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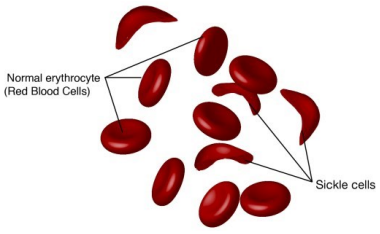
SICKLE CELL DISEASE AND SICKLE CELL TRAIT

Author: Julie Scarborough, CRC, CCS, RHIT

Sickle Cell Anemia belongs to a group of inherited disorders known as **sickle cell disease (SCD)**. According to the CDC, *"SCD is a group of inherited red blood cell disorders. Healthy red blood cells are round, and they move through small blood vessels to carry oxygen to all parts of the body. In someone with SCD, the red blood cells become hard and sticky and look like a C-shaped farm tool called a "sickle". The sickle cells die early, which causes a constant shortage of red blood cells. Also, when they travel through small blood vessels, they get stuck and clog the blood flow. This can cause pain and other serious problems such as infection, acute chest syndrome and stroke."*[1]



*"People who have **sickle cell trait (SCT)** inherit a hemoglobin "S" gene from one parent and a normal gene (one that codes for hemoglobin "A") from the other parent. People with SCT usually do not have any of the signs of the disease. However, in rare cases, a person with SCT may develop health problems; this occurs most often when there are other stresses on the body, such as when a person becomes dehydrated or exercises strenuously. Additionally, people who have SCT can pass the abnormal hemoglobin "S" gene on to their children."*[1]

Types of SCD [2]

- HbSS (Sickle cell anemia)
  2 sickle cell genes, 1 from each parent
- HbSC (Sickle cell/Hb-C disease)
  1 sickle cell gene from 1 parent and 1 abnormal hemoglobin gene (C)
- HbS beta thalassemia
  1 sickle cell gene from 1 parent and 1 beta thalassemia gene from 1 parent.
  Two types of beta thalassemia: "0" and "+".
  - HbS beta 0 thalassemia (serious form)
  - HbS beta + thalassemia (milder form)
- HbSD, HbSE and HbSO
  1 sickle cell gene from one parent and 1 abnormal hemoglobin gene (D, E or O) from 1 parent

Diagnosis

Simple blood test, usually done at birth.

Treatment

- Treatment comes down to managing the condition to avoid pain episodes, relieving symptoms and preventing complications.
- There are medications to treat symptoms and blood transfusions can also be used.
- A possible cure for children and teenagers is a stem cell transplant.

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Sickle Cell Disease and Sickle Cell Trait (Cont'd)

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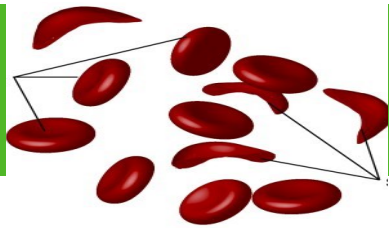

For HCC and Documentation:

- Sickle cell disease (Sickle Cell Anemia) can be indexed in ICD-10 CM as "Disease, Sickle Cell" with a default code of **D57.1.**

  Complications associated with Sickle Cell disease are listed in subcategories and include such examples as "crisis" (**D57.00**) and Sickle Cell Thalassemia (**D57.40**).

- Subcategory for specific types listed above are also present in the ICD-10 CM index and should be used when documentation is present. These all are in HCC category **46**.

- Sickle Cell Trait (**D57.3**) carries a lower HCC value of HCC **48** and can be indexed in ICD-10 CM under "sickle cell, trait".

MEAT includes managing symptoms, prescribing medications to help prevent "crisis" and/or blood transfusions or stem-cell transplants.

Sources:

1. https://www.mayoclinic.org/diseases-conditions/sickle-cell-anemia/symptoms-causes/syc-20355876
2. https://www.healthline.com/health/sickle-cell-anemia
3. https://www.cdc.gov/ncbddd/sicklecell/traits.html

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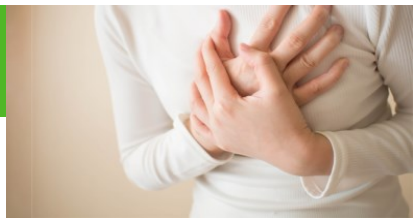
REFRACTORY ANGINA

Author: Cindy Falen, RHIT, CCS



Refractory angina pectoris (*RAP*) is defined as a chronic condition (greater or equal to 3 months in duration) characterized by angina in the setting of coronary artery disease (*CAD*), which cannot be controlled by a combination of optimal medical therapy, angioplasty or bypass surgery, and where reversible myocardial ischemia has been clinically established to be the cause of the symptoms.[1]

Cause

Refractory angina is caused by insufficient blood flow to the heart muscle. It often occurs with physical activity or emotion, which causes the heart to work harder and require more oxygen.

Risk Factors

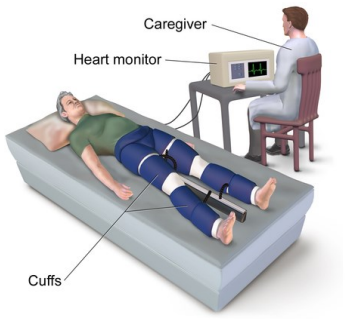
Increased risk factors include smoking, obesity, hypertension, diabetes, and high cholesterol. It is estimated that as many as 1,000,000 in the United States have coronary artery disease with chronic refractory angina.[2]

Treatment

Treatment can be divided into 3 groups:

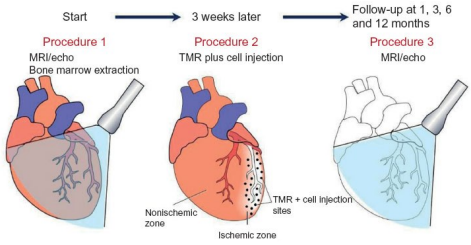
- Pharmacologic: Some conventional pharmacologic therapies include oral nitrates, Beta-Blockers, calcium channel blockers, antiplatelet agents and lipid lowering agents. Newer therapies may include ranolazine hydrochloride and Ivabradine.
- Non-invasive
- Invasive therapies

One non-invasive therapy for angina is **enhanced external counterpulsation therapy** (EECP). This is achieved by rapid sequential compression of the lower extremities during the diastolic phase followed by decompression during the systolic phase. Inflatable cuffs are put on the calves and sequentially compress the lower limbs during diastole and rapidly deflating before systole. This treatment course is typically for 35 outpatient treatments over seven weeks.[3]



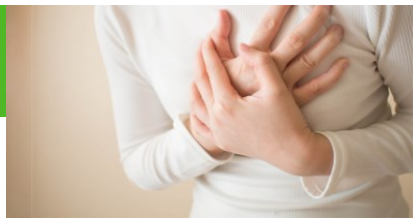
Cardiac Enhanced External Counterpulsation

Invasive treatment may include **transmyocardial vascularization** (TMR). Research is also ongoing for **angiogenesis**, in which there is formation of new blood vessels to help treat chronic ischemic heart disease/angina. Animal studies have shown that using bone marrow cells may improve myocardial perfusion with increased left ventricular function. Ongoing human trials are showing improvement in myocardial perfusion and reduction of anginal episodes per week.[3]



REFRACTORY ANGINA (Cont'd)

Author: Cindy Falen, RHIT, CCS



New codes to include refractory angina have been added to FY 2023 ICD-10-CM codes.

These codes include:[4]

- I20.2 Refractory angina pectoris (not related to CAD)
- I25.112 Atherosclerosis heart disease of native coronary artery with refractory angina pectoris
- I25.702 Atherosclerosis of coronary artery bypass graft(s), unspecified, with refractory angina pectoris
- I25.712 Atherosclerosis of autologous vein coronary artery bypass graft(s) with refractory angina pectoris
- I25.722 Atherosclerosis of autologous artery coronary artery bypass graft(s) with refractory angina pectoris
- I25.732 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with refractory angina pectoris
- I25.752 Atherosclerosis of native coronary artery of transplanted heart with refractory angina pectoris
- I25.762 Atherosclerosis of bypass graft of coronary artery of transplanted heart with refractory angina pectoris
- I25.792 Atherosclerosis of other coronary artery bypass graft(s) with refractory angina pectoris

The new codes are classified as a complication or comorbidity (CC).

Careful review of the record, with possible query, will be necessary to assign the most precise code and accurate DRG.

Sources:

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6159461/
2. https://www.pijn.com/en/chronic-refractory-angina-pectoris
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096292/
4. https://www.cms.gov/medicare/icd-10/2023-icd-10-cm

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FQHC CHALLENGES

Author: Cheryl Mumm, CPC

As the business relationship between MARSI and HMA continues to strengthen, MARSI will likely begin to see some different types of coding that are typically used for Medicaid-specific scenarios, particularly FQHC coding. **FQHC** stands for **Federally Qualified Health Center**.

Federally Qualified Health Centers furnish services often provided in an outpatient physician clinic. Coding, billing, and reimbursement methodologies are slightly different in the FQHC setting, so there can be a unique set of challenges commonly seen in billing, coding, and documentation.

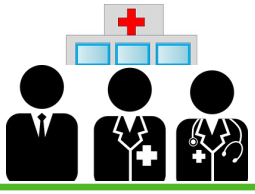
To qualify as an FQHC, clinics must:[3]

- ☑ Serve a designated medically-underserved area or medically-underserved population
- ☑ Offer a sliding fee scale to persons with incomes below 200 percent of the Federal poverty level
- ☑ Be governed by a board of directors, of whom a majority of the members receive care at the FQHC

FQHC visits are only billable if a medically necessary service is provided by a qualified practitioner.

The qualified practitioners are:[3]

- ⇒ Physician, MD, DO
- ⇒ Nurse Practitioners
- ⇒ Physician Assistants



- ⇒ Certified nurse-midwives
- ⇒ Clinical Psychologists
- ⇒ Clinical Social Workers

The following services can be provided in an FQHC:[1]

* Physician services
* Services and supplies incident to the services of physicians Nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services
* Services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs
* Medicare Part B-covered drugs furnished by and incident to services of a FQHC practitioner
* Visiting nurse services to the homebound in an area where CMS determined there is a shortage of home health agencies
* Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for patients with diabetes or renal disease furnished by qualified practitioners of DSMT and MNT

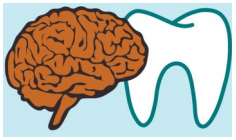
Many of the charges for services are bundled for FQHCs. Sometimes FQHC practitioners and billing departments, mistake this as meaning that services that would not be paid are not to be billed. That is an incorrect notion. All services should be billed and documented properly to ensure that the patient's chart is complete, and the insurance payor receives correct information regarding the services rendered.[2] In addition, commercial payors still follow national coding guidelines, so failure to bill and code properly can result in loss of revenue and/or sub-standard patient care. Failure to document and code accurately can give false information to CMS, insurance companies, and any other regulatory entities that may review the patient information.

As you can see, the qualified practitioners list does not include RNs. These services are sent to government payors on a cost report that the clinics submit for payment. The visits still need to be properly documented to safeguard from repercussions in the event of an audit. Many FQHC patients receive Medicaid and/or Medicare benefits. Commercial, and self-pay is quite common as well.

FQHC CHALLENGES (Cont'd)

Author: Cheryl Mumm, CPC

In addition to primary care services, FQHCs offer dental services, and mental/ behavioral health services. Dental and mental health services are considered separate



and are not considered when determining whether a patient is new or established. Behavioral health services, on the other hand, require a physical health issue that is being addressed, such as diabetes mellitus or hypertension, so those visits do establish patients. Patients are considered new unless they've seen a practitioner at the FQHC within 3 years. Excluding dental and mental health services.

Proper level-of-service selection and diagnosis code specificity are key to ensuring that the complexity of the patients is communicated to the proper entity. Medicare Advantage often pays bonuses to FQHCs that provide necessary services to risk adjust. For an FQHC to remain sustainable, it's crucial to collect any reimbursement legally billed for these services.

Some states are transitioning to a value-based care model. It would be beneficial for all FQHCs to ensure that they are coding and documenting to the highest level of specificity possible. Not only does it improve patient care, but it will ensure that various insurance payors have accurate information regarding the patient's health conditions.

Often, states have Medicaid programs that have specific billing requirements and reimbursement methods. The details of the requirements should be expressed to anyone auditing the records and documentation, as the requirements don't always meet national coding guidelines. Therefore, accurate coding and billing guidelines should be applied to ensure accuracy. The specific state Medicaid rules can usually be found with research. Behavioral health and mental health services have a very specific set of requirements for both documentation and coding.

The OIG workplan has mentioned that FQHCs are beginning to scrutinize billing, coding, and documentation. As well as grant usage, to ensure that the funds are being utilized properly. This creates demand for auditing, coding, billing, and other consulting services for FQHCs in general.

Sources:

1. Medicare. (2021, April 21). Benefit Policy Manual Chapter 13-RHC and FQHC Services Rev. 10729. Retrieved from CMS.gov: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
2. Medicare. (2022, January 12). Medicare Claims Processing Manual Chapter 9-Rural Health Clinics/Federally Qualified Health Centers Rev. Retrieved from CMS.gov: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf
3. Medicare Learning Network. (2022, October). Federally Qualified Health Center MLN006397. Retrieved from CMS.gov: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/fqhcfactsheet.pdf