



Australian Government

HLTCCD005 Abstract information for clinical coding

Release: 2

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Modification History

Release	Comments
Release 2	Release 2 HLTCCD005 Abstract information for clinical coding supersedes and is equivalent to Release 1 HLTCCD005 Abstract information for clinical coding. Updated: Mapping details and minor corrections.
Release 1	HLTCCD005 Abstract information for clinical coding no equivalent unit.

Application

This unit describes the performance outcomes, skills and knowledge required to identify and abstract clinical information from a patient health care record for clinical coding.

This unit applies to clinical coders who are responsible for extracting and interpreting patient clinical information for the purposes of clinical coding. Work may be performed as an individual or as part of a team under limited supervision.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian standards and industry codes of practice.

No occupational licensing, certification or specific legislative requirements apply to this unit at the time of publication.

Pre-requisite Unit

Note: Units marked with an asterisk* include one or more prerequisite units of competency. Refer to unit of competency for prerequisite requirements.

Unit code	Unit title
HLTCCD002*	Interpret and navigate health care records
HLTCCD003	Use medical terminology in health care
HLTCCD004	Interpret clinical documentation using knowledge of anatomy and physiology

Competency Field

Clinical Coding

Unit Sector

Health Administration

Elements and Performance Criteria

ELEMENTS

Elements describe the essential outcomes

1. Evaluate clinical information from health care records.

2. Abstract clinical data from health care records.

PERFORMANCE CRITERIA

Performance criteria describe the performance needed to demonstrate achievement of the element.

- 1.1. Determine method of accessing patient information held in health care records and Patient Administration System (PAS).
- 1.2. Interpret patient health care records completed by health care professionals.
- 1.3. Establish validity of clinical information and patient demographic and administrative data sourced in relation to episode of care being coded.
- 1.4. Confirm documentation supports coding criteria in detail required to meet coding requirements.
- 1.5. Identify ambiguous, absent and incomplete documentation and data in health care records that could affect code assignment.
- 2.1. Identify principal diagnosis according to current coding standards for an episode of care from information identified in patient health care record.
- 2.2. Identify additional diagnoses from identified patient information according to current coding standards.
- 2.3. Identify condition onset flags for diagnosis codes.
- 2.4. Identify interventions from identified patient information according to current coding standards.
- 2.5. Identify data required for coding and reporting.
- 2.6. Use reference material to assist in clarifying information.

Foundation Skills

Foundation skills essential to performance are explicit in the performance criteria of this unit of competency.

Unit Mapping Information

No Equivalent Unit

Links

Companion Volume implementation guides are found in VETNet -

<https://vetnet.gov.au/Pages/TrainingDocs.aspx?q=ced1390f-48d9-4ab0-bd50-b015e5485705>