



# Louisiana

## Bioengineered Skin and Soft Tissue Substitutes

**Policy #** 00572

**Original Effective Date:** 12/01/2017

**Current Effective Date:** 05/16/2018

*Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.*

*Note: Amniotic Membrane and Amniotic Fluid is addressed separately in medical policy 00458.*

### **When Services Are Eligible for Coverage**

*Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:*

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider breast reconstructive surgery using allogeneic acellular dermal matrix products\* (including each of the following: AlloDerm<sup>®†</sup>, AlloMend<sup>®†</sup>, Cortiva<sup>®†</sup> [AlloMax<sup>™‡</sup>], DermACELL<sup>™‡</sup>, DermaMatrix<sup>™‡</sup>, FlexHD<sup>®†</sup>, FlexHD<sup>®†</sup> Pliable<sup>™‡</sup>, Graftjacket<sup>®†</sup>; to be **eligible for coverage**.

- When there is insufficient tissue expander or implant coverage by the pectoralis major muscle and additional coverage is required,
- When there is viable but compromised or thin postmastectomy skin flaps that are at risk of dehiscence or necrosis, or
- The inframammary fold and lateral mammary folds have been undermined during mastectomy and reestablishment of these landmarks is needed.

Based on review of available data, the Company may consider treatment of chronic, noninfected, full-thickness diabetic lower-extremity ulcers using the following tissue-engineered skin substitutes to be **eligible for coverage**.

- AlloPatch<sup>®† \*</sup>
- Apligraf<sup>®† \*\*</sup>
- Dermagraft<sup>®† \*\*</sup>
- Integra<sup>®†</sup> Omnigraft Dermal Regeneration Matrix (also known as Omnigraft) and Integra Flowable Wound Matrix.

Based on review of available data, the Company may consider treatment of chronic, noninfected, partial- or full-thickness lower-extremity skin ulcers due to venous insufficiency, which have not adequately responded following a 1-month period of conventional ulcer therapy, using the following tissue-engineered skin substitutes to be **eligible for coverage**.

- Apligraf<sup>f\*\*</sup>
- Oasis<sup>™‡</sup> Wound Matrix<sup>\*\*\*</sup>

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Based on review of available data, the Company may consider treatment of dystrophic epidermolysis bullosa using the following tissue-engineered skin substitutes to be **eligible for coverage**.

- OrCel<sup>™‡</sup> (for the treatment of mitten-hand deformity when standard wound therapy has failed and when provided in accordance with the humanitarian device exemption (HDE) specifications of the U.S. Food and Drug Administration [FDA])<sup>\*\*\*\*</sup>

Based on review of available data, the Company may consider treatment of second- and third-degree burns using the following tissue-engineered skin substitutes to be **eligible for coverage**.

- Epicel<sup>®‡</sup> (for the treatment of deep dermal or full-thickness burns comprising a total body surface area  $\geq 30\%$  when provided in accordance with the HDE specifications of the FDA)<sup>\*\*\*\*</sup>
- Integra Dermal Regeneration Template<sup>™\*\*</sup>

\* Banked human tissue.

\*\* FDA premarket approval.

\*\*\* FDA 510(k) cleared.

\*\*\*\* FDA-approved under an HDE.

### When Services Are Considered Investigational

*Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.*

Based on review of available data, the Company considers all other uses of the bioengineered skin and soft tissue substitutes listed above to be **investigational**.\*

Based on review of available data, the Company considers all other skin and soft tissue substitutes not listed above to be **investigational**\* including but not limited to:

- ACell<sup>®‡</sup> UBM Hydrated/Lyophilized Wound Dressing
- AlloSkin<sup>™‡</sup>
- AlloSkin<sup>™‡</sup> RT
- Aongen<sup>™‡</sup> Collagen Matrix
- Architect<sup>®‡</sup> ECM, PX, FX
- ArthroFlex<sup>™‡</sup> (Flex Graft)
- Atlas Wound Matrix
- Avagen Wound Dressing
- AxoGuard<sup>®‡</sup> Nerve Protector (AxoGen)
- Biobrane<sup>®</sup>/Biobrane-L
- CollaCare<sup>®‡</sup>
- CollaCare<sup>®‡</sup> Dental
- Collagen Wound Dressing (Oasis Research)
- CollaGUARD<sup>®‡</sup>

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- CollaMend<sup>TM‡</sup>
- CollaWound<sup>TM‡</sup>
- Collexa<sup>®‡</sup>
- Collieva<sup>®‡</sup>
- Conexa<sup>TM‡</sup>
- Coreleader Colla-Pad
- CorMatrix<sup>®‡</sup>
- Cymetra<sup>TM</sup> (Micronized AlloDerm<sup>TM‡</sup>)
- Cytal<sup>TM‡</sup> (previously MatriStem<sup>®</sup>)
- Dermadapt<sup>TM‡</sup> Wound Dressing
- DermaPure<sup>TM‡</sup>
- DermaSpan<sup>TM‡</sup>
- DressSkin
- Durepair Regeneration Matrix<sup>®‡</sup>
- Endoform Dermal Template<sup>TM</sup>
- ENDURAGen<sup>TM‡</sup>
- Excellagen
- ExpressGraft<sup>TM‡</sup>
- E-Z Derm<sup>TM‡</sup>
- FlexiGraft<sup>®‡</sup>
- GammaGraft
- Graftjacket<sup>®‡</sup> Xpress, injectable
- Helicoll<sup>TM</sup>
- Hyalomatrix<sup>®‡</sup>
- Hyalomatrix<sup>®‡</sup> PA
- hMatrix<sup>®‡</sup>
- Integra<sup>TM‡</sup> Bilayer Wound Matrix
- Keramatrix<sup>®</sup>
- Kerecis<sup>TM</sup>
- MariGen<sup>TM‡</sup>/Kerecis<sup>TM‡</sup> Omega3<sup>TM‡</sup>
- MatriDerm<sup>®‡</sup>
- Matrix HD<sup>TM‡</sup>
- Mediskin<sup>®‡</sup>
- MemoDerm<sup>TM‡</sup>
- Microderm<sup>®‡</sup> biologic wound matrix
- NeoForm<sup>TM‡</sup>
- NuCel
- Oasis<sup>®‡</sup> Burn Matrix
- Oasis<sup>®‡</sup> Ultra

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- Pelvicol®/PelviSoft®†
- Permacol™‡
- PriMatrix™‡
- PriMatrix™‡ Dermal Repair Scaffold
- PuraPly™‡ Wound Matrix (previously FortaDerm™)
- PuraPly™‡ AM (Antimicrobial Wound Matrix)
- Puros®† Dermis
- RegenePro™‡
- Repliform®†
- Repriza™‡
- StrataGraft®†
- Strattice™‡ (xenograft)
- Suprathel®†
- SurgiMend®†
- Talymed®†
- TenoGlide™‡
- TenSIX™‡ Acellular Dermal Matrix
- TissueMend
- TheraForm™‡ Standard/Sheet
- TheraSkin®†
- TransCyte™
- TruSkin™‡
- Veritas®† Collagen Matrix
- XCM Biologic®† Tissue Matrix
- XenMatrix™‡ AB.

### **Background/Overview**

#### **SKIN AND SOFT TISSUE SUBSTITUTES**

Bioengineered skin and soft tissue substitutes may be either acellular or cellular. Acellular products (eg, dermis with cellular material removed) contain a matrix or scaffold composed of materials such as collagen, hyaluronic acid, and fibronectin. Acellular dermal matrix products can differ in a number of ways, including as species source (human, bovine, porcine), tissue source (eg dermis, pericardium, intestinal mucosa), additives (eg antibiotics, surfactants), hydration (wet, freeze dried), and required preparation (multiple rinses, rehydration).

Cellular products contain living cells such as fibroblasts and keratinocytes within a matrix. The cells contained within the matrix may be autologous, allogeneic, or derived from other species (eg, bovine, porcine). Skin substitutes may also be composed of dermal cells, epidermal cells, or a combination of

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dermal and epidermal cells, and may provide growth factors to stimulate healing. Bioengineered skin substitutes can be used as either temporary or permanent wound coverings.

### **Applications**

There are a large number of potential applications for artificial skin and soft tissue products. One large category is nonhealing wounds, which potentially encompasses diabetic neuropathic ulcers, vascular insufficiency ulcers, and pressure ulcers. A substantial minority of such wounds do not heal adequately with standard wound care, leading to prolonged morbidity and increased risk of mortality. For example, nonhealing lower-extremity wounds represent an ongoing risk for infection, sepsis, limb amputation, and death. Bioengineered skin and soft tissue substitutes have the potential to improve rates of healing and reduce secondary complications.

Other situations in which bioengineered skin products might substitute for living skin grafts include certain postsurgical states (eg, breast reconstruction) in which skin coverage is inadequate for the procedure performed, or for surgical wounds in patients with compromised ability to heal. Second- and third-degree burns are another indication in which artificial skin products may substitute for auto- or allografts. Certain primary dermatologic conditions that involve large areas of skin breakdown (eg, bullous diseases) may also be conditions in which artificial skin products can be considered as substitutes for skin grafts. Acellular dermal matrix products are also being evaluated in the repair of other soft tissues including rotator cuff repair, following oral and facial surgery, hernias, and other conditions.

### **FDA or Other Governmental Regulatory Approval**

U.S. Food and Drug Administration (FDA)

A large number of artificial skin products are commercially available or in development. The following summary of commercially available skin substitutes describes those products that have substantial relevant evidence on efficacy.

#### **Acellular Dermal Matrix Products**

Allograft acellular dermal matrix (ADM) products derived from donated human skin tissue are supplied by tissue banks compliant with standards of the American Association of Tissue Banks (AATB) and U.S. FDA guidelines. The processing removes the cellular components (ie, epidermis, all viable dermal cells) that can lead to rejection and infection. ADM products from human skin tissue are regarded as minimally processed and not significantly changed in structure from the natural material; FDA classifies ADM products as banked human tissue and therefore, not requiring FDA approval.

- AlloDerm (LifeCell Corp.) is an ADM (allograft) tissue-replacement product created from native human skin and processed so that the basement membrane and cellular matrix remain intact. Originally, AlloDerm required refrigeration and rehydration before use. It is currently available in a ready-to-use product stored at room temperature. An injectable micronized form of AlloDerm (Cymetra) is available.
- Cortiva (previously marketed as AlloMax Surgical Graft and before that NeoForm) is an acellular non-cross-linked human dermis allograft.

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- AlloPatch (Musculoskeletal Transplant Foundation) is an acellular human dermis allograft derived from the reticular layer of the dermis and marketed for wound care. This product is also marketed as FlexHD for postmastectomy breast reconstruction.
- FlexHD and the newer formulation FlexHD Pliable (Musculoskeletal Transplant Foundation) are acellular hydrated reticular dermis allograft derived from donated human skin.
- DermACELL (LifeNet Health) is an allogeneic ADM processed with proprietary technologies MATRACELL<sup>®‡</sup> and PRESERVON<sup>®‡</sup>.
- DermaMatrix (Synthes) is a freeze-dried ADM derived from donated human skin tissue. DermaMatrix Acellular Dermis is processed by the Musculoskeletal Transplant Foundation.
- DermaPure (Tissue Regenix Wound Care) is a single-layer decellularized human dermal allograft for the treatment of acute and chronic wounds.
- Graftjacket Regenerative Tissue Matrix (also called Graftjacket Skin Substitute; KCI) is an acellular regenerative tissue matrix that has been processed from human skin supplied from U.S. tissue banks. The allograft is minimally processed to remove the epidermal and dermal cells while preserving dermal structure. Graftjacket Xpress is an injectable product.

FDA product codes: FTM, OXF.

### Xenogenic Products

Cytal (previously called MatriStem<sup>®)‡</sup> Wound Matrix, Multilayer Wound Matrix, Pelvic Floor Matrix, MicroMatrix, and Burn Matrix (all manufactured by ACell) are composed of porcine-derived urinary bladder matrix.

Helicoll (Encol) is an acellular collagen matrix derived from bovine dermis. In 2004, it was cleared for marketing by FDA through the 510(k) process for topical wound management that includes partial and full-thickness wounds, pressure ulcers, venous ulcers, chronic vascular ulcers, diabetic ulcers, trauma wounds (eg, abrasions, lacerations, second-degree burns, skin tears), and surgical wounds including donor sites/grafts.

Keramatrix (Keraplast Research) is an open-cell foam comprised of freeze-dried keratin that is derived from acellular animal protein. In 2009, it was cleared for marketing by FDA through the 510(k) process under the name of Keratec. The wound dressings are indicated in the management of the following types of dry, light, and moderately exudating partial and full-thickness wounds: pressure (stage I-IV) and venous stasis ulcers, ulcers caused by mixed vascular etiologies, diabetic ulcers, donor sites, and grafts.

Kerecis Omega3 Wound (Kerecis) is an ADM derived from fish skin. It has a high content of omega 3 fatty acids and is intended for use in burn wounds, chronic wounds, and other applications.

Permacol (Covidien) is xenogeneic and composed of cross-linked porcine dermal collagen. Cross-linking improves the tensile strength and long-term durability but decreases pliability.

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PriMatrix (TEI Biosciences) is a xenogeneic ADM processed from fetal bovine dermis. It was cleared for marketing by FDA through the 510(k) process for partial- and full-thickness wounds; diabetic, pressure, and venous stasis ulcers; surgical wounds; and tunneling, draining, and traumatic wounds. FDA product code: KGN.

SurgiMend PRS (TEI Biosciences) is a xenogeneic ADM processed from fetal bovine dermis.

Strattice Reconstructive Tissue Matrix (LifeCell Corp.) is a xenogenic non-cross-linked porcine-derived ADM. There are pliable and firm versions, which are stored at room temperature and come fully hydrated.

Oasis Wound Matrix (Cook Biotech) is a collagen scaffold (extracellular matrix) derived from porcine small intestinal submucosa. In 2000, it was cleared for marketing by FDA through the 510(k) process for the management of partial- and full-thickness wounds, including pressure ulcers, venous ulcers, diabetic ulcers, chronic vascular ulcers, tunneled undermined wounds, surgical wounds, trauma wounds, and draining wounds. FDA Product code: KGN.

### **Living Cell Therapy**

Apligraf (Organogenesis) is a bilayered living cell therapy composed of an epidermal layer of living human keratinocytes and a dermal layer of living human fibroblasts. Apligraf is supplied as needed, in 1 size, with a shelf-life of 10 days. In 1998, it was approved by FDA for use in conjunction with compression therapy for the treatment of noninfected, partial- and full-thickness skin ulcers due to venous insufficiency and in 2001 for full-thickness neuropathic diabetic lower-extremity ulcers nonresponsive to standard wound therapy. FDA product code: FTM.

Dermagraft (Organogenesis) is composed of cryopreserved human-derived fibroblasts and collagen derived from newborn human foreskin and cultured on a bioabsorbable polyglactin mesh scaffold. Dermagraft has been approved by FDA for repair of diabetic foot ulcers. FDA product code: PFC.

TheraSkin (Soluble Systems) is a cryopreserved split-thickness human skin allograft composed of living fibroblasts and keratinocytes and an extracellular matrix in epidermal and dermal layers. TheraSkin is derived from human skin allograft supplied by tissue banks compliant with the American Association of Tissue Banks and FDA guidelines. It is considered a minimally processed human cell, tissue, and cellular- and tissue based product by FDA.

Epicel (Genzyme Biosurgery) is an epithelial autograft composed of a patient's own keratinocytes cultured ex vivo and is FDA-approved under a humanitarian device exemption for the treatment of deep dermal or full-thickness burns comprising a total body surface area of 30% or more. It may be used in conjunction with split-thickness autografts or alone in patients for whom split-thickness autografts may not be an option due to the severity and extent of their burns. FDA product code: OCE.

OrCel (Forticell Bioscience; formerly Composite Cultured Skin) is an absorbable allogeneic bilayered cellular matrix, made of bovine collagen, in which human dermal cells have been cultured. It was approved

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by FDA premarket approval for healing donor site wounds in burn victims and under a humanitarian device exemption (HDE) for use in patients with recessive dystrophic epidermolysis bullosa undergoing hand reconstruction surgery to close and heal wounds created by the surgery, including those at donor sites. FDA product code: ODS.

### **Biosynthetic Products**

Biobrane/Biobrane-L (Smith & Nephew) is a biosynthetic wound dressing constructed of a silicon film with a nylon fabric partially imbedded into the film. The fabric creates a complex 3-dimensional structure of trifilament thread, which chemically binds collagen. Blood/sera clot in the nylon matrix, adhering the dressing to the wound until epithelialization occurs. FDA product code: FRO.

Integra Dermal Regeneration Template (also marketed as Omnigraft Dermal Regeneration Matrix; Integra LifeSciences) is a bovine, collagen/glycosaminoglycan dermal replacement covered by a silicone temporary epidermal substitute. It was approved by FDA for use in the postexcisional treatment of life-threatening full-thickness or deep partial-thickness thermal injury where sufficient autograft is not available at the time of excision or not desirable because of the physiologic condition of the patient and for certain diabetic foot ulcers. Integra Matrix Wound Dressing and Integra Meshed Bilayer Wound Matrix are substantially equivalent skin substitutes and were cleared for marketing by FDA through the 510(k) process for other indications. Integra Bilayer Matrix Wound Dressing (Integra LifeSciences) is designed to be used in conjunction with negative pressure wound therapy. The meshed bilayer provides a flexible wound covering and allows drainage of wound exudate. FDA product code: MDD.

TransCyte (Advanced Tissue Sciences) consists of human dermal fibroblasts grown on nylon mesh, combined with a synthetic epidermal layer and was approved by FDA in 1997. TransCyte is intended as a temporary covering over burns until autografting is possible. It can also be used as a temporary covering for some burn wounds that heal without autografting.

### **Synthetic Products**

Suprathel (PolyMedics Innovations) is a synthetic copolymer membrane fabricated from a tripolymer of polylactide, trimethylene carbonate, and s-caprolactone. It is used to provide temporary coverage of superficial dermal burns and wounds. Suprathel is covered with gauze and a dressing that is left in place until the wound has healed.

### **Centers for Medicare and Medicaid Services (CMS)**

CMS issued the following national coverage determination: Porcine (pig) skin dressings are covered, if reasonable and necessary for the individual patient as an occlusive dressing for burns, donor sites of a homograft, and decubiti and other ulcers.

Since 2014, CMS has no longer distinguished between different skin substitutes and classifies them as either high cost or low cost. CMS packages skin substitutes of the same class into the associated surgical

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procedures for hospital outpatient departments and ambulatory surgical centers. A separate payment might be made if the item is furnished on a different date of service as the primary service.

## **Rationale/Source**

Evidence reviews 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. 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.

The primary end points of interest for trials of wound closure are as follows, consistent with guidance from the U.S. FDA for industry in developing products for treatment of chronic cutaneous ulcer and burn wounds:

1. Incidence of complete wound closure.
2. Time to complete wound closure (reflecting accelerated wound closure).
3. Incidence of complete wound closure following surgical wound closure.
4. Pain control.

The following is a summary of key literature to date.

## **BREAST RECONSTRUCTION**

A variety of breast reconstruction techniques are used postmastectomy, including implant-based (immediate or delayed following use of a tissue expander) and those using autologous tissue flaps. Some of these techniques have been used with ADM to provide additional support or tissue coverage. The literature on ADM for breast reconstruction consists primarily of retrospective, uncontrolled series and systematic reviews of these studies.

A 2013 study used data from the American College of Surgeon's National Surgical Quality Improvement Program to compare ADM-assisted tissue expander breast reconstruction (n=1717) to submuscular tissue expander breast reconstruction (n=7442) after mastectomy. Complication rates did not differ significantly

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between the ADM-assisted (5.5%) and the submuscular tissue expander groups (5.3%;  $p=0.68$ ). Rates of reconstruction-related complications, major complications, and 30-day reoperation did not differ significantly between cohorts.

### Systematic Reviews

A 2016 meta-analysis by Lee and Mun included 23 studies (total  $N=6199$  cases) on implant-based breast reconstruction that were published between February 2011 and December 2014. The analysis included an RCT and 3 prospective comparative cohort studies; the remainder was retrospective comparative cohort studies. Use of ADM did not affect the total complication rate (see Table 1). ADM significantly increased the risk of major infection, seroma, and flap necrosis, but reduced risks of capsular contracture and implant malposition. Use of ADM allowed for significantly greater intraoperative expansion (mean difference [MD], 79.63; 95% confidence interval [CI], 41.99 to 117.26;  $p<0.001$ ) and percentage of intraoperative filling (MD=13.30; 95% CI, 9.95 to 16.65;  $p<0.001$ ), and reduced the frequency of injections to complete expansion (MD = -1.56; 95% CI, -2.77 to -0.35;  $p=0.01$ ).

**Table 1. Meta-Analysis of Breast Reconstruction Outcomes With and Without ADM**

Outcome Measure	Relative Risk	95% Confidence Interval	p
Infection	1.42	1.02 to 1.99	0.04
Seroma	1.41	1.12 to 1.78	0.004
Mastectomy flap necrosis	1.44	1.11 to 1.87	0.006
Unplanned return to the operating room	1.09	0.63 to 1.90	NS
Implant loss	1.00	0.68 to 1.48	NS
Total complications	1.08	0.87 to 1.34	NS
Capsular contracture	0.26	0.15 to 0.47	<0.001
Implant malposition	0.21	0.07 to 0.59	0.003

Adapted from Lee and Mun (2016).

ADM: acellular dermal matrix; NS: not significant.

### AlloDerm

#### Randomized Controlled Trials

In 2012, McCarthy et al reported on a multicenter, blinded RCT of AlloDerm in 2-stage expander/implant reconstruction. Seventy patients were randomized to AlloDerm ADM-assisted tissue expander/implant reconstruction or to submuscular tissue expander/implant placement. The trial was adequately powered to detect clinically significant differences in immediate postoperative pain but underpowered to detect the secondary end point of pain during tissue expansion. There were no significant differences between the groups in the primary outcomes of immediate postoperative pain (54.6 AlloDerm vs 42.8 controls on a 100-point visual analog scale) or pain during the expansion phase (17.0 AlloDerm vs 4.6 controls), or in the secondary outcome of rate of tissue expansion (91 days AlloDerm vs 108 days controls) and patient-reported physical well-being. There was no significant difference in adverse events, although the total number of adverse events was small.

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## Comparisons Between Products

### ***AlloDerm vs AlloMax***

Hinchcliff et al (2017) conducted an RCT that compared AlloDerm with AlloMax (n=15 each) for implant-based breast reconstruction. Complications were assessed 7, 14, and 30 days postoperatively and biopsies of the ADMs were taken during implant exchange. Vessel density in the AlloMax biopsies was higher than in the AlloDerm biopsies. Complications were reported in 26.1% of AlloMax cases and 8.0% of AlloDerm cases; these complication rates did not differ statistically with the 30 patients in this trial.

### ***AlloDerm vs DermaMatrix***

Mendenhall et al (2017) conducted an RCT that compared AlloDerm with DermaMatrix in 111 patients (173 breasts). There were no significant differences in overall rates of complications (AlloDerm, 15.4%; DermaMatrix, 18.3%; p=0.8) or implant loss (AlloDerm, 2.2%; DermaMatrix, 3.7%; p=0.5) between the 2 ADMs.

### ***AlloDerm vs FlexHD***

A 2014 retrospective review by Liu et al compared complication rates following breast reconstruction with AlloDerm or FlexHD in 382 consecutive women (547 breasts). Eighty-one percent of the sample was immediate reconstruction: 165 used AlloDerm and 97 used FlexHD. Mean follow-up was 6.4 months. Compared with breast reconstruction without the use of AlloDerm or FlexHD, ADM had a higher rate of delayed healing (20.2% vs 10.3%), although this finding might have been related to differences in fill volumes. In univariate analysis, there were no significant differences in complications (return to operating room, surgical site infection, seroma, hematoma, delayed healing, implant loss) between AlloDerm and FlexHD. In multivariate analysis, there were no significant differences between AlloDerm and FlexHD for the return to the operating room, surgical site infection, seroma, or delayed healing. Independent risk factors for implant loss included the use of FlexHD, single-stage reconstruction, and smoking.

### ***AlloDerm vs FlexHD Pliable and DermACELL***

Chang and Liu (2017) reported on a prospective comparison of FlexHD Pliable (32 breasts), AlloDerm (22 breasts), and DermACELL (20 breasts) in breast reconstruction. The choice of ADM was based on different years when each ADM was available for use at the investigators' institution; patient demographics were comparable between groups. The pieces of ADM used were all the same size (8 x 16 cm) to eliminate an effect of size on outcomes. The time to drain removal was longer with AlloDerm (26 days) than with FlexHD (20 days) or DermACELL (15 days; p=0.001). Complications were low (4 in the Flex Pliable group, 2 in the AlloDerm group, 1 in the DermACELL group), with no significant differences between groups. At the time of exchange for a permanent implant or free flap reconstruction, all grafts had completely incorporated into the mastectomy skin flaps. No patients developed complications requiring removal of the ADM.

Pittman et al (2017) reported a retrospective pilot study of the use of AlloDerm (50 breasts) and DermACELL (50 breasts). The choice of ADM was based on products available during different years and patient demographics were similar between the 2 groups. Patients in the DermACELL group had a significantly

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lower incidence of “red breast syndrome” (0% vs 26%,  $p=0.001$ ) and fewer days until drain removal (15.8 days vs 20.6 days,  $p=0.017$ ). There were no significant differences in the rates of other complications.

### Strattice

Dikmans et al (2017) reported on early safety outcomes from an open-label multicenter RCT that compared porcine ADM-assisted 1-stage expansion with 2-stage implant-based breast reconstruction (see Table 2). One-stage breast reconstruction with porcine ADM was associated with a higher risk of surgical complications, reoperation, and with removal of implant, ADM, or both (see Table 3). The trial was stopped early due to safety concerns, but it cannot be determined from this study design whether the increase in complications was due to the use of the xenogenic ADM or to the comparison between 1-stage and 2-stage reconstruction.

**Table 2. Summary of Key RCT Characteristics**

Author	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
Dikmans et al (2017)	EU	8	2013-2015	Women intending to undergo skin-sparing mastectomy and immediate IBBR	59 patients (91 breasts) undergoing 1-stage IBBR with ADM	62 women (92 breasts) undergoing 2-stage IBBR

ADM: acellular dermal matrix; IBBR: implant-based breast reconstruction; RCT: randomized controlled trial.

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

Study	Surgical Complications	Severe Adverse Events	Reoperation	Removal of Implant, ADM, or Both
Dikmans et al (2017)				
1-stage with ADM, n (%)	27 (46)	26 (29)	22 (37)	24 (26)
2-stage with ADM, n (%)	11 (18)	5 (5)	9 (15)	4 (5)
OR (95% CI)	3.81 (2.67 to 5.43)		3.38 (2.10 to 5.45)	8.80 (8.24 to 9.40)
p	<0.001		<0.001	<0.001

ADM: acellular dermal matrix; CI: confidence interval; OR: odds ratio; RCT: randomized controlled trial.

### Section Summary: Breast Reconstruction

Results of a systematic review found no difference in overall complication rates between ADM allograft and standard procedures for breast reconstruction. Although reconstructions with ADM have been reported to have higher seroma, infection, and necrosis rates than reconstructions without ADM, rates of capsular contracture and malposition of implants may be reduced. Thus, in cases where there is limited tissue coverage, the available studies may be considered sufficient to permit informed decision-making about risks and benefits of using allogeneic ADM for breast reconstruction.

### TENDON REPAIR

#### Graftjacket

In 2012, Barber et al reported an industry-sponsored multicenter RCT of augmentation with Graftjacket human ADM for arthroscopic repair of large (>3 cm) rotator cuff tears involving 2 tendons. Twenty-two patients were randomized to Graftjacket augmentation and 20 patients to no augmentation. At a mean



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follow-up of 24 months (range, 12-38 months), the American Shoulder and Elbow Surgeons score improved from 48.5 to 98.9 in the Graftjacket group and from 46.0 to 94.8 in the control group ( $p=0.035$ ). The Constant score improved from 41 to 91.9 in the Graftjacket group and from 45.8 to 85.3 in the control group ( $p=0.008$ ). The University of California, Los Angeles score did not differ significantly between groups. Gadolinium-enhanced magnetic resonance imaging (MRI) scans showed intact cuffs in 85% of repairs in the Graftjacket group and 40% of repairs in the control group. However, no correlation was found between MRI findings and clinical outcomes. Rotator cuff retears occurred in 3 (14%) patients in the Graftjacket group and 9 (45%) patients in the control group.

### **Section Summary: Tendon Repair**

One small RCT was identified that found improved outcomes with Graftjacket ADM allograft for rotator cuff repair. Although results of this trial were promising, additional study with a larger number of patients is needed to evaluate consistency of findings and determine the effects of this technology with greater certainty.

### **SURGICAL REPAIR OF HERNIAS OR PARASTOMAL REINFORCEMENT**

A 2013 systematic review evaluated the clinical effectiveness of acellular collagen-based scaffolds for the repair of incisional hernias. The bioprosthetic materials could be harvested from bovine pericardium, human cadaveric dermis, porcine small intestine mucosa, porcine dermal collagen, or bovine dermal collagen. Products included in the search were Surgisis, Tutomesh, Veritas, AlloDerm, FlexHD, AlloMax, CollaMend, Permacol, Strattice, FortaGen, ACell, DermaMatrix, XenMatrix, and SurgiMend. Sixty publications with 1212 repairs were identified and included in the review, although meta-analysis could not be performed. There were 4 level III studies (2 AlloDerm, 2 Permacol); the remainder was level IV or V. The largest number of publications were on AlloDerm ( $n=27$ ) and Permacol ( $n=18$ ). No publications on incisional hernia repair were identified for AlloMax, FortaGen, DermaMatrix, or ACell. The overall incidence of a surgical site occurrence (eg, postoperative infection, seroma/hematoma, pain, bulging, dehiscence, fistula, mechanical failure) was 82.6% for porcine small intestine mucosa, 50.7% for xenogenic dermis, 48.3% for human dermis, and 6.3% for xenogenic pericardium. No comparative data were identified that could establish superiority to permanent synthetic meshes.

### **AlloDerm as an Overlay**

In 2007, Espinosa-de-los-Monteros et al retrospectively reviewed 39 abdominal wall reconstructions with AlloDerm performed in 37 patients and compared them with 39 randomly selected cases. They reported a significant decrease in recurrence rates when human cadaveric acellular dermis was added as an overlay to primary closure plus rectus muscle advancement and imbrication in patients with medium-sized hernias. However, no differences were observed when adding human cadaveric acellular dermis as an overlay to patients with large-size hernias treated with underlay mesh.

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## Comparisons Between Products

### ***AlloDerm vs Surgisis Gold***

Gupta et al (2006) compared the efficacy and complications associated with use of AlloDerm and Surgisis bioactive mesh in 74 patients who underwent ventral hernia repair. The first 41 procedures were performed using Surgisis Gold 8-ply mesh formed from porcine small intestine submucosa, and the remaining 33 patients had ventral hernia repair with AlloDerm. Patients were seen 7 to 10 days after discharge from the hospital and at 6 weeks. Any signs of wound infection, diastasis, hernia recurrence, changes in bowel habits, and seroma formation were evaluated. The use of the AlloDerm mesh resulted in 8 (24%) hernia recurrences. Fifteen (45%) of the AlloDerm patients developed a diastasis or bulging at the repair site. Seroma formation was only a problem in 2 patients.

### ***AlloDerm vs FlexHD***

A 2013 study compared AlloDerm with FlexHD for complicated hernia surgery. From 2005 to 2007, AlloDerm was used to repair large (>200 cm<sup>2</sup>) symptomatic complicated ventral hernias that resulted from trauma or emergency surgery (n=55). From 2008 to 2010, FlexHD was used to repair large, complicated ventral hernias in patients meeting the same criteria (n=40). The 2 groups were comparable at baseline. At 1 year follow-up, all AlloDerm patients were diagnosed with hernia recurrence (abdominal laxity, functional recurrence, true recurrence) requiring a second repair. Eleven (31%) patients in the FlexHD group required a second repair. This comparative study is limited by the use of nonconcurrent comparisons, which is prone to selection bias and does not control for temporal trends in outcomes.

### ***FlexHD vs Strattice***

Roth et al (2017) reported on a prospective study assessing clinical and quality of life outcomes following complex hernia repair with a human (FlexHD) or porcine (Strattice) ADM. The study was funded by the Musculoskeletal Transplant Foundation, which prepares and supplies FlexHD. Patients were enrolled if they had a hernia at least 6 cm in the transverse dimension, active or prior infection of the abdominal wall, and/or enterocutaneous fistula requiring mesh removal. Eighteen (51%) of the 35 patients had undergone a previous hernia repair. After abdominal wall repair with the ADM, 20 (57%) patients had a surgical site occurrence, and nearly one-third had hospital readmission. The type of biologic material did not impact hernia outcomes. There was no comparison with synthetic mesh in this study, limiting interpretation.

### ***Strattice vs Synthetic Mesh***

In 2014, Bellows et al reported early results of an industry-sponsored multicenter RCT that compared Strattice (non-cross-linked porcine ADM, n=84) with a standard synthetic mesh (n=88) for the repair of inguinal hernias. The trial was designed by the surgeons and was patient- and assessor-blinded to reduce risk of bias. Blinding continued through 2 years of follow-up. The primary outcome was resumption of activities of daily living at 1 year. Secondary outcomes included complications, recurrences, or chronic pain (ie, pain that did not disappear by 3 months postsurgery). At 3-month follow-up, there were no significant differences in either the occurrence or type of wound events (relative risk, 0.98; 95% CI, 0.52 to 1.86). Pain

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was reduced from 1 to 3 days postoperative in the group treated with Strattice, but at 3 month follow-up pain scores did not differ significantly between groups.

### **Strattice vs No Reinforcement**

Also in 2014, the PRISM Study Group reported a multicenter, double-blinded, randomized trial of Strattice for parastomal reinforcement in patients undergoing surgery for permanent abdominal wall ostomies. Patients were randomized to standard stoma construction with no reinforcement (n=58) or stoma construction with Strattice as parastomal reinforcement (n=55). At 24-month follow-up (n=75), the incidence of parastomal hernias was similar for the 2 groups (13.2% of controls, 12.2% of study group).

### **Section Summary: Surgical Repair of Hernias or Parastomal Reinforcement**

Current evidence does not support a benefit of ADMs in hernia repair or prevention of parastomal hernia. Additional RCTs are needed to compare biologic mesh with synthetic mesh and to determine if there is a patient population that would benefit from these products.

## **DIABETIC LOWER-EXTREMITY ULCERS**

### **Systematic Reviews**

A 2016 Cochrane review evaluated skin substitutes for the treatment of diabetic foot ulcers. Seventeen trials (total N=1655 participants) were included in the meta-analysis. Most trials identified were industry-sponsored, and an asymmetric funnel plot indicated publication bias. Pooled results of published trials found that skin substitutes increased the likelihood of achieving complete ulcer closure compared with standard of care (SOC) alone (relative risk, 1.55; 95% CI, 1.30 to 1.85). Use of skin substitutes also led to a statistically significant reduction in amputations (relative risk, 0.43; 95% CI, 0.23 to 0.81), although the absolute risk difference was small. Analysis by individual products found a statistically significant benefit on ulcer closure for Apligraf, EpiFix, and Hyalograft-3D. The products that did not show a statistically significant benefit for ulcer closure were Dermagraft, Graftjacket, Kaloderm, and OrCel. Individual RCTs are described next.

Martinson and Martinson (2016) conducted an industry-sponsored analysis of Medicare claims data (13,193 treatment episodes) to compare efficacy and cost of skin substitutes for the management of diabetic foot ulcers. Included in the analysis were treatment episodes with Apligraf (37%), Dermagraft (42%), Oasis (19%), and Cytal (MatriStem, 2%). The mean number of applications was 3.24 for Apligraf, 4.48 for Oasis, 5.53 for Cytal, and 5.96 for Dermagraft. All comparisons were statistically significant. Healing at 90 days was modestly but statistically higher for Oasis (63%) and Cytal (62%) than for Apligraf (58%) or Dermagraft (58%). Amputation rates were similar after treatment with the 4 products, ranging from 1.3% for Oasis to 2.1% for Cytal.

Guo et al (2017) reported a systematic review of ADM for the treatment diabetic foot ulcer. Most data were from an RCT of Integra Dermal Regeneration Template, which is a bilayer product with the outer layer composed of a thin silicone film and not a pure ADM.

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## **Apligraf, Dermagraft, AlloPatch, Integra Dermal Regeneration Template, or Integra Flowable Wound Matrix**

### ***Apligraf***

Veves et al (2001) reported on a randomized prospective trial on the effectiveness of Apligraf (previously called Graftskin), a living skin equivalent, in treating noninfected nonischemic chronic plantar diabetic foot ulcers. The trial involved 24 centers in the United States; 208 patients were randomized to ulcer treatment with Apligraf (112 patients) or saline-moistened gauze (96 patients, control group). Standard state-of-the-art adjunctive therapy, including extensive surgical débridement and adequate foot off-loading, was provided in both groups. Apligraf was applied at the beginning of the study and weekly thereafter for a maximum of 4 weeks (maximum of 5 applications) or earlier if complete healing occurred. At the 12-week follow-up visit, 63 (56%) Apligraf-treated patients achieved complete wound healing compared with 36 (38%) in the control group ( $p=0.004$ ). The Kaplan-Meier method median time to complete closure was 65 days for Apligraf, significantly lower than the 90 days observed in the control group ( $p=0.003$ ). The rates of adverse reactions were similar between groups, except osteomyelitis and lower-limb amputations, both of which were less frequent in the Apligraf group. Trialists concluded that application of Apligraf for a maximum of 4 weeks resulted in higher healing rates than state-of-the-art treatment and was not associated with any significant adverse events. This trial was reviewed in a 2001 TEC Assessment, which concluded that Apligraf, in conjunction with good local wound care, met the TEC criteria for the treatment of diabetic ulcers that fail to respond to conservative management.

Steinberg et al (2010) reported on a study of 72 subjects from Europe and Australia that assessed the safety and efficacy of Apligraf in the treatment of noninfected diabetic foot ulcers. Study design and patient population were similar to the 208-subject U.S. study (previously described), which led to FDA approval of Apligraf for the treatment of diabetic foot ulcers. For these studies, subjects with noninfected neuropathic diabetic foot ulcers present for at least 2 weeks were enrolled in prospective, multicenter, open-label RCTs that compared Apligraf use plus standard therapy (sharp débridement, standard wound care, off-loading) with standard therapy alone. Pooling of data was performed because of the similarity and consistency of the 2 studies. Efficacy and safety results were consistent across studies independent of mean ulcer duration, which was significantly longer in the European study (21 months vs 10 months in the U.S. study). Reported adverse events by 12 weeks were comparable across treatment groups in the 2 studies. Efficacy measures demonstrated superiority of Apligraf treatment over control-treated groups in both studies. Combining the data from both studies, 55.2% (80/145) of Apligraf subjects had complete wound closure by 12 weeks, compared with 34.3% (46/134) of control subjects ( $p<0.001$ ), and Apligraf subjects had a significantly shorter time to complete wound closure ( $p<0.001$ ). The authors concluded that both the EU and U.S. studies exhibited superior efficacy and comparable safety for subjects treated with Apligraf compared with control subjects and that the studies provided evidence of the benefit of Apligraf in treating diabetic foot ulcer.

In 2010, Kirsner et al analyzed 2517 patients with diabetic neuropathic foot ulcers treated between 2001 and 2004. This retrospective analysis used a wound care database; the patients received advanced biologic

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therapy, specifically, Apligraf (446 patients), Regranex, or Procuren. The analysis found that advanced biologic therapy was used, on average, within 28 days from the first wound clinic visit and was associated with a median time to healing of 100 days. Wounds treated with engineered skin (Apligraf) as the first advanced biologic therapy were 31% more likely to heal than wounds first treated with topical recombinant growth factor ( $p < 0.001$ ) and 40% more likely to heal than those first treated with platelet releasate ( $p = 0.01$ ). Wound size, wound grade, duration of wound, and time to initiation of advanced biologic therapy affected the time to healing.

### ***Dermagraft***

A 2003 pivotal multicenter FDA-regulated trial randomized 314 patients with chronic diabetic ulcers to Dermagraft (human-derived fibroblasts cultured on mesh) or control. Over the 12-week study, patients received up to 8 applications of Dermagraft. All patients received pressure-reducing footwear and were encouraged to stay off their study foot as much as possible. At 12 weeks, the median percent wound closure for the Dermagraft group was 91% compared with 78% for the control group. Ulcers treated with Dermagraft closed significantly faster than ulcers treated with conventional therapy. No serious adverse events were attributed to Dermagraft. Ulcer infections developed in 10.4% of the Dermagraft patients compared with 17.9% of the control patients. Together, there was a lower rate of infection, cellulitis, and osteomyelitis in the Dermagraft-treated group (19% vs 32.5%). A 2015 retrospective analysis of the trial data found a significant reduction in amputation/bone resection rates with Dermagraft (5.5% vs 12.6%,  $p = 0.031$ ). Of the 28 cases of amputation/bone resection, 27 were preceded by ulcer-related infection.

### ***AlloPatch***

AlloPatch Pliable human reticular acellular dermis was compared with SOC in a 2017 industry-sponsored multicenter trial by Zelen et al. The trial was powered to detect a 45% difference between groups in percent healing at 6 weeks with 20 patients per group. Evaluation of the outcome measures was not blinded. At 6 weeks, 65% (13/20) of wounds treated using AlloPatch had healed compared with 5% (1/20) in the SOC-alone group ( $p < 0.001$ ). After adjusting for wound area at baseline, the hazard ratio for healing was 168 (95% CI, 10 to 2704;  $p < 0.001$ ), indicating a lack of precision in the estimate. Per protocol, 10 patients in the SOC group and 1 in the AlloPatch group exited the study at 6 weeks because their wounds failed to reduce in area by at least 50%. According to ITT analysis with last observation carried forward, the percentage of wounds healed at 12 weeks was 80% in the AlloPatch group compared with 20% in the SOC group. However, because there was a high (50%) withdrawal rate in the SOC group, this result has a high risk of bias.

### ***Integra Omnigraft Dermal Regeneration Template or Integra Flowable Wound Matrix***

Integra Dermal Regeneration Template is a biosynthetic skin substitute that is FDA-approved for life-threatening thermal injury. The FOUNDER (Foot Ulcer New Dermal Replacement) multicenter study (32 sites) assessed Integra Dermal Regeneration Template (marketed as Omnigraft) for chronic nonhealing diabetic foot ulcers under an FDA-regulated investigational device exemption. A total of 307 patients with at least 1 chronic diabetic foot ulcer were randomized to treatment with the Integra Template or a control condition (sodium chloride gel 0.9%). Treatment was given for 16 weeks or until wound closure. There was

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a modest increase in wound closure with the Integra Template (51% vs 32%,  $p=0.001$ ) and a shorter median time to closure (43 days vs 78 days,  $p=0.001$ ). There was a strong correlation between investigator-assessed and computerized planimetry assessment of wound healing ( $r=0.97$ ). Kaplan-Meier analysis showed the greatest difference between groups in wound closure up to 10 weeks, with diminishing differences after 10 weeks. Trial strengths included adequate power to detect an increase in wound healing of 18%, which was considered to be clinically significant, secondary outcomes of wound closure and time to wound closure by computerized planimetry, and ITT analysis.

Integra Flowable Wound Matrix is composed of a porous matrix of cross-linked bovine tendon collagen and glycosaminoglycan. It is supplied as a granular product that is mixed with saline. Campitiello et al (2017) published an RCT that compared the flowable matrix with wet dressing in 46 patients who had Wagner grade 3 diabetic foot ulcers. The ulcers had developed over 39 weeks. Complete healing at 6 weeks was achieved in significantly more patients in the Integra Flowable Wound Matrix group than in the control group, while the risk of rehospitalization and major amputation was reduced with Integra Flowable Wound Matrix (see Table 4).

**Table 4. Probability of Wound Healing With IFWM vs SOC**

Study	Complete Wound Healing	Rehospitalization	Major Amputation
Campitiello et al (2017)			
IFWM, n (%)	20 (86.95)	2 (6.69)	1 (4.34)
SOC, n (%)	12 (52.17)	10 (43.47)	7 (30.43)
RR (95% CI)	1.67 (1.09 to 2.54)	0.10 (0.01 to 0.72)	0.16 (0.02 to 1.17)
p	0.010	0.001	0.028

CI: confidence interval; IFWM: Integra Flowable Wound Matrix; RR: relative risk; SOC: standard of care.

### **Section Summary: Apligraf, Dermagraft, AlloPatch, or Integra for Diabetic Lower-Extremity Ulcers**

RCTs have demonstrated the efficacy of Apligraf, Dermagraft, AlloPatch, Integra Dermal Regeneration Template, and Integra Flowable Wound Matrix over SOC for the treatment of diabetic lower-extremity ulcers.

### **Bioengineered Skin Substitutes Other Than Apligraf, Dermagraft, AlloPatch, or Integra Graftjacket Regenerative Tissue Matrix**

Brigido et al (2004) reported a small (N=40) randomized pilot study comparing Graftjacket with conventional treatment for chronic nonhealing diabetic foot ulcers. Control patients received conventional therapy with débridement, wound gel with gauze dressing, and off-loading. Graftjacket patients received surgical application of the scaffold using skin staples or sutures and moistened compressive dressing. A second graft application was necessary after the initial application for all patients in the Graftjacket group. Preliminary one month results showed that, after a single treatment, ulcers treated with Graftjacket healed at a faster rate than conventional treatment. There were significantly greater decreases in wound length (51% vs 15%), width (50% vs 23%), area (73% vs 34%), and depth (89% vs 25%), respectively. With follow-up to four weeks, no data were reported on the proportion with complete closure or the mean time to heal. All grafts were incorporated into the host tissue.

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Reyzelman et al (2009) reported an industry-sponsored multicenter randomized study that compared a single application of Graftjacket with SOC in 86 patients with diabetic foot ulcers. Eight patients, six in the study group and two in the control group, did not complete the trial. At 12 weeks, complete healing was observed in 69.6% of the Graftjacket group and 46.2% of controls. After adjusting for ulcer size at presentation, a statistically significant difference in nonhealing rate was calculated, with odds of healing 2.0 times higher in the study group. Mean healing time was 5.7 weeks for the Graftjacket group vs 6.8 weeks for the control group. The authors did not report whether this difference was statistically significant. Median time to healing was 4.5 weeks for Graftjacket (range, 1-12 weeks) and 7.0 weeks for control (range, 2-12 weeks). Kaplan-Meier method survivorship analysis for time to complete healing at 12 weeks showed a significantly lower nonhealing rate for the study group (30.4%) than for the control group (53.9%). The authors commented that a single application of Graftjacket, as used in this study, was often sufficient for complete healing. Conclusions drawn from this study are limited by the small study population and differences in ulcer size at baseline. Questions also remain whether the difference in mean time to healing is statistically or clinically significant.

In 2015, Reyzelman and Bazarov reported an industry-sponsored meta-analysis of Graftjacket for diabetic foot ulcers that included the 2 studies described above and a third RCT by Brigido (2006) with 28 patients (total N=154 patients). The time to heal was estimated for the 2004 Brigido study, based on the average wound reduction per week. The estimated difference in time to heal was considerably larger for Brigido's 2004 study (-4.30 weeks) than for the other 2 studies that measured the difference in time to heal (-1.58 weeks and -1.10 weeks). Analysis of the proportion of wounds that healed included Brigido (2006) and Reyzelman et al (2009). The odds ratio in the smaller study by Brigido was considerably larger, with a lack of precision in the estimate (odds ratio, 15.0; 95% CI, 2.26 to 99.64), and the combined odds (3.75; 95% CI, 1.72 to 8.19) was not significant when analyzed using a random-effects model. Potential sources of bias, noted by Reyzelman and Bazarov, included publication and reporting biases, study selection biases, incomplete data selection, post hoc manipulation of data, and subjective choice of analytic methods. Overall, results of these studies do not provide convincing evidence that Graftjacket is more effective than SOC for healing diabetic foot ulcers.

### ***DermACELL vs Graftjacket Regenerative Tissue Matrix or SOC***

DermACELL and Graftjacket are both composed of human ADM. In 2016, Walters et al reported on a multicenter randomized comparison of DermACELL, Graftjacket, or SOC (2:1:2 ratio) in 168 patients with diabetic foot ulcers. The study was sponsored by LifeNet Health, a nonprofit organ procurement association and processor for DermACELL. At 16 weeks, the proportion of completely healed ulcers was 67.9% for DermACELL, 47.8% for Graftjacket, and 48.1% for SOC. The 20% difference in completely healed ulcers was statistically significant for DermACELL vs SOC ( $p=0.039$ ). The mean time to complete wound closure did not differ significantly for DermACELL (8.6 weeks), Graftjacket (8.6 weeks), and SOC (8.7 weeks).

A second report from this study was published in 2017. This analysis compared DermACELL with SOC and did not include the Graftjacket arm. The authors reported that either 1 or 2 applications DermACELL led to a greater proportion of wounds healed compared with SOC in per protocol analysis (see Table 5), but there

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was no significant difference between DermACELL (1 or 2 applications) and SOC when analyzed by intention-to-treat. For the group of patients who received only a single application, the percentage of patients who achieved complete wound healing was significantly higher than SOC at 16 and 24 weeks, but not at 12 weeks. Although reported as ITT analysis, results were analyzed only for the group who received a single application of DermACELL. This would not typically be considered ITT unless the number of DermACELL applications was prespecified.

**Table 5. Probability of Wound Healing in Per Protocol Analysis of DermACELL vs SOC**

Study	Single Application			1 or 2 Applications		
	% With Wound Healing at 12 Wk	% With Wound Healing at 16 Wk	% With Wound Healing at 24 Wk	% With Wound Healing at 12 Wk	% With Wound Healing at 16 Wk	% With Wound Healing at 24 Wk
Cazzell et al (2017)						
DermACELL, %	65.0%	82.5%	89.7%	NR	67.9%	83.7%
SOC, %	41.1%	48.1%	67.3%	NR	48.1%	67.3%
HR (95% CI)	1.97 (1.1 to 3.5)	2.40 (1.4 to 4.1)	2.11 (1.3 to 3.5)		1.72 (1.04 to 2.83)	1.55 (0.98 to 2.44)
p	0.012	<0.001	<0.001	NS	0.028	0.049

CI: confidence interval; HR: hazard ratio; NR: not reported; NS: not significant; SOC: standard of care.

### ***TheraSkin vs Dermagraft***

Sanders et al (2014) reported on a small (N=23) industry-funded randomized comparison of TheraSkin (cryopreserved human skin allograft with living fibroblasts and keratinocytes) and Dermagraft for diabetic foot ulcers. Wound size at baseline ranged from 0.5 to 18.02 cm<sup>2</sup>; the average wound size was about 5 cm<sup>2</sup> and was similar for the 2 groups (p=0.51). Grafts were applied according to manufacturers' instructions over the first 12 weeks of the study until healing, with an average of 4.4 TheraSkin grafts (every 2 weeks) compared with 8.9 Dermagraft applications (every week). At week 12, complete wound healing was observed in 63.6% of ulcers treated with TheraSkin and 33.3% of ulcers treated with Dermagraft (p<0.049). At 20 weeks, complete wound healing was observed in 90.9% of the TheraSkin-treated ulcers compared with 66.7% of the Dermagraft group (p=0.428).

### ***TheraSkin vs Apligraf***

DiDomenico et al (2011) compared TheraSkin with Apligraf for the treatment of diabetic foot ulcers in a small (N=29) RCT. The risk of bias in this study is uncertain, because reporting did not include a description of power analysis, statistical analysis, method of randomization, or blinding. The percentage of wounds closed at 12 weeks was 41.3% in the Apligraf group and 66.7% in the TheraSkin group. Results at 20 weeks were not substantially changed from those at 12 weeks, with 47.1% of wounds closed in the Apligraf group and 66.7% closed in the TheraSkin group. The percentage healed in the Apligraf group was lower than expected based on prior studies. The average number of grafts applied was similar for both groups (1.53 for Apligraf, 1.38 for TheraSkin). The low number of dressing changes may have influenced results, with little change in the percentage of wounds closed between 12 and 20 weeks. An adequately powered trial with blinded evaluation of wound healing and a standard treatment regimen would permit greater certainty on the efficacy of this product.

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Original Effective Date: 12/01/2017

Current Effective Date: 05/16/2018

### ***Cytal (MatriStem) vs Dermagraft***

Frykberg et al (2017) reported a prespecified interim analysis of an industry-funded multicenter noninferiority trial of Cytal (a porcine urinary bladder-derived extracellular matrix) vs Dermagraft in 56 patients with diabetic foot ulcers. The mean duration of ulcers before treatment was 263 days (range, 30-1095 days). The primary outcome was the percent wound closure with up to 8 weeks of treatment using blinded evaluation of photographs. Intention-to-treat (ITT) analysis found complete wound closure in 5 (18.5%) wounds treated with Cytal compared with 2 (6.9%) wounds treated with Dermagraft ( $p=NS$ ). Quality of life, measured by the Diabetic Foot Ulcer Scale, improved from 181.56 to 151.11 in the Cytal group and from 184.46 to 195.73 in the Dermagraft group ( $p=0.074$ ). It should be noted that this scale is a subjective measure and patients were not blinded to treatment. Power analysis indicated that 92 patients would be required; further recruitment is ongoing for completion of the study.

### ***PriMatrix***

Kavros et al (2014) reported a prospective multicenter study of PriMatrix (a xenograft fetal bovine dermal collagen matrix) for the treatment of chronic diabetic foot ulcers in 55 patients. Average duration of ulcers before treatment was 286 days, and average wound area was 4.34 cm<sup>2</sup>. Of the 46 patients who completed the study, 76% healed by 12 weeks with an average of 2 applications of PriMatrix. For the ITT population, 64% of wounds healed by 12 weeks.

Karr (2011) published a retrospective comparison of PriMatrix and Apligraf in 40 diabetic foot ulcers. The first 20 diabetic foot ulcers matching the inclusion and exclusion criteria for each graft were compared. The criteria were: diabetic foot ulcers of 4 weeks in duration; ulcer of at least 1 cm<sup>2</sup> in diameter and to the depth of subcutaneous tissue; healthy tissue at the ulcer; adequate arterial perfusion to heal; and ability to off-load the diabetic ulcer. The time to complete healing for PriMatrix was 38 days with 1.5 applications compared with 87 days with 2 applications for Apligraf. Although promising, additional study with a larger number of subjects is needed to compare the efficacy of PriMatrix with current SOC or advanced wound therapies.

### ***Oasis Wound Matrix vs Regranex Gel***

Niezgoda et al (2005) compared healing rates at 12 weeks for full-thickness diabetic foot ulcers treated with OASIS Wound Matrix (a porcine acellular wound care product) to Regranex Gel. This industry-sponsored, multicenter RCT was conducted at 9 outpatient wound care clinics and involved 73 patients with at least 1 diabetic foot ulcer. Patients were randomized to receive either Oasis Wound Matrix ( $n=37$ ) or Regranex Gel ( $n=36$ ) and a secondary dressing. Wounds were cleansed and débrided, if needed, at a weekly visit. The maximum treatment period for each patient was 12 weeks. After 12 weeks, 18 (49%) Oasis-treated patients had complete wound closure compared with 10 (28%) Regranex-treated patients. Oasis treatment met the noninferiority margin but did not demonstrate that healing in the Oasis group was statistically superior ( $p=0.055$ ). Post hoc subgroup analysis showed no significant difference in incidence of healing in patients with type 1 diabetes (33% vs 25%) but showed a significant improvement in patients with type 2 diabetes (63% vs 29%). There was also an increased healing of plantar ulcers in the Oasis group (52% vs 14%). These post hoc findings are considered hypothesis-generating. Additional study with a larger number of subjects is needed to compare the effect of Oasis treatment to current SOC.

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Original Effective Date: 12/01/2017

Current Effective Date: 05/16/2018

### **Section Summary: Bioengineered Skin Substitutes Other Than Apligraf, Dermagraft, AlloPatch, or Integra for Diabetic Lower-Extremity Ulcers**

Results from a multicenter RCT showed some benefit of DermACELL that was primarily for the subgroup of patients who only required a single application of the ADM. Studies are needed to further define the population who might benefit from this treatment. Additional study with a larger number of subjects is needed to evaluate the effect of Graftjacket, TheraSkin, DermACELL, Cytal, PriMatrix, and Oasis Wound Matrix, compared with current SOC or other advanced wound therapies.

### **LOWER-EXTREMITY ULCERS DUE TO VENOUS INSUFFICIENCY**

#### **Apligraf**

Falanga et al (1998) reported on a multicenter randomized trial of Apligraf living cell therapy. A total of 293 patients with venous insufficiency and clinical signs of venous ulceration were randomized to compression therapy alone or to compression therapy and treatment with Apligraf. Apligraf was applied up to a maximum of 5 (mean, 3.3) times per patient during the initial 3 weeks. The primary end points were the percentage of patients with complete healing by 6 months after initiation of treatment and the time required for complete healing. At 6-month follow-up, the percentage of patients healed was higher with Apligraf (63% vs 49%), and the median time to complete wound closure was shorter (61 days vs 181 days). Treatment with Apligraf was superior to compression therapy in healing larger (>1000 mm<sup>2</sup>) and deeper ulcers and ulcers of more than 6 months in duration. There were no symptoms or signs of rejection, and the occurrence of adverse events was similar in both groups. This study was reviewed in a 2001 TEC Assessment, which concluded that Apligraf (Graftskin), in conjunction with good local wound care, met TEC criteria for the treatment of venous ulcers that fail to respond to conservative management.

#### **Oasis Wound Matrix**

Mostow et al (2005) reported on an industry-sponsored multicenter (12 sites) randomized trial that compared weekly treatment using Oasis Wound Matrix (xenogenic collagen scaffold from porcine small intestinal mucosa) with SOC in 120 patients who had chronic ulcers due to venous insufficiency that had not adequately responding to conventional therapy. Healing was assessed weekly for up to 12 weeks, with follow-up performed after 6 months to assess recurrence. After 12 weeks of treatment, there was a significant improvement in the percentage of wounds healed in the Oasis group (55% vs 34%). After adjusting for baseline ulcer size, patients in the Oasis group were 3 times more likely to heal than those in the group receiving SOC. Patients in the SOC group whose wounds did not heal by week 12 were allowed to cross over to Oasis treatment. None of the healed patients treated with Oasis wound matrix who was seen for the 6-month follow-up experienced ulcer recurrence.

A research group in Europe has described 2 comparative studies of the Oasis matrix for mixed arteriovenous ulcers. In a 2007 quasirandomized study, Romanelli et al compared the efficacy of 2 extracellular matrix-based products, Oasis and Hyaloskin (extracellular matrix with hyaluronic acid). Fifty-four patients with mixed arteriovenous leg ulcers were assigned to the 2 arms based on order of entry into the study; 50 patients completed the study. Patients were followed twice weekly, and dressings changed more than once a week, only when necessary. After 16 weeks of treatment, complete wound closure was

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achieved in 82.6% of Oasis-treated ulcers compared with 46.2% of Hyaloskin-treated ulcers. Oasis treatment significantly increased the time to dressing change (mean, 6.4 days vs 2.4 days), reduced pain on a 10-point scale (3.7 vs 6.2), and improved patient comfort (2.5 vs 6.7).

In a 2010 trial, Romanelli et al compared Oasis with a moist wound dressing (SOC) in 23 patients with mixed arteriovenous ulcers and 27 patients with venous ulcers. The trial was described as randomized, but the method of randomization was not described. After the 8-week study period, patients were followed monthly for 6 months to assess wound closure. Complete wound closure was achieved in 80% of the Oasis-treated ulcers at 8 weeks compared with 65% of the SOC group. On average, Oasis-treated ulcers achieved complete healing in 5.4 weeks compared with 8.3 weeks for the SOC group. Treatment with Oasis also increased the time to dressing change (5.2 days vs 2.1 days) and the percentage of granulation tissue formed (65% vs 38%).

### ***Subsection Summary: Apligraf or Oasis Wound Matrix for Lower-Extremity Ulcers due to Venous Insufficiency***

RCTs have demonstrated the efficacy of Apligraf or Oasis Wound Matrix over SOC for lower-extremity ulcers due to venous insufficiency. Evidence is considered sufficient for these products.

### **Bioengineered Skin Substitutes Other Than Apligraf or Oasis Wound Matrix for Lower-Extremity Ulcers due to Venous Insufficiency**

#### ***Dermagraft***

Dermagraft living cell therapy has been approved by FDA for repair of diabetic foot ulcers. Use of Dermagraft for venous ulcers is an off-label indication. In 2013, Harding et al reported an open-label multicenter RCT that compared Dermagraft plus compression therapy (n=186) with compression therapy alone (n=180). The trial had numerous inclusion and exclusion criteria that restricted the population to patients who had nonhealing ulcers with compression therapy but had the capacity to heal. ITT analysis revealed no significant difference between the 2 groups in the primary outcome measure, the proportion of patients with completely healed ulcers by 12 weeks (34% Dermagraft vs 31% control). Prespecified subgroup analysis revealed a significant improvement in the percentage of wounds healed for ulcers of 12 months or less in duration (52% vs 37%) and for ulcers of 10 cm or less in diameter (47% vs 39%). There were no significant differences in the secondary outcomes of time to healing, complete healing by week 24, and percent reduction in ulcer area.

#### ***PriMatrix***

In 2011, Karr published a retrospective comparison of PriMatrix (xenogenic ADM) and Apligraf in 28 venous stasis ulcers. The first 14 venous stasis ulcers matching the inclusion and exclusion criteria for each graft were compared. Criteria were venous stasis ulcers of 4 weeks in duration, at least 1 cm<sup>2</sup> in diameter, and to a depth of subcutaneous tissue, with healthy tissue at the ulcer edge, adequate arterial perfusion to heal, and ability to tolerate compression therapy. The time to complete healing for PriMatrix was 32 days with 1.3 applications compared with 63 days with 1.7 applications for Apligraf. Although promising, additional study

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with a larger number of subjects is needed to assess the effect of PriMatrix treatment in compared with current SOC.

### ***Section Summary: Bioengineered Skin Substitutes Other Than Apligraf or Oasis Wound Matrix for Lower-Extremity Ulcers due to Venous Insufficiency***

In a moderately large RCT, Dermagraft was not shown to be more effective than controls in the primary or secondary end points for the entire population and was slightly more effective than controls (an 8%-15% increase in healing) only in subgroups of patients with ulcer duration of 12 months or less or wound diameter of 10 cm or less. Additional study with a larger number of subjects is needed to evaluate the effect of PriMatrix treatment compared with current SOC.

### **DYSTROPHIC EPIDERMOLYSIS BULLOSA**

OrCel was approved under an HDE for use in patients with dystrophic epidermolysis bullosa undergoing hand reconstruction surgery, to close and heal wounds created by the surgery, including those at donor sites. HDE status has been withdrawn for Dermagraft for this indication.

Fivenson et al (2003) reported the off-label use of Apligraf in 5 patients with recessive dystrophic epidermolysis bullosa who underwent syndactyly release.

### **Section Summary: Dystrophic Epidermolysis Bullosa**

Dystrophic epidermolysis bullosa is a rare disorder. Because this is a rare disorder, it is unlikely that RCTs will be conducted to evaluate whether OrCel improves health outcomes for this condition. Therefore, the HDE for OrCel is considered sufficient.

### **DEEP DERMAL BURNS**

#### **Epicel**

One case series from 2000 has described the treatment of 30 severely burned patients with Epicel. The cultured epithelial autografts were applied to a mean of 37% of total body surface area (TBSA). Epicel achieved permanent coverage of a mean of 26% of TBSA, an area similar to that covered by conventional autografts (mean, 25%). Survival was 90% in these severely burned patients.

#### **Integra Dermal Regeneration Template**

A 2013 study compared Integra with split-thickness skin graft and with viscose cellulose sponge (Cellonex), using three 10x5 cm test sites on each of 10 burn patients. The surrounding burn area was covered with meshed autograft. Biopsies were taken from each site on days 3, 7, 14, and 21, and at months 3 and 12. The tissue samples were stained and examined for markers of inflammation and proliferation. The Vancouver Scar Scale was used to assess scars. At 12-month follow-up, the 3 methods resulted in similar clinical appearance, along with similar histologic and immunohistochemical findings.

Branski et al (2007) reported on a randomized trial that compared Integra with a standard autograft-allograft technique in 20 children with an average burn size of 73% TBSA (71% full-thickness burns). Once

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vascularized (about 14-21 days), the Silastic epidermis was stripped and replaced with thin (0.05-0.13 mm) epidermal autograft. There were no significant differences between the Integra group and controls in burn size (70% vs 74% TBSA), mortality (40% vs 30%), and hospital length of stay (41 vs 39 days), all respectively. Long-term follow-up revealed a significant increase in bone mineral content and density (24 months) and improved scarring in terms of height, thickness, vascularity, and pigmentation (at 12 months and 18-24 months) in the Integra group. No differences were observed between groups in the time to first reconstructive procedure, cumulative reconstructive procedures required during 2 years, and cumulative operating room time required for these procedures. The authors concluded that Integra can be used for immediate wound coverage in children with severe burns without the associated risks of cadaver skin.

Heimbach et al (2003) reported on a multicenter (13 U.S. burn care facilities) postapproval study involving 222 burn injury patients (36.5% TBSA; range, 1%-95%) who were treated with Integra Dermal Regeneration Template. Within 2 to 3 weeks, the dermal layer regenerated, and a thin epidermal autograft was placed over the wound. The incidence of infection was 16.3%. Mean take rate (absence of graft failure) of Integra was 76.2%; the median take rate was 98%. The mean take rate of epidermal autograft placed over Integra was 87.7%; the median take rate was 95%.

### **TransCyte**

TransCyte is no longer commercially available.

Earlier studies included a 2001 report by Lukish et al that found improved healing in 20 consecutive cases of pediatric burns greater than 7% TBSA that underwent wound closure using TransCyte compared to the previous 20 consecutive burn cases greater than 7% TBSA that received standard therapy. In 2006, Amani et al found significant improvement in healing in 110 consecutive patients who had deep partial-thickness burns treated with TransCyte as compared to results from the American Burn Association Patient Registry for similar burns.

### **Section Summary: Deep Dermal Burns**

Epicel is FDA-approved under an HDE for the treatment of deep dermal or full-thickness burns comprising a TBSA of 30% or more, with patient survival of 90%. Integra Dermal Regeneration Template has been compared with autograft in a within-subject study and with autograft-allograft in a small RCT with 10 patients per group. Outcomes are at least as good as with autograft or allograft, with a reduction in scarring and without risks associated with cadaver skin. This product has also been studied in a large series with over 222 burn patients, showing a take rate of 76% and with a take rate of epidermal autograft placed over Integra of 87.7%.

### **OTHER INDICATIONS**

#### **Punch Biopsy Wounds**

Baldursson et al (2015) reported a double-blinded RCT with 81 patients (162 punch biopsy wounds) that compared Kerecis Omega3 Wound (derived from fish skin) with Oasis SIS ECM (porcine small intestinal submucosa extracellular matrix). The primary outcome (the percentage of wounds healed at 28 days) was similar for the fish skin ADM (95%) and the porcine SIS ECM (96.3%). The rate of healing was faster with

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Kerecis Omega3 (p=0.041). At 21 days, 72.5% of the fish skin ADM group had healed compared with 56% of the porcine SIS ECM group. Interpretation of this study is limited because it did not include an accepted control condition for this indication.

## **Split-Thickness Donor Sites**

There is limited evidence to support the efficacy of OrCel compared with SOC for the treatment of split-thickness donor sites in burn patients. In 2003, Still et al examined the safety and efficacy of bilayered OrCel to facilitate wound closure of split-thickness donor sites in 82 severely burned patients. Each patient had 2 designated donor sites that were randomized to a single treatment of OrCel or standard dressing (Biobrane-L). The healing time for OrCel sites was significantly shorter than for sites treated with a standard dressing, enabling earlier recropping. OrCel sites also exhibited a nonsignificant trend for reduced scarring. Additional studies are needed to evaluate the effect of this product on health outcomes.

## **Miscellaneous**

In addition to indications previously reviewed, off-label uses of bioengineered skin substitutes have included pressure ulcers, inflammatory ulcers (eg, pyoderma gangrenosum, vasculitis), scleroderma digital ulcers, postkeloid removal wounds, genetic conditions, and variety of other conditions. Products that have been FDA-approved or -cleared for one indication (eg, lower-extremity ulcers) have also been used off-label in place of other FDA-approved or -cleared products (eg, for burns). No controlled trials were identified for these indications.

## **SUMMARY OF EVIDENCE**

### **Breast Reconstruction**

For individuals who are undergoing breast reconstruction who receive allogeneic ADM products, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, morbid events, functional outcomes, quality of life, and treatment-related morbidity. A systematic review found no difference in overall complication rates with ADM allograft compared with standard procedures for breast reconstruction. Reconstructions with ADM have been reported to have higher seroma, infection, and necrosis rates than reconstructions without ADM. However, capsular contracture and malposition of implants may be reduced. Thus, in cases where there is limited tissue coverage, the available evidence may inform patient decision making about reconstruction options. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

### **Tendon Repair**

For individuals who are undergoing tendon repair who receive Graftjacket, the evidence includes an RCT. Relevant outcomes are symptoms, morbid events, functional outcomes, quality of life, and treatment-related morbidity. The RCT identified found improved outcomes with the Graftjacket ADM allograft for rotator cuff repair. Although these results were positive, additional study with a larger number of patients is needed to evaluate the consistency of the effect. The evidence is insufficient to determine the effects of the technology on health outcomes.

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### **Surgical Repair of Hernias or Parastomal Reinforcement**

For individuals who are undergoing surgical repair of hernias or parastomal reinforcement who receive acellular collagen-based scaffolds, the evidence includes RCTs. Relevant outcomes are symptoms, morbid events, functional outcomes, quality of life, and treatment-related morbidity. Several comparative studies including RCTs have shown no difference in outcomes between tissue-engineered skin substitutes and either standard synthetic mesh or no reinforcement. The evidence is sufficient to determine that the technology is unlikely to improve the net health outcome.

### **Diabetic Lower-Extremity Ulcers**

For individuals who have diabetic lower-extremity ulcers who receive AlloPatch, Apligraf, Dermagraft, or Integra, the evidence includes RCTs. Relevant outcomes are disease-specific survival, symptoms, change in disease status, morbid events, and quality of life. RCTs have demonstrated the efficacy of AlloPatch (reticular ADM), Apligraf and Dermagraft (living cell therapy), and Integra (biosynthetic) over the standard of care. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have diabetic lower-extremity ulcers who receive ADM products other than AlloPatch, Apligraf, Dermagraft, or Integra, the evidence includes RCTs. Relevant outcomes are disease-specific survival, symptoms, change in disease status, morbid events, and quality of life. Results from a multicenter RCT showed some benefit of DermACELL that was primarily for the subgroup of patients who only required a single application of the ADM. Studies are needed to further define the population who might benefit from this treatment. Additional study with a larger number of subjects is needed to evaluate the effect of Graftjacket, TheraSkin, DermACELL, Cytal, PriMatrix, and Oasis Wound Matrix, compared with current SOC or other advanced wound therapies. The evidence is insufficient to determine the effects of the technology on health outcomes.

### **Lower-Extremity Ulcers due to Venous Insufficiency**

For individuals who have lower-extremity ulcers due to venous insufficiency who receive Apligraf or Oasis Wound Matrix, the evidence includes RCTs. Relevant outcomes are disease-specific survival, symptoms, change in disease status, morbid events, and quality of life. RCTs have demonstrated the efficacy of Apligraf living cell therapy and xenogenic Oasis Wound Matrix over the standard of care. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have lower-extremity ulcers due to venous insufficiency who receive bioengineered skin substitutes other than Apligraf or Oasis Wound Matrix, the evidence includes RCTs. Relevant outcomes are disease-specific survival, symptoms, change in disease status, morbid events, and quality of life. In a moderately large RCT, Dermagraft was not shown to be more effective than controls for the primary or secondary end points in the entire population and was only slightly more effective than controls (an 8%-15% increase in healing) in subgroups of patients with ulcer durations of 12 months or less or size of 10 cm or less. Additional study with a larger number of subjects is needed to evaluate the effect of the xenogenic

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PriMatrix skin substitute vs the current standard of care. The evidence is insufficient to determine the effects of the technology on health outcomes.

### **Dystrophic Epidermolysis Bullosa**

For individuals who have dystrophic epidermolysis bullosa who receive OrCel, the evidence includes case series. Relevant outcomes are symptoms, change in disease status, morbid events, and quality of life. OrCel was approved under a humanitarian drug exemption for use in patients with dystrophic epidermolysis bullosa undergoing hand reconstruction surgery, to close and heal wounds created by the surgery, including those at donor sites. Outcomes have been reported in small series (eg, 5 patients). The evidence is insufficient to determine the effects of the technology on health outcomes.

### **Deep Dermal Burns**

For individuals who have deep dermal burns who receive bioengineered skin substitutes (ie, Epicel, Integra Dermal Regeneration Template), the evidence includes RCTs. Relevant outcomes are disease-specific survival, symptoms, change in disease status, morbid events, functional outcomes, quality of life, and treatment-related morbidity. Overall, few skin substitutes have been approved, and the evidence is limited for each product. Epicel (living cell therapy) has received FDA approval under a humanitarian device exemption for the treatment of deep dermal or full-thickness burns comprising a total body surface area of 30% or more. Comparative studies have demonstrated improved outcomes for biosynthetic skin substitute Integra Dermal Regeneration Template for the treatment of burns. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

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Original Effective Date: 12/01/2017

Current Effective Date: 05/16/2018

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### **Policy History**

Original Effective Date: 12/01/2017

Current Effective Date: 05/16/2018

09/07/2017 Medical Policy Committee review

09/20/2017 Medical Policy Implementation Committee approval. New policy.

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05/03/2018 Medical Policy Committee review  
 05/16/2018 Medical Policy Implementation Committee approval. DermACELL and FlexHD Pliable added to medically necessary statement on breast reconstructive surgery. Integra Flowable Wound Matrix added to medically necessary statement on use of Integra Dermal Regeneration Template for diabetic lower-extremity ulcers. Several products added to investigational list.

Next Scheduled Review Date: 05/2019

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Code Type	Code
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HCPCS	C9354, C9356, C9358, C9360, C9363, C9364, Q4100, Q4101, Q4102, Q4103, Q4104, Q4105, Q4106, Q4107, Q4108, Q4110, Q4111, Q4112, Q4113, Q4114, Q4115, Q4116, Q4117, Q4118, Q4121, Q4122, Q4123, Q4124, Q4125, Q4126, Q4127, Q4128, Q4130, Q4134, Q4135, Q4136, Q4141, Q4142, Q4143, Q4146, Q4147, Q4149, Q4152, Q4158, Q4161, Q4164, Q4165, Q4166, Q4167, Q4172, Q4175 Code added eff 1/1/18: Q4176, Q4180, Q4182
ICD-10 Diagnosis	C50.01, C50.111-C50.119, C50.211-C50.219, C50.311-C50.319, C50.411-C50.419, C50.511-C50.519, C50.611-C50.619, C50.811-C50.819, C50.911-C50.919, E08.321-E08.622, E09.621-E09.622, E10.621-E10.622, E11.621-E11.622, E13.621-E13.622, I83.001-I83.029, I83.201-I83.229, Q81.2, T20-T25, Z85.3, Z90.10

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- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. FDA and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
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- A. In accordance with nationally accepted standards of medical practice;
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- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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