Clinical Policy: Allergy Testing and Therapy

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Description
Allergy testing is performed to determine immunologic sensitivity or reaction to antigens for the purpose of identifying the cause of the allergic state. This policy addresses immediate (IgE-mediated) hypersensitivity and delayed (cell-mediated) hypersensitivity. Allergen immunotherapy is the repeated administration of specific allergens to patients with IgE-mediated conditions, for the purpose of providing protection against the allergic symptoms and inflammatory reactions associated with exposure to these allergens.

Please note: unit limitations for allergy testing and treatment are based on state specific guidelines (defined in the provider fee schedule). In the absence of state-specific rules, the CMS Medicaid/Medicare NCCI MUE limitations are applied.

Policy/Criteria

I. It is the policy of PA Health & Wellness that allergy testing is **medically necessary** for members with clinically significant allergic symptoms and the following indications:
- **A.** As part of a complete diagnostic evaluation by a licensed practitioner acting within their scope of practice to perform allergy and immunology services;
- **B.** Antigens include only those that are reasonably possible for the member to be exposed to;
- **C.** Chosen test and units allowed per year are as follows:
  1. *Percutaneous* testing (also called "scratch testing;" CPT 95004, 95017, 95018) for offending allergens such as pollen, molds, mites, dust, feathers, animal fur or dander, venoms, foods, or drugs.
  2. *Intracutaneous* (intradermal), *sequential and incremental testing* (CPT 95024, 95027, 95028) when percutaneous tests are negative;
  3. *Skin endpoint titration* (95027) for determining the starting dose for immunotherapy for members highly allergic to an inhalant allergen or hymenoptera venom allergy (insect stings);
  4. *In vitro testing* (CPT 86003, 86005);
  5. *Patch testing* (CPT 95044);
  6. If photo patch test(s) (CPT 95052) are performed (same antigen/same session) with patch or application test(s) (CPT 95044), only the photo patch tests should be reported;
  7. If photo tests (CPT 95056) are performed with patch or application test(s) (CPT 95044), only the photo tests should be reported.

II. It is the policy of PA Health & Wellness that allergy immunotherapy administered in a medical facility is **medically necessary** when meeting all of the following indications:
- **A.** Positive skin test or serologic evidence of an IgE-mediated antibody for allergens which cause any of the following:
  1. Allergic (extrinsic) asthma,
  2. Dust mite atopic dermatitis,
  3. Hymenoptera (bees, hornets, wasps, fire ants) allergic reactions,

4. Mold-induced allergic rhinitis,
5. Perennial allergic rhinitis,
6. Seasonal allergic rhinitis or conjunctivitis;

B. Symptoms of allergic rhinitis or asthma after natural exposure to the allergen; or a life-threatening allergy to insect stings (bees, hornets, wasps, and fire ants);

C. Avoidance or pharmacologic therapy does not control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

D. If rapid desensitization/rush immunotherapy is requested, it is only medically necessary for medication or hymenoptera (bees, hornets, wasps, fire ants) sensitivities;

E. Antigens are prepared by an allergist, immunologist, or otolaryngologist who has examined the patient.

III. It is the policy of PA Health & Wellness that the following are considered **not medically necessary** because safety or effectiveness have not been established:

A. Testing for the following antigens:

1. Newsprint
2. Tobacco smoke
3. Dandelion
4. Orris root
5. Phenol
6. Alcohol
7. Sugar
8. Yeast
9. Grain mill dust
10. Soybean dust (except when the patient has a known exposure to soybean dust such as a food processing plant)
11. Wool (unless patient has history of continuous exposure to sheep or unprocessed wool)
12. Marigold
13. Honeysuckle
14. Fiberglass
15. Green tea
16. Chalk.

B. The following tests for the evaluation allergic reactions:

1. Antigen leukocyte cellular antibody (ALCAT) automated food allergy testing
2. Applied kinesiology or Nambudripad's allergy elimination test (NAET (i.e., muscle strength testing or measurement after allergen ingestion)
3. Candidiasis test
4. Chemical analysis of body tissues (e.g., hair)
5. Chlorinated pesticides (serum)
6. Complement (total or components)
7. C-reactive protein
8. Cytokine and cytokine receptor assay

9. Cytotoxic testing for food, environmental or clinical ecological allergy testing (Bryans Test, ACT)
10. Electrodermal testing or electro-acupuncture
11. ELISA/Act qualitative antibody testing
12. Food immune complex assay (FICA)
13. Immune complex assay
14. Ingestion challenge food testing for diagnosing rheumatoid arthritis, depression, or respiratory disorders not associated with anaphylaxis or similar systemic reactions
15. In vitro metal allergy testing
16. Iridology
17. Leukocyte histamine release test (LHRT)/basophil histamine release test
18. Lymphocyte function assay
19. Lymphocytes (B or T subsets)
20. Lymphocyte Response Assay (LRA) by ELISA/ACT and Lymphocyte Mitogen Response Assays (LMRA) by ELISA/Act
21. Mediator release test (MRT)
22. Ophthalmic mucus membrane tests/conjunctival challenge test
23. Prausnitz-Kustner (P-K testing) passive cutaneous transfer test
24. Provocative and neutralization testing and neutralization therapy (sublingual, intracutaneous and subcutaneous) also referred to as the Rinkel Test, for food allergies, inhalants, and environmental chemicals because available evidence does not show these tests and therapies are effective.
25. Provocative nasal test
26. Pulse test (pulse response test, reaginic pulse test)
27. Rebuck skin window test
28. Sage Complement Antigen Test
29. Testing for multiple chemical sensitivity syndrome (a.k.a., idiopathic environmental intolerance [IEI], clinical ecological illness, clinical ecology, environmental illness, chemical AIDS, environmental/chemical hypersensitivity disease, total allergy syndrome, cerebral allergy, 20th century disease)
30. Testing of specific immunoglobulin G (IgG) (e.g., by Radioallergosorbent [RAST] or Enzyme-linked immunosorbent assay [ELISA])
31. Testing of total serum IgG, immunoglobulin A (IgA) and immunoglobulin M (IgM)

C. The following services in relation to allergy testing and immunotherapy:

1. Desensitization with commercially available extracts of poison ivy, poison oak, or poison sumac
2. Desensitization for hymenoptera sensitivity using whole body extracts, with the exception of venom extracts and fire ant extracts
3. Desensitization with bacterial vaccine (BAC: bacterial, antigen complex, streptococcus vaccine, staphylo/strepto vaccine, serobacterin, staphylococcus phage lysate)
4. Food allergenic extract immunotherapy
5. Intracutaneous desensitization (Rinkel Injection Therapy, RIT)
6. Neutralization therapy (intradermal and subcutaneous)

7. Repository emulsion therapy
8. Sublingual provocative therapy
9. Urine autoinjection (autogenous urine immunotherapy)
10. Allergen immunotherapy for the management of skin and mucous membrane disease such as urticaria, and Candida vulvovaginitis
11. Home administration of allergy immunotherapy
12. Ingestion challenge food testing performed by the patient in the home
13. Intradermal testing for food allergies
14. Food allergen testing for patients who present with gastrointestinal symptoms suggestive of food intolerance;
15. Rush immunotherapy for inhalant allergens.

Limitations

Allergy Testing

- Retesting with the same antigen(s) should rarely be necessary within a 3-year period. Exceptions include young children with negative skin tests or older children and adults with negative skin tests in the face of persistent symptoms;
- Routine repetition of skin tests is not indicated (e.g., annually);
- Measurements of total IgE levels (CPT code 82785-Gammaglobulin [immunoglobulin]; IgE) are not appropriate for most general allergies for the purpose of identifying the cause of the allergic state. Total serum IgE levels should not be billed unless evidence exists for allergic bronchopulmonary Aspergillosis (ABPA), select immunodeficiencies, such as the syndrome of hyper-IgE, eczematous dermatitis, atopic dermatitis in children and recurrent pyogenic infections, or in the evaluation for omalizumab therapy.
- Serial, repeat testing of total IgE will be subject to medical review.

Documentation Requirements

Medical record documentation (e.g., history & physical, office/progress notes, procedure report, test results) must include the following information:

- A complete medical and immunologic history and appropriate physical exam obtained by face-to-face contact with the patient;
- The medical necessity for performing the test;
- The test methodology used;
- The measurement (in mm) of reaction sizes of both wheal and erythema response (in vivo testing);
- The quantitative result (in kIU/L) for specific IgE testing (in vitro testing);
- The interpretation of the test results and how the results of the test will be used in the patient's plan of care.
- Periodic clinical evaluation of treatment benefits and, if no benefit within 12-24 months, other treatment options which should be considered.
- Clinical re-evaluation at 3 to 5 years to determine need for continuing immunotherapy.

Background

Allergy Testing

CLINICAL POLICY
Allergy Testing and Immunotherapy

Allergy is a form of exaggerated sensitivity or hypersensitivity to a substance that is either inhaled, ingested, injected, or comes in contact with the skin or eye. The term allergy is used to describe situations where hypersensitivity results from heightened or altered reactivity of the immune system in response to external substances. Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as localized reactions in any part of the body. The reactions may be acute, subacute, or chronic; immediate or delayed, and may be caused by a variety of offending agents (e.g., pollen, molds, mites, dust, feathers, animal fur or dander, venoms, foods, drugs). Allergy testing is performed to determine a patient's immunologic sensitivity or reaction to particular allergens for the purpose of identifying the cause of the allergic state.

Allergy testing must be a part of a complete diagnostic evaluation by a physician with specialized training in allergy and immunotherapy. A complete medical and immunologic history and appropriate physical examination must be done prior to performing diagnostic testing. The testing must be performed based on this history and a physical exam, which documents that the antigens being used for testing exist with a reasonable probability of exposure in the patient's environment. The number of tests performed must be judicious and related to the history, physical findings, and clinical judgment specific to each individual.

In vivo immunologic tests have been shown to be reliable and valid diagnostic tools and include skin tests with standardized allergenic extracts by prick/puncture (percutaneous) and intradermal (intracutaneous) techniques, photo and patch testing, inhalation bronchial challenge testing, and ingestion challenge testing. Percutaneous testing remains the test of choice in most clinical situations where immediate hypersensitivity reactions are suspected. Percutaneous tests require medical supervision, since there is a small but significant risk of anaphylaxis. Overall, skin testing is quick, safe, and cost-effective.

Intradermal tests are usually performed when increased sensitivity is needed when percutaneous tests (CPT codes 95004, 95017, 95018) are negative and there is still a strong suspicion of allergen sensitivity. For intradermal testing, the clinician should narrow the area of investigation so that the minimal number of skin tests necessary for diagnosis is performed. Intradermal testing is appropriate when IgE-mediated reactions occur to inhalants, hymenoptera (insect stings), and specific drugs, such as penicillins and macroglobular agents. The usual testing program may include two concentrations of an extract: a weaker concentration and a stronger concentration. It would not be expected that three or more concentrations of one extract would be necessary. Skin end-point dilution testing is a variant of intradermal testing that analyzes the highest dilution of a substance that produces a reaction, and may be used to determine the starting dose(s) of allergen immunotherapy.

Delayed hypersensitivity skin testing measures the presence of activated T cells that recognize a certain substance. It has been commonly used in three ways: anergy testing, testing for infection with intracellular pathogens, and testing for sensitivity to contact allergens. Accurate testing for contact allergy requires careful attention to technique, and limitation of testing to the specific allergens known to be associated with a contact reaction.

Other skin tests include photo testing and patch testing. Photo testing is skin irradiation with a specific range of ultraviolet light. Photo tests are performed for the evaluation of photosensitivity disorders. Patch testing is indicated to evaluate a nonspecific dermatitis, allergic contact dermatitis, pruritus, and other dermatitis to determine the causative antigen. Photo Patch testing uses two patches, with one of them being irradiated with ultraviolet light half way through the occlusive period. It is indicated to evaluate unique allergies resulting from light exposure.

Inhalation bronchial challenge testing involves the inhalation of agents that can trigger respiratory responses. The agents include drugs that cause airway constriction, antigens and chemical sensitizers, usually related to occupational breathing problems. Generally, three measures of each determination (e.g., spirometry, prolonged post exposure evaluation of bronchospasm) are performed. The best of the three is accepted and represents one unit of service. A unit is defined as each set of three measurements.

Ingestion challenge test involves the administration of sequentially or incrementally larger doses of the test item. The test items may include food or antibiotics. The service is allowed once per patient encounter, regardless of the number of items tested, and includes evaluation of the patient's response to the test items.

Quantitative or semi-quantitative in vitro allergen specific IgE testing includes radioallergosorbent test (RAST), multiple radioallergosorbent tests (MAST), fluorescent allergosorbent test (FAST), enzyme-linked immunosorbent assay (ELISA) and ImmunoCAP. These tests detect specific IgE antibodies in the patient's blood serum. In vitro testing (CPT codes 86003 and 86005) is appropriate under conditions where skin testing is not possible or is not reliable. Examples of indications for in vitro testing include:

- Severe dermatographism, ichthyosis or generalized eczema;
- Increased risk for anaphylactic response to skin testing based on clinical history (e.g., when an unusual allergen is not available as a licensed skin test extract);
- Inability to discontinue long-acting antihistamines, tricyclic antidepressants, or medications that may put the patient at undue risk if they are discontinued long enough to perform skin tests;
- Those with mental or physical impairments who are uncooperative;
- History is highly suggestive of an allergy and skin testing is negative or equivocal; or
- Evaluation of cross-reactivity between insect venoms.

Total serum IgE concentration testing is not indicated in all allergic patients, but should be reserved for those patients suspected of having allergic bronchopulmonary aspergillosis, immune deficiency disease (e.g., Wiskott-Aldrich syndrome, hyper-IgE staphylococcal abscess syndrome), IgE myeloma or pemphigoid, or for consideration of Xolair (omalizumab) administration in patients with moderate to severe asthma.

Allergen Immunotherapy

Allergen immunotherapy is effective for pollen, mold, animal allergens, cockroach, and dust mite. Immunotherapy is indicated for patients who show evidence of specific IgE antibodies to clinically relevant allergens and whose allergic symptoms warrant the time and risk of allergen

immunotherapy. This includes those with allergic asthma, allergic conjunctivitis, allergic rhinitis, or stinging insect hypersensitivity depending on the results of allergy testing (immediate hypersensitivity skin tests or in vitro tests for specific IgE). Initiating allergen immunotherapy may depend on the degree to which symptoms can be reduced by medication, the amount and type of medication required to control symptoms, and whether appropriate avoidance is possible.

There is limited data showing effectiveness in atopic dermatitis when this condition is associated with aeroallergen sensitivity. Immunotherapy should not be given to patients with negative results for specific IgE antibodies or those with positive test results for specific IgE antibodies that do not correlate with suspected triggers, clinical symptoms, or exposure.

Venom immunotherapy is indicated for patients who have anaphylaxis after an insect sting and a positive skin test or other documented IgE sensitivity to specific insect venom. Patients with delayed systemic reactions with symptoms of anaphylaxis or serum sickness and with a positive skin test or presence of venom specific IgE by in vitro testing are also recommended for treatment.

Rapid desensitization is indicated in cases of allergy to insulin, penicillin and horse serum, as well as sulfonamides, cephalosporins and other commonly used drugs. In patients with a positive history of reaction and with documented skin test reactivity, every effort should be made to avoid the use of these substances. When circumstances require the use of one of these substances, the patient will have to be desensitized. Full-dose therapy should be initiated immediately after reactions (treated and controlled), requiring strict physician monitoring in a setting with continuous monitoring of vital signs and cardio-respiratory status. In most cases, this can be performed in a physician's office if a physician trained to treat anaphylaxis is physically present for the entire duration. In cases where the initial reaction was severe, desensitization should be performed in the ambulatory care department of a hospital.

Desensitization may need to be repeated if future circumstances require an additional course of the offending allergen. Rapid desensitization in the form of rush immunotherapy may also be appropriate for hymenoptera venom (bees, hornets, wasps, fire ants), according to a recent American Academy of Allery, Asthma & Immunology practice parameter.

Treatment Schedules

The starting dose of an allergenic extract and the progression of the dose must be individualized for each patient. The immunotherapy build-up schedule entails administration of gradually increasing doses during a period of approximately 14 to 28 weeks. In conventional schedules a single dose increase is given on each visit, and the visit frequency can vary from 1 to 3 times a week. Accelerated schedules such as rush or cluster immunotherapy entail administration of several injections at increasing doses on a single visit. Accelerated schedules offer the advantage of achieving the therapeutic dose earlier but might be associated with increased risk of systemic reaction in some patients.

Length of Therapy

CLINICAL POLICY
Allergy Testing and Immunotherapy

The duration of all forms of immunotherapy must be individualized. A presumption of failure can be made when, after 12-24 months of therapy, a person does not experience a noticeable decrease of symptoms, an increase in tolerance to the offending allergen and a reduction in medication usage. Treatment will not be reimbursed after a 2-year period when there is no apparent clinical benefit.

The major risk of allergen immunotherapy is anaphylaxis. Allergen immunotherapy should, therefore, be administered under the supervision of an appropriately trained physician who can recognize early symptoms and signs of anaphylaxis and administer emergency medications where necessary. In addition, immunotherapy should be administered only in facilities equipped to treat anaphylaxis.

Evaluation and management codes are separately reimbursable on the same day as allergen immunotherapy only when a significant, separately identifiable service is performed.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Code Table 1: Procedure codes considered medically necessary

CPT* Codes	Description
86003	Allergen specific IgE; quantitative or semiquantitative, each allergen
86005	Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle, or disk)
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

CPT* Codes	Description
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
95071	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with antigens or gases, specify
95076	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing
95079	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (list separately in addition to code for primary procedure)
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)

CPT* Codes	Description
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 (eg, insulin, penicillin, equine serum)
95199	Unlisted allergy/clinical immunologic service or procedure

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CPT Code Table 2: Procedure codes considered not medically necessary

CPT®* Codes	Description
95060	Ophthalmic mucous membrane tests
95065	Direct nasal mucous membrane test

ICD-10 codes with an * indicate additional digits are needed.

ICD-10-CM Code Table 1: Diagnoses that support medical necessity for CPT codes 86003, 86005, 95004, 95017, 95018, 95024, 95027, 95028

ICD-10-CM Code	Description
H10.01* – H10.45	Conjunctivitis
J30.1 – J30.9	Allergic rhinitis
J31.0	Chronic rhinitis
J45.2* - J45.998	Asthma
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified
L23.0 – L23.9*	Allergic contact dermatitis
L25.1 – L25.9	Unspecified contact dermatitis
L27.0 – L27.9	Dermatitis due to substances taken internally
L50.0	Allergic urticaria
L50.1	Idiopathic urticaria
L50.6	Contact urticaria
L50.8	Other urticaria
L50.9	Urticaria, unspecified
T36.0X5A – T50.995S	Adverse effect of drugs
T63.001* - T63.94*	Toxic effects of venoms

ICD-10-CM Code	Description
T78.00X*–T78.1XXS	Anaphylactic reaction due to food
T78.49XA – T78.49XS	Other allergy
T80.52XA – T80.52XS	Anaphylactic reaction due to vaccination
T88.6XXA – T88.6XXS	Anaphylactic reaction due to adverse effect of correct drug or medicament properly administered

ICD-10-CM Code Table 2: Diagnoses that support medical necessity for CPT code 95044

ICD-10-CM Code	Description
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified
L23.0 – L23.9	Allergic contact dermatitis
L50.0	Allergic urticaria
L50.1	Idiopathic urticaria
L50.6	Contact urticaria
L50.8	Other urticaria
L50.9	Urticaria, unspecified

ICD-10-CM Code Table 3: Diagnoses that support medical necessity for CPT codes 95052, 95056

ICD-10-CM Code	Description
L56.1	Drug photoallergic response
L56.2	Photocontact dermatitis (berloque dermatitis)
L56.3	Solar urticaria

ICD-10-CM Code Table 4: Diagnoses that support medical necessity for CPT codes 95076, 95079

ICD-10-CM Code	Description
L27.2	Dermatitis due to ingested food
T36.0X5A – T50.995S	Adverse effect of drugs
T78.00X*–T78.1XXS	Anaphylactic reaction due to food
Z88.0 – Z88.9	Allergy status to drugs, medicaments and biological substances

ICD-10-CM Code Table 5: Diagnoses that support medical necessity for CPT codes 95115, 95117, 95144, 95145, 95146, 95147, 95148, 95149, 95165, 95170, and 95199

ICD-10-CM Code	Description
H10.01* – H10.45	Conjunctivitis
J30.1 – J30.9	Allergic rhinitis
J31.0	Chronic rhinitis
J45.20 – J45.998	Asthma
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified
L23.0 – L23.9*	Allergic contact dermatitis
L25.1 – L25.9	Unspecified contact dermatitis
L27.0 – L27.9	Dermatitis due to substances taken internally
L50.0	Allergic urticaria
L50.6	Contact urticaria
T36.0X5A – T50.995S	Adverse effects of drugs
T63.001* - T63.94*	Toxic effects of venoms
T78.49XA – T78.49XS	Other allergy
T80.52XA – T80.52XS	Anaphylactic reaction due to adverse effect of correct drug or medicament properly administered
Z88.0 – Z88.9	Allergy status to drugs, medicaments, and biological substances
Z91.030 – Z91.038	Insect allergy status

ICD-10-CM Code Table 6: Diagnoses that support medical necessity for CPT code 95180

ICD-10-CM Code	Description
T36.0X5A – T50.995S	Adverse effect of other drugs, medicaments and biological substances
Z91.030 – Z91.038	Insect allergy status

Reviews, Revisions, and Approvals	Date	Approval Date
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