

Screening for Hepatitis C Virus (HCV) in Adults (NCD 210.13)

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[↪ Terms and Conditions](#)

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Related Medicare Advantage Policy Guideline

- [Clinical Diagnostic Laboratory Services](#)

Policy Summary

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Overview

Hepatitis C Virus (HCV) is an infection that attacks the liver and leads to inflammation. The infection is often asymptomatic and can go undiagnosed for decades. The presence of HCV in the liver initiates a response from the immune system which in turn causes inflammation. It is difficult for the human immune system to eliminate the HCV and it is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis and liver cancer and a primary indication for liver transplant in the Western World.

Under §1861(ddd) of the Social Security Act (the Act), the Centers for Medicare & Medicaid Services (CMS) has the authority to add coverage of additional preventive services if certain statutory requirements are met. The regulations provide: [42 CFR §410.64 Additional preventive services](#)

- Medicare Part B pays for additional preventive services not described in paragraph (1) or (3) of the definition of “preventive services” under 42 CFR §410.2, that identify medical conditions or risk factors for individuals if the Secretary determines through the national coverage determination process (as defined in section 1869(f)(1)(B) of the Act) that these services are all of the following:
 - Reasonable and necessary for the prevention or early detection of illness or disability,
 - Appropriate for individuals entitled to benefits under Part A or enrolled under Part B,
 - Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF).
- In making determinations under paragraph (a) of this section regarding the coverage of a new preventive service, the Secretary may conduct an assessment of the relation between predicted outcomes and the expenditures for such services and may take into account the results of such an assessment in making such national coverage determinations.

The scope of the review for this policy guideline evaluated the existing evidence and determined if the body of evidence was sufficient for coverage for screening for HCV in adults at high risk for HCV infection and one-time screening for HCV infection for adults born between 1945 and 1965, which is recommended with a grade B by the United States Preventive Services Task Force (USPSTF).

Guidelines

Nationally Covered Indications

Medicare has determined the evidence is adequate to conclude that screening for Hepatitis C Virus (HCV), consistent with the grade B recommendations by the U.S. Preventive Services Task Force (USPSTF), is reasonable and necessary for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B, as described below.

Therefore, Medicare will cover screening for HCV 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 provider for these services, for beneficiaries who meet either of the following conditions:

- A screening test is covered for adults at high risk for Hepatitis C Virus infection. "High risk" is defined as persons with a current or past history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.
- A single screening test is covered for adults who do not meet the high risk as defined above, but who were born from 1945 through 1965.

For services provided to beneficiaries born between the years 1945 and 1965, who are not considered high risk, HCV screening is limited to once per lifetime.

The determination of "high risk for HCV" 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.

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, independent diagnostic testing facilities, 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.

A "primary care physician" and "primary care practitioner" will be defined consistent with existing sections of the 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

Unless specifically covered in this policy, any other policy, or in statute, preventive services are non-covered by Medicare.

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.

HCPSC Code	Description
G0472	Hepatitis C antibody screening for individual at high risk and other covered indication(s)

Place of Service Code	Description
11	Physician's office
19	Off campus-outpatient hospital
22	On campus-outpatient hospital
49	Independent clinic
50	Federally Qualified Health Center
71	State or local public health clinic
72	Rural Health Clinic
81	Independent laboratory

References

CMS National Coverage Determinations (NCDs)

[NCD 210.13 Screening for Hepatitis C Virus \(HCV\) in Adults](#)

CMS Claims Processing Manual

[Chapter 18, §1 Medicare Preventive and Screening Services](#)

CMS Transmittal(s)

[Transmittal 177, Change Request 8871, Dated 11/19/2014 \(Screening for Hepatitis C Virus \(HCV\) in Adults\)](#)

[Transmittal 1875, Change Request 10184, Dated 07/27/2017 \(ICD-10 Coding Revisions to National Coverage Determinations \(NCDs\)\)](#)

MLN Matters

[Article MM8871, Screening for Hepatitis C Virus \(HCV\) in Adults](#)

[Article MM10184, ICD-10 Coding Revisions to National Coverage Determinations \(NCDs\)](#)

UnitedHealthcare Commercial Policy

[Hepatitis Screening](#)

Other(s)

[Medicare Preventive Services, MLN 006559, August 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	Template Update <ul style="list-style-type: none"> Reformatted policy; transferred content to new template
11/11/2020	Policy Summary <i>Nationally Covered Indications</i> <ul style="list-style-type: none"> Replaced references to "UnitedHealthcare" with "Medicare"

Date	Summary of Changes
	<p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information Archived previous policy version MPG275.05

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](#).