Coagulation disorders overview

What are coagulation disorders?

Coagulation disorders are dysfunctions in the body's ability to control the formation of blood clots, which may result in either a bleeding disorder or clotting disorder.

	Bleeding disorders	Clotting disorders
Definition	Too little blood clotting that can lead to abnormal bleeding (hemorrhage)	Too much blood clotting that can lead to abnormal blood clot formation
Examples	**Inherited** ▪ Hemophilia ▪ von Willebrand Disease **Acquired** ▪ Platelet disorders ▪ Clotting factor deficiencies ▪ Disseminated intravascular coagulation ▪ Liver disease ▪ Vitamin K deficiency ▪ Renal disease ▪ Arteriovenous malformations ▪ Certain medications	**Inherited** ▪ Factor V Leiden ▪ Prothrombin 202010 mutation ▪ Hyperhomocysteinemia ▪ Protein C or protein S deficiencies **Acquired** ▪ Cancer ▪ Infections ▪ Heart disease ▪ Hypothyroidism ▪ Immune and autoimmune disorders ▪ Myeloproliferative disorders ▪ Certain medications
Signs and symptoms	▪ Blood in urine or stool ▪ Unexplained nosebleeds ▪ Bleeding gums ▪ Other excessive bleeding or bruising ▪ Sweating ▪ Redness, swelling, stiffness, pain due to bleeding into muscles and joints ▪ Prolonged bleeding from ordinary cuts or from surgery or dental work	▪ Heart - chest heaviness or pain, discomfort in other areas of the upper body, shortness of breath, sweating, nausea, light-headedness ▪ Brain - weakness of the face, arms or legs, difficulty speaking, vision problems, sudden and severe headache, dizziness ▪ Arm or Leg - sudden or gradual pain, swelling, tenderness and warmth ▪ Lung - sharp chest pain, racing heart, shortness of breath, sweating, fever, coughing up blood ▪ Abdomen - severe abdominal pain, vomiting, diarrhea
Related conditions	Thrombocytopenia - A condition in which the blood has a lower than normal number of blood cell fragments called platelets. With too few platelets, mild to serious bleeding can occur inside the body (internal bleeding) or underneath the skin or from the surface of the skin (external bleeding).	Hypercoagulable state - Presence of a condition that increases risk of abnormal blood clot development ▪ Primary - Inherited abnormalities in which body's natural anticoagulant mechanism is defective ▪ Secondary - An underlying disease or condition that predisposes a person to developing clots

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Office note documentation – best practices

Subjective: Document current patient complaints of symptoms related to coagulation disorders (blood in urine, unusual bruising, unexplained nosebleed, chest pain, shortness of breath, pain in calf, etc.).

Objective: Include related physical examination findings (bruising, petechiae, joint swelling or leg swelling, etc.) and results of related diagnostic tests (platelet count, partial thromboplastin time, prothrombin time, clotting factor tests, liver panel, genetic testing, etc.).

Assessment/final diagnostic statement:

- Describe each final diagnosis to the highest level of specificity, clearly linking causative and other associated conditions.
- Spell diagnosis out in full; avoid abbreviations and acronyms.

Terms of uncertainty

- Do not describe a confirmed coagulation disorder using terms of uncertainty (e.g., "probable", "apparently", "likely," "consistent with," etc.)
- Do not document a suspected coagulation disorder as if it is confirmed. Rather, document the signs and symptoms in the absence of a confirmed diagnosis.

Current versus historical

- Do not describe a current, confirmed coagulation disorder as "history of." In diagnosis coding, the phrase "history of" means the condition is historical and no longer exists as a current problem.
- Do not document past coagulation disorder as current if condition has resolved and is no longer being treated.

Document a clear and concise treatment plan.

- Clearly link the coagulation disorder to medications being used to treat the condition.
- Include details of planned diagnostic testing and specialist referrals (e.g., hematologist).
- Include date of next appointment.

ICD-10-CM is a statistical classification; it is not a substitute for a healthcare provider's final diagnostic statement. It is the provider's responsibility to provide legible, clear, concise and complete documentation of each final diagnosis described to the highest level of specificity, which is then translated to a code for reporting purposes. It is not appropriate for a provider to simply list a code number or select a code number from a list of codes in place of a written final diagnosis.

For electronic health records (EHRs) that insert diagnosis codes: The provider's final statement of diagnosis should classify in ICD-10-CM to the EHR-inserted diagnosis code with description. Avoid mismatches between the two.

Coding coagulation disorders

The ICD-10-CM classification provides many different codes to represent the many different types and causes of coagulation disorders.

Most coagulation disorders are coded from **Chapter 3, Diseases of the Blood and Blood-forming organs**, and are classified under categories **D65-D69 Coagulation defects, purpura and other hemorrhagic conditions**.

The categories, subcategories and codes in the series D65-D69 have multiple inclusions, exclusions and instructional notes that must be carefully reviewed and applied as indicated based on the medical record documentation.

Steps to ensure accurate and specific diagnosis code assignment:

1. Review the entire medical record to verify the condition remains a current problem.
2. Note the exact diagnosis description documented in the medical record.
3. Search the alphabetic index for that specific diagnosis description and the corresponding code.
4. Verify the code in the tabular list, carefully following all instructional notes, as applicable.

ICD-10-CM coding considerations

- The intent of anticoagulation therapy, use of blood thinners, is to reduce the ability of blood to clot or coagulate and to induce prolonged bleeding times. This is the desired therapeutic effect and expected outcome. It is not a coagulation defect and should not be coded as such.
- Current, long-term anticoagulant drug therapy classifies to code **Z79.Ø1**, Long term (current) use of anticoagulants.
- Prolonged prothrombin time or other abnormal coagulation profiles are not coded as coagulation defects.
- An increased risk of bleeding is an adverse effect associated with anticoagulation therapy. An adverse effect code is assigned for bleeding resulting from an anticoagulant that is properly administered.

  For abnormal bleeding in a patient who is being treated with warfarin (Coumadin), heparin, anticoagulants or other antithrombotics as a part of anticoagulation therapy, assign code **D68.32**, Hemorrhagic disorder due to extrinsic circulating anticoagulants.

  To report adverse effect of properly administered anticoagulant, assign either code **T45.515-** (Adverse effect of anticoagulant), or code **T45.525-** (Adverse effect of antithrombotic drugs).

  Heparin-induced thrombocytopenia classifies to code **D75.82**.

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