Documentation Tips – Nephrologists

Principal Diagnoses (PDx):

- PDx is the condition(s) after careful study, present on admission (POA), requiring admission and treatment. Need to confirm even after resolved (i.e., *"Acute Renal Failure POA, resolved")*
- Explain underlying etiology where possible (i.e., *"Acute renal failure due to rhabdomyolysis"*)

Secondary Diagnoses (CCs/MCCs):

- Include *all* diagnoses which are treated and/or monitored
- Identify as "present on admission if appropriate
- Utilize subspecialty/surgical consults when needed to improve specificity of all diagnoses
- Consider documenting a diagnosis any time you do something to a patient *("Dialysis catheter placement due to acute oliguric renal failure")*

Pearls for Nephrologist Documentation:

- Describe "Clinical Impression" (e.g. thought process)
  - Diagnoses are commonly not "certain"
  - Use words like *probable, likely, suspect*, etc.
- **Heart Failure** ("CHF" no longer adds to severity)
  - *Chronic* systolic, diastolic (or combined) failure adds severity as a comorbidity (CC)
  - *Acute* systolic, diastolic (or combined) failure adds severity as a *major* comorbidity (MCC)
- **Sepsis** = SIRS + infection (as the cause) – an MCC
  - Positive blood cultures not necessary
  - *Not* synonymous with "bacteremia"
  - "Urosepsis" = UTI (to a hospital coder) – must document "*Sepsis (or SIRS) due to UTI*"
- **Acute Renal Failure/Acute Kidney Injury** (AKI) – a CC
  - AKI criteria - ↑ in Cr by 0.3-0.5 above normal baseline = *St 1 AKI,* also a CC
  - Acute Renal *Insufficiency*, pre-renal azotemia, dehydration, etc = *low severity*

- ARnF(AKI) with ATN (acute tubular necrosis) remains an MCC

- **Chronic Kidney Disease** (CKD) – *must* identify stage
  - Stage 4 (GFR<30) and stage 5 (GFR<15) = CC
  - Chronic Renal Insufficiency (CRI) = *low severity*
- **Noncompliance with dialysis**
  - Document if CHF present in addition to just "fluid overload"
  - Document "non-cardiogenic pulmonary edema" if appropriate
  - List specific reason for emergent/urgent HD, e.g. fluid overload/CHF, acidemia, etc.
- **Kidney Transplants**
  - Remember to identify both chronic kidney disease (CKD) and acute renal failure/AKI s/p transplant
  - Specifically identify "transplant rejection" if present, even if presumed
- **Acute Respiratory Failure** – an MCC
  - Clinical diagnosis, no need for ETT/mechanical ventilation
  - Respiratory distress = *low severity*
  - Pulmonary insufficiency (except post-op) = *low severity*
- **Encephalopathy** – an MCC
  - *"Encephalopathy due to profound azotemia"*
  - "Delirium" is not a CC unless specified as a certain type. Altered MS is a *symptom* – not even a CC
- ***Severe* Malnutrition** (MCC)
  - Malnutrition or cachexia = CC
  - Emaciation is also an MCC
- **Symbols**
  - ↑K^+ ≠ hyperkalemia (to a coder)
  - ↑Cr ≠ acute renal failure