Title: Allergy Testing	Division: Medical Management Department: Utilization Management
Approval Date: 4/6/18	LOB: Medicaid, Medicare, FIDA, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP
Effective Date: 4/6/18	Policy Number: UM-MP231
Review Date: 4/6/19	Cross Reference Number:
Retired Date:	Page 1 of 4

1. POLICY DESCRIPTION:

In accordance with NYS Medicaid's conditions of coverage for allergy testing, Metroplus Health Plan will implement quantity limitations on all reimbursable allergy testing CPT codes. Coverage criteria will also be implemented to ensure appropriateness of use for all requests exceeding the plans' limitations.

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claims Department, Provider Contracting.

3. POLICY:

A. Metroplus will cover Allergy Testing with the following quantity limitations before authorization is required:

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,	40

	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	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
86001	Allergen specific IgG quantitative and semiquantitative, each allergen	30
86003	Allergen specific IgE; quantative or semiquantative, each allergen	30
86005	Allergen specific IgG quantitative and semiquantitative, qualitative, multiallergen screen(dipstick, paddle or disk)	30

B. After these quantity limits have been exhausted, the following conditions of coverage must be met for additional tests to be approved. Metroplus will not cover allergy test requests of previously administered tests and will approve at maximum, one additional quantity limit exception within the 5 year period.

a. Allergy testing in vitro/in vivo will only be covered for the following conditions up to the limits specified in the Limitations/Exclusions section:
   i. Suspected food allergies
   ii. Suspected stinging insect allergies
   iii. Chronic rhinitis or conjunctivitis where the cause is suspected environmental allergies and the patient has been nonresponsive to avoidance and pharmacologic therapy
   iv. Suspected medication allergy, when no alternative is available and treatment is medically necessary
   v. Suspected allergic dermatitis

AND

b. In vitro allergy testing should only be ordered for members who are unable to participate in traditional skin testing due to the following contraindications:
    i. Extensive skin condition such as psoriasis, severe eczema or symptomatic dermagraphism
    ii. Inability to discontinue medications such as antihistamines
    iii. Children 3 or younger

OR

c. Oral Ingestion Challenge testing
    i. Oral ingestion challenge testing may be medically necessary for the following situations:
        1. Foods/ingested substances when in vivo/ in vitro testing is inconclusive or inconsistent with clinical symptoms
        2. Oral medications when:
            a. Patient has a history of allergy to the medication AND
            b. There is no effective alternative or equivalent drug AND
            c. Patient requires treatment with the drug class
        3. Oral ingestion challenge testing should be utilized in a supervised allergy specialist setting with emergency support access.

References

1. New York Medicaid Update May 2016. New York State Medicaid Expansion of Allergy Testing.

REVISION LOG:

REVISIONS	DATE
Creation date	

Approved:	Date:	Approved:	Date:

Title: Allergy Testing	**Division: Medical Management** **Department: Utilization Management**
Approval Date: 4/6/18	**LOB: Medicaid, Medicare, FIDA, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP**
Effective Date: 4/6/18	**Policy Number: UM-MP231**
Review Date: 4/6/19	**Cross Reference Number:**
Retired Date:	**Page 4 of 4**

Sosler Bruce, MD Clinical Medical Director	Talya Schwartz, MD Chief Medical Officer

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.