Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used With Autologous Bone Marrow)

Policy Number: 8.01.52
Origination: 9/2018
Last Review: 9/2020
Next Review: 9/2021

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will not provide coverage for Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used With Autologous Bone Marrow). This is considered investigational.

When Policy Topic is covered
n/a

When Policy Topic is not covered
Mesenchymal stem cell therapy is considered investigational for all orthopedic applications, including use in repair or regeneration of musculoskeletal tissue.

Allograft bone products containing viable stem cells, including but not limited to demineralized bone matrix with stem cells, are considered investigational for all orthopedic applications.

Allograft or synthetic bone graft substitutes that must be combined with autologous blood or bone marrow are considered investigational for all orthopedic applications.

Considerations
This policy does not address unprocessed allograft bone.

Description of Procedure or Service

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals: With cartilage defects</td>
<td>Interventions of interest are: - Stem cell therapy</td>
<td>Comparators of interest are: - Conservative management</td>
<td>Relevant outcomes include: - Symptoms - Morbid events - Functional outcomes</td>
</tr>
</tbody>
</table>
**Summary**

Mesenchymal stem cells (MSCs) have the capability to differentiate into a variety of tissue types, including various musculoskeletal tissues. Potential uses of MSCs for orthopedic applications include treatment of damaged bone, cartilage, ligaments, tendons, and intervertebral discs.

For individuals who have cartilage defects, meniscal defects, joint fusion procedures, or osteonecrosis who receive stem cell therapy, the evidence includes small RCTs and nonrandomized comparative trials. The relevant outcomes are symptoms, morbid events, functional outcomes, quality of life, and treatment-related morbidity. Use of MSCs for orthopedic conditions is an active area of research. Despite continued research into the methods of harvesting and delivering treatment, there are uncertainties regarding the optimal source of cells and the delivery method. Studies have included MSCs from bone marrow, adipose tissue, and peripheral blood. Overall, the quality of evidence is low and there is a possibility of publication bias. The strongest evidence to date is on MSCs expanded from bone marrow, which includes several phase 1/2 RCTs. Limitations in these initial trials preclude reaching conclusions, but the results to date do support future study in phase 3 trials. Alternative methods of obtaining MSCs have been reported in a smaller number of trials and with mixed results. Additional study in a larger sample of patients with longer follow-up would be needed to evaluate the long-term efficacy and safety of these procedures. Also, expanded MSCs for orthopedic applications are not FDA approved (concentrated autologous MSCs do not require agency approval). Overall, there is a lack of evidence that clinical outcomes are improved. The evidence is insufficient to determine the effects of the technology on health outcomes.
Background
Mesenchymal Stem Cells
MSCs are multipotent cells (also called multipotent stromal cells) that can differentiate into various tissues including organs, trabecular bone, tendon, articular cartilage, ligaments, muscle, and fat. MSCs are associated with the blood vessels within the bone marrow, synovium, fat, and muscle, where they can be mobilized for endogenous repair as occurs with the healing of bone fractures. Tissues, such as muscle, cartilage, tendon, ligaments, and vertebral discs, show limited capacity for endogenous repair because of the limited presence of the triad of functional tissue components: vasculature, nerves, and lymphatics. Orthobiologics is a term introduced to describe interventions using cells and biomaterials to support healing and repair. Cell therapy is the application of MSCs directly to a musculoskeletal site. Tissue engineering techniques use MSCs and/or bioactive molecules such as growth factors and scaffold combinations to improve the efficiency of repair or regeneration of damaged musculoskeletal tissues.1

Bone marrow aspirate is considered the most accessible source and, thus, the most common place to isolate MSCs for the treatment of musculoskeletal disease. However, harvesting MSCs from bone marrow requires a procedure that may result in donor-site morbidity. Also, the number of MSCs in bone marrow is low, and the number and differentiation capacity of bone marrow-derived MSCs decreases with age, limiting their efficiency when isolated from older patients.

In vivo, the fate of stem cells is regulated by signals in the local 3-dimensional microenvironment from the extracellular matrix and neighboring cells. It is believed the success of tissue engineering with MSCs will also require an appropriate 3-dimensional scaffold or matrix, culture conditions for tissue-specific induction, and implantation techniques that provide appropriate biomechanical forces and mechanical stimulation. The ability to induce cell division and differentiation without adverse effects, such as the formation of neoplasms, remains a significant concern. Given that each tissue type requires different culture conditions, induction factors (signaling proteins, cytokines, growth factors), and implantation techniques, each preparation must be individually examined.

Regulatory Status
The FDA regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research, under Code of Federal Regulation, Title 21, parts 1270 and 1271. MSCs are included in these regulations.

The regulatory status of the stem cell or stem cell-containing products addressed in this review is summarized below.

Concentrated autologous MSCs do not require approval by the FDA. No products using engineered or expanded MSCs have been approved by the FDA for orthopedic applications.
The following products are examples of commercialized demineralized bone matrix (DBM) products. They are marketed as containing viable stem cells. In some instances, manufacturers have received communications and inquiries from the FDA related to the appropriateness of their marketing products that are dependent on living cells for their function. The following descriptions are from the product literature.

- **AlloStem®** (AlloSource) is a partially demineralized allograft bone seeded with adipose-derived MSCs.
- **Map3®** (RTI Surgical) contains cortical cancellous bone chips, DBM, and cryopreserved multipotent adult progenitor cells (MAPC®).
- **Osteocel Plus®** (NuVasive) is a DBM combined with viable MSCs isolated from allogeneic bone marrow.
- **Trinity Evolution Matrix™** (Orthofix) is a DBM combined with viable MSCs isolated from allogeneic bone marrow.
- Other products contain DBM alone and are designed to be mixed with bone marrow aspirate:
  - **Fusion Flex™** (Wright Medical) is a dehydrated moldable DBM scaffold (strips and cubes) that will absorb autologous bone marrow aspirate;
  - **Ignite®** (Wright Medical) is an injectable graft with DBM that can be combined with autologous bone marrow aspirate.

A number of DBM combination products have been cleared for marketing by the FDA through the 510(k) process. FDA product code: MQV.

Table 1 provides a representative sample of these products; some of which are specifically labeled for mixing with bone marrow aspirate.

### Table 1. Demineralized Bone Matrix Products Cleared by FDA

<table>
<thead>
<tr>
<th>Product</th>
<th>Matrix Type</th>
<th>Mix With Autologous MSCs</th>
<th>Manufacturer or Sponsor</th>
<th>Date Cleared</th>
<th>510(k) No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitoss® Bioactive Foam Bone Graft Substitute</td>
<td>Type I bovine collagen</td>
<td>X</td>
<td>Stryker</td>
<td>Nov 2008</td>
<td>K083033</td>
</tr>
<tr>
<td>NanOss BVF-E</td>
<td>Nanocrystalline hydroxyapatite</td>
<td></td>
<td>Pioneer Surgical</td>
<td>Aug 2008</td>
<td></td>
</tr>
<tr>
<td>OrthoBlast® II Demineralized bone matrix putty and paste</td>
<td>Human cancellous bone chips</td>
<td></td>
<td>SeaSpine</td>
<td>Sep 2007</td>
<td>K070751</td>
</tr>
<tr>
<td>CopiOs® Bone Void Filler (sponge and powder disc)</td>
<td>Type I bovine dermal collagen</td>
<td>X</td>
<td>Kensey Nash</td>
<td>May 2007</td>
<td>K071237</td>
</tr>
<tr>
<td>DBX® Demineralized bone matrix putty, paste and mix</td>
<td>Processed human bone and sodium hyaluronate</td>
<td>X</td>
<td>Musculoskeletal Transplant Foundation</td>
<td>Dec 2006</td>
<td>K053218</td>
</tr>
<tr>
<td>Product</td>
<td>Matrix Type</td>
<td>Mix With Autologous MSCs</td>
<td>Manufacturer or Sponsor</td>
<td>Date Cleared</td>
<td>510(k) No.</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>Integra MOZAIK™ Osteoconductive Scaffold-Putty</td>
<td>Human cancellous bone</td>
<td>X</td>
<td>IsoTis OrthoBiologics</td>
<td>Dec 2006</td>
<td>K062353</td>
</tr>
<tr>
<td>Formagraft™ Collagen Bone Graft Matrix</td>
<td>Bovine fibrillary collagen</td>
<td>X</td>
<td>R and L Medical</td>
<td>May 2005</td>
<td>K050789</td>
</tr>
<tr>
<td>DynaGraft® II Gel and Putty</td>
<td>Processed human bone particles</td>
<td></td>
<td>IsoTis Orthobiologics</td>
<td>Mar 2005</td>
<td>K040419</td>
</tr>
</tbody>
</table>

FDA: Food and Drug Administration; MSCs: mesenchymal stem cells.

In 2017, the FDA published "Regulatory Considerations for Human Cells, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and Homologous Use" [https://www.fda.gov/media/124138/download](https://www.fda.gov/media/124138/download)

Human cells, tissues, and cellular and tissue-based products (HCT/P) are defined as human cells or tissues that are intended for implantation, transplantation, infusion, or transfer into a human recipient. If an HCT/P does not meet the criteria below and does not qualify for any of the stated exceptions, the HCT/P will be regulated as a drug, device, and/or biological product and applicable regulations and premarket review will be required.

An HCT/P is regulated solely under section 361 of the PHS Act and 21 CFR Part 1271 if it meets all of the following criteria:

"1) The HCT/P is minimally manipulated;

2) The HCT/P is intended for homologous use only, as reflected by the labeling, advertising, or other indications of the manufacturer’s objective intent;

3) The manufacture of the HCT/P does not involve the combination of the cells or tissues with another article, except for water, crystalloids, or a sterilizing, preserving, or storage agent, provided that the addition of water, crystalloids, or the sterilizing, preserving, or storage agent does not raise new clinical safety concerns with respect to the HCT/P; and

4) Either: i) The HCT/P does not have a systemic effect and is not dependent upon the metabolic activity of living cells for its primary function; or

   ii) The HCT/P has a systemic effect or is dependent upon the metabolic activity of living cells for its primary function, and: a) Is for autologous use; b) Is for allogeneic use in a first-degree or second-degree blood relative; or c) Is for reproductive use."

The FDA does not consider the use of stem cells for orthopedic procedures to be homologous use. In June 2019, the FDA issued a statement on a stem cell clinic
permanent injunction and FDA's ongoing efforts to protect patients from risks of unapproved stem cell products.2

### Rationale

This evidence review was created in April 2010 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through November 19, 2019.

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The RCT is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

### Cartilage Defects

#### Clinical Context and Therapy Purpose

The purpose of stem cell therapy is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with osteoarthritis (OA) or focal cartilage defects.

The question addressed in this evidence review is: Is stem cell therapy associated with improved health outcomes for patients with cartilage defects?

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

#### Patients

The relevant population of interest is individuals with OA or focal cartilage defects.
**Interventions**
The therapy being considered is treatment with mesenchymal stem cells (MSCs).

**Comparators**
Comparators of interest include conservative management with medication or hyaluronic acid (HA) injection, microfracture, and autologous chondrocyte implantation.

**Outcomes**
The general outcomes of interest are symptoms, morbid events, functional outcomes, QOL, and treatment-related morbidity (TRM). Specific scales may include the

- Knee Injury and Osteoarthritis Outcome Score (KOOS; 5 subscales with 0-100 scale),
- Lysolm Knee Scale (LKS) score (0-100 scale),
- Tegner Activity Score (TAS); a visual analog scale (VAS) for pain (0-100 mm or 0-10 cm scale),
- Western Ontario and McMaster Universities Arthritis Index (WOMAC) which has 3 subscores: pain, which includes 5 items; stiffness, with 2 items; and physical function, with 17 items.
- WOMAC response criteria is an improvement of 20% in at least 2 items together with an improvement of 10 points in the overall scale.
- Cartilage is evaluated with the Magnetic Resonance Observation of Cartilage Repair Tissue (MOCART, 0-100 points, where higher scores indicate better cartilage repair).
- Follow-up over months to years is of interest for relevant outcomes.

**Study Selection Criteria**
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

**Review of Evidence**
A systematic review and meta-analysis by Borakati et al (2017) included 15 comparative studies (n=582) on the use of MSCs to treat OA or focal osteochondral lesions. The studies (13 published and 2 unpublished data) included 5 RCTs, 1 case-control, and 9 cohort studies. A majority of the studies were conducted in Asia, and the source of the MSCs varied (bone marrow, blood, amniotic fluid, adipose tissue). The largest trial had only 56 participants, giving low statistical power for the individual studies. The overall quality of the evidence was considered low, with 3 studies rated as "satisfactory" and the rest rated "poor" on the Jadad scale. Pain assessment results were noted for each of the controlled studies, resulting in a pooled standardized mean difference of -1.27
(95% confidence interval, -1.95 to -0.58) in favor of the group treated with MSCs. Reviewers reported a Z-statistic effect size of 3.62, again in favor of the groups treated with MSCs (p<0.001); although there was high heterogeneity across controlled studies (I²=92%). There was also suggestion of publication bias; the investigators found 79 trials on clinicaltrials.gov, of which only 3 were listed as ‘complete with results,’ many trials had been inactive for several years, and 9 had ‘unknown’ status.

The source of MSCs may have an impact on outcomes, but this is not well-understood, and the available literature uses multiple sources of MSCs. Because of the uncertainty over whether these products are equivalent, the evidence is grouped by the source of MSC.

**MSCs Expanded From Bone Marrow**

**Autologous Bone Marrow**
Wakitani et al (2002) first reported on the use of expanded MSCs for repair of cartilage defects.\(^4\) Cells from bone marrow aspirate of 12 patients with OA knees were culture-expanded, embedded in collagen gel, transplanted into the articular cartilage defect, and covered with autologous periosteum at the time of high tibial osteotomy. Clinical improvement did not differ between the experimental group and a group of 12 control patients who underwent high tibial osteotomy alone. Wakitani et al (2007) have since published several cases of patients treated for isolated cartilage defects, with clinical improvement reported at up to 27 months.\(^5\) However, most of the defects appear to have been filled with fibrocartilage. A report from Wakitani et al (2011) was a follow-up safety study of 31 of the 41 patients (3 patients had died, 5 had undergone total knee arthroplasty) who had received MSCs for articular cartilage repair in their clinics between 1998 and 2008.\(^6\) At a mean of 75 months (range, 5-137 months) since the index procedure, no tumors or infections were identified. Functional outcomes were not reported.

A publication from Centeno et al (2010) of Regenerative Sciences in the United States described the use of percutaneously injected culture-expanded MSCs obtained from the iliac spine in 226 patients.\(^7\) Following harvesting, cells were cultured with autologous platelet lysate and reinjected under fluoroscopic guidance into peripheral joints (n=213) or intervertebral discs (n=13). Culture-expanded MSCs requires approval by the FDA and is no longer offered in the United States.

The largest study included in the systematic review by Borakati et al (2017) was by Wong et al (2013), who reported on an RCT of cultured MSCs in 56 patients with OA who underwent medial opening wedge high tibial osteotomy and microfracture of a cartilage lesion (See Tables 2 and 3).\(^8\) Patients received an intra-articular injection of MSCs suspended in HA, or for controls, intra-articular injection of HA alone. The primary outcome was the International Knee Documentation Committee (IKDC) score at 6 months, 1 year, and 2 years. Secondary outcomes were the TAS and LKS scores through 2 years and the MOCART scoring system byMRI at 1 year. All patients completed the 2-year follow-
up. After adjusting for age, baseline scores, and time of evaluation, the group treated with MSCs showed significantly better scores on the IKDC (mean difference, 7.65 on 0-100 scale; p=0.001), LKS (mean difference, 7.61 on 0-100 scale; p=0.02), and TAS (mean difference, 0.64 on a 0-10 scale; p=0.02) scores. The clinical significance of these differences is uncertain. Blinded analysis of MRI results found higher MOCART scores in the MSC group. The group treated with MSCs had a higher proportion of patients who had complete cartilage coverage of their lesions (32% vs. 0%), greater than 50% cartilage cover (36% vs. 14%), and complete integration of the regenerated cartilage (61% vs. 14%).

Emadedin et al (2018) reported a triple-blind placebo-controlled phase 1/2 trial of expanded MSCs in 47 patients with OA of the knee.9 Compared to the placebo group, the MSC group showed statistically significant improvements in WOMAC pain and function subscales but not VAS. The WOMAC stiffness subscale improved to a similar extent in the 2 groups. Minimum Clinically Important Improvement and Patient Acceptable Symptom State were not significantly different between the 2 groups. Study limitations included the short duration of follow-up, statistical analysis, and lack of information regarding use of analgesic medications (see Tables 4 and 5).

Another phase 1/2 RCT of expanded MSCs was reported by Lamo-Espinosa et al (2016, 2018) in 30 patients with OA of the knee.10,11 Two doses of MSCs (10x10^6, 100x10^6) were administered with HA and compared to injection of HA alone. VAS scores were significantly decreased in both MSC groups compared to baseline throughout the 12 months of follow-up, while the decrease in VAS in the control group was not statistically significant. Similarly, total WOMAC scores were statistically decreased only in the high dose group at 12 months. Four-year follow-up was available for 27 of the 30 participants. Two patients in the control group and 1 patient in the low dose group had undergone total knee arthroplasty. VAS scores group were higher than at baseline in the HA control but remained low in the 2 MSC groups. WOMAC scores at the long-term follow-up showed a similar course (see Table 3). Limitations of this study are described in Tables 4 and 5.

Table 2. Summary of Key RCT Characteristics

<table>
<thead>
<tr>
<th>Study; Trial</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wong et al (2013)⁸</td>
<td>Asia</td>
<td>1</td>
<td></td>
<td>Patients with OA who underwent HTO and microfracture (n=56)</td>
<td>Microfracture followed by expanded MSCs suspended in HA</td>
</tr>
<tr>
<td>Emadedin et al (2018)⁹</td>
<td>Iran</td>
<td>1</td>
<td>2012-2016</td>
<td>Patients who met the ACR clinical and radiological criteria for knee OA</td>
<td>40x10⁶ expanded MSCs with serum albumin (n=22)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Placebo (n=25)</td>
</tr>
</tbody>
</table>
Patients who met the ACR clinical and radiological criteria for knee OA (n=30)

One of 2 doses of expanded MSCs with HA 10x10^6, 100x10^6

HA alone

Table 3. Summary of Key RCT Results

<table>
<thead>
<tr>
<th>Study</th>
<th>IKDC at 6 mo</th>
<th>IKDC at 2 yr Tegner Activity Scale at 2 yr</th>
<th>Lysolm Knee Score at 2 yr</th>
<th>MOCART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wong et al (2013)^8</td>
<td></td>
<td>IKDC at 2 yr Tegner Activity Scale at 2 yr</td>
<td>Lysolm Knee Score at 2 yr</td>
<td>MOCART</td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td>Diff (95% CI)</td>
<td>7.65 (3.04 to 12.26)</td>
<td>0.64 (0.10 to 1.19)</td>
<td>7.61 (1.44 to 13.79)</td>
<td>19.6 (10.5 to 28.6)</td>
</tr>
<tr>
<td>p-Value</td>
<td>0.001</td>
<td>0.021</td>
<td>0.016</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Emadedin et (2018)^9</td>
<td>WOMAC Total</td>
<td>WOMAC Pain WOMAC Stiffness WOMAC Function</td>
<td>VAS</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>43</td>
<td>43</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>MSC (95% CI)</td>
<td>-25.7(-35.4 to 16)</td>
<td>-35(-44.9 to 25)</td>
<td>-16.9(-30.4 to 3.5)</td>
<td>-22.9(-32.9 to 12.9)</td>
</tr>
<tr>
<td>Placebo (95% CI)</td>
<td>5.5(-2.8 to 13.8)</td>
<td>-12.2(-18.5 to 5.9)</td>
<td>-13.1(-20.7 to 5.4)</td>
<td>-9.5(-21.8 to 2.7)</td>
</tr>
<tr>
<td>Diff (95% CI)</td>
<td>-13.5(-24.3 to 2.7)</td>
<td>-21.8(-33.8 to 9.9)</td>
<td>-7.4 (-25.4 to 10.5)</td>
<td>-11.3(-22.1 to 0.4)</td>
</tr>
<tr>
<td>p-Value</td>
<td>0.01</td>
<td>0.001</td>
<td>0.04</td>
<td>0.65</td>
</tr>
<tr>
<td>Effect size (95% CI)</td>
<td>0.7(0.1 to 1.4)</td>
<td>1.1(0.4 to 1.7)</td>
<td>0.6(0.03 to 1.2)</td>
<td></td>
</tr>
<tr>
<td>Lamo-Espinosa et al (2016, 2018)^10,11</td>
<td>WOMAC Total at 12 mo, median (IQR)</td>
<td>WOMAC Total at 4 yr, median (IQR)</td>
<td>VAS at 4 yr, median (IQR)</td>
<td></td>
</tr>
<tr>
<td>MSC low dose</td>
<td>21.5(15, 26)</td>
<td>17 (13, 25.5)</td>
<td>2 (2, 5)</td>
<td></td>
</tr>
<tr>
<td>MSC high dose</td>
<td>16.5 (12, 19)</td>
<td>16.5 (8, 23)</td>
<td>3 (3, 4)</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>13.5 (8, 33)</td>
<td>27 (17, 30)</td>
<td>7 (6, 7)</td>
<td></td>
</tr>
</tbody>
</table>

CI: confidence interval; IKDC: International Knee Documentation Committee score; IQR: interquartile range; MOCART: Magnetic Resonance Observation of Cartilage Repair Tissue; MSC: mesenchymal stem cell; RCT: randomized controlled trial; VAS: visual analog scale; WOMAC: Western Ontario and McMaster Universities Arthritis Index.
### Table 4. Relevance Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Population&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Intervention&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Comparator&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Outcomes&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Follow-Up&lt;sup&gt;e&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wong et al (2013)&lt;sup&gt;6&lt;/sup&gt;</td>
<td>4. The population was restricted to patients younger than 55</td>
<td>4. The intervention included microfracture with/without stem cells</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emadedin et al (2018)&lt;sup&gt;9&lt;/sup&gt;</td>
<td></td>
<td>2. Did not use an active control and use of analgesics was not reported</td>
<td>1. Evaluation of cartilage was not performed.</td>
<td>1, 2. Follow-up was reported out to 6 mo.</td>
<td></td>
</tr>
<tr>
<td>Lamo-Espinosa et al (2016, 2018)&lt;sup&gt;10,11&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>1. Evaluation of cartilage was not performed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

### Table 5. Study Design and Conduct Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Allocation&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Blinding&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Selective Reporting&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Data Completeness&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Power&lt;sup&gt;e&lt;/sup&gt;</th>
<th>Statistical&lt;sup&gt;f&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wong et al (2013)&lt;sup&gt;8&lt;/sup&gt;</td>
<td>3. Patients selected from 1 of 2 identical envelopes</td>
<td>1, 2, 3. Not blinded except for evaluation of MRI</td>
<td></td>
<td></td>
<td>1. The authors used non-inferiority compared to placebo and chi-square tests for continuous variables</td>
<td></td>
</tr>
<tr>
<td>Emadedin et al (2018)&lt;sup&gt;9&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>3. Details of power analysis were not reported</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamo-Espinosa et al (2016, 2018)&lt;sup&gt;10,11&lt;/sup&gt;</td>
<td>1, 2, 3. Not blinded</td>
<td></td>
<td>3. Details of power analysis were not reported</td>
<td></td>
<td>1. The authors used non-parametric tests for</td>
<td></td>
</tr>
</tbody>
</table>
The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.

d Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
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. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

**Allogeneic Bone Marrow**

Vega et al (2015) reported on a small phase 1/2 RCT of 30 patients with OA unresponsive to conventional treatments. The MSC-treated group received an intra-articular injection of expanded allogeneic bone marrow MSCs from healthy donors, and the control group received an intra-articular injection of HA. Follow-up using standard outcome measures was performed at 3, 6, and 12 months postinjection. In the MSC-treated group, pain scores (VAS and WOMAC) decreased significantly between baseline and the 12-month follow-up, whereas pain scores in the control group did not improve significantly. A significant improvement in cartilage quality in the MSC group was supported by T2 MRI. Not reported was whether the patients or assessors were blinded to treatment.

**MSCs From Bone Marrow Aspirate Concentrate**

Shapiro et al (2017) reported on the results of a prospective, single-blind, placebo-controlled trial assessing 25 patients with bilateral knee pain from bilateral OA. Patients were randomized to BMAC into one knee and to saline placebo in to the other. Fifty-two milliliters of bone marrow was aspirated from the iliac crests and concentrated in an automated centrifuge. The resulting BMAC was combined with platelet-poor plasma for injection into the arthritic knee and was compared with a saline injection into the contralateral knee, thereby using each patient as his or her control. Safety outcomes, pain relief, and function as measured by Osteoarthritis Research Society International measures and aVAS score were tracked initially at 1 week, 3 months, and 6 months postprocedure. Study patients experienced a similar relief of pain in both BMAC- and saline-treated arthritic knees.
Adipose-Derived MSCs
Adipose-derived stem cells are multipotent MSCs that can be harvested from multiple anatomic locations and with greater ease than bone marrow-derived MSCs. The literature on adipose-derived MSCs for articular cartilage repair comes primarily from research groups in Korea. One group appears to have been providing this treatment as an option for patients for a number of years. They compared outcomes of this new add-on treatment with those for patients who only received other cartilage repair procedures.

Koh et al (2014) reported on results of an RCT that evaluated cartilage healing after high tibial osteotomy in 52 patients with OA. Patients were randomized via sealed envelopes to high tibial osteotomy with the application of platelet-rich plasma (PRP) or to high tibial osteotomy with the application of PRP plus MSCs. A total of 44 patients completed second-look arthroscopy and 1- and 2-year clinical follow-ups. The primary outcomes were the KOOS (0-100 scale), the LKS score (0-100 scale), and a VAS for pain (0-100 scale). There were statistically significant differences between PRP only and PRP plus MSC on 2 of 5 KOOS subscales: pain (74 vs. 81.2, p<0.001) and symptoms (75.4 vs. 82.8, p=0.006), all respectively. There were also statistically significant differences on the final pain score between the PRP only (16.2) and PRP plus MSC groups (10.2; p<0.001), but the final LKS score did not differ significantly between the PRP only (80.6) and PRP plus MSC groups (84.7; p=0.36). Articular cartilage healing was rated as improved with MSCs following video review of second-look arthroscopy; blinding of this measure is unclear. There were limitations in study design (small sample size, short duration of follow-up). Also, significant improvements were found only on some outcomes, all significant differences in outcomes were modest in magnitude and, as a result, there is uncertainty about the clinical significance of the findings.

MSCs From Peripheral Blood
A 2013 report from Asia has described a small RCT assessing the use of autologous peripheral blood MSCs for focal articular cartilage lesions. Fifty patients with grade 3 or 4 lesions of the knee joint underwent arthroscopic subchondral drilling followed by 5 weekly injections of HA. Half the patients were randomized to injections of peripheral blood stem cells or no further treatment. The peripheral blood stem cells were harvested after stimulation with recombinant human granulocyte colony-stimulating factor, divided in vials, and cryopreserved. At 6 months after surgery, HA and MSCs were re-administered over 3 weekly injections. At 18 months postsurgery, second-look arthroscopy on 16 patients in each group showed significantly higher histologic scores (>10%) for the MSC group (1066 vs. 957 by independent observers) while blinded evaluation of MRI scans showed a higher morphologic score (9.9 vs. 8.5). There was no difference in IKDC scores between the 2 groups at 24 months after surgery.

Section Summary: Cartilage Defects
The evidence on MSCs for cartilage repair is increasing, although nearly all studies to date have been performed outside of the United States with a variety of methods of MSC preparation. Overall, the quality of evidence is low and there is a possibility of publication bias. The strongest evidence base is on MSCs expanded...
from bone marrow, which includes several phase 1/2 RCTs. Compared to either placebo or an active HA control, treatment with expanded MSCs has been shown to provide some improvement in pain and function. Limitations in these initial trials preclude reaching conclusions, but the results to date do support future study in phase 3 trials. Alternative methods of obtaining MSCs that have been reported in RCTs include peripheral blood, adipose tissue, and bone marrow concentrate. These have been reported in a smaller number of trials and with mixed results. Additional study in a larger sample of patients with longer follow-up would be needed to evaluate the long-term efficacy and safety of these procedures. FDA approval for these methods has also not been obtained.

**Meniscal Defects**

**Clinical Context and Therapy Purpose**
The purpose of stem cell therapy is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with meniscal defects.

The question addressed in this evidence review is: Is stem cell therapy associated with improved health outcomes for patients with meniscal defects?

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

**Patients**
The relevant population of interest is individuals with meniscal defects.

**Interventions**
The therapy being considered is stem cell therapy.

**Comparators**
Comparators of interest include conservative management.

**Outcomes**
The general outcomes of interest are symptoms, morbid events, functional outcomes, QOL, and TRM.

**Study Selection Criteria**
Methodologically credible studies were selected using principles detailed above.

**Review of Evidence**
Damage to the meniscal cartilage in the knee is a very common orthopedic injury and predisposes to the development of OA. The tissue is relatively avascular and does not spontaneously heal well.

Kingdom allows cell manipulation and requires immunohistochemical documentation of the presence and volume of mesenchymal cells. Over the first 12 months postprocedure, 3 of the 5 patients were reported to have clinical symptom relief, which persisted through 24 months. MRI scans showing lack of meniscal displacement were the only other postoperative assessment. The 2 patients who failed to obtain symptom relief at 6 and 12 months had to repeat arthroscopic procedures with meniscectomy.

Vangsness et al (2014) reported on an industry-sponsored phase 1/2 randomized, double-blind, multicenter Study of Chondrogen - Adult Universal Cell Delivered by Intra-Articular Injection Following Meniscectomy in Patients 18-60 Years (NCT00225095, NCT00702741) of cultured allogeneic MSCs (Chondrogen; Osiris Therapeutics) injected into the knee after partial meniscectomy. The 55 patients in this United States study were randomized to intra-articular injection of either 50 \( \times \) 10^6 allogeneic MSCs, 150 \( \times \) 10^6 allogeneic MSCs in HA, or an HA vehicle control at 7 to 10 days after meniscectomy. The cultured MSCs were derived from BMAC of unrelated donors. At 2-year follow-up, 3 patients in the low-dose MSC group had significantly increased meniscal volume measured by MRI (with an a priori determined threshold of at least 15%) compared with none in the control group or the high-dose MSC group. There was no significant difference between the groups in LKS scores. On subgroup analysis, patients with OA who received MSCs had a significantly greater reduction in pain at 2 years than patients who received HA alone. This trial appears to have been a post hoc analysis and, hence, should be considered preliminary. No serious adverse events were reported as related to the investigational treatment.

**Section Summary: Meniscal Defects**
The evidence on the use of MSCs to repair or regenerate damaged meniscal tissue consists of preclinical animal studies, first-in-human uncontrolled implantation of expanded autologous MSCs into meniscal tears, and an early-phase randomized trial of cultured allogeneic MSCs injected into the site of partial meniscectomy. Results are preliminary.

**Joint Fusion Procedures**

**Clinical Context and Therapy Purpose**
The purpose of stem cell therapy is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with joint fusion procedures.

The question addressed in this evidence review is: Is stem cell therapy associated with improved health outcomes for patients with joint fusion procedures?

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

**Patients**
The relevant population of interest is individuals with joint fusion procedures.
**Interventions**
The therapy being considered is stem cell therapy.

**Comparators**
Comparators of interest include iliac crest bone graft.

**Outcomes**
The general outcomes of interest are symptoms, morbid events, functional outcomes, QOL, and TRM.

Follow-up over months to years is of interest for relevant outcomes.

**Study Selection Criteria**
Methodologically credible studies were selected using principles detailed above.

**Review of Evidence**
There is limited evidence on the use of allografts with stem cells for bone fusion of the extremities or spine or the treatment of nonunion. The results of several industry-sponsored, early-phase trials are available.

A prospective, clinical, and radiographic 12-month outcomes study (2016) of patients undergoing single-level anterior cervical discectomy and fusion (ACDF) for symptomatic cervical degenerative disc disease using a novel viable allogeneic stem cell and cancellous bone matrix (Trinity Evolution) was reported using historical controls as the comparator.\(^1\) The ACDF procedure was performed using the polyetheretherketone interbody spacer and bone graft substitute (Trinity Evolution) in 31 patients at multiple clinical sites. At 6 and 12 months, the primary endpoint of radiographic fusion was evaluated as determined by an independent radiographic review and the fusion rate was 78.6% at 6 months and 93.5% at 12 months. Secondary endpoints included a function as assessed by Neck Disability Index scores, and neck and arm pain as assessed by individual VAS scores. Neck function and neck and arm pain were reported as significantly improved at both 6 and 12 months postprocedure. Reported adverse events included carpal tunnel syndrome, minor pain, numbness, permanent and/or unresolved pain, and swelling. Independent medical adjudication of the 26 adverse events occurring in 31 patients found that no adverse events were definitely or probably related to Trinity Evolution. However, 5 adverse events were found to be possibly related to Trinity Evolution with 3 events of mild severity and 2 of moderate severity.

A similar study (2017) involving several of the same investigators and clinical sites reported on the clinical and radiographic evaluation of an allogeneic bone matrix containing stem cells (Trinity Evolution Viable Cellular Bone Matrix) in patients undergoing 2-level ACDF.\(^2\) This study involved 40 patients exposed to the ACDF and bone graft substitute procedure at 2 adjacent disc levels. A panel blinded to clinical outcomes reviewed 12-month dynamic motion plain radiographs and thin-cut computed tomography with multiplanar reconstruction. At 12 months, the per-
subject and per-level fusion rates were 89.4% and 93.4%, respectively. The clinical function assessments using the Neck Disability Index and VAS scores were reported to have improved from baseline.

A 2015 prospective, multicenter, open-label clinical trial using a cryopreserved, donor mesenchymal cell scaffold (Trinity Evolution) was performed in subjects undergoing foot and/or ankle arthrodesis with surgeons’ preferred technique. A total of 103 subjects were prospectively enrolled at 10 participating sites. No restrictions were placed on the diagnosis, which included arthritis (primary OAs, posttraumatic OA, and rheumatoid), deformity, neuropathy (Charcot and diabetic), revision surgery, and degenerative joint disease, and arthrodesis was performed in 171 joints. The per-protocol population consisted of 92 patients at 6 months and 76 patients at 12 months, with 153 and 129 total arthrodeses, respectively. The primary endpoint was fusion at 6 months, as assessed from computed tomography scans and standard radiographs by an independent radiology consultant. At 6 months, the fusion rate for all patients was 68.5% and 81.1% for all joints. American Orthopaedic Foot and Ankle Society Hindfoot Scale scores for disability improved over time.

Eastlack et al (2014) reported on outcomes from a series of 182 patients treated with ACDF using Osteocel Plus in a polyetheretherketone cage and anterior plating. At 24 months, 74% of patients (180/249 levels treated) were available for follow-up. These patients had significant improvements in clinical outcomes, with 87% of levels achieved solid bridging, and 92% of levels had a range of motion less than 3°. With 26% loss to follow-up at 24 months and lack of a standard of care control group, interpretation of these results is limited.

**Section Summary: Joint Fusion Procedures**
The evidence on the use of MSCs as a component of joint fusion procedures primarily comes from industry-sponsored, prospective, open-label procedures. Outcomes included radiologic assessments of fusion, sometimes made independently, and patient-reported measures (eg, VAS scores). The MSCs used were cryopreserved allogeneic in origin. Presumptive benefits of allogeneic MSCs are that patients undergoing an orthopedic intervention procedure do not need another graft harvesting procedure and that dose of stem cells can be managed.

**Osteonecrosis**

**Clinical Context and Therapy Purpose**
The purpose of stem cell therapy is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with osteonecrosis.

The question addressed in this evidence review is: Is stem cell therapy associated with improved health outcomes for patients with osteonecrosis?

The following PICO was used to select literature to inform this review.
**Patients**
The relevant population of interest is individuals with osteonecrosis.

**Interventions**
The therapy being considered is therapy with MSCs.

**Comparators**
Comparators of interest include core decompression.

**Outcomes**
The general outcomes of interest are symptoms, morbid events, functional outcomes, QOL, and TRM.

Follow-up over months to years is of interest for relevant outcomes.

**Study Selection Criteria**
Methodologically credible studies were selected using principles detailed above.

At least 2 randomized comparative trials from Asia have evaluated the use of MSCs for osteonecrosis of the femoral head.

**MSCs Concentrated From BMAC**
Sen et al (2012) randomized 40 patients (51 hips) with early-stage femoral head osteonecrosis to core decompression plus concentrated bone marrow MSCs or core decompression alone.22. Blinding of assessments in this small trial was not described. Harris Hip Score was significantly improved in the core decompression plus MSC group compared with the core decompression alone group at 12 months (scores, 83.65 vs. 76.68, p<0.016) but not at 24 months (scores, 82.42 vs. 77.39; p=0.09), all respectively. Kaplan-Meier analysis showed improved hip survival in the MSC group (mean, 51.9 weeks) compared with the core decompression group (mean, 46.7 weeks). There were no significant differences between groups in radiographic assessment or MRI results.

Hernigou et al (2018) reported average 25-year follow-up (range, 20 to 30 years) of 250 hips that had been treated with bone marrow

**MSCs Expanded From Bone Marrow**
Zhao et al (2012) reported on a randomized trial that included 100 patients (104 hips) with early-stage femoral head osteonecrosis treated with core decompression and expanded bone marrow MSCs or with core decompression alone.23. At 60 months postsurgery, 2 (3.7%) of the 53 hips treated with MSCs progressed and underwent vascularized bone grafting compared with 10 (23%) of 44 hips in the decompression group who progressed and underwent either vascularized bone grafting (n=5) or total hip replacement (n=5). The MSC group also had improved Harris Hip Scores compared with the control group on independent evaluation (data presented graphically). Lesion volume was also reduced by treatment with MSCs.
Section Summary: Osteonecrosis
Two small studies have compared core decompression alone with core decompression plus MSCs in patients with osteonecrosis of the femoral head. Both reported improvement in the Harris Hip Score in patients treated with MSCs, although it was not reported whether the patients or investigators were blinded to the treatment group. Hip survival was significantly improved following treatment with either expanded or concentrated MSCs. The effect appears to be larger with expanded MSCs than with concentrated MSCs. Additional, well-designed RCTs with a large number of patients are needed to permit greater certainty on the efficacy of this treatment for osteonecrosis.

Summary of Evidence
For individuals who have cartilage defects, meniscal defects, joint fusion procedures, or osteonecrosis who receive stem cell therapy, the evidence includes small RCTs and nonrandomized comparative trials. The relevant outcomes are symptoms, morbid events, functional outcomes, quality of life, and treatment-related morbidity. Use of MSCs for orthopedic conditions is an active area of research. Despite continued research into the methods of harvesting and delivering treatment, there are uncertainties regarding the optimal source of cells and the delivery method. Studies have included MSCs from bone marrow, adipose tissue, and peripheral blood. Overall, the quality of evidence is low and there is a possibility of publication bias. The strongest evidence to date is on MSCs expanded from bone marrow, which includes several phase 1/2 RCTs. Limitations in these initial trials preclude reaching conclusions, but the results to date do support future study in phase 3 trials. Alternative methods of obtaining MSCs have been reported in a smaller number of trials and with mixed results. Additional study in a larger sample of patients with longer follow-up would be needed to evaluate the long-term efficacy and safety of these procedures. Also, expanded MSCs for orthopedic applications are not FDA approved (concentrated autologous MSCs do not require agency approval). Overall, there is a lack of evidence that clinical outcomes are improved. The evidence is insufficient to determine the effects of the technology on health outcomes.

SUPPLEMENTAL INFORMATION

Practice Guidelines and Position Statements
American Association of Orthopaedic Surgeons
The 2013 and 2014 American Association of Orthopaedic Surgeons’ guidelines on the treatment of glenohumeral joint osteoarthritis have indicated that:

- Treatment using an allograft, autograft, biologic, and interpositional grafts in patients with glenohumeral joint osteoarthritis is inconclusive; and that
- Treatment using growth factor injections and/or platelet-rich plasma for patients with symptomatic osteoarthritis of the knee is inconclusive.
American Association of Neurological Surgeons
The American Association of Neurological Surgeons (2014) guidelines on fusion procedures for degenerative disease of the lumbar spine relevant to this evidence review have indicated that “The use of demineralized bone matrix (DBM) as a bone graft extender is an option for 1- and 2-level instrumented posterolateral fusions. Demineralized Bone Matrix: Grade C (poor level of evidence).”26.

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 6. Many are observational studies with commercially available products (eg, Cartistem, AlloStem).

Table 6. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT03467919</td>
<td>The Effect of Adipose-Derived Stem Cell on Knee Osteoarthritis</td>
<td>40</td>
<td>Jun 2020</td>
</tr>
<tr>
<td>NCT03990805</td>
<td>Multi-center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Clinical Trial to Evaluate Efficacy and Safety of Mesenchymal Stem Cells JointStem in Patients With Knee Osteoarthritis</td>
<td>260</td>
<td>Nov 2020</td>
</tr>
<tr>
<td><strong>Unpublished</strong></td>
<td></td>
<td></td>
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<tr>
<td>NCT01413061</td>
<td>Study of Subtalar Arthrodesis Using AlloStem® Versus Autologous Bone Graft</td>
<td>140</td>
<td>Mar 2018 (completed)</td>
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<tr>
<td>NCT01626677</td>
<td>Long Term Follow-Up Study of CARTISTEM® Versus Microfracture for the Treatment of Knee</td>
<td>104</td>
<td>May 2015 (completed)</td>
</tr>
<tr>
<td>NCT01504464</td>
<td>Evaluation the Effects of Intra-articular Injection of Mesenchymal Stem Cells in Patients With Knee Joint Osteoarthritis, Triple Blind Randomized Clinical Trial</td>
<td>40</td>
<td>Oct 2015 (completed)</td>
</tr>
<tr>
<td>NCT02838069</td>
<td>A Phase IIb, Prospective, Multicentre, Double-blind, Triple-arm, Randomized Versus Placebo Trial, to Assess the Efficacy of a Single Injection of Either 2 or 10 x 106 Autologous Adipose Derived Mesenchymal Stromal Cells (ASC) in the Treatment of Mild to Moderate</td>
<td>153</td>
<td>Jun 2019</td>
</tr>
</tbody>
</table>
Osteoarthritis (OA) of the Knee, Active and Unresponsive to Conservative Therapy for at Least 12 Months

NCT: national clinical trial.

a Denotes industry-sponsored or cosponsored trial.

REFERENCES


Billing Coding/Physician Documentation Information

20930 Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)

20931 Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)

20932 Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone (List separately in addition to code for primary procedure)
20933  Allograft, includes templating, cutting, placement and internal fixation, when performed; hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure)
20934  Allograft, includes templating, cutting, placement and internal fixation, when performed; intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)
20999  Unlisted procedure, musculoskeletal system, general
38205  Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38206  Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38230  Bone marrow harvesting for transplantation; allogeneic
38232  Bone marrow harvesting for transplantation; autologous
38240  Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38241  Hematopoietic progenitor cell (HPC); autologous transplantation
0263T  Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest
0264T  Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest
0265T  Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy
0565T  Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation
0566T  Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral
C9359  Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra Os Osteoconductive Scaffold Putty), per 0.5 cc
C9362  Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc

ICM-10 Codes
M00.00-M25.9  Arthropathies code range
M84.30-M84.9  Disorder of continuity of bone code range
M91.0-M94.9  Chondropathies code range
Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used With Autologous Bone Marrow) 8.01.52

Additional Policy Key Words
N/A

Policy Implementation/Update Information
9/1/18  New Policy. Considered Investigational.
9/1/19  No policy statement changes.
9/1/20  No policy statement changes.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.