DISCLAIMER/INSTRUCTIONS FOR USE

Medical Policy provides general guidance for applying Blue Cross of Idaho benefit plans (for purposes of Medical Policy, the terms “benefit plan” and “member contract” are used interchangeably). Coverage decisions must reference the member specific benefit plan document. The terms of the member specific benefit plan document may be different than the standard benefit plan upon which this Medical Policy is based. If there is a conflict between a member specific benefit plan and the Blue Cross of Idaho’s standard benefit plan, the member specific benefit plan supersedes this Medical Policy. Any person applying this Medical Policy must identify member eligibility, the member specific benefit plan, and any related policies or guidelines prior to applying this Medical Policy. Blue Cross of Idaho Medical Policies are designed for informational purposes only and are not an authorization, explanation of benefits or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the member specific benefit plan coverage. Blue Cross of Idaho reserves the sole discretionary right to modify all its Policies and Guidelines at any time. This Medical Policy does not constitute medical advice.

POLICY

Genetic testing for Factor V and Factor II Blood Clotting Protein mutations may be considered medically necessary for any of the following conditions:

• Age less than 50, any venous thrombosis; or
• Myocardial infarction in female smokers under age of 50; or
• Recurrent venous thrombosis; or
• First or second degree relative of individuals with venous thrombosis under age of 50; or
• Relative with confirmed Factor V or Factor II mutation; or
• Venous thrombosis and a first or second degree relative with venous thrombosis; or
• Venous thrombosis in pregnant women or women taking oral contraceptives; or
• Venous thrombosis in unusual sites (such as hepatic, mesenteric and cerebral veins).

Genetic testing for Factor V and Factor II mutations is considered investigational for all other indications.

Factor V HR2 allele DNA mutation analysis is considered investigational.

Other genetic tests for inherited thrombophilia, including MTHFR are considered investigational.

The following tests are considered investigational in the evaluation of recurrent pregnancy loss:

• Tests for inherited thrombophilic disorders:
  o antithrombin III antibody;
  o antithrombin III antigen;
factor V Leiden (genetic testing);
- factor V Leiden coagulation (ACPR);
- prothrombin G20210A mutation;
- serum homocysteine;
- protein C activity;
- protein C antigen;
- protein S activity;
- protein S antigen;
- prothrombin (Factor II) mutation;
- deficiencies of the anticoagulants protein C, protein S, and antithrombin II.

POLICY GUIDELINES

Genetics Nomenclature Update

The Human Genome Variation Society nomenclature is used to report information on variants found in DNA and serves as an international standard in DNA diagnostics. It is being implemented for genetic testing medical evidence review updates starting in 2017 (see Table PG1). The Society's nomenclature is recommended by the Human Variome Project, the HUman Genome Organization, and by the Human Genome Variation Society itself.

The American College of Medical Genetics and Genomics and the Association for Molecular Pathology standards and guidelines for interpretation of sequence variants represent expert opinion from both organizations, in addition to the College of American Pathologists. These recommendations primarily apply to genetic tests used in clinical laboratories, including genotyping, single genes, panels, exomes, and genomes. Table PG2 shows the recommended standard terminology—“pathogenic,” “likely pathogenic,” “uncertain significance,” “likely benign,” and “benign”—to describe variants identified that cause Mendelian disorders.

Table PG1. Nomenclature to Report on Variants Found in DNA

<table>
<thead>
<tr>
<th>Previous</th>
<th>Updated</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutation</td>
<td>Disease-associated variant</td>
<td>Disease-associated change in the DNA sequence</td>
</tr>
<tr>
<td>Variant</td>
<td>Change in the DNA sequence</td>
<td></td>
</tr>
<tr>
<td>Familial variant</td>
<td>Disease-associated variant identified in a proband for use in subsequent targeted genetic testing in first-degree relatives</td>
<td></td>
</tr>
</tbody>
</table>

Table PG2. ACMG-AMP Standards and Guidelines for Variant Classification

<table>
<thead>
<tr>
<th>Variant Classification</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathogenic</td>
<td>Disease-causing change in the DNA sequence</td>
</tr>
<tr>
<td>Likely pathogenic</td>
<td>Likely disease-causing change in the DNA sequence</td>
</tr>
<tr>
<td>Variant of uncertain significance</td>
<td>Change in DNA sequence with uncertain effects on disease</td>
</tr>
<tr>
<td>Likely benign</td>
<td>Likely benign change in the DNA sequence</td>
</tr>
<tr>
<td>Benign</td>
<td>Benign change in the DNA sequence</td>
</tr>
</tbody>
</table>

ACMG: American College of Medical Genetics and Genomics; AMP: Association for Molecular Pathology.

Genetic Counseling

Experts recommend formal genetic counseling for patients who are at risk for inherited disorders and who wish to undergo genetic testing. Interpreting the results of genetic tests and understanding risk factors can be difficult for some patients; genetic counseling helps individuals understand the impact of
genetic testing, including the possible effects the test results could have on the individual or their family members. It should be noted that genetic counseling may alter the utilization of genetic testing substantially and may reduce inappropriate testing; further, genetic counseling should be performed by an individual with experience and expertise in genetic medicine and genetic testing methods.

Coding

Specific CPT codes for this testing became available in 2012:

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

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

a The genes above are also found in panel test: 81400 Pathology testing Level 1.

BENEFIT APPLICATION

BLUECARD/NATIONAL ACCOUNT ISSUES

Some plans may have contract or benefit exclusions for genetic testing.

BACKGROUND

Venous Thromboembolism

The overall U.S. incidence of VTE is approximately 1 per 1000 person-years, and the lifetime clinical prevalence is approximately 5%, accounting for 100000 deaths annually. The risk is strongly age-related, with the greatest risk in older populations. VTE also recurs frequently; estimated cumulative incidence of first VTE recurrence is 30% at 10 years. These figures do not separate patients with known predisposing conditions from those without.

Risk factors for thrombosis include clinical and demographic variables, and at least 1 risk factor can be identified in approximately 80% of patients with thrombosis. The following list includes the most important risk factors:

- Malignancy
- Immobility
- Surgery
- Obesity
- Pregnancy
- Hormonal therapy such as estrogen/progestin or selective estrogen modulator products
- Systemic lupus erythematosus and/or other rheumatologic disorders
- Myeloproliferative disorders
- Liver dysfunction
- Nephrotic syndrome
- Hereditary factors.

Pregnancy often is considered a special circumstance because of its frequency and unique considerations for preventing and treating VTE. Pregnancy is associated with a 5- to 10-fold increase in VTE risk, and absolute VTE risk in pregnancy is estimated to be 1 to 2 per 1000 deliveries. In women with a history of pregnancy-related VTE, risk of recurrent VTE with subsequent pregnancies is increased greatly at approximately 100-fold.
Treatment

Treatment of thrombosis involves anticoagulation for a minimum of three to six months. After this initial treatment period, patients deemed to be at a continued high-risk for recurrent thrombosis may continue on anticoagulation therapy for longer periods, sometimes indefinitely. Anticoagulation is effective for reducing subsequent risk of thrombosis but carries its own risk of bleeding.

Inherited Thrombophilia

Inherited thrombophilias are a group of clinical conditions characterized by genetic variant defects associated with a change in the amount or function of a protein in the coagulation system and a predisposition to thrombosis. Not all individuals with a genetic predisposition to thrombosis will develop VTE. The presence of inherited thrombophilia will presumably interact with other VTE risk factors to determine an individual’s VTE risk.

A number of conditions fall under the classification of inherited thrombophilias. Inherited thrombophilias include the following conditions, which are defined by defects in the coagulation cascade:

- Activated protein C resistance (factor V Leiden [FVL] variant)
- Prothrombin (factor II) gene variant (G20210A)
- Protein C deficiency
- Protein S deficiency
- Prothrombin deficiency
- Hyper-homocysteinemia (5,10-methylenetetrahydrofolate reductase [MTHFR] variant).

The most common type of inherited thrombophilia is FVL, which accounts for up to 50% of inherited thrombophilia syndromes. In unselected patients with an idiopathic thrombosis, the incidence of FVL is 17% to 24%, compared with a rate of 5% to 6% in normal controls. The prothrombin G20210A variant is found less commonly, in approximately 5% to 8% of unselected patients who have thrombosis compared with 2% to 2.5% of normal controls.

Genetic Testing

Genetic testing for gene variants associated with thrombophilias is available for FVL, the prothrombin G20210A variant, and MTHFR. Genetic testing for inherited thrombophilia can be considered in several clinical situations. Clinical situations addressed herein include the following:

- Assessment of thrombosis risk in asymptomatic patients (screening for inherited thrombophilia)
- Evaluation of a patient with established thrombosis, for consideration of a change in anticoagulant management based on results
- Evaluation of close relatives of patients with documented inherited thrombophilia or with a clinical and family history consistent with an inherited thrombophilia
- Evaluation of patients in other situations who are considered at high-risk for thrombosis (eg, pregnancy, planned major surgery, exogenous hormone use).

Regulatory Status

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments. Commercial thrombophilia genetic tests are available under the auspices of the Clinical Laboratory Improvement Amendments. Laboratories that offer laboratory-developed tests must be licensed by the Clinical Laboratory Improvement Amendments for high-complexity testing. To
date, the U.S. Food and Drug Administration (FDA) has chosen not to require any regulatory review of this test.

The FDA has cleared several genetic tests for thrombophilia have been cleared for marketing by the FDA through the 510(k) process for use as an aid in the diagnosis of patients with suspected thrombophilia. Some of these tests are listed in Table 1.

**Table 1. Genetic Tests for Thrombophilia Cleared by FDA**

<table>
<thead>
<tr>
<th>Test</th>
<th>Manufacturer</th>
<th>Cleared</th>
<th>510(k) No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT Dx™ Factor V Leiden and Factor II Genotyping Test</td>
<td>Agena Bioscience*</td>
<td>06/14</td>
<td>K132978</td>
</tr>
<tr>
<td>Invader® Factor II, V, and MTHFR (677, 1298) tests</td>
<td>Hologic</td>
<td>04-06/11</td>
<td>K100943, K100980, K100987, K100496</td>
</tr>
<tr>
<td>VeraCode® Genotyping Test for Factor V and Factor II</td>
<td>Illumina</td>
<td>04/28/10</td>
<td>K093129</td>
</tr>
<tr>
<td>eSensor® Thrombophilia Risk Test, FII-FV, FII, FV and MTHFR (677, 1298) Genotyping Tests</td>
<td>GenMark Dxb</td>
<td>04/22/10</td>
<td>K093974</td>
</tr>
<tr>
<td>INFINITI™ System Assay for Factor II &amp; Factor V</td>
<td>AutoGenomics</td>
<td>02/07/07</td>
<td>K060564</td>
</tr>
<tr>
<td>Xpert® Factor II and Factor V Genotyping Assay</td>
<td>Cepheid</td>
<td>09/18/09</td>
<td>K082118</td>
</tr>
<tr>
<td>Verigene® Factor F2, F5, and MTHFR Nucleic Acid Test</td>
<td>Nanosphere</td>
<td>10/11/07</td>
<td>K070597</td>
</tr>
<tr>
<td>Factor V Leiden Kit</td>
<td>Roche Diagnostics</td>
<td>12/17/03</td>
<td>K033607</td>
</tr>
<tr>
<td>Factor II (Prothrombin) G20210A Kit</td>
<td>Roche Diagnostics</td>
<td>12/20/03</td>
<td>K033612</td>
</tr>
</tbody>
</table>

**FDA:** Food and Drug Administration.

* FDA marketing clearance was granted to Sequenom Bioscience before it was acquired by Agena Bioscience.
* FDA marketing clearance was granted to Osmetech Molecular Diagnostics.

Other commercial laboratories may offer a variety of functional assays and genotyping tests for F2 (prothrombin, coagulation factor II) and F5 (coagulation factor V), and single or combined genotyping tests for MTHFR.

On April 6, 2017, the FDA permitted marketing of 23andMe Personal Genome Service Genetic Health Risk tests for 10 diseases or conditions. These direct-to-consumer tests are the first authorized by the FDA that provide information on an individual’s genetic predisposition to certain medical diseases or conditions, which may help to make decisions about lifestyle choices or to inform discussions with a health care professional. The 23andMe Genetic Health Risk tests work by isolating DNA from a saliva sample, which is then tested for more than 500000 genetic variants. The presence or absence of some of these variants is associated with an increased risk of developing any one of ten diseases or conditions. Testing for hereditary thrombophilia (two variants in the F5 and F2 genes; relevant for European descent) is included.

**RATIONALE**

This evidence review was created in July 2012 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through March 4, 2019.

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of
benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

**MTHFR Variant Testing**

Indication 1: (Paste in template here and complete)

**Clinical Context and Test Purpose**

The purpose of genetic testing for variants in the 5,10-methylenetetrahydrofolate reductase (MTHFR) gene is to provide a diagnostic option that is an alternative to or an improvement on existing tests, such as standard clinical management without testing, in patients who are asymptomatic with or without a personal or family history of venous thromboembolism (VTE).

The question addressed in this evidence review is: Does genetic testing for MTHFR, factor V gene, and prothrombin gene variants improve the net health outcome in individuals with inherited thrombophilias?

The following PICOTS were used to select literature to inform this review.

**Patients**

The relevant population of interest are individuals who are asymptomatic with or without a personal or family history of VTE.

**Interventions**

The test being considered is genetic testing for variants in MTHFR.

Inherited thrombophilias are a group of disorders that predispose individuals to thrombosis. Genetic testing is available for some of these disorders and could assist in the diagnosis and/or management of patients with thrombosis. For example, testing is available for types of inherited thrombophilia, including variants in the MTHFR gene, the factor V gene (factor V Leiden variant), and the prothrombin (factor II) gene.

Patients who are asymptomatic with or without a personal or family history of VTE are actively managed by cardiologists and primary care providers in an outpatient clinical setting.

**Comparators**

Comparators of interest include standard clinical management without testing. This is managed by cardiologists and primary care providers in an outpatient clinical setting.

**Outcomes**

The general outcomes of interest are morbid events and treatment-related morbidity.

The beneficial outcomes of a true-positive test result are an appropriate treatment for VTE. The beneficial outcome of a true-negative test result is potentially avoiding unnecessary treatment.

The harmful outcome of a false-positive result is having unnecessary treatment for VTE. The harmful outcome of a false-negative result is a potential delay in diagnosis and treatment.
Table 2. Outcomes of Interest for Individuals Who are asymptomatic with or without a personal or family history of venous thromboembolism

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Details</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid events</td>
<td>Evaluating risk, including relative risk and absolute annual risk for VTE</td>
<td>1-10 years</td>
</tr>
<tr>
<td>Treatment-related morbidity</td>
<td>Evaluating risk, such as relative risk, for morbidities associated with the treatment of VTE such as major bleeding</td>
<td>1-10 years</td>
</tr>
</tbody>
</table>

**Study Selection Criteria**

Below are selection criteria for studies to assess whether a test is clinically valid.

- a. The study population represents the population of interest. Eligibility and selection are described.
- b. The test is compared with a credible reference standard.
- c. If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- d. Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (eg, receiver operating characteristic, area under receiver operating characteristic, c-statistic, likelihood ratios) may be included but are less informative.
- e. Studies should also report reclassification of diagnostic or risk category.

**Simplifying Test Terms**

There are three core characteristics for assessing a medical test. Whether imaging, laboratory, or other, all medical tests must be

- Technically reliable
- Clinically valid
- Clinically useful

Because different specialties may use different terms for the same concept, we are highlighting the core characteristics. The core characteristics also apply to different uses of tests, such as diagnosis, prognosis, and monitoring treatment.

The approach and metrics for assessing each of the core characteristics are described below.

**Technically Reliable**

Assessment of technical reliability focuses on specific tests and operators and requires review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review, and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

**Clinically Valid**

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Variants in the *MTHFR* gene are associated with hyperhomocysteinemia, which in turn is considered a weak risk factor for VTE.\(^1\)

**Clinically Useful**
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials (RCTs).

The clinical utility of testing for homocysteine levels has not been established. There is a large body of literature on the association between homocysteine levels and coronary artery disease, and clinical trials have assessed the impact of lowering homocysteine levels. This body of evidence has indicated that testing or treating for homocysteinemia is not associated with improved outcomes.

**Chain of Evidence**

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

The evidence for the association between *MTHFR* and VTE is not definitive. Some studies have shown an association,⁴ ⁵ ⁶ ⁷ ⁸ while others have not.⁹ ¹⁰ ¹¹ One larger study (n=9231), the 2007 MEGA study, reported by Bezemer et al (2007) showed no association between the common *MTHFR* 677C>T variant with recurrent VTE.⁹ An RCT by der Heijer et al (2007) reported no reduction in VTE associated with the treatment of hyperhomocysteinemia.¹²

**Section Summary: *MTHFR* Variant Testing**

Published evidence on the utility of testing for *MTHFR* variants in patients who have or are at risk for VTE is limited. Given the available evidence, and lack of clinical utility for serum homocysteine testing in general, it is unlikely that testing for *MTHFR* will improve outcomes.

**Factor V Leiden and Prothrombin variant Testing**

**Clinical Context and Test Purpose**

The purpose of genetic testing for variants in coagulation factor V and coagulation factor II is to provide a diagnostic option that is an alternative to or an improvement on existing tests, such as standard clinical management without testing, in patients who are asymptomatic with or without a personal or family history of VTE.

The question addressed in this evidence review is: Does genetic testing for *MTHFR*, factor V gene, and prothrombin gene variants improve the net health outcome in individuals with inherited thrombophilias?

The following PICOTS were used to select literature to inform this review.

**Patients**

The relevant population of interest are individuals who are asymptomatic with or without a personal or family history of VTE.

**Interventions**

The test being considered is genetic testing for variants in coagulation factor V and coagulation factor II. Inherited thrombophilias are a group of disorders that predispose individuals to thrombosis. Genetic testing is available for some of these disorders and could assist in the diagnosis and/or management of patients with thrombosis. For example, testing is available for types of inherited thrombophilia,
including variants in the MTHFR gene, the factor V gene (factor V Leiden [FVL] variant), and the prothrombin (factor II) gene.

Patients who are asymptomatic with or without a personal or family history of VTE are actively managed by cardiologists and primary care providers in an outpatient clinical setting.

Comparators

Comparators of interest include standard clinical management without testing. This is managed by cardiologists and primary care providers in an outpatient clinical setting.

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The general outcomes of interest are morbid events and treatment-related morbidity.

The beneficial outcomes of a true-positive test result are an appropriate treatment for VTE. The beneficial outcome of a true-negative test result is potentially avoiding unnecessary treatment.

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Table 3. Outcomes of Interest for Individuals Who are asymptomatic with or without a personal or family history of venous thromboembolism

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Details</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid events</td>
<td>Evaluating outcomes such as recurrence risk and odds ratios for recurrent VTE</td>
<td>1-10 years</td>
</tr>
<tr>
<td>Treatment-related morbidity</td>
<td>Evaluating outcomes such as recurrence risk and odds ratios for morbidities associated with treatment of VTE, such as major bleeding</td>
<td>1-10 years</td>
</tr>
</tbody>
</table>

VTE: venous thromboembolism.

Study Selection Criteria

Below are selection criteria for studies to assess whether a test is clinically valid.

a. The study population represents the population of interest. Eligibility and selection are described.

b. The test is compared with a credible reference standard.

c. If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.

d. Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (eg, receiver operating characteristic, area under receiver operating characteristic, c-statistic, likelihood ratios) may be included but are less informative.

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Simplifying Test Terms

There are three core characteristics for assessing a medical test. Whether imaging, laboratory, or other, all medical tests must be:

- Technically reliable
- Clinically valid
- Clinically useful
Because different specialties may use different terms for the same concept, we are highlighting the core characteristics. The core characteristics also apply to different uses of tests, such as diagnosis, prognosis, and monitoring treatment.

The approach and metrics for assessing each of the core characteristics are described below.

**Technically Reliable**

Assessment of technical reliability focuses on specific tests and operators and requires review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review, and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

**Clinically Valid**

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

The clinical validity and clinical utility are discussed for four distinct patient populations. They are:

- Individuals without a personal history of VTE
- Individuals with a personal history of VTE
- Family members of individuals with thrombophilia
- Pregnancy and other high-risk situations.

**Individuals Without a Personal History of VTE**

**Factor V Leiden Variant**

Individuals with FVL or prothrombin variants have an elevated risk of thrombosis compared with the general population. For individuals with the FVL variant, the risk may be 2- to 5-fold higher than that in the general population. In a retrospective study by Middledorp et al (1998) of first-degree relatives of individuals with documented VTE and heterozygosity for FVL, those with an FVL variant had an absolute annual risk for a first VTE episode of 0.45%, compared with an annual incidence of 0.1% in those family members without the variant.13

**Prothrombin G20210A Variant**

For the prothrombin G20210A variant, risk also has been estimated to be 2 to 5 times greater than the general population.14 A meta-analysis by Gohil et al (2009) evaluated 79 studies and reported combined relative risk was 3.0.15 Heterozygosity for the prothrombin G20210A variant also is associated with an increased risk of upper-extremity thrombosis, estimated to be 5 times that of the general population.14

**Individuals With a Personal History of VTE**

**Factor V Leiden**

An Agency for Healthcare Research and Quality (AHRQ) report by Segal et al (2009) reviewed the evidence on recurrence risk for patients with a history of VTE and the FVL variant.16 For individuals with a heterozygous FVL variant, 13 studies compared recurrence risk to a variant with recurrence risk without a variant. Pooled analysis of these 13 studies yielded an odds ratio (OR) of 1.56 (95% confidence interval [CI], 1.14 to 2.12) for recurrent VTE in patients with the FVL variant. For patients with a homozygous variant, seven studies evaluated recurrence risk. Pooled odds for recurrent VTE in these studies was 2.65 (95% CI, 1.18 to 5.97).

Not all studies have reported an increased risk of recurrent VTE in patients with inherited thrombophilia. For example, the 2005 Leiden Thrombophilia Study followed 474 patients who had completed a course
of anticoagulation for a mean of 7.3 years. All patients were tested for thrombophilia at baseline, with
20% found to have an FVL variant and 6% a prothrombin variant. Recurrence did not increase either for
patients with an FVL variant or patients with a prothrombin variant. For FVL, there was a mild increase in
recurrence risk that was not statistically significant on multivariate analysis (hazard ratio [HR], 1.3; 95%
CI, 0.8 to 2.1). For the prothrombin G20210A variant, there was no increased risk of recurrence (HR=0.7;
95% CI, 0.3 to 2.0). Factors that predicted recurrence were mainly clinical variables, such as
provoked vs unprovoked VTE, patient sex, and oral contraceptive use.

One of the larger RCTs that was included in the above-mentioned AHRQ review was the 2008 Influence
of thrombophilia on risk of recurrent venous thromboembolism while on warfarin trial. This
trial randomized 738 patients from 16 clinical centers to low-intensity or conventional-intensity
anticoagulation. All patients were tested for inherited thrombophilias, and recurrence risk was
calculated for patients with and without inherited thrombophilias. For patients with an FVL variant, there
was no increased risk of recurrence over a mean follow-up of 2.3 years (HR=0.7; 95% CI, 0.2 to 2.6).

**Prothrombin G20210A Variant**

The AHRQ report by Segal et al (2009) identified 18 studies that evaluated recurrence risk in patients
heterozygous for the prothrombin G20210A variant. Some of these studies included only
heterozygotes, while others combined both heterozygotes and homozygotes. For 9 studies that included
only heterozygotes, pooled odds for recurrent VTE was 1.45 (95% CI, 0.96 to 2.2). For 7 studies that did
not specify homozygous or heterozygous, the combined odds were 0.73 (95% CI, 0.37 to 1.44).

The prothrombin G20210A variant is less common and, therefore, the number of patients evaluated in
clinical trials and cohort studies is smaller than for FVL. In the 2008 Influence of thrombophilia on risk of
recurrent venous thromboembolism while on warfarin trial, the risk of recurrent VTE in those with the
prothrombin G20210A variant could not be calculated because there were no recurrences among 60
patients with the variant. In the 2005 Leiden Thrombophilia Study, 29 patients had a prothrombin
variant. For patients with a prothrombin variant, there was no increased risk of recurrence (HR=0.7;
95% CI, 0.3 to 2.0). Factors that predicted recurrence were mainly clinical variables, such as
provoked vs unprovoked VTE, patient sex, and oral contraceptive use.

**Family Members of Individuals with Thrombophilia**

**Factor V Leiden**

The AHRQ (2009) report identified 9 studies that evaluated VTE risk in family members of a proband
with a heterozygous variant. The pooled odds for future VTE was 3.49 (95% CI, 2.46 to 4.96). Six studies
evaluated a total of 48 probands with homozygous FVL variants. The pooled odds for family members of
homozygous individuals was 18 (95% CI, 7.8 to 40).

In a larger study of VTE risk in family members, Lijfering et al (2009) pooled results from 5 retrospective
family studies of thrombophilia. A total of 2479 relatives of patients with thrombophilia who were
themselves also tested for thrombophilia were included. For relatives with FVL variants, annual
incidence of thrombosis was 0.49% (95% CI, 0.39% to 0.60%). In relatives without thrombophilia, the
incidence of VTE was approximately 0.05% per year, and the adjusted relative risk for VTE in relatives
with an FVL variant was 7.5 (95% CI, 4.4 to 12.6). In patients treated with anticoagulation, the annual
risk of major bleeding was 0.29% (95% CI, 0.03% to 1.04%)

**Prothrombin Variants**

Evidence on VTE risk for family members of individuals with a prothrombin variant is lower than for FVL,
with 5 studies identified by Segal et al (2009) in the AHRQ evaluating heterozygotes and only 1 study
evaluating homozygotes. For heterozygote probands, family members had an odds for future VTE of 1.89 (95% CI, 0.35 to 10.2).

In the Lijfering et al (2009) family study, relatives with prothrombin variants had an annual VTE incidence of 0.34% (95% CI, 0.22% to 0.49%). In relatives without thrombophilia, the incidence of VTE was approximately 0.05% per year, and the adjusted relative risk for VTE in relatives with a prothrombin variant was 5.2 (95% CI, 2.8 to 9.7).

**Pregnancy and Other High-Risk Conditions**

**Pregnancy**

Evidence of the risk of recurrent pregnancy loss in women with FVL or a prothrombin gene variant comprises primarily retrospective case-control studies and cohort studies. Several case-control studies have reported a higher prevalence of FVL in women with recurrent, unexplained pregnancy loss compared with controls (OR range, 2-5). Retrospective cohort studies have found a 2- to 3-fold increased risk of pregnancy loss in FVL heterozygous carriers; homozygotes have a 2-fold higher risk than heterozygous carriers. Risk of pregnancy loss for heterozygous carriers is highest during the second and third trimesters.

A systematic review by Bradley et al (2012) analyzed evidence on the association between FVL and prothrombin variants with pregnancy loss. They identified the highest quality studies, which were cohort studies that: (1) excluded patients with other causes of VTE, (2) tested eligible women for thrombophilia at baseline, (3) reported on subsequent pregnancy outcomes, and (4) compared rates of pregnancy loss between carriers and noncarriers. Four cohort studies met all 4 criteria; these studies primarily included patients with FVL variants. Two of the four studies reported a significantly increased rate of recurrence for carriers and two did not. Pooled analysis of these 4 studies yielded a significantly increased odds for recurrent pregnancy loss in carriers (OR=1.93; 95% CI, 1.21 to 3.09).

A number of meta-analyses have concluded that the risk of pregnancy loss for patients who are heterozygous for the prothrombin G20210A variant also is increased, in the 2- to 3-fold range.

**Oral Contraceptives**

Oral contraceptive use alone is associated with an approximately 4-fold increase in the risk of thrombosis; in combination with FVL, risk multiplies 34-fold in heterozygotes and more than 100-fold in homozygotes. However, the absolute incidence estimated in a study by Vanderbroucke et al (1994) was 28 thrombotic events per 10000 per year, 2% of which were estimated to be fatal.

**Hormone Replacement Therapy**

Women using hormone replacement therapy have a 2- to 4-fold increased risk of thrombosis. Absolute-risk is low and may be restricted to the first year of use. Limited data have suggested that women using selective estrogen receptor modulators (eg, tamoxifen) may have a similarly increased risk.

**Section Summary: Clinically Valid**

The clinical validity of genetic testing for thrombophilia has been evaluated by assessing the association between thrombophilia status and VTE in various clinical populations. For populations discussed herein, the clinical validity has been reported in numerous case-control and cohort studies. The presence of an FVL or a prothrombin gene variant is associated with an increased risk for subsequent VTE across a number of populations. However, the magnitude of the association is relatively modest, with OR most commonly between one and two, except for family members of individuals with inherited thrombophilia, for whom OR somewhat higher.
Clinically Useful

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

The clinical utility of genetic testing for thrombophilia is considered in the context of overall VTE risk and the risk-benefit ratio of treatment, primarily with anticoagulants. The following factors are part of the decision-making process on whether to test for:

- Overall low incidence of thromboembolism in the general population.
- Modest increased risk associated with most forms of inherited thrombophilia, meaning that the absolute-risk of thrombosis in patients with inherited thrombophilia is still relatively low.
- Potential risk of prophylactic treatment, especially bleeding risk with anticoagulation. This risk may outweigh the benefit in patients with a relatively low absolute-risk of thrombosis.

Some have suggested that functional testing for activated protein C resistance may be more clinically relevant than genetic testing for FVL in persons with increased risk of thromboembolism.\(^2\)

Individuals Without a Personal History of VTE

Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No published studies identified have directly evaluated the clinical utility of screening asymptomatic individuals for inherited thrombophilia.

Chain of Evidence

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

It is unlikely that screening asymptomatic individuals will result in a net health benefit because prophylactic anticoagulation is likely to do more harm than benefit. Risk of major bleeding with full anticoagulation is approximately 1% per year; therefore, the number of major bleeding episodes may far exceed the number of VTEs prevented. Knowledge of thrombophilia status may lead to behaviors that reduce VTE risk, such as avoidance of prolonged immobility, but this is unproven.

Individuals with a Personal History of VTE

Clinical Context and Test Purpose

The purpose of genetic testing for variants in coagulation factor V and coagulation factor II is to provide a diagnostic option that is an alternative to or an improvement on existing tests, such as standard clinical management without testing, in patients who are asymptomatic with increased VTE risk (eg, due to pregnancy).

The question addressed in this evidence review is: Does genetic testing for MTHFR, FVL, and prothrombin gene variants improve the net health outcome in individuals with inherited thrombophilias?

The following PICOTS were used to select literature to inform this review.

Patients
The relevant population of interest are individuals who are asymptomatic with increased VTE risk (eg, due to pregnancy).

**Interventions**

The test being considered is genetic testing for variants in coagulation FVL and coagulation factor II. Inherited thrombophilias are a group of disorders that predispose individuals to thrombosis. Genetic testing is available for some of these disorders and could assist in the diagnosis and/or management of patients with thrombosis. For example, testing is available for types of inherited thrombophilia, including variants in the MTHFR gene, the FVL, and the prothrombin (factor II) gene.

Patients who are asymptomatic with increased VTE risk (eg, due to pregnancy) are actively managed by cardiologists and primary care providers in an outpatient clinical setting.

**Comparators**

Comparators of interest include standard clinical management without testing. This is managed by cardiologists and primary care providers in an outpatient clinical setting.

**Outcomes**

The general outcomes of interest are morbid events and treatment-related morbidity.

No studies have directly evaluated the clinical utility of thrombophilia testing in pregnant women.

**Table 4. Outcomes of Interest for Individuals who are asymptomatic with increased venous thromboembolism risk (eg, due to pregnancy)**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Details</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid events</td>
<td>Evaluating outcomes such as risk of pregnancy loss or recurrence of VTE</td>
<td>9 months to 10 years</td>
</tr>
<tr>
<td>Treatment-related morbidity</td>
<td>Evaluating outcomes such as risk and odds ratios for morbidities associated with treatment of VTE, oral contraceptives, or hormone replacement therapy</td>
<td>9 months to 10 years</td>
</tr>
</tbody>
</table>

**VTE: venous thromboembolism.**

**Study Selection Criteria**

Below are selection criteria for studies to assess whether a test is clinically valid.

a. The study population represents the population of interest. Eligibility and selection are described.

b. The test is compared with a credible reference standard.

c. If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.

d. Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (eg, receiver operating characteristic, area under receiver operating characteristic, c-statistic, likelihood ratios) may be included but are less informative.

e. Studies should also report reclassification of diagnostic or risk category.

**Simplifying Test Terms**

There are three core characteristics for assessing a medical test. Whether imaging, laboratory, or other, all medical tests must be:
Genetic Testing for Inherited Thrombophilia

- Technically reliable
- Clinically valid
- Clinically useful

Because different specialties may use different terms for the same concept, we are highlighting the core characteristics. The core characteristics also apply to different uses of tests, such as diagnosis, prognosis, and monitoring treatment.

The approach and metrics for assessing each of the core characteristics are described below.

Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

Case-control studies

The 2008 MEGA study was a large, population-based, case-control study that evaluated whether testing for thrombophilia in patients with the first episode of VTE was associated with a decrease in recurrence rate. The MEGA database comprised 5051 patients between the ages of 18 and 70 years with the first episode of VTE. Researchers identified 197 patients with a recurrence of VTE and matched these patients by age, sex, year of VTE, and geographic region with 324 patients who were free of recurrent VTE. Recurrence rates for VTE were similar in patients tested for thrombophilia compared with patients not tested (OR=1.2; 95% CI, 0.9 to 1.8). The presence of FVL or the prothrombin G20210A variant was not associated with an increased recurrence rate (OR=0.8; 95% CI, 0.3 to 2.6).

Cohort studies

Mahajerin et al (2014) conducted a single-center, retrospective cohort study of pediatric patients (mostly adolescents) who presented with VTE (88% deep vein thrombosis) “to help clarify the role of thrombophilia testing in pediatric VTE.” Of 392 inpatients and outpatients, thrombophilia tests (FVL; prothrombin gene variant; MTHFR; protein C, protein S, and antithrombin activity; antiphospholipid antibodies; plasminogen activator inhibitor-1 levels and variant testing) were ordered in 310 (79%); of these, testing found positive 37 (12%) results. Given that most patients had at least one risk factor for VTE and, as noted by the authors, the “presence or absence of thrombophilia rarely influences VTE management,” this evidence does not support thrombophilia genetic testing in pediatric patients who present with VTE.

Cross-sectional studies

A study by Hindorff et al (2009) surveyed 112 primary care physicians about the impact of FVL testing in patients with VTE. Most physicians indicated that they would use results in clinical practice, with 82% reporting that they would use results to counsel patients on risk of recurrence and 67% reporting that they would use results to make treatment changes. However, physician confidence in their decisions was not high, including decisions to order FVL testing.

Chain of Evidence

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Family Members of Individuals with Thrombophilia

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

There are no comparative trials assessing testing with no testing in relatives of individuals who have thrombophilia.

**Chain of Evidence**

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

The clinical utility of testing depends on the balance between the benefit of altering management as a result of knowledge of variant status and the risk of bleeding with the intensification of anticoagulation. This risk-benefit is unknown, as previously discussed. The absolute-risk of VTE remains low, even in patients with inherited thrombophilia, and potential risks of prophylactic treatment with anticoagulants may outweigh potential benefits.

**Pregnancy and Other High-Risk Conditions**

**Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No studies have directly evaluated the clinical utility of thrombophilia testing in pregnant women.

**Chain of Evidence**

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

The clinical utility of testing depends on the efficacy of potential treatments in decreasing fetal loss vs the risks of treatment. Potential treatments in pregnancy include aspirin, low-dose unfractionated or low-molecular-weight heparin, and full-dose heparin. Benefits of these treatments in reducing pregnancy loss are questionable. At least 2 RCTs (both 2010) have reported that there is no significant reduction in risk with aspirin or heparin therapy.\(^{26,27}\) Additionally, several meta-analyses have reported that evidence is insufficient to conclude that these interventions reduce recurrent pregnancy loss in patients with FVL or prothrombin variants.\(^{21,28,29}\) In contrast, the real risks of anticoagulation include bleeding, thrombocytopenia, and allergic reactions. There also are costs and inconvenience associated with these treatments.

Bradley et al (2012) reviewed the evidence on the clinical utility of testing for heritable thrombophilias in pregnancy and found it adequate to conclude there are no safe and effective treatments to reduce recurrent pregnancy loss in women with inherited thrombophilia.\(^{21}\) The certainty of the evidence that treatment resulted in net harm was moderate.

The clinical utility of testing for prothrombin-related thrombophilia was evaluated in a secondary analysis of data from the Stillbirth Collaborative Research Network, a population-based case-control study of stillbirth. Testing for FVL, prothrombin G20210A, methylenetetrahydrofolate reductase C677T, and A1298C, and plasminogen activating inhibitor-1 4G/5G variants was done on maternal and fetal (or placental) DNA from singleton pregnancies. There was increased odds of stillbirth for maternal homozygous FVL variant \((2/488 [0.4\%] \text{ vs } 1/1380 [0.0046\%]; \text{ OR}=87.44; 95\% \text{ CI, 7.88 to 970.92}).\)
However, there were no significant differences in the odds of stillbirth for any other maternal thrombophilia, even after stratified analyses.30

An open-label, international, multicenter randomized trial, reported by Rodger et al (2014), evaluated antepartum use of low-molecular-weight heparin dalteparin in women with the prothrombin variant.31 The intervention did not reduce the occurrence of VTE, pregnancy loss, or placenta-mediated pregnancy complications, and was associated with an increased risk of minor bleeding.

The current chapter (updated in 2014) on prothrombin-related thrombophilia in GeneReviews concluded: “Although technically possible, prenatal diagnosis and preimplantation genetic diagnosis are rarely, if ever, performed because the 20210G>A allele only increases the relative risk for thrombophilia and is not predictive of a thrombotic event.”14

**Section Summary: Clinically Useful**

The clinical utility of testing for FVL or prothrombin variants has not been demonstrated. Although the presence of inherited thrombophilia increases the risk for subsequent VTE events, the increase is modest, and the absolute-risk of thrombosis remains low. Available prophylactic treatments, such as anticoagulation, have defined the risks of major bleeding and other adverse events that may outweigh the reduction in VTE and therefore result in net harm. Currently, available evidence has not defined a role for thrombophilia testing in decisions concerning the initiation of prophylactic anticoagulation or the length of anticoagulation treatment.

**Summary of Evidence**

For individuals who are asymptomatic with or without a personal or family history of VTE or who are asymptomatic with increased VTE risk (eg, due to pregnancy) who receive genetic testing for variants in MTHFR, or genetic testing for coagulation factor V and coagulation factor II, the evidence includes a large RCT, prospective cohort analyses, retrospective family studies, case-control studies, and meta-analyses. The relevant outcomes are morbid events and treatment-related morbidity. The clinical validity of genetic testing has been demonstrated by the presence of a FVL variant or a prothrombin gene variant, and an association with an increased risk for subsequent VTE across various populations studied. However, the magnitude of the association is relatively modest, with OR most commonly between one and two, except for family members of individuals with inherited thrombophilia, for whom OR are somewhat higher. The clinical utility of testing for FVL or prothrombin variants has not been demonstrated. Although the presence of inherited thrombophilia increases the risk for subsequent VTE events, the increase is modest, and the absolute-risk of thrombosis remains low. Available prophylactic treatments (eg, anticoagulation) have defined risks of major bleeding and other adverse events that may outweigh the reduction in VTE and therefore result in net harm. Currently, available evidence has not defined a role for thrombophilia testing in decisions concerning the initiation of prophylactic anticoagulation or the length of anticoagulation treatment.

**SUPPLEMENTAL INFORMATION**

**Clinical Input from Physician Specialty Societies and Academic Medical Centers**

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input
received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 4 physician specialty societies (6 reviewers) and 6 academic medical centers, for a total of 12 reviewers, while this policy was under review in 2012. Input was mixed, and there was no consensus that genetic testing for thrombophilia was medically necessary for any of the specific clinical situations included. Several reviewers noted that testing could be useful in isolated instances but were unable to define specific criteria for testing.

**Practice Guidelines and Position Statements**

Many guidelines and position statements on testing for thrombophilia have been published over the last two decades. These guidelines have evolved over time, often inconsistent and do not typically give specific parameters on when to perform genetic testing. The following are examples of U.S. guidelines developed by major specialty societies and published more recently.

**Evaluation of Genomic Applications in Practice and Prevention**

The Evaluation of Genomic Applications in Practice and Prevention (2011) recommendations did not support the clinical utility of genetic testing for factor V Leiden and prothrombin variants for prevention of initial episodes of venous thromboembolism (VTE) or for recurrence.\(^{32}\) The recommendations have been archived.

**American College of Chest Physicians**

The American College of Chest Physicians (2016) guidelines and expert panel report on antithrombotic therapy for VTE disease no longer includes recommendations for pregnant women with known factor V Leiden or prothrombin G20210A variants, which had been included in the 2012 edition.\(^{33,34}\) Also, there are no guidelines on genetic testing for thrombophilia. The 2008 edition had indicated that the presence of a hereditary thrombophilia was not a major factor to guide duration of anticoagulation for VTE.\(^{35}\)

**American College of Obstetricians and Gynecologists**

The American College of Obstetricians and Gynecologists (2013) published management guidelines for inherited thrombophilias in pregnancy, which were reaffirmed in 2014 and in 2018.\(^{4,36}\) These guidelines stated that a definitive causal link between inherited thrombophilias and adverse pregnancy outcomes could not be made. Screening for inherited thrombophilias is controversial, but may be considered for pregnant women in the following situations:

- A personal history of VTE associated with a nonrecurrent risk factor (eg, fracture, surgery, or prolonged immobilization).
- A first-degree relative (eg, parent, sibling) with a history of high-risk thrombophilia.

The guidelines also recommended (as listed in Table 2) the following.

**Table 5. Guidelines for Managing Inherited Thrombophilias During Pregnancy**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>GOE</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing for inherited thrombophilias should include FVL, prothrombin G20210A</td>
<td>C</td>
<td>Consensus and expert opinion</td>
</tr>
<tr>
<td>mutation, and tests for deficiencies in antithrombin, protein S and protein C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing for inherited thrombophilias in women who have experienced recurrent</td>
<td>B</td>
<td>Limited or inconsistent scientific evidence</td>
</tr>
<tr>
<td>fetal loss or placental abruption is not recommended because it is unclear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>whether anticoagulation therapy reduces recurrence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Because an association between either heterozygosity or homozygosity for</td>
<td>B</td>
<td>Limited or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
the \textit{MTHFR C677T} polymorphism and any negative pregnancy outcomes, including any increased risk for VTE, has not been shown, screening with either \textit{MTHFR} mutation analyses or fasting homocysteine levels is not recommended.

<table>
<thead>
<tr>
<th>Society</th>
<th>Year</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASH</td>
<td>2013</td>
<td>“Don’t test for thrombophilia in adult patients with venous thromboembolism (VTE) occurring in the setting of major transient risk factors (surgery, trauma or prolonged immobility).”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Thrombophilia testing is costly and can result in harm to patients if the duration of anticoagulation is inappropriately prolonged or if patients are incorrectly labeled as thrombophilic. Thrombophilia testing does not change the management of VTEs occurring in the setting of major transient VTE risk factors. When VTE occurs in the setting of pregnancy or hormonal therapy, or when there is a strong family history plus a major transient risk factor, the role of thrombophilia testing is complex and patients and clinicians are advised to seek guidance from an expert in VTE.”</td>
</tr>
<tr>
<td>SMFM</td>
<td>2014</td>
<td>“Don’t do an inherited thrombophilia evaluation for women with histories of pregnancy loss, intrauterine growth restriction (IUGR), preeclampsia and abruption.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Scientific data supporting a causal association between either methylenetetrahydrofolate reductase (MTHFR) polymorphisms or other common inherited thrombophilias and adverse pregnancy outcomes, such as recurrent pregnancy loss, severe preeclampsia and IUGR, are lacking. Specific testing for antiphospholipid antibodies, when clinically indicated, should be limited to lupus anticoagulant, antiphospholipid antibodies and beta 2 glycoprotein antibodies.”</td>
</tr>
<tr>
<td>ASRM</td>
<td>2013</td>
<td>“Don’t routinely order thrombophilia testing on patients undergoing a routine infertility evaluation.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“There is no indication to order these tests, and there is no benefit to be derived in obtaining them in someone that does not have any history of bleeding or abnormal clotting and in the absence of any family history. This testing is not a part of the infertility workup. Furthermore, the testing is costly, and there are risks associated with the proposed treatments, which would also not be indicated in this routine population.”</td>
</tr>
</tbody>
</table>

\textbf{U.S. Preventive Services Task Force Recommendations}

Not applicable.

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

**Ongoing and Unpublished Clinical Trials**

Some currently unpublished trials that might influence this review are listed in Table 7.

**Table 7. Summary of Key Trials**

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02385461</td>
<td>Study on Antithrombotic Prevention in Thrombophilia and Pregnancy Loss (OTTILIA)</td>
<td>108</td>
<td>Jun 2017</td>
</tr>
<tr>
<td>NCT02841085</td>
<td>New Genetic Mutations in Thromboembolic Venous Disease Idiopathic</td>
<td>450</td>
<td>May 2019</td>
</tr>
<tr>
<td>NCT02685800</td>
<td>A Registry on Outcomes in Women Undergoing Assisted Reproductive Techniques After Recurrent Failures</td>
<td>624</td>
<td>Sep 2020</td>
</tr>
<tr>
<td>NCT02990403</td>
<td>The Novel Immunomodulatory and Anticoagulant Therapies for Recurrent Pregnancy Loss</td>
<td>500</td>
<td>Dec 2018</td>
</tr>
<tr>
<td>NCT02407730</td>
<td>Effects of Thrombophilia on the Outcomes of Assisted Reproduction Technologies</td>
<td>715</td>
<td>Jun 2019</td>
</tr>
<tr>
<td>NCT02986594</td>
<td>Diagnosis and Treatment Strategy of Recurrent Spontaneous Abortion Associated With Thrombophilia</td>
<td>600</td>
<td>Oct 2019</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

**ESSENTIAL HEALTH BENEFITS**

The Affordable Care Act (ACA) requires fully insured non-grandfathered individual and small group benefit plans to provide coverage for ten categories of Essential Health Benefits (“EHBs”), whether the benefit plans are offered through an Exchange or not. States can define EHBs for their respective state.

States vary on how they define the term small group. In Idaho, a small group employer is defined as an employer with at least two but no more than fifty eligible employees on the first day of the plan or contract year, the majority of whom are employed in Idaho. Large group employers, whether they are self-funded or fully insured, are not required to offer EHBs, but may voluntary offer them.

The Affordable Care Act requires any benefit plan offering EHBs to remove all dollar limits for EHBs.

**REFERENCES**


<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>81240</td>
<td>F2 (prothrombin, coagulation factor II)(e.g., hereditary hypercoagulability) gene analysis,</td>
</tr>
</tbody>
</table>
### Genetic Testing for Inherited Thrombophilia

<table>
<thead>
<tr>
<th>Code</th>
<th>Description and Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>81241</td>
<td>20210G&gt;A variant F5 (coagulation Factor V) (e.g., hereditary hypercoagulability) gene analysis, Leiden variant</td>
</tr>
<tr>
<td>81291</td>
<td>81291 MTHFR (5, 10-methylene tetrahydrofolate reductase) (e.g., hereditary hypercoagulability) gene analysis, common variants (e.g., 677T, 1298C)</td>
</tr>
<tr>
<td>81400</td>
<td>F2 (coagulation factor 2) (e.g., hereditary hypercoagulability), 1199G&gt;A variant F5 (coagulation factor V) (e.g., hereditary hypercoagulability) HR2 Variant</td>
</tr>
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</table>

**ICD-10-CM**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description and Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D68.51</td>
<td>Activated protein C resistance (includes Factor V Leiden mutation)</td>
</tr>
<tr>
<td>D68.52</td>
<td>Prothrombin gene mutation</td>
</tr>
<tr>
<td>D68.59</td>
<td>Other primary thrombophilia</td>
</tr>
<tr>
<td>D68.61-D68.69</td>
<td>Other thrombophilia (includes other hypercoagulable states)</td>
</tr>
<tr>
<td>I26</td>
<td>Pulmonary embolism code range</td>
</tr>
<tr>
<td>I51</td>
<td>Complications and ill-defined descriptions of heart disease</td>
</tr>
<tr>
<td>I67.6</td>
<td>Nonpyogenic thrombosis of intracranial venous system</td>
</tr>
<tr>
<td>I82.0</td>
<td>Hepatic vein thrombosis</td>
</tr>
<tr>
<td>K55.0</td>
<td>Acute vascular disorders of intestine</td>
</tr>
<tr>
<td>Z86.718</td>
<td>Personal history of other venous thrombosis and embolism</td>
</tr>
<tr>
<td>Z92.0</td>
<td>Personal history of contraception</td>
</tr>
</tbody>
</table>

**ICD-10-PCS**

- Not applicable. ICD-10-PCS codes are only used for inpatient services. There are no ICD procedure codes for laboratory tests.

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Place of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory/ Pathology</td>
<td>Laboratory/ Reference Laboratory</td>
</tr>
</tbody>
</table>

### POLICY HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/10/14</td>
<td>Replace policy</td>
<td>Policy updated with literature review through June 19, 2014; references 5-8, 10-11, 24, and 29 added; references 4 and 12 updated. No change to policy statement.</td>
</tr>
<tr>
<td>07/09/15</td>
<td>Replace policy</td>
<td>Policy updated with literature review through June 24, 2015; references 16 and 23 added. Policy statement unchanged.</td>
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<tr>
<td>09/15/15</td>
<td>Replace policy</td>
<td>Policy updated with med nec indications for Factor V Leiden indications.</td>
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<tr>
<td>02/24/17</td>
<td>Replace policy</td>
<td>Added list of investigational tests for inherited thrombophiliac disorders in the evaluation of</td>
</tr>
<tr>
<td>Date</td>
<td>Action</td>
<td>Details</td>
</tr>
<tr>
<td>------------</td>
<td>----------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>06/01/17</td>
<td>Replace policy</td>
<td>Policy updated with literature review through April 12, 2017; references 29-32, 34, and 37. The policy is revised with updated genetics nomenclature; “mutations” changed to “variants” throughout policy. Policy statement otherwise unchanged.</td>
</tr>
<tr>
<td>04/30/18</td>
<td>Update only</td>
<td>Medical policy renumbered from 2.04.82 to 2.04.582.</td>
</tr>
<tr>
<td>05/30/18</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho updated policy with literature review through March 5, 2018; no references added; reference 3 updated. Policy statement unchanged.</td>
</tr>
<tr>
<td>06/20/19</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho adopted changes as noted, effective 06/20/2019. Policy updated with literature review through March 4, 2019; references added. Policy statement unchanged.</td>
</tr>
</tbody>
</table>