Priority Health	BILLING POLICY No. 103
ALLERGY INJECTIONS / IMMUNOTHERAPY	
Date of origin: Sept. 2021	**Review dates: 06/2024, 10/2025, 8/2026**

POLICY OVERVIEW

This policy outlines billing and payment requirements associated with Allergy injections / immunotherapy. This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual and industry standards. Allergy Testing is a diagnostic procedure that identifies the specific triggers or allergens (such as pollen, pet dander, or food) that is causing the immune system to overreact.

DEFINITION

Immunotherapy, often called "desensitization," is a form of treatment that involves regular, increasing exposure to allergens to "train" the immune system not to overreact without causing a full allergic reaction.

MEDICAL POLICY

- Allergy Testing / Immunotherapy (#91037)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Allergy and immunotherapy services that are coded incorrectly will be denied or subject to overpayment recoupment.

Allergy services and Evaluation and Management (E/M) services should not be coded for the same date of service unless documentation supports a significant, separately identifiable service. The appropriate modifiers should be appended to the original claim submission.

Allergy testing and allergy immune therapy are not performed on the same date of service based on standard medical practice and should not be coded on the same date of service.

Retesting with the same antigen(s) should rarely be necessary within a three-year period. Claims for retesting within a three-year period should be submitted with documentation of the medical necessity.

Coding Specifics

Allergy testing

Percutaneous and intracutaneous (intradermal) tests are reported with CPT 95004 or 95024.

- These are single tests.
- A unit identifies each different allergen or different dilutions of the same allergen.

Sequential and incremental tests are reported with 95017, 95018 or 95027.

- Multiple units may be coded based on different allergens or different dilutions of the same allergen.

Single allergy tests should not be coded on the same date as sequential and incremental tests, and only one test is reimbursed if the same dilution of the same allergen(s) is tested.

Allergy testing is considered an integral component of rapid desensitization kits (CPT 95180). Allergy testing and rapid desensitization kits are not reported or reimbursed separately.

The number of tests per antigen should be reported on the claim.

For interpretation of allergy tests, the appropriate CPT is reported with one unit for each test performed.

Photo patch tests performed with patch or application tests should not be coded for the same date of service. Instead, more comprehensive photo patch testing (CPT 95052) should be coded.

Allergy studies for percutaneous and intradermal tests (reported with CPT codes 95004, 95024, and 95027) should not exceed 120 units per year regardless of rendering/administering provider.

Allergy immunotherapy

CPT codes 95120-95134 identify allergy immunotherapy services for both professional services and the provision of the allergen extract.

Allergy immunotherapy services for component codes should be used when the rendering provider is not performing the professional services and provision defined for CPT codes 95120 - 95134.

Component codes include CPT codes 95115, 95117, 95144-95170.

- If both administration and antigen preparation and provision are performed by the same provider, report on the appropriate CPT code that accurately describes the professional service and provision of extract.

Professional services for injection of antigen include 95115-95117.

- This does not include the supply of antigens.
- Codes 95115 and 95117 are reimbursed only in an office setting (POS 11).
- CPT 96372 should not be coded for allergy related injection services.
- Administration services are not billable when performed by the member.
- Code 95115 or 95117 are reported with one unit per date of service. Both codes are not payable on the same date of service.
- CPT 95115 and/or 95117 are payable for one to three injections per week. Any combination of these codes exceeding three injections per week will be denied.

Preparation and provision of a single dose antigen include 95144-95170.

- Reimbursement is based on a single dose when the code description is specific to a single dose. Pay close attention to the full CPT description for accurate coding.
- Units would reflect the number of doses supplied.
- Codes 95144 and 95145-95170 are payable in an office setting and hospital outpatient setting (POS 19 and 22).
- Code 95145-95170 may also be payable in a skilled nursing facility (POS 31) if a physician is present.

Preparation and provision of allergen immunotherapy for single or multiple antigen extract(s) is reported with 95165.

- This service includes the preparation of non-venom antigens.

- Should not exceed 120 units per year.

If both administration and provision of the allergen extract is performed by the same physician, report the appropriate CPT code to define this service.

In alignment with CMS, a reasonable supply of antigens should not exceed a supply of more than 12 months for a patient. This is intended to ensure the antigen remains potent and effective over the time these are administered to members.

In vitro testing isn't payable when a skin test is also performed for the same antigen with the exception of latex sensitivity, Hymenoptera, and nut/peanut sensitivity.

In vitro testing, the medical record must be supported within the medical record as a substitute for in vivo testing (skin testing) and, effective Nov. 11, 2024, will be limited to 30 allergens over a 12-month period.

Preparation and administration
Reimbursement of preparation of reasonable supply of antigens is made when antigens are prepared by a physician (MD or DO) and the physician exam results in a plan of treatment to define the dosage regimen.

- Documentation must reflect the antigens that are administered in accordance with the documented plan of treatment.
- Administration of the antigen may be performed by the physician or those properly trained, including the member if under the supervision of the physician.

Modifiers
Maintenance allergy immunotherapy should be reported with the **EJ modifier**.

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements
Documentation of allergy and immunotherapy services must be detailed in the member's medical record. This must support medical necessity as defined in the medical policy referenced above.

The medical record must support the accurate CPT coding and units billed, and should include:

- Allergy test performed along with its interpretation
- All reactions and complications
- Testing and plan of treatment that includes dosage regimen
- Retention of allergy tests in alignment with applicable legal and facility requirements
- Elements of medical and immunological history
- Progress notes associated with management during course of allergic disease, treatment length and deviations from the treatment plan or frequency.

Reimbursement specifics
Submit references for fee schedules or specific reimbursement. Usually present in older versions of the policy.

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization

isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
June 19, 2024	This policy was created primarily using content previously available on the Provider Manual. The following additions were made: • Allergy studies for percutaneous and intradermal tests (reported with CPT codes 95004, 95024, and 95027) should not exceed 120 units per year regardless of rendering/administering provider. • CPT 95115 and/or 95117 are payable for one to three injections per week. Any combination of these codes exceeding three injections per week will be denied.
October 2025	CPT 95165 should not exceed 120 units per year.