ICD-10 Documentation Training for Nephrology
Objectives

At the completion of this lesson the learner will be able to:

• Identify frequently utilized nephrology diagnoses and procedures
• Identify the ICD-10 changes associated with frequently utilized nephrology diagnoses and procedures
• Define documentation recommendations for each diagnosis and procedure
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ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Diagnostic and Procedure Documentation Overview

• While the actual number of pulmonology diagnoses and procedure codes has increased from ICD-9 to ICD-10
• The structure and function of coding has improved to better represent the diagnosis and acuity of patients with respiratory illness and procedures performed
• This training is not inclusive of every diagnosis and procedure but the major themes across renal documentation are included
Renal Documentation Themes

- Document location with as much specificity as possible
- Document organisms specific to infection
- Document the clinical findings/indicators to support the diagnosis documented
- Document related, secondary or causal illness whenever appropriate
- Recall the procedure code axes and ensure documentation required to support the required specificity
- Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an infrequently performed procedure
Section 1: ICD-10 Diagnostic Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Most Common Renal Diagnosis

This module is focused on the most frequently documented diagnoses that will have the greatest impact on the provider including:

- Hypertensive Renal Disease
- Urinary Tract Infections
- Infections of the Kidney
- Renal Failure and End Stage Renal Disease
- Renal Complications Secondary to Other Procedures
- Neoplasms
- Document severity
- Document specific location e.g. location of the calculi
- Document laterality when applicable
- Document underlying cause or indicate unknown etiology e.g. gout, sepsis
- Document any organism or infectious agent causing the problem e.g. E. coli
- Document any information regarding associated drug or toxic agent e.g. ARF due to post-op IV toradol
- Document signs and symptoms e.g. dysuria
- Document the stage of CKD
- Document if presence or absence of hematuria

Note: This training module is not intended to be an all-inclusive training tool to teach the provider every coding nuance within ICD-10
Complications with a procedure or a device requires the same specificity of documentation regardless of the initial cause or patient presentation:

1. Clearly defining the complication either of procedure or device
2. Identifying the complication as causal to the patient presentation
3. Clearly identifying if this was an expected or unexpected outcome
Hypertension

- Hypertension has become streamlined with ICD-10
- There is no longer a distinction or documentation requirement for “malignant”, “benign”, or the catch all “not otherwise specified”
- While descriptors are still found in some clinical settings, ICD-10 has structured hypertension to be:

**Hypertension Categories**

**Essential HTN**
- R/T Pregnancy and Childbirth are separate categories
- Eye, Brain, Pulmonary are specific dx sets

**Hypertensive Heart Disease**
- Document the presence of heart failure when appropriate
- Document the type and acuity of heart failure

**Hypertensive Chronic Kidney Disease**
- Document Stage of Kidney Disease
- Diagnoses codes are divided by Stage 1-4

**Secondary HTN**
- Document the primary cause:
  - Renovascular HTN
  - Secondary to other renal disorders
  - Secondary to endocrine disorders
  - Other secondary

**Hypertensive Heart and Chronic Kidney Disease**
- Document the presence of heart failure
- Type and acuity of the heart failure
- Document the stage of kidney Disease by stage 1-4
## Hypertension

<table>
<thead>
<tr>
<th>ICD-10 Category</th>
<th>Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential HTN</td>
<td>• This does not include HTN associated with pregnancy, childbirth</td>
</tr>
<tr>
<td></td>
<td>• Vessels of the eye and brain and pulmonary HTN are all individual</td>
</tr>
<tr>
<td></td>
<td>• Document symptoms related to HTN</td>
</tr>
<tr>
<td>Hypertensive Heart Disease</td>
<td>• Document the presence of heart failure when appropriate</td>
</tr>
<tr>
<td>Hypertensive Chronic Kidney</td>
<td>• Document stage of kidney disease, diagnosis is divided by Stage 1-4 and Stage 5</td>
</tr>
<tr>
<td>Disease</td>
<td></td>
</tr>
<tr>
<td>Hypertensive Heart and Chronic</td>
<td>• Document the presence of heart failure when appropriate</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>• Document the stage of renal disease</td>
</tr>
<tr>
<td>Secondary HTN</td>
<td>• Document the primary condition</td>
</tr>
<tr>
<td></td>
<td>• ICD-10 sub-categories include:</td>
</tr>
<tr>
<td></td>
<td>• Renovascular HTN</td>
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<tr>
<td></td>
<td>• Secondary to other renal disorders</td>
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<tr>
<td></td>
<td>• Secondary to endocrine disorders</td>
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<tr>
<td></td>
<td>• Other secondary HTN</td>
</tr>
</tbody>
</table>
Infections of the Kidney and Urinary Tract

When documenting infections remember to document the following:

1. Identify if the problem is chronic or acute
2. Identify the presence of hematuria
3. Identify the causal organism (Candidiasis, streptococcus, staphylococcus, MRSA)
4. Document the site
5. Document if any urethritis
6. Document when hydronephrosis is accompanied by a ureteral stricture, calculus obstruction, etc.
7. Document cystitis as being acute, chronic obstructive, interstitial, trigonitis, irradiation, etc.

Example: Acute cystitis with hematuria with presence of MRSA
Documenting Renal Insufficiency and Renal Calculi

• Renal Insufficiency
  – Be aware using the term “renal insufficiency” may result in query
  – Avoid using the terms “renal insufficiency” and “renal failure” interchangeably
  – Document specific condition that describes the clinical picture e.g. acute tubular necrosis
  – Document the underlying cause or disease (dehydration, post traumatic, drug induced, etc.

• Renal Calculi (kidney stones):
  • Document specific location of the calculi e.g. bladder, urethra
  • Document if accompanied by hydronephrosis or obstruction
  • Document any signs and symptoms e.g. dysuria
  • Document the underlying cause or indicate unknown etiology e.g. gout
  • Differentiate between congenital and acquired
# Acute Renal Failure and Chronic Renal Disease

## Acute Renal Failure
1. Identify Underlying or causal condition
2. Identify if presence of necrosis, tubular, acute cortical, medullary,
3. Document if hemodialysis is required

**NOTE:** Post-traumatic renal failure is coded independently. If trauma is the cause of ARF, please clearly indicate the event and the correlation

## Chronic Kidney Disease
1. Identify if CKD is diabetes or hypertension related
2. Specify Stage of CKD
   - Stage 1-5
3. Indicate if Stage 5 or End Stage CKD is hemodialysis is required

**NOTE:** If patient is a transplant candidate, please indicate status

## Stages of Chronic Kidney Disease
- **Stage I** (protein in urine) - No decrease in GFR (>90)
- **Stage II** (mild) - Mild decrease in GFR (60-89)
- **Stage III** (moderate) - Moderate decrease in GFR (30-59)
- **Stage IV** (severe) - Severe decrease in GFR (15-29)
- **Stage V** (failure) - Kidney failure with GFR (<15)
Renal Complications Secondary to Other Causes or Procedures

When renal complications are a direct effect of other causes or procedures it is important to note:

1. Acute vs. Chronic
2. Document the causal factor
3. Document a clear link between the causal factor and the resulting kidney dysfunction

Examples:
- Acute kidney failure secondary to blunt force trauma to abdomen
- Severe hypertensive chronic kidney disease
Neoplasms

Neoplasms will be defined location and behavior - Location specificity should include:

- Laterality
- Specificity
- Any overlapping sites
- Document site, state morphology e.g. benign, in situ, malignant, uncertain behavior, document the stage and any metastatic sites.
- Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
- Reason for the patient’s current admission/encounter, or when the patient is admitted for a specific treatment related to the neoplasm, e.g. chemo, surgical removal, radiation therapy

Examples:

- Malignant neoplasm of overlapping sites of urinary organs- Overlapping
- Malignant neoplasm of left kidney, except renal pelvis- specificity
- Malignant neoplasm of left renal pelvis- laterality
Neoplasms

Primary vs. Metastatic Sites
Coding for treatment of primary sites differs from that of treatment directed at secondary or other sites
• Document primary site
• Document malignancies
• Identification of direction of treatment

Documenting Histology of Neoplasms
• The documentation of a specific histology helps to direct coding of neoplasm diagnosis
• Document that a neoplasm cannot be determined after histology study to be Malignant, benign, or uncertain behavior.
• Clinical information by acknowledging the cytology, pathology or histology findings in the notes
• When histology is known, document clearly
• Neoplasm complication:
• These are conditions that complicates the neoplasm, they are either adverse reaction to neoplastic treatment or the progression of neoplastic disease e.g. neoplastic anemia, pathological fracture due to a neoplastic process, vomiting secondary to chemo.
• Clearly document the reason for the encounter, the conditions that requires treatment e.g. dehydration, anemia
• Specify any drug causing adverse effects and the adverse effects of treatments e.g. anemia secondary to anemia
Section 2: ICD-10 Procedure Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Review of ICD-10 Procedure Code Structure

ICD-10 Procedure documentation: More granular and precise

Focus for Providers: Understand concepts coders capture rather than memorize every detail

- Procedure documentation can be thought of on multiple axes
- Each axis captures an increased amount of provider documentation in respect to the service or procedure provided
Axis 1: Starting point for coding procedures.

Provides the coder with the initial criteria to class information and narrows available codes.

Pulmonology procedures are located in all of these highlighted sections.

Examples include:

Medical and Surgical—Renal Biopsy
Extracorporeal Assistance and Performance—Hemodialysis Placement—Vas cath, HD Cath placement

<table>
<thead>
<tr>
<th>Medical and Surgical</th>
<th>Chiropractic</th>
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<tbody>
<tr>
<td>Obstetrics</td>
<td>Imaging</td>
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<td>Placement</td>
<td>Nuclear Medicine</td>
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<td>Administration</td>
<td>Radiation Oncology</td>
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<td>Measurement and Monitoring</td>
<td>Physical Rehabilitation and Diagnostic</td>
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<td>Extracorporeal Assistance and Performance</td>
<td>Audiology</td>
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<tr>
<td>Extracorporeal Therapies</td>
<td>Mental Health</td>
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<tr>
<td>Osteopathic</td>
<td>Substance Abuse Treatment</td>
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<tr>
<td>Other Procedures</td>
<td></td>
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</table>
**Axis 2: Body System**

**Body System** is the next axis for understand ICD-10 coding. As the Axes increase so does the specificity of documentation AND coding.

Depending on the section identified the axis may be:

- Body System
- Physiologic System
- Anatomic Region

**Examples of Axis 2:**
- Heart and Great Vessels
- Upper Veins
- Lower Veins
- Upper Arteries
- Lower Arteries
- Central Nervous System
- Upper Extremities
- Lower Extremities
Axis 3: Root Operation

Root Operation determines the purpose of a procedure. There are 31 specific types of root operations that are in 9 groups:

1. Procedures that take out some or all of a **body part**
2. Procedures that take out **solids/fluids/gases** from a body part
3. Procedures involving **cutting or separating** only
4. Procedures that **put in/put back** or **move** some/all of a body part
5. Procedures that **alter the diameter/route of a tubular body part** - can be performed only on tubular body parts
6. Procedures that always involve a **device**
7. Procedures involving **examination only**
8. Procedures that **define other repairs**
9. Procedures that **define other objectives**
Axis 3: Root Operation

Renal Examples of Axis 3-Root Operation:
• Transplantation—kidney transplant
• Extirpation—removal of AV fistula hematoma
• Dilation—Renal vessel stent placement

Documenting for Axis 3:
• Don’t attempt to memorize the coding verbiage for each root operation
• Ensure that documentation of the procedure has a clear objective/purpose
• Ensure that one of the 9 groupings of operations can be identified
Axis 4: Body Part

Axis 4: Very specific and detailed procedure dictates the specificity of documentation:

- A body part
- Some of a body part
- Area around a body part
- In or On a body Part
- Conduction mechanism
  (brain or heart)

Respiratory Examples of Axis 4:

- Bilateral Kidney
- Right Kidney
- Renal Tubule
- Renal Cortex
- Glomerulus

INCREASING SPECIFICITY
Axis 4: Body Part

Documenting for Axis 4:

- Be as specific as the body part and procedure allow
- If there is laterality capture right, left or bilateral
- If there is distance capture proximal and distal
- Multiple procedures in the same organ or vessel need to have clear documentation
Axis 5: Approach

Axis 5: Defined based on access location, method and types of instrumentation used:

- **Open**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site
- **Percutaneous**—Entry, by puncture or incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach procedure site
- **Percutaneous endoscopic**—Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach and visualize procedure site
- **Via natural or artificial opening**—Entry of instrumentation through natural or artificial external opening to reach procedure site
- **Via natural or artificial opening endoscopic**—Entry of instrumentation through natural or artificial external opening to reach and visualize procedure site
- **Open with percutaneous endoscopic assistance**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site, and entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to aid in performance of the procedure.
- **External**—Procedures performed directly on skin or mucous membrane and procedures performed indirectly by application of external force through skin or mucous membrane
Axis 6: Devices left in place at the completion of a procedure require a code.

Examples include:

- Endotrachial Tube
- Radioactive Element
- Vas Cath

Important Note:

When a catheter is placed specifically for the use of hemodialysis, it must be reflected in documentation:

Vascular catheter placed in right subclavian for HD
**Axis 7: Qualifier**

**Axis 7:** Defines “qualifier” or an additional attribute of the procedure when appropriate.

- Not all procedure codes require qualifiers
- Data adds specific, clarifying information that is not contained in another axis

**Examples of Renal Qualifiers:**

- Access type for hemodialysis
- Procedures including biopsy for diagnostic purposes
New Concepts for Mechanical Ventilation in ICD-10:

1. Respiratory Assistance vs. Respiratory Performance
   - Assistance is respiratory support delivered via mask or non-invasive device (CPAP, BiPAP)
   - Performance is respiratory support delivered via invasive ETT device (nasal, oral, trach)

2. Duration of Ventilator support
   - less than 24 hours
   - 24-96 hours
   - more than 96 hours

3. Capture of detail of support
   - Continuous Positive Airway Pressure
   - Intermittent Positive Airway Pressure
   - Continuous Negative Airway Pressure
   - Intermittent Negative Airway Pressure

Respiratory Arrest:
- Is not a diagnosis
- Is a clinical finding for which a more definitive diagnosis should be determined
- Is appropriate to describe an initial finding
Blood Transfusions

The single data point captured in ICD-9 for blood transfusion was the occurrence of the transfusion. With ICD-10 there are multiple data points that will be captured:

1. Type of cells transfused (RBC or Frozen RBC)
2. Document location or infusion site (Peripheral artery, Peripheral vein, Central Vein, Central Artery)
3. Document the approach
4. Specify if Autologous or non-Autologous

Important Note:
The receipt of transfusions has to be acknowledged by the provider
Dialysis

- Document if hemodialysis or peritoneal
- Document if therapy performed in single or multiple visits
- Dialysis catheter insertion
- Document anatomic specificity, site and laterality
- Document approach
- Dialysis shunt creation
- Document the body system e.g. upper or lower arteries, below or above diaphragm
- Document specific artery and laterality
- Document approach
- Document the anastomosis site when created in the upper arteries
- Document if any device used
- Document if hemodialysis was performed
- Nephrectomy
- Document if partial or complete
- Document laterality left, right or both
- Document approach
While the actual number of renal diagnosis and procedure codes has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis and acuity of renal patients and procedures performed.

This training is not inclusive of every diagnosis and procedure but highlights the following themes across renal documentation:

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