CareSource

REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

Policy Name	Policy Number	Effective Date
Hepatitis Panel for Acute Viral Hepatitis	PY-0208	10/01/2020-08/31/2022

Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Contents of Policy

A. SUBJECT

Hepatitis P nel for Acute Viral Hepatitis

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Acute viral hepatitis (AVH) is a systemic infection that mostly affects the liver. It can be caused by a virus, a toxin, or could be the beginning of chronic liver disease. The viruses that most often cause AVH are hepatitis A, B, C, D, and E. The typical symptoms are shown in all forms of AHV including jaundice, fatigue, abdominal pain, loss of appetite, nausea, diarrhea, fever, and dark urine.

C. DEFINITIONS

- **Hepatitis panel:** consists of the following tests:
  - Hepatitis A antibody (HAAb), IgM Antibody
  - Hepatitis B core antibody (HBcAb), IgM Antibody
  - Hepatitis B surface antigen (HBsAg)
  - Hepatitis C antibody

D. POLICY

I. Prior authorization is not required for hepatitis panel tests that are medically necessary.

Note: Although a Hepatitis panel does not require a prior authorization, CareSource may request documentation to support medical necessity. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

II. Hepatitis panel is considered medically necessary when used for a differential diagnosis in members with **ANY** of the following:
   A. Symptoms of hepatitis infection **OR**
   B. Abnormal liver function tests **OR**
   C. Before and after a liver transplantation.

III. Hepatitis panel must be ordered and performed by a provider for these services, and when used in compliance with the Clinical Laboratory Improvement Act ("CLIA") regulations.

IV. Non-Covered Services
A. Once a diagnosis of hepatitis has been made, CareSource will not cover ongoing hepatitis panel testing. CareSource will cover, appropriate and medically necessary, individual hepatitis testing for its members.

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting Indiana Medicaid approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the Indiana Medicaid fee schedule

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced source for the most current coding information.**

CPT Codes	Description
80074	Acute Hepatitis Panel

Diagnosis Codes	Description
M25.50	Pain in unspecified joint
M79.10	Myalgia, unspecified site
R10.0	Acute abdomen
R10.10	Upper abdominal pain, unspecified
R10.11	Right upper quadrant pain
R10.12	Left upper quadrant pain
R10.13	Epigastric pain
R10.33	Periumbilical pain
R10.811	Right upper quadrant abdominal tenderness
R10.821	Right upper quadrant rebound abdominal tenderness
R10.83	Colic
R10.84	Generalized abdominal pain
R10.9	Unspecified abdominal pain
R11.0	Nausea
R11.10	Vomiting, unspecified
R11.11	Vomiting without nausea
R11.12	Projectile vomiting
R11.14	Bilious vomiting
R11.2	Nausea with vomiting, unspecified
R17	Unspecified jaundice
R19.5	Other fecal abnormalities (abnormal stool color)
R50.9	Fever, Unspecified
R53.1	Weakness
R53.81	Other malaise
R53.82	Chronic fatigue, unspecified
R53.83	Other fatigue

R56.00	Simple febrile convulsions
R56.01	Complex febrile convulsions
R56.1	Post traumatic seizures
R62.0	Delayed milestone in childhood
R62.50	Unspecified lack of expected normal physiological
R62.51	Failure to thrive (child)
R62.59	Other lack of expected normal physiological development in
R63.0	Anorexia
R63.1	Polydipsia
R63.2	Polyphagia
R63.3	Feeding difficulties
R63.4	Abnormal weight loss
R63.5	Abnormal weight gain
R63.6	Underweight – This code requires additional codes to identify Body Mass Index, if known
R74.0	Nonspecific elevation of levels of transaminase and lactic acid dehydrogenase [LDH]
R74.8	Abnormal levels of other serum enzymes
R74.9	Abnormal serum enzyme level, unspecified
R82.998	Other abnormal findings in urine
R94.5	Abnormal results of liver function studies
T86.40	Unspecified complication of liver transplant
T86.41	Liver transplant rejection
T86.42	Liver transplant failure
T86.43	Liver transplant infection
T86.49	Other complications of liver transplant
Z76.82	Awaiting organ transplant status
Z94.4	Liver transplant status

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	1/1/2017	
Date Revised		
Date Effective	10/01/2020	Removed ICD-10 and references to asymptomatic members. Title changed – was hepatitis panel.
Date Archived	08/31/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. REFERENCES

1. National Coverage Determination (NCD) for Hepatitis Panel/Acute Hepatitis Panel (190.33). (2003, January 1). Retrieved November 21, 2019 from https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=166&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Ohio&KeyWord=hepatitis+panel&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAA&
2. Centers for Medicare and Medicaid Services. Lab NCDs - ICD-10. (n.d.). Retrieved November 21, 2019, from https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10
3. World Gastroenterology Organisation Practice Guidelines: (2003, December). Retrieved November 21, 2019, from https://www.worldgastroenterology.org/UserFiles/file/guidelines/management-of-acute-viral-hepatitis-english-2003.pdf

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

IN-MED-P-125072 Date Issued 01/01/2017 OMPP Approved 07/17/2020