

ALLERGY TESTING / IMMUNOTHERAPY**Effective Date:** March 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**Date Of Origin:** June 30, 1988**Status:** Current**Summary of Changes**

Additions:

- I. Notes: Reference to the **Priority Health Billing & Coding Policy** entitled *Allergy Injections / Immunotherapy* has been added.

Changes:

- I. B.: In the prior revision (R9), all sublingual immunotherapy (SLIT) was listed as not medically necessary. With this revision (R10), only SLIT tablets that have not been approved by the FDA, as well as all aqueous SLIT formulations, are not medically necessary. Reader is now referred to Priority Health's current Pharmacy Benefit regarding coverage for FDA-approved SLIT tablets.

I. POLICY/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 Clarifix device (Arrinex, Meno Park, CA) cryosurgical tool to treat rhinitis.

Notes:

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

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, 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](#).

III. APPLICATION TO PRODUCTS

Coverage is subject to 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) and/or the Evidence of Coverage (EOC); 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 located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.*

IV. DESCRIPTION

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.



V. CODING INFORMATION

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)



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

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