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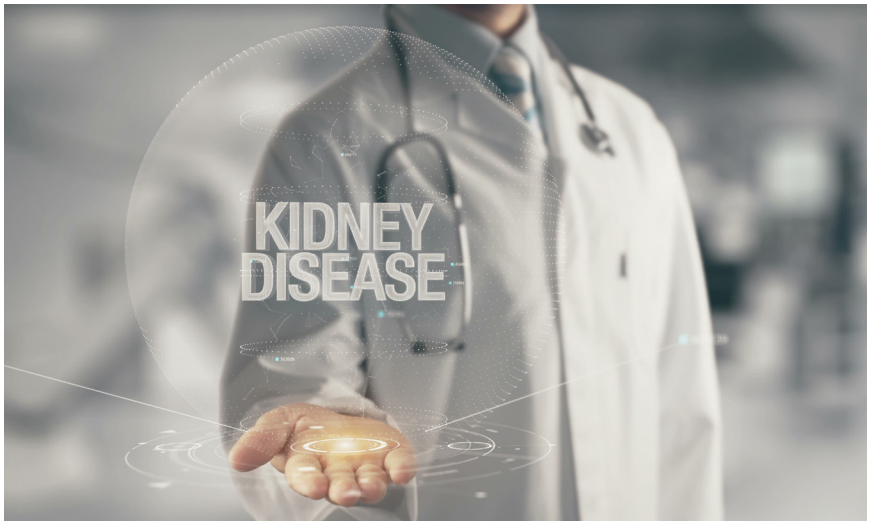
Solving the inpatient conundrum of coding for acute kidney diseases



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by Jennifer Cayce, RHIT, CCS, CCS-P, CPC, AHIMA-approved ICD-10-CM/PCS trainer

As with many diagnoses in the inpatient setting, acute kidney disorders can be confusing for coders to report due to multiple abbreviations and varying clinical criteria. Although the ICD-10-CM codes for the genitourinary system may seem straightforward, they don't always line up precisely with the provider's documentation in the medical record.

In this article, we will explore this coding conundrum and address some of the problematic areas of nephrology coding. We will focus on acute conditions, as chronic kidney disease presents some very different coding challenges.

Some of the commonly coded conditions that we will discuss are acute renal failure, acute renal insufficiency, acute kidney injury, and acute kidney infection. Difficulties involving these conditions that coders often encounter include:

- Alphabet soup: Common renal disease abbreviations have multiple meanings, each of which result in a different code. And conversely, several renal conditions with differing abbreviations are all reported with the same code.
- Clinical documentation red flags: The clinical criteria for a condition may not correlate to the condition documented in the record.
- Variety of ICD-10-CM codes: The coding classification requires careful attention to details such as chronicity and severity levels, instructional notes, additional codes, and causal relationships.

Alphabet soup

In medical record documentation, coders may see various abbreviations used for kidney disease, and too often, the terms are not spelled out elsewhere in the record. This makes it difficult for coders to confirm the meaning of the abbreviation.

Two common abbreviations are AKI and ARF. Coders should be cautious of these as each may have more than one meaning. It can be tricky to determine if the "AKI" in the record refers to acute kidney injury, acute kidney insufficiency, or acute kidney infection. The coder must search for clues within the record to be sure which condition the provider is documenting.

Coders must also be very careful not to confuse ARF, as it could pertain to acute **renal** failure or acute **respiratory** failure. When in doubt, coders should always query the provider.

In another example, providers utilize AKI, AKF, and ARF as abbreviations for acute kidney injury, acute kidney failure, and acute renal failure, respectively, which for coding purposes all mean the same thing. All three of these abbreviations lead to the same ICD-10-CM code: N17.9 (acute kidney failure, unspecified).

Occasionally these abbreviations can be interpreted incorrectly by the coder. To avoid this, careful reading of the documentation is the key. Look for supportive clinical information to be sure the provider is referring to a renal condition versus a respiratory condition, for example, or to an infection versus insufficiency. Coders should review lab values, treatment plans, and notes by consultants, which can point to the correct diagnosis.

Clinical documentation red flags

To further explore this coding conundrum, coders need to review the clinical criteria the providers use to diagnose renal conditions. Various sets of criteria exist to identify kidney disease, which makes it especially confusing to define. Acute kidney injury, for example, may be defined slightly differently in each of the following recognized classifications:

- RIFLE (Risk of renal dysfunction, Injury to kidney, Failure or Loss of kidney function, and End-

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stage kidney disease)
- AKIN (Acute Kidney Injury Network stage)
- KDIGO (Kidney Disease: Improving Global Outcomes group)

Although coders should never assign diagnosis codes based upon lab values alone, they should be knowledgeable about certain documentation red flags that signal them to refer appropriate cases to a CDI specialist or query the provider themselves. It may also be helpful to know which set of criteria the physicians are using.

Coders should also have a strong understanding of disease processes. The more familiar the coder is with signs, symptoms, and treatment of kidney conditions, the less likely they will be led astray by abbreviation "alphabet soup."

Acute kidney infection and acute kidney injury, both abbreviated with AKI, are good examples of conditions the coder should be able to distinguish by understanding their clinical presentation. In general, acute kidney infection is defined as a bacterial infection affecting the kidney. This is a sudden and potentially severe infection also called pyelonephritis. Meanwhile, acute kidney injury is defined as sudden and acute kidney failure or damage caused by a sudden event such as dehydration, blood loss from surgery, or an injury, leading to a buildup of waste products in the blood.

Again, the terms "acute kidney injury," "acute kidney failure," and "acute renal failure" may be used interchangeably by providers. According to the report Acute Kidney Injury: A Guide to Diagnosis and Management, you may see the following provider documentation related to typical clinical criteria or interventions associated with these diagnoses:

- Increase in serum creatinine level and reduced urine output
- Since causes of acute kidney injury may include dehydration and volume depletion, the provider may maintain the fluid balance with normal saline
- Diuretics may be given if the cause is volume overload
- Decreased arterial pressure from heart failure and sepsis may reduce the glomerular filtration rate (rate of blood moving through the glomeruli each minute—this varies by age, gender, and body size)
- Renal ultrasound may be performed to rule out obstruction
- Medications may be documented as the cause of acute kidney injury
- The acute kidney injury/failure may be related to a patient's chronic kidney disease, which would be coded in addition to the acute code

Variety of ICD-10-CM codes

The coding classification itself can be difficult to follow if you're not paying close attention. This table demonstrates how the documentation will lead the coder in the ICD-10-CM Index, depending on specific terminology and condition:

AKI Acute kidney insufficiency	**ARI Acute renal insufficiency**	**AKI Acute kidney injury**	**AKI Acute kidney infection**
Insufficiency Kidney, N28.9 Acute, N28.9	Insufficiency Renal (acute), N28.9	Injury Kidney Acute (nontraumatic), N17.9 [Specific codes are available for a traumatic injury based on whether the injury is a contusion or laceration]	Infection Kidney (cortex) (hematogenous) N15.9 [No descriptor for "acute"]

Based on the variety of codes available, the coder needs to review the documentation thoroughly to be sure the appropriate code is chosen. The coder also needs to be aware of Excludes1 and Excludes2 notes attached to these codes in the ICD-10-CM classification.

With kidney infections, an additional code may be needed to report the infecting organism. Combination codes are also available to include some urinary symptoms associated with the infection.

As a reminder, ICD-10-CM assumes a causal relationship between hypertension and chronic kidney disease only. This cause-and-effect relationship does not pertain to acute kidney diseases.

Simplifying the process

Clearly, there is an abundance of information that a coder needs to remember when coding kidney conditions.

Assigning accurate ICD-10-CM codes requires checking and double-checking the documentation, abbreviations, and clinical indicators.

A recommendation for coding departments is to define the flags that help the coder identify certain documentation and clinical mismatches. Examples include:

- A documented condition may not appear to be clearly supported by clinical criteria
- An associated condition such as dehydration and volume depletion or a medication may be responsible for an isolated abnormal lab value rather than a confirmed renal condition
- Supportive clinical criteria may be present, but a corresponding condition is not mentioned

Coders should be guided by facility policies to forward such cases to a CDI specialist for review or to query the provider, as appropriate. Only the provider can appropriately apply clinical criteria and arrive at a final diagnosis.

EDITOR'S NOTE:

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