with serum creatinine levels. It is not necessary to perform a 24-hour urine collection to measure creatinine clearance, even though this may be a more precise measure of GFR if done correctly.

The stage of CKD can only be correctly assigned when renal function (and therefore serum creatinine levels) is at a stable baseline. If there is any acute component to a patient’s renal disease, wait until renal function is stabilized, or use the prior baseline.

Although the clinical significance and associated risks of CKD begin to accelerate at stage 3, Medicare does not assign significant comorbidity status until stage 4 (see box at right). If the stage is unspecified it won’t be considered significant comorbidity. ESRD rarely goes undocumented and clearly represents even greater severity than other stages of CKD.

Always use the currently accepted clinical terminology of “chronic kidney disease” or CKD. Avoid nonspecific, imprecise terminology such as “renal insufficiency” or “chronic renal insufficiency (CRI)” as the appropriate codes for CKD will not be assigned.

In summary, always review the calculated GFR associated with the creatinine level on clinical lab reports. Documentation of any stage of CKD is important; documentation of stage 4 or 5 is crucial for correct coding, hospital reimbursement and classification of CKD patients’ severity of illness. Remember, the CKD stage can only be determined when renal function (and creatinine levels) are stable; otherwise, a prior baseline stage can be used for documentation purposes.

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