

Hepatitis Screening (for New Jersey Only)

Policy Number: CS053NJ.P
Effective Date: October 14, 2020

[Instructions for Use](#)

Table of Contents	Page
Application	1
Coverage Rationale	1
Definitions	2
Applicable Codes	3
Description of Services	3
Clinical Evidence	5
U.S. Food and Drug Administration	6
References	6
Policy History/Revision Information	8
Instructions for Use	8

Commercial Policy
• Hepatitis Screening
Medicare Advantage Coverage Summary
• Preventive Health Services and Procedures

Application

This Medical Policy only applies to the state of New Jersey.

Coverage Rationale

Hepatitis screening is proven and medically necessary for high risk individuals with the following indications:

- Blood transfusion prior to 1992
- Birth in regions or have traveled to countries with high or intermediate prevalence of hepatitis A virus (HAV) or hepatitis B virus (HBV) infection
- Chronic or long-term liver disease with elevated liver enzymes (abnormal ALT/AST)
- Clotting-factor disorders, such as hemophilia
- Donors of blood, plasma, organs, tissue, or semen
- Exposure to individuals with HBV infection through household, secondary contacts or needle sharing
- Health-care workers
- Hemodialysis
- Hepatitis C virus (HCV) positive
- High-risk sexual behavior, multiple partners, intercourse with trauma, and sexually transmitted diseases (STD)
- Immunosuppression due to immunosuppressive therapy, including chemotherapy, immunosuppression related to organ transplantation, and immunosuppression for rheumatologic or gastroenterologic disorders
- Infants born in the U.S. whose parents were born in regions with high rates of Hepatitis B
- Infants born to HBV or HCV infected mothers (do not test before 18 months of age)
- Known exposure to HCV (health care workers after needle sticks involving HCV positive blood)
- Men who have sexual relations with men (MSM)
- Pregnancy
- Present sexual partners of infected
- Prior to anti-TNF initiation
- Recipient of clotting factor concentrates made before 1987
- Recipients of blood or organs from a donor who later tested HCV positive

- Residents and Institutional care workers
- Those who work with non-human primates
- Use of recreational drugs, whether injected or not

Hepatitis screening is proven and medically necessary for one-time screening for HCV infection for adults born between 1945-1965, whether or not risk factors have been identified.

Definitions

HCV Antibody Test: The third-generation HCV EIA test is the most frequently used antibody test to initially screen for HCV infection. This test has high sensitivity, wide availability, and low cost. However, antibody is not detected for many months after infection.

Hepatitis A: A highly contagious viral condition that causes inflammation affecting the liver's ability to function. Hepatitis A virus (HAV) infection is primarily transmitted by the fecal-oral route, by either person-to-person contact or consumption of contaminated food or water. Although viremia occurs early in infection and can persist for several weeks after onset of symptoms, bloodborne transmission of HAV is uncommon. HAV has an incubation period of approximately 28 days (range: 15–50 days). HAV replicates in the liver and is shed in high concentrations in feces from 2 weeks before to 1 week after the onset of clinical illness. HAV infection produces a self-limited disease that does not result in chronic infection or chronic liver disease.

Hepatitis A Antibody Test: Also known as HAV IgM antibody, is the preferred test for diagnosis of acute hepatitis A infection because it rises early and persists only 3 to 12 months.

Hepatitis B: Hepatitis B virus (HBV) is transmitted through exposure to infective blood, semen, and other body fluids. HBV can be transmitted from infected mothers to infants at the time of birth or from family member to infant in early childhood. Transmission may also occur through transfusions of HBV-contaminated blood and blood products, contaminated injections during medical procedures, and through injection drug use. HBV also poses a risk to healthcare workers who sustain accidental needle stick injuries while caring for infected-HBV patients. Among persons with chronic HBV infection, the risk for premature death from cirrhosis or hepatocellular carcinoma is 15% to 25%.

Hepatitis B Core Antibody Test: Also known as HBV Core IgM Antibody (HBcAb, IgM), is detectable during acute but not chronic HBV infection.

Hepatitis B Surface Antigen Test: Also known as HBV Surface Antigen (HBsAg). Hepatitis B antigen is a protein on the surface of hepatitis B virus; it can be detected in high levels in serum during acute or chronic hepatitis B virus infection. The presence of HBsAg indicates that the person is infectious. The body normally produces antibodies to HBsAg as part of the normal immune response to infection. HBsAg is the antigen used to make hepatitis B vaccine.

Hepatitis C: Hepatitis C virus (HCV) is mostly transmitted through exposure to infective blood. This may happen through transfusions of HCV-contaminated blood and blood products, contaminated injections during medical procedures, and through injection drug use. Sexual transmission is also possible but is much less common. According to the Center for Disease Prevention and Control and Prevention (CDC) Hepatitis C Guideline, hepatitis C virus (HCV), is the most common chronic bloodborne pathogen in the United States; approximately 2.7-3.9 million persons are chronically infected.

Hepatitis D: Hepatitis D (HDV), also known as "delta hepatitis," is a serious liver disease caused by infection with the Hepatitis D virus. This is an RNA virus structurally unrelated to the Hepatitis A, B, or C viruses. Hepatitis D, which can be acute or chronic, is uncommon in the United States. HDV is an incomplete virus that requires the helper function of HBV to replicate and only occurs among people who are infected with the Hepatitis B virus (HBV). The dual infection of HDV and HBV can result in a more serious disease and worse outcome.

Hepatitis E: Hepatitis E virus (HEV) is mostly transmitted through consumption of contaminated water or food. HEV is a common cause of hepatitis outbreaks in developing parts of the world and is increasingly recognized as an important cause of disease in developed countries. HEV infection usually results in a self-limited, acute illness. When HEV infection does occur, it is usually the result of travel to a developing country where Hepatitis E is endemic. (CDC Division of Viral Hepatitis, 2018) (Quest Diagnostics, 2017)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver
86704	Hepatitis B core antibody (HBcAb); total
86705	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
86707	Hepatitis Be antibody (HBeAb)
86708	Hepatitis A antibody (HAAb)
86709	Hepatitis A antibody (HAAb); IgM antibody
86803	Hepatitis C antibody
86804	Hepatitis C antibody; confirmatory test (e.g., immunoblot)
87340	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg)
87341	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg) neutralization
87350	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis Be antigen (HBeAg)
87902	Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus
87912	Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis B virus

CPT® is a registered trademark of the American Medical Association

HCPCS Code	Description
G0472	Hepatitis C antibody screening for individual at high risk and other covered indication(s)
G0499	Hepatitis B screening in non-pregnant, high-risk individual includes hepatitis B surface antigen (HBSAG), antibodies to HBSAG (anti-HBS) and antibodies to hepatitis B core antigen (anti-HBC), and is followed by a neutralizing confirmatory test, when performed, only for an initially reactive HBSAG result

Diagnosis Codes

[Hepatitis Screening \(for New Jersey Only\): Diagnosis Code List](#)

Description of Services

The word "hepatitis" means inflammation of the liver and also refers to a group of viral infections that affect the liver. Viral hepatitis is a relatively common disease (25 per 100,000 individuals in the United States) caused by a diverse group of

hepatotropic agents that lead to liver inflammation and cell death. Viral hepatitis is the leading cause of liver cancer and the most common reason for liver transplantation. Five hepatitis viruses have been well characterized (A, B, C, D, and E). All of the major hepatotropic viruses can cause viral hepatitis but only hepatitis B with or without co-infection with hepatitis D and hepatitis C can cause liver disease. Chronic infection can lead to cirrhosis and hepatocellular carcinoma (Turner, White 2004). The most common types are Hepatitis A, Hepatitis B, and Hepatitis C. The following statements regarding all forms of viral hepatitis were listed on the documents on the CDC website (CDC Division of Viral Hepatitis, 2017).

Testing and diagnosis of hepatitis B and C infection is the gateway for access to both prevention and treatment services and is a crucial component of an effective response to the hepatitis epidemic. Early identification of persons with chronic HBV or HCV infection enables them to receive the necessary care and treatment to prevent or delay progression of liver disease. Testing also provides an opportunity to link people to interventions to reduce transmission, through counselling on risk behaviors and provision of prevention commodities (such as sterile needles and syringes) and hepatitis B vaccination. (WHO, 2017)

Regions with High Rates of Hepatitis B (USPSTF 2015)

- Africa: All countries
- Asia
- Australia and South Pacific: All countries except Australia and New Zealand
- Middle East: All countries except Cyprus and Israel
- Eastern Europe: All countries except Hungary
- Western Europe: Malta, Spain and indigenous populations of Greenland
- North America: Alaska natives and indigenous populations of northern Canada
- Mexico and Central America: Guatemala and Honduras
- South America: Ecuador, Guyana, Suriname, Venezuela, and Amazonian areas of Bolivia, Brazil, Colombia and Peru
- Caribbean: Antigua and Barbuda, Dominica, Grenada, Haiti, Jamaica, St. Kitts and Nevis, St. Lucia, Turks and Caicos

Clinical Spectrum of Viral Hepatitis (Nichols, Updated 2017)

Hepatitis Virus	Transmission Route	Incubation Period	Mortality	Likelihood of Carrier State	Likelihood of Chronic Disease	Association with Hepatocellular Carcinoma
HAV	Fecal-oral	2-6 wk	1%	None	None	No
HBV	Parenteral, perinatal, sexual	4-26 wk	1%-2%	10% (adults) 90% (infants)	5%	Yes
HCV	Parenteral, perinatal, sexual	2-23 wk	1%-5%	50%-80%	50%-85%	Yes
HDV	Parenteral, perinatal, sexual	6-26 wk	2%-20%	Variable	90% in superinfection ^a	Yes ^b
HEV	Fecal-oral	2-9 wk	1% ^c	Rare	Rare ^c	No

HCC, hepatocellular carcinoma.

a – Higher in immunocompromised patients.

b – Requires coinfection with HBV. Simultaneous infection with HBV is associated with severe acute disease and low likelihood of chronic infection (<5%); superinfection with HBV carries high likelihood of fulminant disease (2%-20%), chronic HDV infection (up to 80%), and cirrhosis (60%-70%), and may progress to hepatocellular carcinoma (HCC).

c – 10%-30% in pregnant women.

Clinical Evidence

The CDC, in collaboration with the New York City (NYC) Department of Health and Mental Hygiene (DOHMH), conducted a chronic HBV surveillance, selecting a random sample of newly reported cases and collecting more detailed information from the patients' clinicians. Analysis was presented on 180 randomly selected HBV cases reported during June 2008 to November 2009. Approximately two-thirds (67%) of the patients were Asian, and the most commonly reported reason for HBV testing was the patient's birth country or race/ethnicity (27%). In 70% of cases, the clinician did not know of any patient risk factors and 62% did not know their patient's hepatitis A vaccination status despite recommendations. Sixty-nine percent of clinicians stated that they counseled their patients about notifying close contacts about their infection, and 75% counseled about transmission and prevention. This surveillance effort provided quantitative data on health disparities, illustrating that not all patients received recommended prevention and treatment services. In response to these findings, DOHMH now routinely distributes HBV patient education materials to populations in need (CDC, 2014).

Pauly et al. (2018) conducted a retrospective analysis of 8887 adult patients. They each began treatment with TNF antagonists for autoimmune diseases (dermatologic, rheumatologic, or gastrointestinal) from 2001 through 2010, followed through December 2012. The authors obtained data on HBV infection (52% of patients were screened for HBV before treatment), demographic features, comorbidities, and use of immunosuppressive agents. Of the 4267 patients with unknown HBV status at baseline, 2 had HBV reactivation. Those treated with TNF antagonists for autoimmune diseases, had 39% HBV reactivation rate in those who were HBsAg+ before therapy, but not patients who were HBsAg-negative and anti-HBc+ before therapy. The authors concluded that patients should be screened for HBV infection before anti-TNF therapy; HBsAg+ patients should receive prophylactic antiviral therapy, but not HBsAg-negative, anti-HBc+ patients.

Evidence regarding the frequency of testing in persons at risk for ongoing exposures to HCV is lacking. Therefore, clinicians should determine the periodicity of testing based on the risk of infection or reinfection. Because of the high incidence of HCV infection among persons who inject drugs and HIV-infected men who have unprotected sex with men, HCV testing at least annually is recommended for these populations (Aberg, 2014); (Linan, 2012); (Wandeler, 2012); (Witt, 2013); (Williams, 2011).

Wiersma et al (2011) reported that most of the estimated 350 million people with chronic hepatitis B virus (HBV) live in resource-constrained settings and that up to 25% of those persons will die prematurely of hepatocellular carcinoma or cirrhosis. They further state that an informal World Health Organization consultation of experts concluded that chronic HBV is a major public health problem in emerging nations, all HIV-infected persons should be screened for HBV infection, HIBV/HBV co-infected persons should be treated with therapies active against both viruses and that reduce the risk of resistance, and that standards for the management of chronic HBV infection should be adapted to resource-constrained settings.

Smith et al (2012) reported that many of the 2.7 to 3.9 million persons living with HCV infection, an increasing cause of morbidity and mortality in the United States, are unaware they are infected and do not receive care (e.g., education, counseling, and medical monitoring) and treatment. The CDC estimates that although persons born between 1945 and 1965 comprise an estimated 27% of the population, they account for approximately three-fourths of all HCV infections in the United States, 73% of HCV-associated mortality, and are at greatest risk for hepatocellular carcinoma and other HCV-related liver disease. The CDC is augmenting previous recommendations for HCV testing to recommend one-time testing without prior ascertainment of HCV risk for persons born during 1945 to 1965. These recommendations do not replace previous guidelines for HCV testing that are based on known risk factors and clinical indications, but rather define an additional target population for testing: persons born during 1945 to 1965. The CDC developed these recommendations with the assistance of a work group representing diverse expertise and perspectives. The recommendations are informed by the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, an approach that provides guidance and tools to define the research questions, conduct the systematic review, assess the overall quality of the evidence, and determine the strength of the recommendations.

Denniston et al (2012) the authors analyzed data from persons who tested positive for past or current HCV infection during participation in the National Health and Nutrition Examination Survey (NHANES) during the years 2001 through 2008. They conducted a follow-up survey 6 months after examination to determine how many participants testing positive for HCV infection were aware of their HCV status, what actions participants took after becoming aware of their first positive test, and participants' knowledge about hepatitis C. Of the 30, 140 participants tested, 393 had evidence of past or current HCV infection and 170 could be contacted during the follow-up survey and interviewed. Only 49.7% were aware of their positive HCV infection status before being notified by NHANES and only 3.7% of these respondents reported that they had first been tested for HCV because

they or their doctor thought they were at risk for infection. The investigators concluded that this data indicated that fewer than 50% of those infected with HCV may be aware of their infection. The findings suggest that more intensive efforts are needed to identify and test persons at risk for HCV infection.

In 2014, U.S. Preventive Services Task Force (USPSTF) recommended screening for HCV infection in persons at high risk for infection and recommends offering one-time screening for HCV infection to adults born between 1945 and 1965. Both are USPSTF “B” recommendations. The rationale for this recommendation is that persons born between 1945 and 1965 are more likely to be diagnosed with HCV infection, possibly because they received blood transfusions before the introduction of screening in 1992 or have other risk factors for exposure decades earlier. Many persons with chronic HCV infection are unaware of their condition. A risk-based approach may miss detection of a substantial proportion of HCV-infected persons in the birth cohort because of a lack of patient disclosure or knowledge about prior risk status. As a result, 1-time screening for HCV infection in the birth cohort may identify infected patients at earlier stages of disease that could benefit from treatment before developing complications from liver damage. The USPSTF reviewed the indirect chain of evidence that showed the benefits of screening through improvement of the intermediate outcome of SVR after triple-regimen antiviral treatments and reductions in all-cause and liver-related mortality and hepatocellular carcinoma. The USPSTF examined the evidence and accepted with moderate certainty the association between SVR after antiviral treatments and improved clinical outcomes. The USPSTF also found adequate evidence that antiviral treatment results in improved clinical outcomes (reduction in hepatocellular carcinoma). In addition, a recent modeling study with more conservative assumptions showed that birth-cohort screening provided nearly twice the benefit of risk-based screening. In reviewing the prevalence data on high-risk groups and the potential for reduced transmission, the USPSTF concluded that screening in high-risk persons (prevalence $\geq 50\%$) and the birth cohort (prevalence of about 3% to 4%) would result in a moderate net benefit. On the basis of the evidence, the USPSTF changed its previous recommendations to a grade “B” recommendation for screening for HCV infection in persons at high risk for infection and 1-time screening for HCV infection in the 1945–1965 birth cohort.

Clinical Practice Guidelines

American Association for the Study of Liver Disease (AASLD)

The AASLD’s practice guidelines for “Treatment of Chronic Hepatitis B” (Terrault et al, 2016) recommended that continued risk-based screening for hepatitis B is necessary to reduce morbidity and mortality of chronic hepatitis B.

American Gastroenterological Association (AGA)

The AGA’s guideline on “The prevention and treatment of hepatitis B virus reactivation during immunosuppressive drug therapy” (Reddy et al, 2015) recommended screening for HBV (HBsAg and anti-HBc, followed by a sensitive HBV DNA test if positive) in patients at moderate or high risk who will undergo immunosuppressive drug therapy. The AGA recommended against routinely screening for HBV in patients who will undergo immunosuppressive drug therapy and are at low risk.

North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN)

The NASPGHAN’s practice guidelines on “Diagnosis and management of hepatitis C infection in infants, children, and adolescents” (Mack et al, 2012) noted that children from a region with high prevalence of HCV infection as well as present sexual partners of HCV-infected persons should be screened for HCV infection.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Laboratories that perform hepatitis antibody screening are regulated by the FDA under the Clinical Laboratory Improvement Amendments. See the following website for more information:

<http://www.fda.gov/medicaldevices/deviceregulationandguidance/ivdregulatoryassistance/ucm124105.htm>.

(Accessed February 1, 2019)

References

Aberg JA, et al. Primary care guidelines for the management of persons infected with HIV. 2009. Updated 2014 by the HIV Medicine Association of the Infectious Diseases Society of America.

American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA). Recommendations for testing, managing, and treating hepatitis C. 2017.

Brunasso AM, Puntoni M, Gulia A, et al. Safety of anti-tumour necrosis factor agents in patients with chronic hepatitis C infection: a systematic review. *Rheumatology (Oxford)*. 2011 Sep;50(9):1700-11.

Centers for Disease Control and Prevention (CDC). Hepatitis A Questions and Answers for Health Professionals. Division of Viral Hepatitis. Atlanta, GA. Updated 2017.

Centers for Disease Control and Prevention (CDC). Hepatitis B Questions and Answers for Health Professionals. Division of Viral Hepatitis. Atlanta, GA. Updated 2018.

Centers for Disease Control and Prevention (CDC). Hepatitis C Questions and Answers for Health Professionals. Division of Viral Hepatitis. Atlanta, GA. Updated 2017.

Centers for Disease Control and Prevention (CDC). Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease. Division of Viral Hepatitis. Atlanta, GA. October 2017.

Centers for Disease Control and Prevention (CDC). Hepatitis D Questions and Answers for Health Professionals. Division of Viral Hepatitis. Atlanta, GA. 2017.

Centers for Disease Control and Prevention (CDC). Hepatitis E Questions and Answers for Health Professionals. Division of Viral Hepatitis. Atlanta, GA. 2017.

Chou R, Dana T, Bougatsos C, et al. Screening for hepatitis B virus infection in nonpregnant adolescents and adults: A systematic review to update the U.S. Preventive Services Task Force Recommendation. *Ann Intern Med*. May 2015.

Denniston MM, Klevens RM, McQuillan GM, et al. Awareness of infection, knowledge of hepatitis C, and medical follow-up among individuals testing positive for hepatitis C: National Health and Nutrition Examination Survey 2001-2008. *Hepatology*. 2012;55(6):1652-1661.

Linac, et al. Cost-effective screening for acute hepatitis C virus infection in HIV-infected men who have sex with men. *Clin Infect Dis*. 2012;55(2):279-290.

Mack CL, Gonzalez-Peralta RP, Gupta N, et al. NASPGHAN practice guidelines: Diagnosis and management of hepatitis C infection in infants, children, and adolescents. *J Pediatr Gastroenterol Nutr*. 2012;54(6):838-855.

Nichols Institute. Viral Hepatitis: Laboratory Support of Diagnosis and Management. *Clinical Focus*. 2015.

Pauly et al. Incidence of Hepatitis B Virus Reactivation and Hepatotoxicity in Patients Receiving Long-term Treatment With Tumor Necrosis Factor Antagonists. *Clinical Gastroenterology and Hepatology*. December 2018.

Quest Diagnostics™. Viral Hepatitis: Laboratory Support of Diagnosis and Management. 2017.

Reddy KR, Beavers KL, Hammond SP, et al. American Gastroenterological Association Institute guideline on the prevention and treatment of hepatitis B virus reactivation during immunosuppressive drug therapy. *Gastroenterology*. 2015;148(1):215-219.

Smith BD, Morgan RL, Beckett GA, et al. Centers for Disease Control and Prevention. Recommendations for the identification of chronic hepatitis C virus infection among persons born during 1945-1965. *MMWR Recomm Rep*. 2012; 61: (RR-4) 1-32.

Terrault NA, Bzowej NH, Chang K-M, et al. AASLD guidelines for treatment of chronic hepatitis B. *Hepatology* 2016.

US Preventive Services Task Force (USPSTF). Hepatitis B in Pregnant Women: Screening. Rockville, MD: U.S. Preventive Services Task Force; June 2009.

US Preventive Services Task Force (USPSTF). Screen High-Risk Individuals for Hepatitis B. Rockville, MD: U.S. Preventive Services Task Force; May 2014.

US Preventive Services Task Force (USPSTF). Hepatitis C: Screening. Rockville, MD: U.S. Preventive Services Task Force; June 2013.

van Rooijen M, Heijman T, de Vrieze N, et al. Earlier detection of hepatitis C virus infection through routine hepatitis C virus antibody screening of human immunodeficiency virus-positive men who have sex with men attending a sexually transmitted infection outpatient clinic: A longitudinal study. *Sex Transm Dis*. 2016;43(9):560-565.

Wandeler, et al. Hepatitis C virus infections in the Swiss HIV Cohort Study: a rapidly evolving epidemic. *Clin Infect Dis*. 2012;55(10):1408-1416.

Wiersma ST, McMahon B, Pawlotsky JM, et al. Treatment of chronic hepatitis B virus infection in resource-constrained settings: Expert panel consensus. *Liver Int.* 2011;31(6):755-756.

Williams, et al. Incidence and transmission patterns of acute hepatitis C in the United States, 1982-2006. *Arch Intern Med.* 2011;171(3):242-248.

Witt, et al. Incident hepatitis C virus infection in men who have sex with men: a prospective cohort analysis, 1984-2011. *Clin Infect Dis.* 2013;57(1):77-84.

World Health Organization. Guidelines on Hepatitis B and C Testing. Geneva. February 2017.

Policy History/Revision Information

Date	Summary of Changes
05/01/2021	Template Update <ul style="list-style-type: none">Replaced content sub-heading titled “Professional Societies” with “Clinical Practice Guidelines” in <i>Clinical Evidence</i> sectionRemoved <i>CMS</i> sectionReplaced reference to “MCG™ Care Guidelines” with “InterQual® criteria” in <i>Instructions for Use</i>
10/14/2020	Applicable Codes <ul style="list-style-type: none">Updated list of applicable CPT codes; revised description for 87340, 87341, and 87350 Supporting Information <ul style="list-style-type: none">Archived previous policy version CS053NJ.O

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.