BLUE CROSS OF NORTHEASTERN PA "BCNEPA" MEDICAL POLICY BULLETIN	**MANUAL:** MEDICAL POLICY
	REFERENCE NO.: MPO-490-0012
EFFECTIVE DATE August 1, 2014	**SUBJECT:** Allergy Testing

Blue Cross of Northeastern Pennsylvania ("BCNEPA") Medical Policy

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical policy and claims payment policy are applied. Policies are provided for informational purposes only and are developed to assist in administering plan benefits and do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment. Policies are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and information are constantly changing and BCNEPA may review and revise its medical policies periodically. Also, due to the rapid pace of changing technology and the advent of new medical procedures, BCNEPA may not have a policy to address every procedure. In those cases, BCNEPA may review other sources of information including, but not limited to, current medical literature and other medical resources, such as Technology Evaluation Center Assessments (TEC) published by the Blue Cross Blue Shield Association. BCNEPA may also consult with health care providers possessing particular expertise in the services at issue.

I. DESCRIPTION:

Allergy Testing is performed to determine a patient's sensitivity to particular allergies and is based on the findings during a complete history and physical examination of the patient.

Immunotherapy consists of the administration of slowly increasing quantities of antigen over a period of months, which is followed by a degree of tolerance to the antigen (as evidenced by the markedly higher doses than can be given) and a decline in the symptoms and medication requirements.

II. BENEFIT POLICY STATEMENT:

BCNEPA makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on product line, group or contract, therefore, Member benefits must be verified. In the event of a conflict between the Member's benefit plan document and topics addressed in Medical Policy Bulletins (i.e., specific contract exclusions), the Member's benefit plan document always supersedes the information in the Medical Policy Bulletins. BCNEPA determines medical necessity only if the benefit exists and no contract exclusions are applicable.

Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

III. MEDICAL POLICY STATEMENT:

Coverage is subject to the terms, conditions, and limitations of the member's contract.

Allergy Skin Testing

A. BCNEPA will provide coverage for allergy skin testing when medically necessary.

1. Direct skin testing (percutaneous and intracutaneous) may be considered medically necessary when used to diagnose allergic disorders and to guide treatment with immunotherapy.

2. The following allergy testing methods are considered not medically necessary:

a) Leukocyte histamine release test

b) Cytotoxic food testing

c) Provocative testing (e.g., Rinkel).

In Vitro Allergy Testing

B. BCNEPA will provide coverage for in vitro allergy testing when medically necessary.

1. The RAST (Radioallergosorbent Test), FAST (Fluoroallergosorbent Test), multiple antigen simultaneous test or ELISA (Enzyme-Linked Immunosorbent Assay) methods may be considered medically necessary under the following circumstances:

a) Direct skin testing is impossible due to an extensive dermatitis or marked dermographism.

b) Direct skin testing is contraindicated because of concomitant drug treatment (e.g., psychotropic drugs frequently have H1 blocking characteristics).

c) When there is difficulty in testing uncooperative patients (.e.g., small children or patients with mental or physical impairments.)

d) If direct skin testing has been inconclusive.

e) As adjunctive tests for allergic bronchopulmonary aspergillosis or parasitic disease.

2. ELISA/Act qualitative antibody testing and IgG ELISA, indirect method, are considered investigational.

IV. DEFINITIONS:

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 reactions may be acute, subacute, or chronic, immediate or delayed, and may be caused by numerous offending agents, such as pollen, molds, dust, mites, animal danders, stinging insect venoms, foods, drugs, etc.

Allergy Testing: Is performed to determine a patient's sensitivity to particular allergies and is based on the findings during a complete history and physical examination of the patient.

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.

IgE ELISA, Indirect Method: This is utilized to test IgG immune reaction in human blood serum.

Immunotherapy: Consists of the administration of slowly increasing quantities of antigen over a period of months, which is followed by a degree of tolerance to the antigen (as evidenced by the markedly higher doses than can be given) and a decline in the symptoms and medication requirements.

Intradermal Testing: Is considered to be a more sensitive but less specific testing method than percutaneous testing for the detection of IgE antibodies. The number of intradermal tests may also vary from patient to patient.

Percutaneous and Intracutaneous (intradermal) Testing: The number of tests required may vary widely from patient to patient, depending upon the patient's history. Rarely are more than 40 Percutaneous or 20 intracutaneous tests required.

Specialist: Includes allergist and ENT physicians.

Specific IgE In Vitro tests (RAST, MAST, FAST, and ELISA): These tests detect antigen-specific IgE antibodies in the patient's serum. They may be considered medically necessary only when testing for: inhalant allergens (pollens, molds, dust, mites, animal danders), foods, insect stings, and other allergens such as drugs, when direct skin testing is impossible due to extensive dermatitis, marked dermatographism; or in children less than four years of age.

V. CODING:

The five character codes included in the **Blue Cross of Northeastern Pennsylvania's Medical Policy** are obtained from Current Procedural Terminology (CPT*), copyright 2013 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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- **The identification of a code in this section does not denote coverage or separate reimbursement.**
- Covered procedure codes are dependent upon meeting criteria of the policy and appropriate diagnosis code.
- The following list of codes may not be all-inclusive, and are subject to change at any time.
- Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

PROCEDURE CODES

82785	95018	95071	95131	95148
86001	95024	95076	95132	95149
86003	95027	95079	95133	95165
86005	95028	95115	95134	95170
86343	95044	95117	95144	95180
86849	95052	95120	95145	95199
95004	95056	95125	95146	
95017	95070	95130	95147	