

**ALLERGY TESTING / IMMUNOTHERAPY****Effective Date:** December 1, 2025**Review Dates:** 1/93, 12/94, 10/97, 12/99, 12/01, 12/02, 01/03, 01/04, 01/05, 12/05, 12/06, 12/07, 12/08, 12/09, 12/10, 12/11, 12/12, 12/13, 5/14, 5/15, 5/16, 2/17, 2/18, 2/19, 2/20, 2/21, 2/22, 2/23, 2/24, 2/25, 11/25**Date Of Origin:** June 30, 1988**Status:** Current**Summary of Changes****Additions:**

- Added use of the RhinAer® radiofrequency device (Aerin medical Inc.) to treat rhinitis as an exclusion (reflects previously established position).
- Added rhinophototherapy (intranasal phototherapy) as an exclusion.
- Added repository emulsion therapy as an exclusion.

**Related policies:**

Priority Health Medical Policy *No. 91506 Septoplasty/Rhinoplasty*

**I. MEDICAL NECESSITY CRITERIA**

A. The following allergy tests are considered medically necessary\*:

1. IgE Specific Antibody (e.g., RAST, micro-Elisa, immunocap) if clinically indicated for history of severe urticaria, hives, or severe allergy, when skin testing is inappropriate.
2. Skin tests (scratch, intradermal, pricks)
3. Patch application tests
4. Drug Provocation testing
5. Skin Endpoint Titration (SET). Skin endpoint titration is effective for quantifying patient sensitivity and for providing a safe starting dose for immunotherapy. SET has not been shown to be an effective guide to a final therapeutic dose.
6. Nitric Oxide Breath Analysis for the management of asthma.

B. The following services have not been proven to be effective in diagnosing and/or treating allergies, and are therefore considered not medically necessary:

1. Cytotoxicity testing (Bryan's test)
2. Urine autoinjection (autogenous urine immunization)
3. Provocation testing and neutralization therapy for food allergy (intracutaneous, subcutaneous or sublingually). Also called Intracutaneous Progressive Dilution Food Test (IPDFT).

4. Antigen leukocyte cellular antibody test (ALCAT) for all indications including but not limited to testing for food allergies or intolerance (chemical sensitivities) and as a tool to establish elimination diets.
5. Electrodermal testing or electro-acupuncture\*\*
6. Applied kinesiology or muscle strength testing of allergies
7. Reaginic pulse testing or pulse testing for allergies
8. Total serum immunoglobulin G (IgG), immunoglobulin A (IgA) and immunoglobulin M (IgM)
9. Testing of specific IgG antibody (e.g., by RAST or ELISA testing)
10. Lymphocyte subset counts
11. Lymphocyte function assay
12. Lymphocyte transformation test (LTT), also known as lymphocyte proliferation test and metal ion testing for metal-induced hypersensitivity response.
13. Cytokine, cytokine receptor assay and Th1/Th2 cytokine ratio
14. Natural Killer (NK) cell assay or activity
15. Food immune complex assay (FICA)
16. Leukocyte histamine release testing
17. Body chemical analysis
18. Sublingual immunotherapy (SLIT) aqueous formulations
19. Sublingual immunotherapy (SLIT) allergy tablets that have **NOT** been approved by the FDA

([Sublingual immunotherapy \(SLIT\) allergy tablets](#) is another form of allergy immunotherapy and involves administering the allergens under the tongue generally on a daily basis. For more information regarding pharmacy coverage of FDA-approved agents, please refer to the appropriate [Approved Drug List](#).)

20. Nitric Oxide Breath Analysis for the diagnosis of asthma
21. Use of the following devices to treat rhinitis (see Priority Health Medical Policy No. 91506 *Septoplasty/Rhinoplasty* for discussion of these devices):
  - Clarifix® cryotherapy device (Stryker) to treat rhinitis.
  - RhinAer® radiofrequency device (Aerin medical Inc.) to treat rhinitis
22. Rhinophototherapy (intranasal phototherapy)
23. Repository emulsion therapy

*Notes:*

- \* See also the related Billing & coding policy entitled [“Allergy injections / immunotherapy.”](#)
- \*\* Acupuncture may be covered with a rider for some commercial plans.

## 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.

<b>National Coverage Determinations (NCDs)</b>	
Antigens Prepared for Sublingual Administration <a href="#">110.9</a>	
Food Allergy Testing and Treatment <a href="#">110.11</a>	
Challenge Ingestion Food Testing <a href="#">110.12</a>	
Cytotoxic Food Tests <a href="#">110.13</a>	
<b>Local Coverage Determinations (LCDs)</b>	
CGS Administrators, LLC	Allergen Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) <a href="#">L40056</a> <a href="#">A59981</a> Allergy Immunotherapy <a href="#">L32553</a> <a href="#">A56424</a> RAST Type Tests <a href="#">L34063</a> <a href="#">A57043</a>
First Coast Service Options, Inc.	Allergen Immunotherapy <a href="#">L37800</a> <a href="#">A57678</a> Allergy Testing <a href="#">L33261</a> <a href="#">A57531</a>
National Government Services, Inc.	Allergen Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) <a href="#">L40048</a> <a href="#">A59973</a> RAST Type Tests <a href="#">L33591</a> <a href="#">A56844</a>
Noridian Healthcare Solutions	Allergen Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) <a href="#">L40050</a> <a href="#">A59976</a> <a href="#">L40052</a> <a href="#">A59978</a> Allergy Testing <a href="#">L34313</a> <a href="#">A57181</a>
Novitas Solutions, Inc.	Allergen Immunotherapy <a href="#">L36240</a> <a href="#">A56538</a> Allergy Testing <a href="#">L36241</a> <a href="#">A56558</a>

Palmetto GBA	Allergen Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) <a href="#">L40046</a> <a href="#">A59971</a> Allergy Skin Testing <a href="#">L33417</a> <a href="#">A56559</a>
WPS Insurance Corporation	Allergen Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) <a href="#">L36408</a> <a href="#">A60276</a> Allergy Immunotherapy <a href="#">L36408</a> <a href="#">A57472</a> Allergy Testing <a href="#">L36402</a> <a href="#">A57473</a>

### III. BACKGROUND

Allergy testing, evaluations, and immunotherapy are eligible for coverage according to the schedule of covered services in plan documents. Testing or treatment methods not considered as standard medical procedures are not eligible for coverage.

**Cryotherapy for chronic rhinitis:** While the American Academy of Otolaryngology-Head and Neck surgery endorses the use of posterior nasal nerve (PNN) ablation for the treatment of medically-refractory chronic rhinitis and does not consider these treatments to be experimental (2023), the National Institute for Health and Care Excellence (NICE) recommends that cryotherapy for chronic rhinitis be used only in research, citing the need for further research reporting details of patient selection, duration of the effect (including whether repeat procedures are needed), and long-term outcomes (2023)

**Repository emulsion therapy:** Allergens are added to vegetable and mineral oils, which are then injected intramuscularly. In theory, there would be slow release of the allergens at the injection site. This therapy is outdated and was discontinued after it was found it had the potential to induce plasma cell myelomas. The American Academy of Allergy, Asthma & Immunology has no statement of support for repository emulsion therapy.

**Rhinophototherapy (intranasal phototherapy):** Phototherapy has been used in treating immune-mediated dermatological conditions such as psoriasis and atopic dermatitis. It has been proposed that phototherapy to the nasal mucosa may be effective in treating allergic rhinitis. This treatment method remains unproven as there is limited peer reviewed literature. The American Academy of Allergy, Asthma & Immunology has no statement of support for rhinophototherapy. The National institute for Health and Care Excellence (NICE) makes the following recommendations:

- *Current evidence on the efficacy and safety of intranasal phototherapy for allergic rhinitis is limited in quantity and quality. Therefore, this procedure should only be used in the context of research.*

- *Further research should include: details of patient selection including medication use; underlying medical conditions; the intensity, duration and wavelength of light used; patient-reported outcomes; comparison with existing treatments; and the effects of repeated long-term use.*

#### IV. GUIDELINES / POSITION STATEMENTS

<b>Medical/Professional Society</b>	<b>Guideline/Position Statement</b>
<a href="#">American Academy of Allergy, Asthma &amp; Immunology (AAAAI)</a>	<a href="#">The Joint Task Force on Practice Parameters GRADE guidelines for the medical management of chronic rhinosinusitis with nasal polyposis (2022)</a>  <a href="#">Peanut allergy diagnosis: A 2020 practice parameter update, systematic review, and GRADE analysis</a>  <a href="#">Rhinitis 2020: A practice parameter update</a>  <a href="#">Sublingual immunotherapy: A focused allergen immunotherapy practice parameter update (2017)</a>  <a href="#">The diagnosis and management of acute and chronic urticaria: 2014 update</a>  <a href="#">Diagnosis and management of rhinosinusitis: a practice parameter update (2014)</a>  <a href="#">Food allergy: A practice parameter update—2014</a>  <a href="#">Atopic dermatitis: A practice parameter update 2012</a>  <a href="#">Allergen immunotherapy: A practice parameter third update (January 2011)</a>  <a href="#">Allergy Diagnostic Testing: An Updated Practice Parameter (March 2008)</a>  <a href="#">Guidance for the Evaluation by Payors of Claims Submitted Using Current Procedural</a>

	<a href="#">Terminology Codes 95165, 95115, and 95117 (November 2024)</a>
<a href="#">American Academy of Otolaryngology-Head and Neck Surgery</a>	<a href="#">CPG: Immunotherapy for Inhalant Allergy (February 26, 2024)</a>  <a href="#">Position Statement: PNN Ablation for the Treatment of Chronic Rhinitis (January 17, 2023)</a>  <a href="#">Clinical Practice Guideline: Allergic Rhinitis (February 2015)</a>
<a href="#">National Institute of Allergy and Infectious Disease (NIAID)</a>	<a href="#">Guidelines for the Diagnosis and Management of Food Allergy in the United States: Report of the NIAID-Sponsored Expert Panel (December 2010)</a>
<a href="#">National Institute for Health and Care Excellence (NICE)</a>	<a href="#">Cryotherapy for chronic rhinitis (September 14, 2025)</a>  <a href="#">Intranasal phototherapy for allergic rhinitis (June 13, 2018)</a>

**V. REGULATORY INFORMATION (US FOOD & DRUG ADMINISTRATION)**

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

<b>Device</b>	<b>Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number</b>	<b>Notice Date</b>
<a href="#">RhinAer® radiofrequency device (Aerin medical Inc.)</a>	<a href="#">K221907</a>	July 29, 2022
<a href="#">Clarifix® cryotherapy device (Stryker)</a>	<a href="#">K190356</a> <a href="#">K162608</a> <a href="#">K160669</a>	February 26, 2019 February 14, 2017 June 24, 2016



VI. CODING

See also the related Billing & coding policy entitled [“Allergy injections / immunotherapy.”](#)

**ICD-10 Codes** that may support medical necessity:

- D69.0 Allergic purpura
- H10.401 – H10.409 Unspecified chronic conjunctivitis
- H10.421 – H10.429 Simple chronic conjunctivitis
- H10.44 Vernal conjunctivitis
- H16.261 – H16.269 Vernal keratoconjunctivitis, with limbar and corneal involvement
- H10.411 – H10.419 Chronic giant papillary conjunctivitis
- H10.45 Other chronic allergic conjunctivitis
- H10.9 Unspecified conjunctivitis
- J30.0 – J30.9 Vasomotor and allergic rhinitis
- J31.0 – J31.2 Chronic rhinitis, nasopharyngitis and pharyngitis
- J32.0 – J32.9 Chronic sinusitis
- J33.0 – J33.9 Nasal polyp
- J45.20 – J45.998 Asthma
- K52.21-K52.29 Allergic and dietetic gastroenteritis and colitis
- K52.89 Other specified noninfective gastroenteritis and colitis
- K52.9 Noninfective gastroenteritis and colitis, unspecified
- L20.0 – L20.9 Atopic dermatitis
- L22 Diaper dermatitis
- L23.0 – L23.9 Allergic contact dermatitis
- L24.0 – L24.9 Irritant contact dermatitis
- L25.0 – L25.9 Unspecified contact dermatitis
- L27.0 – L27.9 Dermatitis due to substances taken internally
- L29.8 Other pruritus
- L29.9 Pruritus, unspecified
- L30.0 – L30.9 Other and unspecified dermatitis
  
- L50.0 Allergic urticaria
- L50.1 Idiopathic urticaria
- L50.6 Contact urticaria
- L50.8 Other urticaria
- L50.9 Urticaria, unspecified
- L56.4 Polymorphous light eruption
- T50.905A-T50.905S Adverse effect of unspecified drugs, medicaments and biological substances
- T50.995A-T50.955S Adverse effect of other drugs, medicaments and biological substances
- T78.00xA-T78.1xxS Anaphylactic reaction due to food
- T78.40xA-T78.49xS Other and unspecified allergy
  
- Z01.82 Encounter for allergy testing
- Z91.010 – Z91.09 Allergy status, other than to drugs and biological substances

**CPT/HCPCS Codes**



# Not covered for Priority Health Medicaid

Testing:

*(Laboratory tests are subject to laboratory benefits)*

- 82785 Gammaglobulin; IgE
  
- 86001 Allergen specific IgG quantitative or semiquantitative, each allergen
- 86003 Allergen specific IgE; quantitative or semiquantitative, each allergen
- 86005 Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle or disk)
- 86008 Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each
- 86021 Antibody identification; leukocyte antibodies
- 95004 Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests.
- 95012 Nitric oxide expired gas determination
- 95017 Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intra dermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests
- 95018 Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intra dermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests
- 95024 Intracutaneous (intra dermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests.
- 95027 Intracutaneous (intra dermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report by a physician, specify number of tests.
- 95028 Intracutaneous (intra dermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests.
- 95044 Patch or application test(s), specify number of tests.
- 95052 Photo patch test(s), specify number of tests.
- 95056 Photosensitivity tests
- 95060 Ophthalmic mucous membrane tests
- 95065 Direct nasal mucous membrane test
- 95070 Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds.
- 95076 Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug or other substance); initial 120 minutes of testing
- 95079 Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug or other substance); each additional 60 minutes of testing (List separately in addition to code for primary procedure)
- 0605U Allergy and immunology (hereditary alpha tryptasemia), DNA, analysis of TPSAB1 gene copy number variation using digital PCR, whole blood, results reported with genotype-specific interpretation of alaphatryptase copy number and algorithmic

classification as normal or abnormal



Immunotherapy

- 95115 Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
- 95117 Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections
- 95120# Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single injection
- 95125# Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; two or more injections
- 95130# Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single stinging insect venom
- 95131# Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; two stinging insect venoms
- 95132# Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; three stinging insect venoms
- 95133# Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; four stinging insect venoms
- 95134# Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; five stinging insect venoms
- 95144# Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)
- 95145 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom
- 95146 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); two single stinging insect venoms
- 95147 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); three single stinging insect venoms
- 95148 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms
- 95149 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); five single stinging insect venoms
- 95165 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)



- 95170# Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)
- 95180 Rapid desensitization procedure, each hour (e.g., insulin, penicillin, equine serum)
- 95199 Unlisted allergy/clinical immunologic service or procedure (Explanatory notes must accompany claims billed with unlisted codes.)

**Not Covered Services:**

- 83516 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method
- 83518 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, single step method (e.g., reagent strip)
- 83519 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, by radioimmunoassay (e.g., RIA)
- 83520 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified
- 86160 Complement; antigen, each component
- 86161 Complement; functional activity, each component
- 86162 Complement; total hemolytic (CH50)
- 86332 Immune complex assay
- 88342 Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure
- 88344 Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure
- 88346 Immunofluorescent study, each antibody; direct method
- 86352 Cellular function assay involving stimulation (e.g., mitogen or antigen) and detection of biomarker (e.g., ATP)
  
- 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)
- 86343 Leukocyte histamine release test (LHR)
- 86353 Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis
- 95199 Unlisted allergy/clinical immunologic service or procedure (*Explanatory notes must accompany claim*) Code not covered if billed for service listed as "Not Covered in this policy.
- 86356 Mononuclear cell antigen, quantitative (e.g., flow cytometry), not otherwise specified, each antigen
- 0604U Allergy and immunology (chronic recurrent angioedema), 4 bradykinin peptides, liquid chromatography and tandem mass spectrometry (LC-MS/MS), whole blood, quantitative

**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, please refer to the [Priority Health Provider Manual](#).

## 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.

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