

Allergy Testing & Immunotherapy Authorization Process

WELLCARE HEALTH PLANS, INC.
THE WELLCARE GROUP OF COMPANIES

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COMPREHENSIVE HEALTH MANAGEMENT, INC.

COMPREHENSIVE REINSURANCE, LTD.

Dear Provider,

The following guidelines are designed to assist you when seeking an authorization from WellCare of Georgia, Inc. for allergy testing and immunotherapy.

Allergy Testing

In the event a provider determines a member requires allergy testing, authorization will be required before administering **percutaneous** or **intra-dermal tests** for reactions to inhaled allergens, foods, hymenoptera and/or drugs. WellCare will utilize the following guidelines when authorizing medically necessary allergy testing:

- Initially, up to 70 percutaneous tests (scratch, prick, or puncture);
- If percutaneous tests are negative, 40 additional intradermal tests can be requested.

Allergy Immunotherapy

If the provider plans for immunotherapy after testing is completed, an authorization will be required. When submitting the authorization request, medical necessity of treatment should be clearly documented.

In cases where the provider administering the immunotherapy is different than the provider conducting testing and/or generating the immunotherapy serum/allergen, the administering provider must take the following action:

1. Obtain a separate authorization for the administration of the immunotherapy; **or**
2. Ensure the allergist includes the administering provider's information on the authorization request for immunotherapy treatments.

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WellCare will utilize the following criteria when determining the medical necessity for immunotherapy:

1. One or more of the following allergies have been diagnosed:

- Allergic asthma
- Hymenoptera
- Mold-induced allergic rhinitis
- Perennial rhinitis
- Seasonal allergic rhinitis and/or conjunctivitis
- Dust mite atopic dermatitis

and,

2. The following conditions exist:

- Member has allergy symptoms after natural exposure;
- Member has skin test and/or serological evidence of antibody to an extract of the allergen; and
- Avoidance of allergen or drug therapy is not effective in controlling symptoms.

and,

3. Allergy immunotherapy is not being requested for the following:

- Food allergy
- Migraine headaches
- Vasomotor rhinitis
- Intrinsic asthma
- Chronic urticaria
- Atopic dermatitis
- Angioedema

In addition to the clinical documentation, the provider should include a schedule for Immunotherapy. WellCare recommends the following schedule which currently meets industry standards for allergy immunotherapy:

- Weekly treatments during buildup period of 18 to 30 weeks
- Following buildup, a maintenance dose every three to four weeks
- Duration of treatment schedule should be no more than three to four years

A course of immunotherapy treatment can be submitted for periods of up to 6 months under one authorization using the Outpatient Authorization

Request Form. The request should include the date immunotherapy was initiated, expected duration, and the following information for the services being requested during the authorization period:

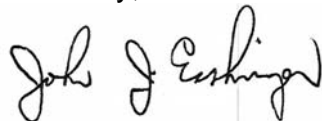
- Start/end dates of service period
- Frequency of visits for injections
- Number of vials of serum required
- Number of follow-up physician visits

Any requests for treatments that are more frequent than once weekly, to administer build-up treatments longer than 30 weeks or to provide therapy beyond 3 years, will require review by our medical director.

Some providers have created forms they elect to submit with their authorization requests. These forms are not required, but a sample is attached for your consideration.

If you need additional information related to authorization requirements or claims payment, please call the WellCare of Georgia, Inc. Provider Hotline at **(866) 231-1821** or your Provider Relations representative. You may also find a wealth of information on our Web site at <http://georgia.wellcare.com>.

Sincerely,



John Esslinger, MD
Senior Medical Director

Allergy Testing & Immunotherapy Authorization

Patients Name: _____ Today's Date: _____

DOB: _____

_____ New Patient starting Immunotherapy

_____ Patient is on build up for Immunotherapy
(comes one or two times a week)

_____ Patient is on maintenance Immunotherapy
(comes every other week, once every 3 weeks, once every 4 weeks)

Patient had scratch skin testing/intradermal skin testing done on ____/____/____.

Patient start date for Immunotherapy will be/was ____/____/____.

The patient had positive reactions to the following:

Mites Cat Dog Cockroach Mold Mix Grass Mix Weed Mix Tree Mix

Other: _____