



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Thalassemia

Quick Reference Guide

2026

Table of Contents

1. CLINICAL SNAPSHOT	3
HCC/RAF V28 Mapping	4
2. RECOGNITION AND DIAGNOSIS	5
Medicare Screenings and Surveillance (Adult and Geriatric)	5
Subtle Early Signs in Adults	6
Geriatric Risk Factors	7
Diagnostic Thresholds (TIF/AHA Staging)	8
Clues to Dig Deeper	9
Common Oversights	9
Key Differentials in Elderly	10
3. MEAT DOCUMENTATION ESSENTIALS	13
Clinical Documentation Elements	14
Reframing Common Documentation Shortcuts	14
4. TREATMENT AND REFERRAL QUICK GUIDE	15
Therapy Escalation Criteria	16
TIF-Aligned Treatment by Transfusion Status and Patient Profile	16
Non-Pharmacologic Care and Supportive Interventions	18
Medication Safety and Key Interactions	18
When to Refer	19
Follow-Up Timing	20
Comorbidity Management — Primary Care Role	20
Patient Education and Adherence	22
5. CODING REMINDERS AND CASE EXAMPLES	25
Coding Specificity	25
Good Documentation — EHR Tips	27
REFERENCES	28

1 CLINICAL SNAPSHOT

Definition: **Thalassemia** is a group of autosomal recessive hemoglobinopathies caused by defective synthesis of the alpha- or beta-globin chains of hemoglobin, producing chain imbalance, ineffective erythropoiesis, and chronic hemolytic anemia.¹ Severity spans a wide spectrum, so a single chart label of “thalassemia” can mean anything from an asymptomatic carrier to a patient in heart failure from decades of iron overload. Two axes define the condition: **alpha** (deletions of one to four **HBA1/HBA2** genes) versus **beta** (point mutations of the **HBB** gene), and carrier/trait versus clinically significant disease.¹ For management, the operative framework is **transfusion-dependent thalassemia (TDT)** versus **non-transfusion-dependent thalassemia (NTDT)** — the classification that drives transfusion protocol, chelation thresholds, monitoring frequency, and therapy eligibility. Thalassemia is best understood as a multisystem disease of iron overload, not simply as anemia: cardiac siderosis, endocrinopathy, hepatic fibrosis, and osteoporosis are the long-term drivers of morbidity, mortality, and cost.²

ICD-10 Codes:

Thalassemia is reported under the **D56** family, with subtype specificity directly determining risk-adjustment documentation. **D56.0** (alpha thalassemia) covers HbH disease (3-gene deletion); **D56.1** (beta thalassemia) covers both major/TDT and intermedia/NTDT; **D56.2** (delta-beta thalassemia); **D56.5** (hemoglobin E-beta thalassemia, common in Southeast Asian populations); **D56.8** (other thalassemias); and **D56.9** (thalassemia, unspecified). Trait and carrier states use **D56.3** (thalassemia minor) and **D56.4** (hereditary persistence of fetal hemoglobin) — neither maps to an HCC. Sickle-cell thalassemia is coded separately: **D57.42** (beta-zero without crisis) and **D57.44** (beta-plus without crisis). Iron overload is coded distinctly from the thalassemia itself — **E83.111** for hemochromatosis due to repeated transfusions (TDT) and **E83.118** for absorption-related overload (NTDT) — and other documentable complications include **I43** (cardiomyopathy), **K74.60** (cirrhosis), **C22.0** (hepatocellular carcinoma), **M81.0** (osteoporosis), **E03.9** (hypothyroidism), **E13.-** (secondary diabetes), and **F32.-/F41.-** (depression/anxiety). Document alpha-vs-beta, TDT-vs-NTDT status, and genetic-testing results to support the most specific code the record allows.³

Prevalence and Burden: Thalassemias are the most common monogenic disorders worldwide — roughly **1.5%** of the global population carries a beta-thalassemia allele and about **5%** an alpha-thalassemia allele, with more than **90%** of clinically affected patients living in a belt extending from the Mediterranean through the Middle East, Indian subcontinent, and Southeast Asia.⁴ US data are sparse and rely on registry extrapolation: an estimated **11,262** patients have clinically significant thalassemia, a combined alpha- and beta-thalassemia prevalence of about **3.5 per 100,000**, and roughly **27%** of US thalassemia patients are foreign-born.^{5,6} No published data describe thalassemia prevalence in Medicare or Medicare Advantage populations; patients surviving to age 65+ are a growing but poorly characterized cohort, the product of improved chelation and transfusion practice.^{4,7}

AAVBC Knowledge Hub Premium Content Access

Continue reading your guide
with an AAVBC subscription

[Subscribe Now](#)

Already a subscriber? [Sign in](#)

Limited offer

Basic Membership Free

Includes access to downloadable Quick Reference Guides, mailing list for industry updates/medical information, research toolkits, AAVBC events and so much more!

Cancel at any time