Priority Health

MEDICAL POLICY
No. 91037-R11

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.

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

Palmetto GBA	Allergen Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) L40046 A59971 Allergy Skin Testing L33417 A56559
WPS Insurance Corporation	Allergen Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) L36408 A60276 Allergy Immunotherapy L36408 A57472 Allergy Testing L36402 A57473

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

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

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

V. REGULATORY INFORMATION (US FOOD & DRUG ADMINISTRTION)

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

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Notice Date
RhinAer® radiofrequency device (Aerin medical Inc.)	K221907	July 29, 2022
Clarifix® cryotherapy device (Stryker)	K190356 K162608 K160669	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 (intradermal), 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 (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests.
95027	Intracutaneous (intradermal) 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 (intradermal) 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

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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