Ethical Standards for Clinical Documentation Improvement (CDI) Professionals (2010)

These standards have been updated. See the latest version here. This version is made available for historical purposes only.

Introduction

The Ethical Standards for Clinical Documentation Improvement (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 Improvement 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 improvement professionals and those who manage the clinical documentation improvement (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 support coding and reporting of high-quality healthcare data.
2. Support the reporting of all healthcare data elements (e.g., diagnosis and procedure codes, and present on admission indicator) required for external reporting purposes (e.g., reimbursement 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 and applicable official coding conventions, rules, and guidelines.
3. Query provider (physician or other qualified healthcare practitioner), whether verbal or written, for clarification and 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 indicator).
4. Refuse to participate in 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 rules and guidelines.
5. Facilitate interdisciplinary collaboration in situations supporting proper reporting practices.
6. Advance professional knowledge and practice through continuing education.
7. Refuse to participate in or conceal unethical reporting practices.
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.

How to Interpret the Ethical Standards

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

http://bok.ahima.org/doc?oid=101609#WBnrkvkrLcs
Example: 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.

Query the provider for sepsis when the clinical indicators are only suggestive of urinary tract infection, such as low grade fever, increased WBCs, no blood cultures obtained, and physician documentation stated urosepsis.

4. Refuse to participate in or support documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statutes, regulations and official rules and guidelines.

Clinical documentation improvement professionals shall:

4.1. Facilitate documentation that supports reporting of diagnoses and procedures such that the organization receives the optimal payment 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 improvement 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 collaboration in situations supporting proper documentation and reporting practices.

Clinical documentation improvement professionals shall:

5.1. Assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, and re-sequence or include diagnoses or procedures when needed to more accurately reflect the acuity, severity, and the occurrence of events.

Example: 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 improvement 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-9-CM) in order to stay abreast of changes in coding guidelines, and regulatory and other requirements.

7. Refuse to participate in or conceal unethical reporting practices.

Clinical documentation improvement 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 colleagues’ 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 is a belief that a colleague has acted unethically or if there is a belief of incompetence or impairment by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive. Take action through appropriate formal channels, such as contacting an accreditation or regulatory body and/or the AHIMA Professional Ethics Committee.