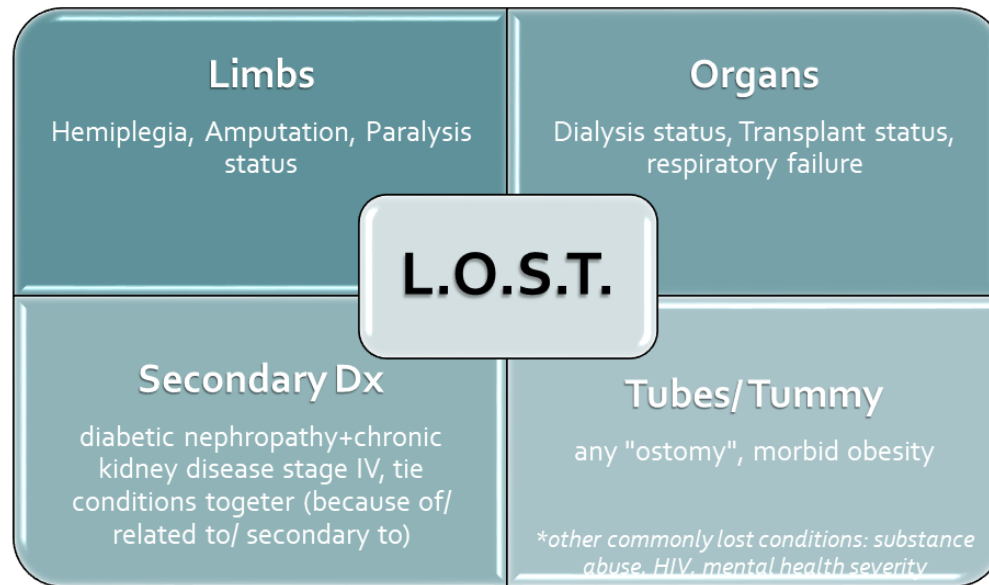
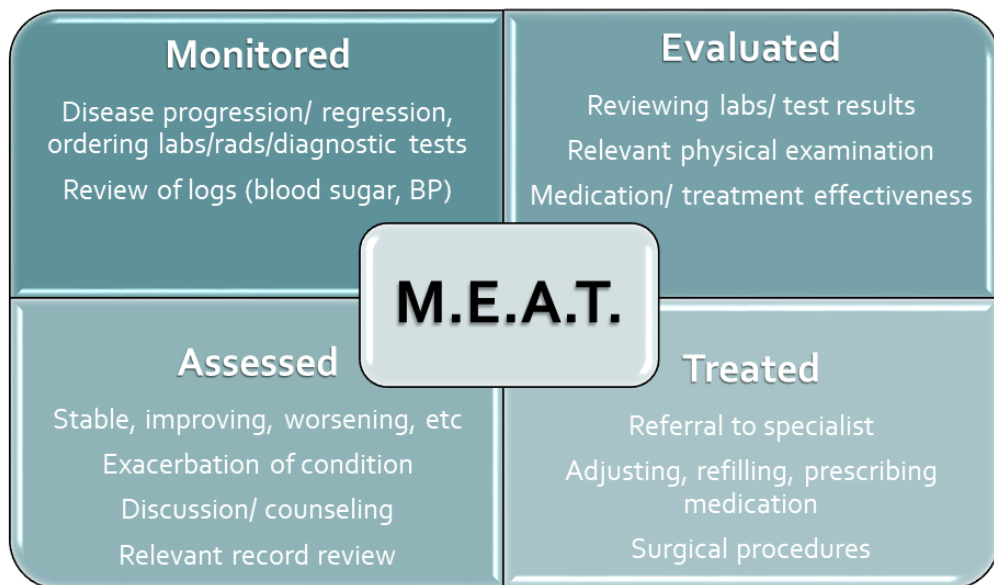


Nephrology Codes

DIAGNOSES	ICD-10 Code Root	Sub Codes	Hierarchical Condition Category (HCC)
Diabetes with Complications (Type 1 or 2)	Type 1: E10.X	E10.21-E10.638, E10.649-E10.8	Diabetes with Chronic Complications
	Type 2: E11.X	E11.21-E11.638, E11.649-E11.8	
Chronic Kidney Disease (Stage 3)	N18.X	N18.3	Chronic Kidney Disease, moderate (Stage 3)
Chronic Kidney Disease (Stage 4)	N18.X	N18.4	Chronic Kidney Disease, Severe (Stage 4)
Chronic Kidney Disease (5 and End Stage)	N18.X	N18.5-N18.6	Chronic Kidney Disease (Stage 5)
Hypertensive chronic kidney disease stage 5 or end stage renal disease	I12.0	-	
Acute Kidney Failure	N17.X	N17.0-N17.2, N17.8-N17.9	Acute Kidney Failure
Complications with Dialysis Access	T82.X	T82.0-.9XXS	Complication of Specified Implanted Device or Graft
Hypertensive chronic kidney disease with stage 1 - 4	I12.9	-	Vascular Disease with Complications
CHF and Cardiac Renal Syndrome	I13.X	I13.0, I13.2	
Ischemia and Infarction of Kidney	N28.0	-	
Arteritis	I77.6	-	Vascular Disease
Dialysis Status	Z99.2	-	Dialysis Status
Dialysis Complications	T8X	T81.: 502, 512, 522, 532, 592 T82.: 41X, 42X, 43X, 49X T85.: 611, 621, 631, 691, 71X	
Wegener's Granulomatosis	M31.3X	M31.30-M31.31	
Lupus	M32.X	M32.0-M32.9	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
Anemia	D61.X	D61.1-D61.3, D61.82, D61.9	Severe Hematological Disorders
Hyperaldosteronism	E26.X	E26.01-E26.9	Other Significant Endocrine and Metabolic Disorders
Hyperparathyroidism	E21.X	E21.0-E21.5	
Chronic Kidney Disease (Stage 1 & 2)	N18.X	N18.1-N18.2, N18.9	Non-Specific Symptom Codes and Non-HCC Codes
Glomerular Nephritis Diseases	NoX	N00-N08	
Obstructive and Reflux Uropathy	N13.X	N13.0-N13.9	
Hypertension Secondary to Renal Disorder	I15.X	I15.0-I15.9	
Cystic Kidney Disease	Q61.X R31.9	Q61.0-.9 -	

Please remember, the diagnoses chosen must meet MEAT criteria, one of the following has to be supported: M-Monitored, E-Evaluated, A-Assessed, T-Treated

Documentation must be complete and accurate before selecting the specific diagnosis code, and always choose the most specific/or combination ICD-10 CM code(s) to fully describe the patient condition(s).



- 1 element required per DX code; more is better
- These factors help providers to establish the presence of a diagnosis during an encounter (“if it wasn’t documented, it doesn’t exist”)
- Review problem list, document as ‘current’ or ‘active’
- Do not use ‘history of’ for chronic conditions unless is fully resolved. Instead use ‘stable

- Document anything that impacts your medical decision making** to reflect the complexity and level of care provided.
- Documentation improves care, coverage, costs and compliance.
- other commonly lost conditions: substance/alcohol abuse, AIDS or HIV, mental health severity and status