**Prior Authorization Review Panel**  
**MCO Policy Submission**

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**Type of Submission – Check all that apply:**
- [x] New Policy*
- [ ] Revised Policy
- [ ] Annual Review – No Revisions

*All revisions to the policy **must** be highlighted using track changes throughout the document. Please provide any clarifying information for the policy below:

**CPB 0358 Invasive Prenatal Diagnosis of Genetic Diseases**

Policy is new to Aetna Better Health of Pennsylvania.

Name of Authorized Individual (Please type or print): Dr. Bernard Lewin, M.D.

Signature of Authorized Individual: [Signature]
Invasive Prenatal Diagnosis of Genetic Diseases

Number: 0358

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.

Policy

I. Aetna considers invasive prenatal diagnosis by CVS, genetic amniocentesis, and percutaneous umbilical blood sampling (PUBS) (cordocentesis) medically necessary for diagnosis of fetal chromosomal abnormalities.

II. Aetna considers invasive prenatal genetic diagnosis following advanced reproductive technologies (ART) (e.g., in-vitro fertilization [IVF]), including the use of intracytoplasmic sperm injection (ICSI), experimental and investigational if performed solely because the member has undergone ART or ICSI. Such indications for testing are considered investigational and are not supported by American Society of Reproductive Medicine guidelines.

III. Preimplantation genetic diagnosis (PGD) can detect specific genetic diseases (usually autosomal recessive conditions) by using molecular analysis techniques on single cells removed from the embryo. For many
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conditions, the usual type of prenatal diagnosis (i.e., chromosomal analysis/karyotyping) is accomplished on multiple cells obtained by CVS or genetic amniocentesis. Preimplantation genetic diagnosis on single cells is considered medically necessary when all of the following criteria are met:

A. Laboratory or clinical tests to definitively diagnose the genetic disorder are unavailable or results are equivocal; and

B. Technical and clinical performance of the genetic test is supported by published peer-reviewed medical literature; and

C. PGD is performed for any of the following indications:

1. Sex selection for X-linked condition when at least one parent is a known carrier; or

2. To diagnose a specific, detectable single gene mutation related to an autosomal dominant condition when at least one parent is a known carrier; or

3. To diagnose a specific, detectable single gene mutation related to a X-linked condition when the female partner is a known carrier (e.g., fragile X syndrome when the mother is a known carrier); or

4. To diagnose specific, detectable single gene mutations related to an autosomal recessive condition when both parents are known carriers (e.g., cystic fibrosis when parents are known mutation carriers); or

5. To test for chromosome rearrangements when at least one parent is a known carrier of a balanced translocation or other structural chromosomal rearrangement or when the male partner is a carrier of a sex chromosome abnormality; and
D. Results of genetic testing will directly impact and change management of the individual being tested who is a covered member; and

E. The PGD procedure will eliminate the need for subsequent invasive prenatal diagnosis by genetic amniocentesis or CVS

Panels including multiple genes or multiple conditions, and in cases where a tiered approach/method is clinically available, are considered medically necessary only for the number of genes or tests deemed medically necessary to establish a diagnosis.

Note: Preimplantation genetic diagnosis is performed on embryos produced after IVF cycles. The methods used to retrieve PGD material from embryos are the same, irrespective of the type of genetic analysis required. The biopsy procedure entails micro-manipulation and special techniques are used to avoid contamination from exogenous DNA (e.g., cellular DNA from non-fertilizing sperm) in the IVF laboratory. However, for carriers of single gene disorders (e.g., cystic fibrosis, spinal muscular atrophy) where polymerase chain reaction [PCR] will be applied, ICSI is considered medically necessary to avoid contamination from non-fertilizing sperm. The procedure to obtain the cell sample for PGD (i.e., the embryo biopsy) is considered medically necessary when criteria for PGD are met. However, the IVF procedure (i.e., the procedures and services required to create the embryos to be tested and the transfer of the appropriate embryos back to the uterus after testing) is covered only for persons with ART benefits.
who meet medical necessity criteria for IVF outlined in CPB 0327 - Infertility (0327.html). Please check benefit plan descriptions.

IV. Preimplantation genetic diagnosis for fetal chromosomal abnormalities is currently not as accurate as cytogenetic analysis performed on prenatal diagnosis specimens obtained by CVS or amniocentesis; therefore PGD is considered experimental and investigational for that indication.

V. Aetna considers preimplantation genetic diagnosis not medically necessary for sex selection for nonmedical purposes.

VI. Aetna considers PGD to determine the human leukocyte antigen (HLA) or other marker status of an embryo as a potential donor for future stem cell transplant experimental and investigational because PGD has not been established as the standard of care for assessing the suitability of embryos for stem cell transplantation.

VII. Aetna considers preimplantation genetic screening (PGS) (i.e., screening embryos for chromosomal abnormalities in the absence of specific inherited genetic conditions identified in either parent) experimental and investigational. The following are considered experimental and investigational: preimplantation genetic screening and comprehensive chromosome screening of polar bodies and blastocysts to enhance delivery rates in advanced reproductive technologies; and aneuploidy screening (AS) in the setting of PGS (also called PGD-AS) for purposes of optimizing IVF outcomes in women with advanced maternal age, history of failed IVF cycles, or recurrent miscarriages, in the absence of inherited
genetic abnormalities.

VIII. Aetna considers conventional cytogenetic analysis and quantitative fluorescent polymerase chain reaction (QF-PCR) a medically necessary method to detect trisomies whenever prenatal testing is performed solely because of an increased risk of aneuploidy in chromosomes 13, 18, 21, X or Y. Both conventional cytogenetics and QF-PCR are considered medically necessary in all cases of prenatal diagnosis referred for a fetal ultrasound abnormality (including an increased nuchal translucency measurement greater than 3.5 mm) or a familial chromosomal rearrangement. Cytogenetic follow-up of QF-PCR findings of trisomy 13 and 21 is considered medically necessary to rule out inherited Robertsonian translocations.

IX. Aetna considers invasive prenatal screening and preimplantation genetic testing for a VUS (also known as unclassified variant or variant of uncertain significance) experimental and investigational.

Note: Established nongenetic indications for amniocentesis include assessment of fetal lung maturity, and evaluation of the fetus for infection, degree of hemolytic anemia, blood or platelet type, hemoglobinopathy, and neural tube defects. Amniocentesis is also performed as a therapeutic procedure to remove excess amniotic fluid. See CPB 0449 - Fetal Surgery in Utero (../400_499/0449.html).

See CPB 0282 - Noninvasive Down Syndrome Screening also (../200_299/0282.html)

; CPB 0464 - Serum Marker Screening for Down Syndrome and (../400_499/0464.html) ;
Background

Preimplantation genetic testing includes two categories: preimplantation genetic diagnosis and preimplantation genetic screening. According to the American Society for Reproductive Medicine, the term "preimplantation genetic diagnosis" (PGD) applies when one or more genetic parents carry a gene mutation or a balanced chromosomal rearrangement and testing is performed to determine whether that specific mutation or an unbalanced chromosomal complement has been transmitted to the oocyte or embryo. Preimplantation genetic diagnosis (PGD) is performed on embryos following in vitro fertilization (IVF) to detect genetic disorders prior to implantation into the uterus. With PGD, cell(s) are removed from embryos under microscopic guidance, analyzed for the presence of genetic disorders and only the unaffected embryos are implanted into the uterus. PGD is used when one or both parents carry a gene mutation and are at high risk of conceiving a child with a particular genetic disease.

The term "preimplantation genetic screening" (PGS), also known as aneuploidy screening, applies when the genetic parents are known or presumed to be chromosomally normal and their embryos are screened for aneuploidy. Preimplantation genetic screening (PGS) is performed on embryos following IVF to screen for aneuploidy in parents who have no known chromosomal anomaly, mutation or other genetic abnormality. PGS has been proposed for individuals at risk for having an increased occurrence of aneuploid embryos, such as women of advanced maternal age and those with a history of recurrent early pregnancy loss or repeated IVF failure.

Preimplantation genetic diagnosis (PGD) can detect specific genetic diseases (usually autosomal recessive conditions) by using molecular analysis techniques on single cells removed from the embryo. For many conditions, the usual type of prenatal diagnosis (i.e., chromosomal analysis/karyotyping)
is accomplished on multiple cells obtained by CVS or genetic amniocentesis. Preimplantation genetic diagnosis on single cells is considered medically necessary only when there is a need to diagnose specific, detectable single gene mutations (e.g., molecular diagnosis of hereditary disease such as cystic fibrosis when parents are known mutation carriers or fragile X syndrome when the mother is a known carrier) in persons with genetic disorders for whom the PGD procedure will eliminate the need for subsequent invasive prenatal diagnosis by genetic amniocentesis or CVS. Preimplantation genetic diagnosis for fetal chromosomal abnormalities is currently not as accurate as cytogenetic analysis performed on prenatal diagnosis specimens obtained by CVS or amniocentesis; therefore PGD is considered experimental and investigational for that indication.

According to the literature, the accuracy of single gene testing conducted on single cells is thought to be as accurate using PGS procedures as it would be on cell samples obtained by conventional chorionic villus sampling (CVS) or amniocentesis. However, PGS procedures have not been shown to be as accurate as conventional techniques for diagnosing chromosomal errors. Because preimplantation genetic diagnostic procedures are less accurate in detecting chromosomal abnormalities (detecting up to 95% of chromosomal errors using fluorescent in-situ hybridization (FISH) techniques, versus 100% detection with analysis of full karyotype), CVS or amniocentesis is usually necessary to confirm the results of FISH-based PGD cytogenetic procedures.

Preimplantation genetic diagnosis-aneuploidy screening (PGD-AS), also known as PGS for fetal aneuploidy, involves in-vitro genetic testing of embryos to detect numerical chromosomal abnormalities (aneuploidies). PGD-AS has been investigated as a method of increasing the effectiveness of in-vitro fertilization (IVF) by increasing the live birth rate and reducing the risk of complications from IVF. Miscarried fetuses
are often found to have an aneuploidy, as most aneuploides are not compatible with life. Aneuploides have also be found in aborted embryos created by means of IVF. Clinical research is currently being conducted to find out whether PGD-AS can increase the likelihood of live birth from each implanted embryo in IVF. By increasing the likelihood of a live birth from each implanted embryo, PGD-AS has the potential to decrease the need to implant 2 embryos instead of 1, thus reducing the risk of multiple pregnancy from IVF and its attendant complications. PGD-AS is also being investigated for use in women undergoing IVF as an alternative to standard methods of prenatal diagnosis of Down syndrome and other aneuploides.

A systematic evidence review of PGD-AS by the Health Council of the Netherlands (GR, 2007) found "little useful research data" on the effect, reliability and safety of PGD-AS. The assessment reported that small-scale studies of PGD-AS have been conducted in women with repeated implantation failure, with recurrent miscarriage, and in women of advanced maternal age; the assessment found that these studies "do not point to any marked improvement in the likelihood of pregnancy." The assessment also found that it "remains unclear" whether PGD-AS is an effective alternative to prenatal diagnosis. The assessment concluded that "[m]ore data is needed before [PGD-AS] can be carried out or offered as a matter of routine." The assessment noted that, if further research established that PGD-AS increases the success rate of IVF, it will be important to clearly establish the indications for PGD-AS and to assure its quality and safety.

In a literature review, Shulman (2003) stated that fetal cells in maternal blood represent the future of prenatal screening and diagnosis. The possibility of analyzing fetal cells recovered from maternal blood could provide screening and diagnostic protocols characterized by high sensitivity and specificity with
no direct risk to the developing fetus. However, years of research have thus far not led to the development of reliable and consistent protocols.

In a review, Sierra and Stephenson (2006) stated that research has generated interest in genetic markers for recurrent pregnancy loss such as skewed X-chromosome inactivation and human leukocyte antigen-G polymorphisms. Assisted reproductive technologies, in particular, PGD have been offered to couples with recurrent pregnancy loss; however, more research is needed before their routine use can be advocated. This is in agreement with the observation of Shahine and Cedars (2006) who noted that although analysis with PGD confirms a high rate of aneuploidy in patients with advanced maternal age, recurrent pregnancy loss, and recurrent IVF failure, its use in these patient populations has not been consistently demonstrated to increase pregnancy rates. They stated that randomized controlled studies with large patient populations, performed in programs with expertise in PGD technology, are needed before PGD can routinely be recommended as a means for increasing pregnancy rates in patients with advanced maternal age, recurrent pregnancy loss, and recurrent IVF failure.

Staessen and colleagues (2004) evaluated the possible benefit of PGD for aneuploidy screening (PGD-AS) on the outcome following assisted reproductive technology (ART). A prospective randomized controlled clinical trial was performed comparing the outcome after blastocyst transfer combined with PGD-AS by means of FISH for the chromosomes X, Y, 13, 16, 18, 21 and 22 in advanced maternal age couples (aged greater than or equal to 37 years) with a control group without PGD-AS. From the 400 (200 for PGD-AS and 200 controls) couples that were enrolled in the trial, an oocyte pick-up was carried out effectively in 289 cycles (148 PGD-AS cycles and 141 control cycles). Positive serum human chorionic gonadotropin rates per transfer and per cycle were the same for PGD-AS and controls: 35.8 % (19.6 %) [DSI]
transfer (per cycle)] and 32.2 % (27.7 %), respectively (not statistically significant). Significantly fewer embryos were transferred in the PGD-AS group than in the control group (p < 0.001). The implantation rate (with fetal heart beat) was 17.1 % in the PGD-AS group versus 11.5 % in the control group (not significant; p = 0.09). These researchers observed a normal diploid status in 36.8 % of the embryos. They concluded that this randomized controlled study provided no arguments in favor of PGD-AS for improving clinical outcome per initiated cycle in patients with advanced maternal age when there are no restrictions in the number of embryos to be transferred.

Urman et al (2005) stated that the success of ART, although gradually increasing over the years, is still less than satisfactory. Even though many couples have benefited from this approach, many have also been frustrated following multiple failed attempts. Couples who fail to conceive after multiple IVF/ICSI treatments often seek treatment options that are new and that have not been offered before. Some of these include immunological testing and treatment, allogeneic lymphocyte therapy, intra-tubal transfer of zygotes and embryos, blastocyst transfer, sequential embryo transfer, assisted hatching, co-cultures, and PGD-AS. Although the evidence behind some of these new approaches is more robust, most suffer from lack of well-designed randomized studies comparing them with other treatment options. Randomized controlled trials are extremely difficult to conduct, as couples will resist being randomized into a treatment group where previously failed procedures will be repeated. In the mean time, ART programs should resist offering treatment options that are not evidence-based, or at least they should share with the couple the information that is available and should stress that none of these is a panacea for their problem.
In a Cochrane review, Twisk and co-workers (2006) concluded that to date there is inadequate data to determine if PGS is an effective intervention in IVF and ICSI for improving live birth rates. These investigators noted that available data on PGS for advanced maternal age showed no difference in live birth rate and ongoing pregnancy rate. Furthermore, only 2 randomized trials were found, of which one included only 39 patients. They noted that for both studies comments on their methodological quality can be made. Therefore more properly conducted randomized controlled trials are needed. Until such trials have been performed, PGS should not be used in routine patient care.

Ogilvie et al (2001) stated that reciprocal translocations are found in about 1 in 500 people, whereas Robertsonian translocations occur with a prevalence of 1 in 1,000. Balanced carriers of these rearrangements, although phenotypically normal, may present with infertility, recurrent miscarriage, or offspring with an abnormal phenotype after segregation of the translocation at meiosis. Once the translocation has been identified, prenatal diagnosis can be offered, followed by termination of pregnancies with chromosome imbalance. Couples who have suffered repeated miscarriage or those who have undergone termination of pregnancy as a result of the translocation carrier status of one partner are looking increasingly to PGD as a way of achieving a normal pregnancy. Similarly, infertile couples in which one partner is a translocation carrier may request PGD to ensure transfer of normal embryos after in-vitro fertilization. Translocation PGD has been applied successfully in several centers worldwide and should now be considered as a realistic treatment option for translocation carriers who do not wish to trust to luck for a successful natural outcome.

Sermon (2002) noted that the first clinically applied PGD was reported more than a decade ago and since then PGD has known an exponential growth. This report described the use of polymerase chain reaction (PCR) to sex embryos from
couples at risk for X-linked diseases. Not surprisingly, in the first years, the development of PCR-based tests led to PGD for well-known monogenic diseases such as cystic fibrosis and thalassaemia. When FISH was introduced it quickly replaced PCR-based methods, which had led to misdiagnoses, for sexing of embryos. FISH was also quickly introduced for aneuploidy screening, which has as its main aim the improvement of IVF results in patients with poor reproductive outcome, and later for PGD in translocation carriers.

Pehlivan et al (2003) noted that PGD using FISH is being used widely to prevent the transmission of sex-linked diseases, to screen for translocations, and for aneuploidy screening in specific IVF patient groups, along with FISH analysis of spermatozoa in infertile men. These investigators analyzed their clinical results in patients at risk of transmitting sex-linked diseases (n = 55), in carriers of translocations (n = 43), in women who have recurrent miscarriage (2 or more miscarriages) (n = 128), recurrent IVF failure (3 or more failed IVF attempts) (n = 47), and patients of advanced maternal age (37 years old or older) (n = 79). The use of the FISH technique in carriers of sex-linked diseases and translocation patients prevents transmission of these conditions and provides good IVF outcome. In patients with recurrent miscarriage, implantation failure, and advanced maternal age, a high incidence of embryos with abnormal chromosomes 13, 16, 18, 21, 22, X, and Y was observed (range 69 to 75 %), as expected. In those 3 groups of patients, the selection of euploid embryos for transfer resulted in good pregnancy rates with a low incidence of miscarriage.

Munne (2005) stated that individuals carrying translocations suffer from reduced fertility or spontaneous abortions and seek help in form of ART and PGD. While most translocations are relatively easy to detect in metaphase cells, the majority of embryonic cells biopsied in the course of IVF procedures are in interphase. These nuclei are thus unsuitable for analysis by chromosome banding or painting using FISH. Thus several
methods have been devised to detect translocation imbalance through FISH in single cells for purpose of PGD, among them polar body chromosome painting, interphase FISH with combination of subtelomeric and centromeric probes, breakpoint spanning probes, and cell conversion. Results with PGD indicate a significant decrease in spontaneous abortions, from 81% before PGD to 13% after PGD. They also indicate very high rates of chromosome abnormalities in embryos from translocation carriers, 72% for Robertsonian translocations and 82% for reciprocal translocations. Sperm analysis was found to be a good predictor of IVF and PGD outcome, with samples with more than 60% abnormal forms indicating poor prognosis. Similarly, the predictability from first PGD cycle results for future cycles was 90%. The authors concluded that PGD can help translocation carriers to achieve viable pregnancies, but the success of the process is conversely related to the baseline of unbalanced gametes.

Donoso and Devroey (2007) stated that PGD diagnosis for aneuploidy screening (PGD-AS) constitutes a technique developed to improve embryo selection in patients with a poor outcome after IVF treatment due to an increased frequency of numerical chromosome abnormalities in the embryos. Although multiple studies have evaluated the performance of PGD-AS in different groups of patients, inconsistencies in the evidence available have not enabled definitive conclusions to be drawn. According to randomized trials, PGD-AS does not improve the outcome of women of advanced age when there is no limitation on the number of embryos to be transferred. In patients who have experienced recurrent implantation failure or recurrent miscarriage, PGD-AS only seems to provide diagnostic information, especially when aneuploid embryos alone are found. The authors concluded that additional evidence is needed before PGD-AS is implemented as part of routine clinical practice.
The American Society for Reproductive Medicine (2007) reached the following conclusions regarding preimplantation genetic screening (PGS):

- Available evidence does not support the use of PGS as currently performed to improve live-birth rates in patients with advanced maternal age.
- Available evidence does not support the use of PGS as currently performed to improve live-birth rates in patients with previous implantation failure.
- Available evidence does not support the use of PGS as currently performed to improve live-birth rates in patients with recurrent pregnancy loss.
- Available evidence does not support the use of PGS as currently performed to reduce miscarriage rates in patients with recurrent pregnancy loss related to aneuploidy
- Because the prevalence of aneuploidy is high in the embryos of patients with recurrent implantation failure, decisions concerning future treatment should not be based on the results of PGS in one or more cycles.

According to the Preimplantation Genetic Diagnosis International Society (PGDIS) program and laboratory quality assurance guidelines for the performance of PGD (2008), there are no restrictions on the technique of insemination in PGD performed for aneuploidy and translocations using FISH; however, for carriers of single gene disorders where PCR will be applied, or for molecular (comparative genomic hybridization [CGH], DNA microarrays) assessment of chromosome status, ICSI is recommended to avoid cellular DNA from non-fertilizing sperm. This is in agreement with the European Society of Human Reproduction and Embryology (ESHRE) PGD Consortium Best Practice Guidelines for Clinical Preimplantation Genetic Diagnosis (PGD) and Preimplantation Genetic Screening (PGS) (2005) that stated, "[t]hese guidelines recommend ICSI as the method for insemination when performing a PCR-based diagnostic test on
single embryonic cells since the risk of contamination from extraneous cells or DNA has greater consequences for the accuracy of the test when using PCR compared with fluorescence in situ hybridization (FISH)." Furthermore, the guidelines stated, "ICSI or conventional insemination is acceptable for FISH cases."

The American College of Obstetricians and Gynecologists (ACOG) (2009) stated "Current data does not support a recommendation for preimplantation genetic screening for aneuploidy using fluorescence in situ hybridization solely because of maternal age. Also, preimplantation genetic screening for aneuploidy does not improve in vitro fertilization success rates and may be detrimental. At this time there are no data to support preimplantation genetic screening for recurrent unexplained miscarriage and recurrent implantation failures; its use for these indications should be restricted to research studies with appropriate informed consent."

In a randomized, controlled, prospective clinical study, Meyer et al (2009) examined if the routine use of PGS in "good prognosis" women improves IVF cycle outcome. Infertile women predicted to have a good prognosis as defined by: age less than 39 years, normal ovarian reserve, body mass index less than 30 kg/m(2), presence of ejaculated sperm, normal uterus, less than or equal to 2 previous failed IVF cycles were included in this study. Patients were randomized to the PGS group or the control group on day 3 after oocyte retrieval; 23 women underwent blastomere biopsy on day 3 after fertilization (PGS group), and 24 women underwent routine IVF (control group). All embryos were transferred on day 5 or 6 after fertilization. Main outcome measures were pregnancy, implantation, multiple gestation, and live birth rates. No statistically significant differences were found between the PGS and control groups with respect to clinical pregnancy rate (52.4 % versus 72.7 %). However, the embryo implantation rate was statistically significantly lower for the PGS group (31.7 % versus 62.3 %) as were the live birth rate (28.6 %
versus 68.2 %) and the multiple birth rate (9.1 % versus 46.7 %). The authors concluded that in a "good prognosis" population of women, PGS does not appear to improve pregnancy, implantation, or live birth rates.

In a systematic review and meta-analysis, Checa and colleagues (2009) evaluated the effectiveness of PGS in raising pregnancy rates in couples without known genetic disorders. Systematic review and meta-analysis of randomized controlled trials were carried out. Two reviewers independently determined study eligibility and extracted data. A total of 10 randomized trials (1,512 women) were included. The quality of evidence was moderate. Meta-analyses using a random-effects model suggest that PGS has a lower rate of ongoing pregnancies (risk ratio [RR] = 0.73, 95 % confidence interval [CI]: 0.62 to 0.87) and a lower rate of live births (RR = 0.76, 95 % CI: 0.64 to 0.91) than standard IVF/ICSI. The authors concluded that in women with poor prognosis or in general IVF program, IVF/ICSI with PGS for aneuploidy does not increase but instead was associated with lower rates of ongoing pregnancies and live births. The use of PGS in daily practice does not appear to be justified.

In a prospective randomized controlled trial (RCT), Debrock et al (2010) tested the hypothesis that patients with advanced maternal age (AMA; greater than or equal to 35 years of age) have a higher implantation rate (IR) after embryo transfer of embryos with a normal chromosomal pattern for the chromosomes studied with PGS compared with patients who had an embryo transfer without PGS. The clinical IR per embryo transferred was compared after embryo transfer on day 5 or 6 between the PGS group (analysis of chromosomes 13, 16, 18, 21, 22, X, and Y) and the control group without PGS. No differences were observed between the PGS group and the control group for the clinical IR (15.1 %; 14.9 %; RR = 1.01; exact CI: 0.25 to 5.27), the ongoing IR (at 12 weeks) (9.4 %; 14.9 %), and the live born rate per embryo transferred (9.4 %; 14.9 %; RR = 0.63; exact CI: 0.08 to 3.37). Fewer embryos
were transferred in the PGS group (1.6 +/- 0.6) than in the control group (2.0 +/- 0.6). A normal diploid status was observed in 30.3% of the embryos screened by PGS. The authors concluded that in this RCT, the results did not confirm the hypothesis that PGS results in improved reproductive outcome in patients with AMA.

Harper and Harton (2010) stated that in PGD, PCR has been used to detect monogenic disorders, and in PGD/PGS, FISH has been used to analyze chromosomes. A total of 10 RCTs using FISH-based PGS on cleavage-stage embryos and 1 on blastocyst-stage embryos have shown that PGS does not increase delivery rates. Is the failure of PGS due to a fundamental flaw in the idea, or are the techniques that are being used unable to overcome their own, inherent flaws?

Array-based technology allows for analysis of all of the chromosomes. Two types of arrays are being developed for use in PGD: (i) array CGH (aCGH) and (ii) single nucleotide polymorphism (SNP)-based arrays. Each array can determine the number of chromosomes, however, SNP-based arrays can also be used to haplotype the sample. The authors described aCGH and SNP array technology and made suggestions for the future use of arrays in PGD and PGS. They concluded that if array-based testing is going to prove useful, 3 steps need to be taken: (i) validation of the array platform on appropriate cell and tissue samples to allow for reliable testing, even at the single-cell level; (ii) deciding which embryo stage is the best for biopsy: polar body, cleavage, or blastocyst stage; and (iii) performing RCTs to show improvement in delivery rates. If RCTs are able to show that array-based testing at the optimal stage for embryo biopsy increases delivery rates, this will be a major step forward for assisted reproductive technology patients around the world.
In a clinical research study, Fragouli and colleagues (2010) identified and transferred cytogenetically normal embryos after screening all chromosomes of first and second polar bodies (PBs) or trophectoderm samples with the use of CGH. Zygotes from 32 couples with repeated implantation failure and poor response to ovarian stimulation underwent PB biopsy. Patients with repeated implantation failure who were candidates for blastocyst transfer received trophectoderm biopsy. Zygotes or blastocysts were vitrified while chromosome analysis took place. Euploid embryos were transferred during a subsequent cycle. Main outcome measures were cytogenetic status and implantation and pregnancy rates. The oocyte and blastocyst aneuploidy rates were 65.5% and 45.2%, respectively. Abnormalities affecting all chromosomes were detected. Implantation and pregnancy rates for the patients with PB biopsy were 11.5% and 21.4%, respectively, whereas for patients receiving blastocyst analysis they were 58.3% and 69.2%. The authors concluded that initial results for patients of AMA (39.8 years) with repeated implantation failure and poor ovarian response were encouraging. However, they stated that further study is needed to confirm whether or not screening is beneficial. Blastocyst analysis was associated with high pregnancy rates, suggesting that comprehensive chromosome screening may assist patients with repeated implantation failure capable of producing blastocysts in achieving pregnancies.

Geraedts and associates (2010) noted that screening of human preimplantation embryos for numerical chromosome abnormalities has been conducted mostly at the preimplantation stage using FISH. However, it is clear that PGS as it is currently practiced does not improve live birth rates. Thus, the ESHRE PGS Task Force has decided to start a proof of principle study with the aim of determining whether biopsy of the first and second polar body followed by subsequent analysis of the complete chromosome complement of these polar bodies using an array-based technique enables a timely identification of the chromosomal
status of an oocyte. If the principle of this approach can be proven, it is obvious that a multi-center RCT should then be started to determine the clinical value of this technique. In this way, the ESHRE PGS Task Force hopes to redirect preimplantation screening from the blind alley to the main road of assisted reproduction.

Wells (2010) stated that chromosome abnormalities are common among human oocytes and are usually lethal to any embryos they produce. Thus, it seems logical that a reliable technique for distinguishing between normal and aneuploid embryos would be a useful tool for physicians and embryologists, assisting the choice of which embryo(s) to prioritize for uterine transfer. This concept has led to the development of a variety of methods for the detection of chromosome abnormalities in oocytes and embryos, most often referred to as PGS. However, several well-controlled studies have been unable to show an advantage of chromosome screening in terms of pregnancy and birth rates. Some investigators have suggested that damage to embryos, sustained during cleavage-stage biopsy, might explain why PGS has not always provided the anticipated benefits.

Mastenbroek et al (2011) performed a systematic review and meta-analysis of RCTs on the effect of PGS on the probability of live birth after IVF. PubMed and trial registers were searched for RCTs on PGS. Trials were assessed following predetermined quality criteria. The primary outcome was live birth rate per woman, secondary outcomes were ongoing pregnancy rate, miscarriage rate, multiple pregnancy rate and pregnancy outcome. A total of 9 RCTs comparing IVF with and without PGS were included in this meta-analysis. Fluorescence in situ hybridization was used in all trials and cleavage stage biopsy was used in all but 1 trial. Preimplantation genetic screening significantly lowered live birth rate after IVF for women of advanced maternal age (risk difference: -0.08; 95 % CI: -0.13 to -0.03). For a live birth rate of 26 % after IVF without PGS, the rate would be between 13
and 23% using PGS. Trials where PGS was offered to women with a good prognosis and to women with repeated implantation failure suggested similar outcomes. The authors concluded that there is no evidence of a beneficial effect of PGS as currently applied on the live birth rate after IVF. On the contrary, for women of advanced maternal age, PGS significantly lowers the live birth rate. Technical drawbacks and chromosomal mosaicism underlie this inefficacy of PGS. They stated that new approaches in the application of PGS should be evaluated carefully before their introduction into clinical practice.

Harper and Sengupta (2012) stated that for the last 20 years, PGD has been mostly performed on cleavage stage embryos after the biopsy of 1-2 cells and PCR and FISH have been used for the diagnosis. The main indications have been single-gene disorders and inherited chromosome abnormalities. Preimplantation genetic screening for aneuploidy is a technique that has used PGD technology to examine chromosomes in embryos from couples undergoing IVF with the aim of helping select the chromosomally “best” embryo for transfer. It has been applied to patients of advanced maternal age, repeated implantation failure, repeated miscarriages and severe male factor infertility. Recent RCTs have shown that PGS performed on cleavage stage embryos for a variety of indications does not improve delivery rates. At the cleavage stage, the cells biopsied from the embryo are often not representative of the rest of the embryo due to chromosomal mosaicism. There has therefore been a move towards blastocyst and polar body biopsy, depending on the indication and regulations in specific countries (in some countries, biopsy of embryos is not allowed). Blastocyst biopsy has an added advantage as vitrification of blastocysts, even post-biopsy, has been shown to be a very successful method of cryo-preserving embryos. However, mosaicism is also observed in blastocysts. There have been dramatic changes in the method of diagnosing small numbers of cells for PGD. Both array-CGH and SNP
arrays have been introduced clinically for PGD and PGS. The authors concluded that for PGD, the use of SNP arrays brings with it ethical concerns as a large amount of genetic information will be available from each embryo. For PGS, RCTs need to be conducted using both array-CGH and SNP arrays to determine if either will result in an increase in delivery rates.

Fiorentino (2012) noted that embryo assessment is a crucial component to the success of IVF. A high rate of embryos produced in-vitro present chromosomal abnormalities and have reduced potential for achieving a viable pregnancy. The author reviewed the use of PGD by array-CGH, for comprehensive aneuploidy screening of embryos, to improve IVF outcomes. Data from comprehensive aneuploidy screening of embryos showed that aneuploidies may occur in any of the 24 chromosomes, indicating that aneuploidy screening of all chromosomes is necessary to determine whether an embryo is chromosomally normal. Initial studies on clinical application of this technology have documented improved pregnancy outcomes following transfer of screened embryos. However, the optimal stage of pre-implantation development at which PGS should be performed still remains to be determined. The author concluded that although clinical results have been promising, further evidence is needed to establish whether PGS results in enhanced live birth rate, and if this is the case, to identify which patients may benefit from the procedure. They stated that the results from several ongoing RCTs, performed at different cell biopsy stage and categories of patients, will provide the data needed to accept or reject the clinical effectiveness of PGS.

Brezina et al (2013) stated that the past several decades have seen tremendous advances in the field of medical genetics. The application of genetic technologies to the field of reproductive medicine has ushered in a new era of medicine that is likely to greatly expand in the coming years. Concurrent with an IVF cycle, it is now possible to obtain a cellular biopsy
from a developing embryo and genetically evaluate this sample with increasing sophistication and detail. Preimplantation genetic screening is the practice of determining the presence of aneuploidy (either too many or too few chromosomes) in a developing embryo. However, how and in whom PGS should be offered is a topic of much debate.

An UpToDate review on “Preimplantation genetic screening (PGS) for aneuploidy” (Schattman, 2014) states that “Because of the limitations of testing a single cell from a heterogeneous multi-cell embryo, an abnormal result from analysis of a single blastomere by any method does not necessarily indicate that the embryo will be abnormal. Since there are false positives, embryos initially considered abnormal may be re-analyzed at the blastocyst stage and transferred if subsequent testing is normal. PGS using day 3 blastomere biopsy and FISH decreases the chances of live birth. For women of advanced maternal age or a history of IVF implantation failure, we recommend not undergoing PGS (Grade 1A). In couples with recurrent pregnancy loss, PGS is unlikely to benefit those with proven karyotypically normal miscarriages. In patients with karyotypically abnormal miscarriages, PGS may decrease the risk of subsequent miscarriage, although there is no evidence that it will increase the probability of having a child. In young, good prognosis couples, PGS using blastocyst biopsy and 23 chromosome analysis may improve the chance of conception with single embryo transfer; however, the chance of live birth after frozen embryo transfers is not increased”.

Schmutzler et al (2014) examined if embryos derived from oocytes detected euploid for 5 chromosomes implant better than those that were biopsied but where the genetic detection failed. They were nevertheless transferred, thus serving as a sham control. From 2004 to 2008, these researchers performed 104 cycles of PGS with laser biopsy of the first polar body and FISH with 5 chromosomes. It was offered to all patients with 8 or more oocytes, free of charge. The average
female age was 36 years. If no euploid oocytes were available, not detected oocytes were transferred. In 104 cycles, 99 embryo transfers (95%) were performed, resulting in 28 pregnancies (27%), 20 births (71%) and 8 miscarriages (29%). The implantation rate in the euploid group was 19 versus 13% in the not detected group (non-significant). This trend was the same independent of age and embryo morphology. The authors concluded that the pregnancy rate does not differ significantly from the national average. Moreover, they stated that the trend in better implantation rates of euploid oocytes justifies a continuation of studies in this matter.

Gleicher et al (2014) stated that only a few years ago the American Society of Assisted Reproductive Medicine (ASRM), the European Society for Human Reproduction and Embryology (ESHRE) and the British Fertility Society declared preimplantation genetic screening (PGS#1) ineffective in improving IVF pregnancy rates and in reducing miscarriage rates. A presumably upgraded form of the procedure (PGS#2) has recently been re-introduced, and was assessed in a systematic review. PGS#2 in comparison to PGS#1 is characterized by: (i) trophectoderm biopsy on day 5/6 embryos in place of day-3 embryo biopsy; and (ii) FISH of limited chromosome numbers is replaced by techniques, allowing aneuploidy assessments of all 24 chromosome pairs. Reviewing the literature, these investigators were unable to identify properly conducted prospective clinical trials in which IVF outcomes were assessed based on "intent-to-treat". Thus, whether PGS#2 improves IVF outcomes cannot be determined. Re-assessments of data, alleged to support the effectiveness of PGS#2, indeed, suggested the opposite. Like with PGS#1, the introduction of PGS#2 into unrestricted IVF practice again appeared premature, and threatens to repeat the PGS#1 experience, when thousands of women experienced reductions in IVF pregnancy chances, while expecting improvements. The authors concluded that PGS#2
is an unproven and still experimental procedure, which, until evidence suggests otherwise, should only be offered under study conditions, and with appropriate informed consents.

Deng and Wang (2015) evaluated the aneuploidy formation in the blastocysts derived from frozen donor eggs and also evaluated the efficiency of egg vitrification as an ART for egg cryopreservation. In this study, donated human eggs from young women were cryopreserved by vitrification and PGS was performed in the resulted blastocysts by DNA microarray. A total of 764 frozen eggs from 75 egg thawing cycles were warmed and 38 blastocysts were biopsied for PGS before embryo transfer. A 97.1% of egg survival rate was obtained and 59.1% of embryos developed to blastocyst stage. After biopsy and PGS, it was found that 84.2% of blastocysts were euploid and 15.8% were aneuploid. Aneuploidy rates varied among donors. Transfers of blastocysts without PGS resulted in higher clinical pregnancy and implantation rates as compared with transfer of blastocysts with PGS. The authors concluded that although the overall aneuploidy rate was low in the blastocysts derived from frozen donor eggs, high aneuploidy rates were observed in the embryos resulting from some donated eggs. They noted that clinical pregnancy rate was not improved by PGS of embryos resulting from donor eggs, indicating that PGS may not be necessary for embryos derived from donor eggs in most cases.

Lee and colleagues (2015) noted that the majority of published studies comparing a strategy of preimplantation genetic diagnosis for aneuploidy (PGD-A) with morphologically assessed embryos have reported a higher implantation rate per embryo using PGD-A, but insufficient data has been presented to evaluate the clinical and cost-effectiveness of PGD-A in the clinical setting. Aneuploidy is a leading cause of implantation failure, miscarriage and congenital abnormalities in humans, and a significant cause of ART failure. Pre-clinical evidence of PGD-A indicates that the selection and transfer of euploid embryos during ART should improve clinical
outcomes. These investigators examined if PGD-A with analysis of all chromosomes during ART is clinically and cost effective? These researchers performed a systematic review of the literature for full text English language articles using MEDLINE, EMBASE, SCOPUS, Cochrane Library databases, NHS Economic Evaluation Database and EconLit. The Downs and Black scoring check-list was used to assess the quality of studies. Clinical effectiveness was measured in terms of pregnancy, live-birth and miscarriage rates. A total of 19 articles meeting the inclusion criteria, comprising 3 RCTs in young and good prognosis patients and 16 observation studies were identified. Five of the observational studies included a control group of patients where embryos were selected based on morphological criteria (matched cohort studies). Of the 5 studies that included a control group and reported implantation rates, 4 studies (including 2 RCTs) demonstrated improved implantation rates in the PGD-A group. Of the 8 studies that included a control group, 6 studies (including 2 RCTs) reported significantly higher pregnancy rates in the PGD-A group, and in the remaining 2 studies, equivalent pregnancies rates were reported despite fewer embryos being transferred in the PGD-A group. The 3 RCTs demonstrated benefit in young and good prognosis patients in terms of clinical pregnancy rates and the use of single embryo transfer. However, studies relating to patients of advanced maternal age, recurrent miscarriage and implantation failure were restricted to matched cohort studies, limiting the ability to draw meaningful conclusions. The authors concluded that given the uncertain role of PGD-A techniques, high-quality experimental studies using intention-to-treat analysis and cumulative live-birth rates including the comparative outcomes from remaining cryopreserved embryos are needed to evaluate the overall role of PGD-A in the clinical setting. It is only in this way that the true contribution of PGD-A to ART can be understood.

Invasive Prenatal Diagnosis
Prenatal invasive diagnostic genetic tests are laboratory studies that are performed during pregnancy when a developing fetus is at risk for or is suspected of having a chromosomal or congenital abnormality. Testing may be performed on a variety of specimens including amniotic fluid, chorionic villi or percutaneous umbilical blood samples.

Chromosome analysis (karyotype) of chorionic villus samples (CVS) or amniotic fluid cells is a laboratory method used to detect aneuploidy such as Down syndrome, trisomy 18 and other chromosome abnormalities in a developing fetus. Other laboratory methods used to detect prenatal chromosome abnormalities via CVS and amniotic fluid include fluorescence in situ hybridization (FISH).

Molecular genetic testing is used to analyze deoxyribonucleic acid (DNA) extracted from fetal cells by CVS and amniocentesis to detect gene mutations prenatally in fetuses that may be at risk for genetic disorders such as cystic fibrosis (CF) or Tay-Sachs disease.

Preimplantation Genetic Screening

Gleicher and colleagues (2016) stated that to preclude transfer of aneuploid embryos, current PGS usually involves 1 trophectoderm biopsy at blastocyst stage, assumed to represent embryo ploidy. Whether one such biopsy can correctly assess embryo ploidy has recently, however, been questioned. This descriptive study investigated accuracy of PGS in 2 ways: (i) 2 infertile couples donated 11 embryos, previously diagnosed as aneuploid and, therefore, destined to be discarded. They were dissected into 37 anonymized specimens, and sent to another national laboratory for repeat analyses to assess (a) inter-laboratory congruity and (b) intra-embryo congruity of multiple embryo biopsies in a single laboratory; and (ii) reports on human IVF cycle outcomes after transfer of allegedly aneuploid embryos into 8 infertile patients. Only 2/11 (18.2 %) embryos were
identically assessed at 2 PGS laboratories; 4/11 (36.4 %), on repeat analysis were chromosomally normal, 2 mosaic normal/abnormal, and 5/11 (45.5 %) completely differed in reported aneuploidies. In intra-embryo analyses, 5/10 (50 %) differed between biopsy sites; 8 transfers of previously reported aneuploid embryos resulted in 5 chromosomally normal pregnancies, 4 delivered and 1 ongoing; 3 patients did not conceive, though 1 among them experienced a chemical pregnancy. The authors concluded that although populations of both study parts were too small to draw statistically adequately powered conclusions on specific degrees of inaccuracy of PGS, the presented results did raise concerns especially about false-positive diagnoses. While inter-laboratory variations may at least partially be explained by different diagnostic platforms utilized, they could not explain observed intra-embryo variations, suggesting more frequent trophectoderm mosiacism than previously reported. The authors conclude that together with recently published mouse studies of lineages-specific degrees of survival of aneuploid cells in early stage embryos, these results called into question the biological basis of PGS, based on the assumption that a single trophectoderm biopsy can reliably determine embryo ploidy. They stated that prudence has to be exercised by practitioners in IVF across all patients when offering PGS under the hypothesis that the procedure improves IVF outcomes.

Majumdar and associates (2016) noted that a majority of human embryos produced in-vitro are aneuploid, especially in couples undergoing IVF with poor prognosis; PGS for all 24 chromosomes has the potential to select the most euploid embryos for transfer in such cases. In a retrospective, case-control study, these researchers examined the effectiveness of PGS for all 24 chromosomes by microarray CGH (array CGH) in Indian couples undergoing IVF cycles with poor prognosis. This study was undertaken in an institution-based tertiary care IVF center to compare the clinical outcomes of 20 patients, who underwent 21 PGS cycles with poor prognosis, with 128
non-PGS patients in the control group, with the same inclusion criterion as for the PGS group. Single cells were obtained by laser-assisted embryo biopsy from day 3 embryos and subsequently analyzed by array CGH for all 24 chromosomes. Once the array CGH results were available on the morning of day 5, only chromosomally normal embryos that had progressed to blastocyst stage were transferred. The implantation rate and clinical pregnancy rate (PR) per transfer were found to be significantly higher in the PGS group than in the control group (63.2 % versus 26.2 %, p = 0.001 and 73.3 % versus 36.7 %, p = 0.006, respectively), while the multiple PRs sharply declined from 31.9 % to 9.1 % in the PGS group. The authors concluded that the findings of this pilot study showed that PGS by array CGH can improve the clinical outcome in patients undergoing IVF with poor prognosis. Moreover, they stated that further prospective, randomized clinical studies with a larger sample size are needed to validate these preliminary findings.

One of the major drawbacks of the study was the considerably smaller number of patients in the PGS group as compared to the control group. The high cost associated with genetic analysis proved to be a major deterrent for patients to undertake PGS, since opting for PGS resulted in doubling the cost of the IVF cycle. Another reason for the low recruitment was probably the nature of the patient population being investigated, since a high percentage of patients tend to drop-out after the first few IVF failures or miscarriages. Moreover, many patients who did give consent to undergo PGS failed to fulfill the minimum criterion required to undergo biopsy. The retrospective design was another drawback of the study.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

http://aetnet.aetna.com/mpa/cpb/300_399/0358.html 10/25/2018
### CPT Codes Covered if Selection Criteria Are Met:

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59000</td>
<td>Amniocentesis; diagnostic</td>
</tr>
<tr>
<td>59012</td>
<td>Cordocentesis (intrauterine), any method</td>
</tr>
<tr>
<td>59015</td>
<td>Chorionic villus sampling, any method</td>
</tr>
<tr>
<td>88271</td>
<td>Molecular cytogenetics</td>
</tr>
<tr>
<td>88299</td>
<td></td>
</tr>
<tr>
<td>89290</td>
<td>Biopsy, oocyte polar body or embryo</td>
</tr>
<tr>
<td>89291</td>
<td>Blastomere, microtechnique (for pre-implantation genetic diagnosis); less than, equal, or greater than 5 embryos [not covered to enhance delivery rates in advanced reproductive technologies]</td>
</tr>
</tbody>
</table>

### CPT Codes Not Covered for Indications Listed in the CPB:

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
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</thead>
<tbody>
<tr>
<td>86828</td>
<td>Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I and/or Class II HLA antigens</td>
</tr>
<tr>
<td>86829</td>
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</tr>
<tr>
<td>86830</td>
<td>Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class I or HLA Class II</td>
</tr>
<tr>
<td>86831</td>
<td></td>
</tr>
<tr>
<td>86832</td>
<td>Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); high definition qualitative panel for identification of antibody specificities (eg, individual antigen per bead methodology), HLA Class I or HLA Class II</td>
</tr>
<tr>
<td>86833</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Code Description</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>86834 - 86835</td>
<td>Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); semi-quantitative panel (eg, titer), HLA Class I or HLA Class II</td>
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Other CPT codes related to the CPB:

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<tr>
<th>Code</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>58321 - 58322</td>
<td>Artificial insemination</td>
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Other HCPCS codes related to the CPB:

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<th>Code</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>S3840</td>
<td>DNA analysis for germline mutations of the RET proto-oncogene for susceptibility to multiple endocrine neoplasia type 2</td>
</tr>
<tr>
<td>S3841 - S3853</td>
<td>Genetic testing</td>
</tr>
<tr>
<td>S4011 - S4022</td>
<td>In vitro fertilization</td>
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</table>

ICD-10 codes covered for indications listed in the CPB (not all-inclusive):

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>E70.310</td>
<td>X-linked ocular albinism</td>
</tr>
<tr>
<td>E71.520 - E71.529</td>
<td>X-linked adrenoleukodystrophy</td>
</tr>
<tr>
<td>Q80.1</td>
<td>X-linked ichthyosis</td>
</tr>
<tr>
<td>Q90.0 - Q90.9</td>
<td>Down syndrome</td>
</tr>
<tr>
<td>Q91.0 - Q91.3</td>
<td>Trisomy 18 [Edward's syndrome]</td>
</tr>
<tr>
<td>Q91.4 - Q91.7</td>
<td>Trisomy 13 [Patau's syndrome]</td>
</tr>
<tr>
<td>Q95.0</td>
<td>Balanced translocation and insertion in normal individual</td>
</tr>
<tr>
<td>Code</td>
<td>Code Description</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Q96.0 -</td>
<td>Turner's syndrome</td>
</tr>
<tr>
<td>Q96.9</td>
<td></td>
</tr>
<tr>
<td>Q98.0 -</td>
<td>Klinefelter syndrome</td>
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<td>Q98.4</td>
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<td>Q98.6</td>
<td>Male with structurally abnormal sex chromosome</td>
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<td>Q98.7</td>
<td>Male with sex chromosome mosaicism</td>
</tr>
<tr>
<td>Q98.8</td>
<td>Other specified sex chromosome abnormalities, male phenotype</td>
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<tr>
<td>Q99.2</td>
<td>Fragile X chromosome</td>
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<td>Z14.01 -</td>
<td>Asymptomatic and symptomatic hemophilia A carrier</td>
</tr>
<tr>
<td>Z14.02</td>
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<tr>
<td>Z14.8</td>
<td>Genetic carrier of other disease</td>
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</tbody>
</table>

ICD-10 codes not covered for indications listed in the CPB:

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<th>Code</th>
<th>Code Description</th>
</tr>
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<tbody>
<tr>
<td>Q99.8</td>
<td>Other specified chromosome abnormalities [not covered for VUS (unclassified variant or variant of uncertain significance)]</td>
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<tr>
<td>Q99.9</td>
<td>Chromosomal abnormality, unspecified [not covered for VUS (unclassified variant or variant of uncertain significance)]</td>
</tr>
</tbody>
</table>

The above policy is based on the following references:


in individuals of Eastern European Jewish descent.


51. Schattman GL. Preimplantation genetic screening (PGS) for aneuploidy. UpToDate [online serial]. Waltham, MA: UpToDate; reviewed January 2014.


66. Alfirevic Z, Navaratnam K, Mujezinovic F.
Amendment to
Aetna Clinical Policy Bulletin Number:
0358 Invasive Prenatal Diagnosis of Genetic Diseases

There are no amendments for Medicaid.