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FOCUS ON: VENOUS THROMBOEMBOLISM

Venous thromboembolism (VTE) includes deep vein thrombosis (DVT) and pulmonary thromboembolism (PE). The incidence is skewed towards the elderly population and maybe as high as 10 to 20 fold higher than in comparable younger adults.¹ It is the third-highest cause of death from a cardiovascular standpoint following acute MI and stroke. VTE is often "silent" as it strikes without symptoms in almost 60% of the cases. In the patients that do present with symptoms such as unilateral swollen limb, approximately one-third have pulmonary embolism while two-thirds have deep venous thrombosis.²

The incidence of VTE is significantly higher in hospitalized patients (about 150 times their ambulatory counterparts).³ The incidence of VTE can be significantly decreased by the appropriate utilization of prophylaxis to delay or prevent venous clotting especially in patients who have the risk factors of stasis (reduced mobility, heart failure), vessel damage (catheter, surgery) and/or hypercoagulability (cancer, smoking, obesity, hormone replacement therapy).⁴

The causes of deep venous thrombosis can be broadly classified into hereditary and acquired.⁵ However, in most instances there is more than cause which contributes to the outcome. The most common inherited causes are Factor V Leiden deficiency, mutations of the prothrombin gene, deficiency of protein C and/or protein S, and antithrombin deficiency. There are several other mutations or deficiencies in the various components of the anti-clotting or clot lysis cascade but these are rare in comparison. The acquired risk factors are immobility (particularly more than 48 hours at a stretch or prolonged travel; the so-called "economy class syndrome"), malignancy, major trauma, oral contraceptive use, and current or recent hospitalization. There are several other causes that can contribute such as myeloproliferative disorders, antiphospholipid antibody syndrome and the nephrotic syndrome.

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Always...

- Document the condition, the vessel and the status: either "acute" or "chronic" or the initiation or continuation of treatment.
- Document and code the condition as "chronic" and not as "history of" if patient is undergoing long-term anticoagulation therapy.

Documentation and Coding Tips⁶

- Patient presents with deep venous thrombosis and is started on enoxaparin and warfarin therapy.
453.40 Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity
 - ♦ DVT unspecified as to "vessel" or "status (acute or chronic)" defaults to 453.40.
 - ♦ Hypercoagulable state cannot automatically be coded when only DVT is documented. The provider must document the condition.⁷
- Patient is continued indefinitely on warfarin after second unprovoked episode of pulmonary embolism.
416.2 Chronic pulmonary embolism
V58.61 Long-term (current) use of anticoagulants
 - ♦ Use additional code, if applicable, for associated long-term use of anticoagulants (V58.61).
 - ♦ Report not only that the patient is on long-term anticoagulants but also the condition that is being treated.
- If the thrombus is due to a device, implant or graft:
 - ♦ document the specific complication and the device, implant or graft
 - ♦ code both 996.7x - Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft - and the specific complication (e.g., thrombus)
- If the provider documents "History of PE" or "History of DVT," code V12.51 - Personal history of diseases of circulatory system, venous thrombosis and embolism.
- If the provider documents thrombosis with thrombophlebitis, code from category 451 - Phlebitis and thrombophlebitis.⁸
- No official definition exists for "chronic" and "acute."
 - ♦ "Initial episode of care" would indicate the acute phase, while "subsequent episode of care" would indicate the chronic phase.⁸

1 Cushman M; Tsai AW; White RH; Heckbert SR; Rosamond WD; Enright P; Folsom AR Deep vein thrombosis and pulmonary embolism in two cohorts: the longitudinal investigation of thromboembolism etiology. *Am J Med* 2004 Jul 1;117(1):19-25.

2 Goodacre S; Sutton AJ; Sampson FC. Meta-analysis: The value of clinical assessment in the diagnosis of deep venous thrombosis. *Ann Intern Med* 2005 Jul 19;143(2):129-39.

3 Heit JA et al, Risk factors for deep venous thrombosis and pulmonary embolism. *Arch. Intern Med* 2000; 160; 809-815

4 Anderson FA. Audet AM. Best Practices: Preventing DVT and PE. www.dvt.org UMass Medical School, Center for Outcomes Research

5 Bauer KA, Lip Gregroy, et al. Overview of causes of venous thrombosis. *UpToDate* 18.1 January 2010

6 World Health Organization, Professional: ICD-9-CM for Physicians-Volumes 1&2. 2010 Alexandria, VA: Ingenix, 2009.

7 AHA Coding Clinic, 2008, 3rd Qtr

8 Ingenix Coders' Desk Reference for Diagnoses 2010 pg. 411