IMPORTANT INFORMATION FOR DOCUMENTING NEPHROLOGY:

- Location and laterality
- Indicate related, secondary, or causal illness
- Document comorbidities that will impact the patient’s condition even when not the primary problem
- Social factors that influence diagnoses – BMI, tobacco use/dependence/past history or exposure (secondhand, occupational, etc.), non-compliance with treatment regimen including over/underdosing, and any corresponding diagnosis
- Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis

Diagnoses

URETER AND URETHRAL STRICTURE
- Specify any Hydronephrosis/ Vesicoureteral Reflux/ Hydroureter/ Pyelonephritis
- Clarify urethral strictures as being congenital/post-procedural/post-traumatic/post-infective
- Location of a male urethral stricture
- Report cause of female urethral stricture
- Clarify obstruction versus stricture
- State laterality
- Clarify underlying cause or state “unknown etiology”
- Specify the location of calculi

KIDNEY STONES
- Specify the location of calculi (bladder/urethra)
- Clarify underlying cause or state “unknown etiology”
- Complications associated with kidney stones
- Differentiate between acquired and congenital

URINARY TRACT INFECTION
- Detail the site and infectious agent or hematuria
- Report cystitis as being acute/chronic obstructive/interstitial/trigonitis/irradiation/or other form
- Identify Pyelonephritis as being acute/chronic/obstructive and reflux uropathy/or drug and heavy metal induced
- Indicate when Hydronephrosis is accompanied by a ureteral stricture/calculus obstruction/reflux nephropathy/or Hydroureter
- List any urethritis

CHRONIC KIDNEY DISEASE (CKD) AND END STAGE RENAL DISEASE (ESRD)
- Specify the stages. Based on the Glomerular Filtration Rate (GFR), CKD has been categorized into five stages:
  » CKD, Stage 1
  » CKD, Stage 2 (Mild)
  » CKD, Stage 3 (Moderate)
  » CKD, Stage 4 (Severe)
  » CKD, Stage 5
- End Stage Renal Disease
- Specify dialysis status
- Associated conditions-diabetes/hypertension/anemia/kidney transplant complications
- Report kidney transplant status

RENAL FAILURE
- Chronicity (chronic/acute)
- Avoid using the terms Renal Insufficiency and Renal Failure interchangeably
- Detail type of necrosis with acute renal failure-tabular/cortical/medullary
- Identify the underlying cause or associated conditions (diabetes/hypertension)

HYPERTENSION
- Identify hypertension as Essential/ Secondary
- Hypertensive Chronic Kidney Disease
  » List the stages of Kidney Disease
- Hypertensive Heart and Chronic Kidney Disease
  » Specify the presence of heart failure, the type and acuity of the heart failure
  » List the stages of Kidney Disease
- Secondary HTN
  » Specify the primary cause

CONGENITAL CYSTIC KIDNEY DISEASE
- Delineate between congenital vs. acquired kidney cysts
- Type of polycystic kidney disease – adult or infantile
- Specify the presence of one or multiple cysts
- Identify any other complications

DOCUMENTING COMPLICATIONS
Complications with a procedure or a device require the same specificity of documentation regardless of the initial cause or patient presentation:
- Document if the complication is either of procedure or device
- Identify the complication as causal to the patient presentation
- Clearly identify if this was an expected or unexpected outcome
- It is important to note that not all conditions that occur during, following medical care or surgical are classified as complications. There must be a cause-and-effect relationship between the care provided, the condition and an indication in the documentation that it is a “complication.”

DIABETES MELLITUS
- Type: (Type 1, Type 2, due to drugs or chemicals, due to underlying condition)
- Body system complications related to diabetes (kidney/neuropathy/etc.)
- Document use of insulin, if applicable
  » If insulin overdosing or underdosing, document if it is related to insulin pump malfunction
• In drug and chemical-induced diabetes, document drug and drug poisoning
• The terms Uncontrolled and Controlled are no longer acceptable. Now classification is Inadequate Control, Out Of Control, and Poorly Controlled Diabetes Mellitus By Type With Hyperglycemia.

SEPSIS
Sepsis documentation requires the documentation of:
1. **Designation of Sepsis** –
   » Identify cause of infection or causal organism
2. **Severe Sepsis** –
   » Identify cause or causal organism
   » Identify acute organ dysfunction
3. **Septic Shock** –
   » Identify cause or causal organism
   » Identify circulatory failure
   » Identify any additional acute organ dysfunction
4. **Do not document Urosepsis, as this is not a condition in ICD-10 CM**

NOTE: If a causal organism cannot be identified, a clear picture of clinical evidence of sepsis must be documented

SEPSIS/SYSTEMIC INFLAMMATORY RESPONSE SYNDROME (SIRS)
- Any non-infectious process that results in septic shock—trauma, burn, post-procedural—the connection between the event and shock must be very clearly documented

ANEMIA
- Type – aplastic/blood loss/hemolytic
- Chronicity – acute/chronic
- If hemolytic, specify as acquired, hereditary, enzyme disorder, auto-immune, non-autoimmune
- If nutritional, specify vitamin/mineral deficiencies
- Underlying cause – ulcer, chemotherapy, CKD
- List medications causing anemia
- Link lab findings to a related diagnosis
- Document blood transfusion

BLOOD LOSS ANEMIA
- Chronicity – acute/chronic
- Underlying cause – trauma/surgery
- Etiology when anemia is identified in the post-operative
- When related to surgical procedure, document if the blood loss was an expected outcome

PAIN
- Location of the pain-RUQ/RLQ/LUQ/LLQ/periumbilical/pelvic and perineal/epigastic/chest
- Chronicity (acute/chronic)
- Specify the etiology

HEMaturIA
- Specify if gross/microscopic/intermittent/idiopathic/persistent
- Cause-medication/stones/infection/cancer/trauma/blockage
- Link lab findings to a related diagnosis

PROTEINURIA
- Specify the cause
- Link lab findings to a related diagnosis

DOCUMENTING UNDERDOSING
- Specify situation when the medication taken is less than prescribed dose and the reason
- Specify the condition, the underdosing and the reason for not taking the medication

Procedures

INTERVENTION DOCUMENTATION
Themes across general surgery intervention documentation include:
- Recall the procedure code Axis and ensure documentation is present to support specificity
- Document location and laterality with as much specificity as possible
- Document related, secondary or causal illness whenever appropriate

GENERAL INFORMATION
ICD-10-PCS procedure codes are seven characters in length with each of the seven characters representing an aspect of the procedure. The list below illustrates the seven characters of a code.
- **Character 1: Section** – Type of procedure
- **Character 2: Body System** - Anatomical regions
- **Character 3: Root Operation** - Objective of the procedure
- **Character 4: Body Part** - Specific body part
- **Character 5: Approach** - Operative approach
- **Character 6: Device** - The device remains after a completed procedure
- **Character 7: Qualifier** - Additional attribute information

NEPHRECTOMY
- Specify whether partial or complete
- Specify laterality and approach

BIOPSY
- Document location, laterality and the approach

BLOOD TRANSFUSIONS
- Type of cell transfused(RBC/Frozen RBC)
- Location of infusion site(peripheral/central venous catheter)
- Autologous or non-autologous
- The receipt of transfusions has to be acknowledged by the provider. It is no longer acceptable to just code from the blood administration record.

MECHANICAL VENTILATION
- Respiratory Assistance (extracorporeal) vs. Respiratory Performance
  » Assistance is respiratory support delivered via mask or non-invasive device (CPAP/ BiPAP/CNP/IPPB)
  » Performance is respiratory support delivered via invasive ETT device (nasal, oral, trach)
- Support type  – CPAP/IPAP/CNAP
- Duration of the support provided
  » Less than 24 hours
  » 24-96 hours
  » More than 96 hours