AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Hepatitis C

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Chronic hepatitis C is a **persistent infection with hepatitis C virus (HCV)**, a single-stranded RNA virus of the Flaviviridae family, defined by **detectable HCV RNA for more than 6 months**.[1] Up to **85%** of acutely infected adults fail to clear the virus spontaneously and transition to chronic infection.[1] The natural history spans decades: approximately **20–30%** of untreated patients develop cirrhosis over **25–30 years**, with an annual hepatocellular carcinoma (HCC) risk of **1–4%** and hepatic decompensation risk of **2–5%** once cirrhosis is established.[2] Chronic HCV is also a systemic disease — extrahepatic manifestations affect **40–74%**[3] of patients and include type 2 diabetes, cardiovascular disease, mixed cryoglobulinemia, chronic kidney disease, and neurocognitive impairment in up to **50%**.[4]

ICD-10 Codes:

Active chronic infection: **B18.2** (chronic viral hepatitis C — only HCV code with HCC mapping). Acute infection: **B17.10** (without hepatic coma), **B17.11** (with hepatic coma). Cured/resolved: **Z86.19** (personal history of resolved infectious disease) — correct code after **SVR12**. Avoid **B19.20/B19.21** (unspecified) — these lose HCC 65 documentation entirely. Companion codes when present: **K74.60** (cirrhosis, unspecified), **K74.01/K74.02** (early/advanced hepatic fibrosis), **D89.1** (cryoglobulinemia).[5]

Prevalence and Burden: An estimated **2.4 million U.S. adults are living with HCV infection**, and approximately **60% or more remain unaware of their status**.[6] HCV prevalence in the Medicare population is around **3.5%**, concentrated in the **Baby Boomer cohort** (born 1945–1965) — particularly those exposed through unscreened blood products before 1992.[7] Despite >**95%** cure rates with current direct-acting antiviral (DAA) regimens, only **28%** of diagnosed Medicare beneficiaries initiated DAA treatment within **360 days** compared with **35%** of privately insured patients (aOR 0.62, **95%** CI 0.56–0.68).[8]

HCC/RAF V28 Mapping

ICD-10 CODE(S)	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
B18.2 (chronic HCV)	HCC 65 — Chronic Hepatitis	0.185	Active chronic HCV infection confirmed by HCV RNA positive for **>6 months**; document **'chronic hepatitis C' explicitly** — coders cannot assume chronicity[1]
B17.10/B17.11 (acute HCV)	No HCC	—	Acute infection **(<6 months)**; **does not map to HCC**. Document acute seroconversion

ICD-10 CODE(S)	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
Z86.19 (Personal history of other infectious and parasitic diseases); resolved	No HCC	—	Correct code after **SVR12** — undetectable HCV RNA ≥12 weeks post-treatment. Document SVR date explicitly
B19.20 (Unspecified viral hepatitis C without hepatic coma) /B19.21 (Unspecified viral hepatitis C with hepatic coma)	No HCC	—	AVOID: **Unspecified HCV — does not map to HCC 65**; using instead of B18.2 loses RAF documentation entirely
Z22.52 (Carrier of viral hepatitis C)	No HCC	—	**AVOID:** Carrier code — appropriate only for **screening-positive, asymptomatic** individuals before HCV RNA confirmation. Once **active infection is confirmed**, transition to **B18.2**
K74.60 (unspecified cirrhosis of the liver)	Cirrhosis codes documented separately	—	Document cirrhosis when present; cirrhosis persists structurally even **after SVR** — post-cure coding is Z86.19 + K74.60

ABBREVIATIONS: CMS-HCC V28 = Centers for Medicare & Medicaid Services Hierarchical Condition Category Model V28; CNA = Community Non-Dual Eligible, Aged; HCC = Hierarchical Condition Category; HCV = hepatitis C virus; RAF = Risk Adjustment Factor; RNA = ribonucleic acid; SVR = Sustained Virologic Response. *Illustrative annual value at 2024 CMS-HCC base rate $10,387 × CNA RAF coefficient.

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

Risk-Adjusted Care Resources per Patient/Year[9]

RAF weight × MA base rate = estimated annual care coordination support per documented HCC

Hepatitis C

~$1,923

HCC 65 · RAF 0.185· per active patient/year

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

RAF coefficients are CNA segment, 2026 CMS-HCC Model V28. The impact of this condition varies across patient populations, particularly in individuals with disability, dual eligibility, or those receiving care in institutional settings

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings and Diagnostic Tests (Adult and Geriatric)

TEST	COVERAGE	FREQUENCY	CPT/HCPCS	CLINICAL INDICATION
HCV antibody screening — high-risk and one-time Baby Boomer screen[10]	Medicare Part B covered (no cost-sharing under preventive services)	Once for all adults 18–79 per USPSTF Grade B (2020); periodic re-testing for ongoing risk	G0472	USPSTF 2020 Grade B universal **one-time screening recommendation** — all adults aged **18–79**; periodic re-testing for individuals with ongoing exposure
HCV antibody (anti-HCV)[10]	Medicare Part B covered when medically indicated — diagnostic benefit, not preventive screening	Once; reactive result requires reflex to HCV RNA (CPT 87522) per CDC two-step HCV testing algorithm	86803	**Sensitivity 92–97%**; positive indicates **exposure**, **not active infection** — reflex to HCV RNA is mandatory
HCV RNA, quantitative (PCR)[10]	Medicare Part B covered	Confirms active infection in antibody-positive patients	87522	**Detectable HCV RNA = active infection. Undetectable** in antibody-positive patient = **resolved** (spontaneous clearance or post-SVR)
HCV genotype[10]	Medicare Part B covered	Less critical with pan-genotypic DAAs	87902	Genotype testing **optional with first-line pan-genotypic regimens**; still useful for retreatment planning

TEST	COVERAGE	FREQUENCY	CPT/HCPCS	CLINICAL INDICATION
FIB-4 Liver Test[10]	Medicare Part B covered — calculated from routine labs already drawn (AST, ALT, platelets, age); no additional cost beyond standard metabolic panel	At diagnosis; repeat annually or with clinical changes to monitor fibrosis progression	Calculated from existing values: AST (84450), ALT (84460), platelets (85049 or as part of CBC 85025)	**Gold standard first-line non-invasive test** for estimating liver fibrosis and scarring
Liver elastography (FibroScan)[10]	Medicare Part B covered when medically necessary	Once at diagnosis; repeat at clinician discretion	91200	**Non-invasive** fibrosis staging; >12.5 kPa supports cirrhosis; AUROC >0.95 for cirrhosis detection
Acute hepatitis panel[10]	Medicare Part B covered	When etiology unclear	80074	Includes HBsAg, HBc IgM, HAV IgM, HCV Ab — comprehensive initial workup; HBV serologies (HBsAg, anti-HBs, anti-HBc) are **mandatory** pre-DAA
HCC surveillance — abdominal ultrasound ± AFP (cirrhosis only)[10]	Medicare Part B covered for cirrhosis	Every 6 months — lifelong after SVR if cirrhosis present	76700/76705; AFP 82105	Required in cirrhosis **pre- and post-**SVR — SVR reduces but **does not eliminate HCC risk**

ABBREVIATIONS: AFP = alpha-fetoprotein; AUROC = area under receiver operating characteristic curve; AWV = Annual Wellness Visit; CPT = Current Procedural Terminology; DAA = direct-acting antiviral; HBV = hepatitis B virus; HCC = hepatocellular carcinoma; HCV = hepatitis C virus; HCPCS = Healthcare Common Procedure Coding System; PCR = polymerase chain reaction; SVR = Sustained Virologic Response; USPSTF = U.S. Preventive Services Task Force

Subtle Early Signs in Older Adults (>65)

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Unexplained fatigue, often the only symptom in Baby Boomers[11]	The most **common presenting complaint** in chronic HCV; commonly misattributed to deconditioning, depression, or polypharmacy in older adults — chronic HCV is silent for **2–3 decades** despite progressive hepatic injury
Mildly elevated AST/ALT on routine chemistries	May be the only early laboratory clue; can be normal in **30–50%** of patients with chronic HCV — normal aminotransferases do **NOT** rule out active infection or significant fibrosis[12]
New-onset type 2 diabetes or worsening glycemic control[11]	Chronic HCV confers approximately **4-fold increased insulin resistance risk**; new-onset DM in a Baby Boomer with no other risk factors should prompt HCV screening if not previously performed[12]
Mixed cryoglobulinemia features — purpura, peripheral neuropathy, arthralgia, glomerulonephritis[11]	Up to **50%** of chronic HCV patients have detectable **cryoglobulins**; **~10–15%** develop symptomatic **vasculitis**. Recognizable triad: palpable purpura, arthralgia, weakness[13]
Cognitive complaints — slowed processing, brain fog[11]	Up to **50%** of chronic HCV patients have measurable neurocognitive impairment that is independent of cirrhosis and frequently misattributed to aging; improves after SVR in many patients[14]
Painless jaundice or scleral icterus (late finding)[10]	Indicates significant **hepatic dysfunction** — most often advanced fibrosis, cirrhosis, or biliary etiology; **do not wait for jaundice to initiate workup** in a Baby Boomer with risk factors
Lower-extremity edema, ascites, or hepatic encephalopathy (late)[10]	**Hepatic decompensation** — requires urgent hepatology referral and decompensated cirrhosis pathway (SOF/VEL + ribavirin); GLE/PIB contraindicated in Child-Pugh B/C

ABBREVIATIONS: ALT = alanine aminotransferase; AST = aspartate aminotransferase; DM = diabetes mellitus; GLE/PIB = glecaprevir/pibrentasvir; HCV = hepatitis C virus; SOF/VEL = sofosbuvir/velpatasvir; SVR = Sustained Virologic Response

Geriatric Risk Factors

FACTOR	RISK SIGNAL	NOTES
Baby Boomer cohort (born 1945–1965)	Highest HCV prevalence in Medicare (3.5%)[7]	Pre-1992 blood supply exposure; many patients **never knew** they were infected — screening must be systematic, not history-driven
History of injection drug use (any era)[8]	**Strongest modifiable risk factor (aOR 3.6)**[15]	**Do not assume self-report** — many older adults are uncomfortable disclosing remote injection drug use; ask in a **non-judgmental way** and **screen regardless**
Blood transfusion or organ transplant before 1992	Pre-routine donor screening era	**Key CDC/USPSTF trigger**; ask about transfusions in any context (surgery, trauma, obstetric, hemophilia)
History of incarceration	Elevated risk per CDC[10]	Ask in a **clinically appropriate way**; HCV prevalence among formerly incarcerated adults is higher than the general population
Hemodialysis	aOR 11.5 in adults ≥55 in one case-control study[16]	Screen at **dialysis initiation** and periodically thereafter; coordinate with nephrology
Healthcare exposure in countries with variable infection control	Tattooing, surgery, or dialysis abroad	Particularly relevant in **immigrant populations**; ask about country of origin and medical/dental procedures pre-emigration
Undomiciled or housing-insecure status[8]	aOR 2.8[16]	Build screening into encounters with **hospital social workers and shelter-based clinic**s; link to navigation services
HIV co-infection	Higher HCV prevalence; faster fibrosis progression	Coordinate with infectious disease; **HIV/HCV co-infection** is a defined hepatology referral indication

FACTOR	RISK SIGNAL	NOTES
Tattoos or piercings obtained outside regulated settings	Modifiable	**Lower-grade risk** but a reason to screen if patient has not been tested

ABBREVIATIONS: aOR = adjusted odds ratio; CDC = Centers for Disease Control and Prevention; HCV = hepatitis C virus; HIV = human immunodeficiency virus; USPSTF = U.S. Preventive Services Task Force

Diagnostic Thresholds

TEST/MARKER	DIAGNOSTIC CRITERION	NOTES
HCV antibody (anti-HCV)	**Sensitivity 92–97%**;[17] positive = exposure, NOT necessarily active infection	**Antibodies persist for life** after spontaneous clearance or post-SVR; positive antibody alone never establishes active disease — reflex HCV RNA is mandatory
HCV RNA	Detectable = active infection; undetectable in antibody-positive patient = resolved	Quantitative (CPT 87522) preferred; provides baseline viral load. Repeat HCV RNA to confirm SVR12 — undetectable **≥12 weeks post-treatment**[10]
Chronicity definition	HCV RNA positive for **>6 months**[10]	Provider must document **'chronic hepatitis C' or duration** of HCV RNA positivity >6 months in the note
FIB-4 score[22]	**<1.45** rules out advanced fibrosis; **≥3.25** indicates probable **cirrhosis** (specificity 93–97%)[12,18]	Incorporates age, AST, ALT, and platelets. Note: FIB-4 incorporates age as a **variable** — scores may be inflated in older adults, reducing specificity. AASLD 2025 explicitly acknowledges this limitation
Liver elastography (FibroScan)[22]	**>12.5 kPa supports cirrhosis**; AUROC >0.95[10]	**More accurate than FIB-4 in elderly patients when FIB-4 is indeterminate (1.45–3.25)**;[12] preferred when available

TEST/MARKER	DIAGNOSTIC CRITERION	NOTES
HBV serologies (HBsAg, anti-HBs, anti-HBc)	**MANDATORY** before any DAA initiation[10]	Treating HCV without HBV screening risks **severe**, potentially **fatal HBV reactivation** as HCV suppression removes competitive viral inhibition. Absolute pre-treatment requirement — never optional
Pre-treatment liver ultrasound	Within **6 months** of DAA initiation[27]	**Excludes HCC and subclinical ascites**; required in patients with cirrhosis and recommended in all patients
Child-Pugh score[12]	B and C = **decompensated** cirrhosis	**Determines DAA regimen choice** — GLE/PIB contraindicated in Child-Pugh B/C; SOF/VEL + ribavirin is preferred regimen, with hepatology co-management

ABBREVIATIONS: AASLD = American Association for the Study of Liver Diseases; ALT = alanine aminotransferase; AST = aspartate aminotransferase; AUROC = area under receiver operating characteristic curve; DAA = direct-acting antiviral; FIB-4 = Fibrosis-4 Index; GLE/PIB = glecaprevir/pibrentasvir; HBV = hepatitis B virus; HCC = hepatocellular carcinoma; HCV = hepatitis C virus; SOF/VEL = sofosbuvir/velpatasvir; SVR = Sustained Virologic Response

Cardinal Symptoms

Hepatitis C is Characteristically Asymptomatic: Chronic HCV is famously a "silent killer" because it typically has ***no*** **cardinal symptoms for 20 to 30 years until it progresses to advanced cirrhosis or end-stage liver disease.** Classic "cardinal" symptoms of acute or decompensated liver disease would be jaundice, ascites, right upper quadrant pain, or variceal bleeding.

CLINICAL CLUE	WHY IT MATTERS	NEXT DIAGNOSTIC STEP
Baby Boomer who has never been tested for HCV[12]	Prior probability of infection is meaningfully elevated regardless of stated risk; **~75% of HCV-positive U.S. adults remain undiagnosed**[9]	Order an **HCV antibody test**) at the next encounter. Do not wait for a self-disclosed risk history
Mixed cryoglobulinemia features (palpable purpura, peripheral neuropathy, arthralgia, glomerulonephritis)[11]	Up to **50%** of chronic HCV patients have detectable **circulating** cryoglobulins; **10–15%** develop symptomatic immune-complex vasculitis that is directly driven by the HCV virus[13]	Screen immediately for HCV RNA. Coordinate a rheumatology referral for active symptomatic vasculitis management alongside antiviral treatment

CLINICAL CLUE	WHY IT MATTERS	NEXT DIAGNOSTIC STEP
Slowed processing, brain fog, or unexplained cognitive decline[12]	Up to **50%** of chronic HCV patients have measurable neurocognitive impairment independent of cirrhosis;[14] improves in many patients after SVR	**Screen for HCV;** do not reflexively attribute cognitive decline or fatigue to aging or idiopathic depression alone

ABBREVIATIONS: ALT = alanine aminotransferase; AST = aspartate aminotransferase; eGFR = estimated glomerular filtration rate; HBsAg = hepatitis B surface antigen; HCV = hepatitis C virus; SVR = Sustained Virologic Response

Common Oversights

OVERSIGHT/SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD
Treating a positive HCV antibody as a confirmed active infection[10,19]	**HCV antibodies persist for life after spontaneous clearance or successful DAA treatment.** A positive antibody in a cured patient is a serologic footprint of past exposure, not active disease. Always reflex to HCV RNA before initiating any treatment decision
Initiating DAA therapy without HBV serologies[10,19]	Treating HCV without HBV screening risks severe, potentially fatal **HBV reactivation** as HCV suppression removes competitive viral inhibition. HBsAg, anti-HBs, and anti-HBc are mandatory pre-treatment — never optional
Skipping pre-treatment medication reconciliation[18,19]	Approximately **54% of patients ≥65 have predicted significant DDIs with DAAs** versus **28% of those <65**.[20] Statin, PPI, dabigatran, amiodarone, and anticonvulsant interactions require structured review using hep-druginteractions.org before initiation
Referring all HCV patients to hepatology[10,19]	**Modern DAAs are designed for primary care delivery.** Uncomplicated chronic HCV — no decompensated cirrhosis, no prior DAA failure, and no unmanageable DDIs — can and should be treated by primary care. Reflexively referring all patients widens the treatment gap
Discontinuing HCC surveillance after SVR in cirrhotic patients[10,19]	SVR reduces but **does not eliminate HCC risk** in patients with established cirrhosis. Surveillance with ultrasound ± AFP every 6 months is lifelong

ABBREVIATIONS: AFP = alpha-fetoprotein; DAA = direct-acting antiviral; DDI = drug–drug interaction; HBsAg = hepatitis B surface antigen; HCC = hepatocellular carcinoma; HCV = hepatitis C virus; PPI = proton pump inhibitor; RAF = Risk Adjustment Factor; SVR = Sustained Virologic Response

Key Differentials in Elderly

PRESENTATION	DIFFERENTIAL	KEY TESTS
Mildly elevated transaminases (chronic)[10]	Chronic HCV **vs**. chronic HBV vs. metabolic dysfunction-associated steatotic liver disease (MASLD) vs. alcohol-associated liver disease vs. medication-induced (statins, methotrexate, amiodarone) vs. autoimmune hepatitis	HCV antibody + HCV RNA; HBsAg; lipid panel + HbA1c; alcohol use history (AUDIT-C); medication review; ANA, anti-smooth muscle antibody
Unexplained fatigue + Baby Boomer cohort[11]	Chronic HCV **vs.** hypothyroidism vs. anemia vs. depression vs. deconditioning vs. obstructive sleep apnea	HCV antibody — **screening must be proactive**; TSH; CBC; PHQ-9; sleep history
New-onset diabetes without traditional risk factors[11]	Chronic HCV **vs**. pancreatic etiology (pancreatitis, malignancy) vs. medication-induced (corticosteroids, atypical antipsychotics) vs. type 1 diabetes (late-onset)	HCV antibody; abdominal imaging if rapid weight loss; medication review; pancreatic enzymes if symptoms
Mixed cryoglobulinemia features[11]	HCV-associated mixed cryoglobulinemia **vs**. HIV vs. HBV vs. lymphoproliferative disease vs. autoimmune (Sjögren, SLE) vs. idiopathic	HCV antibody + HCV RNA; HBsAg; HIV; cryoglobulins; complement; ANA; SPEP/UPEP
Cognitive decline in older adult[11]	HCV-associated neurocognitive impairment **vs.** Alzheimer disease vs. vascular dementia vs. hypothyroidism vs. B12 deficiency vs. depression vs. obstructive sleep apnea vs. medication-induced (anticholinergics, benzodiazepines)	**HCV antibody as part of reversible-cause workup**; MoCA; TSH; B12; medication review; depression screen
Painless jaundice or hepatic decompensation[19]	Cirrhosis from any cause — HCV **vs**. HBV vs. alcohol vs. MASLD vs. pancreaticobiliary malignancy vs. choledocholithiasis vs. drug-induced liver injury	**Liver function panel;** imaging (RUQ ultrasound, MRCP); HCV antibody if not previously screened; hepatology referral

ABBREVIATIONS: ANA = antinuclear antibody; AUDIT-C = Alcohol Use Disorders Identification Test (Consumption); CBC = complete blood count; HBV = hepatitis B virus; HbA1c = hemoglobin A1c; HCV = hepatitis C virus; HIV = human immunodeficiency virus; MASLD = metabolic dysfunction-associated steatotic liver disease; MoCA = Montreal Cognitive Assessment; MRCP = magnetic resonance cholangiopancreatography; PHQ-9 = Patient Health Questionnaire-9; SLE = systemic lupus erythematosus; SPEP = serum protein electrophoresis; TSH = thyroid stimulating hormone; UPEP = urine protein electrophoresis

Comorbidity Screening

CONDITION	PREVALENCE/ASSOCIATION	SCREENING APPROACH
Cirrhosis (K74.60)	**20–30%** of untreated chronic HCV **over 25–30 years**[2]	**FIB-4 at diagnosis and annually** if no advanced fibrosis; elastography if FIB-4 indeterminate; hepatology referral if cirrhosis confirmed
Hepatocellular carcinoma (C22.0)	**1–4% annual risk in cirrhotic patients**;[2] risk reduced but not eliminated by SVR	Abdominal ultrasound ± AFP **every 6 months** — lifelong in cirrhotic patients regardless of SVR status
Type 2 diabetes/insulin resistance (E11.x)	**~4-fold** increased insulin resistance risk vs. general population[12]	**HbA1c at diagnosis and annually**; monitor for improved glycemic control after SVR — insulin sensitivity may improve, requiring dose adjustment
Cardiovascular disease	Increased risk of **CV events** (OR 1.20) and **cerebrovascular events** (OR 1.35);[21] DAA treatment associated with HR 0.57 for CV events post-SVR[22]	Standard CV risk assessment; consider HCV cure as a cardiovascular risk reduction intervention in Medicare population
Mixed cryoglobulinemia (D89.1)	Up to **50%** with detectable **cryoglobulins**; **~10–15% symptomatic vasculitis**[13]	Symptom screening (purpura, neuropathy, arthralgia, glomerulonephritis); cryoglobulin testing if symptomatic; rheumatology co-management
Chronic kidney disease/ glomerulonephritis (N18.x, N03.x)[16]	Increased risk; HCV-associated membranoproliferative glomerulonephritis	eGFR at diagnosis and annually; urine ACR; nephrology referral if proteinuria or declining GFR
Neurocognitive impairment	Up to **50%** with measurable cognitive deficits; partially reversible with SVR[14]	**Brief cognitive screen** (Mini-Cog, MoCA) at **baseline** and **post-SVR**; recognize HCV as a contributor in younger-onset cognitive complaints
HBV co-infection[19]	Variable by population; absolute pre-treatment screening requirement	HBsAg, anti-HBs, anti-HBc mandatory before any DAA initiation; positive HBsAg → hepatology coordination for HBV management to prevent reactivation

CONDITION	PREVALENCE/ASSOCIATION	SCREENING APPROACH
HIV co-infection[19]	Increases fibrosis **progression rate**	**HIV testing in patients with HCV risk factors or unknown HIV status**; coordinate with infectious disease if positive

ABBREVIATIONS: ACR = albumin-to-creatinine ratio; AFP = alpha-fetoprotein; CV = cardiovascular; DAA = direct-acting antiviral; eGFR = estimated glomerular filtration rate; HBV = hepatitis B virus; HBsAg = hepatitis B surface antigen; HCC = hepatocellular carcinoma; HCV = hepatitis C virus; HIV = human immunodeficiency virus; HR = hazard ratio; OR = odds ratio; SVR = Sustained Virologic Response

AAVBC PERSPECTIVE

The AAVBC encourages primary care providers to adopt a systematic, point-of-care test-and-treat approach to chronic hepatitis C, beginning with a ***universal, one-time HCV antibody screening for all adults aged 18–79*** *per the USPSTF 2020 Grade B recommendation. Because risk-history disclosures are notoriously unreliable and many individuals are completely unaware of legacy exposures from shared equipment, unregulated procedures, or un-screened blood products, testing must be entirely routine rather than history-driven, expanding far beyond the legacy Baby Boomer birth-cohort boundaries. While the general population requires only this single baseline test, clinicians must* ***implement ongoing, periodic rescreening for patients with continuous or high-yield risk factors.*** *This* ***targeted monitoring*** *is strictly required for people who currently or formerly injected drugs, individuals living with HIV, current or formerly incarcerated individuals, maintenance hemodialysis patients, recipients of blood transfusions or organ transplants prior to 1992, healthcare workers following a documented needlestick exposure, and children born to HCV-positive mothers.*

When HCV antibody testing is positive, reflex HCV RNA testing is required to confirm active viremia before any coding or treatment decision is made.

AAVBC supports initiation of first-line pan-genotypic DAA therapy in the primary care setting, rather than deferring to specialist referral, for patients with confirmed chronic HCV infection and no decompensated cirrhosis, prior DAA failure, or unresolvable drug-drug interactions. A structured pre-treatment checklist, including HBV screening, FIB-4 assessment, liver ultrasound, and DDI review, must be completed before therapy is initiated. This ensures the right patients are identified, evaluated, and treated at the right time.

RED FLAG — EMERGENCY/ACTIVATE CRISIS RESPONSE

Activate emergency department or direct hepatology contact for any of the following:

- **Hepatic decompensation** — new ascites, hepatic encephalopathy (asterixis, altered mental status), variceal bleeding, or jaundice with coagulopathy→ DO NOT initiate DAA in primary care if decompensated cirrhosis is suspected
- **Spontaneous bacterial peritonitis in known cirrhosis** — fever, abdominal pain, or unexplained mental status change→ Emergency department; IV antibiotics; hepatology contact
- **Acute hepatitis with coma (B17.11)** — rare in HCV but life-threatening→ ED transfer; hepatology consultation

RED FLAG — URGENT (24–72 HOURS)

- **Suspected HBV reactivation during or after DAA therapy** — rising HBV DNA, ALT flare, or jaundice in a patient with prior HBsAg+ or anti-HBc+ status→ Stop DAA; contact hepatology immediately
- **New symptomatic mixed cryoglobulinemic vasculitis** — purpura with renal involvement or progressive neuropathy→ Urgent rheumatology and nephrology referral; HCV RNA confirmation
- **New decompensation features in a known cirrhotic patient** — on or off DAA therapy→ Same-day hepatology contact; do not manage in primary care setting

3 MEAT DOCUMENTATION ESSENTIALS

Hepatitis C documentation translates clinical complexity into a record that supports continuity, accurate quality measurement, and appropriate care planning. **The most consequential documentation boundary in chronic HCV is the active-versus-cured distinction**: the same antibody-positive serology can describe a patient who needs DAA therapy and a patient who has already been cured. Only HCV RNA, and explicit documentation of SVR, can carry that distinction into the medical record.

Case vignette: A **68-year-old** patient born in **1958** presents for routine diabetes follow-up. Review of records shows mildly elevated **ALT (62 U/L)** and **AST (54 U/L)** on the prior visit, attributed at the time to 'fatty liver.' The patient has never been screened for HCV. HbA1c is 7.4. Medications include atorvastatin 40 mg**, omeprazole 20 mg, lisinopril, metformin, and aspirin.** The patient denies any history of injection drug use but reports a **blood transfusion** after a motor vehicle accident in 1984.

MONITOR: Weight stable at **198 lb, BP 138/82. HbA1c 7.4,** up from **6.9 six months ago** — glycemic trend worsening despite stable metformin dose. **ALT 62, AST 54**, persistently elevated over **14 months** with no prior workup beyond "fatty liver." Functional status: independent in all

ADLs. Patient reports intermittent word-finding difficulty over the past 6 months, no falls or safety concerns. Current medications: **atorvastatin 40 mg, omeprazole 20 mg daily, lisinopril 20 mg, metformin 1000 mg BID, aspirin 81 mg** — five chronic medications, two of which are DDI-relevant if DAA therapy is initiated.

EVALUATE: Patient is **born 1958, never screened for HCV,** with a history of **blood transfusion in 1984 after a motor vehicle accident.** Ordered HCV antibody today given cohort risk and pre-1992 transfusion exposure. If antibody is positive, lab will reflex to HCV RNA per standing order. Also ordering **HBsAg, anti-HBs, and anti-HBc**. Calculated **FIB-4** using today's labs. Ordered **abdominal ultrasound** to evaluate liver parenchyma and rule out focal lesions. Will run a **structured drug interaction** check through hep-druginteractions.org once HCV status is confirmed.

ASSESS: HCV antibody returned **positive**. **HCV RNA 1.2 million IU/mL** — confirms **active chronic hepatitis C infection**. **FIB-4** calculated at **1.8**, which is indeterminate, so I referred for **elastography**. FibroScan returned **7.2 kPa**, consistent with mild to moderate fibrosis **(F1–F2)**, no cirrhosis. HBV serologies: HBsAg negative, anti-HBs positive, anti-HBc negative — consistent with prior vaccination, no active or resolved HBV infection, safe to proceed with DAA. Ultrasound showed no focal hepatic lesions and no ascites. Diagnoses documented today: chronic hepatitis C **(B18.2)**, type 2 diabetes mellitus without complications **(E11.9)**, hyperlipidemia **(E78.5)**, essential hypertension **(I10)**. Genotype testing deferred — not required for first-line pan-genotypic regimen selection.

TREAT: Patient is a **DAA candidate** — **treatment-naive, no cirrhosis, no decompensation, no prior DAA failure.** Prescribing **sofosbuvir/velpatasvir 400/100 mg once daily for 12 weeks.** Chose **SOF/VEL over GLE/PIB** because atorvastatin is **contraindicated** with GLE/PIB due to OATP1B1 inhibition and risk of statin toxicity. **Omeprazole 20 mg** is acceptable with SOF/VEL when taken **simultaneously with food**; counseled patient **not to separate doses.** Submitted prior authorization to Medicare Part D today. Counseled on adherence — explained that missing doses reduces cure rates and that the full **12-week course is essential.** Scheduled SVR12 HCV RNA for 12 weeks after treatment completion to confirm cure. Will recheck HbA1c at SVR12 and again at 6 months — hepatic insulin sensitivity often improves after viral clearance, and metformin dose may need to be reduced if glucose trends down. HCC surveillance is not indicated given absence of cirrhosis; if cirrhosis had been present, ultrasound plus AFP **every 6 months would be lifelong regardless of cure.**

Clinical Documentation Elements

- **Document chronicity explicitly:** 'Chronic hepatitis C — HCV RNA positive for >6 months' supports **B18.2** and HCC 65 documentation. 'Hepatitis C' alone without chronicity is insufficient and may default to **B19.20** (no HCC) — a documentation gap, not a coding error
- **Document the active-versus-resolved status at every encounter:** 'Active chronic HCV — on DAA cycle X' or 'Post-SVR12, undetectable HCV RNA as of [date]'. A positive HCV antibody alone never establishes active disease — only HCV RNA does
- **Code each associated condition:** Cirrhosis **(K74.60)**, fibrosis stage **(K74.01/K74.02)**, mixed cryoglobulinemia **(D89.1, link to HCV)**, HBV co-infection **(B18.1)**, HIV co-infection **(B20)**. Each separately documented condition reflects true patient complexity and supports continuity across the care team.
- **Document the pre-treatment checklist when initiating DAA:** HBV serologies completed and result, FIB-4 score, liver ultrasound date and result, medication reconciliation

with DDI screen (specify tool — hep-druginteractions.org), and patient counseling on adherence. This documentation supports clinical continuity and quality measurement

- **Document the cure transition explicitly:** 'SVR12 confirmed — undetectable HCV RNA as of [date]; transitioning ICD-10 from **B18.2** to **Z86.19**'. Coders cannot make this transition without explicit provider documentation. If cirrhosis was present, retain **K74.60** and continue surveillance

Reframing Common Documentation Shortcuts

INSTEAD OF…	DOCUMENT…
'Hepatitis C'	'Chronic viral hepatitis C, active — HCV RNA 1.2 million IU/mL, positive for >6 months **(B18.2)**'
'History of hepatitis C'	'Post-SVR12 — undetectable HCV RNA as of 2025-08-15; cirrhosis **K74.60** persists with ongoing HCC surveillance **(Z86.19 + K74.60)**'
'Hepatitis C carrier'	'Active chronic HCV infection confirmed by HCV RNA **(B18.2)**'— **Z22.52 is appropriate only for screening-positive**, asymptomatic individuals before HCV RNA confirmation
'Cirrhosis from hepatitis C'	'Chronic viral hepatitis C with compensated cirrhosis — METAVIR F4, Child-Pugh A, FIB-4 4.2, elastography 16.8 kPa **(B18.2 + K74.60)**'
'On treatment for hep C'	'Active chronic HCV **(B18.2)** on sofosbuvir/ velpatasvir 400/100 mg daily, week 6 of 12 — adherent; ALT 28 (down from 62)'
'Cryoglobulinemia'	'HCV-associated mixed cryoglobulinemia **(D89.1)** — palpable purpura and peripheral neuropathy; linked to active chronic HCV infection **(B18.2)**'
'New-onset diabetes'	'Type 2 diabetes mellitus, new onset; will monitor glycemic control after SVR'

ABBREVIATIONS: ALT = alanine aminotransferase; FIB-4 = Fibrosis-4 Index; HCC = hepatocellular carcinoma; HCV = hepatitis C virus; SVR = Sustained Virologic Response

DOCUMENTATION

Active HCV encounter should document chronicity (HCV RNA positive >6 months), current treatment status (untreated, on DAA cycle X of Y, or post-SVR), fibrosis stage, and any associated conditions (cirrhosis, cryoglobulinemia, HCV-associated diabetes, neurocognitive impairment). After SVR, document the cure date explicitly and transition from B18.2 to Z86.19 — preserving K74.60 if cirrhosis persists.

4 TREATMENT AND REFERRAL QUICK GUIDE

Treatment in chronic hepatitis C is driven by **virologic confirmation and fibrosis stage**, not chronological age or performance status alone. **Pan-genotypic direct-acting antiviral** (DAA) therapy is highly effective **(>95% SVR)** and designed for **primary care delivery** in eligible patients. The clinical complexity is not in the medication itself but in the **pre-treatment checklist (HBV serologies, FIB-4, liver ultrasound, DDI screen)** and in matching the regimen to the patient's polypharmacy profile. The single highest-value behavior change in the Medicare HCV population is systematic test-and-treat in primary care, rather than reflexive specialist referral for uncomplicated cases.

Therapy Escalation Criteria

TRIGGER	ACTION*
Unscreened adult aged 18–79[19]	Order HCV antibody at the **next encounter** — USPSTF Grade B universal one-time screening (HCPCS G0472)
HCV antibody positive[19]	Reflex HCV RNA (CPT 87522) — without it, active versus cured **cannot be distinguished**
HCV RNA positive, no decompensated cirrhosis, no prior DAA failure	Initiate simplified **primary-care DAA therapy after HBV serologies**, FIB-4, ultrasound, and DDI screen are complete[19]
FIB-4 ≥3.25 or elastography ≥12.5 kPa[19]	**Hepatology referral** for staging, variceal screening, and HCC surveillance enrollment
Decompensated cirrhosis (Child-Pugh B/C)[19]	**Hepatology referral** — SOF/VEL + ribavirin under specialist management; GLE/PIB contraindicated
Prior DAA treatment failure[19]	**Hepatology referral** — retreatment with sofosbuvir/velpatasvir/voxilaprevir (Vosevi); resistance testing **may guide therapy**
HBV co-infection (HBsAg positive)[19]	Hepatology/infectious disease coordination to manage HBV reactivation risk during DAA
Unmanageable DDIs after structured review (e.g., chronic CYP3A4 inducer that cannot be switched)[19]	Pharmacist + specialist consult; consider regimen switch (e.g., anticonvulsant to levetiracetam) before DAA initiation[19]
12 weeks after DAA completion[19]	**Repeat HCV RNA** to confirm **SVR12**

TRIGGER	ACTION*
Cirrhotic patient at SVR12[19]	**Continue HCC surveillance** — ultrasound ± AFP **every 6 months lifelong**; variceal screening per hepatology

ABBREVIATIONS: AFP = alpha-fetoprotein; DAA = direct-acting antiviral; DDI = drug–drug interaction; FIB-4 = Fibrosis-4 Index; GLE/PIB = glecaprevir/pibrentasvir; HBV = hepatitis B virus; HBsAg = hepatitis B surface antigen; HCC = hepatocellular carcinoma; HCV = hepatitis C virus; SOF/VEL = sofosbuvir/velpatasvir; SVR = Sustained Virologic Response; USPSTF = U.S. Preventive Services Task Force
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

First-Line DAA Regimens by Patient Profile

PATIENT PROFILE	PREFERRED REGIMEN(S)	KEY NOTES
Treatment-naive, no/ compensated cirrhosis, no contraindicating DDIs	**Glecaprevir/pibrentasvir** (Mavyret) 300/120 mg once daily with food × 8 weeks; OR **Sofosbuvir/velpatasvir** (Epclusa) 400/100 mg once daily × 12 weeks[10]	Both pan-genotypic; both first-line. Select by polypharmacy profile and patient-specific factors below
Chronic PPI use (e.g., GERD, Barrett esophagus)	**Glecaprevir/pibrentasvir (Mavyret) preferred**[10]	**GLE/PIB has no PPI interaction.** SOF/VEL requires PPI limitation to **omeprazole ≤20 mg taken simultaneously** with dose[23]
Cardiovascular polypharmacy (statin + antiplatelet ± antiarrhythmic)	**Sofosbuvir/velpatasvir (Epclusa) preferred**[10]	**GLE/PIB has higher contraindicated DDI burden with statins** (atorvastatin, lovastatin, simvastatin contraindicated; rosuvastatin capped at 10 mg)[10]
Amiodarone user	Glecaprevir/pibrentasvir (Mavyret)[19]	**Amiodarone is contraindicated with sofosbuvir-containing regimens** — risk of symptomatic bradycardia including pacemaker requirement[19]
Dabigatran user	**Sofosbuvir/velpatasvir (Epclusa) preferred**[19]	**Dabigatran is contraindicated with GLE/ PIB** due to P-gp inhibition; switch anticoagulant during DAA if GLE/PIB required[24]

PATIENT PROFILE	PREFERRED REGIMEN(S)	KEY NOTES
CKD/on hemodialysis	**Glecaprevir/pibrentasvir (Mavyret) preferred**[16]	**No renal dose adjustment required** — safe in eGFR <30 and hemodialysis. SOF/VEL also studied in CKD but GLE/PIB has the most robust renal data[16]
Decompensated cirrhosis (Child-Pugh B/C)	Sofosbuvir/velpatasvir (Epclusa) + ribavirin × **12 weeks** — hepatology co-management[10]	**GLE/PIB contraindicated in Child-Pugh B/C**; SOF/VEL is the only first-line option
Anticonvulsant on CYP3A4 inducer (carbamazepine, phenytoin, phenobarbital)[25]	Switch anticonvulsant (e.g., to levetiracetam) **BEFORE** initiating any DAA	**All current DAAs are contraindicated with strong CYP3A4/P-gp inducers** due to subtherapeutic DAA levels — coordinate with neurology before treatment
Prior DAA failure (retreatment)[19]	Sofosbuvir/velpatasvir/voxilaprevir (Vosevi) **× 12 weeks** — hepatology referral	**Resistance testing may guide therapy**; not appropriate for primary-care–only management

ABBREVIATIONS: CKD = chronic kidney disease; CYP = cytochrome P450; DAA = direct-acting antiviral; DDI = drug–drug interaction; eGFR = estimated glomerular filtration rate; GERD = gastroesophageal reflux disease; GLE/PIB = glecaprevir/pibrentasvir; P-gp = P-glycoprotein; PPI = proton pump inhibitor; SOF/VEL = sofosbuvir/velpatasvir

Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Pre-treatment medication reconciliation[19]	**Mandatory** for all patients **before DAA initiation**; pharmacist involvement recommended in patients on 10+ medications	**54%** of patients **≥65** have predicted **significant DDIs** vs. **28%** of those **<65**[20]
Alcohol counseling[19]	Brief intervention for any current alcohol use; **complete cessation strongly preferred** during DAA course and especially with cirrhosis	**Alcohol accelerates fibrosis progression**; cessation supports treatment outcomes and cancer (HCC) risk reduction

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Hepatitis A and B vaccination[19]	**HAV and HBV vaccination** for non-immune patients with chronic HCV	Anti-HBs–negative patient who is HBsAg-negative and anti-HBc–negative should be **vaccinated against HBV**; HAV per CDC adult immunization schedule
Nutritional and weight counseling[26]	Address concurrent metabolic dysfunction — **MASLD frequently co-occurs and accelerates fibrosis**	Weight management and glycemic control **reduce hepatic injury** independent of viral cure
Patient education on adherence[19]	**Take medication daily**; do not skip doses; report adverse events promptly	Adherence is the dominant determinant of SVR; counsel on consistent timing with PPI if SOF/VEL
Harm reduction for ongoing risk[19]	Syringe service program referral; safer-use education; HIV/HCV co-screening	Reinfection risk persists if exposure continues; harm reduction is integral to care, not separate from it
HCC surveillance education (cirrhosis only)[19]	Ultrasound ± AFP **every 6 months** — lifelong, including post-SVR if cirrhosis present	Patients often **misunderstand SVR as 'fully cured'**. Reinforce that surveillance remains necessary in cirrhosis

ABBREVIATIONS: AFP = alpha-fetoprotein; CDC = Centers for Disease Control and Prevention; DAA = direct-acting antiviral; DDI = drug–drug interaction; HAV = hepatitis A virus; HBV = hepatitis B virus; HBsAg = hepatitis B surface antigen; HCC = hepatocellular carcinoma; HCV = hepatitis C virus; MASLD = metabolic dysfunction-associated steatotic liver disease; PPI = proton pump inhibitor; SOF/VEL = sofosbuvir/velpatasvir; SVR = Sustained Virologic Response

Medication Safety and Key Interactions

DRUG/CLASS	INTERACTION/TOXICITY*	CLINICAL ACTION
Statins — atorvastatin, lovastatin, simvastatin[19]	**Contraindicated with GLE/PIB** due to OATP1B1/1B3 inhibition (2–5-fold increase in statin exposure);[19] **rosuvastatin** capped at **10 mg/day** with GLE/PIB[24]	**Temporary statin hold** during the **8-week GLE/PIB course** is often preferred; or choose SOF/VEL which has a more favorable statin profile[19]
Proton pump inhibitors (omeprazole, pantoprazole, esomeprazole)[19]	SOF/VEL: limit to omeprazole **≤20 mg** taken simultaneously with dose;[19] GLE/PIB: no PPI interaction[27]	If chronic high-dose PPI is essential (Barrett esophagus, refractory GERD), prefer GLE/PIB

DRUG/CLASS	INTERACTION/TOXICITY*	CLINICAL ACTION
Dabigatran[19]	**Contraindicated with GLE/PIB** due to P-gp inhibition[28]	Use **SOF/VEL** instead; or switch to an **alternative anticoagulant during DAA therapy** with careful coordination[19]
Amiodarone[19]	**Contraindicated with all sofosbuvir-containing regimens** — risk of symptomatic bradycardia, including cases requiring pacemaker[29]	Use **GLE/PIB if no decompensated cirrhosis**; if SOF/VEL is essential, hepatology + cardiology co-management with telemetry
Anticonvulsants — carbamazepine, phenytoin, phenobarbital[30]	**Absolute contraindication with all current DAA regimens** — CYP3A4/P-gp induction reduces DAA to subtherapeutic levels[19]	Switch to a **non-inducing** anticonvulsant (e.g., levetiracetam) BEFORE initiating DAA; coordinate with neurology
Ribavirin (when used with SOF/VEL in decompensated cirrhosis)[19]	Hemolytic anemia; teratogenicity[1]	**Weekly CBC initially**; hepatology co-management; reproductive counseling[1]
Warfarin[31]	DAA-induced changes in hepatic function may alter INR — particularly improved hepatic synthetic function after SVR	**Monitor INR** more frequently during and after DAA; expect potential warfarin dose reduction post-SVR
Diabetes agents (insulin, metformin, sulfonylureas)[32]	Hepatic insulin sensitivity improves after SVR — may precipitate hypoglycemia in patients on insulin or sulfonylureas	**Monitor HbA1c and home glucose during and after DAA**; anticipate diabetes medication reduction post-SVR

ABBREVIATIONS: CBC = complete blood count; CYP = cytochrome P450; DAA = direct-acting antiviral; GERD = gastroesophageal reflux disease; GLE/PIB = glecaprevir/pibrentasvir; INR = international normalized ratio; OATP = organic anion-transporting polypeptide; P-gp = P-glycoprotein; PPI = proton pump inhibitor; SOF/VEL = sofosbuvir/velpatasvir; SVR = Sustained Virologic Response ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

When to Refer

CRITERION	SPECIALIST	URGENCY
Hepatic decompensation — new ascites, encephalopathy, variceal bleeding, jaundice with coagulopathy[19]	Emergency department/ hepatology	**Emergent**

CRITERION	SPECIALIST	URGENCY
Decompensated cirrhosis (Child-Pugh B/C) considering DAA[19]	Hepatology — for SOF/VEL + ribavirin under specialist co-management	**Urgent** (within 1–2 weeks)
Prior DAA failure (retreatment candidate)[19]	Hepatology — Vosevi-based retreatment, resistance testing[1=]	**Urgent** (within 2–4 weeks)
HBV co-infection (HBsAg positive)[19]	Hepatolog/infectious disease — coordinate to prevent HBV reactivation	**Urgent** (before DAA initiation)
FIB-4 ≥3.25 or elastography ≥12.5 kPa[19]	Hepatology — variceal screening, HCC surveillance enrollment, staging	Routine (within 4 weeks)
HIV co-infection[19]	Infectious disease — DAA-ART interaction review[1]	Routine (within 4 weeks)
Confirmed HCC on surveillance imaging[19]	Hepatology + oncology/ multidisciplinary tumor board	**Urgent** (within 1–2 weeks)
Symptomatic cryoglobulinemic vasculitis with renal or neurologic involvement[19]	Rheumatology + nephrology	**Urgent** (within 1–2 weeks)
Unmanageable DDIs after structured review[19]	Pharmacist + relevant specialist (cardiology, neurology) before DAA initiation	Routine (within 2–4 weeks)

ABBREVIATIONS: ART = antiretroviral therapy; DAA = direct-acting antiviral; DDI = drug–drug interaction; FIB-4 = Fibrosis-4 Index; HBV = hepatitis B virus; HBsAg = hepatitis B surface antigen; HCC = hepatocellular carcinoma; HCV = hepatitis C virus; HIV = human immunodeficiency virus

Follow-Up Timing

STAGE/CATEGORY	FREQUENCY	LABS/MONITORING
Pre-treatment workup	**1–2 visits** (can be condensed where clinically appropriate)[19]	HCV antibody → HCV RNA reflex; HBV serologies; FIB-4 (CBC, CMP, AST, ALT, platelets); abdominal ultrasound; medication reconciliation; **pregnancy testing if ribavirin considered**

STAGE/CATEGORY	FREQUENCY	LABS/MONITORING
During DAA (8-week GLE/PIB or 12-week SOF/VEL)	Mid-course check at **~week 4**[19]	ALT, AST; symptom assessment; adherence review; **DDI re-screen if new medications added**
End of treatment	Within **2 weeks** of completion[19]	ALT, AST; **counsel** on the **SVR12 test** at week 12 post-treatment
SVR12 confirmation	**12 weeks** after last DAA dose[19]	Quantitative HCV RNA — **undetectable confirms SVR**
Post-SVR, no cirrhosis	**Annual** primary care follow-up[19]	ALT/AST; metabolic monitoring (HbA1c if diabetic — insulin sensitivity may improve); reinfection screening if ongoing exposure
Post-SVR, with cirrhosis	Every **6 months** indefinitely[19]	Abdominal ultrasound ± AFP; CBC, CMP, INR; symptom assessment for decompensation; variceal screening per hepatology protocol[27]
Active HCV not yet treated[1]	Every **6–12 months** until treatment initiation[19]	ALT/AST; FIB-4; reinforce treatment recommendation; address barriers (prior authorization, polypharmacy, social factors)

ABBREVIATIONS: AFP = alpha-fetoprotein; ALT = alanine aminotransferase; AST = aspartate aminotransferase; CBC = complete blood count; CMP = comprehensive metabolic panel; DAA = direct-acting antiviral; DDI = drug–drug interaction; FIB-4 = Fibrosis-4 Index; GLE/PIB = glecaprevir/pibrentasvir; HBV = hepatitis B virus; HCV = hepatitis C virus; INR = international normalized ratio; SOF/VEL = sofosbuvir/velpatasvir; SVR = Sustained Virologic Response

Comorbidity Management — Primary Care Role

COMORBIDITY	APPROACH	CAUTION
Type 2 diabetes (E11.x)[11]	HbA1c trending; coordinate medication adjustments **around DAA initiation and after SVR** — hepatic insulin sensitivity improves and may precipitate hypoglycemia	Patients on insulin or sulfonylureas need **closer home-glucose monitoring** during and after DAA

COMORBIDITY	APPROACH	CAUTION
Mixed cryoglobulinemia (D89.1)[11]	**Document and link to HCV**; rheumatology co-management for symptomatic vasculitis	Renal or severe neurologic involvement is an **urgent referral indication**
Compensated cirrhosis (K74.60)[19]	Surveillance ultrasound ± AFP every **6 months**; hepatology co-management; variceal screening	Cirrhosis persists structurally even **after SVR** — surveillance is lifelong
HBV co-infection (B18.1)[19]	HBsAg, anti-HBs, anti-HBc at HCV diagnosis; **hepatology coordination if positive**	Treating HCV without HBV management risks HBV reactivation — **never optional**
HIV co-infection[19]	ART optimization in coordination with infectious disease; DAA-ART interaction review	Some HIV regimens have significant DAA interactions; consult infectious disease
Cardiovascular disease[11]	Standard secondary prevention; cure may reduce CV event risk (HR 0.57 post-SVR)	Frame HCV cure as a CV risk-reduction intervention in conversations with patients
Polypharmacy in older adults[19,20]	Annual deprescription review; pharmacist involvement at DAA initiation	DDI risk almost doubles in patients ≥65 **(54% vs. 28%)** — **never initiate DAA without structured review**
Depression/cognitive complaints[33]	PHQ-9 at baseline and after SVR; reassess cognitive symptoms post-SVR — improvement is common but not universal	**Do not attribute cognitive decline to age alone in chronic HCV** — partial reversibility after cure is well-documented

ABBREVIATIONS: AFP = alpha-fetoprotein; ART = antiretroviral therapy; CV = cardiovascular; DAA = direct-acting antiviral; DDI = drug–drug interaction; HBV = hepatitis B virus; HbA1c = hemoglobin A1c; HBsAg = hepatitis B surface antigen; HCV = hepatitis C virus; HIV = human immunodeficiency virus; HR = hazard ratio; PHQ-9 = Patient Health Questionnaire-9; SVR = Sustained Virologic Response

Cost-Smart Options

BRAND (EST. COST)	GENERIC/ ALTERNATIVE	MO. SAVINGS	COST-SMART TIP
Mavyret (glecaprevir/ pibrentasvir, 8-week course) ~$26,400 list[34]	**No FDA-approved generic** or authorized generic currently available for glecaprevir/pibrentasvir; patient assistance via AbbVie ProCeed	**Variable**	**8-week course is the shortest first-line option** — workflow efficiency advantage in primary care; check Medicare Part D tier

BRAND (EST. COST)	GENERIC/ ALTERNATIVE	MO. SAVINGS	COST-SMART TIP
Epclusa (sofosbuvir/ velpatasvir, 12-week course) ~$78,078 list[35]	Authorized generic sofosbuvir/velpatasvir — **~$26,000–$28,000**/12-week course[35]	**~67% lower list price** with authorized generic[36]	Generic launch has reduced acquisition costs substantially; confirm coverage tier and step-therapy requirements
Harvoni (ledipasvir/ sofosbuvir) ~$94,500 list (historical)[36]	Authorized generic ledipasvir/sofosbuvir —~ **$36,000–$46,000**/12-week course;[36] not preferred for new initiations (Epclusa is pan-genotypic)	**~62% lower list price** with authorized generic[36]	Reserve for specific scenarios; new patients generally use Epclusa or Mavyret
Vosevi (sofosbuvir/ velpatasvir/ voxilaprevir, 12-week retreatment) ~$78,000–$89,712[37]	**No current generic**; specialist-managed retreatment[1]	—	**Reserve for documented DAA failure**; routed through hepatology
Brand statin during DAA	Hold statin during 8-week GLE/PIB; resume after completion[19]	**Variable**	Temporary discontinuation often safer and cheaper than regimen change
Brand PPI	Generic omeprazole ≤20 mg daily, taken with SOF/VEL[19]	**Modest**	**Avoids regimen switch**; counsel on simultaneous dosing

ABBREVIATIONS: DAA = direct-acting antiviral; GLE/PIB = glecaprevir/pibrentasvir; PPI = proton pump inhibitor; SOF/VEL = sofosbuvir/velpatasvir

Patient Education and Adherence

Patient education for hepatitis C virus (HCV) is uniquely challenging due to the combination of its largely asymptomatic nature, a population that may have been **silently infected for decades**, and widespread misconceptions about what a positive test implies. Because many patients mistakenly assume an HCV diagnosis is a life sentence, communicating that a **greater than 95% cure rate** is achievable with a short, daily oral course of **direct-acting antivirals** is a foundational education task. Equally critical is clarifying **post-treatment serology**: a positive HCV antibody test will remain positive for life regardless of treatment success and does not indicate active infection after a cure. Patients who are not counseled on this routinely present in a panic after seeing a positive antibody result on a future lab report. To lower barriers to care, providers should actively minimize historical transmission stigma by normalizing the conversation and framing **HCV screening as a routine, universal, age-based recommendation**.

Beyond the initial diagnosis, education must define what a **true cure** accomplishes. Patients need to understand that achieving an SVR reduces not only liver-related mortality but also downstream cardiovascular, renal, and cognitive risks. Because **strict daily adherence** is the dominant

determinant of SVR, missed doses must be framed as clinically consequential rather than trivial. Crucially, patients with **pre-existing cirrhosis** require lifelong HCC surveillance even after a confirmed cure — a mandate that is frequently misunderstood by patients who assume their cancer risk evaporates once the virus is gone. For individuals with ongoing exposure pathways, counseling must emphasize that **a cure does not confer immunity**; reinfection remains possible, necessitating harm-reduction strategies and periodic RNA rescreening. Finally, for older adults facing cognitive changes or polypharmacy, care teams should utilize **teach-back validation, caregiver inclusion, and written medication schedules** to protect the daily adherence that makes a cure possible.

DOCUMENTATION : PATIENT EDUCATION

Document the topics covered (cure expectation, adherence, DDI counseling, HCC surveillance for cirrhosis, post-cure coding transition), the patient's understanding, and any teach-back validation. Education documentation supports continuity, quality measurement, and shared decision-making — and signals to other clinicians that the cure narrative has been carried into the patient's understanding of their condition

Quality Metrics Tie-In

MEASURE[38]	STANDARD	APPLICABILITY TO HEPATITIS C
Hepatitis C Screening (HEDIS HCS)[38]	**Denominator:** members 18-79, no prior documented HCV screen **Numerator:** one-time HCV antibody test documented during MY 2022 or later, any time on or after the member's 18th birthday. **Exclusions:** hospice, palliative care, limited life expectancy	**Aligned with USPSTF 2020 Grade B universal one-time screening recommendation for ages 18-79**; the highest-yield Medicare HCV preventive measure given how many Baby Boomers have never been screened
HCC Surveillance in HCV Cirrhosis (MIPS Quality #401)[38]	**Denominator:** patients ≥18 with chronic HCV cirrhosis diagnosis and a qualifying encounter during the performance period. **Numerator:** abdominal imaging (ultrasound, contrast-enhanced CT, or contrast MRI) for HCC performed at least once during the 12-month period **Exclusions:** none specified	**Surveillance is lifelong in cirrhosis and applies both pre- and post-sustained virologic response (SVR)**; achieving SVR reduces but does not eliminate HCC risk, so this measure should not be discontinued after successful treatment

MEASURE[38]	STANDARD	APPLICABILITY TO HEPATITIS C
HCV RNA Reflex Testing (MIPS Quality #400, Criterion 2)[38]	**Denominator:**patients ≥18 with a reactive/positive HCV antibody result and a qualifying encounter during the performance period **Numerator:** quantitative HCV RNA test performed to confirm active infection **Exclusions:** documented medical reason for not testing due to limited life expectancy	**Closes the antibody-to-RNA gap**; this is the most common documentation deficiency at the screening-to-confirmation transition, since a positive antibody alone does not confirm active infection
Medication Reconciliation Post-Discharge (HEDIS MRP)[38]	**Denominator:** patients ≥18 seen in outpatient setting within 30 days of inpatient discharge **Numerator:** discharge medication list reconciled with current medication list documented in outpatient record **Exclusions:** none specified	**Critical for polypharmacy and direct-acting antiviral (DAA) initiation safety in elderly patients**; DAA regimens carry meaningful interaction potential with statins, amiodarone, and certain anticonvulsants
Care for Older Adults (HEDIS COA)[38]	**Denominator:** MA enrollees ≥66, continuously enrolled. **Numerator:** 4 sub-measures documented annually: functional status, medication review, pain assessment, advance care planning **Exclusions:** hospice, ESRD	**No single MIPS number maps to COA as a composite**; it remains HEDIS/ Stars-only. Most directly applicable cross-cutting measure supporting comprehensive HCV care planning in older adults

ABBREVIATIONS: AFP = alpha-fetoprotein; COA = Care for Older Adults; DAA = direct-acting antiviral; HCC = hepatocellular carcinoma; HEDIS = Healthcare Effectiveness Data and Information Set; HCS = Hepatitis C Screening; HCV = hepatitis C virus; MIPS = Merit-based Incentive Payment System; MRP = Medication Reconciliation Post-Discharge; MY = Measurement Year; SVR = Sustained Virologic Response; USPSTF = U.S. Preventive Services Task Force

AAVBC PERSPECTIVE

AAVBC supports the recognition of chronic HCV as a systemic disease with significant extrahepatic burden, and encourages treatment decisions that reflect the full clinical case for viral cure in elderly patients. ***Extrahepatic manifestations extend well beyond hepatology*** *and include a* ***fourfold increased risk of insulin resistance****, elevated cardiovascular and cerebrovascular event risk, cryoglobulinemia, CKD progression, and neurocognitive impairment in up to 50% of patients. This multidomain burden underscores that untreated HCV in older adults carries compounding risk across organ systems.*
DAA-treated patients demonstrate significantly reduced cardiovascular event risk compared with untreated patients, with benefit extending across metabolic, renal, and cognitive domains. *AAVBC encourages providers to frame viral cure as a systemic*

intervention with measurable impact on the full comorbidity burden carried by elderly patients, not as a hepatology outcome in isolation.

Post-SVR, AAVBC supports proactive metabolic monitoring as hepatic synthetic and metabolic function recovers. Glucose metabolism frequently improves after viral eradication, warranting reassessment and potential dose adjustment in patients on antihyperglycemic therapy. Warfarin users require INR monitoring, as recovering hepatic function alters drug metabolism and may necessitate dose recalibration to avoid supratherapeutic anticoagulation. Lipid profiles should be re-evaluated, as normalization of hepatic lipid metabolism can shift baseline cardiovascular risk parameters. These monitoring steps reflect a VBC principle: viral cure changes the patient's metabolic baseline, and regimens calibrated for chronic disease may require adjustment after eradication.

QUALITY OUTCOME

When primary care systematically screens unscreened adults aged 18–79, reflexes positive HCV antibody to HCV RNA, completes the pre-treatment checklist (HBV serologies, FIB-4, ultrasound, DDI screen), and initiates simplified DAA therapy in eligible patients — the result is a >95% cure rate, downstream reduction in cardiovascular events (HR 0.57), improved glycemic control, and a closed treatment gap that currently leaves 72% of diagnosed Medicare patients untreated within a year of diagnosis.[8]

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

ELEMENT	DOCUMENTATION REQUIREMENT
Chronicity (B18.2 vs. B17.10)	Document **'chronic hepatitis C'** explicitly OR document **HCV RNA positive for >6 months**. Coders cannot assume chronicity without written confirmation
Active versus resolved status	**B18.2** requires documented **active HCV RNA positivity. Z86.19** requires documented **SVR12** (undetectable HCV RNA ≥12 weeks post-treatment) — explicit transition documentation is mandatory
Cirrhosis (K74.60)	Code **alongside B18.2** (or alongside **Z86.19 post-SVR**) when cirrhosis is present; **do not omit after cure** — cirrhosis persists structurally

ELEMENT	DOCUMENTATION REQUIREMENT
Fibrosis stage (K74.01/K74.02)	**Document stage from FIB-4**, elastography, or pathology when available; supports continuity of care for hepatology and surveillance decisions
Extrahepatic manifestations	**Document and code each:** mixed cryoglobulinemia (**D89.1, link to HCV**), HCV-associated diabetes (**E11.x with note linking to HCV**), cardiovascular comorbidity (I-codes), neurocognitive impairment
HBV co-infection (B18.1)	Code when HBsAg positive; mandatory screening before DAA
HIV co-infection (B20	Code when applicable; coordinate **ART** and **DAA**
Avoid traps	**Avoid B19.20/B19.21** (unspecified — no HCC mapping); **avoid Z22.52** (carrier) once HCV RNA confirms active infection; **avoid continuing B18.2 after SVR**
Companion documentation	Include treatment status (untreated; on DAA cycle X of Y; post-SVR), fibrosis stage, and pre-treatment checklist completion

ABBREVIATIONS: ART = antiretroviral therapy; CMS = Centers for Medicare & Medicaid Services; DAA = direct-acting antiviral; FIB-4 = Fibrosis-4 Index; HCC = Hierarchical Condition Category; HCV = hepatitis C virus; SVR = Sustained Virologic Response

Annual Clinical Review and Confirmation

- **Annual review:** Active chronic hepatitis C must be reassessed annually with MEAT documented. Active disease is established by HCV RNA positivity for >6 months; reassessment confirms treatment status (untreated, on DAA, or post-SVR), fibrosis stage, and any new associated conditions
- **Visit modality:** Face-to-face or synchronous audio-video telehealth qualifies when it supports meaningful clinical evaluation; chart updates without an encounter do not satisfy MEAT
- **Clinical context:** Under CMS-HCC V28, active chronic HCV **(B18.2)** maps to HCC 65. Cirrhosis is documented separately and persists structurally after cure. Extrahepatic manifestations support additional documentation when documented and linked to HCV
- **Avoid rollover:** Do not copy forward last year's HCV note without updating treatment status, current line of therapy and cycle, current fibrosis stage, and any associated conditions. The **B18.2 → Z86.19** transition at SVR12 is the highest-stakes coding boundary in this QRG — it cannot be carried by template alone

Good Documentation — EHR Tips

EHR TIP	WHAT TO INCLUDE
Problem list precision	**'Chronic viral hepatitis C, active (B18.2)'** — not 'hepatitis C' alone. After SVR12, change problem list entry to 'Personal history of resolved viral hepatitis C (Z86.19)' with date of SVR confirmation; retain 'Cirrhosis (K74.60)' if present
Smart phrases/dot phrases	Build a **Pre-DAA Checklist macro** covering HBV serologies, FIB-4, ultrasound date, DDI screen tool/date, and patient adherence counseling; build an SVR Confirmation macro covering HCV RNA date and result and coding transition
Lab linking	Link the confirmatory **HCV RNA** result to **B18.2**; link the **SVR12 HCV RNA result** to **Z86.19**; link **FIB-4** inputs to **fibrosis coding**
Active vs. resolved status	Use a status field or note tag to display **'Active'** or **'Post-SVR'** at the top of every note — visible to other team members
Surveillance flags (cirrhosis only)	Set a recurring **6-month reminder** for ultrasound ± AFP in any patient with K74.60, regardless of SVR status
Education templates	Use teach-back templates so the SVR-not-eradication-of-cirrhosis distinction is recorded as patient-understood, not just provider-stated

ABBREVIATIONS: AFP = alpha-fetoprotein; DAA = direct-acting antiviral; DDI = drug–drug interaction; EHR = electronic health record; FIB-4 = Fibrosis-4 Index; HBV = hepatitis B virus; HCV = hepatitis C virus; SVR = Sustained Virologic Response

- **SMARTPHRASE —** .HCV_VISIT — Visit template: infection status (B18.2 active vs Z86.19 resolved), genotype if relevant, fibrosis stage (FIB-4/elastography), DAA regimen and start date, SVR12 result, companion cirrhosis (K74.60)
- **ALERT —** SVR confirmation — fires 12 weeks after DAA completion to confirm cure and update status from B18.2 to Z86.19
- **ALERT —** DAA drug-interaction check — screens the active medication list against the selected DAA regimen before initiation (statins, amiodarone, acid suppression)
- **ORDER SET —** HCV workup — HCV RNA, FIB-4/transient elastography for fibrosis staging, DDI review; one-time universal screening for adults
- **FILTER —** Hepatology — for cirrhosis, prior treatment failure, or HCC surveillance

Brief Case Examples

SUCCESS — Test-and-Treat in a Single Visit

SCENARIO

68M, routine diabetes follow-up. Never screened for HCV. History of **1984 blood transfusion**. ALT **62 U/L**, AST **54 U/L**. Current meds include **atorvastatin** and **omeprazole**.

Documentation:
“**HCV screening ordered today** per USPSTF Grade B. Anti-HCV ordered with **reflex HCV RNA if positive**. Pre-treatment workflow started: **HBV serologies**, HIV test, CBC/CMP/INR, medication reconciliation for DAA interactions, and fibrosis assessment planned with **FIB-4**. Liver ultrasound scheduled. Patient counseled that HCV screening is routine, confirmatory RNA determines active infection, and modern DAA therapy cures >95% of treated patients.”

Outcome: HCV RNA positive at **1.2 million IU/mL**. FIB-4 **1.8**; HBV serologies negative; ultrasound unremarkable. Started **sofosbuvir/velpatasvir 400/100 mg daily × 12 weeks** in primary care after interaction review. **SVR12 confirmed** with undetectable HCV RNA. Problem list updated from **B18.2** to **Z86.19** after cure. HbA1c improved from **7.4% to 6.6%** post-cure; cardiovascular risk reduction reviewed with patient. **MEAT** present: **MONITOR:** ALT/AST, HCV RNA, FIB-4, ultrasound, HbA1c trend. **EVALUATE:** antibody/RNA interpretation, fibrosis risk, HBV status, drug interactions. **ASSESS:** active chronic HCV before treatment; cured HCV after SVR12. **TREAT:** DAA therapy, counseling, medication reconciliation, follow-up RNA testing, problem-list update.

Result: Supports accurate documentation of **active chronic HCV before treatment** and appropriate transition to **history of HCV after SVR12**. The record preserves the full clinical sequence: screening indication, reflex RNA confirmation, fibrosis staging, HBV safety check, medication review, DAA treatment, SVR12 confirmation, problem-list update, and post-cure chronic disease follow-up.

PITFALL — Continuing B18.2 After Cure

Documentation: “**72-year-old with hepatitis C. SVR achieved last year. Continues monitoring. Anti-HCV remains positive.**” Problem list still shows **B18.2** as active.

Consequence: The record represents a cured patient as having active chronic HCV. **Anti-HCV can remain positive after cure** and does not establish active infection. Active HCV requires detectable **HCV RNA**. Ongoing liver surveillance may still be needed if cirrhosis is present, but surveillance need does not equal active viremia.

RAF Impact: If **B18.2** is carried forward after SVR12, **HCC 65** may be erroneously sustained. Using the supplied RAF value, **0.185 RAF** may misrepresent the patient’s current disease status. The issue is not missed documentation; it is inaccurate representation of clinical reality after cure.

Fix: “**History of hepatitis C after cure (Z86.19)**. SVR12 confirmed on **[date]** with **undetectable HCV RNA**. Prior chronic HCV treated with **sofosbuvir/velpatasvir × 12 weeks**, completed **[date]**. Anti-HCV remains positive as expected and does not indicate active infection. Transition problem list from **B18.2** to **Z86.19** today. If cirrhosis present, continue **K74.60** and 6-month HCC surveillance with ultrasound ± AFP.”

Coding after fix: Z86.19 replaces **B18.2** after SVR12-confirmed cure. If cirrhosis is documented, retain **K74.60** and continue surveillance. Documentation includes **SVR12 date, undetectable RNA, completed DAA course, antibody interpretation, problem-list update, and cirrhosis surveillance plan** = clinically accurate MEAT documentation after cure.

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