

Allergy Testing and Injections

Policy Number: BIP003.K
Effective Date: January 1, 2022

[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, including 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 Physician.
- Allergy Testing and Treatment: Services and supplies are covered, including provocative antigen testing, to determine appropriate Allergy Treatment. Services and supplies for the Treatment of Allergies, including allergen/antigen immunotherapy and serum, 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, IgE level, smear of nasal secretions).
 - 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
 - Sputum exam
 - Paranasal sinus X-ray

- 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	Summary of Changes
01/01/2022	<ul style="list-style-type: none">● Routine review; no change to benefit coverage guidelines● Archived previous policy version BIP003.J

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.