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# Orthopedic Applications of Platelet-Rich Plasma

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## Disclaimer

*Medical policies are a set of written guidelines that support current standards of practice. They are based on current peer-reviewed scientific literature. A requested therapy must be proven effective for the relevant diagnosis or procedure. For drug therapy, the proposed dose, frequency and duration of therapy must be consistent with recommendations in at least one authoritative source. This medical policy is supported by FDA-approved labeling and/or nationally recognized authoritative references to major drug compendia, peer reviewed scientific literature and acceptable standards of medical practice. These references include, but are not limited to: MCG care guidelines, DrugDex (IIa level of evidence or higher), NCCN Guidelines (IIb level of evidence or higher), NCCN Compendia (IIb level of evidence or higher), professional society guidelines, and CMS coverage policy.*

### Carefully check state regulations and/or the member contract.

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

## Legislative Mandates

**EXCEPTION: For Illinois only:** Illinois Public Act 103-0458 [Insurance Code 215 ILCS 5/356z.61] (HB3809 Impaired Children) states all group or individual fully insured PPO, HMO, POS plans amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for therapy, diagnostic testing, and equipment necessary to increase quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

## Coverage

Use of platelet-rich plasma **is considered experimental, investigational and/or unproven** for all orthopedic indications. This includes, but is not limited to, use in the following situations:

- Primary use (injection) for the following conditions:
  1. Achilles tendinopathy,
  2. Lateral epicondylitis,
  3. Plantar fasciitis,
  4. Osteochondral lesions,
  5. Osteoarthritis.
- Adjunctive use in the following surgical procedures:
  1. Anterior cruciate ligament reconstruction,
  2. Hip fracture,
  3. Long-bone nonunion,
  4. Patellar tendon repair,
  5. Rotator cuff repair,
  6. Spinal fusion,
  7. Subacromial decompression surgery,
  8. Total knee arthroplasty.

## Policy Guidelines

None.

## Description

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

**Background**

Platelet-Rich Plasma

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 (see medical policy RX501.034).

Autologous platelet concentrate suspended in plasma, also known as PRP, 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, PRP 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 PRP has been used in conjunction with bone-replacement grafting (using either autologous grafts or bovine-derived xenograft) in periodontal and maxillofacial surgeries. Alternatively, PRP 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 PRP for tendon and ligament pain is theoretically related to prolotherapy (see medical policy MED201.013). 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 medical policy 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 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.

A number of PRP 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 PRP outside of this setting (e.g., 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 (e.g., autoLog® Autotransfusion system [Medtronic], the SmartPReP® [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.

## Rationale

Medical policies assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function - including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to 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 a technology, 2 domains are examined: the relevance and the 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. Randomized controlled trials 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.

At present, there are a large number of techniques available for the preparation of platelet-rich plasma (PRP) or PRP gel. The amount and mixture of growth factors produced by different cell-separating systems vary, and it is also uncertain whether platelet activation before the injection is necessary. (1-6)

**Platelet-Rich Plasma as a Primary Treatment for Tendinopathy**

Clinical Context and Therapy Purpose

The purpose of PRP injections is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as nonpharmacologic therapy (e.g., exercise, physical therapy), analgesics, and anti-inflammatory agents, in individuals with tendinopathy.

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

*Populations*

The relevant population of interest is individuals with tendinopathy.

*Interventions*
The therapy being considered is PRP injections. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators*
Comparators of interest include nonpharmacologic therapy (e.g., exercise, physical therapy), analgesics, and anti-inflammatory agents.

*Outcomes*
The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. The existing literature evaluating PRP injections as a treatment for tendinopathy has varying lengths of follow-up, ranging from six months to two years. While studies described below all reported at least one outcome of interest, longer follow-up was necessary to fully observe 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.

Systematic Reviews
Many systematic reviews have evaluated PRP for treating mixed tendinopathies. They include trials on tendinopathies of the Achilles, rotator cuff, patella, and/or lateral epicondyle (tennis elbow). Select, recent (i.e., 2019 to present) systematic reviews of RCTs and/or nonrandomized studies are described next. Characteristics and results of these systematic reviews are found in Tables 1 and 2.

Masiello et al. (2022) conducted a systematic review and meta-analysis of 33 RCTs (N=2025) comparing ultrasound-guided PRP to control (injection of steroids, saline, autologous whole blood, mesenchymal stem cells, or local anesthetic; dry needling; prolotherapy; or other non-injection intervention) for the treatment of tendinopathy. (7) Tendinopathies included lateral epicondylitis (n=8), plantar fasciitis (n=5), Achilles tendinopathy (n=5), rotator cuff tendinopathy (n=7), patellar tendinopathy (n=3), and carpal tunnel syndrome (n=3). Most trials (n=20) administered platelet-rich plasma as a single injection; however, up to 4 injections were administered in some trials. Few differences in efficacy between control and platelet-rich plasma were found with the exception of patients with carpal tunnel where pain and severity

scores were reduced in the short and medium term. Results were reported for individual tendinopathies and, therefore, are not included in Table 2. However, overall mean differences in pain scores were: -0.24 (95% confidence interval [CI], -0.73 to 0.25) for lateral epicondylitis, -3.62 (95% CI, -8.16 to 0.91) for plantar fasciitis, -0.17 (95% CI, -4.25 to 3.90) for Achilles tendinopathy, 0.16 (95% CI, -0.18 to 0.50) for rotator cuff tendinopathy, 0.17 (95% CI, -0.64 to 0.98) for patellar tendinopathy, and -0.24 (95% CI, -0.32 to -0.16) for carpal tunnel syndrome. The evidence was rated as low quality due to risk of bias, imprecision, and inconsistency.

Dai et al. (2023) conducted a systematic review and meta-analysis of RCTs evaluating PRP versus control (saline injection, dry needling, or no treatment) for the treatment of tendinopathy. (8) A total of 13 trials met the eligibility criteria and included patients with lateral epicondylitis (5 RCTs), Achilles tendinopathy (4 RCTs), rotator cuff tendinopathy (2 RCTs), and patellar tendinopathy (2 RCTs). Among the 13 RCTs, 7 studies were judged to be at low risk of bias and 6 were found to have a high risk of bias. The meta-analysis demonstrated that PRP was not superior to control for the primary outcomes of change in pain intensity or function at 12 weeks; these trends also persisted at 24 weeks. The authors noted that included trials displayed significant heterogeneity with respect to PRP preparation and patient characteristics and had important methodological limitations.

Muthu et al. (2021) conducted a systematic review with meta-analysis of RCTs comparing PRP, autologous blood, corticosteroids, local anesthetics, laser therapy, and surgery for patients with lateral epicondylitis. (9) A total of 25 trials met the eligibility criteria (N=2040). Results demonstrated that based on data from 22 trials, only leukocyte-rich PRP significantly improved visual analog scale (VAS) pain scores compared to saline control (weighted mean difference [MD], -14.8; 95% CI, -23.18 to -6.39); in a subgroup analysis of 14 studies with at least 12 months of follow up, the weighted MD did not reach statistical significance (-7.69; 95% CI, -27.28 to 11.90). Based on data from 11 trials, none of the interventions were superior to saline control for improvement in the Disabilities of the Arm, Shoulder, and Hand (DASH) score. Treatment ranking based on the P-score approach demonstrated that leukocyte-rich PRP was most likely to be the best treatment amongst autologous blood, corticosteroids, laser therapy, local anesthetics, and leukocyte-poor PRP.

Johal et al. (2019) conducted a systematic review and meta-analysis of RCTs on PRP for various orthopedic indications, including 10 RCTs of lateral epicondylitis. (10) The meta-analysis evaluated the standardized mean difference in pain at both 3 and 12 months. Systematic review authors used the Cochrane Collaboration risk of bias tool to assess study quality. At 12 months, pain scores were statistically significantly lower for PRP versus its comparators (i.e., steroids, whole blood, dry needling, local anesthetics). However, these results should be interpreted with caution due to important limitations including high statistical heterogeneity ($I^2$=73%), lack of a clinically significant difference (i.e., < effect size threshold of 0.5 for a clinically important difference), and moderate to high risk of bias in study conduct.

**Table 1. Systematic Reviews & Meta-Analysis Characteristics**

| Study | Dates | Trials | Participants | N (Range) | Design | Duration |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Masiello et al. (2022) (7) | Through 2021 | 33 | Patients with tendinopathy | 2025 (NR) | RCT | 3 to 36 mo |
| Dai et al. (2023) (8) | 2010-2020 | 13 | Patients with tendinopathy | 576 (23 to 79) | RCT | 4 to ≥ 24 wk |
| Muthu et al. (2021) (9) | 2010-2020 | 25 | Patients with lateral epicondylitis | 2040 (25 to 230) | RCT | 3 to 24 mo |
| Johal et al. (2019) (10) | 2010-1016 | 10 | Patients with epicondylitis | 25 to 231 | RCT | 6 wk to 24 mo |

Mo: months; NR: not reported; RCT: randomized controlled trial; wk: weeks.

**Table 2. Systematic Reviews & Meta-Analysis Results**

| Study | SMD in pain for PRP | SMD in functional disability for PRP | WMD in pain reduction (between LR-PRP and control) | WMD in functional disability (between LR-PRP and control) | WMD in pain reduction at 3 months (between LR-PRP and control) | WMD in pain reduction at 1 year (between LR-PRP and control) |
|---|---|---|---|---|---|---|
| **Dai et al. (2023) (8)** | -0.14 | 0.18 | | | | |
| 95% CI | -0.55 to 0.26 | -0.13 to 0.49 | | | | |
| **Muthu et al. (2021) (9)** | | | -14.8 | -8.77 | | -7.69 |
| 95% CI | | | -23.18 to -6.39 | -30.60 to 13.07 | | -27.28 to 11.90 |
| **Johal et al. (2019) (10)** | -0.69 | | | | | |
| 95% CI | -1.15 to -0.23 | | | | | |

CI: confidence interval; LR: leukocyte-rich; PRP: platelet-rich plasma; SMD: standard mean difference; WMD: weighted mean difference.

Randomized Controlled Trials

One larger RCT not included in the above systematic reviews was published in 2021 (N=240) comparing PRP to sham control. (11) Victorian Institute of Sport Assessment-Achilles (VISA-A) score was not significantly different between groups. Tables 3 and 4 summarize the RCT characteristics and results, respectively, and Tables 5 and 6 describe study design and conduct limitations.

**Table 3. Summary of Key RCT Characteristics**

| Study | Countries | Sites | Dates | Participants | Interventions | Comparator |
|---|---|---|---|---|---|---|
| | | | | | **Active** | **Comparator 1** |
| Kearney et al. (2021) (11) | UK | 24 | 2016-2020 | Adults with painful midportion Achilles tendinopathy lasting longer than 3 months | PRP (n=121) | Sham (n=119) |

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

**Table 4. Summary of Key RCT Results**

| Study | Other pain/disability assessment |
|---|---|
| **Kearney et al. (2021) (11)** | 6 mo VISA-A score |
| PRP | 54.4 |
| Sham | 53.4 |
| Adjusted MD; 95% CI | -2.7 (-8.8 to 3.3) |

CI: confidence interval; MD: mean difference; mo: month(s); PRP: platelet-rich plasma; RCT: randomized controlled trial; VISA-A: Victorian Institute of Sport Assessment-Achilles score.

**Table 5. Study Relevance Limitations**

| Study | Population[a] | Intervention[b] | Comparator[c] | Outcomes[d] | Follow Up[e] |
|---|---|---|---|---|---|
| Kearney et al. (2021) (11) | | 1. 37 participants received additional treatments during the 6-month follow up | 1. 40 participants received additional treatments during the 6-month follow up | | |

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

[a] Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4, Enrolled populations do not reflect relevant diversity; 5. Other.

[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5: Other.

[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.

[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.

[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other.

**Table 6. Study Design and Conduct Limitations**

| Study | Allocation[a] | Blinding[b] | Selective Reporting[c] | Follow Up[d] | Power[e] | Statistical[f] |
|---|---|---|---|---|---|---|
| Kearney et al. (2021) (11) | | 1. Single blinded (participants only) | | | | |

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

[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

[b] Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

[d] Follow-Up 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).

[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference; 4. Underpowered.

[f] Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention 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 as a Primary Treatment of Tendinopathy

Multiple RCTs and systematic reviews with meta-analyses have evaluated the efficacy of PRP injections in individuals who have tendinopathy. The majority of the more recently published systematic reviews and meta-analyses that only included RCTs failed to show a statistically and/or clinically significant impact on symptoms (i.e., pain) or functional outcomes. Although 1 systematic review found statistically significantly lower pain scores at 12 months with PRP versus the comparators, its results should be interpreted with caution due to important study conduct limitations. Additionally, in a recent RCT compared to sham control, PRP did not significantly improve pain after 6 or 12 months.

## Platelet-Rich Plasma as a Primary Treatment of Non-Tendon Soft Tissue Injury or Inflammation

Clinical Context and Therapy Purpose

The purpose of PRP injections is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as nonpharmacologic therapy (e.g., exercise, physical therapy), analgesics, and anti-inflammatory agents, in individuals with non-tendon soft tissue injury or inflammation (e.g., plantar fasciitis).

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

*Populations*

The relevant population of interest is individuals with non-tendon soft tissue injury or inflammation (e.g., plantar fasciitis).

*Interventions*
The therapy being considered is PRP injections. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators*
Comparators of interest include nonpharmacologic therapy (e.g., exercise, physical therapy), analgesics, and anti-inflammatory agents.

*Outcomes*
The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. The existing literature evaluating PRP injections as a treatment for non-tendon soft tissue injury or inflammation (e.g., plantar fasciitis) has varying lengths of follow-up. While studies described below all reported at least 1 outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, 2 years of follow-up is considered necessary to demonstrate efficacy.

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.

In individuals with non-tendon soft tissue injury or inflammation (e.g., plantar fasciitis), there are no large double-blind RCTs of sufficient duration (i.e., 2 years) to demonstrate efficacy.

Systematic Reviews
Seth et al. (2023) published a systematic review comparing corticosteroid injections to either PRP or extracorporeal shock wave therapy in patients with plantar fasciitis. (12) The studies were limited to RCTs up to April 2021. A total of 18 studies were included, 12 of which evaluated platelet-rich plasma compared to corticosteroid injections. VAS scores were higher in the corticosteroid group than the platelet-rich plasma group at both 3 (MD, 0.62; 95% CI, 0.13 to 1.12; p=.01) and 6 months (MD, 1.49; 95% CI, 0.22 to 2.76; p=.02). Notably, numerical differences between groups were small. Functional outcomes were similar with corticosteroids compared to platelet-rich plasma at 3 months but worse with corticosteroids at 6 months (American Orthopaedic Foot and Ankle Society [AOFAS] MD, -11.53; 95% CI, -16.62 to -6.43;

p<.0001). The authors deemed the evidence very low quality, and most studies had either high or unclear risk of bias.

Randomized Controlled Trials

There are several additional RCTs not included in the Seth et al. (2023) review. (13-15) None were large double-blind RCT's of sufficient duration (i.e., 2 years) to conclusively demonstrate efficacy. The RCT's compared PRP treatment with corticosteroid injection or saline injection. The PRP protocols differed across RCTs. The RCTs were small, ranging in size from 28 (15) to 155 participants. (13) Follow-up duration ranged from 6 months (15, 16) to 18 months. (14) Two were conducted in single centers in either the United Kingdom, (15) or India. (14) The other was a multicenter RCT of 5 sites in the Netherlands. (15) None prespecified any methods to assess potential harms. Results were mixed across RCTs. The largest RCT (n=115) by Peerbooms et al. (2019) compared PRP with corticosteroid injection and had a follow-up to 12 months. (13) In the RCT by Peerbooms et al. (2019), the proportion of patients with at least a 25% improvement in Foot Function Index Pain Scores between baseline and 12 months was significantly greater in the PRP group (88.4% versus 55.6%; p=0.003). Additionally, mean Foot Function Index Disability Scores were significantly lower in the PRP group at 12 months (MD, 12.0; 95% CI, 2.3-21.6). But these improvements did not translate into significantly greater quality of life in the PRP group. Also, important study design and conduct gaps exist that seriously limit the interpretation of these findings, including that analysis excluded 29% of the randomized patients, which was less than the calculated sample size. Therefore, although evidence continues to develop, important uncertainties in efficacy and safety remain and larger double-blind RCTs are still needed.

Section Summary: Platelet-Rich Plasma as a Primary Treatment of Non-Tendon Soft Tissue Injury or Inflammation

Several small RCTs, multiple prospective observational studies, and systematic reviews of these studies have evaluated the efficacy of PRP injections in individuals with chronic plantar fasciitis. The preparation of PRP and outcome measures differed across studies. Results among the RCTs were inconsistent. The largest of the RCTs showed that treatment using PRP compared with corticosteroid resulted in statistically significant improvements in pain and disability, but not quality of life. Larger RCTs completed over a sufficient duration of time (i.e., 2 years) are still needed to address important uncertainties in efficacy and safety.

**Platelet-Rich Plasma as a Primary Treatment of Osteochondral Lesions**

Clinical Context and Therapy Purpose

The purpose of PRP injections is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as nonpharmacologic therapy (e.g., exercise, physical therapy), analgesics, anti-inflammatory agents, and surgery in individuals with osteochondral lesions.

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

*Populations*

The relevant population of interest is individuals with osteochondral lesions.

*Interventions*
The therapy being considered is PRP injections. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators*
Comparators of interest include nonpharmacologic therapy (e.g., exercise, physical therapy), analgesics, anti-inflammatory agents, and surgery.

*Outcomes*
The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. The existing literature evaluating PRP injections as a treatment for osteochondral lesions has varying lengths of follow-up. While studies described below all reported at least 1 outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, 28 weeks of follow-up is considered necessary to demonstrate efficacy.

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.

Comparative Studies
No high-quality RCTs on the treatment of osteochondral lesions were identified. Mei-Dan et al. (2012) reported on a quasi-randomized study of 29 patients with 30 osteochondral lesions of the talus assigned to 3 intra-articular injections of hyaluronic acid or PRP. (17) At 28-week follow-up, scores on the AOFAS Ankle-Hindfoot Scale score improved to a greater extent in the PRP group (from 68 to 92) than in the hyaluronic acid group (from 66 to 78) ($p<0.05$). Subjective global function also improved to a greater extent in the PRP group (from 58 to 91) than in the hyaluronic acid group (from 56 to 73). Interpretation of the composite measures of VAS scores for pain and function is limited by differences between the groups at baseline. Also, neither the patients nor the evaluators were blinded to treatment in this small study.

Section Summary: Platelet-Rich Plasma as a Primary Treatment of Osteochondral Lesions
A single quasi-randomized study has evaluated the efficacy of PRP injections in individuals who have osteochondral lesions. Compared with hyaluronic acid, treatment with PRP resulted in

statistically significant improvements in AOFAS Ankle-Hindfoot Scale scores and global function, indicating improved outcomes. Adequately powered and blinded RCTs are required to confirm these findings.

**Platelet-Rich Plasma as a Primary Treatment of Knee or Hip Osteoarthritis**

Clinical Context and Therapy Purpose

The purpose of PRP injections is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as nonpharmacologic therapy (e.g., exercise, physical therapy), analgesics, anti-inflammatory agents, and surgery in individuals with knee or hip osteoarthritis.

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

*Populations*

The relevant population of interest is individuals with knee or hip osteoarthritis.

*Interventions*

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

*Comparators*

Comparators of interest include nonpharmacologic therapy (e.g., exercise, physical therapy), analgesics, anti-inflammatory agents, and surgery.

*Outcomes*

The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. The existing literature evaluating PRP injections as a treatment for knee or hip osteoarthritis has varying lengths of follow-up, ranging from 6-12 months. While studies described below all reported at least one outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, 12 months of follow-up is considered necessary to demonstrate efficacy.

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.

A number of RCTs and several systematic reviews of RCTs evaluating the use of PRP for knee osteoarthritis have been published. (10, 18-26) Protocols used in PRP interventions for knee OA varied widely. For example, in the studies identified in the Laudy et al. (2015) systematic review, PRP was prepared using single, double, or triple spinning techniques and interventions included between 1 and 3 injections delivered 1 to 3 weeks apart. (20)

Systematic Reviews

In individuals with knee osteoarthritis undergoing PRP injections, findings from 6 systematic reviews are reported. (10, 18-21, 27) The systematic review by Anil et al. (2021) did not delineate which of its included studies evaluated PRP. The systematic reviews have varied in their outcomes of interest and their findings. Systematic reviews have generally found that PRP 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.

Anil et al. (2021) published a systematic review with network meta-analysis to compare the efficacy of nonoperative injectable treatments for knee osteoarthritis (see Tables 7 and 8). (18) A total of 79 RCTs (N=8761) were included, and the follow-up ranged from 4 weeks to 24 months. Intra-articular injectable treatments included PRP, autologous conditioned serum, bone marrow aspirate concentrate, botulinum toxin, corticosteroids, hyaluronic acid, mesenchymal stem cells, ozone, saline placebo, plasma rich in growth factor, and stromal vascular fraction; the publication did not delineate the number of RCTs that specifically evaluated on PRP. At 12 months, the treatment with the highest P-Score for the MD in Western Ontario and McMaster Osteoarthritis Index (WOMAC) scale score and VAS score was stromal vascular fraction. However, the MD in WOMAC scale and VAS scores for leukocyte-poor PRP and leukocyte-rich PRP versus saline placebo at 12 months did not reach statistical significance.

Trams et al. (2020) published a systematic review that included 38 RCTs (N=2962) evaluating the effects of PRP on patients with knee osteoarthritis (see Tables 7 and 8). (19) The meta-analysis focused on the review of 33 blinded studies. Follow-up ranged from 6 months to 2 years. Comparators included hyaluronic acid in 23 studies, placebo (e.g., saline, no injection, physical therapy) in 10 studies, corticosteroids in 4 studies, and acetaminophen in 2 studies. Twenty-two studies reported VAS pain outcomes for placebo (n=5), hyaluronic acid (n=15), and corticosteroids (n=2). Placebo and hyaluronic acid subgroups showed significant VAS differences in favor of PRP ($p<.00001$). The corticosteroid subgroup was not significantly different from PRP ($p=.23$). Six studies comparing single versus multiple injections of PRP showed a significant difference in favor of 3 PRP injections ($p<.00001$). Functional outcomes were reported via the WOMAC scale for placebo (n=9), corticosteroids (n=1), and hyaluronic acid (n=15). Both pooled and subgroup analyses favored PRP ($p<.00001$). In 5 studies assessing multiple versus single PRP injections, significant differences in favor of multiple injections were found ($p<.00001$). Functional outcomes assessed via International Knee Documentation Committee (IKDC) scores were reported in 2 placebo studies and 5 hyaluronic acid studies. While a significant difference was found for hyaluronic acid ($p=.004$), no significant difference

was found for placebo (p=.24). Pooled estimates for 6 studies comparing PRP to corticosteroids, hyaluronic acid, or mesenchymal stem cells found no significant differences in Knee injury and Osteoarthritis Outcome Score (KOOS) sport, quality of life, activities of daily living, symptoms, or pain subscales. The pooled estimates for adverse events showed non-significant differences in favor of the control groups (p=.15). The risk of bias was assessed using Cochrane criteria. One study was at high risk of bias for 3 domains, 2 studies were at high risk of bias for 2 domains, and 12 studies were at high risk of bias for 1 domain. The most impacted domains were performance bias and reporting bias.

Johal et al. (2019) conducted a systematic review and meta-analysis of RCTs comparing PRP with hyaluronic acid (8 trials, n=927), or placebo (2 trials, n=105), no PRP (2 trials, n=123), acetaminophen (1 trial, n=75), or a corticosteroid (1 trial, n=48). (10) Meta-analysis of VAS pain scores showed that PRP was more effective than its comparators at 12 months (standard MD, -0.91; 95% CI, -1.41 to -0.41). However, the systematic review authors noted that important limitations of this finding included lack of a clinically significant difference (i.e., less than the effect size threshold of 0.5 for a clinically important difference), high residual statistical heterogeneity between studies ($I^2$=89%) and high risk of bias in study conduct.

Xu et al. (2017) conducted a systematic review and meta-analysis of RCTs comparing PRP with hyaluronic acid (8 trials), or placebo (2 trials), for the treatment of knee OA (see Tables 7 and 8). (27) Risk of bias was assessed using Cochrane criteria. Four studies were assessed as being of low quality, 3 as moderate quality, and 3 as high quality. Meta-analyses including 7 of the trials comparing PRP with hyaluronic acid showed that PRP significantly improved WOMAC or IKDC scores compared with hyaluronic acid at 6-month follow-up; however, when meta-analyses included only the 2 high-quality RCTs, there was not a significant difference between PRP and hyaluronic acid (see Table 8). Note that WOMAC evaluates 3 domains: pain, scored from 0 to 20; stiffness, scored from 0 to 8; and physical function, scored from 0 to 68. Higher scores represent greater pain and stiffness as well as worsened physical capability. The IKDC is a patient-reported, knee-specific outcome measure that measures pain and functional activity. In the meta- analysis comparing PRP with placebo, a third trial was included, which had four treatment groups, two of which were PRP and placebo. This analysis showed that PRP significantly improved WOMAC or IKDC scores compared with placebo; however, only one of the trials was considered high quality and that trial only enrolled 30 patients. All meta-analyses showed high heterogeneity among trials ($I^2$≥90%).

Laudy et al. (2015) conducted a systematic review of RCTs and nonrandomized clinical trials to evaluate the effect of PRP on patients with knee OA (see Tables 7 and 8). (20) Ten trials (N=1110 patients) were selected. Cochrane criteria for risk of bias were used to assess study quality, with 1 trial rated as having a moderate risk of bias and the remaining 9 trials as high risk of bias. While meta-analyses showed that PRP was more effective than placebo or hyaluronic acid in reducing pain and improving function (see Table 8), larger randomized studies with lower risk of bias are needed to confirm these results.

Chang et al. (2014) published a systematic review that included 5 RCTs, 3 quasi-randomized controlled studies, and 8 single-arm prospective series (N=1543 patients) (see Tables 7 and 8). (21) The Jadad scale was used to assess RCTs, and the Newcastle-Ottawa Scale was used to assess the other studies; however, results of the quality assessments were not reported. Meta-analysis of functional outcomes at 6 months found that the effectiveness of PRP (effect size, 1.5; 95% CI, 1.0 to 2.1) was greater than that of hyaluronic acid (effect size, 0.7; 95% CI, 0.6 to 0.9; when only RCTs were included). However, there was no significant difference at 12-month follow-up between PRP (effect size, 0.9; 95% CI, 0.5 to 1.3) and hyaluronic acid (effect size, 0.9; 95% CI, 0.5 to 1.2) when only RCTs were included. Fewer than 3 injections, single spinning, and lack of additional activators led to greater uncertainty in the treatment effects. Platelet-rich plasma also had lower efficacy in patients with higher degrees of cartilage degeneration. Results were consistent when analyzing only RCTs, but asymmetry in funnel plots suggested significant publication bias.

**Table 7. Systematic Review Characteristics for Knee Osteoarthritis**

| Study | Search Date | Trials | Participants | Design |
|---|---|---|---|---|
| Anil et al. (2021) (18) | Through 2020 | RCTs of patients receiving PRP, autologous conditioned serum, bone marrow aspirate concentrate, botulinum toxin, corticosteroids, hyaluronic acid, mesenchymal stem cells, ozone, saline placebo, plasma rich in growth factor, or stromal vascular fraction | Patients with knee OA | 79 RCTs |
| Trams et al. (2020) (19) | 2005-2020 | • 10 PRP vs. placebo<br>• 23 PRP vs. HA<br>• 4 PRP vs. corticosteroid<br>• 2 PRP vs. acetaminophen<br>• 6 PRP, single vs. multiple injections | Patients with knee OA | 38 RCTs |
| Johal et al. (2019) (10) | Through Feb 2017 | • 8 PRP vs. HA<br>• 2 PRP vs. placebo<br>• 2 PRP vs. no PRP | Patients with knee OA | 14 RCTs |

| | | | | |
|---|---|---|---|---|
| | | • 1 PRP vs. corticosteroid<br>• 1 PRP vs. acetaminophen | | |
| Xu et al. (2017) (27) | Through May 2016 | • 8 PRP vs. HA<br>• 2 PRP vs. placebo | Patients with knee OA | 10 RCTs |
| Laudy et al. (2015) (20) | Through Jun 2014 | • 8 PRP vs. HA<br>• 1 PRP vs. placebo<br>• 1 PRP, different preparations | Patients with knee OA | 6 RCTs<br>4 nonrandomized |
| Chang et al. (2014) (21) | Through Sep 2013 | • 6 PRP vs. HA<br>• 1 PRP vs. placebo<br>• 1 PRP, different preparations<br>• 8 single-arm PRP | Patients with knee OA | 5 RCTs<br>3 quasi-randomized<br>8 single-arm |

HA: hyaluronic acid; OA: osteoarthritis; PRP: platelet-rich plasma; RCT: randomized controlled trial.

**Table 8. Systematic Review Functional Score Results for Knee Osteoarthritis**

| Study | Change in Functional Scores (95% CI)[a] | |
|---|---|---|
| | **6 Months to 2 Years** | |
| Anil et al. (2021) (18) | WOMAC at 1 year: Leukocyte-poor PRP vs. saline placebo, -7.65 (-27.18 to 11.88); Leukocyte-rich PRP vs. saline placebo, -13.28 (-28.74 to 2.18) | |
| Trams et al. (2020) (19) | WOMAC: All trials, -12.10 (-14.12 to -7.24); PRP vs. placebo, -14.56 (-21.17 to -7. 96); PRP vs. steroid, -16.10 (-19.61 to -12.59); PRP vs. HA, -10.68 (-14.12 to -7.24)<br>IKDC: All trials, 6.94 (2.53 to 11.34); PRP vs. placebo, 8.96 (-5.88 to 23.81); PRP vs. HA, 6.58 (2.12 to 11.05)<br>KOOS - ADL: All trials, 1.23 (-4.85 to 7.31) | |
| | **6 Months** | **12 Months** |
| Xu et al. (2017) (27) | PRP vs. HA: All trials: -0.9 (-1.4 to -0.3); Low quality: -13.3 (-33.9 to 3.7); Moderate quality: -1.3 (-1.6 to -1.0); High quality: -0.1 (-0.3 to 0.1)<br>PRP vs. placebo: All trials (3): -2.1 (-3.3 to -1.0) | NR |
| Laudy et al. (2015) (20) | PRP vs HA: -0.8 (-1.0 to -0.6) | PRP vs HA: -1.3 (-1.8 to -0.9) |
| Chang et al. (2014) (21) | PRP, baseline vs. post-treatment: All studies: 2.5 (1.9 to 3.1); Single-arm: 3.1 (2.0 to 4.1); Quasi-randomized: 3.1 (1.4 to 3.8); RCT: 1.5 (1.0 to 2.1) | PRP, baseline vs. posttreatment: All studies: 2.9 (1.0 to 4.8); Single-arm: 2.6 (-0.4 to 5.7); Quasi-randomized: 4.5 (4.1 to 5.0); RCT: 0.9 (0.5 to 1.3) |

ADL: activities of daily living; CI: confidence interval; HA: hyaluronic acid; IKDC: International Knee Documentation Committee; KOOS: Knee Injury and Osteoarthritic Outcome Score; NR: not reported; PRP: platelet-rich plasma; RCT: randomized controlled trial; WOMAC: Western Ontario McMaster Osteoarthritis Index.
[a] Functional outcomes were measured by the IKDC, KOOS, or WOMAC.

In individuals with hip osteoarthritis undergoing PRP injections, findings from 2 systematic reviews are reported. Belk et al. (2021) identified 6 RCTs comparing the efficacy of PRP (n=211) and hyaluronic acid injections (n=197). (28) The mean follow-up was approximately 12 months. In an analysis of 4 RCTs, PRP and hyaluronic acid groups had similar improvements in VAS score (MD, 5.9; 95% CI, -0.741 to 1.92) and WOMAC score (MD, 0.27; 95% CI, -0.05 to 0.59). Gazendam et al. (2020) identified 11 RCTs (N=1353) assessing the efficacy of PRP, corticosteroids, and saline injections. (29) Pooled pain and functional outcomes were reported for 2 to 4- and 6-months follow-up. No intervention significantly outperformed saline intra-articular injection at any time point. Clinically significant improvements in pain from baseline were observed for all treatment groups, including placebo.

Randomized Controlled Trials

In individuals with knee osteoarthritis undergoing PRP injections, 3 RCTs with follow-up durations of at least 12 months have been published subsequent to the above-described systematic reviews (Tables 9 to 12 below). (30-32) All were conducted outside of the United States. Sample sizes ranged from 40 to 200 patients. Comparator treatments included corticosteroids, celecoxib, or hyaluronic acid. Two RCTs found statistically significantly greater 1-year reductions in pain and function scores with PRP versus the corticosteroids or celecoxib. Sdeek et al. (2021) reported on the results of a 36-month RCT that compared 3 intraarticular injections of either PRP (n=95) or hyaluronic acid (n=94) in patients with knee osteoarthritis. (30) Both PRP and hyaluronic acid were effective in improving pain and functional status. Statistical analyses were not performed, however, trends for pain and function scores showed greater improvement in the group that received PRP. The findings of these RCTs should be interpreted with caution due to important study conduct limitations, including potential inadequate control for selection bias and limited or unclear blinding. No significant differences in pain or function scores were observed within the first month of treatment in either study.

Dallari et al. (2016) reported on results of an RCT that compared PRP with hyaluronic acid alone or with a combination PRP plus hyaluronic acid in 111 patients with hip OA. (33) Although this well-conducted RCT reported positive results, with statistically significant reductions in VAS scores (lower scores imply less pain) at 6 months in the PRP arm (21; 95% CI, 15 to 28) vs the hyaluronic acid arm (35; 95% CI, 26 to 45) or the PRP plus hyaluronic acid arm (44; 95% CI, 36 to 52), the impact of treatment on other secondary outcome measures such as Harris Hip Score and WOMAC scores was not observed. Notably, there was no control for type I error for multiple group comparisons at different time points, and the trial design did not incorporate a sham-control arm. Nouri et al. (2022) also conducted an RCT comparing platelet-rich plasma with hyaluronic acid in patients with hip osteoarthritis. (34) A total of 105 patients were randomized to platelet-rich plasma, hyaluronic acid, or the combination. There were no

differences in VAS scores between groups at 6 months; however, functional outcomes were improved in the platelet-rich plasma groups compared with hyaluronic acid alone.

**Table 9. Summary of Key RCT Characteristics**

| Study | Countries | Sites | Dates | Participants | Interventions | Comparator | |
|---|---|---|---|---|---|---|---|
| | | | | | **Active** | **Comparator 1** | **Comparator 2** |
| Nouri et al. (2022) (34) | Iran | 1 | 2019-2020 | Patients with hip OA, grade II to III | PRP (n=35); 2 x 5 mL 14 days apart | HA (n=35); 2 x 2.5 mL 14 days apart | HA + PRP (n=35); 2 x 5 mL PRP + 2.5 mL HA 14 days apart |
| Sdeek et al. (2021) (30) | Egypt | NR | 2016-2020 | Patients with knee OA, grade II to III | PRP (n=95); 3 x 2.5 mL 14 days apart | HA (n=94); 3 x 2.5 mL 14 days apart | |
| Reyes-Sosa et al. (2020) (31) | Mexico | 1 | NR | Patients with knee OA, grade II to III, who were previously treated with acetaminophen without improve-ment | Activated PRP (n=30); 2 x 3 mL 15 days apart | NSAID: (n=30); 200 mg celecoxib every 24 hours for 1 year | |
| Elksnins-Finogejevs et al. (2020) (32) | Latvia | 1 | 2016-2017 | Patients with knee OA, grade II to III | PRP (n=20); 8 mL single dose | CS (n=20); 1 mL 40 mg/mL triamcinolone + 5 mL 2% lidocaine | |
| Dallari et al. (2016) (33) | Italy | NR | 2010-2011 | Patients with hip OA | PRP (n=44) | PRP+HA (n=31) | HA (n=36) |

CS: corticosteroid; HA: hyaluronic acid; NR: not reported; NSAID: non-steroidal anti-inflammatory drug; OA: osteoarthritis; PRP: platelet-rich plasma; RCT: randomized controlled trial.

**Table 10. Summary of Key RCT Results**

| Study | Pain Outcomes | Functional Outcomes |
|---|---|---|
| **Knee OA** | | |
| **Sdeek et al. (2021) (30)** | *Mean VAS Score* | *Mean IKDC and WOMAC Scores* |

| | | |
|---|---|---|
| PRP | Baseline: 57.8<br>12 months: 47.1<br>36 months: 40.9 | IKDC:<br>Baseline: 49.1<br>12 months: 67.9<br>36 months: 55.2<br><br>WOMAC:<br>Baseline: 66.5<br>12 months: 52.8<br>36 months: 60.6 |
| HA | Baseline: 59.3<br>12 months: 50.3<br>36 months: 60.3 | IKDC:<br>Baseline: 47.3<br>12 months: 61.6<br>36 months: 46.1<br><br>WOMAC:<br>Baseline: 66.9<br>12 months: 54.9<br>36 months: 64.2 |
| **Reyes-Sosa et al. (2020) (31)** | *Change in VAS Score from Baseline at 12 mo, %* | *Change in WOMAC Score from Baseline at 12 mo* |
| PRP | -68.69 (p<.001) | -11.5[a] |
| Celecoxib | -40.94 (p<.001) | -4[a] |
| *P*-value for Difference | p<.001 | p<.001 |
| **Elksnins-Finogejevs et al. (2020) (32)** | *Mean VAS Score, 95% CI* | *Mean IKDC Score, 95% CI* |
| PRP | Baseline: 6.1 (5.4 to 6.6)<br>30 weeks: 1.6 (0.7 to 2.6)<br>58 weeks: 2.9 (2.2 to 3.6) | Baseline: 36.3 (31.2 to 41.4)<br>30 weeks: 77.5 (70.6 to 84.3)<br>58 weeks: 62.0 (54.5 to 69.6) |
| CS | Baseline: 6.0 (5.2 to 6.8)<br>30 weeks: 4.0 (3.2 to 4.8)<br>58 weeks: 5.1 (4.1 to 6.0) | Baseline: 28.0 (24.6 to 33.1)<br>30 weeks: 56.3 (47.4 to 65.3)<br>58 weeks: 39.8 (32.8 to 46.8) |
| **Hip OA** | | |
| **Nouri et al. (2022) (34)** | *VAS at 6 mo* | *WOMAC at 6 mo* |
| PRP | 3.13 ± 1.29 | 21.53 ± 10.40 |
| HA | 3.90 ± 1.40 | 27.21 ± 9.25 |
| PRP + HA | 3.13 ± 1.18 | 21.16 ± 8.00 |
| **Dallari et al. (2016) (35)** | *VAS Score at 6 mo* | *NR* |
| PRP | 21 | |
| HA | 35 | |
| PRP + HA | 44 | |

CI: confidence interval; CS: corticosteroids; HA: hyaluronic acid; IKDC: International Knee Documentation Score; mo: months; NR: not reported; OA: osteoarthritis; PRP: platelet-rich plasma; RCT: randomized controlled trial; VAS: visual analog scale; WOMAC: Western Ontario and McMaster Universities

Osteoarthritis Index.
[a] Calculated estimate.

**Table 11. Study Relevance Limitations**

| Study | Population[a] | Intervention[b] | Comparator[c] | Outcomes[d] | Follow Up[e] |
|---|---|---|---|---|---|
| Nouri et al. (2022) (34) | | | | | 1. Only 6 months follow-up |
| Sdeek et al. (2021) (30) | | | | | |
| Reyes-Sosa et al. (2020) (31) | | | 3. Unclear adherence to treatment | 5. Clinically significant difference not defined | |
| Elksnins-Finogejevs et al. (2020) (32) | | | | | |
| Dallari et al. (2016) (33) | | | | | |

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4. Enrolled populations do not reflect relevant diversity; 5. Other.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5: Other.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other.

**Table 12. Study Design and Conduct Limitations**

| Study | Allocation[a] | Blinding[b] | Selective Reporting[c] | Follow Up[d] | Power[e] | Statistical[f] |
|---|---|---|---|---|---|---|
| Nouri et al. (2022) (34) | | 1. Patients not fully blind due to differences in administration procedures | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Sdeek et al. (2021) (30) | | | | | 1. Power calculations not reported; 2. Power not calculated for primary outcome | 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated |
| Reyes-Sosa et al. (2020) (31) | 2. Allocation not concealed from patients or health care providers; 4. Inadequate control for selection bias in celecoxib group | 1-3. Blinding of outcome assessors not clear | 1. Not registered | | 1. Power not calculated | 2. Confidence intervals not reported |
| Elksnins-Finogejevs et al. (2020) (32) | 2. Allocation not concealed from patients or health care providers | 1-3. Not double-blinded | | | | |
| Dallari et al. (2016) (33) | 2. Allocation not concealed from patients or health care providers | 1. Only data collectors and outcome assessors blinded to treatment assignment | | | | |

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

[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation

concealment unclear; 4. Inadequate control for selection bias.
[b] Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.
[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
[d] Follow-Up 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).
[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
[f] Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention 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 as a Primary Treatment of Knee or Hip Osteoarthritis
Multiple RCTs and systematic reviews with meta-analysis have evaluated the efficacy of PRP injections in individuals with knee or hip OA. Most trials have compared PRP with hyaluronic acid for knee OA. A single RCT compared PRP with hyaluronic acid alone or combination PRP plus hyaluronic acid in hip OA. Systematic reviews have generally found that PRP 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. Randomized controlled trials 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 outcomes, but these findings were also limited by important study conduct flaws including potential inadequate control for selection bias and 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 OA is not robust. Two systematic reviews evaluating hip OA did not report any statistically or clinically significant differences in pain or functional outcomes compared to hyaluronic acid, corticosteroids, or placebo. Additional larger controlled studies comparing PRP with placebo and alternatives other than hyaluronic acid are needed to determine the efficacy of PRP for knee and hip OA. Further studies are also needed to determine the optimal protocol for delivering PRP.

## PLATELET-RICH PLASMA AS AN ADJUNCT TO SURGERY

### Anterior Cruciate Ligament Reconstruction

Clinical Context and Therapy Purpose
The purpose of PRP injections plus orthopedic surgery is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as orthopedic surgery alone, in individuals with anterior cruciate ligament (ACL) reconstruction.

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

*Populations*

The relevant population of interest is individuals with ACL reconstruction.

*Interventions*
The therapy being considered is PRP injections plus orthopedic surgery. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators*
Comparators of interest include orthopedic surgery alone.

*Outcomes*
The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The existing literature evaluating PRP injections plus orthopedic surgery as a treatment for ACL reconstruction has varying lengths of follow-up. While studies described below all reported at least one outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, two years of follow-up is considered necessary to demonstrate efficacy.

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.

Systematic Reviews
A Cochrane review by Moraes et al. (2014) on platelet-rich therapies for musculoskeletal soft tissue injuries identified 2 RCTs and 2 quasi-randomized studies (N=203) specifically on PRP used in conjunction with ACL reconstruction. (36) Pooled data found no significant difference in IKDC scores between the PRP and control groups.

A systematic review and meta-analysis by Trams et al. (2020) identified 16 RCTs (N=740). (19) Five studies showed no significant overall difference with respect to pain (p=.43). In 4 studies reporting IKDC scores, no significant differences were noted (p=.83). In 4 studies, no significant differences in functional outcomes as measured by the Lysholm score were reported (p=.19). Pooled estimates for Tegner scale activity assessments in 5 studies showed no significant differences (p=.38) in favor of the control. Twelve studies were deemed to be at high risk of bias in at least 1 domain.

A systematic review and meta-analysis by Lv et al. (2022) identified 17 RCTs (N=970) in patients undergoing ACL reconstruction. (37) Compared to controls, platelet-rich plasma improved VAS score (MD, -1.12; 95% CI, -1.92 to -0.31; p=.007), Lysholm score (MD, 8.49; 95% CI, 1.63 to 15.36) and subjective IKDC score (MD, 6.08; 95% CI, 4.39 to 7.77; p<.00001) at 6 months. The authors only considered the difference in pain score to be clinically relevant, and they did not consider any differences between groups at 12 months to be clinically meaningful (VAS MD, -0.47 and subjective IKDC score MD, 3.99). Overall, the evidence was determined to be of moderate quality.

Randomized Controlled Trials

A RCT reported by Nin et al. (2009), randomized 100 patients to arthroscopic ACL reconstruction with or without PRP. (38) The use of PRP on the graft and inside the tibial tunnel in patients treated with bone-patellar tendon–bone allografts had no discernable clinical or biomechanical effect at 2-year follow-up.

Ye et al. (2024) randomized 120 patients undergoing ACL reconstruction 1:1 to receive either postoperative platelet-rich plasma at monthly intervals for 3 months or no postoperative injection. (39) At 12 months, there were no significant differences in function or symptoms based on KOOS score between groups.

Retrospective Cohort Studies

Bailey et al. (2021) reported on a retrospective matched case-control study evaluating the effects of intraoperative PRP on postoperative knee function and complications at 2 years after ACL reconstruction with meniscal repair. (40) The study was conducted between 2013 and 2017 and included 162 patients who received PRP and 162 patients who did not. Results demonstrated that there were no differences in knee function scores between the PRP and matched-control groups at 2 years, as well as no differences in the timing of return to activity (mean, 7.8 vs 8.0 months; p=.765). However, the PRP group demonstrated a higher rate of postoperative knee motion loss compared with the control group (13.6% vs. 4.6%; p<.001).

Subsection Summary: Platelet-Rich Plasma as Adjunctive Treatment of ACL Reconstruction

Several systematic reviews that included multiple RCTs, quasi-randomized studies, and/or prospective studies have evaluated the efficacy of PRP injections in individuals undergoing ACL reconstruction. Three systematic reviews conducted a meta-analysis. Two showed that adjunctive PRP treatment did not result in a significant effect on function and activity outcomes, including IKDC score. One systematic review did find statistically significant benefit with platelet-rich plasma compared with control in terms of VAS, Lysholm score, and IKDC at 6 months; however, the authors only considered the differences in pain scores to be clinically relevant. By 12 months, none of the differences between groups were clinically relevant. Individual studies have shown mixed results. A retrospective matched case-control study found no differences in knee function scores or time to return of activity between PRP and matched-control groups at 2 years; however, the PRP group demonstrated a higher rate of postoperative knee motion loss compared with the control group (13.6% vs 4.6%).

**Hip Fracture**

Clinical Context and Therapy Purpose

The purpose of PRP injections plus orthopedic surgery is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as orthopedic surgery alone, in individuals with hip fracture.

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

*Populations*

The relevant population of interest is individuals with hip fracture.

*Interventions*

The therapy being considered is PRP injections plus orthopedic surgery. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators*

Comparators of interest include orthopedic surgery alone.

*Outcomes*

The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The existing literature evaluating PRP injections plus orthopedic surgery as a treatment for hip fracture has varying lengths of follow-up. While studies described below all reported at least one outcome of interest, longer follow-up was necessary to fully observe 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.

Randomized Controlled Trials

One RCT was identified for treatment of a hip fracture with PRP. Griffin et al. (2013) reported on a single-blind randomized trial assessing the use of PRP for the treatment of hip fractures in patients ages 65 years and older. (41) Patients underwent internal fixation of a hip fracture with cannulated screws and were randomized to standard-of-care fixation (n=99) or standard-of-care fixation plus injection of PRP into the fracture site (n=101). The primary outcome measure

was the failure of fixation within 12 months, defined as any revision surgery. The overall risk of revision by 12 months was 36.9%, and the risk of death was 21.5%. There was no significant risk reduction (39.7% control vs 34.1% PRP; absolute risk reduction, 5.6%; 95% CI, -10.6% to 21.8%) or significant difference between groups for most of the secondary outcome measures. For example, mortality was 23% in the control group and 20% in the PRP group. The length of stay was significantly reduced in the PRP-treated group (median difference, 8 days). For this measure, there is a potential for bias from the nonblinded treating physician.

Subsection Summary: Platelet-Rich Plasma as Adjunctive Treatment for Hip Fracture
A single open-labeled RCT has evaluated the efficacy of PRP injections in individuals with hip fracture. This trial failed to show any statistically significant reductions in the need for revision surgery after PRP treatment.

**Long Bone Nonunion**
Clinical Context and Therapy Purpose
The purpose of PRP injections plus orthopedic surgery is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as recombinant human bone morphogenetic protein-7 (rhBMP-7) plus orthopedic surgery, in individuals with long bone nonunion.

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

*Populations*
The relevant population of interest is individuals with long bone nonunion.

*Interventions*
The therapy being considered is PRP injections plus orthopedic surgery. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators:*
Comparators of interest include rhBMP-7 plus orthopedic surgery.

*Outcomes*
The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The existing literature evaluating PRP injections plus orthopedic surgery as a treatment for long bone nonunion has varying lengths of follow-up. While studies described below all reported at least one outcome of interest, longer follow-up was necessary to fully observe 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.

Systematic Reviews

A Cochrane review by Griffin et al. (2012) found only 1 small RCT (N=21) evaluating PRP for long bone healing. (42) However, because only studies comparing PRP with no additional treatment or placebo were eligible for inclusion, reviewers did not select a larger RCT by Calori et al. (2008) (discussed below). (43)

Randomized Controlled Trials

The trial study by Dallari et al. (2007), which was included in the Cochrane review, compared PRP plus allogenic bone graft with allogenic bone graft alone in patients undergoing corrective osteotomy for medial compartment osteoarthrosis of the knee. (35) According to Cochrane reviewers, the risk of bias in this study was substantial. Results showed no significant differences in patient-reported or clinician-assessed functional outcome scores between groups at 1 year. However, the proportion of bones united at 1 year was statistically significantly higher in the PRP plus allogenic bone graft arm (8/9) compared with the allogenic bone graft alone arm (3/9; relative risk, 2.67; 95% CI, 1.03 to 6.91). This benefit, however, was not statistically significant when assuming poor outcomes for participants who were lost to follow-up (8/11 vs 3/10; relative risk, 2.42; 95% CI, 0.88 to 6.68). Tables 13 and 14 describe this RCT and the subsequent RCT's characteristics and results, respectively. Tables 15 and 16 describe study design and conduct limitations.

Calori et al. (2008) compared application of PRP with rhBMP-7 for the treatment of long bone nonunions in a RCT involving 120 patients and 10 surgeons. (43) Inclusion criteria were posttraumatic atrophic nonunion for at least 9 months, with no signs of healing over the last 3 months and considered as treatable only by means of fixation revision. Autologous bone graft had been used in a prior surgery in 23 cases in the rhBMP-7 group and 21 cases in the PRP group. Computer-generated randomization created 2 homogeneous groups; there were generally similar numbers of tibial, femoral, humeral, ulnar, and radial nonunions in the 2 groups. Following randomization, patients underwent surgery for nonunion, including bone grafts according to the surgeon's choice (66.6% of rhBMP-7 patients, 80% of PRP patients). Clinical and radiologic evaluations by 1 radiologist and 2 surgeons trained in the study protocol revealed fewer unions in the PRP group (68%) than in the rhBMP-7 group (87%). Clinical and radiographic healing times were also found to be slower by 13% to 14% with PRP.

Samuel et al. (2017) conducted a controlled trial in which patients with delayed unions (15 to 30 weeks old) were randomized to 2 PRP injections at the fracture site at baseline and 3 weeks (n=23) or no treatment (n=17). (44) The delayed unions were in the tibia (n=29), femur (n=8),

forearm (n=2), and the humerus (n=1). The main outcome was long bone union, defined as no pain or tenderness on weight bearing, no abnormal mobility, and bridging at three or more cortices in x-ray. Examinations were conducted every 6 weeks for 36 weeks or until union. Percent union did not differ significantly between the 2 groups (78% in the PRP group vs 59% in the control group). Time to union also did not differ significantly (15.3 weeks for the PRP group vs 13.1 weeks for the control group).

**Table 13. Summary of Key RCT Characteristics**

| Study | Countries | Sites | Dates | Participants | Interventions | Comparator | |
|---|---|---|---|---|---|---|---|
| | | | | | **Active** | **Comparator 1** | **Comparator 2** |
| Dallari et al. (2007) (35) | Italy | NR | NR | Patients undergoing high tibial osteotomy to treat genu varum | Implantation of lyophilized bone chips with platelet gel (n=11) | Implantation of lyophilized bone chips with platelet gel and bone marrow stromal cells (n=12) | Implantation of lyophilized bone chips without gel (n=10) |
| Calori et al. (2008) (43) | Italy | 1 | 2005-2007 | Patients undergoing treatment of long bone nonunions | PRP (n=60) | rhBMP-7 (n=60) | |
| Samuel et al. (2017) (44) | India | 1 | 2010-2014 | Patients with delayed unions | PRP (n=23) | No treatment (n=17) | |

rhBMP-7: recombinant human bone morphogenetic protein-7; RCT: randomized controlled trial; PRP: platelet-rich plasma; NR: not reported.

**Table 14. Summary of Key RCT Results**

| Study | Knee Society Score at 1 year | Knee Society Functional Score at 1 year | Union Rate | Median Healing Time |
|---|---|---|---|---|
| **Dallari et al. (2007) (35)** | | | | |
| PRP | 91.3 ± 2 | 99.0 ± 0.6 | | |
| PRP+bone marrow | 89.9 ± 4 | 99.2 ± 0.5 | | |
| Non-PRP | 90.3 ± 4 | 98.8 ± 0.6 | | |
| **Calori et al. (2008) (43)** | | | | |
| PRP | | | 41 (68.3%) | 4 ± 0.61 months |
| rhBMP-7 | | | 52 (86.7%) | 3.5 ± 0.48 months |

| | | | | |
|---|---|---|---|---|
| P-value | | | 0.016 | |
| **Samuel et al. (2017) (44)** | | | | |
| PRP | | | 18 (78%) | 15.3 weeks |
| Control | | | 10 (59%) | 13.1 weeks |
| P-value | | | 0.296 | 0.54 |

RCT: randomized controlled trial; PRP: platelet-rich plasma; rhBMP-7: recombinant human bone morphogenetic protein-7.

**Table 15. Study Relevance Limitations**

| Study | Population[a] | Intervention[b] | Comparator[c] | Outcomes[d] | Follow Up[e] |
|---|---|---|---|---|---|
| Dallari et al. (2007) (35) | 3. Only 33 patients included | | | | |
| Calori et al. (2008) (43) | | | | | |
| Samuel et al. (2017) (44) | | | | | |

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

[a] Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4, Enrolled populations do not reflect relevant diversity; 5. Other.

[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5: Other.

[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.

[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.

[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other.

**Table 16. Study Design and Conduct Limitations**

| Study | Allocation[a] | Blinding[b] | Selective Reporting[c] | Follow Up[d] | Power[e] | Statistical[f] |
|---|---|---|---|---|---|---|
| Dallari et al. (2007) (35) | 3. Allocation concealment unclear | 1,2,3. No blinding described | | | 1,2. Study was underpowered and non-parametric statistical tests were performed | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Calori et al. (2008) (43) | 2. Allocation not concealed | 1,2,3. No blinding described | | | | |
| Samuel et al. (2017) (44) | 1. Randomization procedure not described, 3. Allocation concealment unclear | 1,2,3. No blinding described | | | | |

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

[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

[b] Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

[d] Follow-Up 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).

[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

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

Subsection Summary: Platelet-Rich Plasma as Adjunctive Treatment for Long Bone Nonunion

Three RCTs have evaluated the efficacy of PRP injections in individuals with long bone nonunion. One trial with a substantial risk of bias failed to show significant differences in patient-reported or clinician- assessed functional outcome scores between patients who received PRP plus allogenic bone graft versus those who received only allogenic bone graft. While the trial showed statistically significant increases in the proportion of bones that healed in patients receiving PRP in a modified intention-to-treat, the results did not differ in the intention-to-treat analysis. A RCT which compared PRP with rhBMP-7 also failed to show any clinical and radiologic benefits of PRP over rhBMP-7. The third RCT found no difference in the number of unions or time to union in patients receiving PRP injections or no treatment.

**Rotator Cuff Repair**

Clinical Context and Therapy Purpose

The purpose of PRP injections plus orthopedic surgery is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as orthopedic surgery alone, in individuals with rotator cuff repair.

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

*Populations*
The relevant population of interest is individuals with rotator cuff repair.

*Interventions*
The therapy being considered is PRP injections plus orthopedic surgery. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators*
Comparators of interest include orthopedic surgery alone.

*Outcomes*
The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The existing literature evaluating PRP injections plus orthopedic surgery as a treatment for rotator cuff repair has varying lengths of follow-up, ranging from 6 months to 3.5 years. While studies described below all reported at least one outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, 3.5 years of follow-up is considered necessary to demonstrate efficacy.

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.

Systematic Reviews
The literature on PRP for rotator cuff repair consists of several RCTs and systematic reviews that have evaluated the efficacy of PRP membrane or matrix combined with surgical repair of the rotator cuff. The systematic reviews have varied in their outcomes of interest and findings (Tables 17 and 18). (10, 36, 45-49) For pain outcomes, systematic reviews consistently found significant reductions with PRP at 12 months. (47, 10) However, systematic review authors noted that the pain findings should be interpreted with caution due to significant residual statistical heterogeneity, (47) lack of a clinically significant difference (i.e., less than the effect size threshold of 0.5 for a clinically important difference), (10) and high risk of bias in study conduct (10, 49). Some systematic reviews generally did not show a statistically or clinically significant benefit of PRP on other outcomes, including function, re-tear rate and Constant

scores. (48) One systematic review found a statistically significant reduction in re-tear rate in a subgroup analysis of 4 long-term RCTs that were at least 24 months in duration. (49) No reviews have demonstrated a consistent statistically and clinically significant benefit of PRP across multiple outcomes of interest for the 3.5 years of follow-up that is considered necessary to conclusively demonstrate efficacy. The systematic review by Wang et al. (2019) reported on adverse effects and reported that complications were only reported in 1 of the included RCTs, occurring in 5.6% of participants in the PRP groups and none in the control groups. The complications included infection, hematoma, and an exanthematous itchy skin lesion in 1 patient each.

**Table 17. Systematic Reviews & Meta-Analysis Characteristics**

| Study | Dates | Trials | Participants | N (Range) | Design | Duration |
|---|---|---|---|---|---|---|
| Li et al. (2021) (49) | Through Oct 2020 | 16 (PRP) | Patients undergoing surgery for rotator cuff repair | 1440 (28 to 120) | RCT | 1.5 to 60 mo |
| Chen et al. (2020) (48) | 2011-2017 | 17 | Patients with rotator cuff tears | 1116[a] (36 to 120) | RCT | NR |
| Johal et al. (2019) (10) | 2011-2016 | 13 | Patients undergoing surgery for rotator cuff repair | 858 (25 to 120) | RCT | 7 w to 24 mo |
| Chen et al. (2018) (47) | 2011-2016 | 37 | Patients with tendon and ligament injuries | 1031[a] (NR) | RCT | NR |
| Fu et al. (2017) (50) | 2011-2015 | 11 | Patients with rotator cuff injury and tendinopathy | 638 (NR) | RCT | NR |
| Zhao et al. (2015) (45) | 2011-2013 | 8 | Patients with rotator cuff injury | 464 (28 to 88) | RCT | NR |
| Moraes et al. (2014) (36) | 2008-2013 | 19 | Patients undergoing rotator cuff repair | 1088 (23 to 150) | RCT and quasi-randomized trials | NR |

NR: not reported; PRP: platelet-rich plasma; RCT: randomized controlled trial; w: weeks; mo: months.
[a] Number of participants which could be included in the quantitative analysis.

**Table 18. Systematic Reviews & Meta-Analysis Results**

| Study | VAS Reduction | VAS Reduction at 1 Year | Difference in Re-tear Rate | Difference in Function | Difference in Function at 1 Year |
|---|---|---|---|---|---|
| **Li et al. (2021) (49)** | 10 RCTs; n=559 | | 12 RCTs; n=700 RCTs ≥ 24 months: 4 RCTs, n=255 | UCLA Score: 7 RCTs; n=437 | |
| Point estimate | 10 RCTs: MD -0.13 | | 12 RCTs: RR, 0.56 RCTs ≥ 24 months: RR, 0.40 | 7 RCTs: MD, 1.55 | |
| 95% CI | 10 RCTs: -0.56 to -0.06 | | 12 RCTs: RR, 0.56 RCTs ≥ 24 months: 0.22 to 0.73 | 7 RCTs: MD, 0.86 to 2.24 | |
| **Chen et al. (2020) (48)** | | 8 RCTs; N=469 | | | UCLA Score: 6 RCTs; N=386 |
| WMD | | -0.34 | | | 1.39 |
| 95% CI | | -0.76 to 0.09 | | | 0.35 to 2.43 |
| $I^2$ | | 87.5% | | | 37.8% |
| **Johal et al. (2019) (10)** | | 7 RCTs, N=324 | | | |
| SMD | | -0.261 | | | |
| 95% CI | | -0.46 to -0.05 | | | |
| $I^2$ | | 0% | | | |
| **Chen et al. (2018) (47)** | | | | | |
| WMD | | -0.84 | | | |
| 95% CI | | -1.23 to -0.44 | | | |
| p-value | | <.01 | | | |
| **Fu et al. (2017) (50)** | | | | | |
| SMD | | 0.142[a] | | | |
| 95% CI | | -0.08 to 0.364 | | | |
| p-value | | .209 | | | |
| **Zhao et al. (2015) (45)** | | | | | |
| RR | | | 0.94 | | |

| | | | | | |
|---|---|---|---|---|---|
| 95% CI | | | 0.70 to 1.25 | | |
| p-value | | | .66 | | |
| **Moraes et al. (2014) (36)** | | | | | |
| SMD | | | | | 0.25 |
| 95% CI | | | | | -0.07 to 0.57 |
| p-value | | | | | .12 |

[a] Change from baseline at final follow-up. Follow-up durations ranged from 6 weeks to 24 months.
CI: confidence interval; MD: mean difference; RCT: randomized controlled trial; RR: risk ratio; SMD: standard mean difference; UCLA: University of California at Los Angeles (UCLA) activity score; VAS: visual analog scale; WMD: weighted mean difference.

Randomized Controlled Trials

Data from a 2011 double-blind RCT by Randelli et al. that included 53 patients randomized to receive arthroscopic rotator cuff repair with or without the addition of PRP is included in multiple meta-analyses summarized above. Randelli et al. (2021) published results of a 10-year follow-up of this trial, which included data for 17 patients who received PRP and 21 control group patients. (51) At the 10-year follow-up, both PRP and control groups experienced improvements in the median (interquartile range [IQR]) University of California at Los Angeles activity score (34 [29 to 35] and 33 [29 to 35] points, respectively) and VAS score (0.34 [0 to 1.85] and 0.70 [0 to 2.45] points, respectively); the between-group differences did not reach statistical significance. Furthermore, approximately 37% of the operated patients had a re-rupture in each group. Re-tears occurred in 6% of the patients who received PRP treatment and 14% of patients in the control group (p=.61).

Rossi et al. (2024) examined if the use of platelet-rich plasma as an adjuvant to arthroscopic rotator cuff repair decreased the rate of re-tears compared with a control group at a single center. (52) Patients with rotator cuff tears <3 cm were enrolled and randomly allocated to rotator cuff repair alone (n=48) or rotator cuff repair with a platelet-rich plasma injection during surgery (n=48). The rate of re-tears in the platelet-rich plasma group was 15.2% (95% CI, 6% to 28%), which was lower than the rate of re-tears in the control group (34.1%; 95% CI, 20% to 49%; p=.037). Overall, functional outcomes were improved after surgery across groups and there were no significant differences in functional scores, postoperative pain, and other patient-reported outcomes between groups.

Yao et al. (2024) reported on an RCT comparing adjunctive platelet-rich plasma, either leukocyte-rich (LR) or leukocyte-poor (LP), to no injection in patients with rotator cuff tears undergoing arthroscopic repairs. (53) Patients randomized to the platelet-rich plasma groups were administered an injection postoperatively into the tendon-to-bone interface. Functional outcomes were analyzed in 142 individuals (LR-PRP n=46; LP-PRP n=47; control n=49). There was no difference in the primary outcome of the UCLA score among the 3 groups (p=.169). Additionally, there were no significant differences in other functional outcomes and range of motion between the groups at 12 months. At 12 months post-surgery, the re-tear rate was 8% and there were no significant differences in the rates of overall re-tear (p=.755). The only

surgical complication reported was postoperative stiffness, which occurred in 3% of patients, and did not differ among groups (p=.790).

Subsection Summary: Platelet-Rich Plasma as Adjunctive Treatment for Rotator Cuff Repair
For individuals undergoing rotator cuff repair who receive PRP injections, the evidence includes multiple systematic reviews with meta-analyses and RCT. Relevant outcomes include 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 PRP at 12 months, important study conduct and relevance weaknesses limit interpretation of these findings. While the systematic reviews and meta-analyses failed to show a statistically and/or clinically significant impact on other outcomes, 1 meta-analysis found a statistically significant reduction in re-tear rate in a subgroup analysis of 4 RCTs that were at least 24 months in duration. Findings of subsequently published 10-year follow-up of a small RCT failed to demonstrate the superiority of PRP 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 6 months or 1 year follow-up. The variability in PRP preparation techniques and PRP administration limits the generalizability of the available evidence.

**Spinal Fusion**
Clinical Context and Therapy Purpose
The purpose of PRP injections plus orthopedic surgery is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as orthopedic surgery alone, in individuals with spinal fusion.

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

*Populations*
The relevant population of interest is individuals with spinal fusion.

*Interventions*
The therapy being considered is PRP injections plus orthopedic surgery. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators*
Comparators of interest include orthopedic surgery alone.

*Outcomes*
The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The

existing literature evaluating PRP injections plus orthopedic surgery as a treatment for spinal fusion has varying lengths of follow-up.

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.

Randomized Controlled Trial

One small (N=62), unblinded, single-center RCT for spinal fusion conducted in Japan and published by Kubota et al. (2019) was identified that compared PRP to no PRP. (54) Follow-up was 24 months. Although fusion rates were significantly improved with PRP, there were no significant differences in visual analog scale scores between the 2 groups. Major limitations of this RCT include that patients were unblinded to treatment and there was no placebo comparator.

Prospective Cohort Studies

Two prospective observational studies found no differences in fusion rates with use of a platelet gel or platelet glue compared with historical controls. (55, 56)

Subsection Summary: PRP as Adjunctive Treatment for Spinal Fusion

For individuals undergoing spinal fusion who receive PRP injections, 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 (i.e., pain).

**Subacromial Decompression Surgery**

Clinical Context and Therapy Purpose

The purpose of PRP injections plus orthopedic surgery is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as orthopedic surgery alone, in individuals with subacromial decompression surgery.

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

*Populations*

The relevant population of interest is individuals with subacromial decompression surgery.

*Interventions*

The therapy being considered is PRP injections plus orthopedic surgery. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators*
Comparators of interest include orthopedic surgery alone.

*Outcomes*
The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The existing literature evaluating PRP injections plus orthopedic surgery as a treatment for subacromial decompression surgery has varying lengths of follow-up. While studies described below all reported at least one outcome of interest, longer follow-up was necessary to fully observe 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.

Randomized Controlled Trials
One small RCT evaluated the use of PRP as an adjunct to subacromial decompression surgery. Everts et al. (2008) reported on a rigorously conducted, small (N=40) double-blinded RCT of platelet and leukocyte-rich plasma (PLRP) gel following open subacromial decompression surgery in a carefully selected patient population. (57) Neither self-assessed nor physician-assessed instability improved. Both subjective pain and use of pain medication were lower in the PLRP group across the 6 weeks of measurements. For example, at 2 weeks after surgery, VAS scores for pain were lower by about 50% in the PLRP group (close to 4 in the control group, close to 2 in the PLRP group), and only 1 (5%) patient in the PLRP group was taking pain medication compared with 10 (50%) control patients. Objective measures of range of motion showed clinically significant improvements in the PLRP group across the 6-week assessment period, with patients reporting improvements in activities of daily living, such as the ability to sleep on the operated shoulder at 4 weeks after surgery and earlier return to work.

Subsection Summary: PRP as Adjunctive Treatment for Subacromial Decompression Surgery
A single small RCT has evaluated the efficacy of PRP injections in individuals undergoing subacromial decompression surgery. Compared with controls, PRP treatment did not improve

self-assessed or physician-assessed instability. However, subjective pain, use of pain medication, and objective measures of range of motion showed clinically significant improvements with PRP. Larger RCTs would be required to confirm these benefits.

**Total Knee Arthroplasty**

Clinical Context and Therapy Purpose

The purpose of PRP injections plus orthopedic surgery is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as orthopedic surgery alone, in individuals with total knee arthroplasty.

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

*Populations*

The relevant population of interest is individuals with total knee arthroplasty.

*Interventions*

The therapy being considered is PRP injections plus orthopedic surgery. The use of PRP has been proposed as a treatment for various musculoskeletal conditions and as an adjunctive procedure in orthopedic surgeries. The potential benefit of PRP has received considerable interest due to the appeal of a simple, safe, low-cost, and minimally invasive method of applying growth factors.

*Comparators*

Comparators of interest include orthopedic surgery alone.

*Outcomes*

The general outcomes of interest are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The existing literature evaluating PRP injections plus orthopedic surgery as a treatment for total knee arthroplasty has varying lengths of follow-up. While studies described below all reported at least one outcome of interest, longer follow-up was necessary to fully observe 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.

Systematic Reviews

Trams et al. (2020) published a systematic review and meta-analysis that included 6 RCTs (N=621) evaluating the effects of intraoperative PRP as an adjunct to total knee arthroplasty. (19) Two studies were deemed at high risk of bias. The primary aim of the studies was to assess blood loss during the procedure. While there were significant differences in favor of PRP in the overall effect on blood parameters in comparison to the control groups (standard MD, -0.29; 95% CI, -0.46 to -0.11), no significant differences in range of motion, functional outcomes, or long-term pain were observed.

Shu et al. (2022) evaluated platelet-rich plasma in patients undergoing total joint replacement including 8 studies in patients with total knee arthroplasty (1 study for total hip arthroplasty and 1 on total hip or knee arthroplasty). (58) Of the 3 studies reporting VAS scores in patients undergoing total knee arthroplasty (n=161), pain scores were similar during the first 2 postoperative days, but by 3 weeks and 2 months had improved with platelet-rich plasma compared with control (MD, -0.92; 95% CI, -1.25 to -0.60 and -0.93; 95% CI, -1.24 to -0.63, respectively). There were no differences in range of motion, WOMAC scores, length of hospital stay, or wound healing within 4 weeks between platelet-rich plasma or controls in patients undergoing total knee arthroplasty. The authors noted high heterogeneity and the need for more high-quality RCTs.

Subsection Summary: PRP as Adjunctive Treatment for Total Knee Arthroplasty

Two systematic reviews have evaluated the efficacy of intraoperative PRP in individuals undergoing total knee arthroplasty. In the review by Trams et al. (2020) there were no significant differences between the platelet-rich plasma and untreated control groups across several functional and pain outcomes. The systematic review by Shu et al. (2022) found improved VAS scores in patients undergoing total knee arthroplasty; however, there were no differences in other outcomes and the authors noted high heterogeneity and the need for well-designed RCTs.

**Summary of Evidence**

Primary Treatment for Tendinopathies

For individuals with tendinopathy who receive platelet-rich plasma (PRP) 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 PRP did not have a statistically and/or clinically significant impact on symptoms (i.e., 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 (e.g., plantar fasciitis) who receive PRP 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 PRP for plantar fasciitis, did not pool study findings. Results among the remaining RCTs were inconsistent. The largest RCT showed that treatment using PRP compared with corticosteroid injection resulted in statistically significant improvement in pain and disability, but not quality of life. A 2023 systematic review found improved visual analog scale (VAS) scores with platelet-rich plasma compared to corticosteroid injections out to 6 months duration, but numerical differences between groups were small. Larger RCTs completed over a sufficient duration of time (i.e., 2 years) 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 PRP 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 PRP 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 (OA) who receive PRP 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 PRP with hyaluronic acid for knee OA. Systematic reviews have generally found that PRP 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 outcomes, 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 statistically or clinically significant differences in pain or functional outcomes compared to hyaluronic acid, corticosteroids, or placebo. Additional studies comparing PRP with placebo and with alternatives other than hyaluronic acid are needed to determine the efficacy of PRP for knee and hip osteoarthritis. Studies are also needed to determine the optimal protocol for delivering PRP. 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 PRP 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 PRP treatment did not result in a significant effect on International Knee Documentation Committee (IKDC) 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 PRP and matched-control groups at 2 years; however, the PRP 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 PRP injections plus orthopedic surgery, the evidence includes an open-labeled RCT. Relevant outcome are symptoms, functional outcomes, health status measures, quality of life, morbid events, resource utilization, and treatment-related morbidity. The single open-labeled RCT failed to show a statistically significant reduction in the need for surgical revision with the addition of PRP treatment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with long bone nonunion who receive PRP injections plus orthopedic surgery, the evidence includes 3 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 PRP plus allogenic bone graft and those who received only allogenic bone graft. While the trial showed a statistically significant increase in the proportion of bones that healed in patients receiving PRP in a modified intention-to-treat analysis, the results did not differ in the intention-to-treat analysis. An RCT which compared PRP with recombinant human bone morphogenetic protein-7 (rhBMP-7) also failed to show any clinical or radiologic benefits of PRP over rhBMP-7. The third RCT found no difference in the number of unions or time to union in patients receiving PRP injections or 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 PRP 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 PRP 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 re-tear 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 PRP 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 6 months or 1 year follow-up. The variability in PRP preparation techniques and PRP 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 PRP 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 (i.e., 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 PRP injections plus orthopedic surgery, the evidence includes small RCT. Relevant outcomes 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 PRP injections. However, subjective pain, use of pain medications, and objective measures of range of motion showed clinically significant improvements with PRP. 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 PRP 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 PRP 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.

**Practice Guidelines and Position Statements**

American Academy of Orthopaedic Surgeons

In 2021, the American Academy of Orthopaedic Surgeons (AAOS) guidelines for the management of osteoarthritis of the knee made the following recommendation: (59)

- "Platelet-rich plasma (PRP) may reduce pain and improve function in patients with symptomatic osteoarthritis of the knee. (Strength of Recommendation: Limited)" The

variability of study findings was noted to have contributed to the low strength of recommendation rating.

In 2023, the AAOS updated evidence-based guidelines on the management of osteoarthritis of the hip. (60) In the section on intra-articular injectables, the guidelines gave a moderate recommendation based on high-quality evidence supporting the use of intra-articular corticosteroids as an option to improve function and reduce pain in the short term for patients with osteoarthritis of the hip. There was also a strong recommendation based on high-quality evidence against the use of intra-articular hyaluronic acid, as it does not perform better than placebo in improving function, stiffness, and pain in patients with hip osteoarthritis. The guidelines did not mention any evidence or make recommendations related to the use of platelet-rich plasma for the treatment of osteoarthritis of the hip.

In 2019, the AAOS issued evidence-based guidelines on the management of rotator cuff injuries. (61) The guideline noted the following recommendations related to the use of PRP in this setting:

- "There is limited evidence supporting the routine use of platelet-rich plasma for the treatment of cuff tendinopathy or partial tears (Strength of Recommendation: Limited)." The variability of study findings was noted to have contributed to the low strength of recommendation rating.
- "Strong evidence does not support biological augmentation of rotator cuff repair with platelet-derived products on improving patient reported outcomes; however, limited evidence supports the use of liquid platelet rich plasma in the context of decreasing re-tear rates (Strength of Recommendation: Strong)."
- "In the absence of reliable evidence, it is the consensus of the work group that we do not recommend the routine use of platelet rich plasma in the non-operative management of full-thickness rotator cuff tears. (Strength of Recommendation: Consensus)"

National Institute for Health and Care Excellence

In 2013, the National Institute for Health and Care Excellence (NICE) issued guidance on the use of autologous blood injection for tendinopathy. (62) The NICE concluded that the current evidence on the safety and efficacy of autologous blood injection for tendinopathy was “inadequate” in quantity and quality.

In 2013, the NICE also issued guidance on the use of autologous blood injection (with or without techniques for producing PRP) for plantar fasciitis. (63) The NICE concluded that the evidence on autologous blood injection for plantar fasciitis raised no major safety concerns but that the evidence on efficacy was “inadequate in quantity and quality”.

In 2019, the NICE issued guidance on the use of PRP for osteoarthritis of the knee. (64) The NICE concluded that current evidence on PRP injections for osteoarthritis of the knee raised “no major safety concerns”; however, the “evidence on efficacy is limited in quality”. Therefore, the NICE recommended that "this procedure should only be used with special arrangements for clinical governance, consent, and audit or research."

**Ongoing and Unpublished Clinical Trials**

Some currently ongoing and unpublished trials that might influence this policy are listed in Table 19.

**Table 19. Summary of Key Trials**

| NCT No. | Trial Name | Planned Enrollment | Completion Date |
|---|---|---|---|
| NCT05742061 | Intra-articular Platelet Rich Plasma vs Corticosteroid in Treatment of Knee Osteoarthritis | 100 | Dec 2023 |
| NCT03734900 | Comparison of Effectiveness Between Platelet Lysate and Platelet Rich Plasma on Knee Osteoarthritis: a Prospective, Randomized, Placebo-controlled Trial | 150 | May 2022 |
| NCT03984955 | A Prospective, Double Blind, Single Centre, RCT, Comparing the Effectiveness of Physiotherapy in Addition to One of 3 Types of Image Guided Injection of the Common Extensor Tendon, on Pain and Function in Patients with Tennis Elbow | 123 | Feb 2026 |
| NCT04697667 | The Combination of Exercise and PRP vs. Exercise Alone in Patients With Knee Osteoarthritis: A Randomized Controlled Clinical Trial | 84 | Feb 2022 |
| NCT01843504 | The Clinical, Biomechanical, and Tissue Regenerating Effects of a Single Platelet-Rich Plasma (PRP) Injection for the Treatment of Chronic Patellar Tendinopathy: a Randomized Controlled Trial | 44 | Dec 2024 |

NCT: national clinical trial.

[a] Denotes industry-sponsored or cosponsored trial.

## Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

| | |
|---|---|
| **CPT Codes** | 0232T, 0481T |
| **HCPCS Codes** | C1734, P9020 |

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

## References


1. Crovetti G, Martinelli G, Issi M, et al. Platelet gel for healing cutaneous chronic wounds. Transfus Apher Sci. Apr 2004; 30(2):145-151. PMID 15062754
2. Eppley BL, Woodell JE, Higgins J. Platelet quantification and growth factor analysis from platelet-rich plasma: implications for wound healing. Plast Reconstr Surg. Nov 2004; 114(6):1502-1508. PMID 15509939
3. Kevy SV, Jacobson MS. Comparison of methods for point of care preparation of autologous platelet gel. J Extra Corpor Technol. Mar 2004; 36(1):28-35. PMID 15095838
4. Castillo TN, Pouliot MA, Kim HJ, et al. Comparison of growth factor and platelet concentration from commercial platelet-rich plasma separation systems. Am J Sports Med. Feb 2011; 39(2):266-271. PMID 21051428
5. Mazzucco L, Balbo V, Cattana E, et al. Not every PRP-gel is born equal. Evaluation of growth factor availability for tissues through four PRP-gel preparations: Fibrinet, RegenPRP-Kit, Plateltex and one manual procedure. Vox Sang. Aug 2009; 97(2):110-118. PMID 19392780
6. Hsu WK, Mishra A, Rodeo SR, et al. Platelet-rich plasma in orthopaedic applications: evidence-based recommendations for treatment. J Am Acad Orthop Surg. Dec 2013; 21(12):739-748. PMID 24292930
7. Masiello F, Pati I, Veropalumbo E, et al. Ultrasound-guided injection of platelet-rich plasma for tendinopathies: a systematic review and meta-analysis. Blood Transfus. Mar 2023; 21(2):119-136. PMID 36346880
8. Dai W, Yan W, Leng X, et al. Efficacy of platelet-rich plasma versus placebo in the treatment of tendinopathy: a meta-analysis of randomized controlled trials. Clin J Sport Med. Jan 01 2023; 33(1):69-77. PMID 34342296
9. Muthu S, Patel S, Gobbur A, et al. Platelet-rich plasma therapy ensures pain reduction in the management of lateral epicondylitis - a PRISMA-compliant network meta-analysis of randomized controlled trials. Expert Opin Biol Ther. Apr 2022; 22(4):535-546. PMID 35078375
10. Johal H, Khan M, Yung SP, et al. Impact of platelet-rich plasma use on pain in orthopaedic surgery: a systematic review and meta-analysis. Sports Health. Jul 2019; 11(4):355-366. PMID 31136726
11. Kearney RS, Ji C, Warwick J, et al. Effect of platelet-rich plasma injection vs sham injection on tendon dysfunction in patients with chronic midportion Achilles tendinopathy: a randomized clinical trial. JAMA. Jul 13 2021; 326(2):137-144. PMID 34255009
12. Seth I, Bulloch G, Seth N, et al. The role of corticosteroid injections in treating plantar fasciitis: A systematic review and meta-analysis. Foot (Edinb). Mar 2023; 54:101970. PMID 36774828

13. Peerbooms JC, Lodder P, den Oudsten BL, et al. Positive effect of platelet-rich plasma on pain in plantar fasciitis: a double-blind multicenter randomized controlled trial. Am J Sports Med. Nov 2019; 47(13):3238-3246. PMID 31603721
14. Shetty SH, Dhond A, Arora M, et al. Platelet-rich plasma has better long-term results than corticosteroids or placebo for chronic plantar fasciitis: randomized control trial. J Foot Ankle Surg. Jan 2019; 58(1):42-46. PMID 30448183
15. Johnson-Lynn S, Cooney A, Ferguson D, et al. A feasibility study comparing platelet-rich plasma injection with saline for the treatment of plantar fasciitis using a prospective, randomized trial design. Foot Ankle Spec. Apr 2019; 12(2):153-158. PMID 29779399
16. Tabrizi A, Dindarian S, Mohammadi S. The effect of corticosteroid local injection versus platelet-rich plasma for the treatment of plantar fasciitis in obese patients: a single-blind, randomized clinical trial. J Foot Ankle Surg. Jan 2020; 59(1):64-68. PMID 31882151
17. Mei-Dan O, Carmont MR, Laver L, et al. Platelet-rich plasma or hyaluronate in the management of osteochondral lesions of the talus. Am J Sports Med. Mar 2012; 40(3):534-541. PMID 22253252
18. Anil U, Markus DH, Hurley ET, et al. The efficacy of intra-articular injections in the treatment of knee osteoarthritis: a network meta-analysis of randomized controlled trials. Knee. Oct 2021; 32:173-182. PMID 34500430
19. Trams E, Kulinski K, Kozar-Kaminska K, et al. The clinical use of platelet-rich plasma in knee disorders and surgery-a systematic review and meta-analysis. Life (Basel). Jun 25 2020; 10(6):94. PMID 32630404
20. Laudy AB, Bakker EW, Rekers M, et al. Efficacy of platelet-rich plasma injections in osteoarthritis of the knee: a systematic review and meta-analysis. Br J Sports Med. May 2015; 49(10):657-672. PMID 25416198
21. Chang KV, Hung CY, Aliwarga F, et al. Comparative effectiveness of platelet-rich plasma injections for treating knee joint cartilage degenerative pathology: a systematic review and meta-analysis. Arch Phys Med Rehabil. Mar 2014; 95(3):562-575. PMID 24291594
22. Meheux CJ, McCulloch PC, Lintner DM, et al. Efficacy of intra-articular platelet-rich plasma injections in knee osteoarthritis: a systematic review. Arthroscopy. Mar 2016; 32(3):495-505. PMID 26432430
23. Lai LP, Stitik TP, Foye PM, et al. Use of platelet-rich plasma in intra-articular knee injections for osteoarthritis: a systematic review. PM R. Jun 2015; 7(6):637-648. PMID 25687110
24. Cole BJ, Karas V, Hussey K, et al. Hyaluronic acid versus platelet-rich plasma: A prospective, double-blind randomized controlled trial comparing clinical outcomes and effects on intra-articular biology for the treatment of knee osteoarthritis. Am J Sports Med. Feb 2017; 45(2):339-346. PMID 28146403
25. Duymus TM, Mutlu S, Dernek B, et al. Choice of intra-articular injection in treatment of knee osteoarthritis: platelet-rich plasma, hyaluronic acid or ozone options. Knee Surg Sports Traumatol Arthrosc. Feb 2017; 25(2):485-492. PMID 27056686
26. Kanchanatawan W, Arirachakaran A, Chaijenkij K, et al. Short-term outcomes of platelet-rich plasma injection for treatment of osteoarthritis of the knee. Knee Surg Sports Traumatol Arthrosc. May 2016; 24(5):1665-1677. PMID 26387122

27. Xu Z, Luo J, Huang X, et al. Efficacy of platelet-rich plasma in pain and self-report function in knee osteoarthritis: a best-evidence synthesis. Am J Phys Med Rehabil. Nov 2017; 96(11):793-800. PMID 28398969
28. Belk JW, Houck DA, Littlefield CP, et al. Platelet-rich plasma versus hyaluronic acid for hip osteoarthritis yields similarly beneficial short-term clinical outcomes: a systematic review and meta-analysis of level I and II randomized controlled trials. Arthroscopy. Jun 2022; 38(6):2035-2046. PMID 34785294
29. Gazendam A, Ekhtiari S, Bozzo A, et al. Intra-articular saline injection is as effective as corticosteroids, platelet-rich plasma and hyaluronic acid for hip osteoarthritis pain: a systematic review and network meta-analysis of randomized controlled trials. Br J Sports Med. Mar 2021; 55(5):256-261. PMID 32829298
30. Sdeek M, Sabry D, El-Sdeek H, et al. Intra-articular injection of platelet rich plasma versus hyaluronic acid for moderate knee osteoarthritis. A prospective, double-blind randomized controlled trial on 189 patients with follow-up for three years. Acta Orthop Belg. Dec 2021; 87(4):729-734. PMID 35172440
31. Reyes-Sosa R, Lugo-Radillo A, Cruz-Santiago L, et al. Clinical comparison of platelet-rich plasma injection and daily celecoxib administration in the treatment of early knee osteoarthritis: a randomized clinical trial. J Appl Biomed. 2020; 18(2-3):41-45. PMID 34907724
32. Elksnins-Finogejevs A, Vidal L, Peredistijs A. Intra-articular platelet-rich plasma vs corticosteroids in the treatment of moderate knee osteoarthritis: a single-center prospective randomized controlled study with a 1-year follow up. J Orthop Surg Res. Jul 10 2020; 15(1):257. PMID 32650801
33. Dallari D, Stagni C, Rani N, et al. Ultrasound-guided injection of platelet-rich plasma and hyaluronic acid, separately and in combination, for hip osteoarthritis: a randomized controlled study. Am J Sports Med. Mar 2016; 44(3):664-671. PMID 26797697
34. Nouri F, Babaee M, Peydayesh P, et al. Comparison between the effects of ultrasound guided intra-articular injections of platelet-rich plasma (PRP), high molecular weight hyaluronic acid, and their combination in hip osteoarthritis: a randomized clinical trial. BMC Musculoskelet Disord. Sep 12 2022; 23(1):856. PMID 36096771
35. Dallari D, Savarino L, Stagni C, et al. Enhanced tibial osteotomy healing with use of bone grafts supplemented with platelet gel or platelet gel and bone marrow stromal cells. J Bone Joint Surg Am. Nov 2007; 89(11):2413-2420. PMID 17974883
36. Moraes VY, Lenza M, Tamaoki MJ, et al. Platelet-rich therapies for musculoskeletal soft tissue injuries. Cochrane Database Syst Rev. Apr 29 2014; 2014(4):CD010071. PMID 24782334
37. Lv ZT, Zhang JM, Pang ZY, et al. The efficacy of platelet rich plasma on anterior cruciate ligament reconstruction: a systematic review and meta-analysis. Platelets. Feb 17 2022; 33(2):229-241. PMID 34048294
38. Nin JR, Gasque GM, Azcarate AV, et al. Has platelet-rich plasma any role in anterior cruciate ligament allograft healing? Arthroscopy. Nov 2009; 25(11):1206-1213. PMID 19896041
39. Ye Z, Chen H, Qiao Y, et al. Intra-Articular Platelet-Rich Plasma Injection After Anterior Cruciate Ligament Reconstruction: A Randomized Clinical Trial. JAMA Netw Open. May 01 2024; 7(5):e2410134. PMID 38728032

40. Bailey L, Weldon M, Kleihege J, et al. Platelet-rich plasma augmentation of meniscal repair in the setting of anterior cruciate ligament reconstruction. Am J Sports Med. Oct 2021; 49(12):3287-3292. PMID 34477016
41. Griffin XL, Achten J, Parsons N, et al. Platelet-rich therapy in the treatment of patients with hip fractures: a single centre, parallel group, participant-blinded, randomized controlled trial. BMJ Open. 2013; 3(6):e002583. PMID 23801709
42. Griffin XL, Wallace D, Parsons N, et al. Platelet rich therapies for long bone healing in adults. Cochrane Database Syst Rev. 2012; 2012(7):CD009496. PMID 22786528
43. Calori GM, Tagliabue L, Gala L, et al. Application of rhBMP-7 and platelet-rich plasma in the treatment of long bone non-unions: a prospective randomized clinical study on 120 patients. Injury. Dec 2008; 39(12):1391-1402. PMID 19027898
44. Samuel G, Menon J, Thimmaiah S, et al. Role of isolated percutaneous autologous platelet concentrate in delayed union of long bones. Eur J Orthop Surg Traumatol. Jul 2018; 28(5):985-990. PMID 29167980
45. Zhao JG, Zhao L, Jiang YX, et al. Platelet-rich plasma in arthroscopic rotator cuff repair: a meta-analysis of randomized controlled trials. Arthroscopy. Jan 2015; 31(1):125-135. PMID 25278352
46. Yang J, Sun Y, Xu P, et al. Can patients get better clinical outcomes by using PRP in rotator cuff repair: a meta- analysis of randomized controlled trials. J Sports Med Phys Fitness. Nov 2016; 56(11):1359-1367. PMID 26473444
47. Chen X, Jones IA, Park C, et al. The efficacy of platelet-rich plasma on tendon and ligament healing: a systematic review and meta-analysis with bias assessment. Am J Sports Med. Jul 2018; 46(8):2020-2032. PMID 29268037
48. Chen X, Jones IA, Togashi R, et al. Use of platelet-rich plasma for the improvement of pain and function in rotator cuff tears: a systematic review and meta-analysis with bias assessment. Am J Sports Med. Jul 2020; 48(8):2028-2041. PMID 31743037
49. Li Y, Li T, Li J, et al. Platelet-rich plasma has better results for retear rate, pain, and outcome than platelet-rich fibrin after rotator cuff repair: a systematic review and meta-analysis of randomized controlled trials. Arthroscopy. Feb 2022; 38(2):539-550. PMID 34052384
50. Fu CJ, Sun JB, Bi ZG, et al. Evaluation of platelet-rich plasma and fibrin matrix to assist in healing and repair of rotator cuff injuries: a systematic review and meta-analysis. Clin Rehabil. Feb 2017; 31(2):158-172. PMID 26928856
51. Randelli PS, Stoppani CA, Santarsiero G, et al. Platelet-rich plasma in arthroscopic rotator cuff repair: clinical and radiological results of a prospective randomized controlled trial study at 10-year follow-up. Arthroscopy. Jan 2022; 38(1):51-61. PMID 34052372
52. Rossi LA, Gorodischer TD, Camino P, et al. Leukocyte-Poor Platelet-Rich Plasma as an Adjuvant to Arthroscopic Rotator Cuff Repair Reduces the Retear Rate But Does Not Improve Functional Outcomes: A Double-Blind Randomized Controlled Trial. Am J Sports Med. May 2024; 52(6):1403-1410. PMID 38587033
53. Yao L, Pang L, Zhang C, et al. Platelet-Rich Plasma for Arthroscopic Rotator Cuff Repair: A 3-Arm Randomized Controlled Trial. Am J Sports Med. Dec 2024; 52(14):3495-3504. PMID 39425250

54. Kubota G, Kamoda H, Orita S, et al. Platelet-rich plasma enhances bone union in posterolateral lumbar fusion: A prospective randomized controlled trial. Spine J. Feb 2019; 19(2):e34-e40. PMID 28735763
55. Carreon LY, Glassman SD, Anekstein Y, et al. Platelet gel (AGF) fails to increase fusion rates in instrumented posterolateral fusions. Spine (Phila Pa 1976). May 1 2005; 30(9):E243-246; discussion E247. PMID 15864142
56. Tsai CH, Hsu HC, Chen YJ, et al. Using the growth factors-enriched platelet glue in spinal fusion and its efficiency. J Spinal Disord Tech. Jun 2009; 22(4):246-250. PMID 19494743
57. Everts PA, Devilee RJ, Brown Mahoney C, et al. Exogenous application of platelet-leukocyte gel during open subacromial decompression contributes to improved patient outcome. A prospective randomized double-blind study. Eur Surg Res. 2008; 40(2):203-210. PMID 17998780
58. Shu H, Huang Z, Bai X, et al. The Application of Platelet-Rich Plasma for Patients Following Total Joint Replacement: A Meta-Analysis of Randomized Controlled Trials and Systematic Review. Front Surg. 2022; 9:922637. PMID 35860197
59. American Academy of Orthopaedic Surgeons. Management of Osteoarthritis of the Knee (Non-Arthroplasty). 2021. Available at: <https://www.aaos.org> (accessed March 2, 2025).
60. American Academy of Orthopaedic Surgeons. Management of Osteoarthritis of the Hip – Evidence-Based Clinical Practice Guideline. 2023. Available at: <https://www.aaos.org> (accessed March 3, 2025).
61. American Academy of Orthopaedic Surgeons. Management of Rotator Cuff Injuries Evidence-Based Clinical Practice Guideline. Published March 11, 2019. Available at: <https://www.orthoguidelines.org> (accessed March 1, 2025).
62. National Institute for Health and Clinical Excellence (NICE). Autologous blood injection for tendinopathy [IPG438]. 2013. Available at: <https://www.nice.org.uk> (accessed March 2, 2025).
63. National Institute for Health and Clinical Excellence. Autologous blood injection for plantar fasciitis [IPG437]. 2013. Available at: <https://www.nice.org.uk> (accessed March 3, 2025).
64. National Institute for Health and Care Excellence (NICE). Platelet-rich plasma injections for knee osteoarthritis of the knee [IPG637]. 2019. Available at: <https://www.nice.org.uk> (accessed March 1, 2025).

## Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

| Policy History/Revision | |
|---|---|
| **Date** | **Description of Change** |
| 10/15/2025 | Document updated with literature review. Coverage unchanged. Added references 39, 52 and 53. |
| 09/15/2024 | Document updated with literature review. Coverage unchanged. Added references 63-107; some updated; others removed. |
| 02/01/2024 | Document updated with literature review. Coverage unchanged. Added/updated references 7, 17, 39, 43, 61, and 68; others removed. |
| 10/01/2022 | Document updated with literature review. Coverage unchanged. The following references were added/updated: 7, 8, 18, 24, 26, 27, 36-40, 47, 55, 56, 58, 63, 65, and 68. |
| 09/01/2021 | Reviewed. No changes. |
| 08/15/2020 | Document updated with literature review. Coverage unchanged. References 7, 12-15, 18-20, 30-32, 43, and 49-52 added. |
| 08/01/2019 | Reviewed. No changes. |
| 11/01/2018 | New medical document originating from RX501.034. Use of platelet-rich plasma is considered experimental, investigational and/or unproven for all orthopedic indications. |