Documentation Tips for Risk Adjustment

Volume Two

Vascular Disease

The Medicare risk adjustment model assigns significant risk to vascular disease, whether it involves central arteries, for example, aortic atherosclerosis, ectasia or aneurysm; or peripheral arteries, for example, peripheral vascular (arterial) disease. Many diseases of the aorta are clinically silent and often found incidentally on imaging studies. Because coding guidelines prohibit code abstraction from stand-along imaging reports, these conditions must be addressed and documented by the provider as part of a face-to-face or audio and visual telehealth visit.

Documentation of vascular disease should identify the arteries affected by atherosclerosis, for example, atherosclerosis of the aorta, iliac or femoral arteries. Documentation should include any manifestations of vascular disease such as claudication, as well as any complications including dissection, skin ulcers or gangrene. Venous disease like varicose veins or venous stasis should be addressed and documented yearly, especially when complicated by a skin ulcer.

In addition to the diagnosis, the management of vascular disease must be documented, whether it's surgical, for example, stenting, bypass or endarterectomy, or medical, such as statins and anti-platelet agents. Controlling risk factors, for example, HTN, DM, or hyperlipemia and smoking, to prevent progression of atherosclerosis, also count as management and should be documented.

All vascular disease, whether symptomatic or not, must be addressed and documented yearly. Documentation should include complications and the management plan, even if it's simply controlling risk factors for atherosclerosis.

Pulmonary Hypertension (PHTN)

Primary PHTN is rare and is seen primarily in young women. Secondary PHTN is more common and is seen in patients with conditions that cause chronic hypoxia or a chronic increase in intrathoracic pressure. Risk factors for the development of secondary PHTN include advanced COPD, emphysema, untreated obstructive sleep apnea, interstitial lung disease and chronic pulmonary embolism.

PHTN is confirmed by the presence of elevated right-sided pressures of echocardiography, and testing should be considered in patients who are at risk. A right ventricular systolic pressure, or RVSP > 35 mmHg is diagnostic for PHTN.

Severity of PHTN	RVSP (mmHg)
Normal	< 35
Mild	35-45
Moderate	46-60
Severe	> 60

Because PHTN, whether primary or secondary, can progress to right-sided heart failure if left untreated or if risk factors are left uncontrolled, it should be addressed by the provider and documented annually. Depending on the cause and severity of PHTN, patients may be monitored or referred to a specialist for evaluation and treatment.

At-risk patients should be screened for pulmonary hypertension and, if confirmed, this diagnosis must be addressed and documented annually. If undiagnosed or untreated, it can cause right-sided heart failure.

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Chronic Deep Venous Thrombosis (DVT) and Chronic Pulmonary Embolism (PE)

According to ICD-10-CM, DVT and PE are classified as acute, chronic or "history of." A DVT or PE should be documented by providers as acute at the time of diagnosis and throughout the course of initial treatment with anticoagulants (typically 3 to 6 months). If the patient has a contraindication to anticoagulation and an inferior vena cava, or IVC, filter is placed instead, then the DVT or PE is considered acute at the time of diagnosis and placement of the filter. Once the initial treatment is completed, history of DVT or PE should be documented.

If a patient is placed on anticoagulation because of multiple episodes of DVT or PE, it is appropriate to document chronic DVT or PE. Clinicians tend to think of DVT and PE as acute occurrences and are inclined to document "recurrent" rather than "chronic." Unfortunately, ICD-10-CM doesn't include a code for "recurrent" DVT or PE and documentation of "recurrent" will result in the assignment of the default "acute" DVT or PE ICD-10-CM code. This is a common pitfall that providers can avoid by getting in the habit of documenting "chronic" DVT or PE for patients on life-long anticoagulation.

Hypercoagulable disorders, when present, must be documented in addition to chronic DVT or PE as an underlying cause. Some of the common disorders are factor V Leiden mutation, protein S and protein C deficiencies and lupus anticoagulant.

Documenting "recurrent" DVT or PE instead of "chronic" leads to the incorrect assignment of the ICD-10-CM code for acute DVT of PE. In patients on life-long treatment with anticoagulants, their DVT or PE is considered chronic and should be documented yearly as such.

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