Clinical Policy: Allergy Testing

Reference Number: WNC.CP.220 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

This policy describes the medical necessity criteria for Allergy Testing.

Definitions

A. Immunoglobulin E (IGE) Antibody
Immunoglobulin E Antibodies is a type of protein in the body. As part of the immune system, the IGE Antibody plays a role in allergic reactions by causing symptoms in the body, commonly the nose, throat, lungs, and skin.

B. Serological Testing (In Vitro)
Serological testing occurs outside of a living organism such as a test tube and laboratory. These are blood tests to detect the presence of antibodies against a microorganism or potential allergen and can determine if individuals have been exposed to a particular allergen.

C. Testing (In Vivo)
Skin testing occurs within a living organism. These tests rely on the reactivity and sensitivity to exposure of specific allergens through various percutaneous and intradermal routes to identify allergic reactions.

Policy/Criteria[1]

I. WellCare of North Carolina® **shall cover** allergy testing when the member meets the following specific criteria:

A. The physician or qualified non-physician practitioner completes **ALL** of the following requirements, prior to performing the allergy test:
1. Completes a medical and immunologic history, along with a physical exam;
2. Determines, upon completion of the history and physical exam, **ONE** of the following:
   a. That the signs and symptoms are suggestive of an allergy; **OR**
   b. A diagnosis indicates an allergy, such as asthma.
3. Establishes reasonable probability of exposure in the member's environment;
4. Documents in the health record that symptoms are not controllable by empiric conservative therapy;
5. Documents in the health record all tried and failed allergy treatments;

6. Selects the appropriate allergy test with proven efficacy published in peer reviewed literature; **AND**
7. Orders the allergy test based on findings from (1) through (6) above, that document and appropriately support the antigen being used for testing.

B. After all requirements in Criteria I.A. are met, the physician or qualified non-physician practitioner performs the appropriate allergy test from the list below:
1. Direct skin testing (for immediate hypersensitivity):
   a. Percutaneous or epicutaneous (scratch, prick, or puncture);
   b. Intradermal;
2. Patch or application test;
3. Photo patch test;
4. Photo test;
5. Bronchial challenge testing;
6. Ingestion (oral) challenge test; **AND**
7. **S**pecific IgE in vitro tests for inhalant allergens (pollens, molds, dust mites, and animal dander), foods, insect stings, and drugs.
   a. Tests can be performed by a clinical laboratory

II. WellCare of North Carolina® **shall not** cover investigational allergy tests including:
- **A.** Leukocyte histamine release;
- **B.** Rebuck skin window;
- **C.** Prausnitz-Kustner test;
- **D.** Cytotoxic food testing (leukocytotoxic test, Bryans test);
- **E.** Conjunctival challenge testing (ophthalmic mucous membrane test);
- **F.** Nasal challenge (provocative) test;
- **G.** Kinesiology testing;
- **H.** Provocation-neutralization testing; or
- **I.** Electrodermal testing.

Background[1]

The term “allergy” indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances are called "allergens.” When an allergic individual comes in contact with an allergen, the immune system mounts a response through the immunoglobulin E (IgE) antibody.

Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as by localized reactions in any organ system of the body. The reaction may be acute, subacute or chronic, immediate or delayed and may be caused by numerous offending agents including pollen, molds, foods, and drugs.

The management of an allergy or hypersensitivity may include identifying the offending substance (allergen) by means of various testing methods. Immunoglobulin E (IgE)-mediated allergy testing is evaluated by measuring allergen-specific IgE. This can be done through skin

testing (in vivo) testing or with serological tests (in vitro). Allergy testing includes the performance, evaluation, and reading of the tests.

It is important to note that skin prick tests, and tests that measure total serum levels of IgE or allergen specific IgE, only detect the presence of allergic sensitization. They do not, by themselves, make a diagnosis of allergy. For instance, almost one-half of the U.S. population has detectable allergen specific IgE against a food allergen, but the overall prevalence of clinical food allergy is only about 4 to 6 percent.

Treatment options for allergies are avoidance of the allergen, pharmacological therapy, and immunotherapy.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description	Testing Limitations
86003	Allergen specific IgE; quantitative or semiquantitative, crude allergen extract, each	30 units per 365 calendar days
86005	Allergen specific IgE; qualitative, multiallergen screen	2 units per day up to 30 allergens per 365 calendar days
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report	80 units per 365 calendar days
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	30 units per date of service
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	19 units per date of service
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report	30 units per 365 calendar days
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report	20 units per 365 calendar days
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading	20 units per 365 calendar days

CPT®* Codes	Description	Testing Limitations
95044	Patch or application test(s)	80 units per 365 calendar days
95052	Photo patch test(s)	36 units per date of service
95056	Photo tests	1 unit per date of service
95070	Inhalation bronchial challenge testing (not including necessary pulmonary function tests), with histamine, methacholine, or similar compounds	1 unit per date of service
95076	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug or other substance); initial 120 minutes of testing	2 units per date of service
95079	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug or other substance); each additional 60 minutes of testing	2 units per date of service

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	04/21	05/21
Reviewed CPT codes.	08/21	11/21
Reviewed CPT codes.	07/22	08/22
CPT 95071 added	08/22	08/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23
Annual Review.	08/23	08/23
Annual Review. Removed HCPCS and ICD-10 code tables.	05/24	05/24
Added definitions for: Immunoglobulin antibody, In Vivo Testing and In Vitro Testing.Criteria I.A. Moved part of (5) to create (7) for clarity; g. Orders the allergy test based on findings from (1) through (6) above, that document and appropriately support the antigen being used for testing. Removed from 7 & added as 3. "Establishes reasonable probability of exposure in the member's environment;" and 4. Orders the allergy test based on findings from (a) through (f) above, that document and appropriately support the antigen being used for testing. Unit limitations changed for the following CPT codes: 86003 changed 36 to 30U/365 days. 86005 added 2U/day up to 30 allergens/365 days. 95004 changed 75 to 80U/365 days. 95024 changed 20 to 30U/365 days. 95027 & 95028 changed per year to per 365 calendar days. 95044 changed 36 to 80U/365 days. 95052 added 36U/date of service. 95056 added 1U/date of service. 95076 changed 1 to 2U/date of service.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1N-1 Allergy Testing. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published July 1, 2024. Accessed July 12, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System

(HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan
g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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