

Welcome to the TIACDI

Clinical Documentation Improvement Training Program

Program Introduction and Overview



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Texas Institute for Advancing Clinical Documentation Integrity (TIACDI), LLC
Clinical Documentation Improvement Education and Certification Preparation
www.tiacdi.org

Table of Contents

Message from the TIACDI Administrative Team	3
Program Introduction	4
1. Program Overview.....	4
2. Mission of TIACDI.....	4
3. Vision.....	5
4. Purpose of the Training Program	5
5. Target Audience	5
6. Training Program Structure.....	6
7. Case-Based Learning Model.....	6
8. Progressive Case Learning	7
9. CDI Question Bank and Mock Certification Exams	7
10. Learning Outcomes	7
11. Program Integration with CDI Practice	8
12. Scope of Clinical Coverage	8
13. Obstetrics, Gynecology, Pediatric, and Neonatal CDI.....	8
14. Certification Preparation	9
15. The CDI Review Process.....	9
Example Training Module Structure.....	10
How Modules Are Organized	19

How to Use This Training Program..... 19

Terms of Use and Training Policies 23

Message from the TIACDI Administrative Team

Welcome to the Texas Institute for Advancing Clinical Documentation Integrity (TIACDI).

Clinical documentation integrity plays a vital role in modern healthcare by ensuring that the patient's clinical story is accurately represented in the medical record. Accurate documentation supports patient care, quality reporting, regulatory compliance, and appropriate reimbursement.

The TIACDI CDI Training Program was developed to provide healthcare professionals with a structured educational pathway for learning both the principles and practical application of Clinical Documentation Integrity. This program integrates clinical knowledge, documentation analysis, and coding awareness to prepare trainees for real-world CDI practice.

Through this program, learners will gain the skills necessary to evaluate medical records, identify documentation gaps, and communicate effectively with providers to improve documentation accuracy and completeness.

We hope this program provides a strong foundation for your CDI career and supports your continued professional development.

Program Introduction

1. Program Overview

The **TIACDI Clinical Documentation Integrity Training Program** is a comprehensive educational curriculum designed to prepare healthcare professionals for effective CDI practice in inpatient acute care settings.

Clinical Documentation Integrity ensures that the patient's medical record accurately reflects the clinical conditions treated during hospitalization. Accurate documentation supports appropriate coding, reliable healthcare data, quality reporting, and regulatory compliance.

The TIACDI curriculum combines **clinical education, documentation analysis, and case-based learning** to develop the skills required for effective CDI review.

2. Mission of TIACDI

The mission of the **Texas Institute for Advancing Clinical Documentation Integrity** is to advance excellence in CDI education by providing structured training programs that integrate clinical medicine, coding science, and documentation improvement strategies.

TIACDI aims to support the development of CDI professionals who can strengthen healthcare documentation quality and data integrity.

3. Vision

The vision of TIACDI is to establish a comprehensive CDI education framework that prepares healthcare professionals to improve documentation accuracy, enhance healthcare data reliability, and support effective clinical communication within healthcare systems.

4. Purpose of the Training Program

The TIACDI training program is designed to:

- Introduce the core principles of CDI practice
 - Develop clinical reasoning skills for documentation review
 - Improve understanding of coding and DRG impact
 - Strengthen physician communication through compliant queries
 - Prepare learners for real-world CDI workflows
-

5. Target Audience

The program is intended for healthcare professionals involved in documentation review and clinical data integrity, including:

- CDI specialists
 - Registered nurses transitioning into CDI roles
 - Inpatient medical coders
 - Physicians and clinical leaders
 - Health information management professionals
-

6. Training Program Structure

The TIACDI curriculum consists of **thirteen modules**, organized primarily by clinical systems.

Each module integrates:

- Clinical education
 - Documentation review principles
 - Coding and DRG considerations
 - Case-based learning scenarios
-

7. Case-Based Learning Model

The program uses a **case-based learning approach** that simulates real CDI chart review.

Each case includes structured clinical documentation elements such as:

- History of Present Illness
- Past Medical History
- Physician documentation
- Vital signs
- Laboratory results
- Imaging studies
- Treatment interventions

Learners analyze these elements to determine appropriate CDI actions.

8. Progressive Case Learning

Many cases follow a progressive format reflecting how clinical conditions evolve during hospitalization.

This structure allows learners to analyze documentation as the clinical story develops and determine when CDI intervention may be appropriate.

9. CDI Question Bank and Mock Certification Exams

The TIACDI training program includes a structured **CDI Question Bank** designed to reinforce learning and prepare trainees for certification exams.

Questions focus on:

- Clinical indicator recognition
- Documentation analysis
- CDI query decisions
- Coding implications
- Present-on-admission determination
- Diagnosis sequencing

The program also includes **mock certification examinations** modeled after nationally recognized CDI certification exams such as **CCDS** and **CDIP**.

10. Learning Outcomes

Upon completion of the program, trainees will be able to:

- Interpret clinical indicators supporting diagnoses
 - Evaluate provider documentation completeness
 - Identify documentation improvement opportunities
 - Apply CDI review strategies across clinical systems
 - Understand the impact of documentation on coding and DRGs
-

11. Program Integration with CDI Practice

The TIACDI curriculum aligns with real-world CDI workflows used in hospitals and healthcare systems.

The program prepares trainees to support:

- Accurate clinical documentation
 - Coding integrity
 - Compliance with documentation standards
 - Reliable healthcare data reporting
-

12. Scope of Clinical Coverage

The primary focus of the TIACDI training program is **adult inpatient acute care documentation**.

Most training cases and clinical examples reflect common inpatient conditions encountered in hospital CDI programs.

13. Obstetrics, Gynecology, Pediatric, and Neonatal CDI

While the program primarily focuses on adult inpatient care, the curriculum includes introductory coverage of:

- Obstetric documentation
- Gynecologic conditions
- Pediatric documentation considerations
- Neonatal documentation concepts

These topics provide foundational awareness for CDI specialists who encounter these patient populations.

14. Certification Preparation

The TIACDI training program incorporates learning strategies designed to support preparation for national CDI certification exams.

Trainees will develop knowledge and analytical skills relevant to certification exams including:

- Certified Clinical Documentation Specialist (CCDS)
 - Certified Documentation Improvement Practitioner (CDIP)
-

15. The CDI Review Process

CDI specialists review medical records using a structured evaluation method.

The TIACDI program teaches trainees to approach chart review using the following workflow:

1. Understand the clinical context of admission
2. Identify clinical indicators
3. Evaluate provider documentation

4. Identify documentation gaps
5. Determine the appropriate CDI action

This structured approach ensures that CDI decisions are grounded in clinical evidence and compliant documentation practices.

Example Training Module Structure

The **TIACDI Clinical Documentation Integrity (CDI) Training Program** is organized into structured modules delivered through the Canvas learning platform. The curriculum guides learners through progressively advanced concepts in clinical documentation integrity and CDI practice.

Each module is divided into focused topic sections that integrate clinical education, documentation analysis, and CDI decision-making strategies. This structure allows learners to progressively build knowledge while developing the analytical skills required for real-world CDI chart review.

For example, **Module 01 – CDI Core Practices & Foundations** introduces the essential principles that form the basis of CDI practice.

The module includes topics such as:

- CDI practice settings and professional roles
- Healthcare payment models and reimbursement fundamentals
- Core CDI decision-making and documentation integrity
- Provider query practice and communication standards
- Hospital-acquired conditions (HACs) and patient safety indicators (PSIs)

- Comorbidity indexes and their relevance to CDI

These topics provide the foundational knowledge required before progressing to system-based clinical modules.

The following images illustrate examples of the module layout, topic organization, and instructional content used throughout the TIACDI training program.

Example: Module-01 _ Core CDI Practices & Foundations _ Topic Structure

Module-01 Main Topics

- [01-1 — CDI Practice Settings & Professional Roles](#)
Inpatient versus outpatient CDI workflows; CDI (CDIP/CCDS) versus coding (CCS) roles; documentation responsibilities and interdisciplinary collaboration.
- [01-2 — Payment Models & Reimbursement Fundamentals](#)
IPPS/MS-DRGs, APR-DRGs, Medicare Advantage (HCC/RAF overview), Accountable Care Organizations (ACOs), and the high-level financial impact of clinical documentation.
- [01-3 — Core CDI Clinical Decision-Making & Documentation Integrity](#)
Diagnosis selection and sequencing, Present on Admission (POA) determination, severity of illness and risk of mortality concepts, distinction between CC/MCC and HCC-based risk adjustment, MEAT criteria, longitudinal documentation consistency, and application of ICD-10-CM Official Guidelines and AHA Coding Clinic for audit-defensible CDI decision-making.
- [01-4 — Query Practice & Provider Communication Standards](#)
Compliant query principles, clinical indicator-based clarification, non-leading and open-ended query structure, professional provider communication, and query fatigue management.
(Delivered as a dedicated multi-part query training series.)
- [01-5 — Hospital-Acquired Conditions \(HACs\) & Patient Safety Indicators \(PSIs\)](#) ✓
POA impact, documentation validation and timing considerations, HAC Reduction Program and PSI-90 implications, quality reporting consequences, and the CDI professional's role in patient safety metrics.
- [01-6 — Elixhauser Comorbidity Index & CDI Relevance](#) ★
Overview of the Elixhauser Comorbidity Index, its use in outcomes analysis and benchmarking, distinctions from CC/MCC and HCC/RAF models, and appropriate CDI interpretation without driving unnecessary or non-compliant queries.

Learners may complete topics in any order unless otherwise instructed.

Figure 1. Example topic structure from Module 01 – CDI Core Practices & Foundations

1 Course Modules Dashboard Overview

Dashboard

Published Courses (15)



[Module-00 Welcome to CDI Train...
Welcome to TIACDI](#)



[Module-01 CDI Core Practices &...
Module-01](#)



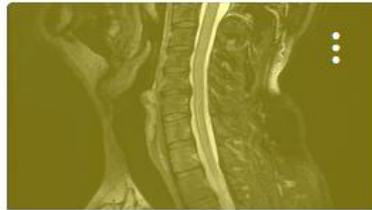
[Module 02 - Respiratory System
Module-02](#)



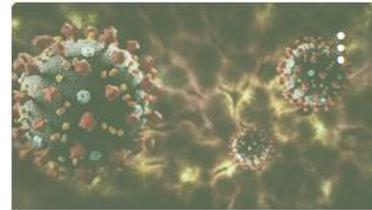
[Module-03 Cardiovascular System
Module-03](#)



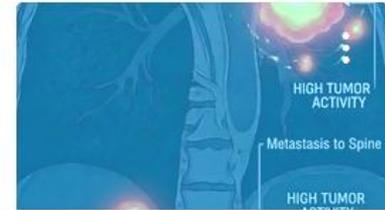
[Module-4 Urinary System/ Metab...
Module-4](#)



[Module-5 Nervous System Disord...
Nervous - 05](#)



[Module-06 Infectious Diseases &...
Module-06](#)



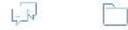
[MODULE 07 - Hematology, Onco...
Module-07](#)



[Module-08 Gastroenterology Syst...](#)
[Module-08](#)



[Module-09 Endocrine System & ...](#)
[Module-09](#)



[Module 10 - Integumentary Syst...](#)
[Module-10](#)



[Module- 11.0 Trauma & Surgical P...](#)
[Module- 11.0](#)



[Module- 11.1 Trauma & Surgical P...](#)
[Module- 11.1](#)



[Module 12 - Critical Care, Multis...](#)
[Module 12](#)



[Module 13 - Mental Health Disor...](#)
[Module 13](#)



Figure 2. Course Modules Dashboard Overview

Course Modules

Module	Focus (Linked)	Description
01	CDI Core Practices & Foundations	Daily CDI tasks, priorities, query workflow, coding reconciliation, sequencing logic (PDX/POA), CC/MCC impact, DRG review, and Coding Clinic references.
02	Respiratory System	CDI principles for COPD, ARDS, pneumonia, and respiratory failure documentation.
03	Cardiovascular System	Guidance for heart failure, MI, arrhythmias, hypertensive crisis, and cardiac arrest documentation.
04	Urinary System/ Metabolic Disorders	CDI indicators for AKI, ATN, CKD, electrolytes, acid-base balance, and rhabdomyolysis.
05	Nervous System Disorders	Documentation for stroke/TIA, encephalopathy, coma, dementia, functional quadriplegia, and mood disorders.
06	Infectious Diseases & Immune Status	Sepsis/SOFA, SIRS, COVID-19, C. difficile, HIV/AIDS, antimicrobial resistance, and immunodeficiency documentation.
07	Hematology, Oncology, and Malignancy-Related Complications	Neoplasms, chemo-related complications, pathologic fractures, documentation for anemia, pancytopenia, coagulopathies, and DVT/PE.
08	Gastroenterology System	Liver failure, pancreatitis, and nutrition overlap (malnutrition).
09	Endocrine System & Nutritional Disorders	Diabetes complications, obesity/BMI, and nutritional risk documentation.
10	Integumentary System & Complex Wound Management	Pressure injuries, staging, and acute skin failure documentation.
11.0	Trauma & Surgical Procedures	Traumatic injuries, accidental puncture/laceration, debridement/biopsy, and drug/toxin adverse effects.
11.1	Trauma & Surgical Procedures (Section 2: Orthopedic & Musculoskeletal Surgery)	This section will focus on ICD-10-PCS coding methods of joint fixation, fusion, or replacement with specific attention to spine surgery.
12	Critical Care, Multisystem Failure, and CDI Strategy	Shock, mechanical ventilation, and systemic physiology cross-links for CDI review.
13	Module 13 – Mental Health Disorders, Substance Use & CDI Strategy	Documentation and CDI strategy for mood disorders, psychotic disorders, substance use severity, suicide-related admissions, psychiatric DRG grouping, poisoning sequencing, and HCC risk adjustment integration.

How to Navigate This Course

2 Example Module Page _Orthopedics Surgery

Module- 11.1 Trauma & Surgical Procedures



Welcome to TIACDI Module - 11.1 Trauma and Surgical Procedures

Section 2. Orthopedic & Musculoskeletal Surgery

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Figure 3. Example Module Page – Orthopedic Surgery

3 Example Module – 11.1 Table of Contents _Orthopedics Surgery

Table of Contents

[Introduction. 3](#)

[Scope of This Section. 3](#)

[ICD-10-PCS Seven-Character Structure \(Reference Table\) 4](#)

[ICD-10-PCS Seven-Character Structure. 5](#)

[Fracture Management 6](#)

[Open Reduction with Internal Fixation \(ORIF\) 6](#)

[Closed Reduction with Internal Fixation. 7](#)

[Why Each Character Matters \(CDI Perspective\) 9](#)

[What is the PCS 7th character "Z"? 11](#)

[Why Some PCS Codes Do Have Qualifiers? 11](#)

[What does 1st character "Section" mean in ICD-10-PCS. 12](#)

[Is Section the same as "Type of Procedure"? 12](#)

[What an ICD-10-PCS "Table" Is. 13](#)

[Hip Procedures. 14](#)

[Spine Procedures 15](#)

[Spinal Vertebra Operations: 16](#)

[The 3-Column Spine Concept \(Denis Model\) 16](#)

[1. Core Spine Root Operations. 18](#)

[Bone Excision vs. Nerve Release: 19](#)

[1. Decompression vs Fusion \(Most Common Confusion\) 23](#)

[2. Spinal Fusion – High Complexity Area. 24](#)

[3. Approach Types in Spine Surgery. 24](#)

Example Module - 01 Topic Structure

Module-01 Main Topics

- **01-1 — CDI Practice Settings & Professional Roles**
Inpatient versus outpatient CDI workflows; CDI (CDIP/CCDS) versus coding (CCS) roles; documentation responsibilities and interdisciplinary collaboration.
- **01-2 — Payment Models & Reimbursement Fundamentals**
IPPS/MS-DRGs, APR-DRGs, Medicare Advantage (HCC/RAF overview), Accountable Care Organizations (ACOs), and the high-level financial impact of clinical documentation.
- **01-3 — Core CDI Clinical Decision-Making & Documentation Integrity**
Diagnosis selection and sequencing, Present on Admission (POA) determination, severity of illness and risk of mortality concepts, distinction between CC/MCC and HCC-based risk adjustment, MEAT criteria, longitudinal documentation consistency, and application of ICD-10-CM Official Guidelines and AHA Coding Clinic for audit-defensible CDI decision-making.
- **01-4 — Query Practice & Provider Communication Standards**
Compliant query principles, clinical indicator-based clarification, non-leading and open-ended query structure, professional provider communication, and query fatigue management.
(Delivered as a dedicated multi-part query training series.)
- **01-5 — Hospital-Acquired Conditions (HACs) & Patient Safety Indicators (PSIs)** 
POA impact, documentation validation and timing considerations, HAC Reduction Program and PSI-90 implications, quality reporting consequences, and the CDI professional's role in patient safety metrics.
- **01-6 — Elixhauser Comorbidity Index & CDI Relevance** 
Overview of the Elixhauser Comorbidity Index, its use in outcomes analysis and benchmarking, distinctions from CC/MCC and HCC/RAF models, and appropriate CDI interpretation without driving unnecessary or non-compliant queries.

Learners may complete topics in any order unless otherwise instructed.

Learners may complete individual module topics in flexible order unless otherwise specified. This allows trainees to focus on specific areas of interest or professional need while maintaining a structured progression through the curriculum.

5 Example Content Page _ ICD-10-PCS _ 7 Character coding

ICD-10-PCS codes have 7 characters, Code Breakdown (Example: 0QS604Z)

Character Position	PCS Character Name	Value	Meaning
1	Section	0	Medical and Surgical
2	Body System	Q	Lower Bones
3	Root Operation	S	Reposition
4	Body Part	6	Femur, Right
5	Approach	0	Open
6	Device	4	Internal fixation device
7	Qualifier	Z	No qualifier

How Modules Are Organized

Each training module follows a consistent educational structure that typically includes:

- Topic-based instructional sections
- Clinical and documentation concepts
- CDI review strategies
- Coding and reimbursement implications
- Case-based learning exercises
- Knowledge assessment questions

This structured approach helps learners develop both **clinical reasoning skills and documentation analysis expertise**.

How to Use This Training Program

The **Texas Institute for Advancing Clinical Documentation Integrity (TIACDI) CDI Training Program** is designed as a structured yet flexible learning experience. The program combines clinical education, documentation analysis, and case-based learning to help trainees develop the analytical skills required for real-world CDI practice.

Learners may progress through the training modules sequentially or focus on specific clinical areas depending on their professional background and learning goals.

Recommended Learning Path

For individuals new to CDI practice, the recommended learning sequence is:

Step 1 – Begin with Module 01: CDI Core Practices & Foundations

This module introduces essential CDI concepts, including:

- CDI workflow and responsibilities
- Documentation integrity principles
- Diagnosis selection and sequencing
- Present-on-admission (POA) determination
- Query compliance and provider communication
- Quality metrics and patient safety indicators

Module 01 provides the foundational knowledge necessary to understand CDI review strategies used throughout the rest of the program.

Step 2 – Progress Through System-Based Modules

After completing the foundational module, learners may progress through the system-based modules covering major clinical areas, including:

- Respiratory conditions
- Cardiovascular diseases
- Renal and metabolic disorders
- Neurologic conditions
- Infectious diseases
- Hematology and oncology complications
- Gastrointestinal and endocrine disorders
- Wound management and trauma documentation

These modules focus on clinical indicators and documentation considerations commonly encountered in inpatient CDI review.

Step 3 – Study Surgical and Critical Care Topics

Advanced modules address more complex documentation scenarios, including:

- Trauma and surgical procedures
- Orthopedic and musculoskeletal surgery
- Critical care and multisystem failure

These modules introduce CDI considerations related to procedure documentation, ICD-10-PCS concepts, and high-acuity clinical conditions.

Using the CDI Question Bank

The training program includes a comprehensive **CDI Question Bank (Q-Bank)** designed to reinforce learning and develop clinical reasoning skills.

Questions are based on realistic patient cases and documentation scenarios. Learners are encouraged to review module content before attempting the corresponding practice questions.

The Q-Bank helps trainees practice:

- Clinical indicator recognition
- Documentation gap identification
- Diagnosis clarification decisions
- CDI query reasoning
- Coding and DRG implications

Mock Certification Examinations

In addition to module-based practice questions, the program includes **mock certification examinations** modeled after national CDI certification exams such as:

- Certified Clinical Documentation Specialist (CCDS)
- Certified Documentation Improvement Practitioner (CDIP)

These mock exams help learners become familiar with certification-style questions and develop effective test-taking strategies.

Self-Paced Learning

The TIACDI training program is designed to support **self-paced learning**.

Learners may review module topics in the order most relevant to their professional needs unless otherwise instructed. Case-based exercises and practice questions can be used to reinforce understanding as learners progress through the curriculum.

Begin Your Training

After completing this introduction, learners may proceed to the first training module:

Module 01 – CDI Core Practices & Foundations

This module establishes the core principles that guide Clinical Documentation Integrity practice and prepares learners for the system-based clinical modules that follow.

Terms of Use and Training Policies

Texas Institute for Advancing Clinical Documentation Integrity (TIACDI)

Welcome to the **Texas Institute for Advancing Clinical Documentation Integrity (TIACDI)** training program. By registering for or participating in any TIACDI training course, you agree to comply with the following terms, policies, and conditions governing the use of training materials and participation in program activities.

1. Acceptance of Terms

By registering for the TIACDI Clinical Documentation Integrity (CDI) Training Program, participants acknowledge that they have read, understood, and agreed to comply with all training policies, including:

- program participation guidelines
- academic integrity standards
- assessment security policies
- copyright protections related to training materials

Participation in the training program constitutes acceptance of these terms.

2. Educational Purpose of the Training Program

The TIACDI training program is designed to provide educational preparation in the principles and practice of **Clinical Documentation Integrity (CDI)**.

The program is intended to help learners develop the clinical reasoning, documentation analysis, and CDI decision-making skills required for professional CDI practice.

Although the training program may support preparation for national CDI certification examinations, participation in this program **does not guarantee certification** or endorsement by any certification organization.

3. Intellectual Property and Copyright

All training materials provided within the TIACDI training program are protected by copyright and intellectual property laws.

These materials include, but are not limited to:

- course modules
- instructional content
- case studies and clinical scenarios
- question bank materials
- quizzes and assessment questions
- educational graphics and diagrams
- downloadable documents and learning resources

Unless otherwise stated, all materials are the intellectual property of the **Texas Institute for Advancing Clinical Documentation Integrity (TIACDI)**.

Training materials are provided solely for the **personal educational use of registered trainees**.

Participants may not copy, reproduce, distribute, publish, or share any training materials without prior written permission from TIACDI.

4. Question Bank and Assessment Security

The TIACDI training program includes a structured **CDI Question Bank (Q-Bank)** used to generate quizzes, practice exercises, and certification-style mock examinations.

To maintain the integrity of the training program, access to assessment materials is controlled by the TIACDI administrative team.

Participants agree not to:

- copy or reproduce quiz questions
- take screenshots of assessment content
- distribute or share questions with other individuals
- post assessment materials on websites, forums, or social media
- attempt to collect or compile questions from other participants

Unauthorized distribution of assessment materials may compromise the integrity of the training program and may result in removal from the course.

5. Academic Integrity

Participants are expected to complete all assessments independently unless otherwise instructed, **in order to avoid learning bias and ensure accurate evaluation of individual competency.**

Maintaining academic integrity supports fair evaluation of learner progress and ensures that the training program remains a reliable preparation pathway for individuals preparing to sit for **national professional Clinical Documentation Integrity (CDI) certification examinations**, including:

- Certified Clinical Documentation Specialist (CCDS)
- Certified Documentation Improvement Practitioner (CDIP)

6. Appropriate Use of Training Materials

Training materials are provided to support professional education in CDI practice.

Participants may use the materials for:

- personal study
- professional knowledge development
- preparation for CDI certification examinations

Training materials may not be used to create competing training programs, redistributed as course content, or incorporated into external commercial educational products without authorization.

7. Program Updates and Content Review

The TIACDI administrative team continuously reviews training materials and assessment content to maintain:

- clinical accuracy
- educational relevance
- alignment with CDI practice standards
- preparation for certification-style examinations

Course content, assessment availability, and training materials may be updated periodically as part of this ongoing quality review process.

8. Limitation of Liability and Educational Use

The **Texas Institute for Advancing Clinical Documentation Integrity (TIACDI)** training program is provided for educational purposes. While every effort is made to ensure the accuracy and relevance of the training materials, instructional staff and training professionals will be available to assist participants via email or through the Canvas student portal regarding questions or concerns related to course content.

Training materials are developed using widely recognized CDI educational references and clinical documentation resources, including guidance commonly referenced in professional CDI practice such as **AHA Coding Clinic publications and other established CDI reference materials**, in order to maintain a high standard of instructional quality.

The TIACDI curriculum is also designed to align with widely recognized **Clinical Documentation Integrity and health information management practice standards**, including principles commonly referenced in guidance from organizations such as **AHIMA (American Health Information Management Association), ACDIS (Association of Clinical Documentation Integrity Specialists), and CMS (Centers for Medicare & Medicaid Services)** documentation and reporting frameworks.

Despite these efforts, **TIACDI does not guarantee that all course materials are free from errors or omissions.**

Participants remain responsible for applying appropriate professional judgment and verifying information when using knowledge obtained through the training program in clinical practice or other professional settings.

References to external publications, professional organizations, or guidance materials are provided for **educational purposes only and do not imply endorsement, sponsorship, or affiliation with those organizations.**

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9. Changes to Terms

TIACDI reserves the right to update or modify these terms and policies as necessary to support the operation and integrity of the training program.

Updated terms will be posted on the TIACDI website.

Continued participation in the training program constitutes acceptance of any revised policies.

10. Contact Information

For questions regarding **training policies, program participation, or course-related matters**, please contact:

Texas Institute for Advancing Clinical Documentation Integrity (TIACDI)

Website: www.tiacdi.org

Email: support@tiacdi.org

Participants who have completed course registration will receive access to the **Canvas student learning portal**, where additional course support and communication with the instructional team will be available.

Prospective participants who have not yet registered may submit inquiries through the TIACDI website or by emailing **support@tiacdi.org**.