PLATELET DERIVED GROWTH FACTORS FOR TREATMENT OF WOUNDS

Policy Number: 2014T0523J
Effective Date: April 1, 2014

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INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificate of Coverage (COC) or Summary Plan Description (SPD) and Medicaid State Contracts) may differ greatly from the standard benefit plans upon which this Medical Policy is based. In the event of a conflict, the enrollee’s specific benefit document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the enrollee specific plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

COVERAGE RATIONALE

Recombinant-Human Platelet Derived Growth Factors

When used according to U.S. Food and Drug Administration (FDA) approved indications, becaplermin (Regranex® Gel) is proven and medically necessary for the treatment of lower extremity diabetic neuropathic ulcers.

In June 2008, the U.S. Food and Drug Administration (FDA) announced the addition of a boxed warning to the labeling of becaplermin (Regranex Gel). Please see the U.S. Food and Drug Administration section for more information.

Platelet Rich Plasma

Autologous platelet rich plasma (e.g., Procuren®, AutoloGel®, or SafeBlood®) is unproven and not medically necessary for the treatment of wounds.

The better designed studies do not demonstrate that autologous platelet rich plasma such as Procuren, AutoloGel or SafeBlood improves health outcomes in patients with wounds. The
remaining studies have design flaws that do not allow confidence in analyzing final study results. The clinical utility of autologous platelet rich plasma remains to be determined in larger well-designed controlled clinical trials comparing their use with standard wound care.

APPLICABLE CODES

The Current Procedural Terminology (CPT®) codes and Healthcare Common Procedure Coding System (HCPCS) codes listed in this policy are for reference purposes only. Listing of a service code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other policies and coverage determination guidelines may apply. This list of codes may not be all inclusive.

<table>
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<th>HCPCS Code (Proven)</th>
<th>Description</th>
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<tr>
<td>S0157</td>
<td>Becaplermin gel 0.01%, 0.5 gm</td>
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<tr>
<th>CPT® Code (Unproven)</th>
<th>Description</th>
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<tr>
<td>0232T</td>
<td>Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed</td>
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CPT® is a registered trademark of the American Medical Association.

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<th>HCPCS Code (Unproven)</th>
<th>Description</th>
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<td>G0460</td>
<td>Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment</td>
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<tr>
<td>S9055</td>
<td>Procuren or other growth factor preparation to promote wound healing</td>
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DESCRIPTION OF SERVICES

Recombinant-Human Platelet-Derived Growth Factors: Platelet-derived growth factors are applied directly to the wound surface to promote growth of skin, soft tissue, and blood vessels. Recombinant DNA technology has been used to produce a recombinant human platelet-derived growth factor (rPDGF, rPDGF-BB, or rhPDGF-BB). Becaplermin (tradename Regranex Gel) is not an autologous product, but is a commercially prepared biotechnology product with recombinant PDGF as the active ingredient. The growth factor is produced in the laboratory by inserting a gene into yeast.

Platelet Rich Plasma: Platelet-rich plasma (also known as platelet-enriched plasma, platelet-rich concentrate, autogenous platelet gel, or platelet releasate) is being evaluated as an enhancement for soft-tissue healing by placing supraphysiologic concentrations of autologous platelets at the site of tissue damage. AutoloGel and SafeBlood are autologous preparations in which blood is drawn from the patient and centrifuged to create platelet-rich plasma that is applied to the wound. Procuren® an autologous product that has been used as treatment in the past for chronic wound healing, but it is no longer manufactured or commercially available.

CLINICAL EVIDENCE

The clinical evidence was reviewed on January 14, 2014 with no additional information identified that would change the proven and medically necessary for Recombinant-Human Platelet Derived
Growth Factors when used according to U.S. Food and Drug Administration (FDA) labeled indications.

The clinical evidence was reviewed on January 14, 2014 with no additional information identified that would change the unproven and not medical necessary conclusion for the use of Platelet Rich Plasma.

**Becaplermin**

The earlier studies evaluating recombinant PDGF or becaplermin for chronic diabetic ulcers were well-designed with large sample sizes. Results of these studies demonstrate that becaplermin, in conjunction with good wound care, is efficacious in accelerating wound closure of chronic diabetic ulcers (Embil et al., 2000; Ehrlich and Freedman, 2002; Wieman et al., 1998; Smiell et al., 1999). Significant increases in the incidence of complete wound closure and decreases in the time to achieve complete wound healing were observed in patients receiving the study medication compared with those receiving placebo.

A total of 922 patients with full-thickness diabetic neuropathic ulcers were entered into 1 of 5 randomized prospective blinded clinical trials comparing treatment of recombinant PDGF with placebo gel. Results showed that patients treated with PDGF had a significant increase in complete healing and decreased time to complete healing compared with patients given placebo (Steed, 2006).

Buchberger et al. (2011) assessed the safety, efficacy and effectiveness of growth factors alone or in combination with other technologies in the treatment of diabetic foot ulcers (DFU). The authors identified 25 studies comparing becaplermin, rhEGF, bFGF and metabolically active skin grafts (Dermagraft and Apligraf) with standard wound care (SWC) alone or extracellular wound matrix. Study duration ranged from 12 to 20 weeks and the study population comprised between 17 and 382 patients. Treatment with becaplermin, rhEGF, Dermagraft and Apligraf resulted in a higher incidence of complete wound closure and shorter time to complete wound healing with statistically significant differences. The authors concluded that add-on therapy with growth factors for treating uncomplicated DFU could be an alternative to SWC alone.

**Professional Societies**

**American Society of Plastic Surgeons:** In a clinical practice guideline for chronic wounds of the lower extremity, the American Society of Plastic Surgeons indicates that there is evidence that recombinant human platelet-derived growth factor-BB (PDGF) may promote healing of chronic diabetic neurotrophic foot ulcers, when combined with basic preferred practices in wound care (American Society of Plastic Surgeons, 2007).

**Wound Healing Society:** In guidelines for the treatment of diabetic ulcers, the Wound healing Society states that Platelet-derived growth factor (PDGF) is effective in treating diabetic neurotrophic foot ulcers (Level 1) (Wound Healing Society, 2006a).

In guidelines for the treatment of pressure ulcers, the Wound Healing Society states that the use of growth factor therapy [this includes platelet-derived growth factor] should be considered for pressure ulcers that are not responsive to initial comprehensive therapy and/or before surgical repair (Level II) (Wound Healing Society, 2006b).

In guidelines for the treatment of venous ulcers, the Wound Healing Society states that cytokine growth factors [includes platelet-derived growth factor] have yet to be shown to demonstrate sufficient statistically significant results of effectiveness to recommend any of them for treatment of venous ulcers, although isolated reports suggest their potential usefulness (Level I) (Wound Healing Society, 2006c).
**Platelet Rich Plasma**

Carter et al. (2011) conducted a systematic review and meta-analysis to evaluate the use of platelet rich plasma (PRP) for the treatment of cutaneous wounds compared to standard wound care. Twenty-four studies met inclusion criteria. These studies included 3 systematic reviews, 12 randomized controlled trials, 2 prospective cohort studies, 3 prospective comparative studies and 4 retrospective reviews. The results of the meta-analysis suggested that PRP therapy can positively impact wound healing and associated factors such as pain and infection in cutaneous wounds. Limitations of the studies included heterogeneous patient populations, lack of long-term follow-up, and pooling of data on different types of PFG products and regimens. Several of the studies included in the meta-analysis had conflicting results.

Litmathe et al. (2009) performed a prospective, double-blind study in 44 high-risk patients for wound healing complications (e.g., obesity, diabetes, smokers, peripheral vascular disease, heart failure) after cardiac surgery. The study group was treated with autologous platelet gel (APG). The control group underwent conventional wound treatment. The incidence of major and minor wound complications at the thoracotomy, as well as in the area of saphenous vein harvesting, was not pronounced in either of the groups. The authors concluded that despite promising results in other fields of surgery, APG shows no beneficial effect in high-risk patients undergoing cardiac surgery.

Saad Setta et al. (2011) investigated the efficiency of platelet releasate on the healing of chronic diabetic ulcers in comparison with platelet-poor plasma (PPP). This study included 24 patients with chronic diabetic ulcers. They were systematically randomized into two groups: PRP group (n = 12) and PPP group (n = 12). The results showed that healing in PRP group was significantly faster. The authors concluded that PRP enhances healing of chronic diabetic foot ulcers. These findings require confirmation in a larger study.

Lawlor et al. (2011) evaluated whether incision application of platelet-rich plasma (PRP) decreased postoperative wound complications in vascular surgery patients. A prospective, randomized trial randomized 81 incisions in 51 patients who underwent femoral artery exposure for elective revascularization procedures or endovascular abdominal aneurysm repairs. Using the ASEPSIS wound classification system, the researchers found no difference in incidence of wound infection. Wound complications occurred in 9 (23%) of 40 of PRP group and 9 (22%) of 41 of non-PRP. Severe wound complications developed in 5 (13%) PRP and 6 (5%) of non-PRP. In multivariate analysis, there were no predictors for wound infection. According to the researchers, platelet-rich plasma did not decrease the incidence of groin wound complications in these patients.

A prospective, randomized, controlled, blinded multicenter study initially included 72 patients with diabetic foot ulcers who were treated with autologous platelet-rich plasma gel or control (saline gel). Thirty-two patients were excluded from the final protocol because of protocol violations and failure to complete treatment. Significantly more wounds healed in patients treated with platelet-rich plasma gel (13 out of 16 or 81.3%) than patients treated with control gel (8 out of 19 or 42.1%) (Driver et al., 2006). Study limitations include small sample size, study supported by manufacturer, protocol violations occurring during the study period, and high rate of patient dropouts.

A prospective, randomized, controlled trial was conducted to evaluate autologous platelet concentrate used during blepharoplasty surgery in 33 patients. The study showed that although there were statistically significant differences in edema using autologous platelet gel, trends towards improvement in postoperative ecchymosis and edema were not significant (Vick et al., 2006). Study limitations include small sample size, no external controls, and lack of blinding.

Within a prospective randomized study, Buchwald et al. (2008) evaluated whether intraoperative use of autologous platelet gel on the leg during a coronary artery bypass graft (CABG) could reduce the incidence of postoperative wound healing disturbances. The application group (AG)
included 35 patients and was compared to a control group (CG) that also had 35 patients. The platelet gel, as well as the thrombin required to activate the platelets, was prepared from autologous patient blood during the operation. Wound healing was photographically documented after surgery, and the patients were contacted by telephone on day 50 after surgery to obtain information on wound healing status. During the primary clinical stay, no statistically significant differences were recorded in the number of hematomas, postoperative leg swelling, or pain level. Large-area hematomas were less frequent in the application group. In the follow-up 51 days after surgery, 17.6% (6/34) of the patients from the AG and 31.4% (11/35) of the patients from the CG showed leg wound healing disturbances. The investigators concluded that despite optimum application of the autologous platelet gel to the wound, no clinically relevant differences were found between the groups, either during the primary clinic stay or in the follow-up period.

In a controlled study by Stacey et al. (2000), 86 patients with chronic venous ulcers were randomly assigned to receive autologous platelet lysate or placebo. The results of the study demonstrated no major difference in healing outcome between the treatment and control groups.

Kirsner et al. (2010) evaluated 2,517 patients with diabetic neuropathic foot ulcers who received advance biological therapies such as Apligraf, Regranex, or Procuren. Advanced biological therapy was used on average within 28 days from the first wound clinic visit. Wounds treated with bilayered living cell therapy (Apligraf) first were 31.2% more likely to heal, and healed faster than wounds first treated with recombinant growth factor therapy and were 40.0% more likely to heal than those first treated with platelet releasate.

Kazakos et al. (2008) conducted a study to assess the benefits of using autologous platelet-rich plasma (PRP) gel in the treatment of acute limb soft tissue wounds. Fifty-nine patients with acute wounds (open fractures, closed fractures with skin necrosis and friction burns) were randomized into two groups. Group A (32 patients) were treated with conventional dressings and Group B (27 patients) were managed with local application of PRP gel. The rate of wound healing rate was significantly faster in Group B at week 1, 2 and 3. The investigators concluded that PRP gel treatment can be a valuable and effective aid in the management of acute trauma wounds. The value of this study is limited by the small sample size.

Almdahl et al. (2010) evaluated if spraying of wounds after open long saphenous vein harvesting with platelet-rich plasma might reduce the frequency of harvest site infections. A total of 140 patients undergoing first-time coronary artery bypass grafting were randomized into two groups of 70 patients. Both groups had standard surgical leg wound closure and care except topical application of platelet-rich plasma as adjunctive treatment in the active treatment group. End points were wound infection and cosmetic result at 6 weeks. The follow-up was 100% complete. Nine patients (13%) in the treatment group and eight (11%) in the control group experienced harvest site infection. The overall cosmetic result was also similar between the groups, but the top score was borderline and more frequent in the treatment group. The investigators concluded that topical application of autologous platelet-rich plasma on vein harvest wounds did not reduce the rate of surgical site infection.

Córdoba-Fernández et al. (2010) analyzed the use of autologous platelet gel in the surgical treatment of ingrown toe nails in a within-patient clinical trial. Thirty-five healthy volunteers (70 feet) underwent surgical treatment for bilateral ingrown hallux nails. Recovery time (days), postoperative pain (analog chromatic scale), and inflammation (digital circumference) at 48 hours postoperative were the outcomes of interest. Recovery time and postoperative pain were less in the experimental group, although the differences of means were not statistically significant. The investigators concluded that local application of APG in surgical ingrown toenail wounds may produce a slight increase in acute inflammatory phase dermal wound healing, but it does not cause a statistically significant reduction in recovery times or postoperative pain.

Villela and Santos (2010) systematically reviewed evidence regarding the use of platelet-rich plasma (PRP) for the topical treatment of chronic leg ulcers. The systematic review of the
A meta-analysis of treatment of chronic diabetic wounds found that platelet releasate, an autologous product, and becaplermin have improved healing rates over standard care, and becaplermin was more effective than platelet releasate after 20 weeks of treatment. Baseline effectiveness for standard care, becaplermin, platelet releasate, and wound care center care were 30.9%, 43.0%, 36.8%, and 35.6% respectively. Data for this meta-analysis was obtained from published clinical trials, meta-analyses, and data on 26,599 patients with wounds (Kantor and Margolis, 2001).

Frykberg et al. (2010) conducted a prospective case series to evaluate how a physiologically relevant concentration of an autologous platelet-rich plasma (PRP) gel affects initial wound healing trajectories of chronic, nonhealing wounds of various etiologies. Using convenience sampling methods, 49 patients with 65 nonhealing wounds (mean duration 47.8 weeks) were prescribed PRP gel. The most common wounds were pressure ulcers (n = 21), venous ulcers (n = 16) and diabetic foot ulcers (n = 14). Mean wound area and volume were 19 cm^2 and 36.2 cm^3, respectively. Following a mean of 2.8 weeks with 3.2 applications, reductions in wound volume (mean 51%, SD 43.1), area (39.5%, SD 41.2), undermining (77.8%, SD 28.9), and sinus tract/tunneling (45.8%, SD 40.2) were observed. For all wound etiologies, 97% of wounds improved. According to the investigators, the results of this study suggest the application of this PRP gel can reverse nonhealing trends in chronic wounds. These findings require confirmation in a statistically robust randomized controlled trial.
Marquez De Aracena Del Cid et al. (2009) evaluated the efficiency of the subconjunctival application of autologous regenerative factor-rich plasma (RFRP) in a study of 35 patients with different degrees of ocular alkali burns. The patients were classified into moderate and relevance groups according to the severity of the burn. A control group underwent conventional topical medical treatment. A further group was added to the severe chemical burn group, which received autohemotherapy. The clinical evolution of the lesions and the period in which the pathology prevented the patient from working were studied; monitoring was carried out until the patient had healed. In the moderate chemical burns, there was a significant reduction in corneal and conjunctival epithelization times, sick leave duration, and healing time when the patients were treated with RFRP in comparison to the control group. With regard to the severe burns, significant reduction in time to corneal scarring in those treated with RFRP in comparison to traditional treatment was reported. RFRP showed, at least as effective and less side effects than the autohemotherapy. The limitation of this study is small sample size.

Spyridakis et al. (2009) evaluated 52 patients with pilonidal sinus disease who underwent open excision and secondary closure of the surgical wound (n = 22) or additional local postoperative infusion of platelet-derived growth factors (n = 30). Duration of total wound healing and time to return to normal activities were evaluated. Wound-healing rates were much greater for the platelet group. Complete healing of the surgical wound required 24 days for the platelet group while the respective time for the control group was more than 30 days. According to the investigators, the study provides evidence that the use of platelet-derived growth factors directly to the surgical wound enhances the healing process resulting in faster recovery of patients surgically treated for pilonidal sinus disease. Study limitations include lack of blinding or randomization.

A study by Mazzucco et al. (2004) evaluated patients with dehiscent sternal wounds and patients with necrotic skin ulcers who were treated with autologous platelet gel and retrospectively compared with patients having similar lesions but undergoing traditional treatment. In patients with dehiscent sternal wounds, the healing rate and hospital stay were significantly reduced. Patients with necrotic skin ulcers required a shorter time to have surgery. Study limitations include lack of blinding or randomization, use of historical controls, and non-reporting of inclusion/exclusion criteria.

Margolis et al. (2001) conducted a retrospective cohort study of 26,599 patients from the Curative Health Services database who were treated with platelet releasate or standard wound therapy. The authors determined that more diabetic neuropathic foot ulcers treated with platelet releasate healed by 32 weeks than ulcers treated with standard wound therapy (50% versus 41% respectively). The study did not control for glycemic control or microbiologic status of the wound and commencement of treatment was not standardized.

de Leon et al. (2011) investigated clinical outcomes in chronic nonhealing wounds following the short-term use of a platelet-rich plasma (PRP) gel (AutoloGel System). The study design was a large, observational case series using a multicenter registry database (all wounds included), which compared different populations within the database. Thirty-nine centers contributed to the registry. The target population included 285 chronic wounds (patient n = 200). Wound etiologies included diabetic, pressure, or venous ulcer; dehisced, surgical, or traumatic wound; and wounds of other etiologies. Clinical relevance was determined by analyzing outcomes in wounds that responded to treatment. A positive response occurred in 96.5% of wounds within 2.2 weeks with 2.8 treatments. In 86.3% of wounds, 47.5% area reduction occurred, and 90.5% of wounds had a 63.6% volume reduction. The authors concluded that in chronic wounds recalcitrant to other treatments, utilization of PRP gel can restart the healing process. The lack of a comparison group limits the conclusions that can be reached from this study.

In a diabetic inpatient clinical guideline, the National Institute for Health and Clinical Excellence (NICE) recommends that autologous platelet-rich plasma gel and platelet-derived growth factor
Platelet Derived Growth Factors for Treatment of Wounds: Medical Policy (04/01/2014)

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

In December 1997, the FDA approved becaplermin for the treatment of patients with lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have adequate blood supply. According to FDA labeled indications, Becaplermin should be used in combination with standard ulcer wound care. This is the first FDA-approved biotechnology product to treat deep diabetic foot and leg ulcers. See the following Web site for more information: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/ucm080471.htm. Accessed January 14, 2014.

In June 2008, the FDA announced the addition of a boxed warning to the labeling of Regranex Gel 0.01% (becaplermin). The new labeling indicates that Regranex (becaplermin) Gel is contraindicated in patients with a known hypersensitivity to any component of this product (e.g., parabens) or a known neoplasm(s) at the site(s) of application. The warnings in the new labeling indicate that Regranex Gel contains becaplermin, a recombinant human platelet-derived growth factor, which promotes cellular proliferation and angiogenesis. The benefits and risks of becaplermin treatment should be carefully evaluated before prescribing. Becaplermin should be used with caution in patients with a known malignancy. Malignancies distant from the site of application have occurred in becaplermin users in both a clinical study and in postmarketing use, and an increased rate of death from systemic malignancies was seen in patients who have received 3 or more tubes of Regranex Gel. See the following Web site for more information: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2008/ucm116909.htm. Accessed January 14, 2014.

The AutoloGel Process Centrifuge is one of several devices cleared for marketing by FDA for point-of-care preparation of platelet-rich plasma (PRP) from a sample of a patient’s blood (see listings under product code JQC for additional devices). However, the AutoloGel System is currently the only autologous PRP product cleared by the FDA specifically for treatment of chronic wounds. See the following Web site for more information: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. Accessed January 14, 2014.

In April 2003, the FDA approved the use of the GPS™ Platelet Separation Kit. The GPS™ separation kit aids separation of the patient’s own blood components by density through the use of the GPS™-Thermo International Equipment Company (IEC) centrifuge. The GPS separation kit permits platelet rich plasma to be rapidly prepared from a small volume of the patient’s blood that is drawn at the time of treatment. The GPS Platelet Separation Kit is designed for use in the clinical laboratory or intraoperatively at point of care, for the safe and effective preparation of platelet poor plasma and platelet concentrate from a small sample (50-60 ml) of whole blood. See the following Web site for more information: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm?ID=10973. Accessed January 14, 2014.

Additional Products
Platelet-enriched plasma, platelet-rich concentrate, autologous platelet gel, platelet releasate, Magellan® Autologous Platelet Separator, Platelet Separator SmartPReP® Centrifuge System, Fibrinet Autologous Fibrin & Platelet System, CASCADE® Autologous Platelet System, Gravitational Platelet Separation System, Mini GPSII, SmartPReP® 2 APC system, Vitagel Surgical Hemostat
Effective August 2, 2012, Medicare has determined that platelet-rich plasma (PRP) – an autologous blood-derived product, will be covered only for the treatment of chronic non-healing diabetic, venous and/or pressure wounds and only when criteria are met. Refer to the National Coverage Determination (NCD) for Blood Derived Products for Chronic Non Healing Wounds (270.3). Local Coverage Determinations (LCDs) do exist. Refer to the LCDs for Category III CPT Codes, Non-Covered Category III CPT Codes, Noncovered Services, Non-Covered Services and Services That Are Not Reasonable and Necessary.
(Accessed January 14, 2014)

REFERENCES


Embil JM, Papp K, Sibbald G, Tousignant J, Smiell JM, Wong B, Lau CY. Recombinant human platelet-derived growth factor-BB (becaplermin) for healing chronic lower extremity diabetic...


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<th>Date</th>
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<tr>
<td>04/01/2014</td>
<td>• Reorganized policy content</td>
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<tr>
<td></td>
<td>• Updated coverage rationale; added language to indicate if service is “medically necessary” or “not medically necessary” to applicable proven/unproven statement</td>
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<td></td>
<td>• Updated supporting information to reflect the most current clinical evidence, CMS information and references</td>
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