovine-derived xenograft) in periodontal and maxillofacial surgeries. Alternatively, platelet-rich plasma may be injected directly into various tissues. Platelet-rich plasma injections have been proposed as a primary treatment of miscellaneous conditions, such as epicondylitis, plantar fasciitis, and Dupuytren contracture.

Injection of platelet-rich plasma for tendon and ligament pain is theoretically related to prolotherapy. However, prolotherapy differs in that it involves the injection of chemical irritants intended to stimulate inflammatory responses and induce the release of endogenous growth factors.

Platelet-rich plasma is distinguished from fibrin glues or sealants, which have been used 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) and VITASEAL™ (Johnson & Johnson Surgical Technologies) are examples of commercially available fibrin sealants. Autologous fibrin sealants can be created from platelet-poor plasma. This evidence review does not address the use of fibrin sealants.

Regulatory Status

The U.S. Food and Drug Administration (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 1,270 and 1,271. Blood products such as platelet-rich plasma are included in these regulations. Under these regulations, certain products including blood products such as platelet-rich plasma are exempt and therefore do not follow the traditional FDA regulatory pathway. To date, the FDA has not attempted to regulate activated platelet-rich plasma.

A number of platelet-rich plasma preparation systems are available, many of which were cleared for marketing by the FDA through the 510(k) process for producing platelet-rich preparations intended to be mixed with bone graft materials to enhance the bone grafting properties in orthopedic practices. The use of platelet-rich plasma outside of this setting (eg, an office injection) would be considered off-label. The Aurix System® (previously called AutoloGel™; Nuo Therapeutics) and SafeBlood® (SafeBlood Technologies) are 2 related but distinct autologous blood-derived preparations that can be used at the bedside for immediate application. Both AutoloGel™ and SafeBlood® have been specifically marketed for wound healing. Other devices may be used during surgery (eg, autoLog® Autotransfusion system [Medtronic], the SmartPRePÒ [Harvest Technologies] device). The Magellan® Autologous Platelet Separator System (Isto Biologics) includes a disposable kit for use with the Magellan Autologous Platelet Separator portable tabletop centrifuge. GPS® II (BioMet Biologics), a gravitational platelet separation system, was cleared for marketing by the FDA through the 510(k) process for use as disposable separation tube for centrifugation and a dual cannula tip to mix the platelets and thrombin at the surgical site. (GPS® III [Zimmer Biomet] is now available). Filtration or plasmapheresis may also be used to produce platelet-rich concentrates. The use of different devices and procedures can lead to variable concentrations of activated platelets and associated proteins, increasing variability between studies of clinical efficacy.

Primary Treatment for Tendinopathies

For individuals with tendinopathy who receive platelet-rich plasma injections, the evidence includes multiple randomized controlled trials (RCTs) and systematic reviews with meta-analyses. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. Findings from meta-analyses of RCTs have been mixed and have generally found that platelet-rich plasma did not have a statistically and/or clinically significant impact on symptoms (ie, pain) or functional outcomes. Findings from a subsequently published RCT failed to find improvement compared with placebo. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Primary Treatment for Non-Tendon Soft Tissue Injury or Inflammation

For individuals with non-tendon soft tissue injury or inflammation (eg, plantar fasciitis) who receive platelet-rich plasma injections, the evidence includes several small RCTs, multiple prospective observational studies, and systematic reviews. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. The 2014 systematic review, which identified 3 RCTs on platelet-rich plasma for plantar fasciitis, did not pool study findings. Results among the remaining RCTs were inconsistent. The largest RCT showed that treatment using platelet-rich plasma compared with corticosteroid injection resulted in statistically significant improvement in pain and disability, but not quality of life. A 2023 systematic review found improved VAS (Visual Analogue Scale) scores with platelet-rich plasma compared to

corticosteroid injections out to 6 months duration, but numerical differences between groups were small. Larger RCTs are still needed to address important uncertainties in efficacy and safety. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Primary Treatment for Osteochondral Lesions
For individuals with osteochondral lesions who receive platelet-rich plasma injections, the evidence includes an open-labeled quasi-randomized study. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. The quasi-randomized study found a statistically significant greater impact on outcomes in the platelet-rich plasma group than in the hyaluronic acid group. Limitations of the evidence base include lack of adequately randomized studies, lack of blinding, lack of sham controls, and comparison only to an intervention of uncertain efficacy. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Primary Treatment for Knee or Hip Osteoarthritis
For individuals with knee or hip osteoarthritis who receive platelet-rich plasma injections, the evidence includes multiple RCTs and systematic reviews. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. Most trials have compared platelet-rich plasma with hyaluronic acid for knee osteoarthritis. Systematic reviews have generally found that platelet-rich plasma was more effective than placebo or hyaluronic acid in reducing pain and improving function. However, systematic review authors have noted that their findings should be interpreted with caution due to important limitations including significant residual statistical heterogeneity, questionable clinical significance, and high risk of bias in study conduct. RCTs with follow-up durations of at least 12 months published subsequent to the systematic reviews found statistically significantly greater 12-month reductions in pain and function scores, but these findings were also limited by important study conduct flaws including potential inadequate control for selection bias and limited or unclear blinding. Also, benefits were not maintained at 5 years. Using hyaluronic acid as a comparator is questionable, because the evidence demonstrating the benefit of hyaluronic acid treatment for osteoarthritis is not robust. Two systematic reviews evaluating hip osteoarthritis did not report any statistically or clinically significant differences in pain or functional outcomes compared to hyaluronic acid, corticosteroids or placebo. Additional studies comparing platelet-rich plasma with placebo and with alternatives other than hyaluronic acid are needed to determine the efficacy of platelet-rich plasma for knee and hip osteoarthritis. Studies are also needed to determine the optimal protocol for delivering platelet-rich plasma. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Adjunct to Surgery
For individuals with anterior cruciate ligament reconstruction who receive platelet-rich plasma injections plus orthopedic surgery, the evidence includes several systematic reviews of multiple RCTs and prospective studies and a retrospective matched case-control study. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. In 2 systematic reviews that conducted a meta-analysis, adjunctive platelet-rich plasma treatment did not result in a significant effect on International Knee Documentation Committee scores, a patient-reported, knee-specific outcome measure that assesses pain and functional activity. One systematic review found improvements with platelet-rich plasma compared to controls in outcomes at 6 months, but these differences were determined to be clinically irrelevant with the exception of pain at 6 months which was improved with platelet-rich plasma. Individual trials have shown mixed results. A retrospective matched case-control study found no differences in knee function scores or time to return of activity between platelet-rich plasma and matched-control groups at 2 years; however, the platelet-rich plasma group demonstrated a higher rate of postoperative knee motion loss compared with the control group. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with hip fracture who receive platelet-rich plasma injections plus orthopedic surgery, the evidence includes an open-labeled RCT. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The single open-label RCT failed to show a statistically significant reduction in the need for surgical revision with the

addition of platelet-rich plasma treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with long bone nonunion who receive platelet-rich plasma injections plus orthopedic surgery, the evidence includes three RCTs. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. One trial with a substantial risk of bias failed to show significant differences in patient-reported or clinician-assessed functional outcome scores between those who received platelet-rich plasma plus allogenic bone graft and those who received only allogenic bone graft. While the trial showed ~~a~~ statistically significant increases in the proportion of bones that healed in patients receiving platelet-rich plasma in a modified intention-to-treat analysis, the results did not differ in the intention-to-treat analysis. The second RCT, which compared platelet-rich plasma with recombinant human bone morphogenetic protein-7, also failed to show any clinical or radiologic benefits of platelet-rich plasma over morphogenetic protein-7. The third RCT reported no difference in the number of unions or time to union in patients receiving platelet-rich plasma injections versus no treatment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with rotator cuff repair who receive platelet-rich plasma injections plus orthopedic surgery, the evidence includes multiple RCTs and systematic reviews. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. Although systematic reviews consistently found significant reductions in pain with platelet-rich plasma at 12 months, important study conduct and relevance weaknesses limit interpretation of these findings. While the systematic reviews and meta-analyses generally failed to show a statistically and/or clinically significant impact on other outcomes, 1 meta-analysis found a statistically significant reduction in retear rate in a subgroup analysis of 4 RCTs that were at least 24 months in duration. The findings of a subsequently published 10-year follow-up of a small RCT failed to demonstrate the superiority of platelet-rich plasma over control for clinical and radiologic outcomes. Two newer RCTs also found no difference in the addition of platelet-rich plasma over control in functional outcomes at either 6months or 1 year follow-up. The variability in platelet-rich plasma preparation techniques and platelet-rich plasma administration limits the generalizability of the available evidence. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals undergoing spinal fusion who receive platelet-rich plasma injections plus orthopedic surgery, the evidence includes a single small RCT and a few observational studies. Relevant outcomes include symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. Studies have generally failed to show a statistically and/or clinically significant impact on symptoms (ie, pain). The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with subacromial decompression surgery who receive platelet-rich plasma injections plus orthopedic surgery, the evidence includes a small RCT. Relevant outcome are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. A single small RCT failed to show a reduction in self-assessed or physician-assessed spinal instability scores with platelet-rich plasma injections. However, subjective pain, use of pain medications, and objective measures of range of motion showed clinically significant improvements with platelet-rich plasma. Larger trials are required to confirm these benefits. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with total knee arthroplasty who receive platelet-rich plasma injections plus orthopedic surgery, the evidence includes systematic reviews. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The reviews showed no significant differences between the platelet-rich plasma and untreated control groups in range of motion, functional outcomes, and long-term pain. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

CODING

The following codes are not covered for Medicare Advantage Plans and not medically necessary for Commercial products:

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

0481T Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed

C1734 Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)

P9020 Platelet rich plasma, each unit

RELATED POLICIES

Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions

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Provider Update, July 2025
Provider Update, August 2024
Provider Update, August 2023
Provider Update, September 2022
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