REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

Original Effective Date	Next Annual Review	Last Revision
01/01/2017	01/01/2018	01/01/2017 - 09/30/2020
Policy Name		**Policy Number**
Hepatitis Panel		PY-0208
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 Panel

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.

Hepatitis is an inflammation of the liver resulting from viruses, drugs, toxins, and other causes. Viral hepatitis can be due to one of at least five viruses, discussed here. Most cases of viral hepatitis are caused by Hepatitis A virus (HAV), Hepatitis B virus (HBV), or Hepatitis C virus (HCV), although viral hepatitis can also be caused by the less-prevalent viruses Hepatitis D and E.

The diagnosis of acute HBV infection is best established by documentation of a positive result for the IgM antibody against the core antigen (HBcAb-IgM), and by identifying a positive result for the hepatitis B surface antigen (HBsAg). The diagnosis of chronic HBV infection is established primarily by identifying a positive hepatitis B surface antigen (HBsAg) and demonstrating positive IgG antibody directed against the core antigen (HBcAb-IgG). Additional tests such as Hepatitis B e-antigen (HBeAg) and Hepatitis B e-antibody (HBeAb), which are the envelope antigen and antibody for Hepatitis B, are not included in the standard Hepatitis Panel. However, they can be a marker of replication and infectivity associated with an increased risk of transmission. This panel of tests is used for differential diagnosis in a patient with symptoms of liver disease or injury.

C. DEFINITIONS

- **Medically necessary –** health products, supplies or services that are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted guidelines of medical practice.

D. POLICY

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

II. Hepatitis panel test referred to in this policy are selected laboratory tests. Material related to diagnostic testing in this policy is included to clarify coverage for diagnostic versus screening indications. Hepatitis panel test consists of the following:
   A. Hepatitis A antibody (HAAb), IgM Antibody
   B. Hepatitis B core antibody (HBcAb), IgM Antibody
   C. Hepatitis B surface antigen (HBsAg)
   D. Hepatitis C antibody

III. CareSource will reimburse providers for the medically necessary screening, diagnoses, and subsequent treatments for, and management of hepatitis as documented in the medical record in the following circumstances:
   A. To detect viral hepatitis infection when there are abnormal liver function test results,

with or without signs or symptoms of hepatitis; and
B. Prior to and subsequent to liver transplantation.

IV. Coverage
A. CareSource will reimburse for hepatitis screening with the appropriate laboratory tests when ordered and performed by a provider for these services, and when used in compliance with the Clinical Laboratory Improvement Act ("CLIA") regulations.
B. CareSource will reimburse for an acute hepatitis panel once per calendar year for screening when medically necessary to test for hepatitis in asymptomatic men and women if accompanied by one or more of the appropriate ICD-10 codes. CareSource will reimburse for a repeat panel approximately two weeks to two months after the initial one to exclude the possibility of hepatitis in a patient with continued symptoms of liver disease despite a completely negative first Hepatitis Panel.

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.

V. 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 http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/maxfee_search.asp

- **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.**

Codes	Description
80074	Acute Hepatitis Panel

Codes	Description
B15.0	Hepatitis A with hepatic coma
B15.9	Hepatitis A without hepatic coma
B16.0	Acute hepatitis B with delta-agent with hepatic coma
B16.1	Acute hepatitis B with delta-agent without hepatic coma
B16.2	Acute hepatitis B without delta-agent with hepatic coma
B16.9	Acute hepatitis B without delta-agent and without hepatic coma
B17.0	Acute delta-(super) infection of hepatitis B carrier
B17.10	Acute hepatitis C without hepatic coma
B17.11	Acute hepatitis C with hepatic coma
B17.2	Acute hepatitis E
B17.8	Other specified acute viral hepatitis
B17.9	Acute viral hepatitis, unspecified
B18.0	Chronic viral hepatitis B with delta-agent
B18.1	Chronic viral hepatitis B without delta-agent
B18.2	Chronic viral hepatitis C
B18.8	Other chronic viral hepatitis
B18.9	Chronic viral hepatitis, unspecified

B19.0	Unspecified viral hepatitis with hepatic coma
B19.10	Unspecified viral hepatitis B without hepatic coma
B19.11	Unspecified viral hepatitis B with hepatic coma
B19.20	Unspecified viral hepatitis C without hepatic coma
B19.21	Unspecified viral hepatitis C with hepatic coma
B19.9	Unspecified viral hepatitis without hepatic coma
G93.3	Post-viral fatigue syndrome
I85.00	Esophageal varices without bleeding
I85.01	Esophageal varices with bleeding
I85.10	Secondary esophageal varices without bleeding
I85.11	Secondary esophageal varices with bleeding
K70.41	Alcoholic hepatic failure with coma
K71.0	Toxic liver disease with cholestasis
K71.10	Toxic liver disease with hepatic necrosis, without coma
K71.11	Toxic liver disease with hepatic necrosis, with coma
K71.2	Toxic liver disease with acute hepatitis
K71.3	Toxic liver disease with chronic persistent hepatitis
K71.4	Toxic liver disease with chronic lobular hepatitis
K71.50	Toxic liver disease with chronic active hepatitis without ascites
K71.51	Toxic liver disease with chronic active hepatitis with ascites
K71.6	Toxic liver disease with hepatitis, not elsewhere classified
K71.7	Toxic liver disease with fibrosis and cirrhosis of liver
K71.8	Toxic liver disease with other disorders of liver
K71.9	Toxic liver disease, unspecified
K72.00	Acute and subacute hepatic failure without coma
K72.01	Acute and subacute hepatic failure with coma
K72.10	Chronic hepatic failure without coma
K72.11	Chronic hepatic failure with coma
K72.90	Hepatic failure, unspecified without coma
K72.91	Hepatic failure, unspecified with coma
K74.0	Hepatic fibrosis
K74.60	Unspecified cirrhosis of liver
K74.69	Other cirrhosis of liver
K75.0	Abscess of liver
K75.1	Phlebitis of portal vein
K75.2	Nonspecific reactive hepatitis
K75.3	Granulomatous hepatitis, not elsewhere classified
K75.81	Nonalcoholic steatohepatitis (NASH)

K75.89	Other specified inflammatory liver diseases
K75.9	Inflammatory liver disease, unspecified
K76.2	Central hemorrhagic necrosis of liver
K76.4	Peliosis hepatis
K76.6	Portal hypertension
K76.7	Hepatorenal syndrome
K76.81	Hepatopulmonary syndrome
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
R10.2	Pelvic and perineal pain
R10.30	Lower abdominal pain, unspecified
R10.31	Right lower quadrant pain
R10.32	Left lower quadrant 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
R16.0	Hepatomegaly, not elsewhere classified
R16.2	Hepatomegaly with splenomegaly, not elsewhere classified
R17	Unspecified jaundice
R53.0	Neoplastic (malignant) related fatigue
R53.1	Weakness
R53.2	Functional quadriplegia
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 development in childhood
R62.51	Failure to thrive (child)
R62.52	Short stature (child)
R62.59	Other lack of expected normal physiological development in childhood
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
Code	Description
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
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R11.14	Bilious vomiting
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R53.0	Neoplastic (malignant) related fatigue
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R63.5	Abnormal weight gain
R63.6	Underweight

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	01/01/2017	New Policy.
Date Revised		
Date Effective	01/01/2017	

H. REFERENCES

1. IHCP Fee-For-Service Fee Schedule - Search. (2017, February 25). Retrieved 3/14/17 from http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/maxfee_search.asp
2. Medically Necessary - HealthCare.gov Glossary | HealthCare.gov. (2017, March 16). Retrieved 3/14/17 from https://www.healthcare.gov/glossary/medically-necessary/
3. Medical Policy Manual. (2017, January). Retrieved 3/14/17 from http://provider.indianamedicaid.com/media/156320/medical%20policy%20manual.pdf
4. National Coverage Determination (NCD) for Hepatitis Panel/Acute Hepatitis Panel (190.33). (2003, January 1). Retrieved 3/14/17 from https://www.cms.gov/medicare-coverage-database/(S(3tjsiy55tghspmei3ysxvqir))/details/ncd-details.aspx?NCDId=166&ncdver=1&CALId=147&ver=9&CalName=Hepatitis+Panel+(Removal+of+ICD-9-CM+Code+784.69%2C+Other+symbolic+dysfunction%2C+from+the+list+of+Codes+Covered+by+Medicare)&bc=BAgAAAAAgBAA&

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