

## Acute Renal Failure: Primaris Position Paper

Objective: Provide guidelines to assist healthcare professionals in identifying and providing adequate medical record documentation to clinically justify inclusion of the diagnosis of acute renal failure (ARF) on acute inpatient claims.

Currently, there is no specific test for acute injury to the kidney; thus, acute renal failure remains a syndrome defined by clinical parameters. The case can not be made for the diagnosis of ARF based on academic or laboratory criteria alone, such as the RIFLE criteria.<sup>1</sup> In order for the facility to be reimbursed for ARF care, the medical record documentation must demonstrate that specific care has been rendered.

Medical record evidence supporting evaluation and treatment of ARF (and thereby justifying code assignment) includes:

- Review of past renal history and renal function;
- Review of current renal function;
- Monitoring of urine output;
- Other electrolyte and metabolic abnormalities in addition to BUN/Cr;
- Physician-documented evaluation of the patient's urinalysis (e.g., presence of hematuria, casts, pyuria); and
- Presence or absence of clinical sequelae of renal failure (hypertension, nausea, edema, fatigue, etc.).

If the physician believes the patient does have ARF, the medical record should contain documentation of the following:

- What is the underlying insult that precipitated kidney failure?
- What did the physician do about it (e.g., ARF diagnostic evaluation, medication changes, correction of electrolyte abnormalities, request for nephrology or vascular surgery consultation)?

Based on previous reviews, Primaris has noted in a high percentage of cases that the inclusion of acute renal failure appears to be based on the following factors:

- In most cases, a single serum creatinine of >1.5 mg/dL or a change in serum creatinine of >0.5 mg/dL is retrospectively cited with minimal concurrent documentation to support the diagnosis of acute renal failure.
- These patients generally are in acute care for less than five days and are treated with one or two days of IV fluids alone as treatment for hypovolemia, which the facility retrospectively cites in response to a DRG validation inquiry as providing diagnostic and therapeutic care for acute renal failure. (The majority of patients in an acute setting do not have ARF, yet most also receive IV fluids at some point during their hospitalization.)
- For these patients, there is no evidence of any diagnostic evaluation for acute renal failure, no examination for other key associated electrolyte and metabolic imbalances

### MO-10-02-CR

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(e.g., potassium, acidosis), no discussion of possible nephrology or vascular surgery consultation, no evaluation to discover intrinsic or post-renal etiologies for the alleged underlying renal failure beyond citing hypovolemia and improvement in response to IV fluids.

- Discharge orders, discharge plans, and discharge summaries contain no instructions for additional short-term or long-term follow up of renal failure post-discharge.

The opinion of the physician review panel is that if a patient has a complex health history and the documentation indicates that an elevated BUN/Cr has not been treated as a clinically significant issue, then it is likely the physician is not considering the diagnosis of ARF. Treatment of ARF requires more than giving fluids for 24 hours and simply improving renal perfusion. Despite the physiological observation of decreased GFR, 24 to 48 hours of IV fluid administered to a patient who is mildly dehydrated, with a mild elevation in serum creatinine and without other complications, is not adequate clinical evidence to justify the clinical diagnosis of ARF.

Typically, patients who have ARF have other clinical indications that point to an etiology, such as additional electrolyte abnormalities, sustained low urine output, and abnormal urinalysis.<sup>2</sup>

ARF is a diagnosis with serious short-term and long-term implications for the patient. In the short term, 20-50% of patients with ARF do not survive.<sup>3-7</sup> A patient with renal failure requires close follow up. Survivors of ARF are three to seven times as likely as patients without ARF to require dialysis in the long-term, even when they have recovered from the ARF episode.<sup>8-10</sup> A secondary but relevant and serious consideration is the impact an incorrect diagnosis of ARF may have on an individual's ability to acquire and maintain health insurance in the future. The ultimate concern is the quality of care that a patient with an ARF diagnosis receives. If the physician believes a patient has ARF, the physician is obligated to perform a standard evaluation for underlying causes of the ARF, to treat appropriately while the patient is in-house, and to design an appropriate, long-term plan for continued follow up, evaluation, and treatment after discharge. Short of this, the physician has not met the standard of care for ARF.

Suggested guidelines to assist facilities in determining whether the inclusion of ARF in an in-patient claim is clinically justifiable:

- Acute decline in the patient's renal function, as noted previously.
- Elevation of the patient's BUN/Cr above the level that a physician would reasonably expect to be normal for that patient (compared to the patient's baseline serum creatinine value).
- BUN/Cr elevations are not due solely to volume depletion (e.g., a patient in whom the creatinine returns to normal within 24-48 hours of fluid administration and observation without other findings, such as hyperkalemia or acidosis). Electrolyte abnormalities must persist after the volume status has been corrected.
- Clear documentation in the medical record that the physician has initiated an evaluation and treatment of elevated BUN/Cr. The diagnostic evaluation should include:
  - Identification of the precipitating insult or attempt to identify the insult.
  - Identification of severity of the problem – other electrolyte abnormalities, oliguria, or anemia.

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- If clinically appropriate, exclusion of obstruction as the underlying etiology.
- Physician-documented evaluation of the patient's urinalysis (presence of hematuria, casts, pyuria, etc.).
- The patient has obvious documented risk factors, or predisposing disease states, or is on medications that would predispose that patient to develop acute renal injury.

The ARF-specific treatment plan should include appropriate clinical observation, medication adjustment, additional evaluation to identify and treat the underlying etiology (other than IV fluids for hypovolemia), and/or requesting nephrology, urology, or vascular surgery consultation, if appropriate.

### References

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