Allergy Testing and Allergen Immunotherapy

Adjudication Guideline

Rule Category:	Ref: No:	Version Control:	Effective Date:	Revision Date:
Medical	2026-MN-0078	Version No.1.0	23/11/2026	23/10/2026

Approved by:	Responsible:	Related Adjudication Guidelines:
Daman	Medical Standards & Governance	N/A

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1. Abstract

1.1 For Members

Allergy is an overreaction by the body's immune system to a normally harmless substance. These substances are called allergens and can include dust, mites, pets, pollen, insects, mold, certain medications, and foods.

Most allergic reactions are mild to moderate, and do not cause major problems. However, a small number of people may experience a severe allergic reaction called anaphylaxis, which requires an immediate treatment with adrenaline (epinephrine); a life-saving medication.

For individuals with severe allergies that do not respond to standard medications, immunotherapy (also called desensitization) may be recommended. This treatment involves gradually exposing the person to increasing doses of the allergen, either by injections or tablets/drops under the tongue, to reduce sensitivity.

Immunotherapy is a well-established treatment and is carried out under very controlled medical conditions.

1.2 For Medical Professionals

Allergic diseases are amongst the most prevalent diseases worldwide and the burden of these diseases continues to increase. An accurate diagnosis coupled with optimal therapy requires the use of appropriate tests to confirm the allergen sensitization and detailed information about exposure to the potential allergen.

Clinical suspicion of allergic sensitization is confirmed by demonstrating the presence of allergen-specific IgE antibodies in vivo (skin tests) or in vitro.

Skin tests, especially Skin Prick Test (SPT), represent the most reliable tool for the diagnosis and management of IgE-mediated diseases.

2. Scope

The aim of this adjudication rule is to highlight the medical necessity and coverage criteria for allergy testing and allergen immunotherapy services for all health insurance plans administered by Daman that has the corresponding benefit, subject to policy terms and conditions.

3. Adjudication Policy

3.1 Eligibility / Coverage Criteria

Daman considers allergy testing and immunotherapy medically necessary when all the following criteria are met:

1. Members presenting with clinically significant symptoms, including but not limited to:
    - Skin rash or urticaria occurring after exposure to a suspected allergen, with or without associated tingling.
    - Acute anaphylactic symptoms including respiratory distress, throat swelling, oropharyngeal edema, and loss of consciousness.
    - For GI symptoms overlapping with dermatological manifestations, refer to Table 1 for clarification of the relevant clinical pathways.
2. Failure of conservative management in controlling clinically significant symptoms. Life-threatening and severe cases are considered an exception from this.
3. Allergens tested should correlate with the member's history, physical examination and risk of exposure in home and/or work environment.

Allergy tests

Allergy tests are divided into two types:

Allergy tests In vivo:

The number and frequency of tests required to diagnose allergies can vary by individual.

Types of In vivo tests:

- Skin prick tests (SPT): Diagnosis of type I, immediate, IgE-mediated allergy
- Intradermal tests (IDT): Used to evaluate both immediate IgE-mediated allergy and delayed-type hypersensitivity
- Skin patch test: Used for delayed type, cell-mediated, hypersensitivity reaction, not used for IgE-mediated allergy
- Photo patch tests
- Oral Challenge Test

Allergy tests In vitro:

- Radioallergosorbent test –RAST/ IgE
- Multiple allergosorbent tests – MAST/ IgE

Table 1: Clinical indications of Allergy Testing

Condition / Scenario	Recommendation on Allergy Testing	Key Clinical Indications
Atopic Dermatitis (Eczema)	Routine allergy testing is not recommended and should only be performed when there is a strong clinical suspicion of food-related exacerbation.	• Clear, reproducible flare of eczema temporally related to ingestion of a specific food (e.g. egg, milk).
		• Moderate–severe or treatment-resistant dermatitis, particularly in children.
		• Distribution or pattern suggestive of contact dermatitis (e.g. hands, face, periorbital involvement).
Allergic Rhinitis	Allergy testing should not be first-line. Allergen-specific IgE testing should be considered only after inadequate response to an appropriate therapeutic trial.	• Persistent or moderate–severe symptoms despite ≥2 weeks of optimal pharmacotherapy (e.g. intranasal corticosteroids ± antihistamines).
		• Diagnostic uncertainty.
		• Prior to consideration of allergen-specific immunotherapy.
Asthma	Routine allergy testing is not recommended; and should be restricted to circumstances where results are expected to influence management.	• Difficult-to-treat or severe asthma despite optimized therapy.
		• Strongly suspected or documented food allergy contributing to asthma exacerbations.
		• Evaluation for biologic therapy or allergen immunotherapy.

Suspected food-related allergic reactions	Allergy testing is indicated when clinical history suggests an IgE-mediated reaction. Diagnosis should be based on history, supported by targeted testing and, where appropriate, oral food challenge.	• Anaphylaxis, immediate acute urticaria or angioedema following food exposure.
		• Immediate worsening of eczema with a clear temporal relationship to food ingestion.
Food intolerance without allergic features	Allergy testing is not recommended.	• Non-IgE-mediated food intolerance (e.g. pharmacologic or metabolic reactions).
		• Functional gastrointestinal disorders such as irritable bowel syndrome in the absence of allergic features.
Latex allergy (suspected)	Allergy testing may be considered only when there is a compatible clinical history. Screening tests are not recommended.	• Immediate hypersensitivity reactions following latex exposure (contact urticaria, rhinitis, wheeze, anaphylaxis).
		• High-risk groups (e.g. healthcare workers, patients with spina bifida) with symptoms.
Assessment prior to allergen immunotherapy (AIT)	Allergy testing is required to identify relevant allergens prior to initiation of immunotherapy.	• Confirmation of clinically relevant sensitisation before AIT.
		• Component-resolved diagnostics in selected polysensitised patients.
Monitoring response to allergen immunotherapy	Routine serial measurement of specific IgE levels is not recommended as a measure of treatment effectiveness.	• Clinical response should be assessed based on symptom control, medication use, and quality-of-life outcomes rather than IgE levels.
Chronic urticaria	Routine allergy testing is not recommended. Testing should be limited to selected cases where history suggests an external allergic trigger.	• Reproducible urticaria following exposure to a specific food, drug, or occupational allergen.
		• Not indicated in chronic spontaneous urticaria without allergic features.
Rare allergic or eosinophilic disorders	Allergy testing may be indicated as part of specialist evaluation.	• Allergic bronchopulmonary aspergillosis (ABPA).
		• Eosinophilic esophagitis.

		• Eosinophilic gastroenteritis.
Asymptomatic individuals	Allergy testing is not recommended.	• Screening based solely on family history of atopy, patient request, or incidental findings in the absence of symptoms.

Table 2: Clinical indications of In Vitro Testing

Indications
• Skin conditions or limitations that prevent reliable skin testing, such as severe eczema, dermographism, ichthyosis, extensive dermatitis, or very young children where skin testing isn't feasible.
• Medication constraints where patients cannot safely stop drugs that interfere with skin testing (e.g., long-acting antihistamines, tricyclic antidepressants, beta-blockers) or have unexplained negative histamine controls.
• Safety concerns, including history of anaphylaxis, prior systemic reactions to skin testing, or high-risk scenarios involving unusual allergens or drug/venom sensitization where false-negatives carry serious consequences.
• Patient factors such as mental or physical impairments make cooperation with skin prick testing difficult.
• Diagnostic needs including inconclusive/equivocal skin test results requiring confirmation, evaluation of cross-reactive insect venoms, or adjunct testing for conditions like allergic bronchopulmonary aspergillosis or certain parasitic diseases.

3.1 Requirements for Coverage

Allergy Testing Clinicians:

Eligible Ordering Clinician Professions
Endocrinology
Infectious Disease
Allergy and Immunology
Dermatologist
Otolaryngologist
Gastroenterology
Pulmonologist
Internal Medicine with relevant categories
Pediatrics

3.2 Non-Coverage

- Allergy testing and Allergy immunotherapy services are subject to policy terms and condition.
- Experimental/investigational/unproven tests are not covered.
- Allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. Allergy testing is performed prior to immunotherapy to determine the offending allergens.
- Blood testing for IgE-Documentation must contain history and allergen being tested for
- In known cases of allergy, with a positive history the medical necessity of requesting either a skin prick or IgE test must be clearly documented along with the conservative management done previously, along with the treatment plan
- The medical report should also specify that Skin Prick Test & In vitro blood test will not be covered if ordered or performed on the same encounter unless clear documentation indicating the necessity of performing both. If the conditions are met it can be used as substitute rather than an additional service unless there is detailed documentation in the medical record to support the necessity to perform for different reasons and/or allergens.
- Measurement of IgG and IgG4 antibodies is considered an unvalidated diagnostic modality. Therefore, they are regarded as unproven and not medically necessary for diagnostic purposes.

Table 2: List of experimental/investigational tests not covered by Daman:

- Leukocyte histamine release (LHR)- Used in the evaluation of food, inhalant, and drug allergies its role has not been established.
- Ophthalmic mucous membrane tests- To diagnose allergic rhinitis and allergic conjunctivitis its role has not been established.
- Direct nasal mucous membrane test- To diagnose allergic rhinitis its role has not been established.

3.3 Payment and Coding Rules

- Allergy testing and allergen immunotherapy is covered for Thiqa and all the other policies that have the allergy testing benefit.
- In case of allergy testing services performed through multiple units of allergens, the number of tests must be shown on the claim units. The codes include the cost of performing the tests as well as the cost of the allergenic extracts being tested.
- If a significant separately identifiable E&M service is performed, the appropriate E&M service code should be reported.
- When photo patch tests are performed (same antigen/same session) with patch or application tests, only the photo patch testing should be reported.

Allergen Immunotherapy

1. Administration/Injection codes:

- Intended to be reported in line with the applicable coding rules. These codes can be billed with preparation codes but cannot be billed with complete service codes.

2. Allergy Injection codes and E/M codes:

- Both should not be filed for the same day unless the E/M is separately identifiable
- For a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series, required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

3. Complete service codes (preparation & administration):

- These are complete service codes representing the entire service of preparing, providing and administering the antigen.

4. Preparation/Component Procedure codes:

- Preparation and provision of single-dose vial of antigens by an allergist to be administered by another physician i.e., to be billed only by an allergist who is preparing extract to be administered which is billed by another physician/provider. These vials are designed for use only when there is concern about the accuracy of measurement of doses from a multiple dose vial by a non-allergist's office.

5. Rapid desensitization:

- It is billed when a physician has established that a patient has sensitivity or a personal history of allergy to a drug that is essential to treatment. This includes each hour spent performing a rapid desensitization procedure to medications (insulin, penicillin, horse serum). It desensitizes the patient and develops the patient's tolerance to the substance.
- This procedure will also require frequent monitoring and skin testing which is a part of service code

4. Denial Codes

CPT Code	Code Description
MNEC-003	Service is not clinically indicated based on good clinical practice
MNEC-004	Service is not clinically indicated based on good clinical practice, without additional supporting diagnoses/activities
MNEC-005	Service/supply may be appropriate, but too frequent
NCOV-001	Diagnosis(es) is (are) not covered
NCOV-003	Service(s) is (are) not Covered
PRCE-002	Payment is included in the allowance for another service
CODE-010	Activity /diagnosis is inconsistent with the clinician specialty

5. Appendices

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5.2 Revision History

Date	Change(s)
23/10/2026	Creation of External Adjudication Guideline

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