

REIMBURSEMENT POLICY STATEMENT INDIANA MEDICAID

| Original Effectiv Date | e Next A | nnual Review | Last Revision |
|---------------------------|----------------|--------------|---------------|
| 01/01/2017 | 17 01/01/2018 | | 01/01/2017 |
| 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.

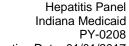
In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization 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) will be the controlling document used to make the determination.

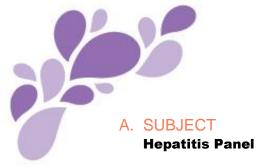
CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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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,



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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

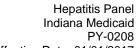
Reimbursement is dependent on, but not limited to, submitting Indiana Medicaid approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the Indiana Medicaid fee schedule http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/maxfee search.asp

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 | |

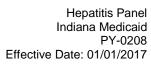






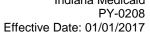
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| sophageal varices with bleeding | |
| econdary esophageal varices without bleeding | |
| econdary esophageal varices with bleeding | |
| coholic hepatic failure with coma | |
| oxic liver disease with cholestasis | |
| oxic liver disease with hepatic necrosis, without coma | |
| oxic liver disease with hepatic necrosis, with coma | |
| oxic liver disease with acute hepatitis | |
| Toxic liver disease with chronic persistent hepatitis | |
| Toxic liver disease with chronic lobular hepatitis | |
| oxic liver disease with chronic active hepatitis without ascites | |
| Toxic liver disease with chronic active hepatitis with ascites | |
| Toxic liver disease with hepatitis, not elsewhere classified | |
| Toxic liver disease with fibrosis and cirrhosis of liver | |
| oxic liver disease with other disorders of liver | |
| Toxic liver disease, unspecified | |
| Acute and subacute hepatic failure without coma | |
| Acute and subacute hepatic failure with coma | |
| hronic hepatic failure without coma | |
| hronic hepatic failure with coma | |
| Hepatic failure, unspecified without coma | |
| Hepatic failure, unspecified with coma | |
| Hepatic fibrosis | |
| Unspecified cirrhosis of liver | |
| Other cirrhosis of liver | |
| Abscess of liver | |
| Phlebitis of portal vein | |
| Nonspecific reactive hepatitis | |
| Granulomatous hepatitis, not elsewhere classified | |
| onalcoholic 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 | |
| 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 | |
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| | 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 | |

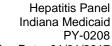
AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

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





Effective Date: 01/01/2017

H. REFERENCES

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- 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 <a href="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&</p>

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

