AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

DVT and Pulmonary Embolism

Quick Reference Guide

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1 CLINICAL SNAPSHOT

Definition: **Venous thromboembolism** (**VTE**) encompasses two presentations of one disease: **deep vein thrombosis** (**DVT**), in which a thrombus forms in a deep vein (most often the lower extremity), and **pulmonary embolism** (**PE**), in which a thrombus travels to and **obstructs the pulmonary arteries**.[1,2] The two share the pathophysiology of **Virchow's triad**: venous stasis, hypercoagulability, and endothelial injury; most patients have **several concurrent contributors** rather than a single cause.[3,4] Two distinctions drive management: **DVT location** (proximal = popliteal, femoral, or iliac; carries far higher recurrence and embolization risk than isolated distal/calf DVT, up to **4.8-fold**),[5] and **the provoking context**: **provoked** (a transient major reversible factor such as surgery or hospitalization), **unprovoked** (no identifiable trigger, the highest long-term recurrence risk), or **cancer-associated** (active malignancy, roughly **20%** of incident VTE).[4,6,7]

ICD-10 Codes:

VTE coding follows an axis of **acuity -> anatomic location -> laterality -> type/severity**, and the most consequential step is **documenting acuity correctly**.[8] Acute lower-extremity DVT is reported with **I82.4-** subcodes by vein (**I82.41-** femoral, **I82.42-** iliac, **I82.43-** popliteal, **I82.44-** tibial, **I82.45-** peroneal); **chronic DVT** is reported with the **I82.5-** series (**I82.51-** femoral, **I82.52-** iliac, **I82.53-** popliteal, **I82.54-** tibial, **I82.55-** peroneal); the 7th character **specifies laterality** (1 = right, 2 = left, 3 = bilateral, 9 = unspecified).[8] PE is reported with **I26.-**: **I26.02** (saddle embolus) and **I26.09** (other PE) **with acute cor pulmonale** (right heart strain), versus **I26.92/I26.99** and the subsegmental codes **I26.93/I26.94 without** acute cor pulmonale → the record must state whether acute cor pulmonale is **present or absent**.[8] **Chronic PE** is **I27.82**.[8] Acute DVT, acute PE, and chronic PE all risk-adjust; the **resolved-clot status codes do not**: **Z86.711** (personal history of PE) and **Z86.718** (personal history of other venous thrombosis) carry no HCC, and **Z79.01** (long-term anticoagulant use) is the **essential secondary code** documenting ongoing therapy and medical necessity.[8] **Complications are coded separately and map independently to their own HCC categories**: post-thrombotic syndrome **I87.0-** (specify laterality and severity) and chronic thromboembolic pulmonary hypertension **I27.2-**.

Prevalence and Burden: VTE incidence rises **exponentially with age**, reaching as high as **1 per 100 persons per year** in adults older than 80, and adults aged **65 and older account for more than 60%** of all VTE events, placing the disease squarely in the **Medicare population**.[9–11] An estimated **900,000** VTE events occur in the United States each year, according to CDC estimates, resulting in approximately **100,000** deaths.[12,13] Outcomes in older adults are serious: in Medicare beneficiaries, cancer-associated VTE carries a 30-day mortality of **6.0%**[5] and a 1-year mortality of **34.7%**.[14] Among elderly patients followed after a first event, the 3-year cumulative incidence of recurrent VTE is **14.8%**, and recurrences are frequently fatal: a case-fatality rate of **20.5%**, which rises to **23%** for unprovoked and **29%** for cancer-related recurrences.[15] **Chronic sequelae are common**: post-thrombotic syndrome develops in **20-50%** of patients after symptomatic DVT, and chronic thromboembolic pulmonary hypertension affects **~3%** after acute PE.[9,16–18]

↔ MAKING CONNECTIONS

For additional context on **anticoagulant utilization**, please consult the **AAVBC Anticoagulant Therapy Utilization Management QRG**.

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