

# Screening for Hepatitis B Virus (HBV) Infection (NCD 210.6)

Guideline Number: MPG366.04  
Approval Date: June 10, 2020

[↪ Terms and Conditions](#)

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Related Medicare Advantage Policy Guidelines
<ul style="list-style-type: none"> <li><a href="#">Clinical Diagnostic Laboratory Services</a></li> <li><a href="#">Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs (NCD 210.10)</a></li> </ul>
Related Medicare Advantage Coverage Summary
<ul style="list-style-type: none"> <li><a href="#">Preventive Health Services and Procedures</a></li> </ul>

## Policy Summary

[↪ See Purpose](#)

### Overview

Hepatitis B Virus (HBV) is transmitted by exposure to blood or blood-containing body fluids such as serum, semen or saliva. HBV infection attacks the liver and leads to inflammation. An infected person may initially develop symptoms such as nausea, anorexia, fatigue, fever and abdominal pain, or may be asymptomatic. An acute HBV infection may become a chronic infection and progress to serious and potentially life-threatening complications including cirrhosis, liver failure, hepatocellular carcinoma and death.

Pursuant to §1861(ddd) of the Social Security Act, the Secretary may add coverage of "additional preventive services" if certain statutory requirements are met.

### Guidelines

Effective for services performed on or after September 28, 2016, CMS has determined that the evidence is sufficient to cover screening for HBV infection with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions.

- A screening test is covered for asymptomatic, nonpregnant adolescents and adults at high risk for HBV infection. "High risk" is defined as persons born in countries and regions with a high prevalence of HBV infection (i.e., ≥ 2%), US born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (i.e., ≥ 8%), HIV-positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection. In addition, CMS has determined that repeated screening would be appropriate annually only for beneficiaries with continued high risk (i.e., men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who do not receive hepatitis B vaccination.
- A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative HBsAg test results.

The determination of "high risk for HBV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

For the purposes of this decision memorandum, a primary care setting is defined by the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

For the purposes of this decision memorandum, a "primary care physician" and "primary care practitioner" will be defined consistent with existing sections of the Social Security Act (§1833(u)(6), §1833(x) (2)(A)(i)(I) and §1833(x)(2)(A)(i)(II)).

- §1833(u)(6) Physician Defined. For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.
- §1833(x) (2) A(i)
  - (I) Is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
  - (II) Is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa) (5)).

### **Nationally Non-Covered Indications**

Effective for claims with dates of service on and after September 28, 2016:

- Medicare beneficiaries who are symptomatic, or who have already been diagnosed with HBV infection, or who are nonpregnant and have already received a hepatitis B vaccination are non-covered.

Payment for HBV is not separately payable for End Stage Renal Disease (ESRD) facilities with diagnosis code N18.6 "end stage renal disease".

Medicare coinsurance and the Part B deductible are waived for this "additional preventive service."

## **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 guideline 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 the member specific benefit plan document 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
86704	Hepatitis B core antibody (HBcAb); total (for pregnant women)
86706	Hepatitis B surface antibody (HBsAb) (for pregnant women)
87340	Infectious agent antigen detection by immunoassay technique, [e.g., enzyme immunoassay (EIA), enzyme-linked immunosorbent assay (ELISA), immunochemiluminometric assay (IMCA)] qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) (For pregnant women) [Previously related to NCD 210.10 Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs]
87341	Infectious agent antigen detection by immunoassay technique, [e.g., enzyme immunoassay (EIA), enzyme-linked immunosorbent assay (ELISA), immunochemiluminometric assay (IMCA)] qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization (For pregnant women) [Previously related to NCD 210.10 Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs]

*CPT® is a registered trademark of the American Medical Association*

HCPCS Code	Description
G0499	Hepatitis B screening in non-pregnant, high risk individual includes hepatitis B surface antigen (HBSAG) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to HBSAG (anti-HBS) and hepatitis B core antigen (anti-HBC)

Place of Service Code	Description
11	Office
19	Off Campus-Outpatient Hospital
22	On Campus-Outpatient Hospital
49	Independent Clinic
71	Public Health Clinic
81	Independent Laboratory

## Questions and Answers

1	Q:	Is HCPCS code G0499 only for non pregnant individuals?
	A:	Yes, according to CMS coverage guidelines.
2	Q:	Does CPT code G0499 for non pregnant individuals require dual diagnosis criteria?
	A:	Yes, according to CMS coverage guidelines.
3	Q:	Are the CPT codes 86704, 86706, 87340 and 87341 only for pregnant individuals?
	A:	Yes, according to CMS coverage guidelines.
4	Q:	Do the CPT codes 86704, 86706, 87340 and 87341 for pregnant individuals require dual diagnosis criteria?
	A:	Yes, according to CMS coverage guidelines.

## References

### CMS National Coverage Determinations (NCDs)

[NCD 210.6 Screening for Hepatitis B Virus \(HBV\) Infection](#)

### CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L34003 Hepatitis B Surface Antibody and Surface Antigen Retired 02/12/2020	A57057 Billing and Coding: Hepatitis B Surface Antibody and Surface Antigen Retired 02/12/2020	First Coast	FL, PR, VI	FL, PR, VI

### CMS Claims Processing Manual

[Chapter 18, § 170 - 170.5 Screening for Sexually Transmitted Infections \(STIs\) and High Intensity Behavioral Counseling \(HIBC\) to Prevent STIs](#)

### CMS Transmittal(s)

[Transmittal 195, Change Request 9859, Dated 04/28/2017 \(Screening for Hepatitis B Virus \(HBV\) Infection\)](#)

[Transmittal 198, Change Request 9859, Dated 06/29/2017 \(Screening for Hepatitis B Virus \(HBV\) Infection\)](#)

[Transmittal 1388, Change Request 8691, Dated 05/23/2014 \(ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations \(NCDs\) - Maintenance CR\)](#)

[Transmittal 2033, Change Request 10473, Dated 02/16/2018 \(ICD-10 and Other Coding Revisions to National Coverage Determinations \(NCDs\)\)](#)

[Transmittal 2039, Change Request 10473, Dated 02/28/2018 \(ICD-10 and Other Coding Revisions to National Coverage Determinations \(NCDs\)\)](#)

[Transmittal 3674, Change Request 9892, Dated 12/09/2016 \(January 2017 Integrated Outpatient Code Editor \(I/OCE\) Specifications Version 18.0\)](#)

[Transmittal 3701, Change Request 9946, Dated 02/03/2017 \(Healthcare Common Procedure Coding System \(HCPCS\) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments \(CLIA\) Edits\)](#)

[Transmittal 3761, Change Request 9859, Dated 04/28/2017 \(Screening for Hepatitis B Virus \(HBV\) Infection\)](#)

[Transmittal 3793, Change Request 9859, Dated 07/09/2017 \(Screening for Hepatitis B Virus \(HBV\) Infection\)](#)

[Transmittal 3804, Change Request 9859, Dated 07/29/2017 \(Screening for Hepatitis B Virus \(HBV\) Infection\)](#)

[Transmittal 3831, Change Request 9859, Dated 08/04/2017 \(Screening for Hepatitis B Virus \(HBV\) Infection\)](#)

[Transmittal 3831, Change Request 9859, Dated 08/24/2017 \(Screening for Hepatitis B Virus \(HBV\) Infection\)](#)

## MLN Matters

[Article MM7610, Screening for Sexually Transmitted Infections \(STIs\) and High Intensity Behavioral Counseling \(HIBC\) to Prevent STIs](#)

[Article MM9859 Revised, Screening for Hepatitis B Virus \(HBV\) Infection](#)

[Article MM9892, January 2017 Integrated Outpatient Code Editor \(I/OCE\) Specifications Version 18.0](#)

## UnitedHealthcare Commercial Policies

[Hepatitis Screening](#)

[Preventive Care Services](#)

## Other(s)

[Place of Service Codes for Professional Claims](#)

[Medicare Preventive Services MLN006559 March 2020](#)

## Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	<b>Template Update</b> <ul style="list-style-type: none"><li>Reformatted policy; transferred content to new template</li></ul>
06/10/2020	<b>Applicable Codes</b> <ul style="list-style-type: none"><li>Removed:<ul style="list-style-type: none"><li>Modifier AY</li><li>Provider specialty codes 01, 08, 11, 16, 37, 38, 42, 50, 89, and 97</li><li>Bill types 13X, 14X, 85X, and 72X</li></ul></li></ul> <b>Supporting Information</b> <ul style="list-style-type: none"><li>Updated <i>References</i> section to reflect the most current information</li><li>Archived previous policy version MPG366.03</li></ul>

## Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

## Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document\* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

\*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).