**LETTER OF MEDICAL NECESSITY FOR CHROMOSOME MICROARRAY ANALYSIS**

**(SNP Array)**

Date: Date of service/claim

To: Utilization Review Department

Insurance Company Name, Address, City, State, ZIP

Re: Patient Name, DOB, ID #

ICD-10 Codes:

The ICD-10 codes listed below are commonly received by Ambry from ordering providers for the testing described in this letter. Ambry provides this information as a customer service but makes no recommendations regarding the use of any diagnosis codes. As a reminder, it is the ordering provider’s responsibility to always determine, for the specific date of service, the appropriate diagnostic codes based on the patient’s signs and symptoms.

Code Description

F84.0 AUTISTIC DISORDER

F80.9 DEVELOPMENTAL DISORDER OF SPEECH AND LANGUAGE, UNSPECIFIED

R62.50 UNSPECIFIED LACK OF EXPECTED NORMAL PHYSIOLOGICAL DEVELOPMENT IN CHILDHOOD

R62.52 SHORT STATURE (CHILD)

Z84.81 FAMILY HISTORY OF CARRIER OF GENETIC DISEASE

Z84.89 FAMILY HISTORY OF OTHER SPECIFIED CONDITIONS

This letter is regarding my patient and your subscriber, referenced above, to request full coverage of medically indicated chromosomal microarray (SNP Array) testing to be performed by Ambry Genetics Corporation.

Developmental delay (DD), intellectual disability (ID), and autism spectrum disorders (ASD) are relatively common in the pediatric population and are often caused by an underlying genetic abnormality.1,2,3 In individuals with DD/ID or congenital anomalies, chromosomal microarray (CMA) has a diagnostic rate of 15-20%.4 For this reason, CMA is recommended as a first-tier test in the evaluation of individuals with unexplained developmental delay, intellectual disability, autism spectrum disorder, and/or congenital anomalies.4,6

**Significant aspects of my patient’s medical history that suggest an underlying chromosomal alteration are as follows** [check all that apply]:

* Unexplained developmental delay
* Unexplained intellectual disability
* Autism spectrum disorder
* Multiple anomalies
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My patient’s phenotypic features are suspicious for a chromosomal alteration.** Per American Academy of Pediatrics, International Standards for Cytogenomic Array (ISCA) Consortium, and American College of Medical Genetics and Genomics guidelines, CMA analysis is recommended as a first-tier test for my patient.3,4,5,6,7

**Due to the medical complications associated with chromosomal alterations, this genetic testing is medically indicated.** Management modifications may include [check all that apply]:

* Genetic testing results will affect medical management strategies
* Genetic testing results will potentially eliminate the need for more invasive diagnostic procedures
* Genetic testing results will guide informed decision making for other family members with similar conditions, or who may be at risk for similar conditions
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A positive test result would confirm a genetic diagnosis in my patient and would ensure my patient is being managed appropriately.**

Based on these factors, this testing is medically necessary, and I request that you approve coverage of diagnostic genetic testing for chromosomal microarray in my patient.  Thank you for your time, and please don’t hesitate to contact me with any questions.

Sincerely,

Ordering Clinician Name (Signature Provided on Test Requisition Form)

(MD/DO, Clinical Nurse Specialist, Nurse-Midwives, Nurse Practitioner, Physician Assistant, Genetic Counselor\*)

\*Authorized clinician requirements vary by state

**Test Details**

CPT codes: 81229

Laboratory: Ambry Genetics Corporation (TIN 33-0892453 / NPI 1861568784), a CAP-accredited and CLIA-certified laboratory located at 7 Argonaut, Aliso Viejo, CA 92656

**References**

1. Ellison JW, *et al*. Clinical utility of chromosomal microarray analysis. Pediatrics 2012 Nov;130(5):1085-95.
2. Schaefer MD and Mendelsohn NJ. Clinical genetics evaluation in identifying the etiology of autism spectrum disorders: 2013 guideline revisions. Genet Med 2013 Mar;15(3):399-407.
3. Moeschler JB, *et al*. Comprehensive evaluation of the child with intellectual disability or global developmental delays. Pediatrics*.*2014 Sep;134(3):903-918.
4. Miller DT, *et al*. Consensus statement: chromosomal microarray is a first-tier clinical diagnostic test for individuals with developmental disabilities or congenital anomalies. Am J Hum Genet*.* 2010 May 14;86(5):749-64.
5. Waggoner D, *et al.* Yield of additional genetic testing after chromosomal microarray for diagnosis of neurodevelopmental disability and congenital anomalies: a clinical practice resource of the American College of Medical Genetics and Genomics (ACMG). Genet Med 2018 June;20:1105-1113.
6. Manning M, *et al.* Array-based technology and recommendations for utilization in medical genetics practice for detection of chromosomal abnormalities. Genet Med 2010 Nov;12(11):742-745.
7. Manning M, *et al.* Addendum: Array-based technology and recommendations for utilization in medical genetics practice for detection of chromosomal abnormalities. Genet Med 2020 Dec;22(12):2126.