Pediatrics and neonatal CDI

As part of the sixteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Rebecca Lewis, MSN, RN, CPN, NPD-BC, CPC, CCDS, CDIP, CCS, CDI supervisor at Nemours Children's Hospital and consultant at Enjoin/PRG, answered these questions. Lewis is a member of the ACDIS Furthering Education Committee, the Florida ACDIS chapter, and the ACDIS Pediatric Networking Group. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (jess.fluegel@hcpro.com).

Q: According to the 2026 CDI Week Industry Survey results, 50.09% of respondents reported their CDI teams review pediatric cases in either the inpatient or outpatient setting, or both. How does your program review pediatric cases, and who reviews them? If you work at a pediatric hospital, what roles make up your team and/or how are responsibilities divided?

A: At Nemours Children's Hospital, our CDI program is entirely pediatric-focused. Our team is composed of CDI specialists with pediatric nursing backgrounds, allowing them to bring clinical expertise specific to neonatal, pediatric, and adolescent populations. We review both inpatient and outpatient encounters, with inpatient CDI focusing on concurrent review, documentation clarification, clinical validation, APR-DRG integrity, coding accuracy, and provider education. We have also expanded into ambulatory CDI to support value-based care, risk adjustment, and documentation improvement initiatives within pediatric primary care.

Through my consulting work, I've seen a variety of staffing models across pediatric organizations. Some hospitals utilize dedicated pediatric CDI teams, while others blend pediatric responsibilities into broader CDI departments. Regardless of structure, the most successful pediatric programs tend to include strong collaboration between CDI, coding, physician advisors, quality, and operational leaders. Because pediatric documentation often involves age-specific conditions, developmental considerations, and diagnoses that differ significantly from adult medicine, pediatric clinical expertise within the CDI team is invaluable.

Q: The most common pediatric setting/service line reviewed by CDI teams was general pediatric inpatient admissions (83.09%), followed by neonatal ICU (NICU, chosen by 79% of respondents) and pediatric ICU (PICU, chosen by 78.7% of respondents). Pediatric surgical services was also chosen by more than half of respondents (61.36%). Which service lines does your CDI program look at for pediatric cases? If you review more than one pediatric setting, how do the tactics, successes, and challenges differ between them? Does your program have any plans to expand into other pediatric settings/service lines?

A: Our CDI program reviews a broad range of pediatric service lines, including general pediatrics, NICU, PICU, hematology/oncology, neurology, pediatric surgical services, and our Comprehensive Cardiac Care Unit (CCCU). As a relatively young pediatric CDI program, we intentionally expanded our review scope over time, beginning with general

pediatrics and gradually moving into more specialized and higher-acuity populations as the team gained experience and confidence. This phased approach allowed us to build pediatric expertise, develop specialty-specific education, and establish strong relationships with providers and service line leaders.

While the goals of CDI remain consistent across service lines, the tactics and challenges can differ significantly. NICU reviews require a strong understanding of neonatal physiology and prematurity-related diagnoses. PICU and cardiac populations often involve complex clinical validation discussions, organ dysfunction, mechanical ventilation, and postoperative management. Hematology/oncology and neurology populations frequently involve chronic disease burden, treatment-related complications, technology dependence, and medically complex patients. Across all specialties, provider education and collaboration remain critical to success.

From my perspective as both a pediatric CDI leader and consultant, one of the most interesting aspects of pediatric CDI is that there is often no universal playbook. Different children's hospitals may use different clinical definitions, documentation practices, and review strategies based on their patient population and provider practice patterns. That variability creates challenges but also highlights the importance of multidisciplinary collaboration when building and expanding pediatric CDI programs.

Looking ahead, I anticipate continued growth in outpatient and ambulatory CDI as value-based care, risk adjustment, and population health initiatives continue to expand within pediatric healthcare.

Q: Clinical validation was the top focus for pediatric reviews (77.47%), followed closely by APR-DRG accuracy (77.47%) and ICD-10 coding accuracy (70.31%). Quality measures were also a top focus, chosen by 47.44% of respondents. What are your top focuses when conducting a pediatric review, and what advice do you have for other CDI professionals seeking to improve the quality and/or expand the focus of their reviews?

A: Clinical validation remains one of our primary focuses, particularly because pediatric medicine lacks universally accepted definitions for many frequently reviewed diagnoses. We also place significant emphasis on APR-DRG accuracy, ICD-10 coding accuracy, severity of illness, risk of mortality, provider education, and denial prevention. In recent years, quality metrics, outpatient documentation, and risk adjustment have become increasingly important areas of focus as pediatric healthcare moves further into value-based care models.

My advice for CDI professionals interested in expanding pediatric reviews is to invest heavily in pediatric-specific education. Adult CDI concepts do not always translate directly to pediatric medicine. Understanding age-specific physiology, normal laboratory ranges, developmental considerations, and common pediatric diagnoses is critical. I would also encourage organizations to partner closely with pediatric physician champions and subject matter experts. Those relationships are instrumental when developing education, establishing clinical definitions, and building credibility with providers.

Q: When respondents were asked how they track their pediatric CDI impact, the most common answer was using a modified version of their adult-specific CDI software (37.2%). About 25% of respondents said they don't currently have a way to track their impact, and another 51.22% track pediatric quality indicators (PDI). Does your program track its impact, and if so, how? Have you noticed benefits from keeping track over time?

A: At Nemours, we track a variety of traditional CDI metrics, including review volume, query volume, physician response rates, APR-DRG impact, productivity, and financial impact. We also monitor trends related to clinical validation, denial prevention, provider engagement, documentation quality, and outpatient initiatives.

Tracking these metrics over time has been invaluable. Longitudinal data allows us to identify educational opportunities, evaluate the success of provider engagement initiatives, demonstrate program value to leadership, and support expansion into new service lines and settings. Through consulting, I've also seen organizations struggle to articulate their value when CDI impact isn't measured consistently. Even simple tracking mechanisms are better than having no data at all, and programs should focus

on measuring outcomes that align with their organization's goals.

Q: The majority of respondents chose respiratory failure as their top queried diagnosis during pediatric reviews (58.7%). This year, sepsis was in second place (39.25%), followed by respiratory distress syndrome (38.57%). Does this reflect the trends at your organization? What strategies has your CDI program implemented to improve accurate documentation of these diagnoses, and have these strategies evolved at all over the last few years with recent changes (such as the Phoenix Sepsis Score criteria)?

A: Respiratory failure and sepsis continue to be among the most common documentation opportunities in pediatric CDI. Respiratory distress syndrome also remains a frequent focus within neonatal populations. These diagnoses can be challenging because clinical presentation varies by age and because pediatric medicine lacks universal consensus definitions in many areas.

At Nemours, one of our major initiatives has been the development of multidisciplinary pediatric respiratory failure definitions. This work brought together CDI, coding, physician leaders, and specialty providers to develop guidance that supports consistency in clinical documentation, coding, provider education, and clinical validation reviews. We have taken a similar approach to provider education around sepsis, emphasizing accurate source documentation, final diagnosis clarification, and alignment between documentation and clinical indicators.

From a consulting perspective, approaches vary widely across children's hospitals. Some organizations have adopted local definitions, others rely on specialty guidance, and many continue to assess emerging evidence. While the Phoenix Sepsis criteria have generated significant discussion, I think most organizations are still evaluating how those criteria fit into their clinical practice, documentation expectations, and CDI workflows. Pediatric CDI professionals should stay informed about evolving literature while recognizing that implementation may look different across organizations.

Q: When asked how their organization establishes clinical definitions for their pediatric population, 43.34% said that a small group does so (e.g., physician advisor, NICU/pediatric physician, coding, CDI) while 11.6% said a clinical criterion committee is organized to do so. How does your organization establish clinical definitions? Do you have any advice for those trying to start this process?

A: At Nemours, we have utilized a multidisciplinary approach when developing clinical guidance, bringing together physician leaders, coding professionals, CDI specialists, and subject matter experts. Our most significant effort has been the development of enterprise pediatric respiratory failure guidance, which was created to support consistency in documentation, coding, provider education, and clinical validation activities across the organization.

Through my consulting work with Enjoin/PRG, I've seen that children's hospitals take a variety of approaches to clinical definitions. Some organizations have long-established internal criteria, while others rely on specialty society guidance or multidisciplinary workgroups to develop or refine definitions that fit their patient population and provider practice patterns. What works well for one children's hospital may not be the best fit for another.

For organizations looking to start this process, I recommend first identifying whether an established industry standard, specialty society guideline, or recognized clinical definition already exists. If so, adopting or aligning with existing guidance can promote consistency and reduce unnecessary variation. When consensus definitions are lacking, organizations may need to develop local guidance that reflects their patient population, provider practice patterns, and available evidence. In either case, physician engagement early in the process is essential to successful adoption and long-term sustainability.

Q: Pediatrics and neonatal CDI have both become important industry topics, especially in recent years. How have you seen the conversation evolve? What external factors do you anticipate influencing how pediatric CDI reviews are conducted, what responsibilities CDI programs are given, etc.?

A: During my time in CDI, I've seen the pediatric CDI conversation evolve significantly. Early discussions often focused on whether pediatric CDI should exist and how pediatric reviews differed from adult CDI. Today, the

conversation is far more advanced and includes topics such as clinical validation, denials management, quality outcomes, ambulatory CDI, risk adjustment, population health, and pediatric-specific clinical definitions.

One trend I've observed through both Nemours and consulting work is growing recognition that pediatric CDI cannot simply mirror adult CDI programs. Pediatric medicine presents unique challenges related to physiology, developmental stages, congenital conditions, and the absence of standardized definitions for many commonly reviewed diagnoses. As a result, organizations are increasingly investing in pediatric-specific education, physician engagement, and multidisciplinary collaboration.

Looking ahead, I believe value-based care, risk adjustment, clinical validation, quality reporting, and payer scrutiny will continue to influence the future of pediatric CDI. I also anticipate significant growth in outpatient and ambulatory CDI as organizations seek to better capture chronic pediatric complexity and support population health initiatives. Most importantly, I think pediatric CDI programs will continue to evolve from a traditional documentation and reimbursement focus into strategic partners supporting data integrity, quality improvement, provider education, and ultimately patient care.