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Medical Policy

Sublingual Immunotherapy

Policy Number: 1095

Policy History			
Approve Date:	06/01/2018	Effective Date:	06/01/2018
Reviewed/Revised Date:	10/1/2019		

Preauthorization	
All Plans	Benefit plans vary in coverage and some plans may not provide coverage for certain service(s) listed in this policy. Decisions for authorization are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations as well as applicable state and/or federal laws. Please review the benefit plan descriptions for details.

Policy

Indications of Coverage

I. Qualified members may be considered for sublingual immunotherapy (SLIT) by Allergy Associates of La Crosse (AAOL)
   A. If the member has an approved referral, the claims will process as in-network and at a discounted rate. Allergy Associates will not be placed in the provider directory.
   B. A Health Tradition in-network provider must refer the member to AAOL for SLIT.

II. Health Tradition considers a *qualified member* one who meets at least one of the following criteria AND meets the criteria in the *Medical Criteria* section. To be eligible to receive SLIT from AAOL all processes and conditions must be met prior to services being rendered. The Health Tradition Medical Director(s) retain the right for final approval on all cases. Lab testing at AAOL is not a benefit of the approved referral authorization.
   A. Qualified Members
      i. Children between the ages of two and six with certain allergic diseases that warrant immunotherapy where subcutaneous immunotherapy (SCIT) is not indicated.
      ii. Members with uncontrolled asthma in which there is a significant allergic component and SCIT is contraindicated.
      iii. Members with severe asthma if, prior to approving a referral to AAOL, the member has demonstrated participation in and compliance with an asthma management program within the last three years AND either of the following:
         a. Member has severe asthma with fixed obstructions, i.e. Forced Expiratory Volume in the first second of less than 50% (FEV1 <50%) OR
         b. Member must have a significant allergic component found in the medical record that cannot be treated by conventional treatments or conventional treatment is not available for the identified antigen.
   B. Members with significant allergic disease who also have extenuating circumstances that limit the ability to travel on a recurrent basis for SCIT as determined by the Health Plan.

III. Possible Qualifying Members
   A. Members with environmental allergies would not be approved for referral unless

i. They had been evaluated through traditional means and had either failed SCIT in the past two years OR
ii. Had met one of the other items listed below in the Medical Criteria section that prevented the use of SCIT.

IV. Non-Qualifying Members
A. Members desiring SLIT for food allergies, food sensitivities, eczema
B. Members desiring SLIT to treat a nickel allergy (desiring nickel desensitization)
C. Member preference for SLIT over SCIT without meeting other qualifying criteria

V. Medical Criteria:
A. Takes certain medications that would exclude them from receiving SCIT, i.e. those using beta blockers, MAO inhibitors, etc. OR
B. Has medical record documentation of an anaphylactic shock reaction or other significant reaction such that the treating allergist documents contraindication to any future SCIT OR
C. Has tried and failed a reasonable regime of medications as determined to be appropriate by the Health Tradition Medical Director AND
D. Has had a consultation with a Board Certified Allergist or a provider with an American Academy of Otolaryngic Allergy (AAOA) designation within the last two years prior to a referral being approved to AAOL. Certain ENT physicians, for example, may hold the AAOA designation.
E. In some situations, IgE testing will be required for consideration before the prior authorization can be approved at the discretion of the HT Medical Director.

Definitions

"**Pre-service Claim**" means any claim for a benefit that requires approval before obtaining medical care. This includes any benefits requiring a referral, prior authorization or pre-certification, including prior authorization for prescription drugs. A Pre-service Claim also includes any situation when a member receives less of a benefit than what the member requested in terms of time, services, or duration.

"**Urgent Care Claim**" means a pre-service claim that requires immediate determination. Urgent care refers to an actual medical condition, not going to an urgent care clinic. The criteria for an urgent care claim are:

1. Could seriously jeopardize life, health or ability to regain maximum function. This determination must be made by an individual acting on behalf of the plan (for example, utilization review staff or a medical director) or a physician with knowledge of the member's medical condition OR
2. Would subject the member to severe pain that cannot be adequately managed without such care or treatment, determined by a physician with knowledge of the member's medical condition

References

1. URAC Health Plan for Health Insurance Marketplace (HIM) Accreditation, Version 7.2, P-HUM 25-Clinical Rationale for Non-Certification Requirements
2. Department of Labor Regulations 2650.503-1 of the Employer Retirement Income
3. Security Act of 1974 – Claims Procedure