



Australian Government

**Assessment Requirements for HLTCCD007
Undertake moderately complex clinical
coding**

Release: 2

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Modification History

Release	Comments
Release 2	Release 2 HLTCCD007 Undertake moderately complex clinical coding supersedes and is equivalent to Release 1 HLTCCD007 Undertake moderately complex clinical coding. Updated: Mapping details and minor corrections.
Release 1	HLTCCD007 Undertake moderately complex clinical coding supersedes and is not equivalent to HLTADM006 Undertake complex clinical coding.

Performance Evidence

Evidence of the ability to complete tasks outlined in elements and performance criteria of this unit in the context of the job role, and:

- use current coding manuals and standards to produce coded clinical data from moderately complex patient health care records for at least five episodes of care for each of the following:
 - infectious and parasitic diseases
 - neoplasms
 - diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
 - endocrine, nutritional and metabolic diseases
 - mental and behavioural disorders
 - diseases of the nervous system
 - diseases of the eye and adnexa
 - diseases of the ear and mastoid process
 - diseases of the circulatory system
 - diseases of the respiratory system
 - diseases of the digestive system
 - diseases of the skin and subcutaneous tissue
 - diseases of the musculoskeletal system and connective tissue
 - diseases of the genitourinary system

- pregnancy, childbirth and the puerperium conditions originating in the perinatal period including congenital malformations, deformations and chromosomal abnormalities
- symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified
- injury, poisoning and causes of morbidity and mortality
- for each of the above, record, edit, amend and maintain validity of coded clinical data according to current classification standards and conventions
- for the above, episodes of care should collectively include the following:
 - differing lengths of stay
 - both acute and chronic forms of a disease or condition
 - different care types
 - with disease or condition in different contexts including co-existing with multiple comorbidities and complications
- participate in at least one coding audit of own work and:
 - identify type of coding audit and its purpose and prepare relevant patient health care records
 - respond to coding audit findings addressing any discrepancies.
 - meet organisational requirements for coding performance including not exceeding acceptable percentage error rate.

Knowledge Evidence

Demonstrated knowledge required to complete the tasks outlined in elements and performance criteria of this unit:

- Australian and State or Territory clinical coding standards and protocols
- rules and conventions applied to clinical data for coding
- sequencing protocols for coding, including those for principal, and additional diagnoses and interventions
- timescales within which coding must take place
- key performance indicators (KPI's) and quality indicators for coded clinical data
- classifications and nomenclature for coding
- coding classifications standards and conventions for:
 - infectious and parasitic diseases
 - neoplasms
 - diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
 - endocrine, nutritional and metabolic diseases
 - mental and behavioural disorders
 - diseases of the nervous system
 - diseases of the eye and adnexa
 - diseases of the ear and mastoid process
 - diseases of the circulatory system.

- diseases of the respiratory system
- diseases of the digestive system
- diseases of the skin and subcutaneous tissue
- diseases of the musculoskeletal system and connective tissue
- diseases of the genitourinary system
- pregnancy, childbirth and the puerperium conditions originating in the perinatal period including congenital malformations, deformations and chromosomal abnormalities
- symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified.
- injury, poisoning and causes of morbidity and mortality
- purpose and types of coding audits
- standard procedures and protocols for coding audits
- common coding errors and how to calculate error rates
- individual coder's role in participating in coding audits and responding to audit findings.

Assessment Conditions

Skills must be demonstrated in the workplace or in a simulated environment that reflects workplace conditions.

Assessment must ensure access to:

- real-life patient health care records or de-identified real patient health care records either electronic or hard copy, that reflect current clinical practice
- moderately complex patient health care records from all clinical specialities to include single condition reason for admission with the existence of at least five multiple co-morbidities or the need for multiple interventions including:
 - multiple condition reason for admission without co-morbidities or the need for interventions:
 - minor multiple trauma
 - deliveries with complication
 - unplanned surgery
 - care type changes
 - preterm babies > 32 weeks
 - diabetes with multiple complications
 - neoplasms with metastases including single or multiple
 - single procedural complication or adverse effect of treatment
 - episodes where a clinical query might be required
- current Australian coding classification
- medical dictionary or other equivalent medical resource
- organisational policies and procedures
- National and State or Territory legislation relevant to clinical coding

Assessors must satisfy the Standards for Registered Training Organisations' requirements for assessors.

Links

Companion Volume implementation guides are found in VETNet -

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