A MEDICAL PROVIDER GUIDE:
Screening for hepatitis C infection in people who inject drugs

HAVE YOU DIAGNOSED EVERY CASE OF HEPATITIS C IN YOUR PRACTICE?
People who inject drugs are at greatest risk of HCV infection in the United States. Many remain undiagnosed, putting them at risk for advanced liver disease and transmission of the virus to others.

These materials are designed for medical providers who provide care for patients who inject drugs, including physicians, nurse practitioners, physicians assistants and nurses as well as allied health professionals.
People who inject drugs (PWID) are at greatest risk of HCV infection in the United States. Many remain undiagnosed, putting them at risk for advanced liver disease and transmission of the virus to others.

Overall, hepatitis C remains under-diagnosed, with anywhere from 50 to 75% of infected Americans who are unaware of their status. Diagnosing hepatitis C remains particularly challenging for PWID for a number reasons including, but not limited to, fear of disclosing drug use, stigma and lack of access to screening.

Routine HCV screening of PWID will help uncover previously undiagnosed disease, engage patients in health and wellness activities while living with HCV, prevent transmission to others and prepare them for treatment. By providing brief and non-judgmental health education and harm reduction counseling, you can create an environment for patients to feel safe to openly discuss their HCV risk, and develop effective screening, management and treatment strategies.

This publication will provide an overview of HCV screening guidelines, guidance for offering the test and explaining the results, and selected billing and ICD-10 diagnosis codes.
Hepatitis C screening guidelines

There are several screening guidelines from a variety of governmental agencies and professional organizations. The AASLD/IDSA “HCV Guidance: Recommendations for Testing, Managing and Treating Hepatitis C” (www.hcvguidelines.org) offers a summary of recommendations for who should be tested for HCV, with this toolkit’s priority population’s found in bold:

- One-time HCV testing for persons born between 1945-1965, without need for prior ascertainment of risk (the so-called birth cohort, or baby-boomer screening guidelines);
- Persons who currently inject or have ever injected drugs (including those who may have injected only once or those who did so many years ago);
- Persons who use non-injectable, intranasal drugs (snorting from straws);
- Persons who ever received a blood transfusion, blood products or an organ transplant before 1992;
- Persons who have been on long-term hemodialysis;
- Persons receiving a tattoo in an unregulated setting;
- Persons who are incarcerated or have a history of incarceration;
- Persons born to an HCV-infected mother;
- Persons with HIV;
- Persons with unexplained chronic liver disease;
- Solid organ donors

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www.hcvguidelines.org
PWID should be screened at least annually, but you can consider more frequent testing (every 3-6 months) as needed. More frequent testing not only has the added benefit of earlier detection for the patient, but also keeps you in more regular contact with your patient to meet their other medical needs.

The AASLD/IDSA HCV Guidance (www.hcvguidelines.org) makes the following recommendations for hepatitis C testing:

**Recommendations for Follow-up of Initial Testing**

www.hcvguidelines.org

- An anti-HCV antibody test is recommended for HCV testing, and if the result is positive, current infection should be confirmed by a sensitive HCV RNA test.
  
  **Rating: Class I, Level A**

- Among persons with a negative anti-HCV antibody test who are suspected of having liver disease, testing for HCV RNA or follow-up testing for HCV antibody is recommended if exposure to HCV occurred within the past six months; testing for HCV RNA can also be considered in persons who are immunocompromised.
  
  **Rating: Class I, Level C**

- Among persons at risk of reinfection after previous spontaneous or treatment-related viral clearance, initial HCV RNA testing is recommended because an anti-HCV test is expected to be positive.
  
  **Rating: Class I, Level C**

- Quantitative HCV RNA testing is recommended prior to the initiation of antiviral therapy to document the baseline level of viremia (ie, baseline viral load).
  
  **Rating: Class I, Level A**

- Testing for HCV genotype is recommended to guide selection of the most appropriate antiviral regimen.
  
  **Rating: Class I, Level A**

- If found to have positive results for anti-HCV test and negative results for HCV RNA by polymerase chain reaction (PCR), persons should be informed that they do not have evidence of current (active) HCV infection.
  
  **Rating: Class I, Level A**
Algorithm for how to screen for hepatitis C infection

1. **SCREEN**
   - test for anti-HCV antibody
   - **+**
   - **-**
   - **yes**
   - Do you suspect severely immuno-compromised status, acute infection?
   - **no**

2. **DIAGNOSE**
   - test for HCV RNA
   - **+**
   - **-**
   - **consider re-testing if ongoing risk factors are present (condomless sex, injection drug use, hemodialysis, etc.)**

3. **REFER**
   - patient has HCV infection, link to care

4. **PREPARE**
   - collaborate with specialist, develop action plan

Chart of results from screening hepatitis C infection

<table>
<thead>
<tr>
<th>Anti-HCV antibody result</th>
<th>HCV RNA result</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>Negative</td>
<td>Patient does not have HCV.</td>
</tr>
<tr>
<td>Positive</td>
<td>Negative</td>
<td>Patient has cleared the virus, either through treatment or as one who has spontaneously cleared the virus.</td>
</tr>
<tr>
<td>Positive</td>
<td>Positive</td>
<td>Patient has chronic HCV.</td>
</tr>
<tr>
<td>Negative</td>
<td>Positive</td>
<td>Patient has acute HCV OR patient has a severely compromised immune system from HIV and cannot produce enough antibodies.</td>
</tr>
</tbody>
</table>
Pre-Antibody Test Discussion To-Do

1. Explain the reasons for doing the HCV test (risk factors, abnormal lab results, birth cohort, etc.);
2. Provide information about the screening process, and the need for confirming a positive antibody result;
3. Discuss the impact of a possible positive result for the patient and assess readiness for it;
4. Discuss plan to obtain results (will the patient return for in-person results, receive them by phone; a ‘no news is good news’ policy, ie, they only get a call if the result is positive); ask the patient for her/his preference in obtaining the result;
5. Explain the window period should the patient test negative and discuss the need for follow-up testing as needed;
6. Review patient confidentiality;
7. Check for the patient’s understanding of the above and address any of their questions or concerns; and
8. Offer the test.

Post-Antibody Test Discussion To-Do

If the antibody result is negative…
1. Explain the meaning of the negative test result and check to see your patient’s understanding;
2. Discuss the window period and make a plan for any follow-up testing. Use the HCV window period and set up a plan for follow-up testing as needed;
3. For those who are at ongoing HCV risk, counsel around any questions the patient may have, provide harm reduction information and resources, and attend to related medical needs (overdose prevention, hepatitis A and B vaccines, etc.); and
4. Develop a follow-up plan for ongoing medical care and assess other social service needs and refer as applicable.

If the antibody result is positive (or “reactive”)…
1. Explain the meaning of the positive test result and check to see your patient’s understanding of the result;
2. Allow for the patient to process the result and give her/him the space to react emotionally to it;
3. Explain the next step in the testing process: The need for an HCV RNA test to confirm chronic, active infection;
4. Educate your patient around alcohol use and transmission risks until its determined that that the she/he is chronically infected; and
5. Make a follow-up plan to return for confirmatory HCV RNA results (or phone call if you and the patient decide to do it that way).
HCV Confirmatory RNA Test: Post-test Discussion To-Do

If the HCV RNA result is negative ...
1. Explain the meaning of the negative test result and check to see your patient’s understanding;
2. Explain the window period and assess for any recent risks for potential HCV exposures;
3. Discuss the risk of HCV reinfection and the fact that antibodies do not offer protection;
4. Educate your patient on harm reduction, HCV risk reduction and other needs;
5. Make a follow-up plan for ongoing HCV screening and medical care.

If the HCV RNA result is positive...
1. Explain the meaning of the positive test result and check to see your patient’s understanding;
2. Allow your patient to process the result and give her/him the space to react emotionally to it;
3. If the HCV risk exposure happened within the last 6 months, discuss the possibility of clearing the virus and plan to re-test once the 6-month window has passed;
4. If the HCV risk exposure happened 6 months ago or longer, explain that she/he is chronically infected and will have HCV until she/he is cured;
5. Give your patient the corresponding patient fact sheets in this toolkit; and
6. Give your patient a HELP-4-HEP brochure and encourage him/her to call the helpline for information and support around the diagnosis.

In addition to the above, the AASLD/IDSA HCV Guidance Panel makes the following recommendations for patients who test positive for hepatitis C:
1. Persons with current (active) HCV infection should receive education and interventions aimed at reducing progression of liver disease and preventing transmission of HCV.
   Rating: Class IIa, Level B

2. Abstinence from alcohol and, when appropriate, interventions to facilitate cessation of alcohol consumption should be advised for all persons with HCV infection.
   Rating: Class IIa, Level B

3. Evaluation for other conditions that may accelerate liver fibrosis, including HBV and HIV infections, is recommended for all persons with HCV infection.
   Rating: Class IIb, Level B

4. Evaluation for advanced fibrosis using liver biopsy, imaging and/or noninvasive markers is recommended for all persons with HCV infection to facilitate an appropriate decision regarding HCV treatment strategy and to determine the need for initiating additional measures for the management of cirrhosis (e.g., hepatocellular carcinoma screening).
   Rating: Class I, Level A

5. Vaccination against hepatitis A and hepatitis B is recommended for all susceptible persons with HCV infection.
   Rating: Class IIa, Level C

6. Vaccination against pneumococcal infection is recommended to all patients with cirrhosis. (Marrie, 2011)
   Rating: Class IIa, Level C

7. All persons with HCV infection should be provided education on how to avoid HCV transmission to others.
   Rating: Class I, Level C
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**Explaining the meaning of the HCV screening process**

Patients have varying degrees of health literacy levels, and HCV screening requirements can be confusing even to those at the highest level. Indeed, PWID have identified the meaning of a positive HCV antibody result as confusing. Additionally, some providers may not be fully aware of the steps involved in HCV screening (MMWR, May 10, 2013).

The first test offered to previously HCV-negative persons is an anti-HCV antibody test. Several FDA-approved tests are available, including a point of care (“rapid”) test that can provide results in 20 minutes. Several lab-based testing options are also available.

A person with a negative anti-HCV antibody test is negative for HCV at this time. However, the “window period” could last up to 6 months before enough antibodies can be detected. Therefore, you may need to order another screening test depending upon the timing of your patient’s last potential exposure to HCV.

A person with a positive anti-HCV antibody test has been exposed to HCV at some point in her/his life, and may be chronically infected. However, an FDA approved HCV RNA test MUST be performed in order to confirm chronic infection.

**A note on signal-to-cut-off ratios**

If you use a signal to cut-off-ratio test, and patients receive that result before getting to speak to you or someone from your office about it, it could lead to confusion. The presence of any number, even one below the cut-off point, can lead a person to think they are infected with HCV. Ideally, you or a member of your staff will be able to deliver the result verbally to your patient, but if there is an electronic medical record or if a physical copy of the lab report is mailed out, make sure you provide a clear explanation on the meaning of results. Approximately 20-25% of people who get infected with HCV will spontaneously clear the virus within the first 6 months of exposure. Those who clear the virus will have anti-HCV antibodies but not have the virus itself, so they will be negative for their HCV RNA result. This is also true of individuals who were successfully treated and cured of HCV.

It’s important to note, and especially important to educate your patients, that the presence of anti HCV antibodies does not offer protection against future reinfections with HCV.
Treating HCV in PWID

The AASLD and IDSA’s “HCV Guidance: Recommendations for Testing, Managing and Treating Hepatitis C” recommend hepatitis C treatment for all people:

“Treatment is recommended for all patients with chronic HCV infection, except those with short life expectancies that cannot be remediated by treating HCV, by transplantation, or by other directed therapy. Patients with short life expectancies owing to liver disease should be managed in consultation with an expert.”

The phrase “all patients” includes people who inject drugs. The guidance panel states: “Recent and active IDU should not be seen as an absolute contraindication to HCV therapy. There is strong evidence from various settings in which persons who inject drugs have demonstrated adherence to treatment and low rates of reinfection, countering arguments that have been commonly used to limit access to this patient population.”

The guidelines panel further states: “There are no data to support the utility of pretreatment screening for illicit drug or alcohol use in identifying a population more likely to successfully complete HCV therapy. These requirements should be abandoned, because they create barriers to treatment, add unnecessary cost and effort, and potentially exclude populations that are likely to obtain substantial benefit from therapy. Scale-up of HCV treatment in persons who inject drugs is necessary to positively impact the HCV epidemic in the United States and globally.”

All this said, people who use drugs and live with HCV can be successfully treated for the disease. You may be willing to treat your patient, but his/her insurance coverage may have restrictions against people who use drugs and require a period of abstinence. Work with your patient to help them with their substance use as needed, but do not let perceived restrictions prevent you from attempting to treat them for HCV. The insurance coverage may say no once, but may approve it upon the first or subsequent appeals.
# HCV ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z20.5</td>
<td>Contact with/suspected exposure to viral hepatitis</td>
</tr>
<tr>
<td>Z20.828</td>
<td>Exposure to viral disease not elsewhere classified (NEC)</td>
</tr>
<tr>
<td>Z23</td>
<td>Encounter for prophylactic vaccination</td>
</tr>
<tr>
<td>Z72.51</td>
<td>High-risk sexual behavior, heterosexual</td>
</tr>
<tr>
<td>Z72.52</td>
<td>High-risk sexual behavior, homosexual</td>
</tr>
<tr>
<td>Z72.53</td>
<td>High-risk sexual behavior, bisexual</td>
</tr>
<tr>
<td>Z11.59</td>
<td>Encounter for screening for other viral disease</td>
</tr>
<tr>
<td>K74.0</td>
<td>Hepatic fibrosis</td>
</tr>
<tr>
<td>B17.10</td>
<td>Acute hepatitis C without hepatic coma</td>
</tr>
<tr>
<td>B18.2</td>
<td>Chronic hepatitis C without hepatic coma</td>
</tr>
<tr>
<td>B19.20</td>
<td>Unspecified viral hepatitis C without hepatic coma</td>
</tr>
<tr>
<td>B17.9</td>
<td>Acute viral hepatitis, unspecified</td>
</tr>
<tr>
<td>B19.9</td>
<td>Unspecified viral hepatitis without hepatic coma</td>
</tr>
<tr>
<td>Z86.19</td>
<td>History of hepatitis B; history of hepatitis C</td>
</tr>
<tr>
<td>098.41</td>
<td>Pregnancy complicated by care of/management affected by viral hepatitis</td>
</tr>
<tr>
<td>Z72.89</td>
<td>Other problems related to lifestyle (can be used for annual HCV screening in Medicare for PWID)</td>
</tr>
<tr>
<td>F19.20</td>
<td>Other psychoactive substance abuse, uncomplicated</td>
</tr>
<tr>
<td>Z22.52</td>
<td>Carrier of viral hepatitis C</td>
</tr>
</tbody>
</table>

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## HCV Billing Codes

- **86803**: Hepatitis C antibody
- **G0472**: Hepatitis C antibody screening for person at high risk and other covered indications
- **86804**: Hepatitis C antibody; confirmatory test
- **87520**: Infectious agent detection by nucleic acid (DNA or RNA): direct probe technique
- **87521**: Infectious agent detection by nucleic acid (DNA or RNA): amplified probe technique
- **87522**: Infectious agent detection by nucleic acid (DNA or RNA): hepatitis C, quantification
- **87902**: Infectious agent genotype analysis by nucleic acid (DNA or RNA): hepatitis C virus
- **3266F**: Hepatitis C, genotype test
- **82105**: Alpha-fetoprotein (AFP); serum
- **91299**: Unlisted Diagnostic Gastroenterology Procedure (for physicians who do their own FibroScan in their office)
- **36415**: Collection of venous blood by venipuncture

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_-- Adapted from the California Department of Public Health_