Allergy Testing and Injections

Policy Number: BIP003.N
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, 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)
  - 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	Summary of Changes
01/01/2025	**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 BIP003.M

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.