INTRAVENOUS HISTAMINE THERAPY (NCD 30.6)

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INSTRUCTIONS FOR USE

This Policy Guideline is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates for healthcare services submitted on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450), or their electronic comparative. The information presented in this Policy Guideline is believed to be accurate and current as of the date of publication.

This Policy Guideline provides assistance in administering health benefits. All reviewers must first identify member eligibility, any federal or state regulatory requirements, Centers for Medicare and Medicaid Services (CMS) policy, the member specific benefit plan coverage, and individual provider contracts prior to use of this Policy Guideline. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document may differ greatly from the standard benefit plan upon which this Policy Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Policy Guideline. Other Policies and Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

UnitedHealthcare follows Medicare coverage guidelines and regularly updates its Medicare Advantage Policy Guidelines to comply with changes in CMS policy. UnitedHealthcare encourages physicians and other healthcare professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other healthcare professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. This Policy Guideline is provided for informational purposes. It does not constitute medical advice.

POLICY SUMMARY

Overview
The only accepted and scientifically valid medical use of histamine is diagnostic, including tests to assess:
- The ability of the stomach to secrete acid;
- The integrity of peripheral sensory nerves (e.g., in leprosy);
- The circulatory competency in limb extremities; and
- The presence of a pheochromocytoma.

Reimbursement Guidelines
However, there is no scientifically valid clinical evidence that histamine therapy is effective for any condition regardless of the method of administration, nor is it accepted or widely used by the medical profession. Therefore, histamine therapy cannot be considered reasonable and necessary, and program payment for such therapy is not made.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.
CPT Code  | Description
---|---
95199 | Unlisted allergy/clinical immunologic service or procedure
96379 | Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion

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REFERENCES

CMS National Coverage Determinations (NCDs)
NCD 30.6 Intravenous Histamine Therapy

GUIDELINE HISTORY/REVISION INFORMATION

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