POLICY STATEMENT:

I. Based upon our criteria and review of the peer-reviewed literature, the following tests are medically appropriate in the diagnosis of the allergic patient:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>95004</td>
<td>Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests</td>
<td>The number of tests required may vary widely from patient to patient, depending upon the patient’s history, and may require up to 70 tests.</td>
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<tr>
<td>95017</td>
<td>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</td>
<td>Usually used when percutaneous testing is not considered to be sensitive enough to the cause of an allergic reaction. The number of tests required may vary widely from patient to patient, depending upon the patient’s history, and may require up to 40 tests.</td>
</tr>
<tr>
<td>95018</td>
<td>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</td>
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<tr>
<td>95024</td>
<td>Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests</td>
<td>A physician or other qualified health care provider uses intracutaneous tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, to determine a patient's specific allergies. The number of tests must be specified (each sequential test = 1 unit). This code includes test interpretation and provider report. (serial endpoint testing)</td>
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<tr>
<td>95027</td>
<td>Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests</td>
<td>Used as a part of an evaluation of the status of immune function. The number of tests is usually small, under 10 tests.</td>
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<tr>
<td>95044</td>
<td>Patch or application test(s) (specify number of tests)</td>
<td>Also known as delayed hypersensitivity testing, this testing modality identifies allergens causing contact dermatitis. The suspected allergens are applied to the patient’s back under dressings and allowed to remain in contact with the skin for 48 to 72 hours. The area is then examined for evidence of delayed hypersensitivity reactions.</td>
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<tr>
<td>95052</td>
<td>Photo patch test(s) (specify number of tests)</td>
<td>This test reflects contact photosensitization. A patch of skin is applied with the suspected sensitizer for 48 hours. If no reaction occurs, the area is exposed to a dose of ultraviolet light sufficient to produce inflammatory redness of the skin. If the test is positive, a more severe reaction develops at the patch site than on the surrounding skin.</td>
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<tr>
<td>95056</td>
<td>Photo tests</td>
<td>Photo, or photosensitivity, tests are performed for the evaluation of photosensitivity disorders by irradiating the skin with a specified range of ultraviolet light.</td>
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<tr>
<td>95070</td>
<td>Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds</td>
<td>Histamine or methacholine is used to perform this test when it is necessary to determine if the patient has hyper-responsive airways. Volatile chemicals are used to perform the test when the allergy is encountered in an occupational setting. If dust, ragweed or other common allergens are the suspected cause of the problem, this test is not medically appropriate since skin tests can be used in these situations.</td>
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<tr>
<td>95071</td>
<td>Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with antigens or gases, specify</td>
<td>With these tests the patient ingests a food, drug or other substance to which sensitivity is suspected. This may be done in an open or blinded manner. Testing may be done at home, but in some instances of extreme suspected hypersensitivity, it may be performed in the office setting.</td>
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<tr>
<td>95076</td>
<td>Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing</td>
<td>Total serum IgE concentration testing is not indicated in most allergic patients, but may be indicated for patients suspected of having allergic bronchopulmonary aspergillosis, immune deficiency disease characterized by increased IgE levels (e.g., Wiskott-Aldrich syndrome, hyper-IgE staphylococcal abscess syndrome), IgE myeloma, pemphigoid, or a poorly controlled moderate to severe asthmatic patient being considered for possible anti IgE treatment.</td>
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<tr>
<td>82785</td>
<td>Gammaglobulin (immunoglobulin), IgE</td>
<td>Commonly known as RAST (radioallergosorbent) testing, these tests detect antigen-specific IgG antibodies in the patient’s serum and are medically appropriate only in testing for insect venoms in patients allergic to insect</td>
</tr>
</tbody>
</table>
SUBJECT: ALLERGY TESTING

POLICY NUMBER: 2.01.10
CATEGORY: Technology Assessment

EFFECTIVE DATE: 01/20/00
REVISED DATE: 10/18/01, 10/16/02, 10/15/03, 09/16/04, 11/17/05, 09/21/06, 12/20/07, 09/18/08, 09/17/09, 09/16/10, 09/15/11, 09/20/12, 09/19/13, 09/18/14, 09/17/15, 9/15/16, 11/16/17

PAGE: 3 OF 9

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<tbody>
<tr>
<td>86003</td>
<td>Allergen specific IgE; quantitative or semiquantitative, each allergen</td>
<td>Commonly known as RAST (radioallergosorbent) testing, these tests detect antigen-specific IgE antibodies in the patient’s serum. They are medically appropriate only when testing for allergens (e.g., inhalant, food, insect, drug):</td>
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<td>I. When direct skin testing is impossible due to extensive dermatitis or marked dermatographism;</td>
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<td>II. For patients unable to discontinue use of interfering medications (e.g., antidepressants, antihistamines, or beta blocking agents);</td>
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<td>III. For those who have had a near fatal reaction to an allergen;</td>
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<td>IV. In children less than four years of age;</td>
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<td>V. In patients who will not or cannot cooperate with percutaneous testing due to mental or physical disease (e.g., Down syndrome, mental retardation, dementia);</td>
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<td>VI. To follow patients with food allergies and/or insect sting allergies previously documented by history and in-vivo or in-vitro testing;</td>
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<td>VII. For patients with suspected latex allergy;</td>
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<td></td>
<td>VIII. For patients with suspected insect sting allergy in the face of negative skin testing; or</td>
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<td>IX. For patients with suspected penicillin allergy.</td>
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<tr>
<td>86005</td>
<td>Allergen specific IgE; qualitative, multi-allergen screen (dipstick, paddle or disk)</td>
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</tbody>
</table>

II. Based upon our criteria and review of the peer-reviewed literature, the following allergy tests have not been medically proven to be effective and are considered investigational:

<table>
<thead>
<tr>
<th>CODE</th>
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<tbody>
<tr>
<td>86343 (E/I)</td>
<td>Leukocyte histamine release test (LHRT)</td>
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<tr>
<td>95060 (E/I)</td>
<td>Ophthalmic mucous membrane test</td>
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<tr>
<td>95065 (E/I)</td>
<td>Direct nasal mucous membrane test</td>
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<tr>
<td></td>
<td>Cytotoxicity, Provocative testing (e.g., Rinkel test), Rebeck skin window test</td>
</tr>
</tbody>
</table>

Refer to Corporate Medical Policy #2.01.04 regarding Clinical Ecology/Multiple Chemical Sensitivities/Idiopathic Environmental Intolerance.

Refer to Corporate Medical Policy # 2.01.11 regarding Allergen Immunotherapy.

Refer to Corporate Medical Policy # 11.01.03 regarding Experimental and Investigational Services.

POLICY GUIDELINES:
The Federal Employees Health Benefit Program (FEHBP/FEP) requires that procedures, devices or laboratory tests approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational and thus these procedures, devices or laboratory tests may be assessed only on the basis of their medical necessity.

Proprietary Information of Excellus Health Plan, Inc.
DESCRIPTION:

Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as localized reactions in any organ system of the body. The reactions may be acute, subacute or chronic, immediate or delayed and may be caused by numerous offending agents (e.g., pollen, molds, dust, mites, animal dander, stinging insect venoms, foods and drugs).

The optimum management of the allergic patient should include a careful history and physical examination and may include confirming the cause of allergic reaction by information from various testing methods. Once the offending allergenic agent(s) are identified treatment is provided by avoidance, medication and/or immunotherapy.

RATIONALE:

Although in vivo (e.g., percutaneous, intracutaneous) testing is presently the preferred method of diagnostic allergy testing for IgE mediated sensitivity in vitro (e.g., RAST) tests are useful when used as stated in the situations identified in the above table.

According to a November 2006 American Academy of Allergy, Asthma and Immunology work group report addressing Allergy Diagnosis in Clinical Practice IgE antibody assay technology has improved with new high binding capacity solid phase matrices, non-isotopic labels for detection antibodies and standards calibrated to the World Health Organization IgE reference preparation. These enhancements have led to an evolution in assay methods from the first generation qualitative assays (e.g., RAST, MAST, EAST), through the second generation semi-quantitative IgE assays (e.g., AutoCAP, Alastat, HYTech, Matrix, MagicLite), to the present state-of-the-art quantitative third generation autoanalyzers. Two third generation immunoassays are the ImmunoCAP System (Phadia) and the Immulite 2000 (Diagnostic Products Corp) whose chemistry is similar to the original RAST, but employ non-isotopic labels and have more rapid throughput with improved precision, accuracy and analytical sensitivity. Their automated chemistries report out allergen-specific IgE antibody quantitatively.

Serial endpoint testing (SET), or intradermal dilutional testing (IDT), is a form of intradermal skin testing that uses increasing doses of antigen to determine the concentration at which the reaction changes from negative to positive (the “endpoint”). The test has been used for diagnosing allergic disorders and to guide the initiation of immunotherapy by using the endpoint dilution as the starting antigen dose.

Ferastaoaru et al reported (2017) in an independent analysis of 75 patients with over 1600 tests between January 2014 and May 2015 for comparison of skin-prick (SPT), intradermal (IDST), and serum specific immunoglobulin E (ssIgE) testing that: IDST detected more additional environmental sensitizations compared with ssIgE testing. IDST, therefore, may be useful when the SPT and/or ssIgE testing results were negative, but the exposure history indicated relevant allergic sensitization. Serology added only a little more information if both SPT and IDST results were negative but may be useful in combination with SPT if IDST cannot be performed.

In a prospective comparative clinical study (Peltier 2007) 134 subjects were tested for a comparison of intradermal dilutional testing, skin prick testing, and modified quantitative testing for common allergens. The researchers found poor correlation between endpoint and wheal size as graded by a 1to 4 system and concluded that although a correlation existed, the use of SPT to determine endpoint was inaccurate and dangerous. Modified quantitative testing appears to be a safe alternative to IDT for determining starting doses for immunotherapy. The data supports the safety and efficacy of MQT (combination SPT & IDT).

In a retrospective review of clinical data (random accrual) the authors (Seshul 2006) concluded that IDT is an important step in the determination of the strongest starting dose of immunotherapy that may be safely administered. Initiating immunotherapy in this manner may potentially create significant health care savings by shortening the time required for a patient to reach their individual maximally tolerated dose. The use of a relatively large screening panel is cost effective and does not increase the average number of antigens treated by immunotherapy. Blended allergy testing techniques that include IDT in their protocol are comparable in cost with commonly used allergy testing protocols. Otolaryngologists
often favor IDT (SET) because of its well-documented sensitivity, specificity, safety, and reproducibility. IDT has been compared with many testing modalities used by other physicians to validate the technique as a part of mainstream allergy care.

CDC https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5511a1.htm (MMWR 2006) recommends the use of serial endpoint testing (IDT) For patients at high risk for anaphylaxis, including those who 1) have a history of penicillin-related anaphylaxis, asthma, or other diseases that would make anaphylaxis more dangerous or 2) are being treated with beta-adrenergic blocking agents should be tested with 100-fold dilutions of the full-strength skin-test reagents before being tested with full-strength reagents. In these situations, patients should be tested in a monitored setting in which treatment for an anaphylactic reaction is available. If possible, the patient should not have taken antihistamines recently (e.g., chlorpheniramine maleate or terfenadine during the preceding 24 hours, diphenhydramine HCl or hydroxyzine during the preceding 4 days, or astemizole during the preceding 3 weeks).

In a Joint Task Force on Practice Parameters for Drug Allergy; American Academy of Allergy, Asthma and Immunology; American College of Allergy, Asthma and Immunology; Joint Council of Allergy, Asthma and Immunology. (2010) included in their executive summary a statement validating the use of intracutaneous (intradermal) tests are generally used for specific allergens (ie, Hymenoptera venoms and penicillin), but they may also be applied if prick/puncture test results are negative and there is a strong historical likelihood of clinical allergy to specific allergens.

Leukocyte histamine release testing (LHRT) is a technique to evaluate the in vitro release of histamine from leukocytes in response to an allergen and provide an in vitro correlate to an in vivo allergic response. Published literature regarding the commercially available LHRTs suffers from not having been performed in a blinded manner or not indicating whether or not there were blinded interpretations of the tests. Some studies included patients with known allergies, which do not represent the same population with equivocal allergy histories that would undergo testing. Studies of LHRT are potentially prone to spectrum, referral, and ascertainment bias, and are not sufficient to permit conclusions on the diagnostic accuracy of the tests. It has been suggested that LHRT may be a valuable test in those patients with discordant results of skin prick testing and RAST testing, but studies focusing on this subgroup of patients have not been identified.

A number of procedures have been shown to be invalid for any clinical purpose. Studies of cytotoxic tests and provocation-neutralization tests have demonstrated that results are not reproducible. Electrodermal diagnosis and applied kinesiology have not been evaluated for efficacy. The “reaginic” pulse test and chemical analysis of body tissues have not been substantiated as valid allergy tests. These tests are considered to be investigational.

Eligibility for reimbursement is based upon the benefits set forth in the member’s subscriber contract.

CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Refer to the tables in the policy statement section.

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Proprietary Information of Excellus Health Plan, Inc.
372.14 Other chronic allergic conjunctivitis
477 Allergic rhinitis
477.0 due to pollen
477.1 due to food
477.2 due to animal (cat) (dog) hair and dander
477.8 due to other allergen
477.9 cause unspecified
493.0 Extrinsic asthma
493.9 Asthma, unspecified
692 Contact dermatitis
692.0 - 692.6 due to contact with detergents, oils, greases, solvents, drugs, medicines, chemical products, food and plants
692.81 due to contact with cosmetics
692.83 due to metal
692.84 due to animal (cat) (dog) dander
692.89 due to other causes
692.9 unspecified cause
693 Dermatitis due to substances taken internally
693.0 due to drugs and medicines
693.1 due to food
693.8 due to other specified substance taken internally
693.9 due to other specified substance taken internally
708.0 Allergic urticaria
708.3 Dermatographia urticaria
989.5 Toxic effects of other substances, chiefly non-medicinal as to source, venom
989.82 latex
995.0 - 995.4 Certain adverse effects not elsewhere classified (code range)
995.6 - 995.69 Anaphylactic shock due to adverse food reaction (code range)
995.9 - 995.99 Allergy, other than to medicinal agents (code range)
ICD10:
B44.0-B44.9 Aspergillosis (code range)
B48.4 Peniciliosis
D80.3 Selective deficiency of immunoglobulin G (IgG) subclasses
D82.0 Wiskott-Aldrich syndrome
H10.411-H10.419 Chronic giant papillary conjunctivitis (code range)
H10.45 Other chronic allergic conjunctivitis
J30.0 Vasomotor rhinitis
J30.1-J30.9 Allergic rhinitis (code range)
J45.20-J45.909 Asthma (code range)
J45.998 Other asthma
L23.0-L23.9 Allergic contact dermatitis (code range)
L24.0-L24.9 Irritant contact dermatitis (code range)
L25.0-L25.9 Unspecified contact dermatitis (code range)
L27.0-L27.9 Dermatitis due to substances taken internally (code range)
L30.0 Nummular dermatitis
L30.2 Cutaneous autosensitization
L30.8 Other specified dermatitis
L30.9 Dermatitis, unspecified
L50.0 Allergic urticaria
L50.3 Dermatographic urticaria
T36.0x5A-T50.Z95A Poisoning by, adverse effects of & underdosing of drugs meds & biological substances (code range)
T63.001A-T63.94A Toxic effect of contact with venemous animals and plants (code range)
T65.811A-T65.814A Toxic effect of latex (code range)
T78.00XA-T78.09XA Anaphylactic reaction (code range)
T88.2xxA Anaphylactic shock, unspecified, initial encounter
T88.3xxA Angioneurotic edema, initial encounter
T88.40XA Allergy, unspecified, initial encounter
T88.41xA Arthus phenomenon, initial encounter
T88.49xA Other allergy, initial encounter
T88.52XA Failed moderate sedation during procedure, initial encounter
T88.59xA Other complications of anesthesia, initial encounter
T88.6XXA Anaphylactic reaction due to adverse effect of correct drug or medicament properly administered, initial encounter
Z91.010-Z91.09 Allergy status other than drugs & biologicals (code range)
REFERENCES:

*American Academy of Allergy, Asthma and Immunology. Allergy diagnosis in clinical practice. Archived Working Group report. 2006 Dec


Peters AT, et al; Joint Task Force on Practice Parameters, representing the American Academy of Allergy, Asthma and Immunology, the American College of Allergy, Asthma and Immunology, and the Joint Council of Allergy, Asthma and Immunology. Diagnosis and management of rhinosinusitis: a practice parameter update. Ann Allergy Asthma Immunol 2014 Oct;113(4):347-85.


*key article

**KEY WORDS:** Allergy tests: Allergen specific IgE, Allergen specific IgG, Challenge, Cytotoxic, Dipstick, Disk, Intracutaneous, Intradermal, Leukocyte histamine release, Mucous membrane, Paddle, Percutaneous, Phadiatop, Prick, Provocation-neutralization, RAST, Rinkel, Scratch, Serial endpoint titration, Skin test.

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**CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS**

There is currently a National Coverage Determination (NCD) addressing Food Allergy Testing and Treatment and a Local Coverage Determination (LCD) addressing RAST Type Tests. Please refer to the following websites for Medicare Members:

NCD: [https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=266&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Upstate&KeyWord=allergy+testing&KeyWordLookUp=Title&KeyWordSearchType=And&ncd_id=110.11&ncd_version=1&basket=ncd%25253A110%25252E11%2525253A1%2525253AFood+Allergy+Testing+and+Treatment&bc=gAAAA BAAAAA&](https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=266&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Upstate&KeyWord=allergy+testing&KeyWordLookUp=Title&KeyWordSearchType=And&ncd_id=110.11&ncd_version=1&basket=ncd%25253A110%25252E11%2525253A1%2525253AFood+Allergy+Testing+and+Treatment&bc=gAAAA BAAAAA&)

LCD: [Proprietary Information of Excellus Health Plan, Inc.](#)