



Ethical Standards for Clinical Documentation Integrity(CDI) Professionals (2020)

Introduction

The Ethical Standards for Clinical Documentation Integrity (CDI) Professionals are based on the American Health Information Management Association's (AHIMA's) Code of Ethics and the Standards for Ethical Coding. A Code of Ethics sets forth professional values and ethical principles and offers ethical guidelines to which professionals aspire and by which their actions can be judged. A Code of Ethics is important in helping to guide the decision-making process and can be referenced by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, insurance providers, courts of law, government agencies, and other professional groups).

The [AHIMA Code of Ethics](#) is relevant to all AHIMA members and credentialed HIM professionals and students, regardless of their professional functions, the settings in which they work, or the populations they serve. The AHIMA Ethical Standards for Clinical Documentation Integrity Professionals are intended to assist in decision making processes and actions, outline expectations for making ethical decisions in the workplace, and demonstrate the professionals' commitment to integrity. They are relevant to all clinical documentation integrity professionals and to those who manage the clinical documentation integrity (CDI) function, regardless of the healthcare setting in which they work, or whether they are AHIMA members or nonmembers.

Ethical Standards

1. Facilitate accurate, complete, and consistent clinical documentation within the health record to demonstrate quality care, support coding and reporting of high-quality healthcare data used for both individual patients and aggregate reporting.
2. Support the reporting of healthcare data elements (e.g. diagnoses and procedure codes, hospital acquired conditions, patient safety indicators) required for external reporting purposes (e.g. reimbursement, value based purchasing initiatives and other administrative uses, population health, quality and patient safety measurement, and research) completely and accurately, in accordance with regulatory and documentation standards and requirements, as well as all applicable official coding conventions, rules, and guidelines.
3. Query the provider (physician or other qualified healthcare practitioner), whether verbal or written, for clarification and/or additional documentation when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g. present on admission indicators). Query the provider if the documentation describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis, or provides a diagnosis without underlying clinical validation.
4. Never participate in or support documentation practices intended to inappropriately increase payment, to qualify for insurance policy coverage, to avoid quality reporting issues, or to skew data by means that do not comply with federal and state statutes, regulations and official rules and guidelines.
5. Facilitate interdisciplinary education and collaboration in situations supporting proper documentation, reporting and data collection practices throughout the facility.
6. Advance professional knowledge and practice through continuing education.

7. Never participate in, conceal unethical reporting practices or support documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or distort data by means that do not comply with federal and state statutes, regulations and official coding rules and guidelines.
8. Protect the confidentiality of the health record at all times and refuse to access protected health information not required for job-related activities.
9. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal reporting practices, and fosters trust in professional activities.
10. Collaborate in a team environment with the coding, quality, and other professionals in the organization.
11. Report unethical, noncompliant, or unlawful activity to the organization's compliance officer or similar official responsible for monitoring such activities.

How to Interpret the Ethical Standards

The following ethical standards are based on the core values of the American Health Information Management Association and the AHIMA Code of Ethics. They apply to all clinical documentation integrity (CDI) professionals. Guidelines for each ethical standard include examples of behaviors and situations that can help to clarify the standard. They are not meant as a comprehensive list of all situations that can occur.

1. Facilitate accurate, complete, and consistent clinical documentation within the health record to demonstrate quality care, support coding and reporting of high-quality healthcare data used for both individual patients and aggregate reporting.

Clinical documentation integrity professionals **shall**:

- 1.1. Facilitate documentation for the reporting of appropriate diagnoses, and procedures, as well as other types of health service related information (e.g. present on admission indicators).
- 1.2. Develop and comply with comprehensive internal reporting policies and procedures that are consistent with official coding rules and guidelines, reimbursement regulations and policies, and prohibit documentation practices that misrepresent the patient's medical conditions and treatment provided.
- 1.3. Foster an environment that supports honest and ethical reporting practices resulting in accurate and reliable data.

The focus of CDI programs should be on the quality and integrity of the documentation regardless of financial impact. Documentation must support the care provided as well as the health status of the patient. Any information not supported by the patient's condition for the current encounter, must not be introduced solely to increase financial reimbursement.

Clinical documentation integrity professionals **shall not**:

- 1.4. Participate in improper preparation, alteration, or suppression of health record information.
- 1.5. Be responsible for updating, adding or deleting diagnoses to the patient problem list in the health record.

2. Support the reporting of healthcare data elements (e.g. diagnoses and procedure codes, hospital acquired conditions, patient safety indicators) required for external reporting purposes (e.g. reimbursement, value based purchasing initiatives and other administrative uses, population health, quality and patient safety measurement, and research) completely and accurately, in accordance with regulatory and documentation standards and requirements as well as all applicable official coding

conventions, rules, and guidelines.

Clinical documentation integrity professionals **shall**:

2.1. Adhere to the official coding conventions and guidelines approved by the Cooperating Parties, the CPT rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets.

Example:

Appropriate tools that assist clinical documentation integrity professionals with proper sequencing and reporting to stay in compliance with existing reporting requirements are available and used.

2.2. Comply with AHIMA's standards governing data reporting practices, including health record documentation and clinician query standards.

3. Query the provider (physician or other qualified healthcare practitioner), whether verbal or written, for clarification and/or additional documentation when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g. present on admission indicators). Query the provider if the documentation describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis, or provides a diagnosis without underlying clinical validation.

Examples 1-3 are documentation of diagnoses not supported by clinical indicators.

Example 1: Acute Hypoxic Respiratory Failure is documented for a patient with COPD exacerbation and the patient's clinical documentation lacks supportive clinical indicators of Acute Respiratory Failure.

Example 2: Sepsis diagnosed without supporting clinical indicators or not meeting all of the facility's established Systemic Inflammatory Response Syndrome (SIRS) criteria and one or more of the criteria could be explained as due to another cause.

Example 3: Provider documentation within the record. 52-year-old female presents with chest pain/pressure. Pain is not sharp or dull in nature and does not radiate. Slight relief while sitting up. No past history of heart issues. Family history of CAD. Vital signs normal. ECG, chest x-ray, and routine blood test to include troponin T ordered. ECG and chest x-ray normal. R/O GERD. Diagnosis: CAD. Suggested action: A query should be sent to the provider as the documentation does not state whether GERD was ruled out; nor do the clinical indicators support the diagnosis of CAD.

Clinical documentation integrity professionals **shall**:

3.1. Participate in the development of query policies that support documentation integrity, and meet regulatory, legal, and ethical standards for coding and reporting.

See AHIMA Practice Brief, [Guidelines for Achieving a Compliant Query Practice](#)

Example 4: Query the provider for clarification: A patient is admitted with pneumonia. 73-year-old male presents with chest pain, dyspnea and productive cough. Physician exam reveals bradycardia and crackles. Admission

diagnosis: Pneumonia. Day 1 progress note: Chest pain, dyspnea, cough, crackles, and fever were present on admission. Antibiotics were ordered. Day 2 progress note: Temperature 98.1 degrees; continue antibiotics; sputum culture positive for *Streptococcus pneumoniae*: diagnosis bacterial pneumonia. Day 3 progress note: Discharge patient. Discharge diagnosis: Pneumonia.

The provider should be queried for greater specificity of pneumonia and if there is a link between the sputum culture results and the pneumonia.

3.2. Query the provider for clarification when documentation in the health record impacts an externally reportable data element and is illegible, incomplete, unclear, inconsistent, or imprecise. The clinical documentation must reflect an accurate and concise representation of the patient's clinical condition(s).

3.3. Query the provider for clarification when a diagnosis is not supported by the clinical indicators in the health record. These types of instances may require referral per the facility's internal escalation policy.

3.4. Use queries as a communication tool to improve the quality of health record documentation, not to inappropriately increase reimbursement or misrepresent quality of care.

Example 5: Policies regarding the circumstances when providers should be queried are designed to promote complete documentation, regardless of whether reimbursement will be affected.

Clinical documentation integrity professionals **shall not**:

3.5. Query the provider when there is no clinical information in the health record prompting the need for a query.

Example 6: Query the provider regarding the presence of gram-negative pneumonia on every pneumonia case, regardless of whether there are any clinical indicators (including treatment) of gram-negative pneumonia documented in the record.

Example 7: Query the provider for sepsis when the clinical indicators are only suggestive of urinary tract infection, such as low grade fever, increased WBCs, and there were no blood cultures obtained.

4. Never participate in or support documentation practices intended to inappropriately increase payment, to qualify for insurance policy coverage, to avoid quality reporting issues, or to skew data by means that do not comply with federal and state statutes, regulations and official rules and guidelines.

Clinical documentation integrity professionals **shall**:

4.1. Facilitate clear, accurate and complete documentation that supports reporting of diagnoses and procedures such that the organization receives proper reimbursement to which the facility is legally entitled, remembering that it is unethical and illegal to increase payment by means that contradict regulatory guidelines.

Clinical documentation integrity professionals **shall not**:

4.2. Misrepresent the patient's clinical picture through intentional incorrect documentation or omission of diagnoses or procedures, or the addition of unsupported diagnoses or procedures to inappropriately increase reimbursement, justify medical necessity, improve publicly reported data, or qualify for insurance policy coverage benefits.

5. Facilitate interdisciplinary education and collaboration in situations supporting proper

documentation, reporting and data collection practices throughout the facility.

Clinical documentation integrity professionals **shall**:

5.1. Assist and educate physicians and other clinicians by advocating proper documentation practices to improve the integrity and specificity that more accurately reflects the acuity, severity and occurrence of events.

Example 8: Failure to advocate for ethical practices that seek to represent the truth in events as expressed by the associated code sets when needed is considered an intentional disregard of these standards.

6. Advance professional knowledge and practice through continuing education.

Clinical documentation integrity professionals **shall**:

6.1. Maintain and continually enhance professional competency and maintaining professional certifications and licensure (e.g., through participation in educational programs, reviewing official coding publications such as the *Coding Clinic for ICD-10-CM and ICD-10-PCS*) in order to stay abreast of changes in official coding guidelines, regulatory, and other requirements.

7. Never participate in, conceal unethical reporting practices or support documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or distort data by means that do not comply with federal and state statutes, regulations and official coding rules and guidelines.

Clinical documentation integrity professionals **shall**:

7.1. Act in a professional and ethical manner at all times.

7.2. Take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

7.3. Be knowledgeable about established policies and procedures for handling concerns about unethical behavior. These include policies and procedures created by AHIMA, licensing and regulatory bodies, employers, supervisors, agencies, and other professional organizations.

7.4. Seek resolution if there has been unethical behavior or if there is a belief of incompetence or impairment through the facility compliance officer or other designated official. Take action through appropriate formal channels, such as contacting an accreditation or regulatory body and/or the AHIMA Professional Ethics Committee.

7.5. Consult with a colleague when feasible and assist the colleague in taking remedial action appropriate to the organization and credentialing licensing body when there is direct knowledge of a professional colleague's incompetence or impairment.

Clinical documentation integrity professionals **shall not**:

7.6. Participate in, condone, or be associated with dishonesty, fraud and abuse, or deception. A non-exhaustive list of examples includes:

- Allowing inappropriate patterns of retrospective documentation to increase reimbursement
- Encouraging documentation that does not justify the diagnoses and/or procedures that have been provided

- Encouraging documentation for an inappropriate level of service
- Adding, deleting, and altering health record documentation (including patient's problem lists) The only exception would be the properly executed, non-leading, appropriate electronic query form, if this document is retained as a permanent part of the medical record.
- Copying and pasting another clinician's documentation without identification of the original author and date
- Supporting documentation practices that knowingly result in reporting incorrect present on admission indicator (s)
- Engaging in the utilization of leading provider queries

8. Protect the confidentiality of the health record at all times and refuse to access protected health information not required for job-related activities.

Clinical documentation integrity professionals **shall**:

8.1. Protect all confidential information obtained in the course of professional service, including personal, health, financial, genetic, and outcome information.

8.2. Access only that information necessary to perform their duties.

9. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal reporting practices, and fosters trust in professional activities.

Clinical documentation integrity professionals **shall**:

9.1. Act in an honest manner and bring honor to self, peers, and the profession.

9.2. Truthfully and accurately represent their credentials, professional education, and experience.

9.3. Demonstrate ethical principles and professional values in their actions to patients, employers, other members of the healthcare team, consumers, and other stakeholders served by the healthcare data they collect and report.

10. Collaborate in a team environment with the coding, quality, and other professionals in the organization.

Clinical documentation integrity professionals **shall**:

10.1. Work in a collaborative team effort with coding professionals. Participate in regularly scheduled team meetings with the coding professionals. Respectfully address differences in opinion regarding the coding of diagnoses and procedures.

11. Report unethical, noncompliant, or unlawful activity to the organization's compliance officer or similar official responsible for monitoring such activities.

Clinical documentation integrity professionals **shall**:

11.1. Follow the organizations procedures for reporting unethical, noncompliant, or unlawful activities.

Resources

[ACDIS Code of Ethics](#)

[AHIMA Code of Ethics](#)

[AHIMA Standards of Ethical Coding](#)

[AHIMA's Data Quality Model](#) (Updated)

AHIMA's position statement on [Statement on Data Stewardship](#)

AHIMA Practice Brief "[Guidelines for Achieving a Compliant Query Practice:](#)"

[ICD-9-CM Official Guidelines for Coding and Reporting](#)

[ICD-10-CM Official Guidelines](#)

[ICD-10-PCS Official Guidelines](#)

[Problem Lists in Health Records: Ownership, Standardization, and Accountability](#)

Approved in June 2016 by the AHIMA House of Delegates