MetroPlus Health

Policy and Procedure

Title: Allergy Testing	Division: Medical Management Department: Utilization Management
Approval Date: 4/6/18	LOB: Medicaid, Medicare, Ultracare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP
Effective Date: 4/6/18	Policy Number: UM-MP231
Review Date: 6/27/22	Cross Reference Number:
Retired Date:	Page 1 of 5

1. **POLICY DESCRIPTION:**
   Effective August 1, 2016 MetroPlus Health will cover allergy testing in accordance with NYS Medicaid guidelines as published in the Medicaid Update dated May 1, 2016.
   Effective 6/3/2021, MetroPlusHealth is revising this policy to only cover allergy testing when it is performed by a board certified or residency trained Allergists/Immunologists or Dermatologists

2. **RESPONSIBLE PARTIES:**
   Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claims Department, Provider Contracting.

3. **POLICY:**
   A. Metroplus will cover in vivo (skin) allergy testing for the following conditions:
      1. Suspected food allergies
      2. Suspected stinging insect allergies
      3. Chronic rhinitis or conjunctivitis where the cause is suspected environmental allergies and the member has been non-responsive to avoidance and pharmalogic therapy
      4. Suspected medication allergy, when no alternative is available and treatment is medically necessary
      5. Suspected allergic dermatitis
   B. MetroPlus will cover in vitro (blood) allergy testing for the following conditions:
      1. Extensive skin condition, such as psoriasis, severe eczema or symptomatic dermagraphism
      2. Inability to discontinue medications, such as antihistamines, that will affect test results
      3. Children age 3 years and younger
   C. MetroPlus will cover oral ingestion challenge testing for the following:
      1. Allergy to a food/ingested substance and in vivo or in vitro testing was inconclusive or inconsistent with clinical symptoms
      2. Allergy to an oral medication when all of the following are met:
         i. Member has a history of allergy to a specified drug
         ii. There is no effective alternative or equivalent drug

iii. Patient requires treatment with the drug class

D. For Medicare LOB Only:
   1. Requests for services above the limits outlined above, provider must submit clinical documentation of units utilized AND clinical documentation to support the need for additional testing.

4. COVERAGE LIMITATIONS

A. MetroPlus will cover allergy testing up to the number of tests eligible for reimbursement within a 5-year period as outlined by NYS Medicaid and noted in the chart below.
Allergy testing only covered when it is performed by a board certified or residency trained Allergists/Immunologists or Dermatologists.

1. Prior authorization is not required for services being provided up to the benefit limits listed below.
2. Services beyond the limits below will be denied for benefit exhaustion.
3. MetroPlus reserves the right to perform retrospective reviews for services provided.

CPT Code	Code Description	# of tests allowed per 5-year period
95004	Percutaneous tests (scratch, puncture, prick) with allergenic. extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests	60
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	60
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	60
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests	40
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction,	40

	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	40
95044	Patch or application tests(s) (specify number of tests)	40
95076	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing	As medically necessary
95079	Ingestion challenge test - each additional 60 minutes of testing (list separately in addition to code for primary procedure)	As medically necessary
86003	Allergen specific IgE; quantative or semiquantative, each allergen	30
86008	Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each	NA

B. CPT codes 86001 and 86005 are considered to be not medically necessary and will be denied.

The following tests are considered to be not medically necessary and will be denied.

- ELISA/Act qualitative antibody testing
- This testing is used to determine in vitro reaction to various foods and relies on lymphocyte blastogenesis in response to certain food antigens.
- LMRA (Lymphocyte Mitogen Response Assays) by ELISA/Act
- IgG ELISA, indirect method
- Qualitative multi-allergen screen
- This is a non-specific test that does not identify a specific antigen.
- IgG and IgG subclass antibody tests for food allergy do not have clinical relevance, are not validated, lack sufficient quality control, and should not be performed.

References

1. New York Medicaid Update May 2016. New York State Medicaid Expansion of Allergy Testing. https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-05.htm

2. CMS Medicare Local Coverage Determination (LCD) L33591, RAST Type Tests. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33591&ver=18&bc=0

Accessed May 25th 2022.

3. CMS Medicare Local Coverage Determination (LCD) Billing and Coding: RAST Type Tests, A56844. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56844&ver=22

Accessed May 25th 2022.

REVISION LOG:

REVISIONS	DATE
Creation date	4/6/2018
Annual Review	6/8/2020
Update to clarify service limitations	10/5/2020
Minor changes	5/12/2021
Annual Review, Code changes	6/27/2022

Approved:	Date:	Approved:	Date:
Glendon Henry Digitally signed by Glendon Henry Date: 2022.06.28 09:44:21 -04'00'		Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2022.07.06 17:36:28 -04'00'	
Glendon Henry, MD Sr. Medical Director		Sanjiv Shah MD Chief Medical Officer	

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Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.