Clinical Practice Guideline for the Screening and Detection of HIV Infection

SUMMARY

Infection with human immunodeficiency virus (HIV) produces a spectrum of disease that progresses from a clinically latent or asymptomatic state to acquired immunodeficiency syndrome (AIDS) as a late manifestation. The pace of disease progression varies. In untreated patients, the time between infection with HIV and the development of AIDS ranges from a few months to as long as 17 years (median: 10 years). The majority of adults and adolescents infected with HIV remain symptom-free for extended periods, but viral replication is active during all stages of infection and increases substantially as the immune system deteriorates. In the absence of treatment, AIDS will develop eventually in nearly all HIV-infected persons. Proper management of HIV infection involves a complex array of behavioral, psychosocial, and medical services. Services might not be available in STD-treatment facilities. Therefore, referral to a health-care provider or facility experienced in caring for HIV-infected patients is advised. Providers working in STD-treatment facilities should be knowledgeable about the options for referral available in their communities. While receiving care in STD-treatment facilities, HIV-infected patients should be educated about HIV infection and options for support services and HIV care.

A person is considered at increased risk for HIV infection, and should be offered HIV testing, if he or she reports 1 or more individual risk factors or receives health care in a high-prevalence or high-risk clinical setting. Individual risk is assessed through a careful patient history. Those at increased risk include:

- Men who have had sex with men after 1975;
- Men and women have unprotected sex with multiple partners;
- Past and present injection drug users;
- Men and women who exchange sex for money or drugs or have sex partners who do;
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users;
- Persons being treated for sexually transmitted diseases (STDs); and,

NOTE: Persons who request an HIV test despite reporting no individual risk factors may also be considered at increased risk, since the group is likely to include individuals not willing to disclose high risk behaviors.

DIAGNOSTIC TESTING AND COUNSELING

HIV infection usually is diagnosed by tests for antibodies against HIV-1. Some combination tests also detect antibodies against HIV-2 (i.e., HIV-1/2). Antibody testing begins with a sensitive screening test (e.g., the enzyme immunoassay [EIA] or rapid test). The advent of HIV rapid testing has enabled clinicians to make a substantially accurate presumptive diagnosis of HIV-1 infection within half an hour. This testing can facilitate the identification of the more than 250,000 persons living with undiagnosed HIV in the United States. Reactive screening tests must be confirmed by supplemental test (e.g., the Western blot [WB]) or an immunofluorescence assay (IFA).
The following are specific recommendations for diagnostic testing for HIV infection:

- HIV screening is recommended for all persons who seek evaluation and treatment for STDs;
- HIV testing must be voluntary;
- Consent for HIV testing should be incorporated into the general consent for care (verbally or in writing) with an opportunity to decline (opt-out screening);
- HIV rapid testing must be considered, especially in clinics where a high proportion of patients do not return for HIV test results;
- Positive screening tests for HIV antibody must be confirmed by a supplemental test (either WB or IFA) before being considered diagnostic of HIV infection;
- Persons who have positive HIV test results (screening and confirmatory) must receive initial HIV prevention counseling before leaving the testing site. Such persons should 1) receive a medical evaluation and, if indicated, behavioral and psychological services, or 2) be referred for these services;
- Providers should be alert to the possibility of acute retroviral syndrome and should perform nucleic acid testing for HIV, if indicated. Patients suspected of having recently acquired HIV infection should be referred for immediate consultation with a specialist.

NOTE: Health-care providers should be knowledgeable about the symptoms and signs of acute retroviral syndrome, which is characterized by fever, malaise, lymphadenopathy, and skin rash. This syndrome frequently occurs in the first few weeks after HIV infection, before antibody test results become positive. Suspicion of acute retroviral syndrome should prompt nucleic acid testing (HIV plasma ribonucleic acid [RNA]) to detect the presence of HIV, although not all nucleic acid tests are approved for diagnostic purposes; a positive HIV nucleic acid test should be confirmed by subsequent antibody testing to document seroconversion (using standard methods, EIA, and WB). Acutely infected patients might be highly contagious because of increased plasma and genital HIV RNA concentrations and might be continuing to engage in risky behaviors. Current guidelines suggest that persons with recently acquired HIV infection might benefit from antiretroviral drugs, and such patients may be candidates for clinical trials. Therefore, patients with acute HIV infection should be referred immediately to an HIV clinical care provider.

Persons can be expected to be distressed when first informed of a positive HIV test result. Such persons face multiple major adaptive challenges, including:

- Accepting the possibility of a shortened life span;
- Coping with the reactions of others to a stigmatizing illness;
- Developing and adopting strategies for maintaining physical and emotional health; and,
- Initiating changes in behavior to prevent HIV transmission to others.

Many persons will require assistance with making reproductive choices, gaining access to health services, confronting possible employment or housing discrimination, and coping with changes in personal relationships. Therefore, behavioral and psychosocial services are an integral part of health care for HIV-infected persons. Such services should be available on site or through referral when HIV infection is diagnosed.

The following are specific recommendations for counseling and referral:

- Persons who test positive for HIV antibody should be counseled, either on site or through referral, concerning the behavioral, psychosocial, and medical implications of HIV infection;
- Health-care providers should be alert for medical or psychosocial conditions that require immediate attention;
- Providers should assess newly diagnosed patients’ need for immediate medical care or support needs and link them to services in which health-care personnel are experienced in providing care for HIV-infected persons. Such persons might need medical care or services for substance abuse, mental health disorders, emotional distress, reproductive counseling, risk-reduction counseling, and case management. Providers should follow-up to ensure that patients have received the needed services; and,
- Patients should be educated regarding what to expect in follow-up medical care.
SPECIAL CONSIDERATIONS

Management of Sex Partners and Injecting-Drug Partners

The following are specific recommendations for implementing partner-notification procedures:

- HIV-infected patients should be encouraged to notify their partners and to refer them for counseling and testing. If requested by the patient, health-care providers should assist in this process, either directly or by referral to health department partner-notification programs;
- If patients are unwilling to notify their partners or if they cannot ensure that their partners will seek counseling, physicians or health department personnel should use confidential partner notification procedures; and,
- Partners who are contacted within 72 hours of a high-risk sexual or injecting-drug exposure to an HIV-infected partner, which involves exposure to genital secretions and/or blood, should be offered post-exposure prophylaxis (PEP) with combination antiretroviral therapy to complete a 28-day course.

Pregnancy

All pregnant women in the United States should be tested for HIV infection as early during pregnancy as possible. Testing should occur after the patient is notified that she will be tested for HIV as part of the routine panel of prenatal tests, unless she declines (i.e., opt-out screening). For women who decline, providers should continue to strongly encourage testing and address concerns that pose obstacles to testing. Women who decline testing because they have had a previous negative HIV test should be informed of the importance of retesting during each pregnancy. Testing pregnant women is particularly important, not only to maintain the health of the patient, but also because interventions (i.e., antiretroviral and obstetrical) can reduce the risk of perinatal transmission of HIV.

After pregnant women have been identified as being HIV-infected, they should be educated about the risk of perinatal infection. Evidence indicates that, in the absence of antiretroviral and other interventions, 15%-25% of infants born to HIV-infected mothers will become infected with HIV; such evidence also indicates that an additional 12%-14% will become infected during breastfeeding where HIV-infected women breastfeed their infants into the second year of life. The risk of perinatal HIV transmission can be reduced substantially to <2% through the use of antiretroviral regimens and obstetrical interventions (i.e., zidovudine [AZT] or nevirapine and elective cesarean-section at 38 weeks of pregnancy) and by avoiding breastfeeding. Pregnant women who are HIV-infected should be counseled concerning their options (either on-site or by referral), given appropriate antenatal treatment, and advised not to breastfeed their infants (for women living in the United States, where infant formula is readily available and can be safely prepared).

HIV Infection Among Infants and Children

Diagnosis of HIV infection in a pregnant woman indicates the need to consider whether other children of the woman might be infected. Infants and young children with HIV infection differ from adults and adolescents with respect to the diagnosis, clinical presentation, and management of HIV disease. For example, because maternal HIV antibody passes through the placenta, antibody tests for HIV are expected to be positive in the sera of both infected and uninfected infants born to seropositive mothers. A definitive determination of HIV infection for an infant aged <18 months is usually based on HIV nucleic acid testing. Management of infants, children, and adolescents who are known or suspected to be infected with HIV requires referral to physicians familiar with the manifestations and treatment of pediatric HIV infection.

CMS STAR METRIC

CMS has not published a metric for this condition.

NCQA HEDIS STANDARD

NCQA has not published a metric for this condition.
REFERENCES


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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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