Allergen Immunotherapy Benefit Changes for Texas Medicaid
Information posted May 23, 2008

Effective for dates of service on or after July 1, 2008, allergen immunotherapy benefit criteria will change for Texas Medicaid.

Texas Medicaid defines allergen immunotherapy as the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage that is maintained as maintenance therapy. The allergen immunotherapy benefit includes preparation of the allergy vial or extracts.

To submit allergen immunotherapy services for reimbursement, providers must use the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes – Preparation of Allergy Vial or Extract</th>
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<tbody>
<tr>
<td>1-95145</td>
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<tr>
<td>1-95149</td>
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Procedure Codes – Administration-Only*

<table>
<thead>
<tr>
<th>1-95115</th>
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<tbody>
<tr>
<td>1-95117</td>
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* When an injection is given from a vial, providers must use the administration-only procedure codes.

** Procedure codes for the preparation of the allergy vial or extract and procedure codes for the administration injection must be submitted with an appropriate diagnosis code. Providers may refer to the 2008 Texas Medicaid Provider Procedures Manual, Section 36.4.2.1, “Allergy Injections, Vials and Extracts,” on page 36-23 for allergen immunotherapy diagnosis restrictions.

The following limitations apply to allergen immunotherapy procedure codes:

- The quantity billed for the allergy extract preparation procedure should represent the total number of doses to be administered from the vial. If the number of doses is not stated on the claim, a quantity of one is allowed.

- Procedure code 1-95165 is limited to a total of 160 doses per one-year period, which begins the date that the immunotherapy is initiated. Additional doses may be considered for reimbursement through prior authorization with documentation of medical necessity.

- Reimbursement for the administration-only codes is limited to a quantity of one per day using procedure code 1-95115 or 1-95117.

- Procedure code 1-95115 is denied when billed by any provider with the same date of service as procedure code 1-95117.

- Procedure code 1-95145 is denied when billed by any provider with the same date of service as procedure code 1-95146, 1-95147, 1-95148, or 1-95149.
• Procedure code 1-95146 is denied when billed by any provider with the same date of service as procedure code 1-95147, 1-95148, or 1-95149.

• Procedure code 1-95147 is denied when billed by any provider with the same date of service as procedure code 1-95148 or 1-95149.

• Procedure code 1-95148 is denied when billed by any provider with the same date of service as procedure code 1-95149.

• The procedure codes in Column A below are denied when billed by the same provider with the same date of service as procedure codes in Column B:

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
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</table>

An office visit, clinic visit, or observation room visit is not considered for reimbursement in addition to the fee for the preparation or the administration of the allergy vial or extract unless the additional visit results in a non allergy-related diagnosis (a significant, separately identifiable service) or a reevaluation of the client’s condition.

Evaluation and management (E/M) procedure codes billed with allergy testing or allergy immunotherapy are reimbursed only if a significant, separately identifiable service is administered. Modifier 25 may be used to identify the significant, separately identifiable E/M service performed by the same physician on the same day as the allergy-related procedure or other service. When billing with Modifier 25, the provider must provide documentation to substantiate the use of the modifier in order for services to be considered for reimbursement. Documentation includes, but is not limited to, office or hospital medical records such as history and physical progress notes and lab results, if applicable.

Procedure code 1-95180 is also a benefit of Texas Medicaid.

Texas Medicaid does not cover allergen immunotherapy that is considered experimental, investigational, or unproven.

The following additional procedure codes are no longer benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tr>
<td>1-95120</td>
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<tr>
<td>1-95133</td>
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Authorization Requirements

Authorization is not required for immunotherapy services within the guidelines noted in this article. Requests for services beyond the established limits may be considered for prior authorization with documentation of medical necessity including:
• A copy of the allergen testing results.
• Severity and periodicity of symptoms.
• Physical limitations created by the symptoms.
• Anticipated treatment program.
• Concurrent drug treatment.
• Success or failure of previous therapy.

To request prior authorization for allergen immunotherapy services beyond the established limits, providers must submit their prior authorization request by fax to the TMHP Special Medical Prior Authorization Department at 1-512-514-4213 or by mail to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

For more information, call the TMHP Contact Center at 1-800-925-9126.