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Coagulation Therapy vs Defect

OVERVIEW

If clinicians do not consider whether a patient's coagulopathy is caused by medication or by an underlying systemic condition, it often results in incorrect diagnostic coding. If a patient's chronic conditions are managed and treated with anticoagulants, coagulation defects should not be coded.

CODING

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.

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 code	ICD-10 description
R04.0	Epistaxis
I48.91	Unspecified atrial fibrillation
D68.32*	Hemorrhagic disorder due to extrinsic circulating anticoagulants
Z79.01*	Long term (current) use if anticoagulant
T45.515A*	Adverse effect of anticoagulants

*D68.32, Hemorrhagic disorder due to extrinsic circulating anticoagulants, T45.515A, Adverse effect of anticoagulants, initial encounter, and Z79.0, Long term (current) use of anticoagulants, should be assigned as additional codes to capture the enhanced bleeding due to Coumadin.[1] In this example the provider documented that Coumadin contributed to the bleeding, making code D68.32 appropriate.

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

ICD-10 code	ICD-10 description
D68.9	Coagulation defect, unspecified

To assign D68.9, the provider needs to specifically diagnose and document the coagulation defect as well as indicate it is not contributed to a prescribed anticoagulant

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 the commercial risk adjustment model (HHS-HCC 75). 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.

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For more information about documentation and coding of this and any other chronic or complex condition, email ProviderClinicalConsulting@Premera.com.

Note: Tip sheets are regularly reviewed and revised with pertinent technical specification updates from ICD-10-CM.

[1] "Traumatic Subdural Hematoma Enhanced by Coumadin." *AHA Coding Clinic for ICD*, vol. 8, no. 1, 2021, pp. 4. First quarter 2021. www.encoderprofp.com. Accessed 16 February 2026.