NO. 91156

RECURRENT PREGNANCY LOSS

Effective: 06/01/2026
Committee Review: 05/13/2026
Last Updated: 05/13/2026

Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Policy scope: This policy outlines the medical necessity for the evaluation and treatment of recurrent pregnancy loss (RPL).

Related policies:

- Genetics: Counseling, Testing, Screening No. 91540
- Infertility Diagnosis and Treatment/Assisted Reproduction No. 91163

I. MEDICAL NECESSITY CRITERIA

Inclusions:

Evaluation may be considered medically necessary when either of the following criteria are met:

- Two (2) or more clinically recognized first-trimester pregnancy losses, documented by ultrasonography or histopathologic examination; or
- A history of one or more pregnancy losses in the second trimester or later, regardless of preceding first-trimester losses.

A. Evaluation of Recurrent Pregnancy Loss (RPL)

1. The following diagnostic tests may be considered medically necessary for the evaluation of recurrent pregnancy loss:

a. Comprehensive history and physical examination including obstetric, medical, surgical, genetic, and family history.
b. Anatomic evaluation of the uterus using pelvic ultrasound and/or saline infusion sonohysterography, hysterosalpingography, or hysteroscopy
c. Genetic evaluation, including:
    i. Cytogenetic analysis of products of conception when available
    ii. Parental peripheral blood karyotyping only when pregnancy tissue demonstrates an unbalanced structural abnormality or when pregnancy tissue is unavailable after recurrent losses.
d. Anti-phospholipid syndrome (APS) testing, including lupus anti-coagulant, anti-cardiolipin antibodies (IgG, IgM), and anti-β2-glycoprotein I (IgG and/or IgM) antibodies
e. Thyroid function testing (TSH) and thyroid peroxidase (TPO)
f. Endometrial biopsy only when clinically indicated for suspected endometrial pathology (e.g., abnormal uterine bleeding or suspected malignancy)

B. Treatment of Recurrent Pregnancy Loss (RPL)

1. The following treatments may be considered medically necessary for the treatment and management of recurrent pregnancy loss:
    a. Low-dose aspirin and heparin therapy for members diagnosed with antiphospholipid syndrome.
    b. Surgical correction of significant uterine structural abnormalities when clinically appropriate.
    c. Cervical cerclage (transvaginal or transabdominal) for individuals with documented cervical insufficiency.
    d. Vaginal progesterone for individuals with a history of recurrent pregnancy loss who present with vaginal bleeding in the first trimester.

Exclusions:

C. Evaluation of Recurrent Pregnancy Loss (RPL)

1. **Not Medically Necessary**

The following diagnostic tests and studies are not medically necessary for the evaluation of recurrent pregnancy loss due to lack of demonstrated clinical utility or evidence that results in improved clinical outcomes:

a. Inherited thrombophilia testing (e.g., Factor V Leiden, prothrombin gene mutation) when performed solely to explain recurrent *first trimester* pregnancy loss, **in the absence of:**
    i. A personal history of venous thromboembolism (VTE), or
    ii. Other established clinical indications.
b. Immunologic testing including but not limited to:

i. Human leukocyte antigen (HLA) typing
ii. Non-Specific natural killer (NK) cell assays
iii. General Cytokine profiling

c. Sperm DNA fragmentation or sperm aneuploidy testing
d. Routine endometrial biopsy for dating as part of RPL evaluation

2. **Not Medically Necessary-Considered Experimental /Investigational**

The following diagnostic tests and studies are considered experimental, investigational, or unproven for the evaluation of recurrent pregnancy loss and are not medically necessary:

a. Reproductive immunophenotyping, including but not limited to:
   i. CD3+, CD4+, CD5+, CD8+, CD16+, CD19+, CD56+
b. Cytokine and Immune Response Testing including:
   i. Cytokine polymorphism analysis
   ii. Th1/Th2 intracellular cytokine ratio testing
c. Natural killer (NK) cell testing, including:
   i. NK cell number
   ii. NK percentage
   iii. NK cell cytotoxicity or functional assays
d. Autoimmune antibody testing not used for diagnosis of antiphospholipid syndrome, including but not limited to:
   i. Anti-nuclear antibody (ANA)
   ii. Anti-ovarian antibodies
   iii. Anti-paternal or anti-partner antibodies
   iv. Anti-adrenal antibodies
e. Genetic polymorphism testing not shown to improve clinical outcomes in recurrent pregnancy loss, including but not limited to:
   i. MTHFR mutation testing
   ii. Plasminogen activator inhibitor-1 (PAI-1) polymorphism testing
   iii. Angiotensin-converting enzyme (ACE) gene polymorphism testing
   iv. Annexin A5 promoter haplotype testing
f. Routine infection testing in the absence of clinical indication, including but not limited to:
   i. Ureaplasma urealyticum
   ii. Mycoplasma hominus
   iii. Chlamydia
   iv. Listeria monocytogenes
   v. Toxoplasmosis
   vi. Rubella
   vii. Cyto-megalovirus
   viii. Herpes virus
g. Routine thyroid antibody screening (e.g., TPO antibodies) in individuals without indication for RPL or without clinical rationale.

D. Treatment of Recurrent Pregnancy Loss (RPL)

1. **Not Medically Necessary as Considered Experimental / Investigational**

The following treatments are not medically necessary for the treatment and management of recurrent pregnancy loss due to lack of evidence demonstrating clinical benefit:

a. Levothyroxine therapy in euthyroid individuals with thyroid antibodies.
b. Granulocyte colony-stimulating factor (G-CSF)
c. Empiric progesterone therapy for sporadic miscarriage or asymptomatic RPL without vaginal bleeding
d. Empiric Immune-modulating or investigational therapies, including the following:
    i. Intravenous immunoglobulin (IVIG)
    ii. Intralipid infusions
    iii. Corticosteroids used solely for immune modulation
    iv. Paternal leukocyte immunization including:
        - Paternal white cell immunization; or
        - Paternal cell alloimmunization.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
Not Identified	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	Not Identified
First Coast Service Options, Inc.	Not Identified
National Government Services, Inc.	Not Identified
Noridian Healthcare Solutions	Not Identified
Novitas Solutions, Inc.	Not Identified
Palmetto GBA	Not Identified
WPS Insurance Corporation	Not Identified

III. BACKGROUND

Recurrent pregnancy loss (RPL) is variably defined across professional societies. Contemporary guidance from the American College of Obstetricians and Gynecologists

(ACOG) supports clinical evaluation after a second clinically recognized first-trimester pregnancy loss (de Assis et al., 2024). The European Society of Human Reproduction and Embryology (ESHRE) defines RPL as the loss of two or more pregnancies, excluding ectopic and molar pregnancies (ESHRE Guideline Group, 2023). In contrast, the Royal College of Obstetricians and Gynaecologists (RCOG) defines recurrent miscarriage as three or more first-trimester losses, while explicitly allowing evaluation after two losses when there is clinical suspicion that the losses are pathologic rather than sporadic (Regan et al., 2023). Contemporary clinical synthesis further notes that most individuals with RPL ultimately achieve a future live birth, even when no single etiology is identified, supporting timely evaluation based on clinical judgment rather than rigid loss thresholds (de Assis et al., 2024). Collectively, these definitions support a targeted, evidence-based diagnostic approach focused on identifying established, potentially modifiable causes of RPL while avoiding routine use of tests that have not demonstrated improvement in clinical outcomes.

Diagnosis

The etiology of recurrent pregnancy loss is heterogeneous. High-quality evidence most consistently supports associations with parental chromosomal rearrangements, uterine or anatomic abnormalities, and antiphospholipid syndrome (APS), while associations with other endocrine, hematologic, immunologic, infectious, and environmental factors are less consistent (de Assis et al., 2024; ASRM Practice Committee, 2012). Accordingly, guideline-based evaluation emphasizes: (1) a targeted history and physical examination; (2) assessment of uterine anatomy using pelvic imaging and/or cavity evaluation techniques; (3) selective genetic evaluation, including cytogenetic analysis of pregnancy tissue when available and parental karyotyping in defined circumstances; and (4) APS laboratory testing (ESHRE Guideline Group, 2023; Regan et al., 2023). ESHRE additionally notes that ultrasound assessment may include evaluation for adenomyosis in individuals with RPL (ESHRE Guideline Group, 2023). Conversely, routine evaluation for inherited thrombophilias, broad immunologic markers, infectious etiologies, or genetic polymorphisms has not been shown to improve pregnancy outcomes and is not recommended as part of standard RPL evaluation.

Endocrine assessment in RPL is generally targeted. RCOG recommends offering thyroid function testing and thyroid peroxidase (TPO) antibody testing as part of recurrent miscarriage evaluation (Regan et al., 2023). However, ESHRE recommends that euthyroid individuals with thyroid antibodies and RPL should not be treated with levothyroxine, reflecting a lack of demonstrated clinical benefit in this population (ESHRE Guideline Group, 2023). Accordingly, thyroid antibody testing may inform prognosis but does not support routine pharmacologic intervention in the absence of overt thyroid dysfunction.

Treatment

Management of RPL is directed at identified and potentially modifiable causes. For individuals meeting diagnostic criteria for APS, RCOG recommends aspirin plus heparin during pregnancy to improve outcomes, while advising against aspirin and/or heparin for unexplained recurrent miscarriage (Regan et al., 2023). Surgical correction may be considered when a clinically significant uterine anomaly is identified, though evidence of benefit varies by anomaly type (de Assis et al., 2024; Regan et al., 2023). For pharmacologic support, both RCOG and ESHRE specify that vaginal progesterone may be considered for individuals with recurrent miscarriage or RPL who present with vaginal

bleeding in early pregnancy, reflecting the subgroup in whom benefit is most consistently observed (ESHRE Guideline Group, 2023; Regan et al., 2023).

Multiple immunologic and empiric interventions have been studied; however, current guidance does not support routine use of many proposed tests and therapies, including broad immunologic screening panels and immunomodulating treatments, because they have not demonstrated consistent improvement in clinically meaningful outcomes (ASRM Practice Committee, 2012; Regan et al., 2023). Studies evaluating peripheral **natural killer (NK)** cell number or activity have not demonstrated consistent associations with live birth outcomes or utility in directing treatment, and routine NK cell testing is not recommended (Bagkou Dimakou et al., 2025; Polanski et al., 2014; Seshadri & Sunkara, 2014).

Granulocyte colony-stimulating factor (G-CSF) is an immunomodulatory cytokine administered systemically or intrauterinely with the aim of improving implantation or reducing miscarriage. Recent (2024–2025) meta-analyses of randomized controlled trials evaluating G-CSF in recurrent pregnancy loss demonstrate inconsistent findings, with no consistent improvement in live birth rates observed in intention-to-treat analyses. Interpretation is limited by substantial heterogeneity, small sample sizes, and risk of bias. Given these limitations, professional societies including RCOG and ESHRE do not recommend G-CSF for routine clinical use outside of clinical trials (Zhang et al., 2024; Su et al., 2024).

Thyroid peroxidase antibody (TPOAb) positivity is common among women of reproductive age and has been associated with an increased risk of adverse pregnancy outcomes, including miscarriage. Levothyroxine therapy in euthyroid individuals with TPO positivity has been studied as a strategy to mitigate autoimmune-associated miscarriage risk despite normal thyroid function. However, ESHRE recommends against levothyroxine treatment in euthyroid, TPO-positive individuals with RPL due to lack of demonstrated benefit (ESHRE Guideline Group, 2023). The T4LIFE multicenter, randomized, double-blind, placebo-controlled trial found no improvement in live birth, pregnancy loss, or obstetric outcomes with levothyroxine compared with placebo in euthyroid TPO-positive women with RPL (van Dijk et al., 2022). Taken together, available randomized evidence does not demonstrate a consistent improvement in live birth sufficient to support routine levothyroxine therapy in this population. While some randomized studies and meta-analyses have explored levothyroxine use in euthyroid, TPO-positive individuals, findings have been inconsistent and have not demonstrated a reproducible improvement in live birth outcomes sufficient to support routine treatment in recurrent pregnancy loss (Provinciatto et al., 2025).

Immune-modulating therapies such as **intravenous immunoglobulin (IVIG),** intralipid infusions, corticosteroids, and paternal leukocyte immunization have been investigated for their potential to alter maternal immune responses implicated in implantation failure or miscarriage. While some studies have explored these therapies in heterogeneous patient populations, randomized evidence has not demonstrated consistent improvement in live birth rates in intention-to-treat analyses. Meta-analyses remain limited by variability in patient selection, immune testing methodologies, and study design (Habets et al., 2022; Saab et al., 2021). IVIG therapy is additionally associated with high cost, limited availability, and potential risks related to pooled donor products. Accordingly, IVIG and other immune-modulating therapies are not recommended for routine

management of recurrent pregnancy loss and remain investigational pending further high-quality trials (Kumar et al., 2021).

Genetic factors are recognized contributors to recurrent pregnancy loss; however, the clinical utility of testing for common genetic polymorphisms remains unproven. A 2024 observational study evaluating MTHFR c.665C>T and c.1286A>C polymorphisms in women with recurrent miscarriages demonstrated no association between genotype and serum homocysteine levels or clinically meaningful outcomes, supporting the conclusion that these variants do not provide actionable information in RPL evaluation (Budzyńska et al., 2024). Similarly, systematic reviews evaluating **microRNA** (miRNA) polymorphisms have reported inconsistent associations across diverse populations, with no evidence that such testing improves clinical management or pregnancy outcomes (Srivastava et al., 2022). Accordingly, genetic polymorphism testing does not alter diagnostic or treatment decisions in RPL and is considered experimental, investigational, or unproven.

Evidence evaluating **intralipid therapy** in recurrent implantation failure or recurrent pregnancy loss suggests theoretical immunologic effects; however, the available literature is limited by substantial heterogeneity in study design, patient selection, and treatment protocols. As a result, intralipid therapy has not been established as a standard treatment for RPL and remains investigational (Kumar et al., 2021).

Given the psychosocial burden of repeated pregnancy loss and the limited availability of proven interventions for unexplained RPL, supportive care and clear counseling regarding prognosis and evidence limitations are emphasized, ideally within specialized miscarriage or RPL services when available (ESHRE Guideline Group, 2023; Regan et al., 2023). Overall, evidence-based management of recurrent pregnancy loss prioritizes treatment of established etiologies while avoiding empiric or immune-modulating therapies that have not demonstrated consistent benefit in improving live birth outcomes.

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
European Society of Human Reproduction and Embryology (ESHRE)	Recurrent pregnancy loss (2023): updated through 2022 evidence
Practice Committee of the American Society for Reproductive Medicine (ASRM)	Evaluation and treatment of recurrent pregnancy loss: a committee opinion (2012)
Royal College of Obstetricians and Gynecologists (RCOG)	Recurrent MiscarriageGreen-top Guideline No. 17 (2023) Management of Thyroid Disorders in Pregnancy (2025)
American College of Obstetricians and Gynecologists (ACOG)	ACOG PRACTICE BULLETIN: NO 24, FEB 2001, MANAGEMENT OF

	RECURRENT EARLY PREGNANCY LOSS 2024 Evaluation of Recurrent Pregnancy Loss Early Pregnancy Loss | ACOG

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Notice date

VI. CODING

See also: Drug information | Priority Health regarding Pharmacy authorization criteria for Intravenous Immunoglobulin

ICD-10 Codes that may support medical necessity

N96	Recurrent pregnancy loss
O09.211-O09.219	Supervision of pregnancy with history of pre-term labor
O09.291-O09.299	Supervision of pregnancy with other poor reproductive or obstetric history
O26.20-O26.23	Pregnancy care for patient with recurrent pregnancy loss
Z31.441	Encounter for testing of male partner of patient with recurrent pregnancy loss

CPT/HCPCS Codes *(list not inclusive)*

Office Visits

99202–99205	New patient E/M
99212–99215	Established patient E/M

Uterine Anatomic Evaluation

58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58555	Hysteroscopy, diagnostic (separate procedure)
74740	Hysterosalpingography, radiological supervision and interpretation
76830	Ultrasound, transvaginal
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)

Genetic / Cytogenetic Testing

88230	Tissue culture for non-neoplastic disorders; lymphocyte
88233	Tissue culture for non-neoplastic disorders; skin or other solid tissue biopsy
88240	Cryopreservation, freezing and storage of cells, each cell line
88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding
88285	Chromosome analysis; additional cells counted, each study
88291	Cytogenetics and molecular cytogenetics, interpretation and report (parents, when criteria met)

Antiphospholipid Syndrome (APS) Testing

85613	Russell viper venom time (includes venom); diluted
86146	Beta 2 Glycoprotein I antibody, each
86147	Cardiolipin (phospholipid) antibody, each Ig class

Endocrine Testing (Targeted)

81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant
84443	Thyroid stimulating hormone (TSH)
86376	Microsomal antibodies (eg, thyroid or liver-kidney), each (TPO)

Not medically necessary- Considered Experimental/Investigational/Unproven:

Lymphocyte Immunotherapy

38242	Allogeneic lymphocyte infusions

Immunologic / Natural Killer (NK) Cell Testing

88184	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker
88185	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)
88187	Flow cytometry, interpretation; 2 to 8 markers
88188	Flow cytometry, interpretation; 9 to 15 markers
88189	Flow cytometry, interpretation; 16 or more markers
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method

Inherited Thrombophilia Testing (**When Performed Solely for RPL**)

81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant
81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant
85300	Clotting inhibitors or anticoagulants; antithrombin III, activity
85301	Clotting inhibitors or anticoagulants; antithrombin III, antigen assay
85302	Clotting inhibitors or anticoagulants; protein C, antigen
85303	Clotting inhibitors or anticoagulants; protein C, activity

Genetic Polymorphism Testing

81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)

Endometrial Biopsy for Dating (Routine Use)

58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (**luteal phase dating only)**

Infectious / Microbiome Testing

0607U	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 31 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations
0608U	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 10 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations

Granulocyte Colony-Stimulating Factor Filgrastim (G-CSF)

J1442	Injection, filgrastim (G-CSF), excludes biosimilars, 1 mcg
J1447	Injection, tbo-filgrastim, 1 mcg
J1449	Injection, eflapegrastim-xnst, 0.1 mg

Immunomodulating Therapies (IVIG)

J1561	Injection, immune globulin, (Gamunex/Gamunex-C/Gammaked), nonlyophilized (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid), nonlyophilized, (e.g., liquid), 500 mg
J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif), intravenous, nonlyophilized (e.g., liquid), 500 mg
96365–96368	Infusion services when billed with IVIG or intralipid

Intralipid or Unclassified Immune Therapies

J3490	Unclassified drugs
J3590	Unclassified biologics

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

To access Evicore guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven

treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

Professional and Society Guidelines

1. American College of Obstetricians and Gynecologists (ACOG). Early Pregnancy Loss. ACOG Practice Bulletin No. 200. Obstetrics & Gynecology. 2018 Nov (reaffirmed 2025); 132 (5) e197-207.
2. American College of Obstetricians and Gynecologists (ACOG). Management of recurrent early pregnancy loss. ACOG Practice Bulletin No. 24. Int J Gynaecol Obstet. 2002 Aug;78(2):179-90.
3. American Society for Reproductive Medicine, Practice Committee. Definitions of infertility and recurrent pregnancy loss: a committee opinion. Fertility and Sterility; 2013: 99 (1), 62-63
4. American Society for Reproductive Medicine, Practice Committee. Evaluation and treatment of recurrent pregnancy loss: a committee opinion. 2012: 98 (5), 1103-11.
5. Chan, S.-Y., Marsh, M.S., Gilbert, J., Boelaert, K., Evans, C., Dhillon-Smith, R. and the Royal College of Obstetricians and Gynaecologists (2025), Management of Thyroid Disorders in Pregnancy. BJOG, 132: e130-e161. https://doi.org/10.1111/1471-0528.18088
6. ESHRE Guideline Group on Recurrent Pregnancy Loss; Bender Atik R, Christiansen OB, Elson J, Kolte AM, Lewis S, Middeldorp S, et al. ESHRE guideline: recurrent pregnancy loss: an update in 2022. *Hum Reprod Open.* 2023;2023(1):hoad002.

doi:10.1093/hropen/hoad002. Available from: https://www.eshre.eu/Guidelines-and-Legal/Guidelines/Recurrent-pregnancy-loss. Accessed March 17, 2026.
7. Regan L, Rai R, Saravelos S, Li T-C, on behalf of the Royal College of Obstetricians and Gynaecologists. Recurrent Miscarriage: Green-top Guideline No. 17. *BJOG*. 2023; 130(12): e9–e39. https://doi.org/10.1111/1471-0528.17515

General
1. de Assis V, Giugni CS, Ros ST. Evaluation of Recurrent Pregnancy Loss. Obstet Gynecol. 2024 May 1;143(5):645-659. doi: 10.1097/AOG.0000000000005498. Epub 2024 Jan 4. PMID: 38176012.

Genetic Polymorphism Testing
1. Srivastava P, Bamba C, Chopra S, Mandal K. Role of miRNA polymorphism in recurrent pregnancy loss: a systematic review and meta-analysis. Biomark Med. 2022 Feb;16(2):101-115. doi: 10.2217/bmm-2021-0568. Epub 2022 Jan 14. PMID: 35026953.

Granulocyte Colony Stimulating Factor
1. Zhang B, Xu J, Wei X, Zhong X. The Role of Granulocyte Colony Stimulating Factor in Mitigating the Risk of Recurrent Miscarriages: A Comprehensive Review and Meta-Analysis. Reprod Sci. 2025 May;32(5):1379-1387. doi: 10.1007/s43032-024-01736-z. Epub 2024 Dec 2. PMID: 39623124; PMCID: PMC12041162.
2. Su, Q., Pan, Z., Yin, R. R., & Li, X. (2024). The value of granulocyte colony-stimulating factor in women experiencing implantation failure: A systematic review and meta-analysis. *Frontiers in Endocrinology, 15*, 1370114. https://doi.org/10.3389/fendo.2024.1370114

Natural Killer Cells
1. Bagkou Dimakou D, Tamblyn J, Lissauer D, Richter A. Evaluation of peripheral NK tests offered to women with recurrent pregnancy loss and a search for novel candidate biomarkers. J Reprod Immunol. 2025 Mar 18;169:104522. doi: 10.1016/j.jri.2025.104522. Epub ahead of print. PMID: 40112444.
2. Polanski LT(1), Barbosa MA, Martins WP, Baumgarten MN, Campbell B, Brosens J, Quenby S, Raine-Fenning N. Interventions to improve reproductive outcomes in women with elevated natural killer cells undergoing assisted reproduction techniques: a systematic review of literature. Hum Reprod. 2014 Jan;29(1):65-75.
3. Seshadri S (1), Sunkara SK. Natural killer cells in female infertility and recurrent miscarriage: a systematic review and meta-analysis. Hum Reprod Update. 2014 May-Jun;20(3):429-38.

Intralipid Therapy
1. Kumar P, Marron K, Harrity C. Intralipid therapy and adverse reproductive outcome: is there any evidence? Reprod Fertil. 2021 Jun 3;2(3):173-186. doi: 10.1530/RAF-20-0052. PMID: 35118388; PMCID: PMC8788620.

Intravenous immunoglobulin G (IVIG)
1. Habets, D. H. J., Pelzner, K., Wieten, L., Spaanderman, M. E. A., Villamor, E., & Al-Nasiry, S. (2022). Intravenous immunoglobulins improve live birth rate among women with underlying immune conditions and recurrent pregnancy loss: A

systematic review and meta-analysis. *Allergy, Asthma & Clinical Immunology, 18*(1), 23. https://doi.org/10.1186/s13223-022-00660-8
2. Saab W, Seshadri S, Huang C, Alsubki L, Sung N, Kwak-Kim J. A systemic review of intravenous immunoglobulin G treatment in women with recurrent implantation failures and recurrent pregnancy losses. Am J Reprod Immunol. 2021 Apr;85(4):e13395. doi: 10.1111/aji.13395. Epub 2021 Apr 13. PMID: 33511656.

Levothyroxine Treatment

1. van Dijk, M. M., Vissenberg, R., Fliers, E., van der Post, J. A. M., van der Hoorn, M.-L. P., de Weerd, S., … Goddijn, M. (2022). Levothyroxine in euthyroid thyroid peroxidase antibody–positive women with recurrent pregnancy loss (T4LIFE trial): A multicentre, randomized, double-blind, placebo-controlled phase 3 trial. *The Lancet Diabetes & Endocrinology, 10*(5), 322–329. https://doi.org/10.1016/S2213-8587(22)00045-6
2. Provinciatto H, Barbalho ME, da Câmara PM, Bertani MS, Marinho AD, Philip CE, Balieiro CCA, Pontes KFM, Araujo Júnior E. Levothyroxine in euthyroid pregnant women with thyroid peroxidase antibody: a systematic review and meta-analysis of randomized controlled trials. Rev Bras Ginecol Obstet. 2025 Nov 18;47:e-rbgo75. doi: 10.61622/rbgo/2025rbgo75. PMID: 41341943; PMCID: PMC12671679.

SUMMARY OF CHANGES

Deletions:

- Removed outdated references and legacy content no longer aligned with current evidence.

Additions:

- New Policy scope section
- New Medical/Professional Society Guidelines section
- New Government Regulations section listing applicable CMS NCDs or LCDs
- New FDA/Regulatory section
- Added medically necessary tests/studies/indications for evaluation and treatment of RPL
- Added not medically necessary tests/studies for evaluation and treatment of RPL

Changes:

- Reorganized medical necessity criteria to distinguish: Evidence-based evaluation and treatment, versus tests and therapies lacking demonstrated clinical benefit.
- Updated the background section to incorporate recent randomized trials, meta-analyses, and recent society guidelines

---

Past committee review dates: 01/1993, 12/1999, 12/2001, 12/2002, 11/2003, 11/2004, 10/2005, 10/2006, 10/2007, 10/2008, 10/2009, 10/2010, 10/2011, 10/2012, 10/2013, 11/2014, 05/2015, 05/2016, 05/2017, 05/2018, 05/2019, 05/2020, 05/2021, 05/2022, 05/2023, 05/2024, 05/2025, 05/2026

AMA CPT Copyright Statement: All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.