Banner Plans & Networks

Renal Care Toolkit

Revised February 2025

Contents

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Introduction Letter

Dear Providers:

Banner Health Network continues to make strides in providing clinically relevant opportunities that impact the quality of care that our providers can deliver. The Banner Health Network Renal Clinical Strategy Committee has devised care standards and a toolkit. These guidelines are geared towards Primary Care Physicians to slow disease progression and improve outcomes of Chronic Kidney Disease (CKD), based on existing current guidelines within KDIGO (Kidney Disease Improving Global Outcomes).

Toolkit Items:

- NEW – Renal Care Provider One Pager
- Renal Care Standards and Renal Medication Alternatives Tool
  - 2024 KDIGO Updated Pharmacy Guidelines
- Early CKD Diagnosis Tip Sheet
- NEW – Palliative Care in Advanced CKD & ESRD
- NEW – HCC CKD Coding Tip Sheets
- NEW – Kidney Health Evaluation for Patients with Diabetes Tip Sheet
- Renal Education and Care Management Support

Diagnosing and coding early CKD is crucial. Earlier identification allows patients to adopt lifestyle changes which may slow down the progression of worsening kidney disease. Early kidney disease is typically asymptomatic. In fact, approximately 37 million US adults are estimated to have CKD with most being undiagnosed, according to the CDC. Early identification, followed by risk stratification and treatment, has been known to potentially reduce the morbidity and mortality from CKD and its related complications, such as cardiovascular disease, hyperlipidemia, anemia and bone-mineral disease.

CKD 4 & 5 without an established Nephrologist - As you are already aware, patients with advanced CKD have multiple sequelae which worsen as CKD progresses. Multiple studies have shown that early Nephrology referral improves outcomes and mortality. Patients should be scheduled for an Annual Wellness Visit, and during that visit, a referral can be made to a Nephrologist if needed. These visits also provide an opportunity to close care gaps and adjust medications as needed.

CKD members on high-risk medications – We have included a Medication Alternatives Tool which has guidelines for renal friendly pharmaceuticals.

We hope these resources assist you in your practice. Thank you for your ongoing work to help Banner Health Network make health care easier, so life can be better. Please consult your Care Transformation Consultant with questions.

Sincerely,

Dr. Sheena Sharma, MD
Medical Director & Renal Clinical Strategy Committee Lead
Banner Health Network

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Care Standards & Best Practices

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Renal Care - Provider One Pager

POP
Provider One Pager

Primary care providers (PCPs) play a critical role in diagnosing and managing early chronic kidney disease (CKD). By focusing on early detection, treatment and careful management, PCPs can significantly improve outcomes for their patients with CKD.

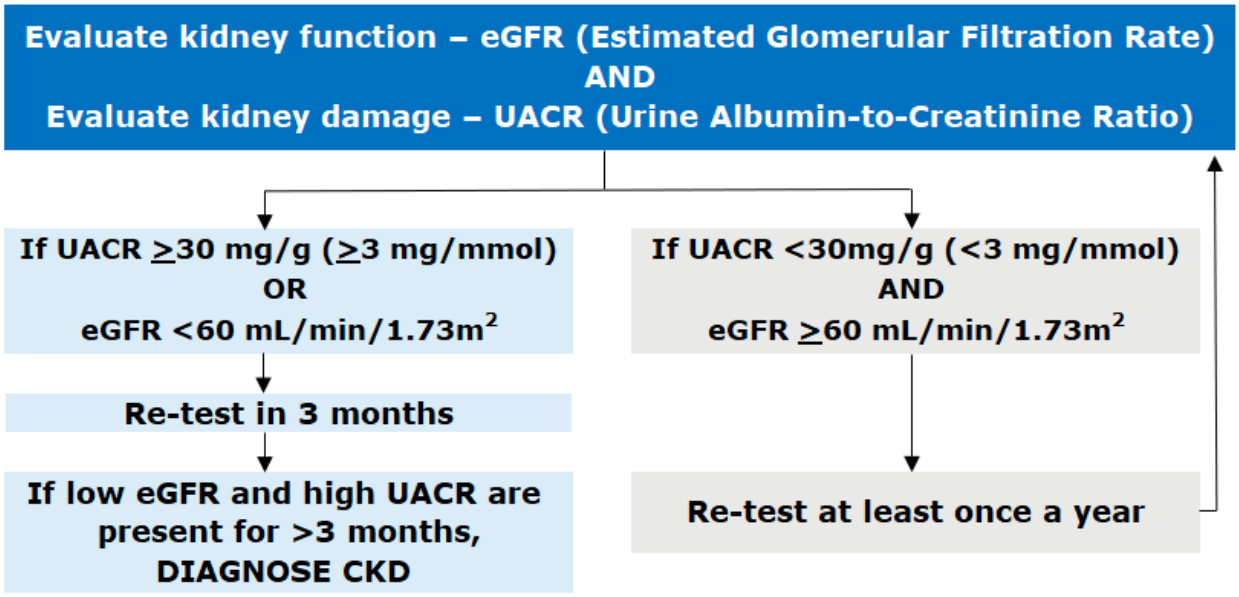
Identify Patients at Risk

CKD is irreversible, and most people do not experience any symptoms until their disease progresses. Early identification allows patients the opportunity to adopt lifestyle changes and/or initiate treatment(s) which may slow down kidney disease progression.

Main risk factors	Additional risk factors
• Hypertension (HTN) • Diabetes mellitus type 1 and type 2 • Cardiovascular Disease (CVD) • Family history of CKD	• History of acute kidney injury • Medical conditions that can impact kidney function (e.g. SLE, HIV, obesity, genetic risk factors) • Environmental exposure to nephrotoxins

Screening for Kidney Disease

Screening for CKD should be completed at least annually for high-risk individuals. Be sure to order both lab components:



Adapted from https://www.theisn.org/wp-content/uploads/media/pcp/PCPOnePage_1Side_English.pdf

Diabetic Nephropathy

- Can be diagnosed if two of three urine tests for microalbuminuria or macroalbuminuria are positive in a three to six-month period with or without reduced eGFR.
- Diabetes with nephropathy (E10.21 or E11.21) does carry a RAF score.
    - Documentation needs to clearly state that the nephropathy is related to the diabetes.

Ensure follow-up with patients
who have a positive result on urine testing to retest in 3 months.

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Proper Staging

Use the KDIGO staging guide to determine CKD level, testing frequency and timely referral.

KDIGO Prognosis of CKD by GFR and Albuminuria Categories

GFR categories (ml/min per 1.73 m²) Description and range			Persistent Albuminuria categories Description and range		
		Stage	A1	A2	A3
		Kidney function	Normal to mildly increased	Moderately increased	Severely increased
Stage	Kidney function	Test Result	<30 mg/g <3 mg/mmol	30-300 mg/g 3-30 mg/mmol	>300 mg/g >30 mg/mmol
G1	Normal or high	≥90	MONITOR 1	MONITOR 1	REFER* 2
G2	Mildly decreased	60-89	MONITOR 1	MONITOR 1	REFER* 2
G3a	Mildly to moderately decreased	45-59	MONITOR 1	MONITOR 2	REFER 3
G3b	Moderately to severely decreased	30-44	MONITOR 2	MONITOR 3	REFER 3
G4	Severely decreased	15-29	REFER* 3	REFER* 3	REFER 4+
G5	Kidney failure	<15	REFER 4+	REFER 4+	REFER 4+

Low risk:
No CKD or lowest risk for progression
Monitor 1 time per year

Moderately increased risk:
Increased risk for CKD getting worse
Monitor 1 time per year

High risk:
High risk for CKD getting worse
Monitor 2 times per year

Highest risk:
Highest risk for CKD getting worse
Monitor at lease 3-4 times per year

Refer: Indicates that a Nephrology referral and services are recommended.

**Consultation with Nephrology service should take place as needed depending on local arrangements regarding frequency of monitoring and timing of referral.*

Adapted from Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. Kidney Int Suppls. 2013;3:1-150 and NKF.

Slowing Kidney Disease Progression

Once CKD is confirmed, discuss potential treatment options including starting an ACE-inhibitor and encouraging compliance with all prescribed diabetes and blood pressure medications.

Medical Treatment	Pharmacy Considerations *

• Keep blood pressure within target range
• Ensure glycemic control
• Monitor complications
  ○ Anemia, mineral bone disorders, acidosis, electrolyte imbalances
• Schedule patients for follow-up appointments and recommended testing
	• Consider starting these medications:
	  ○ ACEi/ARB to lower blood pressure and/or protect kidneys
	  ○ SGLT2i to help manage diabetes and protect kidneys
	  ○ Loop diuretics to treat fluid overload
	• Avoid Nephrotoxic medications:
	  ○ NSAIDs and PPIs

**See the Renal Care Guidelines & Renal Medication Guidelines & Alternatives for specific recommendations.*

Recommend Lifestyle Changes

- ✓ Recommend a kidney friendly diet (avoid excessive protein intake, processed food, limit sodium)
- ✓ Encourage regular exercise and weight management
- ✓ Urge smoking cessation for patients who use tobacco products or e-cigarettes
- ✓ Suggest enrollment in a Kidney Smart® class

The Importance of Early Referrals

Early referrals to a Nephrologist have been proven to decrease morbidity and mortality associated with CKD. As kidney disease progresses, treatment options should be discussed early to allow time for well-planned and thoughtful choices to be made with the patient and family members.

Patients with CKD 4 should be referred to a Nephrologist for specialized care.

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Renal Care Guidelines

Follow KDIGO Guidelines for testing frequency:

	CKD Stage 3a and 3b (eGFR 30-15mL/min/1.73m^2)	CKD Stage 4 (eGFR 15-29mL/min/1.73m^2)	CKD Stage 5 (eGFR <15-29mL/min/1.73m^2)
Anemia	Measure hemoglobin at least **annually** if no anemia exists Measure hemoglobin at least every **3 months** if anemic not on an ESA	Measure hemoglobin at least **twice per year** if not anemic and not on dialysis Measure hemoglobin at least every **3 months** if anemic not on an ESA	Measure hemoglobin at least **twice per year** if not anemic and not on dialysis Measure hemoglobin at least every **3 months** if anemic not on an ESA
CKD-Mineral Bone Disease	Serum calcium and phosphorus every 6-12 months	Serum calcium and phosphorus every 6-12 months	Serum calcium and phosphorus every 6-12 months
	Obtain baseline PTH Frequency of further testing based upon clinical judgement	PTH every 6-12 months	PTH every 6-12 months
	Obtain a baseline level of alkaline phosphatase	Alkaline phosphatase should be monitored every 12 months	Alkaline phosphatase should be monitored every 12 months
	Measure 25-OH vitamin D		
Metabolic Acidosis	Start measuring when eGFR <40mL/min/1.73m^2	Frequency of testing based upon nephrologist's clinical judgement	Frequency of testing based upon nephrologist's clinical judgement
Hypertension	24-hour Ambulatory Blood Pressure Monitor to establish diagnosis Home blood pressure monitoring for ongoing monitoring		

Indications for Nephrology Referral:

- AKI or abrupt sustained fall in GFR
- GFR <30mL/min/1.73m^2 (GFR category G4-G5)
- A consistent finding of significant albuminuria (ACR >300mg/g or AER >300mg/24 hours)
- Progression of CKD
- Urinary red cell casts, RBC >20hpf
- CKD and hypertension refractory to treatment with 4 or more antihypertensive agents
- Persistent abnormalities in serum potassium
- Recurrent or extensive nephrolithiasis
- Hereditary kidney disease

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CKD with Hypertension:

Target systolic blood pressure <120mmHg for all patients, when tolerated ***consider less intensive blood pressure-lowering therapy in people with frailty, high risk of falls or fractures, very limited life expectancy, or symptomatic postural hypotension*	
First line blood pressure agents for patients with CKD and hypertension	
<u>without</u> albuminuria	**<u>with</u> albuminuria (urine ACR >30 mg/g)**
ACEi or ARB, calcium channel blocker, or diuretic	ACEi or ARB
All 3 classes are often needed to attain blood pressure target.	

Consider starting these medications for patients with CKD:

	Recommended to START for CKD patients:	DISCONTINUE for patients with:
RAAS antagonists (ACEi/ARB) Prevent progression of CKD	with severely increased albuminuria (>300 mg/g) without diabetes	rise in serum creatinine by >30% within 4 weeks of starting/increasing dose of ACEi/ARB *OR* eGFR <60 with serious illness that may increase risk of AKI such as infection (temporary – may resume once illness resolves)
	with moderately-to-severely increased albuminuria (≥30 mg/g) with diabetes	
SGLT2i Prevent progression of CKD and reduce risk of cardiovascular death and hospitalization	with type 2 diabetes and eGFR ≥20	during times of prolonged fasting or critical illness (temporary - may resume once risk factors for ketoacidosis are resolved) *OR* when kidney replacement therapy (KRT) is initiated or at time of transplant
	without type 2 diabetes and eGFR ≥20 with urine ACR ≥200 mg/g	
	with heart failure, irrespective of level of albuminuria	
	with eGFR 20-45 with urine ACR <200 mg/g	
Loop diuretics Treat fluid overload via sodium excretion	consider using for elevated blood pressure due to fluid overload	
	consider changing thiazide diuretics to loop diuretics when eGFR <30	
***consider temporary discontinuation of these medications 48-72 hours before elective surgery to prevent complications; note that failure to restart medications after procedure may lead to unintentional harm*		

Common medications requiring renal dose adjustments:

Medications to adjust in CKD: **List is not conclusive of all renally dosed medications*		
Allopurinol	Fenofibrate	Nadolol
Antimicrobials	Fluconazole	Sitagliptin
Anticoagulants	Gabapentin/pregabalin	Sulfonylureas
Atenolol	Lithium	Statins
Digoxin	Metformin	Tramadol
Famotidine	Metoclopramide	

See the Renal Medication Guidelines & Alternatives Tip Sheet for specific medication recommendations.

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Renal Medication Guidelines & Alternatives

Medications play an important role in preventing the progression of CKD and symptom management. However, many medications can contribute to worsening renal function if known to be nephrotoxic. There may be an opportunity to choose an alternative renal-friendly medication and/or adjust a dosage of a medication based on most recent eGFR. Please review the following medication considerations for your patients with CKD.

Consider avoiding nephrotoxic medications that may worsen CKD:

Nephrotoxic Medication	Alternative
NSAIDs Increase sodium and fluid retention, potentially increasing blood pressure and worsen efficacy of diuretics	Acetaminophen up to 4000 mg/day
	Topical diclofenac solution or gel for joint pain (<7% systemic absorption)
	Antiepileptics or antidepressants for neuropathy
	Opioids for severe chronic pain
PPIs May result in AKI and CKD due to tubulointerstitial nephritis and acute interstitial nephritis	H2-receptor antagonists (may require renal dose adjustment)
	Calcium carbonate

Consider adjusting the dose or finding alternatives for these common medications that are renally eliminated:

Drug	Dose adjustment per drug monograph	Alternatives
Atenolol Eliminated renally, increasing risk for ADRs: bradycardia, heart block, dizziness/falls	CrCl > 30: none CrCl 10-30: maximum 50 mg daily CrCl < 10: maximum 25 mg daily	Metoprolol tartrate or succinate Carvedilol Labetalol
Ciprofloxacin and Levofloxacin Eliminated renally, increasing risk for ADRs: QT prolongation, CNS effects, tendinopathy	**Ciprofloxacin:** CrCl > 50: none CrCl 30-50: 250-500 mg q12 hrs CrCl < 30: 500 mg q24 hrs	Alternative antibiotics as applicable
	Levofloxacin: CrCl > 50: none CrCl 20-49: maximum 750 mg q48 hrs CrCl < 20: maximum 500 mg q48 hrs	
Famotidine Eliminated renally, increasing risk for ADRs: agitation, confusion, delirium	CrCl <50: Administer 50% of usual dose or continue usual dose but increase the dosing interval to every 36 to 48 hours	Calcium carbonate
Fenofibrate Eliminated renally, increasing risk for ADRs: increase in Cr, AKI usually in association with rhabdomyolysis	CrCl >30 to 80: Use lowest available tablet strength (if a formulation is not available in a strength that is ≤67 mg then an alternate formulation should be used); do not titrate. CrCl ≤30: Use contraindicated.	Omega-3 fatty acids
Gabapentin Eliminated renally, increasing risk for ADRs: dizziness, drowsiness	CrCl 50-79: Max 1,800mg/day in 3 divided doses CrCl 30-49: ~50% reduction; max 900mg/day in 2-3 divided doses CrCl 15-29: ~75% reduction; max 600mg/day in 1-2 divided doses CrCl <15: ~90% reduction; max 300 mg/day in 1 dose 600mg/day in 1-2 divided doses CrCl <15: ~90% reduction; max 300 mg/day in 1 dose	Amitriptyline, Lidoderm Patch, Capsaicin
Metformin Eliminated renally, increasing risk for ADRs: lactic acidosis, GI upset	GFR > 45: none GFR 30-45: maximum 500 mg BID GFR < 30: use is contraindicated	GLP-1 RAs Insulin Linagliptin SGLT2i

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The Importance of Early Detection of Kidney Disease

Early kidney disease is typically asymptomatic. In fact, approximately 37 million US adults are estimated to have CKD with most being undiagnosed, according to the CDC. Early identification, followed by risk stratification and treatment, has been known to potentially reduce the morbidity and mortality from CKD and its related complications such as cardiovascular disease, hyperlipidemia, anemia, and bone-mineral disease.

Who to Screen

Approximately 75% of cases of kidney failure are due to diabetes or high blood pressure. Early identification of CKD should be implemented through **targeted** screening for kidney disease based on known risk factors which include:

- High blood pressure
- Diabetes
- Cardiovascular disease
- Family history of kidney disease
- History of acute kidney injury
- Medical conditions that impact kidney function (e.g. SLE, HIV, obesity, genetic risk factors)
- High-risk occupations and environmental exposure to nephrotoxins

How to Screen

Serum creatinine and GFR estimating equation should be used for initial assessment. KDIGO recommends using the 2009 CKD-EPI creatinine equation, if possible, for calculating eGFR. If eGFR is <60mL/min/1.73m2 for >3 months, the diagnosis of CKD is confirmed. Evaluation for albuminuria using an early morning urine sample can be accomplished in many ways. The order of preference for testing is:

- Urine albumin-to-creatinine ratio
- Urine protein-to-creatinine ratio
- Reagent strip urinalysis for total protein with automated reading, or
- Reagent strip urinalysis for total protein with manual reading

Coding the Stages of CKD

ICD-10-CM Code	Description	Category	GFR
N18.1	Chronic Kidney Disease, Stage 1	G1	≥90mL/min/1.73m2
N18.2	Chronic Kidney Disease, Stage 2	G2	60-89mL/min/1.73m2
N18.30	Chronic Kidney Disease, Stage 3 Unspecified	G3	30-59mL/min/1.73m2
N18.31	Chronic Kidney Disease, Stage 3a	G3a	45-59mL/min/1.73m2
N18.32	Chronic Kidney Disease, Stage 3b	G3b	30-44mL/min/1.73m2
N18.4	Chronic Kidney Disease, Stage 4	G4	15-29mL/min/1.73m2
N18.5	Chronic Kidney Disease, Stage 5	G5	<15mL/min/1.73m2

Guide to frequency of assessment for CKD progression

Once the diagnosis of CKD has been established, use of the **KDIGO Heat Map** (which incorporates both GFR category and persistent albuminuria) can be utilized to evaluate the risk of CKD progression, progression to kidney failure, and can help guide timely referral to Nephrology.

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KDIGO Heat Map

GFR categories (ml/min per 1.73 m²) Description and range			Persistent Albuminuria categories Description and range		
	Stage		A1	A2	A3
		Kidney function	Normal to mildly increased	Moderately increased	Severely increased
	Stage	Kidney function	Test Result	<30 mg/g <3 mg/mmol	30-300 mg/g 3-30 mg/mmol	>300 mg/g >30 mg/mmol
	G1	Normal or high	≥90	MONITOR 1	MONITOR 1	REFER* 2
	G2	Mildly decreased	60-89	MONITOR 1	MONITOR 1	REFER* 2
	G3a	Mildly to moderately decreased	45-59	MONITOR 1	MONITOR 2	REFER 3
	G3b	Moderately to severely decreased	30-44	MONITOR 2	MONITOR 3	REFER 3
	G4	Severely decreased	15-29	REFER* 3	REFER* 3	REFER 4+
	G5	Kidney failure	<15	REFER 4+	REFER 4+	REFER 4+

Low Risk: Do not have CKD or at lowest risk for progression. **Monitor 1 time per year.**
Moderately increased risk: Increased risk for CKD getting worse. **Monitor 1 time per year.**
High risk: Hight risk for CKD getting worse. **Monitor 2 times per year.**
Very high risk: Highest risk for CKD getting worse. **Monitor at least 3 to 4 or more times per year.**

Numbers: Represent a recommendation for the number of times per year the patient should be monitored.
Refer: Indicates that a Nephrology referral and services are recommended.
**Consultation with Nephrology service should take place as needed depending on local arrangements regarding frequency of monitoring and timing of referral.*

It should be noted that even at the relatively normal-mildly decreased categories of GFR (that is, G1 or G2), persistent albuminuria can accelerate a patient's progression towards worsening CKD or kidney failure, highlighting the need to monitor albuminuria closely. This also underscores the importance of early identification and accurate coding of CKD, even at relatively early stages including G1-G3, to monitor these patients closely over time.

If your patient has CKD, we recommend these important steps:

- Follow KDIGO Guidelines as above
- Complete a wellness visit yearly
- Recommend lifestyle changes and provide CKD Education
- Treat underlying health conditions:
  - Keep blood pressure within target range
  - Keep blood sugar or diabetes under control
  - Take medications as prescribed by doctor

  Note: Consult with doctor or pharmacist before taking any over-the-counter medications or supplements to avoid agents that may worsen kidney function, hypertension, or diabetes

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Palliative Care in Advanced CKD & ESRD

Palliative care is supportive, team-based care and a crucial component of the management of advanced chronic kidney disease (CKD) and end-stage renal disease (ESRD), focusing on improving quality of life, alleviating symptoms, and supporting patients and their families. It is important to remember that palliative care is not necessarily the pathway to hospice and can be appropriate at any stage of a patient's disease journey.

How can palliative care help patients with Advanced CKD & ESRD?

Multidisciplinary Team Based-Care

Palliative care providers will collaborate with nephrologists, social workers, dietitians, spiritual care providers, and other specialists to ensure seamless communication amongst the care teams to provide coordinated, holistic care.

Symptom Management

Palliative care can be provided in conjunction with ongoing treatment(s) and can help manage distressing symptoms often experienced by patients with advanced CKD & ESRD including:

- **Pain:** Use medications safe for renal impairment (e.g., acetaminophen) and avoid NSAIDs. Opioids may be used cautiously.
- **Fatigue and Weakness:** Assess for anemia, metabolic disturbances, and malnutrition. Tailor interventions to the patient's functional goals.
- **Nausea/Vomiting:** Common in uremia; consider alterations in dialysis prescription and dietary adjustments.
- **Pruritus (Itching):** Optimize dialysis, manage phosphate levels, and consider treatments like gabapentin or antihistamines.
- **Breathlessness:** Address fluid overload or metabolic acidosis. Oxygen therapy may help if hypoxic.
- **Depression/Anxiety:** Screen regularly and offer counseling, antidepressants, or anxiolytics as needed.

Psychosocial Support

Advanced CKD and kidney failure can be overwhelming; however, palliative care provides emotional support for both patients and their families

Emotional Support	Family and Caregiver Support
• Address the psychological impact of advanced CKD/ESRD, including grief, fear, and loss of independence. • Provide counseling or connect patients with mental health professionals if needed.	• Offer guidance to family members, helping them understand the disease trajectory and how they can assist. • Encourage caregiver self-care to prevent burnout.

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Patient Centered Support for Decision-Making

Palliative care helps to facilitate conversations about a patient's values, preferences and goals of care when discussing treatment options and impact on quality of life.

- **Advance Care Planning:**
  - Address topics such as advance directives, code status, and preferred place of care or death.
  - Ensure regular updates to the care plan as the patient's condition evolves.
- **ESRD Decision-Making:**
  - Dialysis or Kidney Transplant Decisions:
    - Help patients weigh the burdens and benefits of dialysis or kidney transplant, especially in frail or elderly patients.
    - Discuss conservative (non-dialysis) management as a viable option for some, focusing on symptom relief and quality of life.
  - Withdrawal from Dialysis:
    - For patients who decide to stop dialysis, provide symptom management and emotional support during the transition to end-of-life care.

Additional Resources

Support Teams & Services		
Care Management Services include: Community resources Disease & lifestyle education Post discharge assistance End of life planning & much more *Link to CM Referral Form*	**Mobile Providers** Services include: Home NP/PCP visits *Link to Home Care Providers*	**Palliative Care** Services include: Home visits Patient centered treatment goals & condition management Extra support Coordination with PCP office *Link to Palliative Care Provider List*

Palliative Care Helps Patients with Kidney Disease | National Kidney Foundation

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Chronic Kidney Disease Coding

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Chronic Kidney Disease, Stage 3A/3B

The Diagnosis	Chronic Kidney Disease, Stage 3A/3B
COMMON CONDITIONS INCLUDED IN HCC GROUPs: 329, 328 **RAF score = 0.127**	Chronic Kidney Disease, Stage 3, unspecified – N18.30 Chronic Kidney Disease, Stage 3a – N18.31 Chronic Kidney Disease, Stage 3b – N18.32
KEY CODING or DOCUMENTATION TIPS	The chronic kidney disease (CKD) Stage 3a and Stage 3b are two separate HCC groups, and their RAF score is the same. The CKD staging MUST be included in the patient encounter for diabetic kidney disease and all CKD diagnoses. If no staging is included in the documentation, then the coder should query the provider. Be sure to include linking words (with, due to, etc.) when documenting the relationship between CKD and another disease, like diabetes.
MEAT the DOCUMENTATION **M= Monitor** **E = Evaluate** **A = Assess/Address** **T = Treat**	Assessment and Plan example: **Type 2 diabetes mellitus with diabetic chronic kidney disease (E11.22)** **CKD stage 3b (N18.32)** **Long term (current) use of oral hypoglycemic drugs (Z79.84)** Mr. L presents for his annual physical. VS stable, although BP was borderline at 140/88. No previous dx of HTN. Reviewed labs. eGFR is stable at 42, uACR 29, and Hgb A1c steady at 7.4. Pt states he usually tries to keep his A1c below 7, yet he recently returned from a two-week vacation, and he splurged a bit. Answered pt's questions regarding the CKD due to his diabetes. Follow-up in 4 months to recheck labs. Blood pressure check with nurse in 2 weeks. **M** – Signs and symptoms, such as swelling, frequent urination, fatigue. **E** – Test results or vital signs, such as eGFR and A1c. **A** – Order tests or patient discussion, such as diet and exercise. **T** – Medications, therapy, or other modalities, such specialist follow-up.
IMPACT on QUALITY – HEDIS MEASURES	Kidney Health Evaluation (CMS 95) – • eGFR and uACR testing at least annually for type 2 diabetic patients. • Only exclusion is for patients with ESRD, CKD stage 5, or in hospice or palliative care during the measurement period.

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Chronic Kidney Disease, Stage 4

The Diagnosis	Chronic Kidney Disease, Stage 4
COMMON CONDITIONS INCLUDED IN HCC 327 **RAF score = 0.514**	Chronic Kidney Disease, Stage 4 – N18.4
KEY CODING or DOCUMENTATION TIPS	The CKD staging MUST be included in the patient encounter for diabetic kidney disease and all CKD diagnoses. If no staging is included in the documentation, then the coder should query the provider. Be sure to include linking words (with, due to, etc.) when documenting the relationship between CKD and another disease, like diabetes.
MEAT the DOCUMENTATION **M= Monitor** **E = Evaluate** **A = Assess/Address** **T = Treat**	Assessment and Plan example: **Hypertensive kidney disease (I12.9)** **CKD stage 4 (N18.4)** Ms. Q presents for her preoperative clearance visit for her hip replacement. VS stable, except for BP 156/92. Pt states her pain is at a 7 today. Pt states she is trying to use the minimal amount of pain medicine before her surgery. Reviewed labs drawn at her preop visit at the hospital. eGFR is stable at 27, uACR 65. Normal exam for pt. Reviewed medications, and no changes in medications. Reviewed pt's instructions for medications to take the day of surgery, answered all questions. Pt cleared for hip replacement surgery. **M –** Signs and symptoms, such as swelling, frequent urination, fatigue. **E –** Test results or vital signs, such as eGFR and A1c. **A –** Order tests or patient discussion, such as diet and exercise. **T –** Medications, therapy, or other modalities, such specialist follow-up.
IMPACT on QUALITY – HEDIS MEASURES	Kidney Health Evaluation (CMS 95) – • eGFR and uACR testing at least annually for type 2 diabetic patients. • Only exclusion is for patients with ESRD, CKD stage 5, or in hospice or palliative care during the measurement period.

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Chronic Kidney Disease, Stage 5 and ESRD

The Diagnosis	Chronic Kidney Disease, Stage 5 and ESRD
COMMON CONDITIONS INCLUDED IN HCC 326 **RAF score = 0.815**	Chronic Kidney Disease, Stage 5 – N18.5 End stage renal disease (ESRD) – N18.6
KEY CODING or DOCUMENTATION TIPS	The CKD staging MUST be included in the patient encounter for diabetic kidney disease and all CKD diagnoses. If no staging is included in the documentation, then the coder should query the provider. Be sure to include linking words (with, due to, etc.) when documenting the relationship between CKD and another disease, like diabetes.
MEAT the DOCUMENTATION **M= Monitor** **E = Evaluate** **A = Assess/Address** **T = Treat**	Assessment and Plan example: **Polycystic kidney, adult type (Q61.2)** **CKD stage 5 (N18.5)** **Secondary Hypertension (I15.1)** **Reactive depression, single episode (F32.9)** Ms. Y presents for her AWV. VS stable, except for BP 163/98. HTN is due to polycystic kidney disease. Reviewed all screenings. PHQ9 was a 6. Pt concerned that she is going to have to start dialysis soon. eGFR is 12. Normal exam for pt. Reviewed medications, and no changes. Pt refused an antidepressant, but stated she would like to talk with a counselor. Will have care coordinator help set up an appt with the social worker for next week. **M** – Signs and symptoms, such as swelling, frequent urination, fatigue. **E** – Test results or vital signs, such as eGFR and A1c. **A** – Order tests or patient discussion, such as diet and exercise. **T** – Medications, therapy, or other modalities, such specialist follow-up.
IMPACT on QUALITY – HEDIS MEASURES	Chronic kidney disease (CKD), stage 5 and End-stage renal disease (ESRD) diagnoses are considered advanced illness diagnoses. When added to a claim twice in the current or prior year meets the advanced illness criteria. Frailty or advanced illness, ESRD, and/or palliative care diagnosis codes may provide a denominator exclusion.

Hypertensive Heart and/or Kidney Disease

The Diagnosis	Hypertensive Heart and/or Kidney Disease
COMMON CONDITIONS INCLUDED IN HCC GROUPs: • **226 (Heart Failure)** • **326, 327, 328, 329 (CKD)** **RAF score = ** Varies**** **Ranging from 0 – 0.815**	Hypertensive heart disease with heart failure – I11.0 Hypertensive heart disease without heart failure – I11.9 Hypertensive kidney disease with stage 5 CKD or ESRD – I12.0 Hypertensive kidney disease with stage 1-4 CKD or unspecified kidney disease – I12.9 Hypertensive heart and kidney disease with heart failure and CKD stage 1-4 or unspecified kidney disease - I13.0 Hypertensive heart and kidney disease without heart failure and CKD stage 1-4 or unspecified kidney disease - I13.10 Hypertensive heart and kidney disease with heart failure and CKD stage 5 or ESRD – I13.2
KEY CODING or DOCUMENTATION TIPS	There is a causal relationship between heart failure and hypertension. If your patient has heart failure and it is NOT linked to a declining cardiovascular status due to hypertension, then your note needs to explain that the two are not linked. Essential or benign hypertension (I10) is NOT the most appropriate diagnosis for a patient with heart failure and/or chronic kidney disease. The coder should update the diagnosis or query the provider.
MEAT the DOCUMENTATION **M= Monitor** **E = Evaluate** **A = Assess/Address** **T = Treat**	Assessment and Plan example: **Hypertensive heart failure and CKD stage 1-4 (I13.0)** **Chronic combined systolic and diastolic heart failure (I50.42)** **CKD stage 3b (N18.32)** Ms. R presents with no changes in heart failure symptoms. 2+ pitting edema bilaterally. Lungs CTA. S1, S2, no gallop. BP 144/82. Reviewed labs and eGFR is stable at 38. Counselled patient regarding heart failure and kidney diets (low sodium). Pt states she usually does better, but the recent holidays made it challenging. Pt sees Dr. Cardio next month. No changes to current meds. **M** – Signs and symptoms, such as pitting edema. **E** – Test results or vital signs, such as eGFR. **A** – Order tests or patient discussion, such as diet. **T** – Medications, therapy, or other modalities, such specialist follow-up.
IMPACT on QUALITY – HEDIS MEASURES	The ***Controlling high blood pressure (CBP)*** quality metric includes patients with the diagnosis of *I10* in the denominator. If a patient has a hypertension diagnosis other than *I10*, then they are NOT included in the denominator. Use of I11 – I13 means the patient is not included in this quality metric.

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Quality Measure: Kidney Health Evaluation

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KED Quick Reference

Measure	Description & Best Practices	Documentation	NSSD
Kidney Health Evaluation for Patients With Diabetes (KED) Weight – 1	Percentage of patients ages 18-85 with diabetes (Types 1 and 2) who had a kidney health evaluation in the measurement year. • Order eGFR and uACR per recommendation of National Kidney Foundation (required) • Complete urine albumin and urine creatinine tests for uACR within 4 days of each other(required) • Education of patient that kidney disease is asymptomatic in early stages and routine testing is recommended	• eGFR and uACR lab results are required via claims Additional Exclusions: • Dialysis or ESRD • Ages 81 and older with frailty only	**Not Accepted**

Exclusions		
• Hospice • Members who had an encounter for palliative care (ICD-10 code Z51.5)	• Ages 66 and older with frailty and advanced illness • Ages 66 and older with I-SNP or who are institutionalized	• Members who died during the measurement year • No diagnosis of diabetes in any setting and steroid-induced diabetes

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Kidney Health Evaluation for Patients with Diabetes (KED)

Measure Description

Percentage of patients ages 18-85 with diabetes (Types 1 and 2) who had a kidney health evaluation in the measurement year.

Measure Compliance

Both an eGFR and a uACR test are required on the same or different dates of service anytime between January 1 and December 31 of a given calendar year:

- At least 1 estimated glomerular filtration rate (eGFR); and
- At least 1 urine albumin-creatinine ratio (uACR) test identified by one of the following:
  - A quantitative urine albumin test and a urine creatinine test 4 or less days apart; or
  - A uACR

Star Cut Points

HEDIS	2 Stars	3 Stars	4 Stars	5 Stars
KED	**33%**	**49%**	**61%**	**73%**

Tips and Best Practices

- **Documentation**
  - eGFR and uACR lab results are required; documented results from EMR Progress Note are not accepted for Non-Standard Supplemental Data submission
  - Medical record documentation is accepted to exclude patients from the denominator in the following cases:
    - Patients with end-stage renal disease any time during patient's history on or prior to December 31
    - Patients who have been diagnosed with polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes
- **Innovaccer**
  - Utilize InNote at point-of-care
  - Utilize Network PCP Dashboard/Quality tab to create list of patients with open care gap for Kidney Health Evaluation for Patients with Diabetes
- **Clinical***
  - Create in-house lab workflow and documentation in EMR
  - Pre-visit huddles/planning process with clinical staff (Provider/Scribe/MA)
  - Analyze appropriateness of routine labs for diabetic patients
  - Education of patient that kidney disease is asymptomatic in early stages and routine testing is recommended
  - Education of patient about disease process for improved management of health condition
  - Care coordination with a network nephrologist for patients with CKD 4 and CKD 5
- **Office Team & Resources**
  - Team member reviews chart following visit to ensure lab was ordered and given to patient
  - Office team member to mail lab order to patient, if needed
  - Workflow in place for staff to generate a list of lab orders placed and monitors for completion; if report not received in 30 days, follow up with patient
  - Creation of alerts in EMR for laboratory test due dates

**Patients with diabetes can request these laboratory tests without an order from their provider.*

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Exclusions*

- Palliative Care any time during the measurement year
- Hospice care or utilization of hospice services any time during measurement year
- Frailty and Advanced Illness (diagnosis must be in current measurement year)
    - Beginning Jan. 1, 2023, Frailty exclusion requires two different dates of service during the measurement year
- Living in Long-term Care Facility any time during the measurement year
- Patients with end-stage renal disease diagnosis or dialysis any time during patient's history on or prior to December 31
- Patients who have not been diagnosed with diabetes
- Patients who have been diagnosed with polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes

**All exclusion considerations must be submitted through claims, by place of service, services provided or exclusionary diagnosis*

Codes Used to Close Measure

Estimated Glomerular Filtration Rate Lab Test:

Code Type	Code	Description
CPT®	80047	Estimated Glomerular Filtration Rate Lab Test
CPT®	80048	Estimated Glomerular Filtration Rate Lab Test
CPT®	80050	Estimated Glomerular Filtration Rate Lab Test
CPT®	80053	Estimated Glomerular Filtration Rate Lab Test
CPT®	80069	Estimated Glomerular Filtration Rate Lab Test
CPT®	82565	Estimated Glomerular Filtration Rate Lab Test
LOINC	48642-3	Estimated Glomerular Filtration Rate Lab Test
LOINC	48643-1	Estimated Glomerular Filtration Rate Lab Test
LOINC	50044-7	Estimated Glomerular Filtration Rate Lab Test
LOINC	50210-4	Estimated Glomerular Filtration Rate Lab Test
LOINC	50384-7	Estimated Glomerular Filtration Rate Lab Test
LOINC	62238-1	Estimated Glomerular Filtration Rate Lab Test
LOINC	69405-9	Estimated Glomerular Filtration Rate Lab Test
LOINC	70969-1	Estimated Glomerular Filtration Rate Lab Test
LOINC	77147-7	Estimated Glomerular Filtration Rate Lab Test
LOINC	88293-6	Estimated Glomerular Filtration Rate Lab Test
LOINC	88294-4	Estimated Glomerular Filtration Rate Lab Test
LOINC	94677-2	Estimated Glomerular Filtration Rate Lab Test
LOINC	96591-3	Estimated Glomerular Filtration Rate Lab Test
LOINC	96592-1	Estimated Glomerular Filtration Rate Lab Test
LOINC	98979-8	Estimated Glomerular Filtration Rate Lab Test
LOINC	98980-6	Estimated Glomerular Filtration Rate Lab Test
SNOMED	12341000	Estimated Glomerular Filtration Rate Lab Test
SNOMED	18207002	Estimated Glomerular Filtration Rate Lab Test
SNOMED	241373003	Estimated Glomerular Filtration Rate Lab Test
SNOMED	444275009	Estimated Glomerular Filtration Rate Lab Test
SNOMED	444336003	Estimated Glomerular Filtration Rate Lab Test
SNOMED	446913004	Estimated Glomerular Filtration Rate Lab Test
SNOMED	706951006	Estimated Glomerular Filtration Rate Lab Test
SNOMED	763355007	Estimated Glomerular Filtration Rate Lab Test

Quantitative Urine Albumin Lab Test:

Code Type	Code	Description
CPT®	82043	Quantitative Urine Albumin Lab Test
LOINC	14957-5	Quantitative Urine Albumin Lab Test
LOINC	1754-1	Quantitative Urine Albumin Lab Test
LOINC	21059-1	Quantitative Urine Albumin Lab Test
LOINC	30003-8	Quantitative Urine Albumin Lab Test
LOINC	43605-5	Quantitative Urine Albumin Lab Test
LOINC	53530-2	Quantitative Urine Albumin Lab Test
LOINC	53531-0	Quantitative Urine Albumin Lab Test
LOINC	57369-1	Quantitative Urine Albumin Lab Test
LOINC	89999-7	Quantitative Urine Albumin Lab Test
SNOMED	104486009	Quantitative Urine Albumin Lab Test
SNOMED	104819000	Quantitative Urine Albumin Lab Test

Urine Creatinine Lab Test:

Code Type	Code	Description
CPT®	82570	Urine Creatinine Lab Test
LOINC	20624-3	Urine Creatinine Lab Test
LOINC	2161-8	Urine Creatinine Lab Test
LOINC	35674-1	Urine Creatinine Lab Test
LOINC	39982-4	Urine Creatinine Lab Test
LOINC	57344-4	Urine Creatinine Lab Test
LOINC	57346-9	Urine Creatinine Lab Test
LOINC	58951-5	Urine Creatinine Lab Test
SNOMED	8879006	Urine Creatinine Lab Test
SNOMED	36793009	Urine Creatinine Lab Test
SNOMED	271260009	Urine Creatinine Lab Test
SNOMED	444322008	Urine Creatinine Lab Test

Renal Education & Care Management Support

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Kidney Smart®

Online, no cost kidney education available to all.

Kidney Smart® Patient Flyer

If you can't make it to an in-person class, attend from the comfort of home and take control of your kidney health.

Instructor-led online classes are taught by kidney care experts. You can easily ask questions similar to if you were in an in-person class setting.

More than 175,000 people have taken the next step in kidney education by attending a Kidney Smart class.

Are you ready to take the next step? Register today at **KidneySmart.org** or

call 623-203-4751

Classes are available to anyone at no cost. You will learn:

- What causes kidney disease
- What kidney diet resources are available
- What can be done to manage a healthy lifestyle
- How medication management can help lead to better kidney health
- Why employment and insurance coverage are important
- What treatment options are available
- How the transplant process works

Kidney Smart® Provider Recommendation Sheet

Recommendation to Kidney Smart

Patient needs:

- ☐ CKD Basics (overview of Managing CKD and all modalities)
- ☐ Managing CKD – Diet & Lifestyle Only
- ☐ Modality Education (overview of all modalities)
- ☐ Home Specific Education – PD
- ☐ Home Specific Education – HHD

To recommend your patient to Kidney Smart, follow these 4 simple steps:

1. Complete this form or print the patient's demographics from your EMR
2. Fax this form along with necessary documents to the number listed below
3. Let your patient know they will receive a call to get scheduled for their class
4. You will receive updates via email on the patient's class completion status via the Physician Status Update Tool (PSUT)

Remind patients that a Kidney Smart Class can include:

- General kidney education
- Kidney diet considerations
- Insurance education
- Resources for working patients
- Treatment options
- How the transplant process works

Patient information

First Name: _____ Last Name: _____

Patient Phone: ___ - ___ - ____ Alternate Phone: ___ - ___ - ____

Date of Birth: _____ Recommending Physician Name: _____

Language Preference: ☐ English ☐ Spanish ☐ Other: _____

Patient GFR: _____

Notes

_____

_____

_____

Please fax this form with patient demographics to: 888-810-2902

Text or call 623-203-4751 for more info.

Kidney Smart

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Care Management Referral Form

Connect high risk members to Complex Care Management.

Banner Plans & Networks

CARE MANAGEMENT REFERRAL FORM

Completed Medical Forms can be sent to:
Fax: 480-655-2537 or Email: BHNPopHealthManagement@BannerHealth.com

Please send Maternal Health or Behavioral Health referrals to:
Behavioral: BUHPCareMgmtBHMailbox@bannerhealth.com Maternal Health: BUHPMaternalChildHealth@bannerhealth.com

Appropriate stabilization of EMERGENT medical or behavioral health concerns shall be initiated through proper emergency or crisis services channels, BEFORE submitting Care Management Referrals. Care Management will outreach to the member within 24 business hours.

Referral Date:_____

Member Information	Referral Information
Primary Health Plan: Please Select	Requested By:_____
Additional Insurances *(If Any)*: _____	Requester Name:_____
Name_____	Phone:_____
Address:_____	
ID #:_____ DOB: _____	Diagnosis:_____
Phone:_____ Language:_____	PCP:_____

Reason(s) for Care Management Request

MEDICAL

- ☐ General Medical Issues *(ex: Member needs help understanding their diseases, coordinating care with their doctors, etc.)*
- ☐ High or Inappropriate medical utilization *(ex: frequent ER visits, frequent PCP changes, medication management issues)*
- ☐ Post Discharge Assistance for continued care management support
- ☐ Medication Assistance *(ex: education, cost barriers, adherence, and polypharmacy)*
- ☐ Chronic condition / Newly diagnosed condition*(s) (specify below)*
- ☐ Non-adherence to PCP treatment plan, missed appointments and/or annual screening
- ☐ High Priority Transplant, HIV, Hemophilia member requesting assistance
- ☐ Interdepartmental Medical Management request for immediate assistance
- ☐ Maternal Child Health – Pregnant, Postpartum (up to 1 year after delivery), Pediatric *(under age 21)*, and CRS
- ☐ Dial Into Diabetes Program – Diabetic Care Management
- ☐ Home Safety Concerns
- ☐ Advance Directive / End of Life Planning
- ☐ Community Resources *(ex: financial needs, transportation, caregiver support, support groups)*
- ☐ ALTCS ONLY – Refer to assigned CM / RN
- ☐ Other *(specify below)*

BEHAVIORAL

- ☐ Routine BH referrals *(ex: member requests advocacy for Behavioral Health or indicates need for BH assistance in some way that is not urgent or related to inpatient and/or medication)*
- ☐ Member / Family member has questions about BH services, how to access covered services, complaints, etc.
- ☐ Suicidal / Homicidal caller. *(Please refer **AFTER** you follow SI/HI protocol)*
- ☐ Member requests referral for BH services *(ex: therapy, groups, etc.)*
- ☐ Mental Health needs *(ex: Dementia, Alzheimer's, depression, substance abuse)*
- ☐ Urgent need for psychotropic medication
- ☐ ALTCS ONLY – Refer to assigned CM/RN
- ☐ Other *(specify below)*

Details Relating to Reason for Referral and Additional Comments *(What happened? What do you want done?)*

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Kidney Disease Virtual Support Group

Virtual support group for anyone affected by kidney disease.

Banner University Medicine Transplant Institute

Transplant Community Alliance

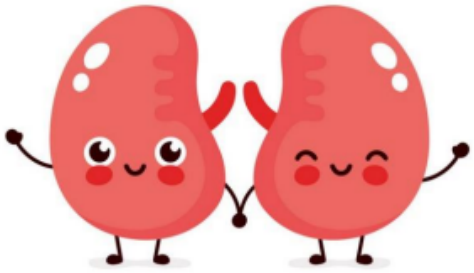
KIDNEY DISEASE VIRTUAL SUPPORT GROUP

In Partnership with the Transplant Community Alliance

Free & All Are Welcome:
Patients, Family, Caregivers, Recipients, Living Donors

When: 1st Thursday of the Month
Where: Join Us Online or by Phone
Time: 7:00PM – 8:00PM

Email for Invite Link:
Loren.Gallegly@bannerhealth.com



Contact: Loren Gallegly, LMSW 602-521-5844 or loren.gallegly@bannerhealth.com

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Palliative Care Providers

Palliative Care										
Provider Name	**Webpage**	**Service Areas**	**Banner MA HMO/PPO**	**Banner MA DUAL**	**Aetna MA**	**BCBS MA**	**UHC MA**	**BUHP ACC**	**BUHP ALTCS**	**Banner Aetna**
Doctor Care 480-575-057 7010 E Acoma Drive Ste 102 Scottsdale, AZ 85254	https://doctorcareaz.com/about.php	Phoenix Metro	x	x				x	x	
Casa De La Luz Palliative Care 520-544-9890 7740 N Oracle Road Tucson, AZ 85704	www.lhcgroup.com	Tucson	x	x				x	x	
Sage Primary & Palliative Care 480-771-3400 3030 N Central Ave Ste 1200 Phoenix, AZ 85012	www.sagefoc.com	Maricopa, Pinal & Pima	x	x				x	x	x
Frances E Davison dba Southwestern Palliative Care 928-366-1067 1950 W 3rd St Yuma, AZ 85364	www.swpchospice.com	Yuma	x	x				x	x	x
Compassus - Phoenix 623-900-2645 5333 N 7th St. STE C-123 Phoenix, AZ 85014	Compassus | Home Health, Infusion, Hospice, & Palliative Care	Maricopa & Pinal	x	x			x	x	x	
Eternity Hospice & Palliative 602-374-68781 4122 W McDowell Rd # 204 Goodyear, AZ 85395	www.eternityhospicepalliativecare.com	Phoenix Metro	x	x				x	x	
Agave Hospice & Palliative Care 602-855-3500 3240 E. Union Hills Drive Ste 145 Phoenix, AZ 85050	Agave – Hospice & Palliative Care (agavehealthcare.com)	Phoenix Metro	X	X			X	X	X	
Palliative Care Alliance 602-269-6011 426 N 44th Street, Suite 450 Phoenix, AZ 85008	https://palliativeca.com/	Maricopa & Pinal							X	
Divine Hospice and Palliative Care 623-566-7995 18185 N 83rd Avenue Suite 203 Glendale AZ, 85308	https://www.divinehospiceaz.com/	Glendale		X				X	X	

It has been the objective of Banner to identify local resources available for patients and their families. Any errors or omissions in the above list is unintentional. Furthermore, exclusion from this list does not imply lack of approval, nor does inclusion indicate coverage endorsement of any resource or its program.

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Home Care Providers

Home Providers										
Provider Information	**Webpage**	**Service Areas**	**Banner MA HMO**	**Banner MA DUAL**	**Aetna MA**	**BCBS MA**	**UHC MA**	**BUHP ACC**	**BUHP ALTCS**	**Banner Aetna**
Geriatric Solutions 602-954-0444 1510 E Flower St. Phoenix, AZ 85014	www.geriatricsolutions.org	Maricopa County	X	X			X	X	X	
My Doctor Now 480-677-4663 Multiple Locations	www.mydrnow.com	Phoenix Metro		X			X			
ASAP Health Solutions 602-996-5595 29455 N Cave Creek Rd #118 Cave Creek, AZ 85331	www.asaphealthsolutions.com	Phoenix Metro		X						
Southwest Geriatric 520-314-3412 6890 E Sunrise Dr Tucson, AZ 85750	www.swgeriatrics.com	Tucson	X	X				X	X	
Dispatch Health Urgent Care at Home 480-351-3918 Multiple locations	www.dispatchhealth.com	Phoenix Metro	X	X			X	X	X	

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References

References

Renal Care Provider One Pager

- Centers for Disease Control and Prevention. *Chronic Kidney Disease in the United States, 2023*. Centers for Disease Control and Prevention, US Department of Health and Human Services; 2023.
- Identify & Evaluate Patients with Chronic Kidney Disease - NIDDK (nih.gov)
- CKD Early Identification & Intervention Toolkit (https://www.theisn.org/initiatives/toolkits/ckd-early-screening-intervention/)
- Heat map adapted from Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. Kidney Int Suppl. 2013;3:1-150 and National Kidney Foundation (https://www.kidney.org/).

Renal Care Guidelines and Renal Medication Alternative Guidelines

- de Brito-Ashurst, I., Varagunam, M., Raftery, M. and Yaqoob, M., 2009. Bicarbonate Supplementation Slows Progression of CKD and Improves Nutritional Status. *Journal of the American Society of Nephrology*, 20(9), pp.2075-2084.
- *Kidney International Supplements*, 2013. Kidney Disease: Improving Global Outcomes (KDIGO) Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. Kidney Int Suppl. 2013;3,1:1–163. 3(1), pp.1-163.
- National Kidney Foundation. 2022. *What is the Criteria for CKD*. [online] Available at: <https://www.kidney.org/professionals/explore-your-knowledge/what-is-the-criteria-for-ckd> [Accessed 11 January 2022].
- Munar, M., Singh, H. 2007. *Drug Dosing Adjustments in Patients with Chronic Kidney Disease*. Am Fam Physician. 2007 May 15;75(10):1487-1496.
- Renal medication recommendations updated per KDIGO 2024 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease, Stevens, Paul E. et al., Kidney International, Volume 105, Issue 4, S117 - S314

The Importance of Early Detection of Kidney Disease Tip Sheet

- Heat map adapted from Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. Kidney Int Suppl. 2013;3:1-150 and National Kidney Foundation (https://www.kidney.org/).
- Lifestyle recommendations adapted from NIDDK: Managing Chronic Kidney Disease - NIDDK (nih.gov), National Kidney Foundation (https://www.kidney.org/).

Palliative Care in Advanced CKD and ESRD Tip Sheet

- https://www.medpagetoday.com/opinion/second-opinions/108848
- National Kidney Foundation: Palliative Care Helps Patients with Kidney Disease (https://www.kidney.org/kidney-topics/palliative-care-helps-patients-kidney-disease)

Acronyms:

ACE-I:	Angiotensin-Converting Enzyme Inhibitor
ACR:	Albumin-to-Creatinine Ratio
AER:	Albumin Excretion Rate
AKI:	Acute Kidney Injury
ARB:	Angiotensin II Receptor Blocker
BHN:	Banner Health Network
CKD:	Chronic kidney disease
eGFR/GFR:	Estimated Glomerular Filtration Rate/Glomerular Filtration Rate
ESA:	Erythropoietin Stimulating Agent
ESRD:	End Stage Renal Disease
KDIGO:	Kidney Disease: Improving Global Outcomes
KED:	Kidney Health Evaluation for Patients with Kidney Disease
NSAIDs:	Non-Steroidal Anti-Inflammatory Drugs
PPIs:	Proton Pump Inhibitors
PTH:	Parathyroid Hormone
RAS:	Renin-Angiotensin-System
RBC:	Red Blood Cells
SGLT2:	Sodium-Glucose Cotransporter-2 Inhibitors
SLE:	Systemic Lupus Erythematosus