



Cigna Medical Coverage Policy

Subject Allergy Testing and Non-Pharmacologic Treatment

Effective Date 2/15/2016
Next Review Date 2/15/2017
Coverage Policy Number 0070

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Coverage Policy

Testing:

Cigna covers the following in vivo allergy tests as medically necessary:

- prick/puncture and/or intradermal allergy testing to diagnose suspected immunoglobulin E (IgE) mediated hypersensitivity to inhalants, foods, hymenoptera (e.g., bee venom), drugs and/or chemicals
- skin patch testing to diagnose suspected contact allergic dermatitis
- photo patch testing to diagnose suspected contact photosensitization (e.g., photoallergic contact dermatitis)
- skin patch testing performed prior to joint replacement surgery for **EITHER** of the following:
 - previous surgery involving an implant with complications suspected to be caused by metal allergy
 - history of severe localized (i.e., blistering, hives, and/or extensive rash) or systemic cutaneous reaction to metals
- skin patch testing performed following joint replacement surgery when **BOTH** of the following criteria are met:
 - presence of symptoms attributable to metal allergy/hypersensitivity (e.g., pain, swelling, cutaneous rash, loss of function)
 - etiology other than metal allergy/hypersensitivity (e.g., infection, mechanical failure) have been ruled out
- food/food additive ingestion double-blind challenge/provocation to diagnose suspected IgE-mediated hypersensitivity if skin testing is negative or equivocal, despite a history and physical findings suggestive of hypersensitivity

- drug provocation/bronchial challenge test to diagnose suspected IgE-mediated hypersensitivity when there is a confirmed history of allergy to a drug, and the individual requires the particular drug for treatment of a diagnosed condition, and there is no effective alternative drug available
- skin serial endpoint titration for determination of a safe starting dose for testing or immunotherapy when there is potential for the specific allergen in question to produce a severe systemic reaction or anaphylaxis (such as with bee venom)

Cigna covers in vitro allergy testing (blood serum analysis, e.g., ImmunoCAP[®], radioallergosorbent test [RAST], multiple radioallergosorbent test [MAST], fluorescent allergosorbent test [FAST], paper radioimmunosorbent test [PRIST], radioimmunosorbent test [RIST], enzyme-linked immunosorbent assay [ELISA], MRT [modified RAST], and VAST) as medically necessary when ANY of the following criteria is met:

- for the diagnosis of suspected IgE-mediated food or inhalant allergies for one of the following indications:
 - individual with severe dermatographism, ichthyosis or generalized eczema
 - individual who cannot be safely withdrawn from medications that interfere with skin testing (such as long-acting antihistamines, tricyclic antidepressants)
 - individual who have a history of a previous systemic reaction to skin testing
 - individual in whom skin testing was equivocal/inconclusive and in vitro testing is required as a confirmatory test
- as an alternative to skin testing for the evaluation of cross-reactivity between insect venoms
- when specific IgE immunoassays are used as adjunctive testing for disease activity of allergic bronchopulmonary aspergillosis and certain parasitic diseases

Cigna covers in vitro metal lymphocyte transformation testing (LTT) performed prior to joint replacement surgery as medically necessary when ALL of the following criteria are met:

- previous surgery involving an implant, with complications suspected to be caused by metal allergy
- history of severe localized (i.e., blistering, hives, and/or extensive rash) or systemic cutaneous reaction to metals
- skin patch testing is contraindicated or results are equivocal

Cigna covers in vitro metal lymphocyte transformation testing (LTT) performed following joint replacement surgery as medically necessary when ALL of the following criteria are met:

- presence of symptoms attributable to metal allergy/hypersensitivity (e.g., pain, swelling, cutaneous rash, loss of function)
- etiology other than metal allergy/hypersensitivity (e.g., infection, mechanical failure) have been ruled out
- skin patch testing (detailed above) is contraindicated or results are equivocal

Cigna does not cover in vitro allergy testing for ANY of the following, because it is considered not medically necessary:

- individual with no contraindications to skin testing
- individual being treated successfully for allergies
- individual with mild symptoms
- individual who have had negative skin testing for the allergy in question

Cigna does not cover in vivo or in vitro allergy testing for any other indication because it is considered experimental, investigational or unproven.

Cigna does not cover the following in vivo and in vitro allergy tests in the diagnosis or management of allergic disease because they are considered experimental/investigational or unproven (this list may not be all-inclusive):

- nasal challenge/provocation

- conjunctival challenge/provocation
- bronchial provocation/challenge testing for common allergens (e.g., dust, ragweed)
- provocation-neutralization testing (subcutaneous, sublingual or intradermal) or Rinkel test
- electrodermal testing or electro-acupuncture
- applied kinesiology or muscle strength testing of allergies
- reaginic pulse testing or pulse testing for allergies
- total serum IgE (except as noted in the General Background section of this coverage policy)
- total serum immunoglobulin G (IgG), immunoglobulin A (IgA) and immunoglobulin M (IgM)
- testing of specific IgG antibody (e.g., by RAST or ELISA testing)
- cytotoxic testing, leukocytotoxic testing or Bryan's test
- lymphocyte subset counts
- lymphocyte function assay
- cytokine and cytokine receptor assay
- food immune complex assay (FICA)
- leukocyte histamine release testing
- body chemical analysis
- antigen leukocyte cellular antibody (ALCAT) automated food allergy testing
- alpha-gal allergy testing
- complement antigen testing *

*Note: Complement antigen testing may be indicated for the diagnosis and management of inflammatory conditions (e.g., rheumatoid arthritis, systemic lupus erythematosus).

Treatment:

Cigna covers subcutaneous allergen immunotherapy as medically necessary for the treatment of allergic asthma and allergic rhinitis (with or without allergic conjunctivitis) when ALL of the following criteria are met:

- presence of specific immunoglobulin E (IgE) to the allergen in question demonstrated by skin testing or serum/in-vitro testing
- hypersensitivity cannot be managed by medications or allergen avoidance
- professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single or multiple antigens (CPT code 95165) up to a maximum of 150 doses per year

Cigna covers subcutaneous allergen immunotherapy as medically necessary for the treatment of Hymenoptera (e.g., hornet, wasp, bee, fire ant) venom allergy when ALL of the following criteria are met:

- history of systemic reaction to a Hymenoptera sting
- presence of Hymenoptera-specific IgE demonstrated by skin testing or serum/in-vitro testing
- professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single or multiple antigens (CPT code 95165) up to a maximum of 150 doses per year

Cigna does not cover subcutaneous allergen immunotherapy for any other indication, including but not limited to the following, because they are considered experimental, investigational or unproven:

- angioedema
- atopic dermatitis
- chronic urticaria
- food hypersensitivity

Cigna does not cover any of the following for the treatment of allergy because each is considered experimental, investigational or unproven (this list may not be all-inclusive):

- acupuncture for allergies
- allergoids

- autogenous urine injections
- detoxification for allergies
- environmental chemical avoidance for idiopathic environmental intolerances
- epicutaneous immunotherapy
- helminth trichuris suis therapy
- homeopathic remedies for allergies
- injection of food extracts
- intranasal immunotherapy
- low-dose immunotherapy
- peptide therapy
- provocation-neutralization therapy
- rhinophototherapy
- rotational and multiple food elimination diets (e.g., rotary diversified diet)
- ultra low dose enzyme activated immunotherapy/ low dose allergens (LDA)

Note: Sublingual immunotherapy (SLIT) is addressed in the Omnibus Codes Coverage Policy.

General Background

Allergies result from an overreaction of the immune system to foreign substances (e.g., pollen, dust, mold, animal fur or dander, stinging insect venom, food). An allergy develops when the body is exposed to a substance that prompts the initiation of an immune response. This response involves the production of antibodies, called immunoglobulins (Igs), which are directed against proteins of the foreign substance, called allergens or antigens. While there are five classes of immunoglobulins, it is IgE that is typically involved in allergic reactions. When an allergy-prone individual is exposed to a specific antigen, B-cells produce an IgE that recognizes only that antigen. This antigen-specific IgE then binds to receptors on specific cells that reside in tissue (mast cells) or circulate in the blood (basophils). Upon re-exposure to the same antigen, the antigen-specific IgE binds to membrane receptors on tissue mast cells and blood basophils and then releases a series of chemicals (histamine, leukotrienes, cytokines and proteases) that regulate the allergic reaction. While the allergic reaction begins immediately, signs and symptoms of the reaction may occur within seconds or minutes (immediate hypersensitivity), may be delayed for several hours (delayed hypersensitivity), or may involve both early- and late-phase reactions.

Testing

Allergy tests are performed to verify or exclude the presence of IgE-mediated hypersensitivity and to identify the causative allergen(s). Testing may involve in vivo procedures, which determine the presence of specific IgE by administering an IgE-specific allergen into, on or near the patient and monitoring the patient's physiological response(s). Allergy tests may also be in vitro procedures that determine the presence of specific IgE or elevated total IgE by analyzing patient serum.

The allergy testing methods and recommendations detailed below are based primarily on practice parameters and recommendations from the American Academy of Allergy, Asthma, and Immunology (AAAAI) and the American Academy of Otolaryngic Allergy (AAOA).

In Vivo Allergy Testing

In vivo allergy tests fall into two general categories: skin tests and organ challenge (or provocation) tests. Both are designed to confirm hypersensitivity and identify the antigen(s) responsible for the allergic reaction. The most common in vivo allergy tests are outlined below. The efficacy of some in vivo allergy tests has not been firmly established, due to the limited numbers of well-designed clinical trials. Few prospective studies are available, and evidence is primarily in the form of expert opinion.

Skin testing can be utilized to detect immediate hypersensitivity (IgE-dependent reactions) and delayed hypersensitivity (cell-mediated immune reactions). The two major methods of skin testing for IgE-mediated disease include the prick-puncture test and the intradermal test. A positive response to skin testing is typically indicated by the presence of a wheal and/or flare at the test site. Scratch testing is no longer a recommended allergy testing procedure, due to reproducibility issues and the high incidence of false-positive reactions.

Skin testing is contraindicated in patients with severe dermatographism (allergy in which a pale, raised wheal is produced when skin is scratched), ichthyosis (condition in which skin is dry and scaly, resembling fish skin) or generalized eczema; in patients who cannot be withdrawn from medications that interfere with skin testing (such as long-acting antihistamines and tricyclic antidepressants); and in patients who have a history of a previous systemic reaction to skin testing.

Prick/puncture tests are used for confirmation of clinical immediate hypersensitivity induced by inhalant and food allergens. Skin prick/puncture tests are generally considered the most specific screening method for detecting the presence of IgE antibodies in patients with appropriate exposure histories. These tests may also be used in the diagnosis of drug and chemical hypersensitivity reactions. Prick/puncture tests are generally less sensitive than intradermal testing. For inhalant allergies, prick/puncture tests have been shown to correlate better with the presence of clinical allergy. Skin testing is considered the gold standard for the diagnosis of IgE-mediated allergic disease. The Joint Task Force of Allergy, Asthma, and Immunology recommends skin prick/puncture tests as the primary test for the diagnosis of IgE-mediated allergic diseases.

Intradermal or intracutaneous tests are generally used when increased sensitivity is the main goal of testing (i.e., when prick/puncture tests are negative despite a compatible history of exposure). Intradermal tests are more sensitive but less specific than prick/puncture tests for most allergens but are superior to other skin tests for assessing hypersensitivity to hymenoptera (stinging insects) and penicillin or allergens of lower potency.

Repeat skin testing with multiple antigens is not indicated on a regular basis (e.g., yearly). Indications for repeat testing include changing symptoms, new exposures, or 3–5 years of venom immunotherapy.

Patch testing is used to determine the presence or cause of delayed hypersensitivity reactions originating on the skin. It is primarily used to assess allergic contact dermatitis, an eczema-type, immunologically-mediated skin reaction which is largely cell-mediated but may contain an IgE-mediated component. The clinical utility of patch testing to identify allergic reactions other than those originating on the skin (such as inhalants or food allergens) has not been determined. It is estimated that 20–30 antigens used in the panel of patch tests will identify between 50% and 70% of the clinically relevant causes of contact dermatitis.

Certain substances may elicit an allergic reaction only when exposed to light. In photo patch testing, the suspected chemical or medication is applied in two separate areas. One of the areas is exposed to a range of ultraviolet type A light and then examined for the presence of a reaction. Testing is considered positive if only the area that has been exposed to the ultraviolet light demonstrates an allergic reaction.

Oral challenge may be used to confirm or diagnose IgE-mediated hypersensitivity to specific foods, food additives and preservatives, or drugs. Food challenge is time-consuming and associated with the potential for anaphylaxis. Simpler measures, such as skin tests and elimination of suspected foods from the diet, are typically tried first. If skin tests are negative or equivocal and inconsistent with a history suggestive of food allergy, and symptoms abate after elimination of suspected foods, one food at a time is added back into the diet (open food challenge) until symptoms recur. Blinded, controlled food challenge (by ingestion) may be undertaken when skin tests are negative or inconsistent with a history that suggests food allergy. Sublingual food allergy testing, in which the food in question is placed under the tongue and not ingested, is an unproven testing method (see "provocation-neutralization," below). Double-blind food challenges are typically reserved for a select subset of patients.

Drug provocation/ bronchial challenge testing is typically undertaken only if the need to confirm or exclude hypersensitivity outweighs the risk of severe reaction. This may occur in patients who have a history of allergy to a particular drug for which there is no effective alternative but who need that drug for treatment. Bronchial challenge testing is used in the diagnosis and management of asthma to quantify allergic airway responsiveness to pharmacological agents, such as methacholine or histamine. Bronchial provocation/challenge testing with extracts of common aeroallergens such as dust or ragweed, however, has no established clinical value and offers no additional clinical information beyond that obtained by a well-taken clinical history and a carefully performed skin test.

Serial endpoint titration (SET) is a variation of intradermal skin testing in which increasing doses of antigen are used to determine the concentration at which the reaction changes from negative to positive (i.e., the endpoint).

SET has been used as an alternative to skin prick testing or in vitro testing and has also been used to guide initiation of immunotherapy, with the endpoint dilution used as the starting dose. Although not considered a replacement for skin testing, SET may be indicated for determination of a safe starting dose for testing or immunotherapy when there is potential for the specific allergen in question to produce a severe systemic reaction or anaphylaxis (such as with bee venom).

Additional In Vivo Diagnostic Procedures

Nasal challenge/provocation testing has been proposed as a tool in the diagnosis of allergic rhinitis. It is used in studies of allergic rhinitis, but its utility in clinical practice has not been established. Evidence available regarding the value of this testing is primarily in the form of expert opinion rather than studies assessing the technique. A review of the current published, peer-reviewed scientific literature indicates that the role of nasal challenge testing in the diagnosis and management of allergic diseases has not been established.

Conjunctival challenge testing also has been used in the diagnosis of allergic rhinitis as well as of allergic conjunctivitis. Few data are available regarding the value of conjunctival challenge. The role of conjunctival challenge testing in the diagnosis and management of allergic diseases has not been established, based on a review of the published, peer-reviewed scientific literature.

Provocation-neutralization, sometimes referred to as the Rinkel test, is a procedure that evolved from serial endpoint titration. This method has been proposed as a test for allergies to foods, inhalants and environmental chemicals; it exposes the patient to test doses of substances intradermally, subcutaneously or sublingually, with the goal of either producing or preventing symptoms. There are no standardized protocols, and its safety and efficacy have not been established. Both the American College of Physicians and the American Academy of Allergy and Immunology consider this testing method unproven. Provocation-neutralization is a method often used by physicians who subscribe to the concept of multiple food and chemical sensitivities, also referred to as idiopathic environmental intolerances (IEIs). Based on a review of the current published, peer-reviewed scientific literature, provocation-neutralization is an unproven testing method.

Electrodermal testing, also referred to as "electro-acupuncture," has been proposed as a method to identify substances, especially foods, to which the patient is allergic and to provide information about optimal dilution of treatment extracts in immunotherapy. It is performed with a device that uses a galvanometer to measure electrical activity of the skin at designated acupuncture points. There is no scientific or clinical evidence available that demonstrates that electrodermal testing can diagnose allergies. This technique is considered unproven.

Applied kinesiology involves testing for specific allergies by measuring the patient's muscle strength. Allergens are placed in containers that the patient holds in one hand while a technician estimates muscle strength in the opposite arm. Based on a review of the published, peer-reviewed scientific literature, this technique is unproven.

Reaginic pulse testing involves measuring a change in pulse rate after the ingestion, injection or sublingual application of an allergen. There is no basis for its role in the diagnosis of allergic disease. A review of the literature indicates that this is an unproven test for the diagnosis of allergies.

In Vitro Allergy Testing

The discovery of the role of IgE in clinical allergy testing resulted in the development of in vitro diagnostic assays to test for allergen sensitivity. The first immunoassays were developed to quantify the serum concentration of total IgE. In normal individuals, IgE is usually present at low levels; 130 ng/ml represents the upper limit of the normal range. However, a significant number of asymptomatic normal individuals, such as those with parasitic diseases or with depressed cell-mediated immunity, exceed this level. Also, some allergic patients may exhibit normal total IgE levels in the presence of elevated levels of specific IgE. Methods were therefore developed to assay allergen-specific IgE. The radioallergosorbent test (RAST) system was developed for in vitro measurement of specific IgE in a patient's serum. Other in vitro tests for specific IgE have been developed and employ the same principles as the RAST but use an enzymatic (MAST) or fluorogenic (FAST) detection system in place of a radioactive label.

In vitro tests that screen for multiple allergens in a single assay (Phadiatop[®], Pharmacia Diagnostics) or that can be used in an automated system (ImmunoCAP[®], Pharmacia Diagnostics) have been developed. The ImmunoCAP is designed as a "sandwich" immunoassay. The sensitivity and specificity of the ImmunoCAP

compares favorably with those of the modified PhadezymRAST[®] system. Results from studies have indicated that, when compared to skin prick testing as the gold standard, the ImmunoCAP system has been shown to have a greater sensitivity (80–95%) than RAST and to have similar specificity (85%). Other modified versions of the RAST test include the PRIST, RIST, MRT (modified RAST) and ELISA IgE tests.

The overall sensitivity of in vitro immunoassays compared with prick/puncture skin tests has been reported to range from 50–90%, with an average of about 70–75% from most studies. Skin testing, therefore, continues to be the preferred method for the diagnosis of IgE-mediated sensitivity. Selective use of in vitro tests may be justified for patients in whom skin testing is inappropriate. Situations in which specific IgE immunoassays may be appropriate include:

- testing of patients with severe dermatographism, ichthyosis or generalized eczema
- testing in patients who cannot be withdrawn from medications that interfere with skin testing (patients receiving long-acting antihistamines or tricyclic antidepressants)
- testing in patients who have a clinical history suggesting an unusually greater risk for anaphylaxis or who have had a previous systemic reaction to skin testing
- testing of patients with mental or physical impairments

It should be noted that specific IgE immunoassays do not have sufficient sensitivity for absolute positive prediction of anaphylactic sensitization to venoms, penicillin and other drugs. This method of testing should not be used to provide definitive diagnoses, due to the potential for serious consequences resulting from a false-negative outcome. Allergen-specific IgE immunoassays provide neither diagnostic nor prognostic information when measured in the cord blood of newborn infants.

In vitro allergy testing is not indicated when there are no contraindications to skin testing or in patients who are successfully being treated for allergies, have mild symptoms and a short allergy season, or have had negative skin testing for the allergy in question.

Total serum IgE testing in patients with allergic disease has no established clinical role. Substantial proportions of individuals with IgE-mediated allergic disease have normal serum IgE levels, and many nonallergic diseases are associated with elevated serum IgE. Measurement of serum IgE may be indicated in adults with conditions such as suspected allergic bronchopulmonary aspergillosis and hyper-IgE syndromes (dermatitis and recurrent pyogenic infections), certain stages of HIV infection, IgE myeloma, drug-induced interstitial nephritis, graft-versus-host disease, several parasitic diseases and specific immune deficiency diseases. In children, serum concentrations of IgE increase slowly with development, with highest levels typically found in late adolescence. High concentrations of serum IgE measured in the first year of life have been shown to correlate with future development of atopic disease. However, in clinical situations when presenting signs of allergic disease are evident, total IgE levels do not provide additional diagnostic information. Furthermore, normal IgE levels do not exclude the diagnosis of allergic disease in infants or children.

Total serum IgG, IgA and IgM testing is not typically clinically useful, since their levels are not altered by allergic diseases. Based on a review of the literature, the role of routine quantitative measurement of serum IgG, IgA and IgM in the diagnosis and management of allergic disease has not been established.

Serum IgG antibodies are not involved in the pathogenesis of atopic disease. Although it has been suggested that IgG antibodies may be responsible for delayed symptoms or vague intolerance to foods, there is no evidence available that validates this contention. RAST and similar technologies are capable of detecting minute quantities of such antibodies, and it is known that low-level IgG antibodies to foods circulate normally but have no known pathogenic significance. The measurement of specific IgG antibodies is of no diagnostic value in the management of patients with atopic (allergic) disease. There is insufficient evidence in the published, peer-reviewed scientific literature to support the use of specific IgG antibody testing by RAST or ELISA in the diagnosis or treatment of allergic disease without suspected immunodeficiency.

The cytotoxic test, also known as the "leukocytotoxic test" or Bryan's Test, has been proposed for food allergies but has no scientific support as a procedure for the diagnosis of food allergies or inhalant allergies. The rationale for this test is based on a claim that morphological changes in peripheral-blood leukocytes in contact with allergens in vitro indicate that the patient is allergic to the particular allergen. There is insufficient evidence in the

published, peer-reviewed scientific literature to support the use of this testing in the diagnosis or management of allergic disease. The role of this testing in the diagnosis or management of allergic disease has not been established.

Lymphocyte subset counts may be useful in the diagnosis of lymphocyte cellular immunodeficiencies and lymphocytic leukemias. Quantifying lymphocyte subsets, however, has not been proven to be of any value in the diagnosis or management of allergic disease.

Lymphocyte function assays may be appropriate in the diagnosis of some immunodeficiency diseases; however, they are not abnormal in allergic diseases. The use of this testing in the diagnosis or management of allergic disease is unproven.

Cytokine and cytokine receptor assays have not been shown to be useful in the diagnosis or management of any allergic disease and are therefore considered unproven.

The food immune complex assay (FICA) is based on the solid-phase radioimmunoassay methodology. It has not been shown in well-designed clinical trials that any well-defined clinical disease involves pathogenic circulating immune complexes to foods. Furthermore, it has not been shown that the assay for such complexes is diagnostic of any disease. The clinical value of food immune complex assays in the diagnosis and management of allergic disease has not been established. The technique is therefore considered unproven.

Leukocyte histamine release testing is an in vitro test that evaluates the presence of specific IgE antibodies. The test has been proposed for the diagnosis of various allergic conditions, including atopic disorders and stinging insect allergies. Leukocyte histamine release testing detects the release of histamine from basophils in a sample of whole blood exposed to allergens in vitro. It is a cumbersome test typically conducted in research laboratories, and has not been studied fully for its predictive value in determining specificity and sensitivity. Its role in the diagnosis and management of allergic disease outside of the investigative setting has not been established.

Body chemical analysis is typically seen in the diagnosis of a condition known as "idiopathic environmental intolerances" (IEIs) or "multiple food and chemical sensitivities." Samples of whole blood, serum, erythrocytes, urine, fat and hair are tested for the presence of environmental chemicals. The most common chemicals measured are organic solvents, other hydrocarbons, pesticides and metals. Some proponents of this testing also recommend measurements of the quantity of vitamins, minerals and amino acids in blood and urine in a search for "environmental sensitivities." The concept of multiple food and chemical sensitivities manifested by numerous symptoms in the absence of objective physical findings lacks scientific foundation. There is no evidence to suggest that these patients suffer from an immunological abnormality. The existence of such an illness is based on anecdotal reports with no verification using well-designed clinical trials. There is no scientific evidence to support the value of diagnostic testing associated with IEIs or multiple food and chemical sensitivities, including body chemical analysis. Body chemical analysis is therefore considered unproven.

Antigen leukocyte cellular antibody testing (ALCAT) is an automated method of testing for food allergies that is purported to identify food sensitivity by using a modified Coulter counter linked to a computer program to measure the change in white blood cells incubated with purified food and mold extract. There is insufficient evidence in the published peer-reviewed scientific literature to support the use of this testing in the diagnosis or management of allergic disease.

Alpha gal (galactose-alpha 1, 3-galactose) is an oligosaccharide that has been associated with an unusual delayed allergic reaction to meat, including beef, pork and lamb. Most allergic responses to food are directed against protein epitopes (the part of an antigen molecule to which an antibody attaches), rather than an oligosaccharide (a carbohydrate composed of simple sugars). In addition, most allergic reactions to food occur within thirty minutes of ingestion. With alpha-gal, however, reaction has been observed to occur three to six hours after ingestion. Symptoms are similar to those seen with other food allergies, and may include urticarial, dyspnea, hypotension, angioedema, and anaphylaxis. It has been suggested that the original sensitizing allergen is exposure to the tick *Amblyomma americanum* (lone star tick) rather than to red meat, with antibodies to alpha-gal produced after a tick bite ((Saleh et al., 2012, Adkinson, 2013).

The link between alpha-gal allergy and exposure to ticks has not been definitively demonstrated, nor has a specific test been established as an accurate diagnostic method.

Complement antigen testing has been proposed for the diagnosis of delayed food allergies. Complement activation is a multi-component immune system response commonly present in inflammatory conditions (e.g., rheumatoid arthritis, arthritis, systemic lupus erythematosus). The degree of complement activation may be used to indicate the intensity of the inflammatory process. The role of complement antigen testing in the diagnosis of allergy has not been established.

Arthroplasty Implants: Testing for Metal Allergy/Hypersensitivity

Metal implants are widely used in orthopedic surgery for joint arthroplasty and fracture fixation. Metallic implants are frequently composed of stainless steel, Vitallium, titanium, Zirconium, and cobalt-chromium-molybdenum alloys. These alloys are typically composed of metals including aluminum, chromium, cobalt, nickel, molybdenum, vanadium, titanium and iron. Intolerance reactions to metal implants include dermatitis, impaired wound healing, effusion, pain, or loosening. It is important to distinguish between cutaneous contact sensitivity and sensitivity to implanted devices. Local reactions at the time of contact (e.g., rash, urticarial, swelling) are seen with hypersensitivity related to cutaneous contact with metallic objects such as jewelry. Metal contact allergy/hypersensitivity is quite common, and there is insufficient evidence to demonstrate that this places patients at increased risk of developing complications following orthopedic implant procedures. Routine testing for metal allergy prior to joint implantation therefore has not been established. There may be a role such testing, however, in patients with a history of severe localized (e.g., hives, blistering, extensive rash) or systemic cutaneous reactions, or in those with a history of complications suspected to be caused by metal allergy with a prior implant,

Evidence evaluating the relationship between metal allergy/sensitivity and implant outcomes is limited. In reviewing the approach to the clinical work-up of patients with putative allergic disease to metallic orthopedic implants, Thyssen et al. (2012) stated that the overall risk of developing extracutaneous allergic reactions following total hip arthroplasty is comparable in metal patch test positive and negative subjects. It has been proposed that up to 5% of total joint arthroplasty failure within seven years of surgery may be caused by debris-induced immune reactivity, including delayed-type hypersensitivity reactions to metals. The authors recommend that clinicians should not perform routine patch testing prior to surgery unless the patient has already had implant surgery with complications suspected to be allergic, or has a history of clinical metal intolerance of sufficient magnitude to be of concern. In this case it would be advisable to avoid an implant containing metal(s) that the patient reacted to during allergy testing. The authors propose that the clinical work-up of a patient suspected of having an allergic reaction to a metal implant would include patch testing and possibly in vitro testing. The toxicity of some metals may hamper in vitro testing, and patch testing may allow screening for more metals. In vitro testing may be useful, however, in doubtful cases and offer quantitative estimates.

Granchi et al. (2012) published results of a systematic review and meta-analysis of metal sensitivity testing in patients undergoing total joint arthroplasty, to assess the risk of developing metal hypersensitivity postoperatively and the impact on outcomes, and also to investigate the advantages of performing hypersensitivity testing. A total of 22 studies (3654 patients) met the inclusion criteria. Fourteen studies were eligible for calculating the risk of metal allergy in patients undergoing joint replacement. The frequency of positive tests increased following joint replacement, particularly in patients with implant failure or a metal-on-metal coupling. The probability of developing a metal allergy was higher postoperatively (odds ratio [OR] 1.52 [95% confidence interval [CI] 1.06-2.31, p=0.02). Ten studies were eligible to calculate the risk of metal allergy according to the status of the replacement. The probability of having a metal allergy was more than double in patients who had a failed replacement than in those with a stable replacement (OR 2.76 [95% CI 1.14-6.70, p=0.02). There was significant heterogeneity between studies, however, and no predictive value regarding the status of the replacement could be attributed to the testing results for metal sensitization. The meta-analysis confirmed that the probability of developing a metal allergy is higher post-operatively, and the risk is even greater when failed replacements are compared with stable replacements.

In terms of defining the advantage of hypersensitivity testing, the findings demonstrated that pre-or post-operative screening has no predictive value. The authors noted, however, that most papers concluded that hypersensitivity testing should be performed preoperatively in patients with a history of metal allergy, and should be performed in those with a failed replacement when hypersensitivity is suspected, after excluding infection and mechanical failure. The authors stated that the question of which test is best is debatable, since both in vitro

and in vivo testing have advantages and disadvantages. Limitations of large-scale application of in vitro testing include the cost and need for specialized laboratories. The patch test is considered the reference method for diagnosing contact allergy, but the use of patch testing in detecting hypersensitivity to implant materials is controversial. The frequency of positive patch tests increases, however, when more haptens are tested.

Metal alloys are also used in other procedures; including dental implants, cardiovascular stents, and gastrointestinal wire mesh stents. There is insufficient evidence evaluate the clinical utility of metal allergy testing for these indications.

The American Board of Internal Medicine's (ABIM) Foundation Choosing Wisely® Initiative (2014): The Choosing Wisely initiative includes the following recommendations from the American Academy of Asthma, Allergy, and Immunology regarding allergy testing:

- Don't perform unproven diagnostic tests, such as immunoglobulin G (IgG) testing or an indiscriminate battery of immunoglobulin E (IgE) tests, in the evaluation of allergy
- Don't routinely do diagnostic testing in patients with chronic urticaria.
- Don't perform food IgE testing without a history consistent with potential IgE-mediated food allergy.

Treatment

The allergy treatment recommendations in this Coverage Policy are based primarily on practice parameters developed by a joint task force representing the American Academy of Allergy, Asthma, and Immunology (AAAAI) and the American College of Allergy, Asthma & Immunology (ACAAI) (Cox et al., 2011).

Subcutaneous Allergen Immunotherapy

Subcutaneous immunotherapy (SCIT) consists of gradual administration of increasing amounts of allergen to which the individual is sensitive, in order to temper the immune response and alleviate allergic symptoms. Subcutaneous injection immunotherapy is an established form of treatment and may be considered for individuals with symptoms of allergic rhinitis, allergic conjunctivitis, or allergic asthma with natural exposure to allergens and who demonstrate specific IgE antibodies to the relevant allergen(s). SCIT is usually only recommended for the treatment of allergic respiratory disease following a period of pharmacologic management and observation. Factors to be considered in determining treatment include the severity/duration of symptoms, patient preference/acceptability, adherence, medication requirements, response to avoidance measures, and the adverse effects of medications. The expected response to immunotherapy is antigen specific and depends on the accurate identification and selection of component allergens based on the individual's history, exposure and diagnostic test results (skin testing or serum/in-vitro testing). Subcutaneous venom immunotherapy is recommended for those who have had a systemic reaction to Hymenoptera (e.g., bee, wasp, yellow jacket, hornet, ant) stings and demonstrate Hymenoptera-specific IgE antibodies, especially if the reaction was associated with respiratory symptoms, cardiovascular symptoms, or both. There is insufficient evidence to support the use of allergen immunotherapy for other indications, including atopic dermatitis, food hypersensitivity, chronic urticarial, or angioedema.

The allergy immunotherapy recommendations in this Coverage Policy are based primarily on practice parameters developed by a joint task force representing the American Academy of Allergy, Asthma, and Immunology (AAAAI) and the American College of Allergy, Asthma & Immunology (ACAAI) (Cox et al., 2011)

Injection Schedules: There are two phases of allergy immunotherapy administration; the initial build-up phase and the maintenance phase. In the build-up phase, the dose and concentration of allergen immunotherapy extract are increased, and in the maintenance phase, the patient receives an effective therapeutic dose over a period of time. With the most common build-up phase schedule, injections are administered one to three times per week. With this schedule, patients usually reach a maintenance dose in three to six months, depending on the starting dilution and occurrence of reactions. If a systemic reaction occurs, immunotherapy may be discontinued, or if continued, the dose is reduced. Immunotherapy schedules may need to be adjusted for a variety of reasons, including missed visits, high pollen or mold seasons, addition of a new allergen, or systemic reaction.

Once a patient reaches the maintenance phase, the interval between injections can be progressively increased as tolerated, to an interval of up to four weeks for inhalant allergens and up to eight weeks for venom. The effective therapeutic dose or maintenance dose is the dose that provides therapeutic efficacy without significant adverse local or systemic reactions. Three to five years of maintenance therapy is generally considered optimal for maximum clinical benefit.

Accelerated Immunotherapy Schedules

Accelerated immunotherapy schedules include cluster immunotherapy and rush immunotherapy. Accelerated immunotherapy schedules may permit an individual to reach a maintenance dose sooner, but are associated with a higher risk of systemic reactions for inhalant allergens, especially with high-risk patients (e.g., those with markedly positive prick/puncture or in vitro IgE test responses).

Cluster immunotherapy: With cluster immunotherapy, several injections (usually two or three) are administered during each visit in order to achieve a maintenance dose more rapidly than conventional schedules. In cluster immunotherapy, several injections at increasing doses (generally 2-3 per visit) are administered sequentially in a single day of treatment on nonconsecutive days. The maintenance dose is usually achieved more rapidly than with a conventional (single injection per session) schedule. Cluster schedules usually include fewer total injections than are used with conventional schedules, and permit a patient to reach a maintenance dose sooner, usually in one to four weeks.

Rush Immunotherapy: With rush immunotherapy, incremental doses of allergen are administered at varying intervals between 15 and 60 minutes over one to three days until the target therapeutic dose is achieved. Rush immunotherapy for inhalant allergies may be associated with a significant risk of systemic reactions. Rush schedules for stinging Hymenoptera venom immunotherapy are not associated with an increased incidence of systemic reactions, however.

Alternative Allergy Treatment Methods

Numerous alternative allergy treatment methods have been identified in the professional society guidelines and textbook literature. These allergy treatment methods remain unproven at this time due to a lack of supporting evidence published in the peer-reviewed scientific literature. The role of these techniques in the management of allergic disease has not yet been established. Some of the alternative allergy treatment methods utilize extracts that are not U.S. Food and Drug Administration (FDA)-approved.

Acupuncture: Acupuncture has been used by allergic patients for the relief of allergic rhinitis, asthma, allergic dermatoses and by patients who have other symptoms or medical problems that they consider to be allergic. Despite the report by some patients of temporary benefit, this is an unproven form of allergy therapy due to lack of published scientific literature.

Allergoids: Allergoids are allergenic proteins that are treated with formaldehyde to produce larger molecules with decreased ability to react with IgE antibodies. Allergoids are licensed and manufactured for general distribution in Europe, but are not available in the United States.

Autogenous urine injection: Autogenous urine injection revolves around the theory that urine produced by the patient contains unspecified chemicals during an allergic reaction and that injection of these chemicals inhibits or neutralizes future allergic reactions. There is no scientific evidence to support autogenous urine injections. Repeated injections of these antigens could induce autoimmune nephritis.

Detoxification: Detoxification is a method used by individuals who believe that an allergic state can be induced by toxic damage to the immune system from exposure to environmental chemicals. It is believed that certain lipid-soluble chemicals may be stored in body fat for long periods. Detoxification consists of sauna and exercise. The individual ingests high-dose niacin to induce erythema. Body fluids are replenished with water and electrolytes and certain essential oils are consumed, presumably to help replace fat-soluble chemical contaminants. This procedure takes approximately five hours and is repeated daily for 20–30 days. This form of therapy has not been well-studied and is unproven.

Environmental chemical avoidance: Individuals with idiopathic environmental intolerance, formerly referred to as multiple chemical sensitivity, have been described as failing to adapt to synthetic chemicals. The 1999 American Academy of Allergy, Asthma and Immunotherapy (AAAAI) position statement on idiopathic

environmental intolerance states that a causal connection between environmental chemicals, foods, and/or drugs and the patient's symptoms continues to be speculative and cannot be based on the results of currently published scientific studies.

Epicutaneous immunotherapy: Epicutaneous immunotherapy involves the use of patches as a dosage form for allergen specific immunotherapy. An adverse effect of this therapy is patch-induced eczema at the patch site. This allergy treatment method remains unproven due to a lack of supporting evidence published in the peer-reviewed scientific literature.

Helminth trichuris suis therapy: Treatment with helminth trichuris suis has been proposed as a treatment for allergic rhinitis. A therapeutic approach has been suggested in different experimental models of allergic disease showing that live ova from trichuris suis, an intestinal helminth of pigs, can protect against allergic reactivity by helminth-induced regulatory T cells and cytokines. Bager et al. (2010) conducted a double-blind, placebo-controlled study (n=100) to evaluate the effectiveness of trichuris suis therapy for the treatment of allergic rhinitis. The authors reported that repeated treatment with the helminth trichuris suis induced a substantial clinical and immunologic response, but had no therapeutic effect on allergic rhinitis. This allergy treatment method remains unproven due to a lack of supporting evidence published in the peer-reviewed scientific literature.

Homeopathic remedies: A homeopathic remedy administers a causative agent of a disease and is administered therapeutically in small amounts. There is no scientific evidence to support homeopathic practice as a method for treating allergies.

Injection of food extracts: An injection of food extracts consists of a combination of foods based on skin test results or a patient's report of intolerance to foods. No clinical trials support this treatment.

Peptide therapy: The concept that the clinical response to allergen immunotherapy probably reflects the induction of nonresponsiveness in Th2 lymphocytes led to the concept of immunotherapy with allergen-derived peptides representing T cell activating epitopes that do not react with IgE antibodies.

Provocation-neutralization therapy: This treatment involves the injection of substances under the skin that are suspected of triggering an allergic reaction in sufficient quantity to cause symptoms similar to the patient's complaints. This is then followed by an immediate injection of a weaker or stronger dilution of the same antigen to relieve the symptoms.

Rhinophototherapy: Rhinophototherapy uses UV-B, UV-A, and visible light to treat allergic rhinitis. This allergy treatment method remains unproven due to a lack of supporting evidence published in the peer-reviewed scientific literature.

Rotational and multiple food elimination diets: Proponents of the concept of multiple food allergies sometimes recommend a "rotary diversified diet," in which the patient rotates foods so that the same food is eaten only once every 4–5 days to help identify foods that may cause allergic responses. This allergy treatment method remains unproven due to a lack of supporting evidence published in the peer-reviewed scientific literature.

Ultra low dose enzyme activated immunotherapy/low dose allergens (LDA): Ultra low-dose enzyme activated immunotherapy consists of intradermal injections of small amounts of various allergens combined with the enzyme beta-glucuronidase. This allergy treatment method remains unproven due to a lack of supporting evidence published in the peer-reviewed scientific literature.

Use Outside the U.S.

A National Institute for Health and Clinical Excellence (NICE) (United Kingdom) clinical guideline on food allergy in children and young people states that, if IgE-mediated allergy is suspected, a skin prick test and/or blood tests for specific IgE antibodies to the suspected foods and likely co-allergens may be offered. The choice of test is based on the clinical history, suitability for, safety for and acceptability to the child (or their parent or carer), and the available competencies of the healthcare professional.

Summary

In vivo allergy testing (i.e., skin test, organ challenge/provocation test) is the most commonly used and preferred method of allergy testing. In vivo allergy tests are designed to confirm hypersensitivity and identify the antigen(s) responsible for the allergic reaction. In vitro allergy testing has been demonstrated to be an effective alternative for patients with suspected IgE-mediated food or inhalant allergies who cannot be tested using in vivo methods, or as an alternative to skin testing for the evaluation of cross-reactivity between insect venoms. In addition, specific IgE immunoassays may be used as adjunctive testing for disease activity of allergic bronchopulmonary aspergillosis and certain parasitic diseases.

Evidence-based clinical practice guidelines support the use of subcutaneous allergen immunotherapy for the management of allergic asthma, allergic rhinitis (with or without conjunctivitis), and stinging insect venom hypersensitivity. Clinical studies do not support the use of allergen immunotherapy for treatment of angioedema, atopic dermatitis, chronic urticaria, and food hypersensitivity. Numerous allergy treatment methods have been proposed as alternatives to subcutaneous allergen immunotherapy, as detailed above. There is insufficient evidence in the published medical literature to demonstrate the safety and efficacy of these alternative treatments.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.

2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

Testing

Covered when medically necessary:

CPT [®] * Codes	Description
86001	Allergen specific IgG quantitative or semiquantitative, each allergen
86003 [†]	Allergen specific IgE; quantitative or semiquantitative, each allergen
86005	Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle or disk)
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis
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)
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)

† Experimental/Investigational/Unproven/Not Covered when used to report alpha-gal allergy testing.

Experimental/Investigational/Unproven/Not Covered when used to report any procedure listed as such in this Coverage Policy.

CPT* Codes	Description
82784	Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; multiple step method
83518	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, single step method (eg, reagent strip)
83519	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, by radioimmunoassay (eg, RIA)
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified
86003	Allergen specific IgE; quantitative or semiquantitative, each allergen
86160	Complement antigen, each component
86343	Leukocyte histamine release test (LHR)
86807	Serum screening for cytotoxic percent reactive antibody (PRA); standard method
86808	Serum screening for cytotoxic percent reactive antibody (PRA); quick method
86849	Unlisted immunology procedure
95060	Ophthalmic mucous membrane tests
95065	Direct nasal mucous membrane test
95199	Unlisted allergy/clinical immunologic service or procedure

Treatment

Covered when medically necessary:

CPT [®] * 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; two or more injections
95120	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; single injection
95125	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 2 or more injections
95130	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; single stinging insect venom
95131	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 2 stinging insect venoms
95132	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 3 stinging insect venoms

95133	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 4 stinging insect venoms
95134	Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 5 stinging insect venoms
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 stinging insect venoms
95147	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, (specify number of doses); 3 stinging insect venoms
95148	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, (specify number of doses); 4 stinging insect venoms
95149	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, (specify number of doses); 5 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 (eg, insulin, penicillin, equine serum)

Experimental/Investigational/Unproven/Not Covered when used to report any non-covered procedure indicated in this policy for the treatment of allergies:

CPT^{®*} Codes	Description
30999	Unlisted procedure, nose
95199	Unlisted allergy/clinical immunologic service or procedure
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

***Current Procedural Terminology (CPT[®]) © 2015 American Medical Association: Chicago, IL.**

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