Bright HealthCare™

Coding and Documentation Guide: Chronic Kidney Disease

Accurate coding and documentation are fundamental to the risk adjustment process and crucial to representing each patient's complex health profile. Bright HealthCare's coding and documentation guides equip coders and medical staff with the information needed to support complete and accurate coding and documentation.

Documentation best practices

- Documentation must be provided. Coders cannot assume diagnoses exist based on medication lists or physician orders.
- All conditions that coexist at the time of the encounter and require or affect patient care, treatment, or management should be documented and coded.
- Coders cannot code current conditions from problem lists, medical history, or superbills.
- Providers should document the underlying cause of chronic kidney disease (CKD) whenever possible (i.e., diabetes, hypertension, etc.).
- Coders must ensure clinical documentation for all diagnoses using the MEAT tool (monitor, evaluate, assess, treat). One or more MEAT detail is required for each condition requiring or affecting patient care.

Monitor	**Evaluate**	**Assess**	**Treat**
Signs Symptoms Disease progression Disease regression	Test results Medication effectiveness Response to treatment Physical exam findings	Test ordered Counseling Record review Discussion	Medication Therapies Referral Other modalities
MEAT Examples: Chronic Kidney Disease			
Chronic kidney disease, stage 2 – Controlled, GFR stable at 65. Continue to monitor.	Hypertensive chronic kidney disease, stage 3b – Edema in both legs. Blood pressure controlled on Lotensin.	Type 2 DM with diabetic CKD, stage 3a – Discussed the importance of adhering to healthy diet and good blood sugar control.	Chronic kidney disease, stage 4 – Following with nephrologist, Dr. X.

Coding and documentation examples

Case study #1: Complete documentation

Gender: F **DOB:** MM/DD/1959

History of present illness
61-year-old female with CKD stage 5, hypertension, low energy

Pt presents for general exam. Pt has stable CKD stage 5 and saw her nephrologist 2 days ago, who recommended more water intake and a low-protein diet. Pt reports being tired with decreased energy lately.

Reason for encounter is clearly documented.

Past medical history
Chronic kidney disease, stage 5
Hypertension
Obesity

Medications
Lisinopril HCTZ 20 – 12.5 mg BID – twice per day
Amlodipine besylate – 5 mg qAM – once per day

Past surgical history
Gastric bypass – no complications

Exam
General appearance: Well-developed, well-nourished, alert and cooperative.
Eyes: PERRL, EOMI. No conjunctival infection or drainage.
ENT: Hearing grossly intact. No nasal discharge. Oral cavity and pharynx normal.
Cardiac: Extremities and face appear well perfused. Radial pulse is regular.
Lungs: No audible coarse breath sounds or wheezing.
Abdomen: No guarding or discomfort with palpation.
No localized RLQ tenderness.
Musculoskeletal: Full ROM intact in spine and extremities.
Skin: Well-perfused. No rashes on face, trunk, or extremities.

Assessment & plan
Chronic kidney disease, stage 5 – Continue to follow with nephrologist. Discussed dietary changes and low-impact exercises like swimming pool aerobics.

Hypertension – Continue Lisinopril and amlodipine besylate. Ordered thyroid panel.

Assessment and plan clearly states patient has hypertensive chronic kidney disease, stage 5

Documentation includes MEAT details: f/u with specialist, discussion with patient, medication, and thyroid panel.

Documentation supports hypertensive chronic kidney disease, stage 5 (I12.0, N18.5).

Case study #2: Missed opportunity

Gender: F DOB: MM/DD/1961

History of present illness
58-year-old female who presents for a follow-up evaluation after hospital visit for uncontrolled hypertension. Most of her recent blood pressure readings have been stable, and she is currently only on amlodipine.

Past medical history
Hyperlipidemia
Chronic kidney disease
Hypertension
Obesity

Current outpatient medications
Amlodipine (NORVASC) 10 MG tablet, take 10 mg by mouth 1 (one) time each day

Lab results

Component	Value
CO2	19 (L)
CREATININE	3.00 (H)
EGFR	17 (L)
GLUCOSE	110 (H)
PHOSPHATE	4.7 (H)

Assessment & plan
Diagnosis:
Essential (primary) hypertension
Chronic kidney disease

Hypertension
Currently only on amlodipine
Continue to monitor blood pressure at home
Currently off beta-blocker and benazepril
We can add beta-blocker if needed

Chronic kidney disease
CKD labs

Note eGFR value of 17, a clinical indicator of severe CKD. Query provider for further clarification.

Provider does not document the stage or severity.

Documentation supports hypertensive chronic kidney disease, unspecified (I12.9, N18.9).

Coding for CKD and CKD comorbidities

Coding CKD severity

If documentation identifies CKD severity using "mild," "moderate," or "severe" instead of a stage, coders may assign the corresponding stage, using the crosswalk information below:

- Mild → stage 2
- Moderate → stage 3
- Severe → stage 4

Hypertensive CKD

Assign the appropriate code from category I12, hypertensive chronic kidney disease, when there is documentation of both hypertension and CKD. Exception: CKD should not be coded as hypertensive if the provider documents that the CKD is not related to the hypertension.

Example: Pt has stage 5 CKD and hypertension. Below is the correct coding for this patient's conditions:

I12.0	Hypertensive chronic kidney disease with stage 5 CKD or ESRD
N18.5	Chronic kidney disease, stage 5

Hypertensive heart disease and CKD

Assign the appropriate code from combination category I13, hypertensive heart and chronic kidney disease, when there is documentation of hypertension with both heart disease and CKD. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

Example: Pt has stage 3 CKD, hypertension, and heart failure. Below is the correct coding for this patient's conditions:

I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1–4 CKD (or unspecified CKD)
I50.9	Heart failure, unspecified
N18.3	Chronic kidney disease, stage 3 (moderate)

CKD with dependence on renal dialysis

Dependence on renal dialysis (Z99.2) should be documented and coded if applicable. This includes documentation of any of the following:

- Hemodialysis status
- Peritoneal dialysis status
- Presence of arteriovenous shunt (for dialysis)
- Renal dialysis status, not otherwise specified

Example: Pt has type 2 diabetic CKD with end-stage renal disease on dialysis. Below is the correct coding for this patient's conditions:

E11.22	Type 2 DM with diabetic CKD
N18.6	End-stage renal disease
Z99.2	Renal dialysis status

Diagnosis codes

Code first any associated:

- Diabetic chronic kidney disease (E08.22, E09.22, E10.22, E11.22, E13.22)
- Hypertensive chronic kidney disease (I12.x, I13.x)

Use additional code to identify kidney transplant status, if applicable (Z94.0).

Diagnosis	Code
Chronic kidney disease, stage 1	N18.1
Chronic kidney disease, stage 2 (mild)	N18.2
Chronic kidney disease, stage 3, unspecified (moderate)	N18.30*
Chronic kidney disease, stage 3a	N18.31*
Chronic kidney disease, stage 3b	N18.32*
Chronic kidney disease, stage 4 (severe)	N18.4**
Chronic kidney disease, stage 5	N18.5**
End-stage renal disease	N18.6**
Chronic kidney disease, unspecified	N18.9

*Risk adjusts in CMS-HCC model only.

**Risk adjusts in CMS-HCC model and HHS-HCC model.

Clinical indicators

Familiarity with CKD clinical indicators (i.e., testing, treatment, medication, etc.) is helpful in recognizing the potential presence and severity of a condition. **Coders cannot assign diagnosis codes based solely on test results and medication lists**, but these clinical indicators can help highlight opportunities for more complete and accurate documentation.

Common tests used to diagnose and monitor chronic kidney disease

Test	Used to measure
Blood work	Creatinine levels, albumin, BUN, electrolytes, GFR, calcium, complete blood count, magnesium, phosphorous, potassium, sodium
Urinalysis	Creatinine clearance, protein (albumin), albumin/creatinine ratio, protein/creatinine ratio, microalbumin

The following diagnostic tests are also used to check for the cause or type of CKD:

- CT scan of the abdomen
- MRI of the abdomen
- Ultrasound of the abdomen
- Kidney biopsy
- Kidney scan
- Kidney ultrasound

Glomerular filtration rate (GFR)

GFR is a measure of the kidney's function. It is a common test to measure the level and kidney function and determine the stage of kidney disease.

Stage	Description	GFR
Stage 1*	Normal kidney function	>90
Stage 2*	**Mild** loss of kidney function	60–89
Stage 3a	**Mild to moderate** loss of kidney function	45–59
Stage 3b	**Moderate to severe** loss of kidney function	30–44
Stage 4	**Severe** loss of kidney function	15–29
Stage 5	Kidney **failure**	<15
End-stage renal disease	Requires **dialysis** or **transplant**	<15

*Patients with stage 1 or 2 CKD (based on results of GFR) require additional evidence of kidney damage (protein in the urine for 3 months or more, ultrasound, or biopsy evidence of kidney disease) before a diagnosis of CKD can be made.