Allergy Testing and Injections

Policy Number: BIP004.M
Effective Date: January 1, 2025

➲ Instructions for Use

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Related Benefit Interpretation Policy

- Physician Services: Primary Care and Specialist Visits

Federal/State Mandated Regulations

None

State Market Plan Enhancements

Members may have benefits for Allergy serum (injectable allergen/antigen extract). Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) or contact the Customer Service Department to determine coverage eligibility.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

- **Allergy Serum**: Allergy serum, as well as needles, syringes, and other supplies for the administration of the serum, are covered for the treatment of allergies. Allergy serum, needles, and syringes must be obtained through a UnitedHealthcare network provider.
- **Allergy Testing and Treatment**: Services and supplies are covered, including antigen testing, to determine appropriate allergy treatment. Services and supplies for the treatment of allergies, including allergen/antigen immunotherapy, are covered according to an established treatment plan.
- Examples of covered allergy testing and treatments include but are not limited to:
  Allergy Testing
  - Provocative antigen testing to determine appropriate allergy treatment
  - Allergy testing may include complete blood count (CBC) with differential (e.g., eosinophil count)
  - When respiratory symptoms are present, allergy testing may also include a chest X-ray
  - Additional testing, as indicated, includes but is not limited to:
    - Skin testing
    - Total gamma globulins
  - Radioallergosorbent test (RAST) only if skin testing is unsuccessful and/or the member is unable to tolerate skin testing due to an already existing skin condition

Refer to the Benefit Interpretation Policy titled Physician Services: Primary Care and Specialist Visits.

Not Covered

Examples of non-covered tests/services include but are not limited to:

- Cytotoxicity testing/Bryan's test
- Urine auto-injection
- Skin end point titration/Rinkel method

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
01/01/2025	All	**Covered Benefits** • Revised list of examples of covered allergy testing and treatments: ***Complete Blood Count (CBC) With Differential Test*** ○ Removed: ▪ IgE level ▪ Smear of nasal secretions ***Additional Testing*** ○ Removed: ▪ Sputum exam ▪ Paranasal sinus X-ray **Supporting Information** • Archived previous policy version BIP004.L

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.