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CDI Quality Documentation Tips Pediatrics

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ABUSE OR NEGLECT

- Document if abuse, neglect, or maltreatment is suspected, confirmed, or ruled out
- Specify reason for suspicion (i.e. inappropriate parental response, inadequate history of injury, mechanism of injury not consistent with physical findings, evidence of neglect or abuse, etc.)
- Specify physical exam findings as appropriate including physical and emotional state of the child, hygiene, appropriateness of clothing, growth measurement, skin findings (i.e. bruises, burns, etc.), ophthalmic exam, genital exam, and radiological findings
- Include drawings of injuries and details of dimensions, color, shape, texture

ACUTE RENAL FAILURE/ACUTE KIDNEY INJURY

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

CLINICAL INDICATORS, ACUTE RENAL FAILURE/ACUTE KIDNEY INJURY

- Serum 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**

EPILEPSY

- Document if Epilepsy is **Intractable AND** with or without **status epilepticus**
- Specify Type (i.e. generalized idiopathic, simple partial, complex partial, etc.)
- Specify any special epileptic syndromes (i.e. seizure r/t ETOH, drugs, sleep deprivation, etc.)
- Specify Control, including descriptions of poorly controlled, pharmacoresistant, treatment resistant, refractory, etc.)

CYSTIC FIBROSIS

- **What CF manifestation is causing the inpatient admission?**
- **Pulmonary** (acute respiratory failure, pneumonia, allergic bronchopulmonary aspergillosis, MRSA/MSSA pneumonia, spontaneous pneumothorax, bronchiectasis)
- Gastrointestinal (meconium ileus, volvulus, distal intestinal obstruction syndrome, intussusception)
- **Hepatobiliary** (exocrine pancreatic insufficiency, secondary diabetic issues like DKA with or without diabetic coma, obstruction of bile duct, acute pancreatitis)
- Document if admission is related to a pulmonary manifestation, complication or exacerbation of cystic fibrosis
- Document any infectious organisms present (i.e. Pseudomonas, Staph, Hemophilus) and clarify if active infection or colonized
- If the patient has pneumonia, please correlate the type (aspiration, due to gram-negative organism, MRSA, MSSA, Pseudomonas, etc.)

CEREBRAL PALSY

- Document the presence of **SPASTICITY**
- Specify type (i.e. quadriplegic, diplegic, hemiplegic, dyskinetic, athetoid, etc.)

INTELLECTUAL DISABILITY

- Formerly known as mental retardation and commonly associated with Down's Syndrome, birth defects, Fetal Alcohol Syndrome, infection, head trauma, drugs, poisons, and toxins
- Document adaptive behavior problem (i.e. language, literacy, self-direction, social skills, or practical skills like activities of daily living, occupation, and safety)
- Specify comorbid conditions (i.e. functional quadriplegia, pressure ulcers, aspiration pneumonia, etc.)
- Specify severity of intellectual disability (see below)

CLINICAL INDICATORS, INTELLECTUAL DISABILITY

- Mild: IQ 50 – 69
- Moderate: IQ 35 – 49
- Severe: IQ 20 – 34
- Profound: IQ < 20
- Borderline intellectual function (IQ 70 – 84) is considered a learning disability

MALNUTRITION

- Acute malnutrition is defined as < 3 months duration
- Chronic malnutrition is defined as > 3 months duration
- **Specify degree of Malnutrition:**
 - Mild
 - Moderate
 - Severe
- Specify any related social or environmental issues (social determinants of health or SDOH can be self-reported):
 - Homelessness
 - Food insecurity or lack of adequate food
 - Inadequate housing utilities

CLINICAL INDICATORS, MALNUTRITION

(for those at least 1 month of age or corrected gestational age)

- Mild: wt.: length or BMI: age z-score < -1
OR z-score decrease < 1 in wt.: age or length/height: age
- Moderate: wt.: length or BMI: age z-score < -2 OR z-score decrease > 1 in wt.: age or length/height: age
- Severe: wt.: length or BMI: age z-score < -3
OR z-score decrease > 2 in wt.: age or length/height: age

OBESITY IN CHILDREN

- Newer codes for childhood obesity were recently introduced
- Nearly 1 in 5 children are obese or morbidly obese in the U.S.
- Even though an 18 y/o is legally considered an adult, the BMI section of ICD-10 explains that BMI adult codes are for patients 20 years of age or older and BMI pediatric codes are for patients age 2 to 19

DOCUMENTATION ASSISTANCE, OBESITY IN CHILDREN

- Provider must document **overweight, obesity** or **morbid obesity**; then CDI/Coding can capture the associated BMI or growth chart range:
 - **Healthy weight**: 5th percentile to < 85th percentile
 - **Overweight**: 85th percentile to < 95th percentile
 - **Obesity**: 95th percentile or greater
 - **Severe obesity**: 120% of the 95th percentile or greater OR 35 kg/m² or greater

NEWBORN DOCUMENTATION

- Document where the **BIRTH** occurred (i.e. in hospital [specify delivery type], or outside hospital)
- Any maternal conditions affecting the Newborn
- Gestational age of the Newborn
- Weight of the Newborn
- Any congenital vs. acquired conditions
- Any associated diagnoses/conditions

RESPIRATORY FAILURE, DOCUMENTATION REQUIREMENTS

- **Acuity** (acute, acute on chronic, chronic)
- **Type** (Hypoxic, hypercapnic/hypercarbic)
- Present on admission (POA) status of respiratory failure

Additional documentation and information:

- Oxygen dependence/Home oxygen
- Present on admission status
- Mechanical ventilation/intubation is NOT required for a diagnosis

CLINICAL INDICATORS, 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. Tachycardia and tachypnea criteria based on age.

Acute on Chronic

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

CLINICAL INDICATORS, RESPIRATORY FAILURE, CONT'D

Chronic

- Typically, on home O2 for chronic hypoxemia. May be described as "oxygen 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.)

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)

SEPSIS

Do not document **Urosepsis**, document Sepsis due to UTI

- Specify causative organism, if known
- Specify related local infection (i.e. Pneumonia, Cellulitis, UTI, etc.)
- Specify if Present on Admission(POA) vs. HospitalAcquired
- Specify if the Sepsis is due to a device, implant, graft, infusion, or abortion
- When Sepsis and cardiovascular organ dysfunction occur (see organ dysfunction criteria)
- Specify any circulatory failure or other associated organ dysfunction as a result of Sepsis

CLINICAL INDICATORS, SEPSIS

Pediatric sepsis is defined as a suspected or confirmed infection and a Phoenix sepsis score of ≥ 2 points. It applies to children <18 YO but not neonates whose post conceptual age is <37 wks.

- Altered mental status
- Brisk or delayed capillary refill
- Mottled or cool extremities
- Hypo- or hyperglycemia
- Electrolyte abnormalities
- Elevated liver and renal function panels
- Elevated CRP
- Hypothermia or fever
- Brady- or tachycardia

SEVERE SEPSIS

Septic shock in pediatric patients is defined as meeting sepsis criteria that includes ≥ 1 cardiovascular point(s)

CLINICAL INDICATORS, SEVERE SEPSIS

Pediatric sepsis is defined as a suspected or confirmed infection and a Phoenix sepsis score of ≥ 2 points. It applies to children <18 YO but not neonates whose post conceptual age is <37 wks.

Cardiovascular

- Hypotension, vasoactive drugs needed to maintain BP or two of the following:
- Metabolic acidosis
- Elevated arterial lactate
- Oliguria
- Prolonged capillary refill

Hematologic

- Platelet count $< 80,000/\text{mm}$ or decline of 50% in the platelet count from highest recorded value over the past 3 days (for chronic hematology/oncology patients)
- International normalized ratio > 2

Hepatic

- Total bilirubin $> 4\text{mg/dl}$ (not applicable for Newborn)
- ALT 2 times upper limit of normal for age

Neurologic

- Glasgow Coma Score < 11
- Acute change in mental status with decrease in Glasgow Coma Scale > 3 points from abnormal baseline

Renal

- Serum creatinine > 2 times upper limit of normal age or 2-fold increase in baseline creatinine

Respiratory (see also criteria under respiratory failure)

- P/F ($p\text{O}_2/\text{FiO}_2$) < 300 in absence of cyanotic heart disease or
- Pre-existing lung disease
- $\text{PaCO}_2 > 65$ or 20 mmHg over baseline PaCO_2

PHOENIX SEPSIS SCORE

- **Respiratory 0-3 pts.**
 - 1 pt – PaO₂:FIO₂ < 400 or SpO₂:FIO₂ < 292
 - 2 pts – PaO₂:FIO₂ < 100-200 and IMV or SpO₂:FIO₂ < 148-220 and IMV
 - 3 pts – PaO₂:FIO₂ < 100 and IMV or SpO₂:FIO₂ < 148 and IMV
- **Cardiovascular 0-6 pts.**
 - 1 pt each (up to 3) – 1 Vasoactive medication Lactate 5-10.9 mmol/L
 - 2 pts each (up to 6) – ≥2 Vasoactive medications Lactate ≥ 11 mmol/L
- **Coagulation 0-2 pts. (1 pt each with max of 2pts)**
 - Platelets <100k
 - INR <1.3
 - D-dimer > 2mg/dL
 - Fibrinogen >100 mg/dL
- **Neurological 0-2 pts.**
 - 1 pt – Glasgow Coma Scale ≤ 10
 - 2 pts – Fixed pupils bilaterally

AGE BASED MAP

	1 point	2 points
Age-based	MAP	MAP
<1 month	17-30	< 17
1 to 11 months	25-38	< 25
1 to < 2 years	31-43	< 31
2 to < 5 years	32-44	< 32
5 to < 12 years	36-48	< 36
12 to 17 years	38-51	< 38

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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