What Kind of Doctor Should You See For Hepatitis C Treatment?

Clinicians in just a few specialties have experience treating hep C, although in the future even general practitioners may treat the virus as well—that is, if insurers don't clamp down too hard on what kinds of providers may receive reimbursement.

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If you're considering treatment for hepatitis C virus (HCV) and haven't yet found a doctor, you may be wondering what kind of clinician is best for you. Today, most people with hep C go to a gastroenterologist or a hepatologist; and those who are coinfected with HIV often continue seeing their infectious disease physician or HIV specialist for hep C treatment. But is there any benefit to seeing one kind of provider over another?

A gastroenterologist is a specialist in the digestive system, which includes the intestines, liver, pancreas and gallbladder. Meanwhile, hepatology is considered a sub-specialty of gastroenterology, focusing on the liver, as well as the gallbladder, biliary tree and pancreas. While it may seem preferable to seek out a physician who hones her expertise more narrowly on the liver, Michael W. Fried, MD, director of the UNC Liver Center at the University of North Carolina at Chapel Hill, says there is really no fundamental reason why hepatologists are more able to treat hep C over gastroenterologists.

"I think the main criteria are that they are interested in hepatitis C and they have experience and that, like anything else, they consider it a high priority in the management of their patients," Fried says of what to look for in a specialist.

Indeed, a well-trained gastroenterologist will have a lot of exposure to hepatology, so even if you have severe liver disease, you should probably be fine seeing a gastro who is experienced in treating hep C. Physicians in both specialties can conduct the necessary tests to determine how far the liver has been damaged as well as your viral genotype (which will shape the best course of treatment for you) and viral load. They can then prescribe treatment and follow you through the process to make sure that any side effects that may crop up are properly managed.

As for the approximate quarter of people with hep C who are coinfected with HIV, they can probably receive treatment directly from their infectious disease (ID) or HIV specialist, so long as he has experience and training in treating hep C. If the liver is more damaged, however, it is

better to see a clinician who has the expertise and know-how to manage that problem in tandem with hep C treatment—a gastroenterologist or hepatologist.

This fall, three new crops of direct-acting antivirals are likely to receive U.S. Food and Drug Administration (FDA) approval to treat hep C. In addition to raising treatment success rates, thus upping the chances of a cure, these new medications should result in diminished side effects, making treatment easier to manage. Consequently, even non-specialists should be able to handle much of the hep C case load in the future.

According to Homie Razavi, PhD, of the Center for Disease Analysis in Louisville, Colorado, a treatment model the medical community is currently discussing involves a general practitioner diagnosing hep C and then treating those with milder cases of liver disease, while sending those with more advanced disease to specialists.

However, Michael Fried cautions that jumping on the hep C bandwagon will be no simple feat for GPs.

“It would take concerted effort for interested primary care physicians to learn more about liver disease, to be able to differentiate mild and severe, and then to make the appropriate choices for their patients,” Fried says.

In addition, your ability to see a non-liver or ID specialist for hep C treatment will depend on whether or not insurance companies agree to compensate those clinicians for their time. On this front, there is troubling news of late, as some state Medicaid programs and Medicaid managed care plans have begun instituting new policies that restrict reimbursement for hep C prescribing to only gastroenterologists, hepatologists and ID docs. This would exclude HIV physicians who are not ID specialists (they may be internists or family practitioners but still already have a wealth of experience treating hep C), as well as the possibility for general practitioners to treat hep C. In fact, some states are even excluding ID specialists all together, limiting coverage only to liver disease specialists.

Physician groups have cried foul, issuing a sharp rebuke of these policies. In an August 19 letter to the Centers for Medicare and Medicaid Services in Baltimore, the heads of Infectious Disease Society of America and the HIV Medicine Association argued, “Not all hepatologists have experience managing HCV, and many have little experience managing the complex care of HCV and HIV coinfected patients, since a majority are cared for by ID or HIV specialists.”

Joel Gallant, MD, MPH, the chair of the HIVMA, says, “HIV doctors, which includes both infectious disease specialists and non-ID specialists, have been managing patients who are coinfected for years. We view [hep C] as a viral disease, just like HIV, and the appropriate treatment is antiviral therapy.”

Gallant believes that these restrictions have nothing to do with providing better care and everything to do with money as the cost of treating hep C has risen with the introduction of Gilead

Sciences' notoriously pricey Sovaldi (sofosbuvir), which has a price tag of $1,000 a day for 12 or 24 weeks of treatment.

"When treatment for hepatitis C was very, very complicated and toxic, there were no restrictions on who could prescribe those incredibly complex drugs," he says. "It's interesting that we have these very simple drugs and suddenly there are restrictions. And so the obvious reason is not the complexity of therapy, but just a way of erecting barriers because the drugs are expensive."

One of the Medicaid managed care organizations placing such restrictions is Pennsylvania's Gateway Health, which has moved to exclude non-ID specialist HIV providers from receiving authorization to prescribe hep C drugs. Responding in a letter to a complaint from the HIVMA and the American Academy of HIV Medicine, Michael Madden, MD, vice president and chief medical officer of Gateway Health, described the new hep C treatments as "both a blessing and a curse." He suggested, firstly, that the success rates of the current crop of hep C therapies may not be as high as found in clinical trials when they are prescribed in real-world settings—thus arguing for a conservative approach to their use. Then he went on to cite the "excessive cost of this therapy and the fact that it was not budgeted for by CMS, most state Medicaid programs, or health plans."

According to Donna Sweet, MD, director and principal investigatorat the Kansas AIDS Education and Training Center in Wichita, "The problem with demanding that a hepatologist, a gastroenterologist or an ID doctor take care of [people with hep C] is: one, there's not enough of those specialists to do what they're doing right now; and two, the bulk of people with hep C—certainly the bulk of people in my practice—if they have insurance it's Medicaid. And there are many, many subspecialists like gastroenterologists and ID people who don't take Medicaid, because of the poor pay."

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