

Chronic kidney disease (CKD)

Chronic kidney disease (CKD) is a multisystem disease characterized by a progressive loss of kidney function, primarily measured through the glomerular filtration rate (GFR). CKD is diagnosed when there is evidence of:

- Kidney damage (e.g., urine albumin > 30 mg/g creatinine), and/or
- A sustained decrease in kidney function (eGFR < 60 mL/min/1.73 m²) for more than three months.

The staging of CKD is based on the assessment of GFR levels

CKD staging based on eGFR (mL/min/1.73 m ²) levels		
Stage 1	Kidney damage with normal or high GFR	≥ 90
Stage 2	Kidney damage with mild decrease in GFR	60-89
Stage 3a	Moderate decrease in GFR (mild-moderate)	45-59
Stage 3b	Moderate decrease in GFR (moderate-severe)	30-44
Stage 4	Severe decrease in GFR	15-29
Stage 5	Kidney failure	< 15

ICD-10 documentation guidance for CKD

- Include the patient's most recent GFR lab results in the documentation.
- For patients currently receiving dialysis, document: Dependence on Renal Dialysis – Z99.2.
- For patients with a kidney transplant, document the transplant status at least once annually: Z94 (Kidney Transplant Status).

Independence Blue Cross coding and documentation education materials are based on current guidelines, are to be used for reference only, and are not intended to replace the authoritative guidance of the ICD-10-CM Official Guidelines for Coding and Reporting as approved by the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). Clinical and coding decisions are to be made based on the following: 1. The independent judgment of the treating physician or qualified health care practitioner. 2. The best interests of the patient. 3. The clinical documentation as contained in the medical record.

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Chronic Kidney Disease (CKD) — Clinical documentation and coding tips

Documentation best practices

Specific comorbidities and ICD-10 documentation guidance:

Use an additional code to document the stage of CKD

I12.0	Hypertensive CKD with stage 5 CKD or end-stage renal disease (ESRD)	I12.9	Hypertensive CKD with stage 1 through 4 CKD, or unspecified CKD
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Use an additional code to document the stage of CKD

E08.22	Diabetes mellitus due to underlying condition with diabetic CKD	E10.22	Type 1 diabetes mellitus with diabetic CKD
E09.22	Drug or chemical induced diabetes mellitus with diabetic CKD	E11.22	Type 2 diabetes mellitus with CKD

Use an additional code to identify: Type of heart failure (I50.-) and stage of CKD

I13.0	Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD, or unspecified kidney disease	I13.11	Hypertensive heart and CKD without heart failure and stage 5 CKD, or ESRD
I13.10	Hypertensive heart and CKD without heart failure and stage 1 through stage 4 CKD, or unspecified kidney disease	I13.2	Hypertensive heart and CKD with heart failure and stage 5 CKD, or ESRD

Note: A dash (-) indicates that additional characters are required to complete the code.

References

- Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance In effect as of 03/20/2019. Yew, K.S. & Cheng, E.M. (2015).
- Optum (2025). ICD-10-CM Expert for Physicians: The Complete Official Code Set (2025)
- ICD-10-CM Official Guidelines for Coding and Reporting FY 2025; Section I.A.15
- ICD-10-CM Official Guidelines for Coding and Reporting FY 2025; Section I.C.9. a3
- ICD-10-CM Official Guidelines for Coding and Reporting FY 2025; Section I.C.14
- <https://www.niddk.nih.gov/health-information/professionals/clinical-tools-patient-management/kidney-disease/identify-manage-patients/evaluate-ckd>