Overview

Wound healing is a dynamic, interactive process that involves multiple cells and proteins. There are three progressive stages of normal wound healing, and the typical wound healing duration is about 4 weeks. While cutaneous wounds are a disruption of the normal, anatomic structure and function of the skin, subcutaneous wounds involve tissue below the skin's surface. Wounds are categorized as either acute, where the normal wound healing stages are not yet completed but it is presumed they will be, resulting in orderly and timely wound repair, or chronic, in where a wound has failed to progress through the normal wound healing stages and repair itself within a sufficient time period.

Platelet-rich plasma (PRP) is produced in an autologous or homologous manner. Autologous PRP is comprised of blood from the patient who will ultimately receive the PRP. Alternatively, homologous PRP is derived from blood from multiple donors.

Blood is donated by the patient and centrifuged to produce an autologous gel for treatment of chronic, non-healing cutaneous wounds that persist for 30 days or longer and fail to properly complete the healing process. Autologous blood derived products for chronic, non-healing wounds includes both: (1) platelet derived growth factor (PDGF) products and (2) PRP (such as AutoloGel).

The PRP is different from previous products in that it contains whole cells including white cells, red cells, plasma, platelets, fibrin, stem cells, and fibrocyte precursors.

The PRP is used by physicians in clinical settings in treating chronic, non-healing wounds, open, cutaneous wounds, soft tissue and bone. Alternatively, PDGF does not contain cells and was previously marketed as a product to be used by patients at home.

Guidelines

_Nationally Covered Indications_

Effective for services performed on or after April 13, 2021, the Centers for Medicare & Medicaid Services (CMS) will cover autologous PRP for the treatment of chronic non-healing diabetic wounds under section 1862(a)(1)(A) of the Social Security Act.
Blood-Derived Products for Chronic Non-Healing Wounds (NCD 270.3)

The Act) for a duration of 20 weeks, when prepared by devices whose Food and Drug Administration-cleared indications include the management of exuding cutaneous wounds, such as diabetic ulcers.

**Nationally Noncovered Indications**

- Autologous PDGF for the treatment of chronic, non-healing cutaneous wounds, and,
- Becaplermin, a non-autologous growth factor for chronic, non-healing subcutaneous wounds, and,
- Autologous PRP for the treatment of acute surgical wounds when the autologous PRP is applied directly to the closed incision, or for dehiscent wounds.

**Other**

Effective for services performed on or after April 13, 2021:

- Coverage of autologous PRP for the treatment of chronic non-healing diabetic wounds beyond 20 weeks will be determined by local Contractors.
- Coverage of autologous PRP for the treatment of all other chronic non-healing wounds will be determined by the local Contractors under section 1862(a)(1)(A) of the Act.

**Applicable Codes**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0460</td>
<td>Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place of Service Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>19</td>
<td>Off campus-outpatient hospital</td>
</tr>
<tr>
<td>22</td>
<td>On campus-outpatient hospital</td>
</tr>
<tr>
<td>49</td>
<td>Independent clinic</td>
</tr>
</tbody>
</table>

**References**

**CMS National Coverage Determinations (NCDs)**

NCD 270.3 Blood-Derived Products for Chronic Non-Healing Wounds

**CMS Local Coverage Determinations (LCDs) and Articles**

<table>
<thead>
<tr>
<th>LCD</th>
<th>Article</th>
<th>Contractor</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>A58307 Billing and Coding: Platelet Rich Plasma</td>
<td>Noridian</td>
<td>AS, CA, GU, HI, MP, NV</td>
<td>AS, CA, GU, HI, MP, NV</td>
</tr>
<tr>
<td>N/A</td>
<td>A58351 Billing and Coding: Platelet Rich Plasma</td>
<td>Noridian</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
</tr>
</tbody>
</table>

**CMS Claims Processing Manual**

Chapter 32; § 11.3 Autologous Platelet-Rich Plasma (PRP) for Chronic Non-Healing Wounds
**CMS Transmittal(s)**

Transmittal 2362, Change Request 11392, Dated 09/19/2019 (International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)—January 2020 Update

Transmittal 10981, Change Request 12403, Dated 09/08/2021 (National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds

**MLN Matters**

Article MM11392, International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update

Article MM12403, National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds

**UnitedHealthcare Commercial Policy**

Prolotherapy and Platelet Rich Plasma Therapies

---

**Guideline History/Revision Information**

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

<table>
<thead>
<tr>
<th>Date</th>
<th>Policy Summary</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/13/2021</td>
<td><em>Updated list of examples of platelet derived growth factor (PDGF) products; removed Procuren</em></td>
<td><em>Updated list of examples of platelet derived growth factor (PDGF) products; removed Procuren</em></td>
</tr>
<tr>
<td></td>
<td><em>Replaced language indicating “platelet-rich plasma (PRP) is different from previous products in that it contains whole cells including white cells, red cells, plasma, platelets, fibrinogen, stem cells, macrophages, and fibroblasts” with “PRP is different from previous products in that it contains whole cells including white cells, red cells, plasma, platelets, fibrin, stem cells, and fibrocyte precursors”</em></td>
<td><em>Replaced language indicating “platelet-rich plasma (PRP) is different from previous products in that it contains whole cells including white cells, red cells, plasma, platelets, fibrinogen, stem cells, macrophages, and fibroblasts” with “PRP is different from previous products in that it contains whole cells including white cells, red cells, plasma, platelets, fibrin, stem cells, and fibrocyte precursors”</em></td>
</tr>
</tbody>
</table>

**Nationally Covered Indications**

- Revised language to indicate, effective for services performed on or after Apr. 13, 2021, the Centers for Medicare & Medicaid Services (CMS) will cover autologous PRP for the treatment of chronic non-healing diabetic wounds under Section 1862(a)(1)(A) of the Social Security Act (the Act) for a duration of 20 weeks, when prepared by devices whose Food and Drug Administration-cleared indications include the management of exuding cutaneous wounds, such as diabetic ulcers

**Nationally Noncovered Indications**

- Revised language to indicate the following services are not covered:
  - Autologous PDGF for the treatment of chronic, non-healing cutaneous wounds; and
  - Becaplermin, a non-autologous growth factor for chronic, non-healing subcutaneous wounds; and
  - Autologous PRP for the treatment of acute surgical wounds when the autologous PRP is applied directly to the closed incision, or for dehiscent wounds

**Other**

- Revised language to indicate, effective for services performed on or after Apr. 13, 2021:
  - Coverage of autologous PRP for the treatment of chronic non-healing diabetic wounds beyond 20 weeks will be determined by local Contractors
  - Coverage of autologous PRP for the treatment of all other chronic non-healing wounds will be determined by the local Contractors under Section 1862(a)(1)(A) of the Act

**Applicable Codes**

- Removed Modifier code Q0
- Removed Condition code 30

**Supporting Information**

- Updated References section to reflect the most current information
Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an “AS IS” basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

*For more information on a specific member’s benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.