Policy and Procedure

Title: Allergy Testing
Division: Medical Management
Department: Utilization Management

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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:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Description</th>
<th># of tests allowed per 5 year period</th>
</tr>
</thead>
<tbody>
<tr>
<td>95004</td>
<td>Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests</td>
<td>60</td>
</tr>
<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>60</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>
<td>60</td>
</tr>
<tr>
<td>95024</td>
<td>Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests</td>
<td>40</td>
</tr>
<tr>
<td>95027</td>
<td>Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens,</td>
<td>40</td>
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</tbody>
</table>
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; quantitative or semiquantitative, 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 dermatographism
   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
Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. 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.