HEPATITIS PANEL/ACUTE HEPATITIS PANEL

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Effective Date: January 1, 2018

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INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, 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 MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines 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.

BACKGROUND

Hepatitis A, B, and C are the most commonly occurring viral hepatitis infections in the United States. The clinical outcomes of viral hepatitis infection are exceedingly different depending on the virus type. Whereas hepatitis A virus (HAV) is usually self-limiting, hepatitis C virus (HCV) is the main cause for death from liver disease in the United States. Because the symptoms of acute hepatitis A, B and C are similar, laboratory diagnosis is imperative to distinguish between the viral types and to direct the appropriate follow-up tests and care. Laboratory panel testing provides a convenient way to screen for acute viral hepatitis.

A hepatitis panel generally consists of the following tests:

- Hepatitis A antibody (HAAb), IgM antibody;
- Hepatitis B core antibody (HBcAb), IgM antibody;
- Hepatitis B surface antigen (HBsAg) and;
- Hepatitis C antibody.

In some cases Hepatitis B envelope antigen may be helpful in determining the rate of perinatal transmission of hepatitis B.

This panel of tests is used for differential diagnosis in a patient with symptoms of liver disease or injury. When the time of exposure or the stage of the disease is not known, a patient with continued symptoms of liver disease despite a completely negative hepatitis panel may need a repeat panel approximately two weeks to two months later to exclude the possibility of hepatitis. Once a diagnosis is established, specific tests can be used to monitor the course of the disease.

Hepatitis A virus is a foodborne RNA virus transmitted by the fecal-oral route. Persons at risk for HAV include those who travel to developing countries, men who have sex with men, persons who use illicit drugs, patients with clotting factor disorders, household contacts of someone with HAV, and those having oral-anal sexual contact with a person infected with HAV. The mean incubation period is 28 days. Signs and symptoms include diarrhea, clay-colored stool, dark urine, and jaundice in addition to flu-like symptoms. The majority of cases in children under age 6 are asymptomatic. The disease runs its course in several weeks to months and supportive care is recommended. HAV does not progress to chronic disease and recovering patients have lifetime immunity to the virus. Infection with HAV is diagnosed by a positive serologic test for immunoglobulin M (IgM) antibody to HAV or a history of contact with another person with laboratory-confirmed HAV. Anti-HAV IgM usually stays positive for 3 to 6 months.

Hepatitis B virus (HBV) is a blood-borne DNA virus transmitted by percutaneous or mucosal exposure. Persons at high risk for HBV include infants born to mothers with HBV, persons born in hyperendemic areas, people having sexual contact with infected persons, sexually active persons with multiple partners or history of a sexually transmitted disease, men who have sex with men, inmates, persons who inject illicit drugs, household contacts of infected persons, workers at risk for occupational exposure to blood or blood-contaminated fluids, hemodialysis patients, residents and staff of facilities for the developmentally disabled, persons with HCV or HIV, persons with chronically elevated alanine aminotransferase and aspartate transaminase levels, and travelers to countries where the prevalence rate is intermediate or high. The mean incubation period for HBV is 90 days.

In the acute phase, nearly half of immunocompetent patients will have symptoms including abdominal pain, clay-colored stool, dark urine, and jaundice in addition to flu-like symptoms. Immunocompromised patients and children under the age of 5 are generally asymptomatic. While the majority of adults will recover from acute infection, the majority of patients under the age of 5 will progress to chronic HBV, which carries significant morbidity and mortality. The presence of IgM antibodies to HBV core antigen is diagnostic of acute HBV infection. Although Hepatitis B surface antigen can be detected earlier in the course of acute HBV infection, its presence is not specific for acute infection because it remains detectable in chronic infection. Treatment of acute HBV is supportive, and chronic HBV is treated with antiviral drugs.

ACOG recommends that all pregnant patients be screened for the hepatitis B carrier state early in their prenatal course. In some states, repeat screening is required in the third trimester or at the time of delivery. Vertical transmission to the newborn occurs in 10 - 15% of cases when the pregnant patient is positive for HBsAg;
transmission increases to 90% in those individuals that are HBEAg positive. Prophylaxis of the newborn with hepatitis B immune globulin in conjunction with hepatitis B vaccine is effective in preventing infection of the newborn in these cases.

Hepatitis C virus (HCV) is a blood-borne RNA virus that is a major cause of chronic liver disease. Persons at high risk are intravenous drug users, HIV patients and hemophilia patients treated with clotting factor concentrates made before 1987. Persons at intermediate risk for infection include recipients of blood transfusions and solid organ transplants before July 1992, patients with unexplained elevated aminotransferase levels, and children born to mothers infected with HCV. People at low risk for infection are those with a known exposure to HCV through needles and persons having sexual relations with multiple partners or an infected partner. The incidence of HCV in hemodialysis patients is ten times higher than the incidence in the general population. The incubation period for HCV is one to several months. Patients with acute HCV are generally asymptomatic but can report abdominal pain, clay-colored stool, dark urine, and jaundice in addition to flu-like symptoms. The first line of testing for suspected HCV is an anti-HCV test. HCV antibody testing cannot distinguish between acute and chronic infection; that distinction requires further laboratory testing. It has been estimated that more than 75% of patients with acute HCV will develop chronic HCV. Treatment of acute HCV with antiviral therapy is a consideration so early detection is important.

**POLICY**

For the following CPT code(s) in Table 1, the patient should have a diagnosis (ICD-10-CM) code(s) listed in the attached files below.

**Table 1. HCPCS Codes (Alphanumeric, CPT® AMA)**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>80074</td>
<td>Acute Hepatitis Panel</td>
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**ICD-10 Diagnosis Codes (Proven)**

CMP-022 Hepatitis Panel ICD10_v1.0
REFERENCES


POLICY HISTORY/REVISION HISTORY

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<tr>
<td>01/21/2017</td>
<td>Updated ICD10 codes as per CMS recommendations. Removed ICD9 code file.</td>
</tr>
<tr>
<td>10/01/2015</td>
<td>Removed ICD9 table. Embedded ICD9/ ICD10 PDF files.</td>
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