AXIS | Audit Intelligence

Audit Review — AI Analysis

AUDITOR	DATE OF SERVICE	ACCOUNT #	ISSUE TYPE	DRG	ANALYSIS TIME
COTIVITI	ClmFromDt: 2/8/2026 ClmThruDt: 2/12/2026	H11XXXXX61099500	DRG CODING	813 → 726	168 seconds

AUDIT RESPONSE

DISAGREE WITH AUDITOR

ISSUE TYPE

TYPE 1

The auditor changed the principal diagnosis from D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants) to N40.1 (Benign prostatic hyperplasia with lower urinary tract symptoms), resulting in a DRG downgrade.

CLINICAL FINDINGS

The patient is an 84-year-old male admitted through the ED with gross hematuria. He had a recent cystoscopy and foley catheter placement for urinary retention 5 days prior. He was also on outpatient Eliquis (apixaban) for a recent pulmonary embolism.

In the ED, the provider noted "Gross hematuria in a patient with a foley catheter" and ordered Continuous Bladder Irrigation (CBI) and to "Hold antiplatelets and NOAC" (H&P, 02/08/26). A Cardiology consult was obtained specifically to address the hematuria in the setting of anticoagulation. Cardiology noted the patient's history of PE and AICD, recommending to "Hold Eliquis until further evaluation with a hematuria" and to monitor closely before resuming (Cardiology Consult, 02/09/26). Urology was also consulted and noted the gross hematuria was "most likely from an enlarged prostate" (Urology Consult, 02/09/26).

Prior to discharge, a clinical documentation query was sent to the attending physician asking to clarify the etiology of the gross hematuria. Dr. responded and signed the query, stating: "Gross Hematuria is possibly related to BPH, Bladder outlet obstruction, and Eliquis use" (Query Response, 02/12/26). The Discharge Summary confirms the hematuria was managed by both CBI and holding the apixaban.

DIAGNOSIS ANALYSIS

UHDDS Principal Diagnosis Logic:

The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

The ICD-10-CM Official Guidelines for Coding and Reporting (Section II.C) state: "When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first."

The attending physician explicitly established that the gross hematuria was related to both the BPH/bladder outlet obstruction and the Eliquis use. Both conditions were actively and concurrently managed during the admission. The BPH/local bleeding source was managed with CBI. The systemic hemorrhagic disorder due to the anticoagulant was managed by withholding the Eliquis, monitoring serial H&H, and obtaining a Cardiology consultation to manage the complex risk-benefit analysis of holding anticoagulation in a patient with a recent pulmonary embolism. Because both conditions occasioned the admission and received significant, active medical management, they equally meet the definition of principal diagnosis. Therefore, the provider's sequencing of D68.32 as the principal diagnosis is fully supported and compliant with coding guidelines.

DRG IMPACT

The original billed DRG 813 (COAGULATION DISORDERS) carries a relative weight of 1.5253 and an expected reimbursement of $13,506.84. The auditor's reassignment to DRG 726 (BENIGN PROSTATIC HYPERTROPHY W/O MCC) shifts the DRG to a lower-weighted male reproductive system category, significantly reducing reimbursement. The documentation supports the original DRG 813 based on the active management of the anticoagulant-induced hemorrhagic disorder.

AUDITOR-SUPPORTING ANALYSIS

The auditor's strongest argument relies on the Urology consultation, which stated that the gross hematuria was "most likely from an enlarged prostate." The auditor argues that because Continuous Bladder Irrigation (CBI) was the primary physical intervention utilized to clear the urine, the BPH was the major focus of care and required the most treatment, making it the most appropriate principal diagnosis.

PROVIDER APPEAL ARGUMENT

The provider's strongest argument is rooted in the attending physician's explicit query response and the UHDDS guidelines for two or more conditions equally meeting the definition of principal diagnosis. Dr. clearly documented that the hematuria was related to both the BPH and the Eliquis use. The auditor's assertion that the BPH required "more" treatment is subjective and dismisses the clinical complexity of managing the coagulopathy. Withholding a high-risk anticoagulant in an 84-year-old patient with a recent pulmonary embolism and an AICD is not a passive action; it required a specialist Cardiology consultation, serial lab monitoring, and careful risk-benefit analysis to prevent a recurrent PE while stopping the bleeding. Because both the local bleeding source (BPH) and the systemic exacerbating factor (Eliquis) were chiefly responsible for the admission and required active management, they equally meet the definition of principal diagnosis. Under UHDDS guidelines, the provider has the

discretion to sequence either condition first, and the auditor cannot arbitrarily override this valid coding choice.

DISPUTE STRENGTH

STRONG APPEAL

RECOMMENDED ACTION

Appeal the DRG downgrade. The medical record and attending physician query response clearly establish that the admission was occasioned by both BPH and an Eliquis-induced hemorrhagic disorder. Both conditions were actively managed, allowing the provider to sequence D68.32 as the principal diagnosis under UHDDS guidelines.

DOCUMENTATION TO OBTAIN

No additional documentation needed.

SUGGESTED APPEAL LANGUAGE

We are appealing the DRG downgrade from DRG 813 to DRG 726. The auditor's removal of D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants) as the principal diagnosis is not supported by the clinical documentation or UHDDS coding guidelines.

The patient presented to the hospital with gross hematuria. Following clinical evaluation, the attending physician explicitly established the etiology of the bleeding, documenting: "Gross Hematuria is possibly related to BPH, Bladder outlet obstruction, and Eliquis use" (Query Response, Dr. , 02/12/26).

The auditor incorrectly asserts that the BPH was the sole major focus of care because the patient received Continuous Bladder Irrigation (CBI). This rationale ignores the significant and complex medical management required for the patient's coagulopathy. The patient's Eliquis-induced hemorrhagic disorder was actively managed by withholding the anticoagulant, monitoring serial H&H, and obtaining a Cardiology consultation. Managing this coagulopathy was highly complex, as Cardiology had to weigh the risks of holding anticoagulation against the patient's recent history of a pulmonary embolism (Cardiology Consult, 02/09/26).

The ICD-10-CM Official Guidelines for Coding and Reporting (Section II.C) clearly state: "When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided... any one of the diagnoses may be sequenced first."

Because both the BPH and the Eliquis-induced hemorrhagic disorder occasioned the admission and required active, concurrent

medical management, they equally meet the definition of principal diagnosis. The provider's selection of D68.32 as the principal diagnosis is fully compliant with UHDDS guidelines. The auditor cannot arbitrarily override a valid sequencing choice. We respectfully request that the original principal diagnosis of D68.32 and DRG 813 be reinstated.

APPEAL SUPPORT MAP

1. **Appeal claim:** The attending physician established that the gross hematuria was related to Eliquis use.
Source support: Query Response, 02/12/26, Dr. ("Gross Hematuria is possibly related to BPH, Bladder outlet obstruction, and Eliquis use").
Why it matters: Establishes the direct clinical link between the admission symptom and the billed principal diagnosis, validating the provider's coding.

2. **Appeal claim:** The hemorrhagic disorder required active and complex medical management, including specialist consultation.
Source support: Cardiology Consult, 02/09/26, Dr. / , APRN ("Hold Eliquis until further evaluation with a hematuria... Was on Eliquis 2.5 mg b.i.d. for recent history of PE in November 2025").
Why it matters: Demonstrates that managing the anticoagulant was a major focus of care and not merely a passive medication hold, proving that the coagulopathy equally met the definition of principal diagnosis.

3. **Appeal claim:** Under UHDDS guidelines, when two conditions equally meet the definition of principal diagnosis, either may be sequenced first.
Source support: ICD-10-CM Official Guidelines for Coding and Reporting, Section II.C.
Why it matters: Validates the provider's right to sequence D68.32 as the principal diagnosis over N40.1, directly refuting the auditor's rationale for the DRG downgrade.