

# Clinical Policy: Allergy Immunotherapy



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Effective Date: 03/01/2006

Date of Last Revision: 01/01/2017

CPT Codes: 95115; 95117; 95120; 95125; 95130-95134; 95144-95149; 95165; 95170; 95180; 95199

Document: BI117:00

## Public Statement

### Effective Date:

- a) This policy will apply to all services performed on or after the above Revision date which will become the new effective date.
- b) For all services referred to in this policy that were performed before the revision date, contact customer service for the rules that would apply.

**Allergic disease and associated asthma are serious and sometimes life-threatening illnesses. Allergies are generally treatable, controllable illnesses. Allergies can be treated in three ways:**

- Avoid the allergen: if you are not exposed, you have nothing to cause an allergic reaction. This may not always be practical.
- Medications: Medications may reduce the tendency to have the allergic reaction or may treat the allergic reaction after it starts. Many medications are available without prescription. Prescription medications may be subject to “step therapy” requirements.
- Immunotherapy: Injections of allergens to which people are sensitive tends to reduce allergic sensitivity. For immunotherapy to work, the shots must be taken regularly over a prolonged period of time (years). Immunotherapy is covered. Periodic random audits may be used to ensure the shots are being administered.

The use of air cleaners, humidifiers, or dehumidifiers is not covered.

## Medical Statement

1. Allergy immunotherapy is covered under the following conditions:
  1. When all of the following are met:
    - The documented allergy corresponds to the allergen planned for immunotherapy.
    - A trial of systemic medications or avoidance of the allergens has been attempted.
    - Two or more medications (antihistamines, steroids, bronchodilators, intranasal cromolyn) if not contraindicated should have been tried during the past year or the patient should be currently receiving immunotherapy.
  2. For the treatment of the following IgE-mediated allergies:
    - Allergic (extrinsic) asthma
    - Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals
    - Mold-induced allergic rhinitis
    - Perennial rhinitis

- Seasonal allergic rhinitis or conjunctivitis
  - Dust mite atopic dermatitis;
3. When all of the following conditions are met:
    - Member has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen, or
    - Member has a life-threatening allergy to insect stings (bees, hornets, wasps, and fire ants), and
    - Member has skin test and/or serologic evidence of IgE-mediated antibody of the allergen.
  4. Allergy immunotherapy is not considered medically necessary for:
    - Food allergy
    - Migraine headaches
    - Non-allergic vasomotor rhinitis
    - Intrinsic (non-allergic) asthma
    - Chronic urticaria
    - Atopic dermatitis except for dust mite atopic dermatitis
    - Angioedema.
2. Billing for Allergy Immunotherapy
    1. A physician who administers allergy immunotherapy but neither does not create nor bills for the creation of the injected antigen, should use codes 95115 and 95117. No more than one of the administration codes may be used on any date of service. A maximum of one unit of either of these codes is allowed per date of service. Periodic random audits may be used to ensure the shots are being administered.
    2. A physician who prepares and bills for the allergen, but who does not administer the allergen, may use codes 95144-95170 to bill for these services. These services are limited to preparation of 24 doses per two sessions. In the event that greater than 144 doses per 365 days are clinically required, prior authorization for the additional doses will be required to ensure the higher number of units is justified due to incompatible antigens that may not be combined.
    3. If a physician prepares the allergen on one occasion and administers it on other occasions, it would be correct to bill 95144-95170 on the day of the preparation of the allergen and 95115 or 95117 on the day of administration of the allergen. No more than one of the administration codes may be used on any date of service. A maximum of one unit of either of these codes is allowed per date of service. Periodic random audits may be used to ensure the shots are being administered.
    4. Mixing and administering the allergen on the same day “off the board” is not considered to be appropriate; codes 95120-95134 will no longer be recognized or paid by QualChoice.

3. Other forms of allergy treatment:
  1. The following allergy treatments are considered medically necessary:
    - Rapid desensitization (a.k.a., rush, cluster or acute desensitization) for members with any of the following conditions:
      1. Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or
      2. IgE antibodies to a particular drug that cannot be treated effectively with alternative medications; or
    - Epinephrine kits (e.g., Ana-Kit, Epi-Pen auto-injectors) to prevent anaphylactic shock for individuals who have had life-threatening reactions to insect stings, foods, drugs or other allergens or have severe asthma or if needed during immunotherapy.

**Codes Used In This BI:**

95115	Immunotherapy one injection
95117	Immunotherapy injections
95120	Immunotherapy one injection
95125	Immunotherapy many antigens
95130	Immunotherapy insect venom
95131	Immunotherapy insect venoms
95132	Immunotherapy insect venoms
95133	Immunotherapy insect venoms
95134	Immunotherapy insect venoms
95144	Antigen therapy services
95145	Antigen therapy services
95146	Antigen therapy services
95147	Antigen therapy services
95148	Antigen therapy services
95149	Antigen therapy services
95165	Antigen therapy services
95170	Antigen therapy services
95180	Rapid desensitization
95199	Allergy immunology services

## Limits

The following allergy treatments are considered experimental and investigational as they have not been proven to be effective:

- Acupuncture for allergies
- Autogenous urine immunization (autogenous urine therapy)
- Allergoids (modification of allergens to reduce allergenicity)
- Bacterial immunotherapy
- Detoxification for allergies
- Ecology units/environmental control units/environmental chemical avoidance for multiple chemical sensitivity syndrome
- Enzyme potentiated desensitization (EPD)
- Homeopathy for allergies
- Neutralization therapy (desensitization neutralization therapy)
- Photo-inactivated extracts
- Polymerized extracts
- Poison ivy/poison oak extracts for immunotherapy in the prevention of toxicodendron (Rhus) dermatitis
- Repository emulsion therapy
- Sublingual drops

## Reference

1. University of Michigan Health System. Allergic rhinitis. Ann Arbor, MI: University of Michigan Health System; July 2002.
2. Global Initiative for Asthma (GINA), National Heart, Lung and Blood Institute (NHLBI), World Health Organization (WHO). Global initiative for asthma. Bethesda, MD: Global Initiative for Asthma (GINA), National Heart, Lung and Blood Institute (NHLBI); February 2002.
3. National Asthma Education and Prevention Program. Expert panel report: Guidelines for the diagnosis and management of asthma update on selected topics - 2002. *J Allergy Clin Immunol.* 2002; 110(5 pt. 2):S141-S219.
4. Nelson HS. Advances in upper airway diseases and allergen immunotherapy. *J Allergy Clin Immunol.* 2003; 111(3 Suppl):S793-S798.
5. Long A, McFadden C, DeVine D. Management of allergic and non-allergic rhinitis. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2002.
6. Blue Cross Blue Shield Association (BCBSA) Technology Evaluation Center. Sublingual immunotherapy for adults. Assessment Program, Vol. 18, No. 4. Chicago, IL: BCBSA; June 2003. Available at: [http://www.bcbs.com/tec/vol18/18\\_04.html](http://www.bcbs.com/tec/vol18/18_04.html).
7. McCrory DC, Williams JW, Dolor RJ, et al. Management of allergic rhinitis in the working-age population. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2003.
8. Huggins JL, Looney RJ. Allergen immunotherapy. *Am Fam Physician.* 2004; 70(4):689-696.
9. Royal Australasian College of Physicians, Working Group on Chronic Fatigue Syndrome. Chronic fatigue syndrome. Clinical Practice Guidelines. *Med J Australia.* 2002; 176(8 Suppl):S17-S55.

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## **Addendum:**

1. Effective 06/01/2017: Clarification regarding proper use of administration codes.
2. Effective 01/01/2017: Clarification on PA requirements.

## **Application to Products**

This policy applies to all health plans administered by QualChoice, both those insured by QualChoice and those that are self-funded by the sponsoring employer, unless there is indication in this policy otherwise or a stated exclusion in your medical plan booklet. Consult the individual plan sponsor Summary Plan Description (SPD) for self-insured plans or the specific Evidence of Coverage (EOC) for those plans insured by QualChoice. In the event of a discrepancy between this policy and a self-insured customer's SPD or the specific QualChoice EOC, the SPD or EOC, as applicable, will prevail. State and federal mandates will be followed as they apply.

Changes: QualChoice reserves the right to alter, amend, change or supplement benefit interpretations as needed.