Coagulation Therapy vs Defect

A LIFEWISE DOCUMENTATION AND CODING SERIES FOR PROVIDERS

Overview
Failure to take into consideration whether a patient's coagulopathy results from medication therapy or from a systemic issue frequently leads to inaccurate diagnostic coding. If a patient's chronic conditions are managed and treated with anticoagulants, coagulation defects should not be coded.

Accurate code assignment
When documenting and coding patients on anticoagulant medication therapy, providers commonly and mistakenly assign the ICD-10 code D68.9, coagulation defect, unspecified. Since any decrease in coagulation is correlated to the medication therapy, it is inaccurate to assign the coagulation defect code. Instead, the code Z79.01, long-term use (current) of an anticoagulant, should be assigned to identify the patient's medication therapy.

Examples
Example 1: A 69-year-old male on coumadin therapy is admitted for gastritis. We will continue to monitor for hematemesis.

ICD-10 Code	ICD-10 Description
K29.70	Gastritis, unspecified, without bleeding
Z79.01	Long term (current) use of anticoagulant

Example 2: An 89-year-old male with a history of atrial fibrillation on Coumadin therapy is admitted for treatment of severe epistaxis secondary to the Coumadin therapy.

ICD-10	ICD-10 Description
R04.0	Epistaxis
I48.91	Unspecified atrial fibrillation
Z79.01	Long term (current) use if anticoagulant
T45.515	Adverse effect of anticoagulants
Note: Per the AHA 1993 Q3 Coding Clinic, Coumadin is not a circulating anticoagulant, but instead induces anticoagulation through other mechanisms. If a patient is on a different anticoagulant therapy and has an associated bleeding, D68.32 Drug-induced hemorrhagic disorder, can be assigned.	

Example 3: Follow up visit for patient being managed for a hemorrhagic defect. This is not attributed to a drug therapy.

ICD-10	ICD-10 Description
D68.9	Coagulation defect, unspecified
To assign D68.9, the provider needs to specifically diagnose and documented the coagulation defect as well as indicate it is not contributed to a prescribed anticoagulant therapy.	

Impact of coding errors
Inaccurate coding of coagulopathy due to anticoagulant use not only impacts clinical continuity of care, but also impacts the accuracy of the risk of your patient panel. Coagulation defects fall into both commercial and Medicare risk adjustment models (HHS-HCC 75 and CMS-HCC 48, respectively). By documenting and coding correctly, you can ensure that an accurate risk score is calculated, and the precise patient health history is on record for continuity of care.

For more information about documentation and coding of coagulation defect, anticoagulation therapy, and any other chronic or complex condition, contact your Quality and Risk Adjustment Provider Clinical Consultant.