Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:
Allergy Testing and Immunotherapy

Effective: April 11, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Allergy is a form of hypersensitivity or reactivity of the immune system to a particular external substance following exposure. This can occur in response to substances that are inhaled, swallowed, injected, or by contact with the skin or eyes. These substances can vary by individual, but common ones include dust, mold, animal dander and pollen.

Allergy testing can be broadly subdivided into two methodologies:

- In vivo testing – includes skin allergy testing (i.e., skin prick testing, skin scratch testing, intradermal testing, skin patch testing, and skin endpoint titration), bronchial provocation tests, and food challenges
- In vitro testing – identifies the presence of allergen-specific immunoglobulin E (IgE) in the blood serum. These tests may be used for inhalant allergens (e.g., pollen, mold, dander, or dust), foods, insect stings for younger children or when direct skin testing is impossible due to extensive dermatitis, or dermatographism or conditions where antihistamines cannot be stopped for skin testing, such as chronic hives.

Allergy immunotherapy is the process of administering progressively increasing doses of an allergen as treatment for a person who has demonstrated sensitivity through allergy testing. Immunotherapy for allergic diseases involves gradual administration and introduction of allergens to which the individual is sensitive to, for the purpose of modulating an immune response and alleviating allergic symptoms.

Clinical Guideline Coverage Criteria

Allergy Testing

The Plan considers allergy testing as reasonable and medically necessary when **ONE** following are met:

1. Percutaneous Tests when documentation confirms testing is required for reaction to **ONE** of the following:
    a. Inhalants; or
    b. Foods where individuals present signs or symptoms of urticaria, angioedema, eosinophilic esophagitis, or anaphylaxis after ingestion of specific foods; or
    c. Hymenoptera; or
    d. Specific drugs
2. Intracutaneous/Intradermal Tests when documentation confirms percutaneous tests are negative and there is suspected allergen sensitivity to **ONE** of the following:
    a. Inhalants; or
    b. Hymenoptera; or
    c. Specific drugs (e.g., penicillin, macromolecular agents); or
    d. Vaccines
3. Patch Tests when documentation confirms the test will be utilized to diagnose allergic contact dermatitis after **ONE** of the following exposures:
    a. Dermatitis due to detergents; or
    b. Oils and greases; or
    c. Solvents, drugs, and medicines in contact with skin; or
    d. Food in contact with skin; or
    e. Plants; or
    f. Cosmetics; or
    g. Metals or rubber additives
4. Photo Patch Testing to diagnose suspected allergies resulting from light exposure (e.g., photo-allergic contact dermatitis); or
5. Photo Tests to evaluate photo-sensitivity disorders; or
6. Delayed Hypersensitivity Skin Testing for allergen testing, testing for infection with intracellular pathogens, or testing for sensitivity to contact allergens; or
7. Ingestion (Oral) Challenge Test when documentation confirms **ONE** of the following:
    a. Food allergy dermatitis; or
    b. Anaphylactic shock due to adverse food reaction; or
    c. Allergy to medicinal agents; or
    d. Allergy to foods; or
8. Allergy has resolved or has been disproven; or
9. In Vitro Allergy Testing when skin testing is not possible, and documentation confirms **ANY** of the following criteria:
    a. Individual has a skin condition that will not make direct skin testing possible; or
    b. Individual requires continued use of H-1 blockers (antihistamines), or in the rare patient with persistent unexplained negative histamine control; or
    c. Individual cannot be safely withdrawn from medications that interfere with skin testing; or
    d. Testing is difficult due to mental or physical impairments; or
    e. To evaluate cross-reactivity between insect venoms (e.g., fire ant, bee, wasp, yellow jacket, hornet) ; or
    f. To utilize for adjunctive laboratory testing for disease activity of allergic bronchopulmonary aspergillosis and certain parasitic disease; or
    g. To diagnose atopy in small children; or
    h. Individual is at increased risk for anaphylactic response from skin testing based on clinical history; or who has a history of a previous systemic reaction to skin testing; or
    i. Skin testing was inconclusive and in vitro testing is required as a confirmatory test.

Exclusions: The Plan considers allergen testing as not medically necessary for all other indications. In addition, The Plan does not cover:

1. Serum IgG testing or IgG subclass testing for any specific allergens
2. IgE testing at home

Allergen Immunotherapy

1. The Plan considers allergen immunotherapy as reasonable and medically necessary when administered under the supervision of an appropriately trained physician and when documentation confirms **ONE** of the following:
2. Diagnosis of Allergic Asthma, Allergic Conjunctivitis, Allergic Rhinitis, or Stinging Insect Hypersensitivity when ALL of the following are met:

a. Results of allergy testing show immediate hypersensitivity to skin tests or in vitro tests for specific immunoglobulin E (IgE); and
b. Contraindication to or failed maintenance by pharmacologic therapy; and
c. Individual's treatment plan, dosage and immunotherapy schedule, antigens to be administered, and target maintenance dose for allergy immunotherapy.

3. Stinging Insect Immunotherapy when the following are met:
   a. Diagnosis of systemic reaction to an insect sting and who have specific IgE to venom allergens.
4. Allergy Immunotherapy for the **ONE** of the following
   a. Animal dander sensitivity (epidermal) when documentation confirms antihistamines do not relieve symptoms; or
   b. Standardized dust mite extracts or perennial allergens such as cat and dog danger and cockroach; or
   c. Environmental allergens (e.g., pollen, mold); or
   d. Delayed systemic reactions with symptoms of anaphylaxis with a positive skin test or presence of venom specific IgE; or
   e. Rapid desensitization for cases of allergy to insulin, penicillin, sulfonamides, cephalosporins and other commonly used drugs

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes – Allergy Testing Codes

Code	Description
82785	Gammaglobulin (immunoglobulin); IgE
86003	Allergen specific IgE; quantitative or semiquantitative, crude allergen extract, each
86008	Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
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
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
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
95044	Patch or application test(s) (specify number of tests)
95052	Photo patch test(s) (specify number of tests)
95056	Photo tests
95070	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds
95076	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug or other substance); initial 120 minutes of testing
95079	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug or other substance); each additional 60 minutes of testing

Table 2: CPT/HCPCS Codes – Allergy Immunotherapy Codes

Codes	Description
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections

95144	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)
95145	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom
95146	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms
95147	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms
95148	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms
95149	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms
95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)
95170	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)
95180	Rapid desensitization procedure, each hour (e.g., insulin, penicillin, equine serum)

List of Medically Necessary ICD-10 Codes – Allergy Testing

List of Medically Necessary ICD-10 Codes – Allergy Immunotherapy

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Approval And Revision History

December 1, 2022: Reviewed by the Medical Policy Approval Committee (MPAC) for integration between Harvard Pilgrim Health Care and Tufts Health Plan for effective date June 1, 2023. Medical necessity edit established for Tufts Health Plan, criteria and limitations clarified.

Subsequent endorsement date(s) and changes made:

- October 18, 2023: Reviewed by MPAC; renewed without changes; template updated
- November 2023: Rebranded Unify to One Care effective January 1, 2024

- May 15, 2024: Reviewed by MPAC, criteria updated regarding Allergen Immunotherapy for Stinging Insects and environmental allergens effective July 1, 2024
- March 19, 2025: Reviewed by MPAC. Clarified criterion Allergy Testing, 1.d. by removing examples of drugs, effective April 11, 2025

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.