Pediatrics & OB/GYN

As part of the fifteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Kelly Benson, BSN, RN, CCDS, regional manager of clinical documentation integrity at Memorial Hermann Texas Medical Center in Houston, Texas, answered these questions. Benson is a member of the ACDIS Furthering Education Committee. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (*jess.fluegel@hcpro.com*).

Q: According to the 2025 CDI Week Industry Survey results, 46.25% of respondents reported their CDI teams review pediatric cases in either the inpatient or outpatient setting. How does your program review pediatric cases, and by whom? Has that structure evolved over time, and if so, how?

A: Our program has been reviewing inpatient neonatal and pediatric ICU cases since approximately 2019. Initially, we started with one reviewer who had both clinical expertise in this population and experience in CDI. Since then, we have expanded the team to include three dedicated reviewers at our flagship hospital. Additionally, there are two other CDI specialists across the other three regional facilities who also review neonatal/pediatric cases.

This structure has evolved as we recognized the need for specialized knowledge to effectively address the unique documentation challenges in pediatric and neonatal care. Expanding the team has allowed us to improve review coverage and enhance the accuracy and quality of our documentation efforts in these critical areas.

Q: The remaining half of CDI programs do not yet review pediatric cases, though 7.48% have plans to in the next 12 months. What advice would you give those looking to expand into pediatric CDI? For those CDI programs with a pediatric population at their organization but who have yet to make the plunge, what do you think are the impediments in their way?

A: For those looking to expand into pediatric CDI, my key advice is to ensure you have reviewers with strong clinical expertise in pediatrics and neonatology. Pediatric cases often involve unique terminology, age-specific diagnoses, and complex care scenarios that require specialized knowledge to accurately assess documentation quality. Starting with a pilot program focused on high-impact areas like the neonatal ICU (NICU) or pediatric ICU (PICU) can help build experience and demonstrate value early on.

It's also important to provide ongoing training and support tailored to pediatric CDI and foster close collaboration with pediatric physicians and care teams. Building trust and rapport with providers is essential to effective documentation improvement.

For programs that haven't started yet, I think the biggest barriers are usually not having enough staff with pediatric experience, lack of training, and juggling other priorities. Sometimes pediatric cases can feel intimidating if your team hasn't worked with them before. Building

good relationships with providers and service line leaders is essential.

Q: The most common pediatric setting/service line reviewed by CDI teams was general pediatric inpatient admissions (chosen by 85.45% of respondents), followed by PICU (79.85%) and NICU (73.51%). Which service lines does your CDI program look at for pediatric cases, and how was that decision made? If you review more than one pediatric setting, what differences are there between them when it comes to chart review, querying, provider engagement, etc.? Does your program have any plans to expand into other pediatric settings/service lines?

A: Our CDI program focuses primarily on pediatric cases in critical care areas, such as NICU and PICU, because we identified these as having the greatest opportunity for documentation improvement and impact on patient care. These settings tend to involve more complex cases, higher acuity, and more detailed documentation needs, making them a natural priority for CDI efforts.

When reviewing multiple pediatric settings, we notice some differences. Critical care cases often require more in-depth chart reviews and detailed clinical queries due to the complexity of diagnoses and treatments. Provider engagement in these units tends to be collaborative but requires sensitivity to the fast-paced environment. In contrast, if we review general pediatric wards or outpatient settings, the documentation challenges and provider interaction styles can vary significantly.

At this time, we have not considered expanding our pediatric CDI coverage beyond critical care to other inpatient pediatric units or outpatient services.

Q: APR-DRG accuracy was the top focus for pediatric reviews (78.36%), followed by ICD-10 coding accuracy (76.12%) and quality measures (53.36%). Risk adjustment was also a top focus, chosen by 39.55% of respondents. What are your top focuses when conducting a pediatric review, and how are those focuses decided by your department? Has it evolved over time, and if so, how and why?

A: When conducting pediatric reviews, our top focuses are ensuring accurate and complete documentation of severity of illness, comorbidities, and risk adjustment factors that impact patient outcomes and reimbursement. We prioritize capturing the complexity of cases because risk adjustment is crucial.

Our focus has been decided through a combination of data analysis—looking at areas with the greatest impact on coding and reimbursement—and collaboration with clinical leaders who help identify common documentation gaps. Over time, our focus has evolved as we've gained more experience and insight into pediatric-specific conditions and coding guidelines. We've expanded from general documentation improvement to a more targeted approach emphasizing risk adjustment to better reflect patient acuity and support quality reporting.

Q: When respondents were asked how they track their pediatric CDI impact, the most common answer was using a modified version of adult-specific CDI software (37.69%). Almost 24% of respondents said they don't currently have a way to track their impact. Does your program track its impact, and if so, how? Do you have any advice for those looking to start? Why do you think this might be a struggle for CDI departments?

A: Yes, our program tracks pediatric CDI impact using a modified version of our adult CDI software. This allows us to capture meaningful metrics and demonstrate our value in pediatric cases, even though the software wasn't originally designed specifically for pediatrics.

For those just starting out, my advice is to find a tracking system that can be adapted to pediatric needs, even if it's not perfect at first. Focus on capturing key metrics like query rates, clarification outcomes, and documentation improvements. Having a way to track impact is critical to showing leadership the value of pediatric CDI and guiding continuous improvement.

I think one of the biggest struggles for CDI departments is either not having any tracking system in place or not knowing which metrics matter most for pediatrics. Without clear data, it's hard to justify resources or tailor your program effectively. Starting with available

tools and refining your approach over time can help overcome these challenges.

Q: The majority of respondents chose respiratory failure as their top queried diagnosis during pediatric reviews (66.79%). Respiratory distress syndrome was in second place (53.36%), and sepsis was in third place (47.01%). Why do you think these three might be the most common diagnoses queried for the pediatric population? Does this reflect the trends at your organization? What strategies has your CDI program implemented to improve accurate documentation of these diagnoses?

A: Respiratory failure, respiratory distress syndrome, and sepsis are among the most common and serious diagnoses in the pediatric population, especially in critical care settings like NICU and PICU. These conditions often involve complex clinical presentations and rapidly changing patient status, which can make documentation challenging and sometimes incomplete or ambiguous. Because these diagnoses significantly impact risk adjustment, severity scores, and reimbursement, they naturally become top targets for CDI queries.

At our organization, this trend is consistent. We see these diagnoses frequently, and ensuring accurate, specific documentation is critical for reflecting the true patient complexity and supporting quality outcomes. To improve documentation, our CDI program has focused on targeted education for providers about the clinical criteria and documentation requirements for these diagnoses. We also use focused query templates to clarify clinical indicators and have fostered strong collaboration with critical care teams to promote timely and precise documentation. Additionally, ongoing collaboration with coding and data monitoring helps us identify patterns and areas needing further attention.

Q: Our team aligns most closely with the group that reviews only OB/GYN charts for high-risk patients or certain conditions. We focus on cases where GYN patients present with complex comorbidities—like cardiac issues—or when complications arise after delivery. The decision was driven by both clinical impact and documentation opportunity. We've found that these high-acuity cases offer the most value from a CDI perspective?

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For programs looking to expand into OB/GYN, I'd suggest starting with high-risk populations or post-delivery complications. Partnering with providers early on and targeting the areas with the greatest potential impact can help build buy-in and show results quickly. ■