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2026 CDI Quality Documentation Tips Adults

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CDI QUALITY DOCUMENTATION TIPS ADULTS

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HEART FAILURE

Documentation Requirements:

- **Acuity:** Acute, exacerbation/acute on chronic, or chronic
- **Type:** With reduced EF, with preserved EF or with diastolic dysfunction
- **If right sided HF:** Document any associated conditions (i.e., pulmonary hypertension, acute or chronic cor pulmonale, etc.)

CLINICAL INDICATORS OF ACUTE OR ACUTE ON CHRONIC HEART FAILURE:

- Elevated weight > 4.5kg in 5 days requiring CHF treatment
- Pulmonary edema, rales/crackles, tachypnea, orthopnea, extremity swelling
- Hyponatremia
- Persistent cough with white/pink blood-tinged phlegm
- Increasing/new pleural effusion on CXR, supplemental oxygen
- IV diuretic (usually Lasix or Bumex)
- In general, a BNP > 500 or proBNP > 3000 (in absence of renal dysfunction) is an indicator of acute or acute on chronic HF

ACUTE RENAL FAILURE/ACUTE KIDNEY INJURY

Documentation Requirements: **"Renal Insufficiency"** and **"Acute Kidney Disease"** are not reported as acute kidney injury or acute renal failure

CLINICAL INDICATORS OF ACUTE RENAL FAILURE/ACUTE KIDNEY INJURY:

- Srum creatinine increased 0.3 mg/dl in 48 hours OR
- Increased 1.5 x base creatinine in 7 days OR
- Urine output < 0.5 ml/kg/hour for 6 hours
- Diagnosis of **ACUTE KIDNEY INJURY** depends on the normal baseline for the individual patient, not the reference range for the test
- **Presence of AKI without improvement in creatinine ≥ 72 hours? Consider a diagnosis of AKI with ACUTE TUBULAR NECROSIS**

ALTERED MENTAL STATUS

Altered Mental Status (AMS) is a **symptom**– what is the cause?
Documentation Requirements – Encephalopathy:

- Presence of encephalopathy
- **Specificity/Etiology** of Encephalopathy:
  - Metabolic
  - Toxic
  - Septic
  - Hypertensive
  - Due to diabetes
  - Due to drugs
  - Hepatic
  - Hypoxic/anoxic
    - Is the encephalopathy acute or chronic?

CLINICAL INDICATORS OF ALTERED MENTAL STATUS

- Any diffuse disease of the brain that alters brain function
- Progressive memory loss, progressive loss of consciousness, lethargy, or loss of cognitive ability
- Reduced Glasgow Coma Scale
- Patient can be described as having delirium, acute confusion, or altered level of consciousness
- EEG demonstrates global dysfunction
- Mental status returns to baseline with correction of the underlying cause

MALNUTRITION

Documentation Requirements:

- Presence of malnutrition
- Severity (mild, moderate, severe)
- With or without cachexia

•Specify **treatment and/or monitoring** associated with malnutrition diagnosis (i.e. dietary consult, dietary supplements, medications to stimulate appetite)

•Relate Malnutrition diagnosis as a link to PREVIOUS GASTROINTESTINAL SURGERY, or other acute illness or trauma, etc., when appropriate

CLINICAL INDICATORS OF MALNUTRITION

- Insufficient energy intake
- Weight loss
- Loss of muscle mass
- Loss of subcutaneous fat
- Localized or generalized fluid accumulation that can mask weight loss (as an alternative to #2)
- Diminished functional status as measured by hand grip strength device

PNEUMONIA

Documentation Requirements:
1)Presence of pneumonia (clinical diagnosis)
2)Specificity of pneumonia based on treatment (Pneumonia due to aspiration, COVID-19, gram-negative bacteria, MRSA, etc.)

- **Documentation of type can be specified based on clinical suspicion and treatment**
- Sputum Culture is NOT required for diagnosis of Pneumonia
- **CAP, HAP, and HCAP** indicate where the Pneumonia was acquired and not a specific type (these will code to a pneumonia unspecified)
- Documentation of a "complex pneumonia" will not suffice
- Specify Type (i.e. bacterial [specify organism], viral, aspiration [specify substance], fungal, ventilator-associated, etc.)
- Specify associated conditions (i.e. sepsis,HIV disease, influenza, etc.)
- Antibiotics typically used to cover "Complex" Pneumonias: Amikin/Amikacin, Ancef/Cefazolin, Avelox/Moxifloxacin, Cefoxitin (Aspiration), Ceftaroline, Ceftin/Cefuroxime, Clindamycin (Aspiration), Gentamycin, Merrem/Meropenem, Unasyn/Ampicillin-Sulbactam,Vancocin/Vancomycin, Zyvox (Linezolid)

RESPIRATORY FAILURE

Documentation Requirements:

- Acuity (Acute, Acute on Chronic, Chronic)
- Type (Hypoxic, hypercapnic/hypercarbic)
- Oxygen dependence/Home oxygen
- Present on admission status

- Specify if applicable, tobacco use, abuse, dependence or exposure
- Mechanical Ventilation/Intubation is NOT required for a diagnosis

CLINICAL INDICATORS OF RESPIRATORY FAILURE

Acute

- Symptoms include: dyspnea, tachypnea (RR > 20, or < 10), nasal flaring, cyanosis, speaking in short sentences, possible use of accessory muscles, or reduced respiratory drive

Hypoxemic

- pO2 < 60 mmHg (SpO2 < 91%) on room air*, or P/F ratio (pO2/FiO2) < 300*, or 10 mmHg decrease in baseline pO2 (if known)
- *Do not use for patient with chronic respiratory failure on continuous home O2*

Hypercapnic

- pCO2 > 50 mmHg with pH < 7.35, or 10 mmHg increase in baseline pCO2 (if known)
-

Acute on Chronic

- Home oxygen levels increase. Also see above for changes in baseline pO2 and pCO2

Chronic

- Typically on home O2 for chronic hypoxemia. May be described as “oxygen and/or steroid dependent”; develops slowly, may demonstrate renal compensation and increased bicarb on ABGs (if Chronic Hypercarbic Respiratory Failure); Common for patients to also have issues with pulmonary mechanics (i.e. neuromuscular disease), pulmonary function (i.e. COPD) or abnormal central respiratory drive (i.e. spinal cord injury, Obesity-Hypoventilation Syndrome, etc.)

SEPSIS

- Do NOT document **"UROSEPSIS"** - document Sepsis secondary to UTI instead
- Bacteremia is NOT synonymous with Sepsis
- Specify Causative Organism if known
- Specify Related Local Infection (i.e. Pneumonia, Cellulitis, UTI, etc.)
- Specify Present on Admission (POA) vs. Hospital Acquired
- Specify Due to or Related to, if Sepsis is due to a Device, Implant, Graft, Infusion, or Abortion
- Specify Acute Organ Dysfunction that is due to Sepsis (i.e. Encephalopathy, ARDS, Acute Respiratory Failure, etc.)

CLINICAL INDICATORS OF SEPSIS

- Sepsis-3: Sepsis defined as acute organ dysfunction due to infection(confirmed or suspected)
- Acute Organ Dysfunction is determined by a 2-point change from baseline of the Sequential (Sepsis-related) OrganFailure Assessment (SOFA) using the six defined organ systems **(see next page)**

RANZANI OT, SINGER M, SALLUH JIF, ET AL. DEVELOPMENT AND VALIDATION OF THE SEQUENTIAL ORGAN FAILURE ASSESSMENT (SOFA)-2 SCORE. JAMA. PUBLISHED ONLINE OCTOBER 29, 2025. DOI:10.1001/JAMA.2025.20516

CLINICAL INDICATORS OF SEPSIS - NEW! SOFA -2

Organ System, Measurement	0	1	2	3	4
Respiratory PaO2/FiO2, mmHg	>300	</= 300	</= 225	</= 150 and advanced ventilatory support	</= 75 and advanced ventilatory support or ECMO
Kidney Creatinine mg/dL	</= 1.2	</= 2.0 or urine output <0.5 mL/kg/h for 6-12 h	</= 3.5 or urine output <0.5 mL/kg/h for >12h	>3.5 or urine output <0.3 mL/kg/h for >/= 24h or anuria >12h	Receiving or fulfills criteria for RRT
Hemostasis Platelets x103/mm3	>150	</= 150	</= 100	</= 80	</= 50
Liver Bilirubin, mg/dL (µmol/l)	</= 1.20	</= 3.0	</= 6.0	</= 12.0	>12.0 (> 204)
Cardiovascular MAP or use of vasopressor	>/= 70 w/o vasopress or or inotrope	< 70 w/o vasopressor or inotrope	Low dose vasopressor or any does of other vasopressor or inotrope	Medium dose vasopressor or low dose vasopressor w/any other vasopressor or inotrope	High dose vasopressor or medium dose vasopressor w/any other vasopressor or inotrope or mechanical support
Brain GCS	GCS 15 or thumbs up, fist or peace sign	13 - 14 or localizing to pain or needing meds for delirium	9 - 12 or withdrawal from pain	6-8 or flexion to pain	3-5 or extension to pain, no response to pain, general myoclonus

Meet the Experts

Alyce Reavis, RN, MSN, CCDS, CCS

Alyce brings extensive clinical experience in adult, pediatric, and neonatal care to her work in CDI education and documentation improvement. She holds an MSN in Leadership/Education along with CCDS, CCS, and AHIMA's outpatient CDI micro credential, supporting organizations in documentation accuracy and quality reporting. She has presented at the ACDIS National Convention, local chapter meetings, and the ACDIS Virtual Best Practices conference.

Rachel Mack, RN, MSN, CCDS, CDIP, CCS, CRC

Rachel is a CDI leader with 13+ years in CDI and 17 years as an RN, with experience building CDI teams and supporting program development across multiple health systems. She has held CDI specialist, educator, manager, and auditor roles at SCL Health/ Intermountain, worked in CDI education and technology at Iodine Software, and consulted on risk adjustment and quality initiatives at Vizient. She has presented at ACDIS and AHIMA events and previously worked as a CVICU nurse at Vanderbilt.

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We partner to BRIDGE THE GAP between financial, clinical and operational processes impacting quality outcomes and improving organizational sustainability.

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