Hepatic Fibrosis Testing for Chronic Liver Disease Policy, Professional and Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses 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.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design, and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the UB-04 Form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or their electronic equivalents or their successor forms. This policy applies to all products, all network and non-network providers, including, but not limited to, non-network authorized and percent of charge contract hospitals, ambulatory surgical centers, physicians, and other qualified health care professionals.

Policy

Overview

This policy describes the reimbursement methodology for allergen testing.

Reimbursement Guidelines

NOTE: Procedure codes appearing in policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

Reimbursable

UnitedHealthcare will consider reimbursement of the following multianalyte assay testing procedure code(s) once every six months to distinguish hepatic cirrhosis from non-cirrhosis for individuals with any of the conditions listed below:

Procedure Code(s)

81517	81596				

Condition(s)

a. Hepatitis B
b. Hepatitis C
c. Metabolic dysfunction-associated steatotic liver disease (MASLD) (including metabolic dysfunction-associated steatohepatitis [MASH]).
d. Alcoholic hepatitis.

Non-Reimbursable

UnitedHealthcare will not consider separate reimbursement of the following multianalyte assay procedure codes:

Procedure Code(s)

0002M	0003M	0166U	0344U	0468U	

State Exceptions	
Arizona	Arizona is exempt from this policy.
Idaho	Idaho is exempt from this policy.
Indiana	Indiana is exempt from this policy.
Kansas	Kansas is exempt from this policy.
Kentucky	Kentucky is exempt from this policy.
Maryland	Maryland is exempt from this policy.
Massachusetts	Massachusetts is exempt from this policy.
Missouri	Missouri is exempt from this policy.
Nebraska	Nebraska is exempt from this policy.
New Jersey	New Jersey is exempt from this policy.
New Mexico	New Mexico is exempt from this policy.
North Carolina	North Carolina is exempt from this policy.
Ohio	Ohio is exempt from this policy.
Pennsylvania	Pennsylvania is exempt from this policy
Rhode Island	Rhode Island is exempt from this policy.
Tennessee	Tennessee is exempt from this policy.
Texas	Texas is exempt from this policy.
Virginia	Virginia is exempt from this policy.
Washington DC	Washington DC is exempt from this policy.
Washington	Washington is exempt from this policy.
Wisconsin	Wisconsin is exempt from this policy.

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Definitions	
Once every six months	One unit every 180 calendar days

Questions and Answers	
1	**Q:** Is the frequency limitation based on individual provider per member? **A:** The frequency limitation is applicable regardless of billing and/or rendering provider (any individual provider OR any facility) for each individual member for the same date of service.

Resources
Individual state Medicaid regulations, manuals & fee schedules
American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History	
10/1/2026	Policy implemented by UnitedHealthcare Community Plan.
4/28/2026	Policy approved by the Reimbursement Policy Oversight Committee
7/1/2026	Policy published

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