Chronic Urticaria Testing, In Vitro (CU Index™)

MPM 3.6

Disclaimer

Refer to the member's specific benefit plan and *Schedule of Benefits* to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description

Chronic urticaria is a skin disorder characterized by recurrent, transitory, pruritic erythematous wheals present for at least six weeks. Thirty to fifty percent of patients with chronic urticaria have an autoimmune etiology and are thought to carry detectable levels of functional autoantibodies in their serum. Such patients have a more severe and unremitting urticaria. Chronic urticaria testing is done to determine if a patient has an autoimmune basis for their disease.

Coverage Determination/ Clinical Indications

This technology has been reviewed by the Technology Assessment Committee and the Medical Policy Committee.

PHP has determined that in vitro chronic urticaria testing for the identification of autoantibodies has not been shown to improve outcomes. **It is not a covered benefit.**

Coding

The coding listed in this Medical Policy is for reference only. Covered and non-covered procedures are included in this list.

CPT Codes	Description
86343	Leukocyte histamine release test (LHR)
86352	Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP)

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ICD-9© Diagnosis Codes	Description
708.0	Allergic urticaria
708.1	Idiopathic urticaria
708.2	Urticaria due to cold and heat
708.3	Dermatographic urticaria
708.4	Vibratory urticaria
708.5	Cholinergic urticaria
708.8	Other specified urticaria (nettle rash, chronic urticaria, recurrent period urticaria)
708.9	Urticaria, unspecified (hives)

References:

1. IBT Laboratories. CU Index™ Testing Services. Reviewed 04-09-10. Accessed 07-23-10. Accessed 7-25-12.
2. Trailblazer Health Enterprises, LLC. Local Coverage Determination Z-14A-R33: Non-Covered Services. Revision Date 07-12-10.Accessed 7-25-12. Updated 7-1-12.

Approval Signatures:

Medical Policy Committee: Mark Whitaker MD

Medical Director: Albert Rizzoli MD

Date: August 22, 2012

Publication History:
08-25-08: Original effective date
08-25-10: Annual review
08-22-12: Biennial Review

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available on the Internet at: http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm

Not every Presbyterian health plan contains the same benefits. Please refer to the member's specific benefit plan and *Schedule of Benefits* to determine coverage.
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