



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Peripheral Arterial Disease Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Peripheral arterial disease (PAD) is atherosclerotic narrowing of the arteries supplying the limbs, most often the lower extremities, producing a clinical spectrum that ranges from asymptomatic disease and intermittent claudication to ischemic rest pain, nonhealing ulceration, and gangrene. Its most severe end — **chronic limb-threatening ischemia (CLTI)** — is defined by **ischemic rest pain, non-healing wounds, or gangrene** present for more than two weeks; among people with known PAD, CLTI incidence is estimated at 11-20% with a historical 1-year mortality of 25-35%.¹ PAD is not a single entity: the **severity tier (claudication -> rest pain -> ulceration -> gangrene)** determines both clinical urgency and the ICD-10 code family that follows.

ICD-10 Codes:

Native-artery atherosclerosis of the extremities is coded in the **I70.2x** series, which requires four axes of specificity — vessel type (native vs. graft), severity (claudication -> rest pain -> ulceration -> gangrene), laterality (right/left/bilateral), and ulcer site when applicable. Code the highest severity present: **I70.26x** (gangrene) outranks **I70.23x-I70.25** (ulceration), which outranks **I70.22x** (rest pain), which outranks **I70.21x** (claudication). Bypass-graft atherosclerosis uses parallel families by graft type (**I70.3x-I70.7x**); using a native-artery code for a graft patient is a frequent error. Ulceration codes require an additional **L97.-** code to specify ulcer site and depth, and chronic total occlusion (**I70.92**) is a commonly omitted companion code.²

Epidemiology: PAD affects approximately **12.5 million persons aged 40 years or older** in the United States and approximately 236 million persons worldwide.³ The disease occurs in approximately 10-15% of persons older than 65 years and 15-20% of those older than 80 years.³ In the US, PAD is approximately twice as common among Black persons as among non-Hispanic White persons.³ PAD carries a substantial cardiovascular risk burden. The rate of cardiovascular events and death from cardiovascular causes among persons with PAD is 2 to 3 times as high as that among persons without PAD, even after adjustment for potential confounders.

HCC/RAF V28 Mapping

ICD-10 CODE(S) ²	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
I70.23x/I70.24x/I70.25 (Native-artery atherosclerosis with ulceration)	HCC 263 — Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene	1.118	Native-artery atherosclerosis with ulceration . Document laterality and ulcer site; add an L97.- code for ulcer depth
I70.261/I70.262/I70.263 (Native-artery atherosclerosis with gangrene)	HCC 263 — Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene	1.118	Native-artery atherosclerosis with gangrene , by laterality. Gangrene outranks ulceration; document tissue death/necrosis explicitly

ICD-10 CODE(S) ²	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
I70.3x-I70.7x (Bypass-graft atherosclerosis with ulceration or gangrene)	HCC 263 — Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene	1.118	Bypass-graft atherosclerosis with ulceration or gangrene. Use the graft-specific family; native-artery codes are incorrect for graft patients
I70.221/I70.222/ I70.223 (Native-artery atherosclerosis with rest pain)	HCC 264 — Vascular Disease with Complications	0.455	Native-artery atherosclerosis with rest pain , by laterality. Rest pain maps to HCC 264, a step below ulceration/gangrene
I74.3/I74.4/I74.5 (Arterial embolism/ thrombosis of the lower extremities or iliac artery)	HCC 264 — Vascular Disease with Complications	0.455	Arterial embolism/thrombosis of the lower extremities or iliac artery; supports acute limb ischemia presentations
I70.211/I70.212/ I70.213 (Atherosclerosis with intermittent claudication)	No HCC (supports complexity)	—	Atherosclerosis with intermittent claudication . Under V28 claudication-only no longer maps to an HCC
I73.9 (unspecified)	No HCC	—	Avoid 'Peripheral vascular disease, unspecified' carries no laterality, severity, or HCC. Do not use when atherosclerosis, ulceration, gangrene, or laterality is documented

ABBREVIATIONS: CNA = Community Non-Dual Eligible, Aged; RAF = Risk Adjustment Factor; HCC = Hierarchical Condition Category (V28); PAD = Peripheral Arterial Disease; *Illustrative annual value = 2024 CMS-HCC base rate x CNA coefficient; confirm payment year and segment against current CMS tables

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

Risk-Adjusted Care Resources per Patient/Year

Risk-adjusted care resource allocation — MA base rate (~\$10,402.34) × RAF coefficient (CNA segment, CY2026)

**Atherosclerosis with ulceration and/
or gangrene + graft
~\$11.6K**

HCC 263 · RAF 1.118 · per active patient/year

**Vascular disease with complications
(rest pain or acute limb ischemia)
~\$4.7K**

HCC 264 · RAF 0.455 per active patient/year

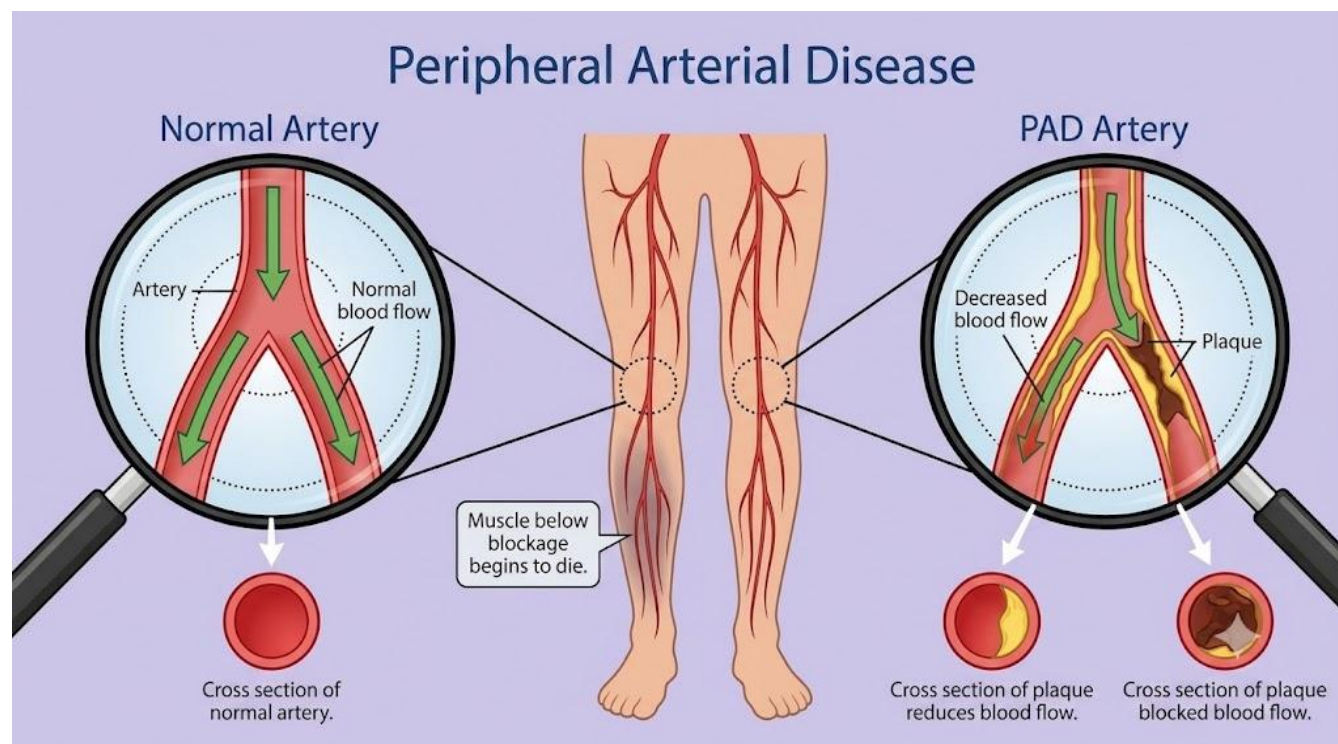
2 RECOGNITION AND DIAGNOSIS

Medicare Diagnostic Workup and Surveillance

TEST/SERVICE ^{1,4}	COVERAGE	FREQUENCY/ INDICATION	CPT/ HCPCS	CLINICAL NOTE
Ankle-brachial index (ABI)	Medicare-covered when ordered for symptomatic patients or those with clinical risk factors	First-line noninvasive test; Class 2a screening in those at increased risk (age ≥ 65 ; 50-64 with risk factors; <50 with diabetes + 1 risk factor)	Within 93922/93923	ABI ≤ 0.90 confirms PAD; >1.40 is noncompressible — obtain toe-brachial index (TBI ≤ 0.70 = PAD)
Limited physiologic study (1-2 levels)	Covered when medically necessary for symptomatic PAD or risk evaluation	Symptomatic evaluation	93922	Includes ABI; segmental pressures when indicated
Complete physiologic study (≥ 3 levels)	Covered for PAD evaluation	When localization is needed	93923	Segmental pressures plus pulse-volume recordings
Duplex ultrasound, lower extremity arteries	Covered when revascularization is being considered	Anatomic localization of stenosis	93925/93926	Bilateral complete (93925) or unilateral/limited (93926)
Supervised exercise therapy (SET)	Medicare-covered benefit	Up to 36 sessions over 12 weeks; extendable to 72 lifetime with reassessment	93668	Class 1 therapy for claudication; underused despite coverage

TEST/SERVICE ^{1,4}	COVERAGE	FREQUENCY/ INDICATION	CPT/ HCPCS	CLINICAL NOTE
Invasive catheter angiography (digital subtraction angiography)	Medicare-covered when revascularization is contemplated; Class III (Harm) if performed solely for anatomic assessment when revascularization is not being considered	Reserved for the time of endovascular intervention or when noninvasive imaging is inconclusive/insufficient and revascularization is planned (Class I, B-NR). In CLTI, may proceed directly to catheter angiography + same-session endovascular treatment to avoid delay	36245 (1st order abdominal/LE catheter placement), 36246 (2nd order), 36247 (3rd order); 75710 (unilateral extremity angiography), 75716 (bilateral)	The definitive diagnostic standard ("gold standard"). Follow-up within 2 weeks post-procedure to assess renal function and access site. CO ₂ angiography is an alternative in patients with CKD to reduce contrast load

ABBREVIATIONS: ABI = Ankle-Brachial Index; TBI = Toe-Brachial Index; SET = Supervised Exercise Therapy; CPT = Current Procedural Terminology; PAD = Peripheral Arterial Disease



Subtle Signs in Older Adults

SUBTLE SIGN (>65) ^{1,3,5}	WHAT IT MAY INDICATE	WHY IT IS MISSED	ACTION
No reported leg pain despite disease	Reduced activity masks exertional claudication	Sedentary older adults do not walk far enough to provoke symptoms	Examine pulses and feet regardless of symptom report
Forefoot or toe pain at night relieved by dependency	Ischemic rest pain (Rutherford 4) — limb-threatening	Mistaken for neuropathy or musculoskeletal pain	Treat as ischemic rest pain until proven otherwise; urgent vascular evaluation
Nonhealing ulcer or dark/black toe	Tissue loss or gangrene (CLTI)	Attributed to 'a wound' rather than ischemia	Assess perfusion; do not rely on wound care alone
Cool, hairless foot with diminished pulses	Chronic hypoperfusion	Subtle on a brief exam; pulses not routinely checked	Document pulse exam and skin findings; consider ABI/TBI
Falsely normal ABI in a diabetic patient	Calcified, noncompressible vessels	Normal ABI wrongly reassures	Use TBI or waveform analysis when ABI is unreliable
Nocturnal leg cramps	May signal underlying peripheral vascular disease; prevalence reaches 50% in elderly outpatients and increases with cardiovascular risk factors	Attributed to aging, electrolyte imbalance, or medications (diuretics, statins) rather than investigated as a vascular symptom; nocturnal timing obscures the exertional ischemic pattern	Ask specifically about nocturnal calf cramping; if present with PAD risk factors (age >65, diabetes, smoking, HTN), obtain resting ABI; differentiate from restless legs syndrome, radiculopathy, and medication side effects

ABBREVIATIONS: CLTI = Chronic Limb-Threatening Ischemia; ABI = Ankle-Brachial Index; TBI = Toe-Brachial Index; PAD = Peripheral Arterial Disease

Geriatric Risk Factors

RISK FACTOR	EFFECT SIZE	GERIATRIC RELEVANCE	ACTION
Diabetes mellitus¹	2- to 4-fold increased PAD risk; adjusted HR for amputation 5.48 (95% CI 4.16-7.22)	Up to 70% of people >70 y with diabetes have PAD; predominantly infrapopliteal disease	Optimize glycemic control; link diabetes to PAD in documentation
Current smoking¹	OR ~2.4 for symptomatic PAD; 5-y mortality 40-50% with active smoking and symptomatic PAD	80-90% of patients revascularized for severe limb symptoms are current smokers	Pharmacotherapy plus counseling at every visit (Class 1)
Hypertension⁶	Population-attributable risk ~41% for incident PAD	Common and treatable in older adults	Target <130/80 mmHg; ACE inhibitor or ARB preferred
Older age (>=75 y)¹	Prevalence ~20% at ≥80 y; older age raises post-revascularization mortality	Frailty and limited life expectancy reshape goals of care	Assess frailty before intervention (Class 2a)
Cumulative risk factors⁷	All four major factors (smoking, HTN, hyperlipidemia, DM) raise PAD risk >20-fold vs. none	Multimorbidity is the norm in the Medicare population	Address every modifiable factor concurrently
Chronic kidney disease¹	Drives medial calcification and worse outcomes	Falsely elevates ABI and limits contrast imaging	Use TBI; weigh contrast risk before angiography
Cerebrovascular disease (prior stroke/TIA)^{1,8}	OR 1.5 for coexistent PAD in patients >65 with CBVD; symptomatic PAD after first ischemic stroke independently increases vascular event risk (HR 2.76, 95% CI 1.10-6.95)	Post-stroke patients are often sedentary, masking claudication symptoms; cerebrovascular and peripheral atherosclerosis share risk factors but PAD screening is frequently omitted in stroke follow-up	Obtain resting ABI in all patients with prior stroke/TIA; examine pedal pulses and feet at every visit regardless of leg symptom report; polyvascular disease status changes antithrombotic strategy (consider rivaroxaban 2.5 mg BID + aspirin per COMPASS)

RISK FACTOR	EFFECT SIZE	GERIATRIC RELEVANCE	ACTION
Coronary artery disease (known CAD)^{1,9}	OR 1.8 for coexistent PAD in patients >65 with CAD; 52% of PAD patients undergoing angiography have underlying CAD ; polyvascular disease (CAD + PAD) increases MACE stepwise (HR 1.47 → 2.33 → 3.12 per additional vascular bed, p = 0.0001)	Elderly patients with CAD may not walk far enough to provoke claudication; ABI <0.90 in CAD patients predicts worse cardiovascular outcomes in a dose-dependent manner; low ABI tertile carries the highest hazard for death, MI, and stroke	Screen with ABI in all CAD patients , especially before cardiac rehabilitation; abnormal ABI reclassifies risk and intensifies lipid targets (LDL-C <55 mg/dL per polyvascular disease guidance); document polyvascular disease status for antithrombotic decision-making

ABBREVIATIONS: ABI = Ankle-Brachial Index ACE = Angiotensin-Converting Enzyme ARB = Angiotensin Receptor Blocker CAD = Coronary Artery Disease CBVD = Cerebrovascular Disease CI = Confidence Interval COMPASS = Cardiovascular Outcomes for People Using Anticoagulation Strategies DM = Diabetes Mellitus HR = Hazard Ratio HTN = Hypertension LDL-C = Low-Density Lipoprotein Cholesterol MACE = Major Adverse Cardiovascular Events MI = Myocardial Infarction OR = Odds Ratio PAD = Peripheral Arterial Disease TBI = Toe-Brachial Index TIA = Transient Ischemic Attack

Diagnostic Thresholds and Staging

SYSTEM/ THRESHOLD ^{1,6,10,11}	CRITERION	SEVERITY TIER	CLINICAL MEANING
ABI ≤0.90	Abnormal resting ABI confirms PAD	Diagnostic threshold	Sensitivity 57-79%, specificity 83-99% for ≥50% stenosis; reduced in diabetes/CKD
ABI >1.40	Noncompressible vessels	Nondiagnostic	Obtain toe-brachial index; TBI ≤0.70 = PAD
Fontaine I-IV	I asymptomatic IIa/IIb claudication III rest pain IV ulceration/gangrene	Chronic severity staging	Widely used in US practice for chronic limb ischemia
Rutherford 0-6	0 asymptomatic 1-3 claudication 4 rest pain 5 minor tissue loss 6 major tissue loss	Chronic severity staging	Maps directly to the I70.2x severity hierarchy

SYSTEM/ THRESHOLD ^{1,6,10,11}	CRITERION	SEVERITY TIER	CLINICAL MEANING
Wifl Clinical Stage 1-4	Wound, Ischemia, foot Infection each graded 0-3	CLTI staging	1-year amputation rates rise from 15% (stage 1) to 55% (stage 4); advanced Wifl stage raises amputation (HR 2.06) and death (HR 1.30); estimates benefit from revascularization
Rutherford ALI I-III	Acute limb ischemia: I viable IIa/IIb threatened III irreversible	Acute presentation	Class IIb requires immediate revascularization; III is nonviable

ABBREVIATIONS: ABI = Ankle-Brachial Index; TBI = Toe-Brachial Index; Wifl = Wound, Ischemia, and foot Infection; CLTI = Chronic Limb-Threatening Ischemia; ALI = Acute Limb Ischemia; HR = Hazard Ratio

Ankle-Brachial Index

ABI VALUE ^{1,6,12}	CLASSIFICATION	CLINICAL SIGNIFICANCE
>1.40	Noncompressible	Falsely elevated due to medial artery calcification (common in diabetes, CKD, elderly); nondiagnostic for PAD — obtain toe-brachial index (TBI ≤ 0.70 = PAD)
1.00-1.40	Normal	No hemodynamically significant stenosis ; if exertional leg symptoms persist, exercise treadmill ABI testing is indicated
0.91-0.99	Borderline	May indicate mild lower extremity atherosclerosis ; associated with higher cardiovascular mortality and functional impairment vs. ABI 1.10-1.30; exercise ABI recommended if symptomatic
0.71-0.90	Mild-moderate PAD	Significant PAD ($\geq 50\%$ arterial stenosis); ABI < 0.90 is 57-79% sensitive and 83-99% specific for angiographic stenosis $\geq 50\%$
0.41-0.70	Moderate-severe PAD	Claudication range; increasing symptom severity correlates with lower ABI values
≤ 0.40	Severe PAD/critical limb ischemia	Rest pain , impending tissue loss; ABI < 0.25 associated with impending tissue loss per Yao classification

ABBREVIATIONS: ABI = Ankle-Brachial Index; CKD = Chronic Kidney Disease; PAD = Peripheral Artery Disease; TBI = Toe-Brachial Index

Clues to Dig Deeper

IF YOU SEE... ^{1,12,13}	DIG DEEPER FOR...	HOW	WHY IT MATTERS
Normal ABI but a foot ulcer	Falsely elevated ABI from calcified vessels	Toe-brachial index or arterial waveforms	A normal ABI must not reassure when tissue loss is present
Diabetic foot ulcer with absent pedal pulses	Underlying CLTI	Perfusion assessment even if ABI appears normal	Up to half of diabetic foot ulcers have PAD
Claudication not improving after 3 months of therapy	Progression toward rest pain	Repeat ABI; assess for rest pain or tissue loss	Signals possible escalation to CLTI
>0.15 drop in ABI from a prior value	Disease progression	Compare serial ABIs	Warrants vascular re-evaluation
Nocturnal forefoot pain relieved by dangling the leg	Ischemic rest pain (Rutherford 4)	Targeted history and perfusion exam	Already beyond claudication — a limb-threatening sign

ABBREVIATIONS: ABI = Ankle-Brachial Index; CLTI = Chronic Limb-Threatening Ischemia; PAD = Peripheral Arterial Disease

Common Oversights

CLINICAL OVERSIGHT	CONSEQUENCE	BETTER PRACTICE
Relying on a normal resting ABI to exclude PAD	Severe ischemia missed in diabetic/CKD patients with calcified vessels	Use TBI or waveform analysis when ABI is unreliable or inconsistent with the exam
Mistaking ischemic rest pain for neuropathy or musculoskeletal pain	Delayed recognition of limb-threatening ischemia	Treat nocturnal forefoot pain relieved by dependency as ischemic until proven otherwise
Treating an ischemic ulcer with wound care alone	Ulcer will not heal without perfusion; limb loss risk rises	Assess perfusion and pursue revascularization; wound care is adjunctive
Not examining feet or pulses in patients without reported leg pain	Silent PAD progresses to tissue loss before detection	Inspect feet at every visit; comprehensive foot exam at least annually

CLINICAL OVERSIGHT	CONSEQUENCE	BETTER PRACTICE
Offering structured exercise therapy for active gangrene or deep ulcers	Delays urgent revascularization	Reserve SET for stable claudication; CLTI needs urgent vascular referral
Omitting frailty and nutrition assessment before intervention	Futile, high-morbidity procedures in patients unlikely to benefit	Assess frailty (Class 2a ≥ 75 y) and screen nutrition; malnutrition affects up to 50% and raises 30-day CLTI mortality 5-fold

ABBREVIATIONS: ABI = Ankle-Brachial Index; TBI = Toe-Brachial Index; PAD = Peripheral Arterial Disease; CLTI = Chronic Limb-Threatening Ischemia; SET = Supervised Exercise Therapy

Key Differentials in Elderly

CONDITION	OVERLAPPING FEATURE	DISTINGUISHING FEATURE
Lumbar spinal stenosis (neurogenic claudication)	Leg pain with walking	Relieved by sitting/flexion, not by standing rest; pulses intact
Peripheral neuropathy	Foot pain and numbness	Burning/tingling not exertional; pulses and ABI may be normal
Chronic venous insufficiency	Leg ulcers and skin changes	Medial/gaiter ulcers, edema, normal pulses; venous reflux on ultrasound
Musculoskeletal/arthritis leg pain	Activity-related discomfort	Joint-localized, variable with weather/use; not relieved by rest in a fixed time
Acute limb ischemia	Limb pain and pallor	Sudden onset, the '6 Ps', symptoms < 2 weeks — an emergency , not chronic PAD

ABBREVIATIONS: PAD = Peripheral Arterial Disease; ABI = Ankle-Brachial Index; '6 Ps' = Pain, Pallor, Pulselessness, Poikilothermia, Paresthesias, Paralysis

PAD vs CVI: KEY DIFFERENTIAL

FEATURE	PERIPHERAL ARTERY DISEASE (PAD)	CHRONIC VENOUS INSUFFICIENCY (CVI)
Vessels Affected	Arteries: Narrowed or blocked by plaque (atherosclerosis)	Veins: Damaged one-way valves that cause blood to pool in the legs
Pain Nature	Cramping, aching, or tightness in the legs that occurs during activity (intermittent claudication) and stops with rest	Dull, heavy, or aching pain that worsens with standing and improves when legs are elevated

FEATURE	PERIPHERAL ARTERY DISEASE (PAD)	CHRONIC VENOUS INSUFFICIENCY (CVI)
Physical Symptoms	Cold feet, numbness, loss of leg hair, thin/shiny skin , and weak or no pulses in the feet	Swelling (edema) in the lower legs and ankles, visible varicose veins, and itchy, discolored (reddish-brown) skin
Ulcer (Sore) Traits	Located on toes, feet, or heels. They have well-defined, “punched out” edges, look pale or yellow, and are very painful	Located usually on the inner ankle. They have irregular borders, are shallow, have a red or pink base, and ooze fluid
Risk Factors	Smoking, diabetes, high blood pressure, and high cholesterol	Family history, obesity, pregnancy, and prolonged sitting or standing

Comorbidity Screening

COMORBIDITY	PREVALENCE/IMPACT	SCREENING/ACTION
Diabetes mellitus ¹	Up to 70% of PAD >70 y ; amputation HR 5.48; predominantly infrapopliteal Up to 70% of PAD >70 y; amputation HR 5.48; predominantly infrapopliteal	Glycemic optimization ; GLP-1 RA or SGLT-2 inhibitor in T2DM (Class 1)
Heart failure ¹	Highly prevalent in Medicare; cilostazol contraindicated in HF of any severity	Screen for HF before cilostazol ; reconsider aggressive revascularization in frail HF/CLTI
Chronic kidney disease ¹	Medial calcification, falsely elevated ABI , higher perioperative risk	Use TBI; rivaroxaban contraindicated in severe CKD
Malnutrition ¹	Affects up to 50% of older PAD patients ; severe malnutrition raises 30-day CLTI mortality 5-fold	Screen with the Geriatric Nutritional Risk Index ; optimize before/after revascularization
Frailty and sarcopenia ¹⁴	Severe frailty in ~48% of BEST-CLI patients; worse MALE/death regardless of strategy	Formal frailty assessment drives shared decision-making
Cognitive impairment ¹⁵	Impairs adherence, wound care, and exercise participation	Cognitive assessment within geriatric syndrome evaluation

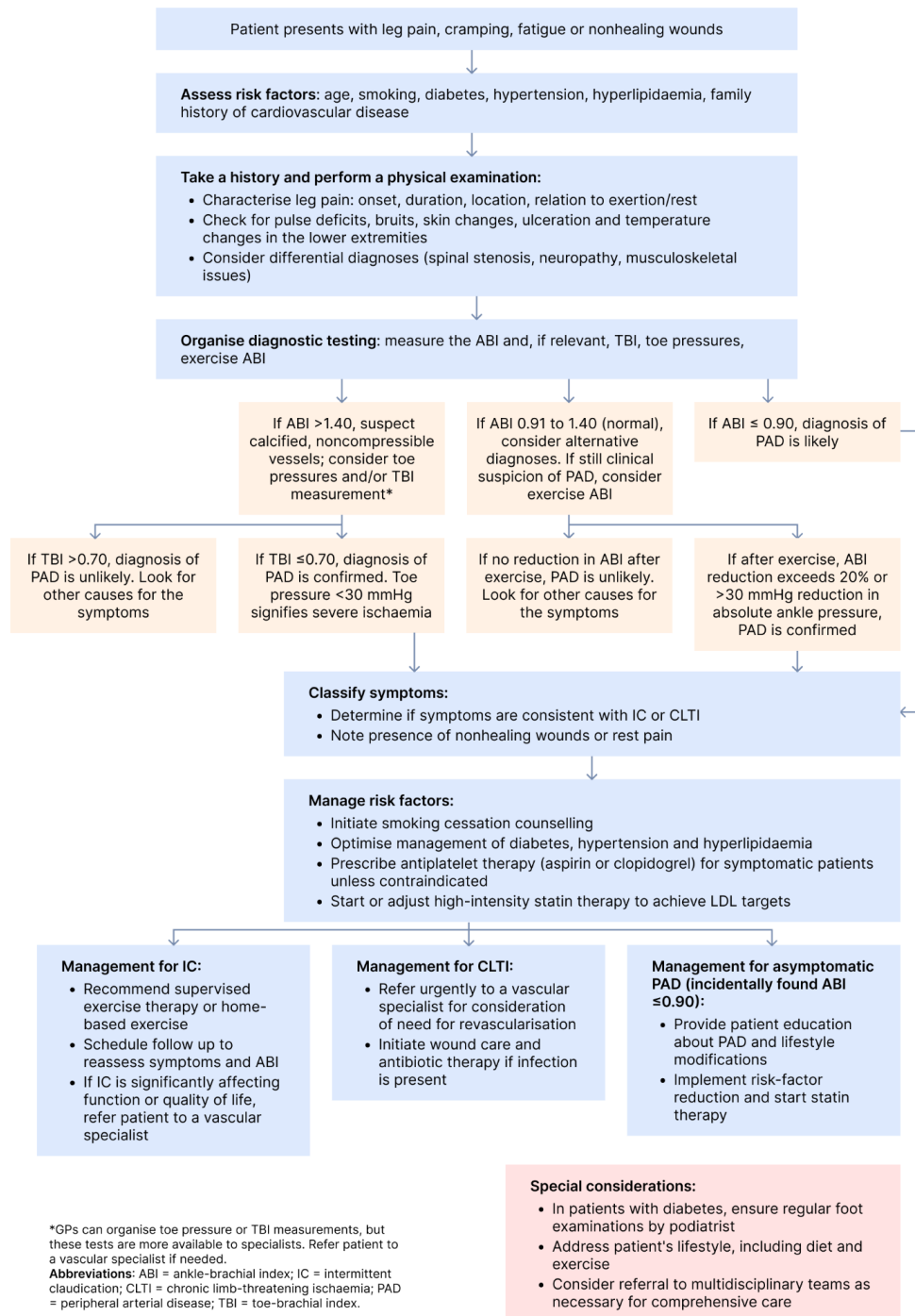
COMORBIDITY

PREVALENCE/IMPACT

SCREENING/ACTION

ABBREVIATIONS: PAD = Peripheral Arterial Disease; HF = Heart Failure; CKD = Chronic Kidney Disease; T2DM = Type 2 Diabetes Mellitus; CLTI = Chronic Limb-Threatening Ischemia; MALE = Major Adverse Limb Events; GLP-1 RA = Glucagon-Like Peptide-1 Receptor Agonist; SGLT-2 = Sodium-Glucose Cotransporter-2

PAD clinical decision algorithm



**RED FLAG — URGENT (24-72 HOURS)**

- **Acute limb ischemia** — sudden onset of the '6 Ps' (Pain, Pallor, Pulselessness, Poikilothermia, Paresthesias, Paralysis) with symptoms <2 weeks. Rutherford Class IIb (sensory loss beyond the toes, motor weakness, inaudible arterial Doppler) requires **immediate revascularization**
 - Rutherford Class III (anesthetic limb, complete paralysis, inaudible arterial and venous Doppler) is a nonviable limb — **emergent surgical consultation for amputation**
- **Wet gangrene with systemic sepsis** (fever, tachycardia, hypotension, or leukocytosis with gangrenous tissue) requires emergent debridement or amputation and IV antibiotics. Transfer to the emergency department now

**RED FLAG — URGENT (24-72 HOURS)**

- Same-day or next-day specialist contact for: **new or worsening ischemic rest pain** (Rutherford 4/Fontaine III) - forefoot pain at rest, worse with elevation, relieved by dependency
- **Rutherford Class IIa acute limb ischemia** (mild sensory loss limited to toes, inaudible arterial but audible venous Doppler) - salvageable if treated promptly; a **rapidly expanding or infected ischemic ulcer** (erythema, purulence, crepitus); or **ABI <0.40** indicating severe ischemia. Within days (not routine scheduling): a **new nonhealing ulcer >2 weeks** in known PAD, an **ABI drop >0.15**, or a **diabetic foot ulcer with absent pedal pulses** even if ABI appears normal

3 MEAT DOCUMENTATION ESSENTIALS

CASE: 72M, Medicare Advantage, Army veteran (6 yrs). PMH: HTN, T2DM, 30 pack-year smoking (quit 10 yrs ago). Presents with 8 months progressive R hand weakness/clumsiness → R forearm, bilateral calf fasciculations, 12-lb weight loss over 4 months. Wife reports impulsivity and inappropriate laughter. Exam: R hand intrinsic atrophy with fasciculations, hyperreflexia in all extremities (including atrophic muscles), bilateral positive Hoffmann sign, tongue fasciculations. Primary diagnosis: ALS (**G12.21**). PAD screening indicated given age ≥65, T2DM, 30 pack-year smoking history, and HTN — all major independent risk factors for peripheral arterial disease.

MONITOR: **"Tobacco status:** former smoker, 30 pack-years, quit 10 years ago; cessation maintenance counseling reinforced today. **Weight:** 168 lbs (↓12 lbs/4 mo; >5% loss). BMI 24.1. BP 128/74 mmHg, at goal <130/80. HbA1c 7.2%, targeting <7%. LDL-C 88 mg/dL on atorvastatin 40 mg, targeting ≥50% reduction. **Pedal pulses examined bilaterally:** dorsalis pedis 1+ right, 1+ left; posterior tibial 1+ right, absent left. **Foot inspection performed:** bilateral hairless feet, cool to touch distally, no ulcers or preulcerative lesions identified today. Asked specifically about

exertional leg pain, nocturnal calf cramping, and forefoot pain at rest — patient reports bilateral calf cramping at night but denies exertional claudication. **Nutritional status reviewed:** caloric intake ~1,400 kcal/day (target 1,900–2,300 kcal/day); malnutrition risk compounds both ALS and PAD prognosis. Caregiver (wife) educated on daily foot inspection given patient's progressive hand weakness from ALS.”

EVALUATE: “**Ordered resting ABI with Doppler waveforms bilaterally (date):** right ABI 0.82, left ABI 0.74 — confirms bilateral mild-to-moderate PAD. Waveforms monophasic at left posterior tibial, biphasic at right dorsalis pedis. **Segmental pressures with pulse volume recordings obtained (date):** pressure gradient localizes disease to left superficial femoral artery segment. **Comprehensive foot evaluation performed (date):** 10-g monofilament intact bilaterally, diminished vibratory sensation at great toes bilaterally (diabetic neuropathy), no deformity, no ulceration. Labs reviewed: fasting lipid panel (LDL-C 88), HbA1c 7.2%, creatinine 1.2/eGFR 62 (CKD stage 2). **Screened for polyvascular disease:** no history of stroke/TIA or known CAD; ECG reviewed, no ischemic changes. Anatomic imaging (CTA/MRA) not ordered — patient is not a revascularization candidate at this time given claudication-range disease and concurrent ALS prognosis.”

ASSESS: “Bilateral lower extremity peripheral arterial disease confirmed: right leg with intermittent claudication (**I70.211**), left leg with intermittent claudication (**I70.212**). Left SFA disease predominant. Risk factor burden: T2DM, 30 pack-year smoking history, HTN, age 72. Nocturnal calf cramping may represent vascular insufficiency given confirmed PAD and risk factor profile — distinguished from ALS-related fasciculations by cramping quality and nocturnal timing. Concurrent ALS (**G12.21**, King's stage 3) limits mobility, masks claudication, and complicates exercise therapy and foot self-care. Associated diagnoses: T2DM without complications (**E11.9**) — will reassess for diabetic peripheral angiopathy (**E11.51**) given confirmed PAD; HTN (**I10**); former tobacco use disorder in remission (**Z87.891**; **F17.211**); CKD stage 2 (**N18.2**).”

TREAT: “Started **clopidogrel 75 mg daily** for confirmed symptomatic PAD. Discussed dual pathway inhibition with **rivaroxaban 2.5 mg BID + aspirin** given polyvascular risk profile — deferred today pending bleeding risk assessment and eGFR stability; will revisit at next visit. Continued atorvastatin 40 mg daily; **LDL-C 88** — considering **uptitration to 80 mg for ≥50% reduction target**; monitoring LFTs closely given concurrent riluzole for ALS. Continued lisinopril for **BP target <130/80**. Discussed adding semaglutide for dual glycemic and PAD benefit given HbA1c 7.2% and confirmed symptomatic PAD — prescription placed, pending insurance authorization. **Cilostazol 100 mg BID** discussed for claudication — confirmed no heart failure history; started today with counseling on headache and GI side effects. Referred to CMS-covered **supervised exercise therapy program (3 sessions/week × 12 weeks)** — discussed with PT that treadmill-based SET will need adaptation to seated/upper-body exercises given ALS-related lower extremity weakness and fall risk; coordinated with existing ALS PT/OT plan. Ordered therapeutic footwear evaluation given diabetic neuropathy and confirmed PAD. **Dietitian already engaged for ALS** — added **PAD-specific nutritional goals to existing plan**. Follow-up: **PCP in 6 weeks** to reassess cilostazol tolerance and dual pathway inhibition decision; **ABI repeat in 6 months**; comprehensive foot evaluation annually; lipid panel, HbA1c, LFTs in 3 months; coordinated with ALS clinic q3 mo and pulmonology q3 mo.”

Clinical Documentation Elements

- **Severity tier present**—claudication, rest pain, ulceration, or gangrene) with ABI severity scale
- **Laterality:** right, left, or bilateral — never default to unspecified when the side is known
- **Vessel type:** native artery (**I70.2x**) versus bypass graft (**I70.3x-I70.7x**)
- **Ulcer site and depth via an L97.-** companion code when ulceration is present

- **Diabetes link** (diabetic peripheral angiopathy) when diabetes and PAD coexist
- **Tobacco status** (current, former, or history) documented at every visit
- **Chronic total occlusion (I70.92)** as an additional code when documented on imaging
- **Frailty, nutrition, and goals-of-care assessment** supporting the chosen management strategy

Reframing Common Documentation Shortcuts

COMMON SHORTCUT	WHY IT FALLS SHORT	DOCUMENT...
'PVD' or I73.9, unspecified	No severity, laterality, or HCC — the most common PAD coding error	'Atherosclerosis of native arteries of the right leg with intermittent claudication (I70.211); ABI 0.68 right, 0.92 left; Rutherford category 3 (limiting claudication)' — use I70.209 only when laterality and severity are truly unspecified'
'Foot ulcer' without ischemic cause	Misses the arterial diagnosis and the L97.- depth code	'Atherosclerosis of native arteries of the right leg with ulceration of the heel (I70.234) + L97.412 (right heel skin breakdown with fat layer exposed); Wifl stage 3 — vascular surgery and multidisciplinary limb-preservation team referral placed; chronic total occlusion documented (I70.92)'
Coding ulceration when gangrene is present	Under-represents severity; gangrene outranks ulceration	'Atherosclerosis of native arteries of the right leg with gangrene (I70.261); dry gangrene of right 4th toe; ABI 0.31; Rutherford 5; Wifl stage 3 — vascular surgery referral for revascularization vs. amputation discussion'
Diabetes and PAD coded separately	Loses the diabetic-angiopathy linkage	'Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene (E11.51) + atherosclerosis of native arteries of the right leg with intermittent claudication (I70.211); ABI 0.68 right; GLP-1 RA initiated per ACC/AHA PM-3; comprehensive foot exam performed'
'Unspecified extremity' for gangrene (I70.269)	Drops laterality specificity	'Atherosclerosis of native arteries of the left leg with gangrene (I70.262); wet gangrene of left forefoot; Rutherford 6; saphenous vein mapping completed — single-segment GSV available; surgical bypass planned per BEST-CLI protocol'
ABBREVIATIONS: PVD = Peripheral Vascular Disease; PAD = Peripheral Arterial Disease; HCC = Hierarchical Condition Category		

**DOCUMENTATION REMINDER IS AN ACCURATE CLINICAL RECORD**

Every active PAD encounter should state the diagnosis with laterality + severity (**I70.211-I70.269** for atherosclerotic PAD of the native arteries; **I70.311-I70.369** for bypass graft; **I70.411-I70.469** for autologous vein graft), clinical stage (Fontaine I-IV or Rutherford 0-6 for chronic disease; Rutherford ALI I-III for acute presentation), Wifl stage (1-4) if CLTI is present, most recent ABI/TBI values, current GDMT regimen (antiplatelet/antithrombotic, statin, antihypertensive, cilostazol, exercise prescription), and **all concurrent comorbidities** that modify risk and management (T2DM **E11.51** if diabetic peripheral angiopathy is present — **not E11.9**; HTN **I10**; CKD **N18.x** with stage; tobacco use **F17.21x** or former **Z87.891**; obesity **E66.x**; HF **I50.x** — contraindicates cilostazol; dyslipidemia **E78.x**; cerebrovascular disease **I63.x/G45.x** if polyvascular). Document pedal pulse exam findings, foot inspection results, and any tissue loss or ulceration with precise anatomic location at every visit. Use **I70.209** (unspecified) only at the initial screening encounter before ABI results are available — once confirmed, lateralize and specify severity at every subsequent encounter. **Z86.79** (personal history of diseases of the circulatory system) applies only after successful revascularization with complete symptom resolution and no residual hemodynamic disease.

4 TREATMENT AND REFERRAL QUICK GUIDE

PAD treatment is severity-tiered, not a flat list. Guideline-directed medical therapy and risk-factor control apply to everyone; structured exercise and cilostazol address claudication; and rest pain, ulceration, or gangrene call for urgent vascular referral, where revascularization takes precedence over exercise or wound care alone. The behavior change this guide asks for is simple: **ulcer + gangrene + PAD = urgent vascular referral**.

Therapy Escalation Criteria

PRESENTATION ^{1,5,13,16}	FIRST STEP	ESCALATION TRIGGER	DESTINATION
Asymptomatic or stable claudication	Guideline-directed medical therapy + structured exercise	No improvement after ≥3 months of GDMT + exercise	Reassess; consider vascular referral for disabling claudication
Disabling claudication despite therapy	Confirm adherence to GDMT, smoking cessation, exercise	Lifestyle-limiting symptoms with anticipated durable benefit	Vascular specialist for selective revascularization

PRESENTATION ^{1,5,13,16}	FIRST STEP	ESCALATION TRIGGER	DESTINATION
Ischemic rest pain (Rutherford 4)	Urgent perfusion assessment	Rest pain confirmed	Same-day/next-day vascular referral (CLTI)
Nonhealing ulcer or gangrene	Assess perfusion; do not delay for wound care	Tissue loss present	Urgent vascular referral + multidisciplinary limb-preservation team
Acute limb ischemia (6 Ps, <2 wk)	Immediate perfusion assessment	Rutherford IIb/III	Emergency department now for emergent revascularization

ABBREVIATIONS: GDMT = Guideline-Directed Medical Therapy; CLTI = Chronic Limb-Threatening Ischemia; '6 Ps' = Pain, Pallor, Pulselessness, Poikilothermia, Paresthesias, Paralysis

Guideline-Aligned Treatment by Profile (2024 ACC/AHA)

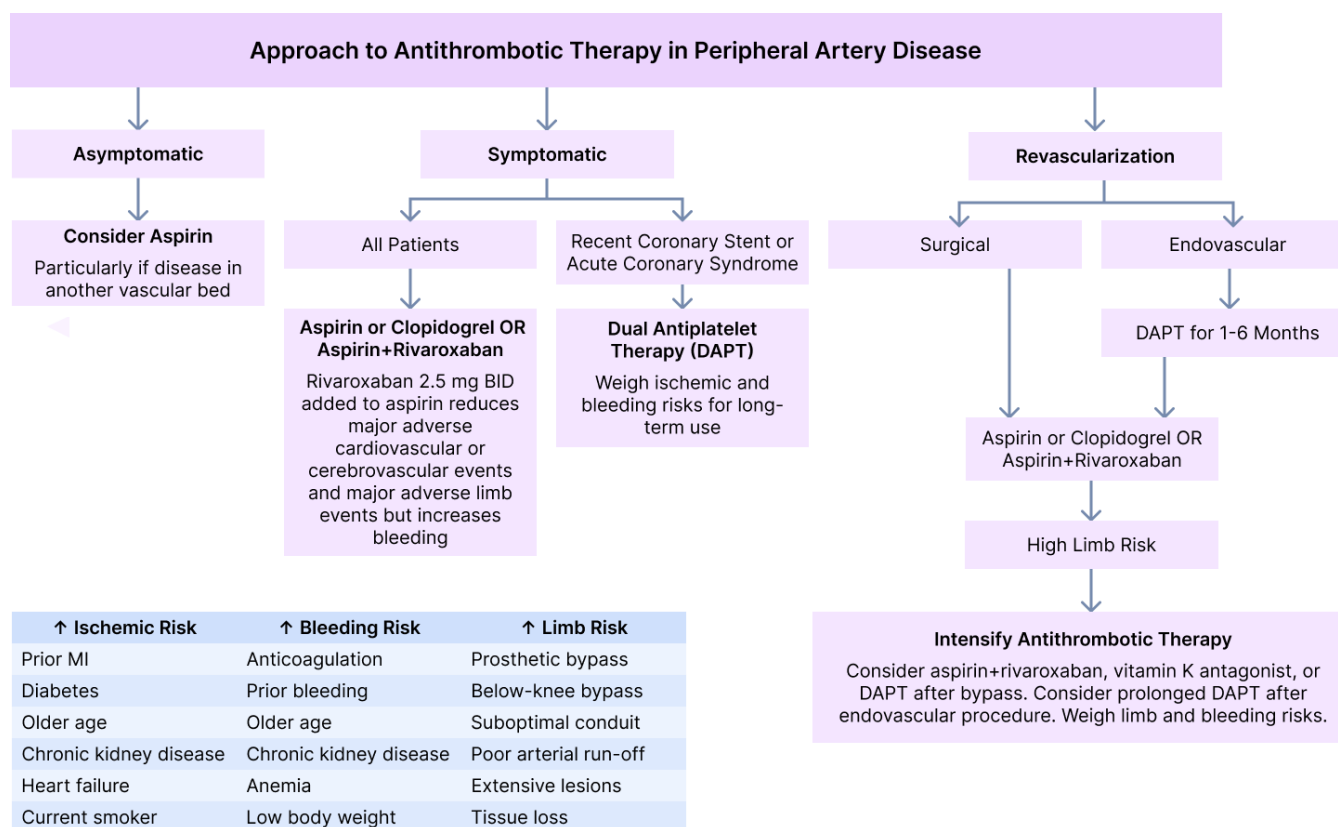
PROFILE/TIER	RECOMMENDED THERAPY	CLASS/EVIDENCE	GERIATRIC CONSIDERATION
All symptomatic PAD — antiplatelet	Aspirin 81 mg daily OR clopidogrel 75 mg daily	Class 1, LOE A	Weigh bleeding risk; monotherapy preferred when bleeding risk is high
Higher-risk PAD without high bleeding risk	Rivaroxaban 2.5 mg twice daily + aspirin 100 mg daily (COMPASS)	Class 1, LOE B-R	Increases major bleeding; avoid with full-dose anticoagulation, prior hemorrhagic/lacunar stroke, or severe CKD
Lipid management	High-intensity statin (atorvastatin 40–80 mg or rosuvastatin 20–40 mg); LDL-C <50 mg/dL	Class 1, LOE A	Monitor for myalgia, cognitive change, falls; review CYP3A4 interactions
Blood pressure	ACE inhibitor or ARB; target <130/80 mmHg	Class 1 (BP); ACEi/ARB Class 1, LOE B-R	Watch orthostasis, hyperkalemia, AKI, cough in older adults
PAD with type 2 diabetes	GLP-1 receptor agonist or SGLT-2 inhibitor	Class 1	GLP-1 RA linked to lower amputation/mortality vs SGLT-2i; avoid canagliflozin amputation signal

PROFILE/TIER	RECOMMENDED THERAPY	CLASS/EVIDENCE	GERIATRIC CONSIDERATION
Claudication symptom relief	Supervised exercise therapy first-line; cilostazol 50 → 100 mg twice daily if tolerated	Class 1, LOE A	Cilostazol [contraindicated in HF of any severity]; ~20% stop within 3 months. Reserve pentoxifylline for patients with claudication with HF.
CLTI (rest pain, ulceration, gangrene)	Urgent revascularization; multidisciplinary team before major amputation	Class 1, LOE B-NR (team)	Frailty assessment first; conservative/palliative care may match outcomes in very elderly

ABBREVIATIONS: LOE = Level of Evidence; CKD = Chronic Kidney Disease; AKI = Acute Kidney Injury; LDL-C = Low-Density Lipoprotein Cholesterol; HF = Heart Failure; CLTI = Chronic Limb-Threatening Ischemia; GLP-1 RA = Glucagon-Like Peptide-1 Receptor Agonist; SGLT-2i = Sodium-Glucose Cotransporter-2 Inhibitor

***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Approach to Antithrombotic Therapy in PAD



Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	ROLE	EVIDENCE/NOTE
Supervised exercise therapy (SET)	First-line for stable claudication	Comparable to revascularization for claudication functional gains; structured programs improve walking and are recommended for implementation; benefits persist up to 7 years
Smoking cessation	Most modifiable risk factor	Pharmacotherapy (varenicline, NRT, bupropion) + counseling, Class 1, LOE A
Preventive foot care	Prevents ulcers and amputations	Foot inspection every visit; comprehensive annual exam; therapeutic footwear for high-risk feet
Mediterranean-style diet	Reduces new PAD diagnoses and CV events	Supported by post-hoc PREDIMED analysis
Nutrition optimization	Supports wound healing and survival	Screen with the Geriatric Nutritional Risk Index; malnutrition affects up to 50%
Influenza and COVID-19 vaccination	Reduces CV events and hospitalization	Recommended for people with PAD
Structured home-based walking exercise	Alternative when SET is unavailable or burdensome; 3-5x/week, 30-50 min/session with behavioral change coaching	Class IIa, LOE A (ACC/AHA, AHA). Individual participant data meta-analysis: +55.6 m in 6-minute walk distance vs. controls — actually greater than SET (+31.8 m) for corridor walking, though SET superior for treadmill distance (+186 m vs. +54 m). Not currently covered by CMS
Alternative exercise modalities (upper-body ergometry, cycling, resistance training, recumbent stepping)¹	For patients unable or unwilling to walk to claudication pain; avoids ischemic symptoms during exercise	Class IIa, LOE A (AHA 2019). Two meta-analyses confirm alternative exercise forms improve walking performance and QOL
Tai chi¹⁸	Mind-body exercise ; may improve blood pressure, arterial compliance, and functional capacity in cardiovascular populations	Small crossover study (n = 7 PAD patients): acutely decreased systolic BP at 30 min post-exercise

INTERVENTION	ROLE	EVIDENCE/NOTE
Yoga/deep breathing ¹⁹	May reduce arterial stiffness and blood pressure via vagal stimulation and stress reduction; no direct PAD claudication evidence	Narrative reviews suggest yoga reduces arterial stiffness in hypertensive and obese populations, but results are inconsistent. Deep diaphragmatic breathing stimulates vagus nerve and reduces cortisol, BP, and heart rate. No RCTs in PAD-specific populations; no guideline recommendation for PAD
Mindfulness-based stress reduction ²⁰	Addresses anxiety, depression, and allostatic load — common in PAD patients	AHA 2023 scientific statement: multicomponent interventions including relaxation training have improved cardiovascular survival, but no intervention trials for stress reduction have been conducted specifically in PAD populations
Acupuncture ²¹	May improve microcirculation in PAD/diabetic foot ; no evidence for claudication outcomes	Pilot study (n = 18): bilateral acupuncture improved 7/8 microcirculatory parameters at wound margins. ACC Task Force: small, unblinded studies show peripheral vasodilation, but confirmation needed

ABBREVIATIONS: SET = Supervised Exercise Therapy; NRT = Nicotine Replacement Therapy; CV = Cardiovascular; PAD = Peripheral Arterial Disease

Medication Safety and Key Interactions

DRUG/CLASS	STATUS	KEY ELDERLY CONCERN	MONITORING
Cilostazol	FDA-approved (claudication)	Black box: contraindicated in HF of any severity ; +5–7 bpm; headache, falls, AKI signals	Heart rate and symptoms at 2–4 wk; reassess benefit at 3–6 mo; reduce dose with CYP3A4/2C19 inhibitors
Aspirin	Approved (antiplatelet)	GI bleeding, dyspepsia; NSAID and anticoagulant interactions	Watch for GI bleeding
Clopidogrel	Approved (antiplatelet)	Bleeding rises with age and renal impairment; omeprazole reduces efficacy	Bleeding signs; avoid CYP2C19-inhibiting PPIs

DRUG/CLASS	STATUS	KEY ELDERLY CONCERN	MONITORING
Rivaroxaban 2.5 mg BID + aspirin	Approved (COMPASS regimen)	Major bleeding (HR ~1.5 vs aspirin alone); higher baseline risk in fragile patients	Renal function and bleeding; avoid with full-dose anticoagulation or severe CKD
High-intensity statin	Approved	Myalgia, cognitive change, falls, neuropathy; reported safe/effective in PAD cohorts	Muscle symptoms, LFTs; review CYP3A4 inhibitors and fibrates
ACE inhibitor/ARB	Approved (preferred antihypertensive)	Falls, orthostatic hypotension, hyperkalemia, AKI, cough	Potassium, creatinine, BP; caution with diuretics and NSAIDs
Beta-blocker	Approved (per comorbidity)	Fatigue, confusion, bronchospasm; rarely worsens claudication in severe PAD	HR, BP, claudication symptoms
SGLT-2 inhibitor	Approved (PAD + T2DM)	DKA, genital infection; canagliflozin amputation signal	eGFR, ketones if ill, foot exams
GLP-1 receptor agonist	Approved (PAD + T2DM)	GI symptoms; weight loss may worsen sarcopenia	Weight, GI tolerance, nutritional status
Pentoxifylline	FDA indicated for claudication Class 3: No Benefit)	Minimal claudication benefit	Reserve for patients with claudication with HF

ABBREVIATIONS: HF = Heart Failure; AKI = Acute Kidney Injury; CKD = Chronic Kidney Disease; DKA = Diabetic Ketoacidosis; BID = Twice Daily; HR = Hazard Ratio/Heart Rate (per context); PPI = Proton Pump Inhibitor; LFT = Liver Function Test; T2DM = Type 2 Diabetes Mellitus; eGFR = Estimated Glomerular Filtration Rate

***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

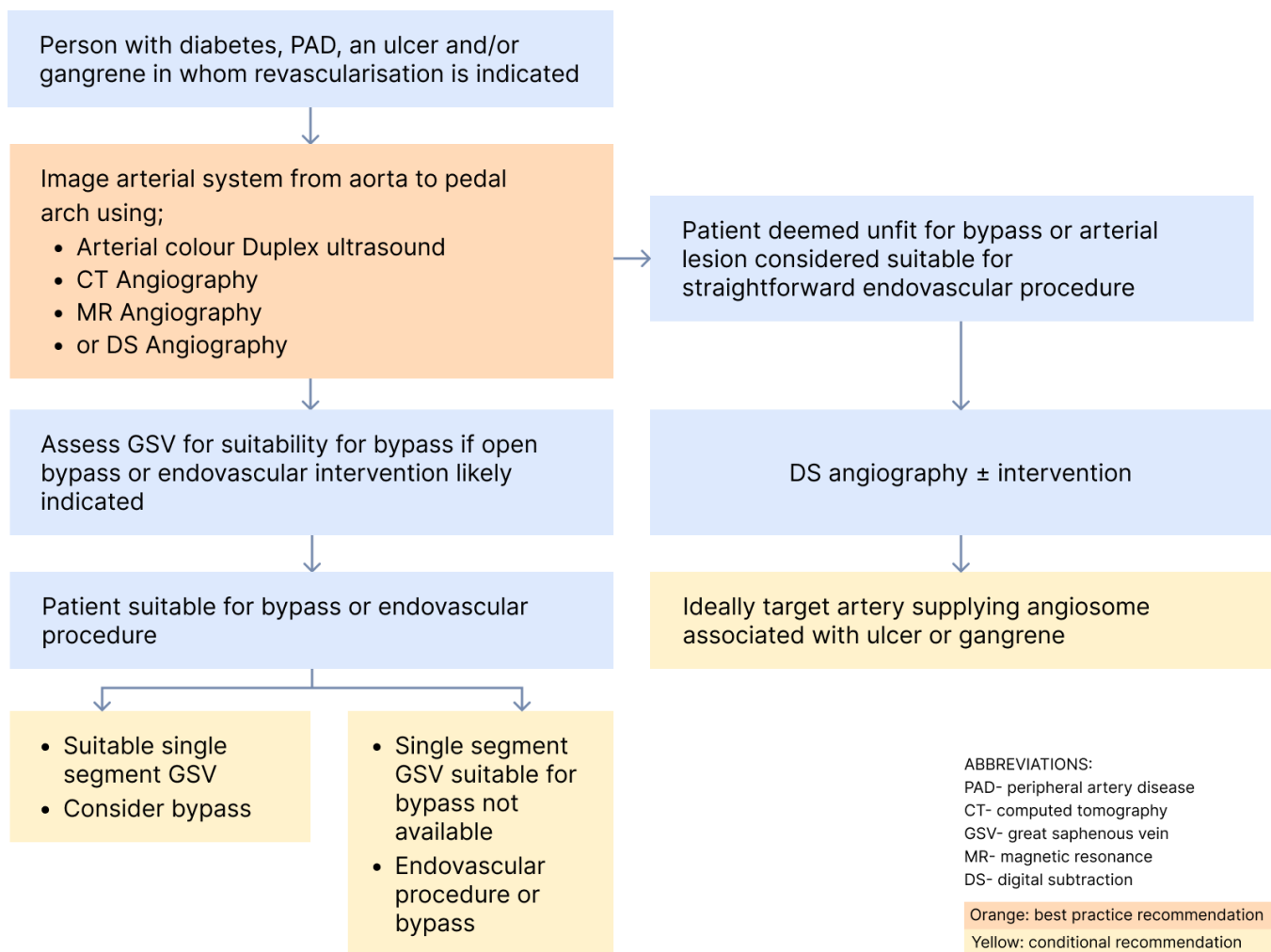
When to Refer

TRIGGER	REFER TO	TIMEFRAME
Disabling claudication despite ≥ 3 months GDMT + exercise	Vascular surgery/interventional specialist	Routine, expedited

TRIGGER	REFER TO	TIMEFRAME
Ischemic rest pain (Rutherford 4)	Vascular specialist (CLTI)	Same-day or next-day
Nonhealing ulcer or gangrene	Vascular + multidisciplinary limb-preservation team	Urgent
Diabetic foot ulcer with absent pulses	Vascular + podiatry/wound care	Urgent, even if ABI appears normal
Acute limb ischemia (6 Ps)	Emergency department/emergent vascular surgery	Immediate

ABBREVIATIONS: GDMT = Guideline-Directed Medical Therapy; CLTI = Chronic Limb-Threatening Ischemia; ABI = Ankle-Brachial Index; '6 Ps' = Pain, Pallor, Pulselessness, Poikilothermia, Paresthesias, Paralysis

Approach to vascular intervention for a person with diabetes + foot ulcer or gangrene



Follow-Up Timing

STATUS ^{1,5,22}	INTERVAL	WHAT TO REASSESS
Stable claudication on GDMT	Every 3–6 months	Symptoms, ABI if changed, adherence, smoking status, foot exam
On cilostazol	2–4 weeks, then 3–6 months	Heart rate, tolerability, symptom benefit; stop if no benefit by 3 months
Post-revascularization	Per specialist, with primary-care co-management	Wound healing, GDMT continuation, graft/limb surveillance
Known PAD with diabetes	Comprehensive foot exam at least annually; inspect every visit	New wounds, pulses, sensation, footwear
Conservative/palliative CLTI	Frequent, goals-of-care driven	Comfort, wound status, function, alignment with goals

ABBREVIATIONS: GDMT = Guideline-Directed Medical Therapy; ABI = Ankle-Brachial Index; PAD = Peripheral Arterial Disease; CLTI = Chronic Limb-Threatening Ischemia

Comorbidity Management — Primary Care Role

COMORBIDITY ^{1,3,22,23}	PRIMARY-CARE ROLE	WHY IT MATTERS
Diabetes	Glycemic control; GLP-1 RA/ SGLT-2i; daily foot care education	Diabetes drives infrapopliteal disease and amputation risk
Heart failure	Optimize HF; screen before cilostazol	Cilostazol is contraindicated in HF of any severity
Chronic kidney disease	Use TBI; weigh contrast and rivaroxaban risk	CKD masks PAD via calcification and raises perioperative risk
Polypharmacy	Medication reconciliation at every visit	39% of older adults take ≥5 medications; interactions amplify harm
Frailty/malnutrition	Screen frailty and nutrition; coordinate goals of care	Both predict poor outcomes regardless of revascularization

ABBREVIATIONS: GLP-1 RA = Glucagon-Like Peptide-1 Receptor Agonist; SGLT-2i = Sodium-Glucose Cotransporter-2 Inhibitor; HF = Heart Failure; TBI = Toe-Brachial Index; CKD = Chronic Kidney Disease; PAD = Peripheral Arterial Disease

Cost-Smart Options

ITEM ^{1,3,20}	COST	ALTERNATIVE/ OPTION	EST. SAVINGS	COST-SMART TIP
GDMT core (generic statin + aspirin + ACE inhibitor/ARB)	~\$15–\$40/month total (all generic)	Already lowest-cost option	Prevents hospitalizations worth \$15,755–\$18,984 median per PAD admission	Full GDMT is linked to lower mortality (HR 1.37 without) and lower amputation (HR 1.20 without), yet only ~48.8% of patients receive it — the single highest-value intervention in PAD
Clopidogrel (generic)	~\$10–\$30/month (generic)	Aspirin 81 mg (~\$3–\$5/month) if clopidogrel not tolerated	Significant vs. brand Plavix	Generic clopidogrel is equivalent to brand; network meta-analysis shows clopidogrel superior to aspirin for MACE reduction in PAD (RR 0.78)
Rivaroxaban 2.5 mg BID + aspirin (Xarelto, brand only)	~\$500–\$600/month (brand; no generic available)	Clopidogrel monotherapy (~\$10–\$30/month) for patients at high bleeding risk	—	Reserve for high-ischemic-risk / polyvascular disease or post-revascularization patients per COMPASS/VOYAGER PAD; reduces MACE (HR 0.72) and MALE (HR 0.54) but increases major bleeding; confirm low bleeding risk before initiating
Cilostazol (generic)	~\$15–\$50/month (generic)	Supervised exercise therapy (SET) — comparable or superior efficacy, Medicare-covered	Significant vs. brand Pletal	Contraindicated in HF of any severity; stop if no symptom benefit by 3 months; SET is first-line and should be tried before or alongside cilostazol
Supervised exercise therapy (SET)	Medicare-covered (12 weeks, 3×/week); patient copay ~\$30–\$50/session	Home-based structured exercise (Class IIa) if SET unavailable	Prevents ~\$60,000 revascularization on procedures	Comparable to endovascular revascularization for claudication functional gains; only 54% of vascular physicians have access to a SET facility — advocate for referral

ITEM ^{1,3,20}	COST	ALTERNATIVE/ OPTION	EST. SAVINGS	COST-SMART TIP
ABI/vascular lab testing	Medicare Part B covered (CPT 93922/93923); minimal copay	—	Early detection prevents costly CLTI care	ABI ≤0.90 confirms PAD; >1.40 requires TBI; screening prevents progression to CLTI, where annual costs reach \$55,700/patient-year
Endovascular revascularization	~\$18,396 per admission (adjusted); reintervention rates 25–30% at 5 years	Surgical bypass with saphenous vein for CLTI (32% fewer MALE events in BEST-CLI Cohort 1)	—	Reserve for claudication only after ≥3 months GDMT + SET failure; anticipated 2-year patency should exceed 60%; index atherectomy for claudication associated with higher reintervention rates (HR 1.33)
Surgical bypass (CLTI)	~\$31,908 per admission (adjusted)	Endovascular therapy (~\$18,396) for patients without suitable saphenous vein	Lower initial cost with endovascular, but higher reintervention	When single-segment saphenous vein is available, bypass is preferred for CLTI (BEST-CLI); higher upfront cost offset by fewer reinterventions and better long-term MALE outcomes
Major amputation	~\$43,033–\$54,000 per admission; \$55,700/patient-year long-term (Medicare)	Limb salvage via revascularization + wound care	Limb salvage reduces long-term costs by ~50%	Amputation carries the highest long-term costs (prosthetics, rehabilitation, institutionalization); 70% of nontraumatic amputations occur in people with diabetes — prevention through GDMT and foot care is far more cost-effective
Wound care (CLTI)	Variable; NPWT, offloading, dressings	Wound-care-first strategy for Wifl stage 1–2	Avoids premature revascularization	Limb salvage 88% conservative vs. 89–91% with revascularization in Wifl stage 1–2 (no significant difference); staged, selective approach reduces unnecessary procedures

ITEM ^{1,3,20}	COST	ALTERNATIVE/ OPTION	EST. SAVINGS	COST-SMART TIP
Avoidable hospitalizations	Median \$15,755– \$18,984 per PAD hospitalization	Proactive GDMT, SET, foot care, smoking cessation	Substantial	30-day readmission rate ~20% for CLTI ; wound complications, infection, and recurrent ischemia are leading drivers — preventive outpatient management is the highest-yield cost strategy

ABBREVIATIONS: ABI = Ankle-Brachial Index; ACE = Angiotensin-Converting Enzyme; ARB = Angiotensin Receptor Blocker; BID = Twice Daily; CLTI = Chronic Limb-Threatening Ischemia; COMPASS = Cardiovascular Outcomes for People Using Anticoagulation Strategies; CPT = Current Procedural Terminology; EST. = Estimated; GDMT = Guideline-Directed Medical Therapy; HF = Heart Failure; HR = Hazard Ratio; MACE = Major Adverse Cardiovascular Events; MALE = Major Adverse Limb Events; NIV = Non-Invasive Ventilation; NPWT = Negative Pressure Wound Therapy; PAD = Peripheral Arterial Disease; RR = Relative Risk; SET = Supervised Exercise Therapy; TBI = Toe-Brachial Index; VOYAGER PAD = Vascular Outcomes Study of ASA Along with Rivaroxaban in Endovascular or Surgical Limb Revascularization for PAD; Wifl = Wound, Ischemia, and foot Infection

***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Patient Education and Adherence

Smoking Cessation¹

- Most modifiable PAD risk factor — **counsel at every visit** (Class I, LOE A)
- Pharmacotherapy (varenicline, bupropion, NRT) + counseling
- Avoid secondhand smoke exposure (independently associated with PAD)

Structured Exercise¹

- **First-line for claudication:** ≥30 min, 3x/week, ≥12 weeks; Medicare-covered
- Comparable to revascularization for functional improvement; benefits persist up to 7 years
- "Walk more" advice alone is insufficient — refer to a formal program or prescribe a structured home-based plan

Foot Self-Care²⁴

- Daily inspection, washing, drying; protect from heat/cold; avoid going barefoot; proper footwear
- Use a mirror or enlist family if vision is impaired
- Foot inspection at every visit; comprehensive exam (monofilament, pulses) at least annually
- Foot infections in diabetes + PAD can progress rapidly to amputation — seek care immediately

Quality Metrics Tie-In

MEASURE (MY2026) ²⁵	STANDARD	APPLICABILITY TO PAD CARE
ACC/AHA PM-1: Target BP for Patients With PAD	Denominator: patients ≥18 y with PAD Numerator: most recent BP <130/80 mmHg Care setting: outpatient	New performance measure based on Class 1 recommendation. ACE inhibitors or ARBs are preferred antihypertensives (PM-2). Population-attributable risk of HTN for incident PAD is ~41% . Balance against orthostatic hypotension and fall risk in elderly — measure standing BP at every visit ¹
ACC/AHA PM-2: Use of ACE Inhibitors or ARB for Patients With PAD	Denominator: patients ≥18 y with PAD and HTN Numerator: prescribed ACE inhibitor or ARB Care setting: inpatient/outpatient	New performance measure. Ramipril significantly reduced MACE in the PAD subgroup of the HOPE trial. Class 1 recommendation (LOE B-R). Document rationale if ACEi/ARB is not prescribed ¹
ACC/AHA PM-3: Diabetes Management for PAD	Denominator: patients ≥18 y with PAD and T2DM Numerator: prescribed GLP-1 RA or SGLT-2 inhibitor Care setting: inpatient/outpatient	New performance measure. GLP-1 RA and SGLT-2 inhibitors decrease MACE in PAD with diabetes (Class 1). Semaglutide specifically improves functional capacity and QOL in symptomatic PAD. Up to 70% of people >70 y with diabetes have PAD; diabetes drives infrapopliteal disease and amputation risk (HR 5.48) ^{26,27}
ACC/AHA PM-4: Antithrombotic Therapy for Symptomatic PAD	Denominator: patients ≥18 y with symptomatic PAD Numerator: prescribed antithrombotic therapy (single antiplatelet or rivaroxaban 2.5 mg BID + aspirin) Care setting: inpatient/outpatient	New performance measure. Rivaroxaban + aspirin reduces MACE (HR 0.72) and MALE (HR 0.54) per COMPASS/VOYAGER PAD; now Class 1 recommendation. Clopidogrel preferred over aspirin for single antiplatelet. Document bleeding risk assessment before intensifying antithrombotic regimen ²⁸
ACC/AHA PM-5: Lipid-Lowering Therapy for PAD (High-Intensity Statins)	Denominator: patients ≥18 y with PAD Numerator: prescribed high-intensity statin with goal ≥50% LDL-C reduction Care setting: inpatient/outpatient	Revised measure — removed maximal dosing language; now focuses on high-intensity statin therapy. Only 30.5% of PAD patients identified by ABI ≤0.9 receive statins. Statin use in CLTI is associated with improved amputation-free survival. Document clinical rationale if statin is held or dose-reduced ²⁹

MEASURE (MY2026) ²⁵	STANDARD	APPLICABILITY TO PAD CARE
ACC/AHA PM-6: Tobacco Use Screening and Cessation Counseling	Denominator: patients ≥18 y with PAD seen within 12 months Numerator: screened for tobacco use AND received cessation counseling/pharmacotherapy if positive Care setting: inpatient/outpatient	Revised to include all forms of tobacco. Tobacco is the single most modifiable PAD risk factor — 80-90% of patients revascularized for severe limb symptoms are current smokers. 5-year mortality 40-50% with active smoking and symptomatic PAD. Pharmacotherapy (varenicline, NRT, bupropion) + counseling at every visit (Class 1, LOE A) ²⁸
ACC/AHA PM-7: SET or Structured Community- Based Exercise Therapy	Denominator: patients ≥18 y with chronic symptomatic PAD Numerator: offered SET or structured community-based exercise program Care setting: outpatient	Revised to include community-based exercise. SET is comparable to revascularization for claudication functional gains (Class 1, LOE A). Medicare-covered benefit. Exercise benefits persist up to 7 years. Only ~54% of vascular physicians have ever referred a patient for SET — the largest treatment gap after GDMT ^{1,28}
ACC/AHA QM-1: Vascular Review of Systems for Lower Extremity PAD	Denominator: patients ≥18 y with ≥1 PAD risk amplifier Numerator: vascular review of systems documented within 24 months Care setting: inpatient/outpatient	Revised to use 2024 PAD guideline risk amplifiers. Many Medicare patients never report classic claudication — reduced activity masks exertional symptoms. Targeted vascular history is necessary to detect asymptomatic PAD before progression to CLTI ²⁸
ACC/AHA QM-2: PAD "At Risk" Pulse Examination	Denominator: patients ≥18 y with ≥1 PAD risk amplifier (excluding those with diagnosed PAD) Numerator: lower extremity pulse exam documented within 12 months. Care setting: outpatient	Revised to use 2024 risk amplifiers. Pulse exam should include femoral, popliteal, dorsalis pedis, and posterior tibial pulses. Absent pulses in at-risk patients should trigger ABI testing. Age and geriatric syndromes alone are independent risk factors ^{1,28}
ACC/AHA QM-3: Preventive Foot Care for PAD	Denominator: patients ≥18 y with PAD Numerator: foot inspection at every visit + comprehensive foot evaluation annually + foot care education Care setting: outpatient	New quality measure. PAD carries a 40% rate of death at 5 years after a foot ulcer develops. Therapeutic footwear for high-risk feet (Class 1). Comprehensive annual exam includes monofilament testing and pulse palpation. Prompt management of foot infections reduces rapid progression to amputation

MEASURE (MY2026) ²⁵	STANDARD	APPLICABILITY TO PAD CARE
ACC/AHA QM-4: Lipid-Lowering Therapy for PAD (Novel Drugs)	Denominator: patients ≥ 18 y with PAD on maximally tolerated statin with LDL-C ≥ 70 mg/dL Numerator: prescribed ezetimibe or PCSK9 inhibitor Care setting: inpatient/outpatient	New quality measure complementing PM-5. PCSK9 inhibitors and ezetimibe are Class 2a recommendations. Greater LDL-C lowering is associated with greater reductions in cardiovascular events without significant adverse event rates ^{1,28}
ACC/AHA QM-5: Identifying Health Disparities in PAD	Denominator: patients ≥ 18 y with PAD Numerator: facility-level assessment of disparities in diagnosis, treatment, and outcomes Care setting: inpatient/outpatient	New quality measure. PAD prevalence is nearly 2-fold higher in Black adults; lifetime risk 30% in Black men vs. 19% in White men. Impacted groups are less likely to receive evidence-based care. Class 1 recommendation (LOE C-EO) ^{1,28}
ACC/AHA QM-6: Saphenous Vein Assessment Before Leg Revascularization	Denominator: patients ≥ 18 y with PAD undergoing leg revascularization Numerator: saphenous vein quality assessed before procedure Care setting: inpatient/outpatient	New quality measure. BEST-CLI demonstrated superior outcomes with single-segment great saphenous vein bypass for CLTI. Class 1 recommendation (LOE B-R). Vein quality assessment changes the revascularization strategy ^{1,28}
ACC/AHA QM-7: Lower Extremity Surveillance After Revascularization	Denominator: patients ≥ 18 y post-revascularization Numerator: ABI and duplex ultrasound at 1–3 months, 6 months, 12 months, then annually (vein bypass) Care setting: outpatient	Revised per 2024 guideline. A decrease in ABI > 0.15 is concerning for revascularization failure. 25–30% of endovascular treatments fail within 5 years — surveillance enables early reintervention
ACC/AHA QM-8: Multidisciplinary Team Evaluation for Patients With CLTI	Denominator: patients ≥ 18 y with CLTI Numerator: evaluated by a multidisciplinary team (vascular surgery, wound care, podiatry, endocrinology, etc.) Care setting: inpatient/outpatient	New quality measure. CLTI requires coordinated, patient-focused, multispecialty management (Class 1, LOE B-NR). Limb-preservation teams reduce amputation rates. EHR tracking of multidisciplinary involvement remains a challenge ^{1,28}
HEDIS COA: Care for Older Adults — Medication Review	Denominator: MA/SNP enrollees ≥ 66 , continuously enrolled. Numerator: medication review documented annually Exclusions: hospice, ESRD	Polypharmacy is common in elderly PAD (statins, antithrombotics, antihypertensives, cilostazol, diabetes medications). Reconcile: cilostazol contraindication in HF, rivaroxaban bleeding risk in CKD, statin interactions, and Beers Criteria medications. 39% of older adults take ≥ 5 medications ^{1,28}

MEASURE (MY2026) ²⁵	STANDARD	APPLICABILITY TO PAD CARE
HEDIS COA: Care for Older Adults – Functional Status Assessment	Denominator: MA/SNP enrollees ≥66 Numerator: functional status assessment documented annually Exclusions: hospice, ESRD	Walking Impairment Questionnaire (WIQ), 6-minute walk test, or treadmill testing directly satisfy this sub-measure. Periodic assessment of functional status and QOL is a Class 1 recommendation (LOE B-NR) in the 2024 PAD guideline. Track walking distance to guide exercise therapy and revascularization decisions ^{1,28,30}
HEDIS COA: Care for Older Adults – Pain Assessment	Denominator: MA/SNP enrollees ≥66 Numerator: pain assessment documented annually Exclusions: hospice, ESRD	Claudication, ischemic rest pain, and wound-related pain are common. Many elderly PAD patients do not report pain due to neuropathy or reduced activity. Document pain type (exertional vs. rest), location, severity, and functional impact. Rest pain (Rutherford 4) is a limb-threatening sign requiring urgent evaluation
HEDIS COA: Care for Older Adults – Advance Care Planning	Denominator: enrollees ≥66 Numerator: advance care planning documented annually; CPT 99497/99498	Billable during AWV with no copay. CLTI carries 25–35% 1-year mortality — ACP is essential. Document goals of care regarding amputation vs. conservative management, revascularization preferences, and comfort-focused care. Frailty assessment should inform shared decision-making (Class 2a) ^{31,32}
HEDIS TSC-E: Tobacco Use Screening and Cessation Intervention	Denominator 1: enrollees ≥12 Denominator 2: positive tobacco users Numerator 1: screened with documented tobacco status Numerator 2: received cessation counseling or pharmacotherapy Exclusions: death, hospice	Overlaps with ACC/AHA PM-6. Tobacco is the most modifiable PAD risk factor. OR ~2.4 for symptomatic PAD; 5-year mortality 40–50% with active smoking. Document tobacco status at every visit using 5 A's framework. Former smokers should be documented as F17.211 ³³
HEDIS DMS-E: Utilization of the PHQ-9 to Monitor Depression Symptoms	Denominator: enrollees ≥12 with major depression or dysthymia AND elevated PHQ-9 ≥10 Numerator: follow-up PHQ-9 documented within 4–8 months Exclusions: hospice	Depression is one of the strongest predictors of health status in PAD and occurs more frequently in PAD patients. Depression screening is a candidate PRO-PM for PAD per AHA Scientific Statement. Follow-up PHQ-9 within 4–8 months if ≥10 ²⁰

MEASURE (MY2026) ²⁵	STANDARD	APPLICABILITY TO PAD CARE
HEDIS DAE: Use of High-Risk Medications in Older Adults	Denominator: enrollees ≥ 67 Numerator: received ≥ 1 high-risk medication per Beers Criteria. Lower rate = better performance	High-yield in PAD: NSAIDs increase cardiovascular and bleeding risk; benzodiazepines compound fall risk in patients with claudication and impaired gait; anticholinergics worsen cognitive impairment. Cilostazol is contraindicated in HF of any severity. Document Beers review at each visit ^{34,35}
CMS Star: Controlling Blood Pressure (CBP)	Denominator: enrollees 18-85 with HTN diagnosis Numerator: most recent BP $< 140/90$ mmHg	Overlaps with ACC/AHA PM-1 (which uses the stricter $< 130/80$ target). HTN has a population-attributable risk of ~41% for incident PAD. ACEi/ARB preferred. Balance against orthostatic hypotension in elderly patients with claudication
CMS Star: Statin Therapy for Patients with Cardiovascular Disease (SPC)	Denominator: enrollees with clinical ASCVD Numerator: received statin therapy of any intensity during measurement year	PAD is clinical ASCVD — all PAD patients qualify. High-intensity statin is recommended (Class 1, LOE A) with goal $\geq 50\%$ LDL-C reduction. Only ~30.5% of PAD patients receive statins — the largest pharmacotherapy gap. Document clinical rationale if statin is held
CMS Star: Diabetes Care — HbA1c Control ($< 8\%$)	Denominator: enrollees 18-75 with diabetes Numerator: most recent HbA1c $< 8.0\%$	Up to 70% of people > 70 y with diabetes have PAD. Diabetes confers 2- to 4-fold increased PAD risk and amputation HR 5.48. GLP-1 RA and SGLT-2 inhibitors are now Class 1 for PAD with T2DM (PM-3). Glucose control before revascularization is associated with improved outcomes ^{1,36}
CMS Star: Plan All-Cause Readmissions (PCR)	30-day readmission rate; lower is better; risk-adjusted	PAD patients have high 30-day readmission rates driven by wound complications, recurrent ischemia, infection, and graft failure. Targeted interventions: post-discharge clinic within 7-14 days, medication reconciliation, GDMT optimization, wound surveillance, and SET referral ^{37,38}

MEASURE (MY2026) ²⁵	STANDARD	APPLICABILITY TO PAD CARE
HEDIS AIS: Adult Immunization Status	Pneumococcal, influenza, Td/Tdap, HZV per age-based schedule	Influenza and COVID-19 vaccination are recommended for people with PAD to reduce cardiovascular events and hospitalization (Class 1 per 2024 guideline). Pneumococcal (PCV20/21) and influenza annually; HZV ≥ 50 . Document vaccination status at AWV ¹
HEDIS TRC: Transitions of Care	Denominator: enrollees ≥ 18 with inpatient discharge Numerator: 4 sub-measures within 30 days: notification, discharge info, patient engagement, medication reconciliation	Post-revascularization and post-amputation patients require medication reconciliation for antithrombotic continuity, statin optimization, diabetes medication management, and wound care coordination. GDMT adherence drops after discharge — reconciliation is critical ³⁹

ABBREVIATIONS: ABI = Ankle-Brachial Index; ACC = American College of Cardiology; ACEi = Angiotensin-Converting Enzyme Inhibitor; ACP = Advance Care Planning; AHA = American Heart Association; AIS = Adult Immunization Status; ARB = Angiotensin Receptor Blocker; ASCVD = Atherosclerotic Cardiovascular Disease; AWV = Annual Wellness Visit; BEST-CLI = Best Endovascular vs. Best Surgical Therapy in Patients with Critical Limb Ischemia; BID = Twice Daily; BP = Blood Pressure; CBP = Controlling Blood Pressure; CKD = Chronic Kidney Disease; CLTI = Chronic Limb-Threatening Ischemia; CMS = Centers for Medicare & Medicaid Services; COA = Care for Older Adults; COMPASS = Cardiovascular Outcomes for People Using Anticoagulation Strategies; CPT = Current Procedural Terminology; DAE = Drug Use in the Elderly; DMS-E = Depression Monitoring and Follow-Up; DME = Durable Medical Equipment; ECDS = Electronic Clinical Data Systems; ED = Emergency Department; EHR = Electronic Health Record; ESRD = End-Stage Renal Disease; GDMT = Guideline-Directed Medical Therapy; GLP-1 RA = Glucagon-Like Peptide-1 Receptor Agonist; HbA1c = Hemoglobin A1c; HEDIS = Healthcare Effectiveness Data and Information Set; HF = Heart Failure; HR = Hazard Ratio; HTN = Hypertension; HZV = Herpes Zoster Vaccine; LDL-C = Low-Density Lipoprotein Cholesterol; LOE = Level of Evidence; MA = Medicare Advantage; MACE = Major Adverse Cardiovascular Events; MALE = Major Adverse Limb Events; NRT = Nicotine Replacement Therapy; NSAIDs = Nonsteroidal Anti-Inflammatory Drugs; OR = Odds Ratio; PAD = Peripheral Artery Disease; PCR = Plan All-Cause Readmissions; PCSK9 = Proprotein Convertase Subtilisin/Kexin Type 9; PCV = Pneumococcal Conjugate Vaccine; PHQ-9 = Patient Health Questionnaire-9; PM = Performance Measure; PRO-PM = Patient-Reported Outcome Performance Measure; QM = Quality Measure; QOL = Quality of Life; SET = Supervised Exercise Therapy; SGLT-2 = Sodium-Glucose Cotransporter-2; SNP = Special Needs Plan; SPC = Statin Therapy for Patients with Cardiovascular Disease; T2DM = Type 2 Diabetes Mellitus; Td/Tdap = Tetanus-Diphtheria/Tetanus-Diphtheria-Pertussis; TRC = Transitions of Care; TSC-E = Tobacco Screening and Cessation; VOYAGER PAD = Vascular Outcomes Study of ASA Along with Rivaroxaban in Endovascular or Surgical Limb Revascularization for PAD; WIQ = Walking Impairment Questionnaire



QUALITY OUTCOME

There are currently no PAD-specific HEDIS or CMS Star measures; the 2026 ACC/AHA PAD measure set is the first comprehensive standard and is not yet integrated into Star Ratings. The highest-value outcome remains complete guideline-directed medical therapy at every encounter — more impactful for survival and limb preservation than repeated procedures.

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

SCENARIO	CODE(S)	HCC/RAF (V28)	SPECIFICITY REQUIRED
Native artery, ulceration, left leg	I70.24x + L97.- (depth)	HCC 263/ 1.118	Laterality, ulcer site and depth
Native artery, gangrene, right leg	I70.261	HCC 263/1.118	Laterality; document tissue necrosis
Bypass graft, ulceration/gangrene	I70.3x-I70.7x	HCC 263/1.118	Graft type; do not use native-artery codes
Native artery, rest pain	I70.22x	HCC 264/ 0.455	Laterality; rest pain ranks below ulceration/gangrene
Diabetes with PAD	E11.51 / E11.52 + I70.2x	Supports diabetes-with-complication capture	Link diabetic peripheral angiopathy explicitly
Chronic total occlusion	I70.92 (additional)	Companion code	Add alongside the severity code when documented on imaging
Unspecified PVD	I73.9	No HCC — TRAP	Avoid when atherosclerosis, ulceration, gangrene, or laterality is documented

ABBREVIATIONS: HCC = Hierarchical Condition Category (V28); RAF = Risk Adjustment Factor; CNA = Community Non-Dual Eligible, Aged; PAD = Peripheral Arterial Disease; PVD = Peripheral Vascular Disease

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

Annual Clinical Review and Confirmation

Annual clinical review: PAD is a chronic condition whose documented severity can change over a year. Re-examine the feet and pulses, repeat ABI/TBI when the picture has changed, and re-document the highest severity present so the record stays accurate as disease evolves.

At each annual visit, **confirm laterality, vessel type** (native vs. graft), and **ulcer depth, and confirm whether the diabetes and tobacco links still apply**. A claudication code from last year should be revisited — if rest pain, ulceration, or gangrene has developed, the severity tier and HCC change.

Confirmation means the record supports the code: a note that names gangrene supports **I70.26x**; a note that says only 'PVD' does not support HCC 263. Re-document persistent conditions each year rather than carrying forward an unspecified code.

Frame the review around the person's current clinical complexity — frailty, nutrition, wound status, and goals of care — so documentation and the care plan stay aligned.

Good Documentation — EHR Tips

EHR TIP	WHAT TO CAPTURE	WHY
Use a structured PAD/CLTI template	Severity tier, laterality, vessel type, ulcer site/depth	Prompts the four axes of I70.2x specificity
Link problems explicitly	Diabetes ↔ PAD (diabetic angiopathy); tobacco status	Records coexisting complexity that is often omitted
Attach the L97.- ulcer code	Site and depth of any ischemic ulcer	Required companion to I70.23x/24x
Avoid carrying forward I73.9	Replace unspecified PVD with the documented severity code	I73.9 forfeits the HCC
Record frailty and foot-exam findings	Frailty score, pulse exam, annual comprehensive foot exam	Supports management rationale and quality measures

ABBREVIATIONS: EHR = Electronic Health Record; PAD = Peripheral Arterial Disease; CLTI = Chronic Limb-Threatening Ischemia; PVD = Peripheral Vascular Disease; HCC = Hierarchical Condition Category

Brief Case Examples

SUCCESS — Severity Captured, Complexity Represented, Coordinated Care

Scenario: 72M, bilateral calf cramping after 2 blocks × 6 months, relieved by rest. PMH: HTN, T2DM (10 yrs), 30 pack-year smoking (quit 10 yrs ago). Exam: absent right dorsalis pedis pulse, cool hairless right foot, no ulceration.

Documentation: 'Exertional calf pain with PAD risk factors — resting ABI obtained: right 0.72, left 0.84, confirming bilateral PAD. Diagnoses: atherosclerosis of native arteries, right leg with claudication (**I70.211**); left leg with claudication (**I70.212**); T2DM (**E11.9**); HTN (I10); former tobacco use in remission (**Z87.891**). GDMT initiated: atorvastatin 40 mg (uptitrate to 80 mg), clopidogrel 75 mg daily, lisinopril continued. Cilostazol 100 mg BID started — no HF on exam. SET referral placed. Diabetic foot exam performed. ACP discussed (CPT 99497).'

Outcome: Full GDMT documented at index encounter — absence of complete GDMT is linked to higher mortality (HR 1.37) and amputation (HR 1.20). ABI confirmed diagnosis and severity, enabling correct **I70.21x** coding with laterality. SET referral placed before revascularization discussion per Class 1 recommendation. Cilostazol screened for HF contraindication. Comorbidity codes documented alongside PAD severity codes to capture full disease burden.

PITFALL — Unspecified Coding Forfeits the HCC

Documentation as written: "PVD, stable. Foot looks okay. Continue meds. F/u 6 months." Coded as I73.9. Patient has known bilateral lower-extremity atherosclerosis with right calf claudication after 1 block and a nonhealing right great toe ulcer present for 3 weeks. ABI from 4 months ago: right 0.68, left 0.82. On atorvastatin and aspirin only. Type 2 diabetes with A1c 8.4%, not linked to PAD in documentation. 30 pack-year smoking history, quit 10 years ago — not coded. Cilostazol never considered. No supervised exercise referral. No vascular referral for the nonhealing ulcer.

Consequence: I73.9 ("peripheral vascular disease, unspecified") is a nonspecific code that does not confirm atherosclerotic PAD, does not capture severity, laterality, or tissue loss, and does not map to HCC 108 (Vascular Disease). The chart contains ABI confirmation of PAD and a nonhealing ulcer — the correct code family is **I70.231-I70.235** (atherosclerosis of native arteries, right leg, with ulceration) plus **L97.5xx** for ulcer site and severity. "Foot looks okay" directly contradicts the active ulcer documented in wound-care notes. Absent GDMT documentation (no antiplatelet rationale, no high-intensity statin, no cilostazol consideration, no exercise referral) fails MEAT for the treatment element. Diabetes and former tobacco use are not linked to PAD in the assessment, understating the clinical complexity driving limb risk. The nonhealing ulcer without vascular referral represents a missed CLTI evaluation — tissue loss with ABI 0.68 meets CLTI criteria and warrants urgent perfusion assessment, not a 6-month follow-up.

RAF Impact: I73.9 does not reliably map to HCC 108 (Vascular Disease). The documented ABI and ulcer support **I70.231-I70.235 + L97.5xx**, which map to HCC 108 and HCC 161 (Chronic Skin Ulcer). Missing diabetes linkage (**E11.51**, type 2 diabetes with diabetic peripheral angiopathy) loses the HCC 18 interaction with vascular disease. Combined, the undercoded record forfeits at least two HCC mappings that reflect the actual clinical burden being managed.

Fix: Update problem list and assessment: "Atherosclerosis of native arteries, right leg, with ulceration of right great toe (**I70.231**) + chronic ulcer right great toe, non-pressure, with fat layer exposed (**L97.512**); left leg with claudication (**I70.212**). ABI: right 0.68, left 0.82 [date] — moderate-severe PAD bilaterally. Nonhealing right great toe ulcer × 3 weeks with ABI 0.68 meets CLTI criteria — urgent vascular surgery referral placed today. Wifl staging: W1 I2 fl⁰, clinical stage 2. Concurrent: T2DM with diabetic peripheral angiopathy (**E11.51**), A1c 8.4% — endocrinology referral for optimization, GLP-1 RA or SGLT-2i consideration; HTN (I10), on lisinopril, BP 138/82 today — target <130/80; former tobacco use in remission (**Z87.891**), 30 pack-years. GDMT optimized today: atorvastatin uptitrated to 80 mg (high-intensity per AHA/ACC Class 1); clopidogrel 75 mg daily started (aspirin alone insufficient for symptomatic PAD); cilostazol 100 mg BID started after confirming no HF; supervised exercise therapy referral placed. Comprehensive diabetic foot exam performed — monofilament absent right forefoot, therapeutic footwear ordered. ACP documented (CPT 99497). Assessment: bilateral PAD with right CLTI (tissue loss) requiring urgent vascular evaluation; left-leg claudication on GDMT + SET; diabetes not at goal driving limb risk; full GDMT now documented. Return 2–4 weeks or sooner for a worsening wound, new rest pain, or color change."

Coding after fix: **I70.231** (right leg PAD with ulceration → HCC 108) + **L97.512** (right great toe ulcer → HCC 161) + **I70.212** (left leg claudication → HCC 108) + **E11.51** (T2DM with peripheral angiopathy → HCC 18) + **I10 + Z87.891** = full clinical picture preserved with correct severity, laterality, ulcer site, and comorbidity linkage.

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