



Australian Government

HLTCCD005 Abstract information for clinical coding

Release: 2

HLTCCD005 Abstract information for clinical coding

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>

Assessment Requirements for HLTCCD005 Abstract information for clinical coding

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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:

- access and interpret clinical information from 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 common 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.

Knowledge Evidence

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

- types of clinical information:
 - correspondence
 - clinical notes
 - orders and prescriptions
 - operation, treatment and procedure reports
 - pathology investigation results
 - diagnostic imaging results
 - discharge summaries
- abstracting and clinical coding methods to identify:
 - principal diagnoses, additional diagnoses and interventions
 - sequencing of diagnoses and interventions
 - ambiguous, absent and incomplete documentation and data
 - issues requiring clarification
- organisational policies and procedures:
 - health care records storage and access
 - hard copy
 - electronic copy
 - coding clarification:
 - oral communication
 - written communication
 - selection of communication method
 - referral of unresolved issues:
 - oral communication
 - written communication
 - selection of communication method
 - protocols for referrals.

Assessment Conditions

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

Assessment must ensure access to:

- moderately complex real-life patient health care records or de-identified real patient health care records either electronic or hard copy, that reflect current clinical practice
- patient health care records encompassing episodes of care including 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
- 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

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