Benefit Criteria to Change for Allergy Testing for the CSHCN Services Program Effective October 1, 2014

Information posted September 10, 2014

Effective October 1, 2014, benefit criteria for allergy testing will change for the Children with Special Health Care Needs (CSHCN) Services Program for dates of service on or after September 1, 2014.

Allergy Blood Testing

Benefits and Limitations

Allergy blood testing (procedure codes 86001 and 86003) will be a benefit of the CSHCN Services Program under the following circumstances:

- The client is unable to discontinue medications
- An allergy skin test is inappropriate for the client because of the following reasons:
  - The client is pediatric
  - The client is disabled
  - The client suffers from a skin condition such as dermatitis

The limitations stated above will also apply to procedure code 86005, which is currently a benefit of the CSHCN Services Program.

Procedure codes 86001 and 86003 will have the following benefit limitations:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>86001</td>
<td>20 allergens per rolling year, any provider</td>
</tr>
<tr>
<td>86003</td>
<td>30 allergens per rolling year, any provider</td>
</tr>
</tbody>
</table>

Prior Authorization

Prior authorization will be required for procedure codes 86001, 86003, and 86005 if the benefit limitations are exceeded.

Requests for prior authorization must be submitted with documentation of medical necessity and include all of the following:

- Results of any previous treatment
- Documentation indicating that the client’s treatment could not be completed within the policy limits for the requested procedures
- Client diagnosis and conditions that support the medical necessity for the additional procedures requested
- Explanation of client outcomes that the requested procedures will achieve

Prior authorization requests must be submitted by the physician to the CSHCN Services Program using the CSHCN Services Program Authorization and Prior Authorization Request form.
Prior Authorization Requirements for Unlisted Procedure Codes

Prior authorization is required for unlisted procedure codes. Every effort should be made to bill with the appropriate Current Procedural Terminology (CPT) code that describes the procedure being performed. If a procedure code does not exist to describe the service performed, then the unlisted procedure code 95199 should be submitted with appropriate documentation to assist in determining coverage. The documentation submitted must include all of the following:

- The client’s diagnosis
- Medical records indicating prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the procedure to be performed
- Reason for recommending the procedure
- A CPT or Healthcare Common Procedure Coding System (HCPCS) procedure code that is comparable to the procedure being requested
- Documentation that the procedure is not investigational or experimental
- Place of service the procedure is to be performed
- The physician’s intended fee for the procedure

Benefit Changes

Allergy blood testing procedure code 86001 will no longer be a benefit when rendered by the following provider types in the indicated places of service:

<table>
<thead>
<tr>
<th>Place of service</th>
<th>Provider types no longer reimbursed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
<td>Independent laboratory, optometrist, registered nurse/nurse midwife, radiation treatment center, hospital, nephrology, renal dialysis facility, rural health clinic (RHC) - hospital based</td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td>Independent laboratory, radiation treatment center, nephrology, renal dialysis facility, RHC - hospital based</td>
</tr>
<tr>
<td>Independent laboratory</td>
<td>Radiation treatment center, hospital, nephrology, renal dialysis facility, RHC – hospital based</td>
</tr>
</tbody>
</table>

Procedure code 86001 will no longer be a benefit when rendered in the inpatient hospital setting.

Claims Reprocessing

Claims with dates of service of September 1, 2014 through September 30, 2014, that were denied inappropriately will be reprocessed. No action on the part of the provider is required. Adjusted payments will be reflected on Remittance and Status (R&S) Reports after these claims are reprocessed.

For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.