ADMINISTRATIVE POLICY STATEMENT
GEORGIA MEDICAID

Policy Name		Policy Number	Date Effective
Allergy Testing and Allergen Immunotherapy		AD-0918	05/01/2021-11/30/2021
Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Allergy Testing and Allergen Immunotherapy

B. Background

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. It is based on findings during a complete medical and immunologic history, and appropriate physical exam obtained by face-to-face contact with the patient.

Allergen Immunotherapy is defined as the repeated administration of specific allergens to patients with IgE-mediated conditions for the purpose of providing protection against allergic symptoms and inflammatory reactions associated with natural exposure to these allergens.

CareSource considers specific allergy testing and allergen immunotherapy medically necessary for members with clinically significant allergic symptoms. Based on a review of the medical literature and the position statements of scientific organizations in the field of allergy and immunology, CareSource considers the specific allergy testing and treatment described below medically necessary in accordance with the selection criteria noted.

C. Definitions

- **Allergy** - Refers to an acquired potential for developing adverse reactions that are mediated by the immune system (via Immunoglobulin E antibodies). Allergic disease represents the clinical manifestations of these adverse immune responses.
- **Allergen immunotherapy** - (Desensitization, Hypo-sensitization) is parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage maintained as maintenance therapy.
- **Allergy testing** - Identifying the offending antigen(s) for a patient by in-vivo testing percutaneous, intradermal, and less commonly, patch and photo patch tests.
- **Dose** - A 1cc aliquot of medicine or serum taken from a single, multi- dose vial. Ten doses are typically obtained from such a vial. In accordance with Centers for Medicare & Medicaid Services (CMS) guidelines, diluted doses will not be reimbursed; instead, if the medication or serum is diluted, only those doses designated from the maintenance vial (a maximum of ten) will be reimbursed.

D. Policy

I. CareSource requires a prior authorization for allergy testing and immunotherapy services administered by a participating provider.
   A. Documentation must be submitted with a complete medical and allergic/immunologic history and physical examination to support medical necessity.
   B. Documentation must include evidence that the antigen tested is appropriate for the exposure in the patient's environment.

II. The expectation is that the testing must be limited to the minimal number of necessary tests required to reach a diagnosis.

III. For percutaneous tests, intra-cutaneous/intradermal tests, photo patch tests, and patch tests, photo tests, or application tests, the provider must specify the number of tests performed.

IV. Quantitative or semi-quantitative in-vitro allergen specific IgE tests (formerly referred to a RAST tests) are covered if skin testing is not possible or not reliable and they are performed by providers certified under the "Clinical Laboratory Improvement Amendment of 1988" (CLIA '88) to perform the tests.

V. Ophthalmic mucous membrane tests and direct nasal mucous membrane tests are allowed only when skin testing cannot test allergens.

VI. Allergy immunotherapy

A. CareSource recognizes two components of allergen immunotherapy:

1. The administration (injection) of the antigen, which includes all professional services associated with the administration of the antigen.
2. The antigen itself.

Note: These two components must be separate on the claim, regardless of whether or not the provider who prescribes and provides the antigen is the same as the provider who administers the antigen.

B. If an office visit code is submitted with an allergen immunotherapy service, correct coding and modifiers must be used.

C. Allergen immunotherapy will not be covered for the following antigens:

- Newsprint
- tobacco smoke
- dandelion
- orris root
- phenol
- formalin
- alcohol
- sugar
- yeast
- grain mill dust
- goldenrod
- pyrethrum
- marigold
- soybean dust
- honeysuckle
- wool
- fiberglass
- green tea
- chalk

VII. Injections
   A. For reimbursement for the administration (injection) of allergenic extract or stinging insect venom, the provider must use appropriate coding.
   B. The allergenic extract may be administered by the physician or by a properly instructed employee under the general supervision of the physician in an office setting.

VIII. Antigens (excluding stinging insect venoms)
   A. When the provider uses a single or multiple-dose vial, the number of doses contained in the vial should be listed on the claim as units.
   B. When the provider dispenses two or more multiple-dose vials of antigen, it must be listed on a separate claim line along with the corresponding number of units.
   C. When providing both components of the service providers must do component billing. The number of units must be specified.

IX. Insect venoms
   A. When a provider uses single dose vials or preparations, appropriate coding must be used, and appropriate number of units must be submitted.
   B. When a provider uses multiple dose vials, appropriate coding must be used, and appropriate number of units must be submitted.
   C. The number reported as the unit of service must represent the total number of doses contained in the vial.
   D. Regardless of the number of doses, the date of service reported should be:
      a. The date the vial is dispensed to the patient, if the patient takes the vial home to be administered at a different office OR
      b. The date that the first dose is administered to the patient, if the vial is kept in the physician's office.
   E. If the provider also administers the venom, the correct quantity is one.

Note: CareSource does not cover:
- Allergen immunotherapy that is considered experimental, investigational, or unproven;
- Allergen therapy administered by the member at home, from vials of serum prepared by the provider.

E. Conditions of Coverage

Documentation to support medical necessity must be submitted with the claim.

F. Related Policies/Rules

N/A

G. Review/Revision History

DATES		ACTION
Date Issued	09/30/2020	
Date Revised		
Date Effective	05/01/2021	
Date Archived	11/30/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

H. References

1. Antigen Therapy. Policies and Procedures for Physician Services Chapter 903.2. Georgia Department of Community Heath. Retrieved August 31, 2020 from www.mmis.georgia.gov.
2. CPT® overview and code approval. (2019, March 22). Retrieved from www.ama-assn.org.
3. Conditions Dictionary. American Academy of Allergy, Asthma & Immunology. (2020). Retrieved July 15, 2020 from www.aaaai.org.
4. Optum360 EncoderProForPayers.com - Login. (2019, February 18). Retrieved July 15, 2020 from www.encoderprofp.com.
5. Physician Fee Schedule. Georgia Medicaid Management Information System (GAMMIS). Retrieved July 15, 2020 from www.mmis.georgia.gov.

The Administrative Policy Statement detailed above has received due consideration as defined in the Administrative Policy Statement Policy and is approved.

GA-MED-P-309108 Issue date 09/30/2020 DCH Approved 02/16/2021