

Risk Adjustment Documentation and Coding Best Practices: CKD

Overview

Chronic Kidney Disease. Our kidneys filter all the blood in the body, removing waste, toxins, and excess fluid. Chronic kidney disease (CKD), also called chronic kidney failure, describes gradual damage to the kidneys that results in their inability to function as well as healthy kidneys. As the kidneys cannot filter blood effectively, dangerous levels of fluid, electrolytes, and wastes can build up in the body. Untreated, CKD can lead to a number of complications and eventually progress to kidney failure, which requires dialysis or a kidney transplant to maintain life.

CKD is caused by slow damage to the kidney over a long period of time. **Diabetes mellitus** (DM) and **hypertension** (HTN) are the most common causes of the disorder, accounting for up to two-thirds of cases. Other causes include: glomerulonephritis, polycystic kidney disease, lupus and other autoimmune disorders, repeated urinary infections, or obstructions that can be a result of kidney stones, tumors, or an enlarged prostate.

Patients may not experience signs or symptoms until kidney function is significantly impaired. As early detection and treatment is key, blood and urine tests to detect CKD are recommended for high risk individuals, including those with diabetes, HTN, heart disease, obesity, or a family history of kidney failure. Once diagnosed, treatment focuses on slowing progression of the disease, usually by controlling the underlying cause.

Documentation Best Practices

Chronic Condition Coding

Chronic conditions that require ongoing care should be documented in the patient record and reported for the visit each time they require or affect patient treatment or management. A chronic, progressive disorder such as CKD would likely impact medical decision-making for all but the most minor of encounters.

Monitor, Evaluate, Assess, Treat (MEAT)

Any disease or disorder reported for a patient should be supported by documentation showing that the condition was monitored, evaluated, assessed or treated (MEAT) during the patient encounter. For CKD, evidence of MEAT might include:

Monitoring

- › Monitoring for signs and symptoms, such as:
 - ✓ Fatigue and weakness
 - ✓ Nausea, vomiting, and loss of appetite
 - ✓ Dry, itchy skin

Evaluation

- › Notation of physical findings, such as:
 - ✓ Edema in the legs, feet, or ankles
 - ✓ Difficult to control (resistant) HTN
- › Review of lab results with interpretation, such as:
 - ✓ Serum creatinine
 - ✓ Urine albumin
 - ✓ Glomerular filtration rate (GFR)

Assessment

- › Conclusions about the condition, such as:
 - ✓ CKD stage
 - ✓ Disease control
 - ✓ Medication effectiveness

Treatment

- › Medical management of key risk factors, such as:
 - ✓ HTN
 - ✓ Diabetes mellitus
- › Counseling and coordination of care, such as:
 - ✓ Adherence to prescribed treatment and health monitoring
 - ✓ Lifestyle recommendations to: get active, maintain a healthy weight, follow a low-sodium, heart-healthy diet, get adequate sleep, quit smoking, and avoid NSAIDs
 - ✓ Referrals to/notation of specialists involved in care, such as a nephrologist or dietitian

Risk Factors, Comorbidities & Complications

Document any contributory factors that can complicate kidney disease, such as smoking, as well as comorbidities, such as obesity and heart disease.

Potential complications of CKD include anemia, weakened bones, hyperkalemia, and early cardiovascular disease. When documenting complications, use language that identifies a relationship between the two conditions, such as:

- ◆ “Due to,” “caused by,” or “secondary to CKD”
- ◆ “xxx of CKD,” or “xxx in CKD”

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ICD-10-CM Diagnosis Codes

Chronic Kidney Disease ICD-10-CM Codes

N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.30	Chronic kidney disease, stage 3 unspecified
N18.31	Chronic kidney disease, stage 3a
N18.32	Chronic kidney disease, stage 3b
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5 <i>EXCLUDES 1</i> CKD 5 requiring dialysis (N18.6)
N18.6	End stage renal disease <i>Includes:</i> CKD requiring dialysis <i>Use additional code to identify dialysis status</i>
N18.9	Chronic kidney disease, unspecified <i>Includes:</i> Chronic renal disease, chronic renal failure, chronic renal insufficiency

Additional ICD-10-CM Codes

D63.1	Anemia in chronic kidney disease <i>Code first underlying CKD</i>
I12.0	Hypertensive CKD with stage 5 CKD or ESRD <i>Use additional code to identify CKD stage</i>
I12.9	Hypertensive CKD with stage 1-4 CKD, or unspecified CKD <i>Use additional code to identify CKD stage</i>
E11.22	Type 2 diabetes mellitus with diabetic CKD <i>Use additional code to identify CKD stage</i>
F17.2-	Tobacco dependence
N25.81	Secondary hyperparathyroidism of renal origin
Z72.0	Tobacco use
Z91.15	Noncompliance with renal dialysis
Z94.0	Kidney transplant status
Z99.2	Dependence on renal dialysis

Coding Guidance

Presumptive Relationship with HTN & Diabetes

ICD-10-CM coding rules presume a cause-and-effect relationship between HTN and CKD, as well as DM and CKD when:

- ✓ The conditions coexist, AND
- ✓ The documentation does not specify the conditions are unrelated

As a result, these conditions must be coded as related, even in the absence of provider documentation explicitly linking them.

- > *Ex. A - Patient is diagnosed with: 1. Diabetes, 2. HTN, 3. CKD stage 2, 4. Polycystic kidney disease*

Correct ICD-10 Coding:

- ♦ E11.22 - Type 2 DM with diabetic CKD
- ♦ I12.9 - Hypertensive CKD

- ♦ N18.2 - CKD stage 2
- ♦ Q61.3 - Polycystic kidney disease

- > *Ex. B - Patient is diagnosed with: 1. Diabetes, 2. HTN, 3. CKD stage 2 secondary to polycystic kidney disease, 4. Polycystic kidney disease*

Correct ICD-10 Coding:

- ♦ E11.9 - Type 2 DM
- ♦ I10 - HTN
- ♦ N18.2 - CKD stage 2
- ♦ Q61.3 - Polycystic kidney disease

GFR Requires Provider Interpretation

While the GFR is the best test to measure kidney function and determine CKD stage, coding rules prohibit the use of GFR to guide diagnosis code selection – code assignment is based on the provider's written diagnostic statement alone. Consequently, providers should include their interpretation of GFR value and document CKD stage explicitly.

- > *Ex. C - Patient is diagnosed with: CKD - controlled, GFR remains stable at 60*

Correct ICD-10 Coding:

- ♦ N18.9 - CKD unspecified

- > *Ex. D - Patient is diagnosed with: CKD stage 2 - controlled, GFR stable at 60*

Correct ICD-10 Coding:

- ♦ N18.2 - CKD stage 2

CKD Documentation Checklist

To ensure accurate reporting of CKD, the following should be included in the diagnostic statement:

- ✓ Underlying (causal) condition
***Use language that draws a relationship between CKD and the underlying disorder*
- ✓ If cause of CKD is unknown or under workup, document this
- ✓ CKD stage

References

2021 ICD-10-CM Expert for Physicians: The Complete Official Code Set, Optum360. 2020 Optum360, LLC

Centers for Disease Control and Prevention
<https://www.cdc.gov/kidneydisease/basics.html>

Mayo Clinic <https://www.mayoclinic.org/diseases-conditions/chronic-kidney-disease/symptoms-causes/syc-20354521>

National Institute of Diabetes and Digestive and Kidney Diseases
<https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd>

National Kidney Foundation
<https://www.kidney.org/atoz/content/about-chronic-kidney-disease>