Subject: **Recurrent Pregnancy Loss (RPL) – Diagnostic***

Effective Date: **March 27, 2007**

Department(s): **Utilization Management**

Policy: Diagnostic testing as delineated below, in the evaluation of patients with RPL (defined as ≥2 consecutive spontaneous abortions **[ICD-9 646.33; ICD-10 O26.20-O26.23]**) is reimbursable under Plans administered by QualCare, Inc.

Objective: To assure proper and consistent reimbursement and to enumerate tests covered in patients with RPL.

Procedure:

1. Diagnostic tests reimbursable in the evaluation of non-genetic causes of RPL include, but are not limited to, the following:

a) Pelvic ultrasound **(CPT 76830, 76856)**
b) Hysteroscopy **(CPT 58555)**
c) Hysterosalpingography **(CPT 74740)**
d) Sonohysterography **(CPT 76831)**
e) Pelvic MRI (**CPT 72197**) when ultrasound shows a complex anomaly or is inconclusive
f) Endometrial biopsy **(CPT 58558)**
g) Testing for lupus anticoagulant
h) Testing for anticardiolipin antibody/ Beta 2 Glycoprotein 1 antibody (IgG and/or IgM) **(CPT 86146, 86147)** (antiphospholipid antibodies)

i) Thyroid function testing, including, but not limited to, antithyroid antibodies **(CPT 86376)** and TSH **(CPT 84443)**
j) Testing for diabetes mellitus

2. Diagnostic tests reimbursable in the evaluation of genetic causes of RPL include, but are not limited to, the following:
    a. Pre- and post-test genetic counseling.
    b. Peripheral blood karyotyping **(CPT 88230, 88233, 88248, 88261, 88262, 88263, 88267, 88269, 88280, 88283, 88285)** of the parents.
    c. Karyotype of the products of conception (see CPT codes above) When karyotyping is unsuccessful or not possible due to sample condition, chromosomal microarray testing **(CPT 81228, 81229)** may be considered medically necessary.
    d. Testing for Factor V Leiden and prothrombin gene mutations **(CPT 81240, 81241)**.
3. The following are deemed investigational and not reimbursable in the evaluation of patients with RPL:

    a. Lymphocyte subset assays
    b. Flow cytometry assays for maternal antibodies to paternal leukocytes
    c. Assays for embryocytotoxicity
    d. Anti-leukocyte antibody detection assays
    e. HLA tissue typing of each parent
    f. Testing for methylene tetrahydrofolate reductase (MTHFR)
    (**CPT 81291**) mutations
    g. Chromosomal microarray testing **(CPT 81228, 81229)** for routine evaluation, when karyotyping is available.

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*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.