

OHCA Guideline

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| Medical Procedure Class: | Allergy Immunotherapy |
| Initial Implementation Date: | 5/1/2014 |
| Last Review Date: | 10/17/2019 |
| Effective Date: | 11/1/2019 |
| Next Review/Revision Date: | 11/1/2022 |
| * This document is not a contract, and these guidelines do not reflect or represent every conceivable situation. Although all items contained in these guidelines may be met, this does not reflect, or imply, any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit. | |
| <input type="checkbox"/> New Criteria <input checked="" type="checkbox"/> Revision of Existing Criteria | |
| Summary | |
| Purpose: | To provide guidelines to assure medical necessity and consistency in the prior authorization process. |
| Definitions | |
| <p>Allergen Immunotherapy: (desensitization, hypo-sensitization) parenteral or oral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage defined as maintenance therapy.</p> <p>Allergy: refers to an acquired potential for developing adverse reactions that are mediated by the immune system (via IgE antibodies). Allergic disease represents the clinical manifestations of these adverse immune responses.</p> <p>Dose: A 1 cc aliquot of medicine or serum taken from a single or multi-dose vial. A 1 cc aliquot of medicine or serum = 1 unit.</p> <p>Multi-dose vial: provider prepares multiple doses of antigen in a vial for administration; typically ten milliliters or ten units are obtained from such a vial. Extract being used to reduce concentration cannot be charged. Charges are generated with the most concentrated vial.</p> <p>Single dose vial: provider prepares a single dose of antigen in a separate vial for administration by another provider, the member, or other individual. Note: One single dose vial or one milliliter = 1 unit. Only the maximum strength vial used for reduced concentration can be charged.</p> | |
| Description | |
| <p>Allergy immunotherapy involves administration of allergenic extracts at periodic intervals, with the goal of reducing symptoms, including titrating to a dosage that is maintained as maintenance therapy. Allergy immunotherapy is initiated once the offending allergen(s) has been identified through exposure and/or allergy testing. The documented allergy should correspond to the allergen planned for immunotherapy. OHCA may consider allergy immunotherapy medically necessary for members who have significant life-threatening symptomology or a chronic allergic state that cannot be managed by medication, avoidance, or environmental control measures. Before beginning allergy immunotherapy, consideration must be given to other common medical conditions that could make allergy immunotherapy more risky.</p> | |

When Allergy Services Require Prior Authorization (PA)

When a provider is preparing single dose vials of antigens to be administered by a different provider, member, or family member, 30 units per treatment period of 90 days is allowed, with a limit of 120 units per year. Note: One single dose vial = 1 unit. **Additional units above the stated limits will require prior authorization with individual consideration.**

When a provider is preparing multi-dose vials, there is a limitation of 10 units per vial, with a maximum of 20 units allowed per 90 day treatment period. There is a limit of 80 units allowed per year. **Additional units above the stated limits will require prior authorization with individual consideration.**

Additional Criteria

- A. Allergy immunotherapy is covered when the following criteria are met and documented in the medical record:
 - 1. The member has allergic asthma; **or**
 - 2. Allergic rhinitis and/or conjunctivitis; **or**
 - 3. Life threatening allergy to hymenoptera (stinging insect allergy); **or**
 - 4. There is clinical evidence of an inhalant allergen(s) sensitivity; **and**
 - 5. Documentation supports that the member's symptoms are not controlled with medications and avoidance of the allergen(s) are impractical.

- B. A presumption of failure can be assumed if, after 12 months of allergy immunotherapy, the member does not experience any signs of improvement and all other reasonable factors have been ruled out.
 - 1. Documented success of allergy immunotherapy treatment is evidenced by:
 - a. A noticeable decrease of hypersensitivity symptoms, **or**
 - b. An increase in tolerance to the offending allergy(s), **or**
 - c. A reduction in medication usage.

- C. Only contracted providers (a physician, physician assistant, or advanced practice nurse) who are board certified or board eligible in allergy and immunology or have received training in allergy and immunology in an accredited academic institution for a minimum of one month rotation (authenticated by a supporting letter from institution or mentor) are allowed to bill for preparing allergy immunotherapy vials. **Note:** Follow-up administration of medically indicated allergy immunotherapy can be done by a practitioner other than the allergist.

References

- 1. Oklahoma Health Care Authority; Policies and Rules, OAC 317:30-3-1, 317: 30-5-14.1
- 2. I. Leonard Bernstein, M.D.; James T. Li, M.D., PhD; David I. Bernstein, M.D, et al, Allergy Diagnostic Testing: An Updated Practice Parameter; developed by the Joint Task Force on Practice Parameters, representing the American Academy of Allergy, Asthma & Immunology (AAAAI); the American College of Allergy, Asthma & Immunology (ACAAI); and the Joint Council of Allergy, Asthma & Immunology.
- 3. CMS Medicare Claims Processing Manual, Chapter 12, Transmittal 200, Allergy Testing and Immunotherapy.
- 4. Aetna, Clinical Policy Bulletin, Number: 0038, Allergy and Hypersensitivity, 3/29/19