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Documenting and Coding Tips: Vascular disease

Medicare Advantage

Peripheral vascular disease (PVD) and peripheral arterial disease (PAD) are more common as people get older. It affects about 6.5 million Americans over the age of 40 and those who smoke, have diabetes or other comorbid conditions are at a higher risk.[1] Atherosclerotic disease is a progressive disease; therefore, avoid documenting "history of PVD." Alternatively, consider assessing the condition by performing routine screenings for patients at risk and document and code PAD/PVD when clinically relevant.

Documentation tips

PAD/PVD

- Screen patients at risk for lower extremity PAD/PVD by reviewing vascular signs and symptoms (example, walking impairment, claudication, atypical leg pain and/or presence of non-healing wounds) and physical examination, evaluation and inspection of lower extremities.[1]
- Obtain an ABI or equivalent device (wave form doppler) for patients who screen positive and for asymptomatic patients age 65 and older, or age 50 with a history of smoking, diabetes and other high-risk comorbid conditions.[1]
- Statements such as "peripheral arterial disease (PAD)," "peripheral vascular disease (PVD)," "spasm of artery" and "intermittent claudication" all default to an unspecified PVD (**I73.9**).
- Treatment of PAD should include documentation of medications such as statin therapy, aspirin or clopidogrel for both asymptomatic and symptomatic patients.[1]

Interpreting the Ankle-Brachial Index (ABI)[2]

ABI	Perfusion Status
≤ 0.90	**Peripheral arterial disease**
0.91 to 0.99	**Borderline**
1.00 to 1.40	**Normal**
> 1.40	**Concern for noncompressible arteries, association with diabetes mellitus**

Atherosclerosis of the extremities and other sites

- Arteriosclerosis and atherosclerosis may be used interchangeably for documentation and coding purposes (I70.-). Unspecified or generalized atherosclerosis does not map to an HCC.
- Document the site, laterality, severity and symptoms or complications such as claudication, rest pain and ulcers. For aortic atherosclerosis (*trace, mild, moderate, severe*), clarify the condition is referring to the vessel itself and/or the aortic valve.[3]
- Consider documenting any clinical support from chest x-rays, kidney ureter bladder (KUBs), ultrasound, ABI and/or doppler units.

Pressure and non-pressure ulcers

- Documentation should specify if the ulcer is a pressure (decubitus) or a non-pressure ulcer. Documentation of "healing" ulcers are considered active and "healed" ulcers are considered resolved.[4]
- Document and code ulcers to the highest level of specificity, including the type, site, laterality and severity (stage) (L89.-, **L97.-**, **L98.49-**).
- Ulcer stages 2, 3, 4 and unstageable map to an HCC. Ulcers with deep tissue damage and unspecified stage do not map to an HCC. The stage of a diagnosed ulcer can be documented by clinicians who are not the patient's provider, including other qualified healthcare practitioners.
    - **Clinical Tip:** It is important to document improvement of the depth of a pressure ulcer (reverse staging). Pressure ulcers must be documented if they were present on admission to the facility, to identify whether the pressure ulcer developed prior to admission or developed during the course of the admission.[5]
- Document any associated underlying or comorbid conditions, such as diabetes mellitus, hypertension, hyperlipidemia and renal insufficiency.
- It is important not to document or code ulcers as "wounds," "open wounds" or "lesions."

Diabetic peripheral angiopathy (PAD/PVD) and other circulatory complications

- If the patient has atherosclerosis of native arteries of extremities (**I70.2-**) and diabetes (**E11.51**), then provide details such as laterality, location, atherosclerotic symptoms such as claudication, rest pain and ulcers, as well as diabetic manifestations, if clinically relevant.

- Diabetes with other circulatory complications (**E11.59**), hypertensive disorders (I10 – I16.-), angina pectoris (**I20.-**), etc., requires a documented causal relationship.

Other vascular diseases

Findings may be incidentally noted on diagnostic reports but should be documented if clinically significant or affects the patients' care, treatment or management, such as atherosclerosis of the aorta (**I70.0**), abdominal aortic aneurysm, without rupture (**I71.4**), stricture of artery (tortuous aorta) (**I77.1**) and aortic ectasia (**I77.8**).

The following references were used in the creation of this document:

Optum360 ICD-10-CM: Professional for Physicians 2021. Salt Lake City, UT: 2020.

1. Peripheral Arterial Disease (PAD) Fact Sheet. Centers for Disease Control and Prevention. cdc.gov/dhdsp/data_statistics/fact_sheets/fs_pad.htm. Published June 16, 2016. Accessed September 21, 2020.
2. Hennion D, Siano K. Diagnosis and Treatment of Peripheral Arterial Disease. aafp.org/afp/2013/0901/p306.html. Published 2020. Accessed September 21, 2020.
3. AHA Coding Clinic for ICD-10-CM. Aortic Stenosis. Vol 5, Q4, 1988.
4. *Optum360. Coders' Desk Reference for Diagnoses 2021.* Salt Lake City, UT: Optum360; 20209
5. Cartwright DJ. ICD-10-CM Lessons Learned: Examining Controversies in Pressure Ulcer Coding Post-Implementation. Today's Wound Clinic. todayswoundclinic.com/articles/icd-10-cm-lessons-learned-examining-controversies-pressure-ulcer-coding-post-implementation. Published February 10, 2016. Accessed January 22, 2020.

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