



Australian Government

HLTCCD007 Undertake moderately complex clinical coding

Release: 2

HLTCCD007 Undertake moderately complex clinical coding

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.

Application

This unit describes the performance outcomes, skills and knowledge required to assign clinical classification codes to an admitted episode of care using patient and clinical data from moderately complex patient health care records.

This unit applies to clinical coders who are responsible for interpreting and extracting 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
-----------	------------

HLTCCD006 *	Undertake basic clinical coding.
-------------	----------------------------------

Competency Field

Clinical Coding

Unit Sector

Health Administration

Elements and Performance Criteria

ELEMENTS

Elements describe the essential outcomes

1. Abstract clinical data from moderately complex patient health care records.

2. Assign codes to episodes of care relating to moderately complex patient health care records.

3. Clarify coding queries.

PERFORMANCE CRITERIA

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

1.1. Interpret and apply the Australian coding standards (ACS) to identify clinical data from moderately complex patient health care records.

1.2. Select conditions, diseases or procedures for coding from moderately complex patient health care records.

1.3. Identify principal diagnosis for admissions when coding from moderately complex patient health care records.

1.4. Identify additional diagnoses for admissions.

1.5. Identify interventions for admissions.

2.1. Assign diagnosis and intervention codes according to current classification indices, standards and conventions.

2.2. Determine sequencing of diagnoses codes according to current classification standards and conventions.

2.3. Assign condition onset flag (COF).

2.4. Determine sequencing of intervention codes according to current classification standards and conventions.

2.5. Use resources to assist in making coding decisions.

2.6. Complete process of assigning codes from moderately complex patient health care records.

2.7. Review and validate Diagnosis Related Group (DRG) assigned to episode of care.

3.1. Identify additional and missing information and clarifications required for accurate coding.

3.2. Formulate written coding queries and forward to clinical health care professionals according to Australian Coding Standards (ACS) and Clinical Coding Practice Framework (CCPF).

3.3. Make verbal enquiries with clinical health care professionals according to national guidelines and organisational policies, procedures and protocols.

- 3.4. Refer unresolved issues concerning clarity and accuracy of the clinical documentation and data according to organisational policies and procedures.
 - 3.5. Identify administrative data factors required for coding including ventilation hours and neonatal admission weight.
- 4. Maintain coding resources.
 - 4.1. Address changes to data collection and coding requirements according to relevant standards, protocols and legislation.
 - 4.2. Amend data collection and coding activities in line with organisational policies and procedures.
 - 4.3. Identify and address own knowledge and skills gaps to ensure deficits are addressed.
- 5. Participate in coding audits.
 - 5.1. Identify and prepare patient health care records for coding audit according to organisational policies and procedures.
 - 5.2. Independently validate own coding and interpret and resolve coding error findings across moderately complex patient health care records.
 - 5.3. Participate in processes to review coding audit findings.

Foundation Skills

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

Unit Mapping Information

HLTCCD007 Undertake moderately complex clinical coding supersedes and is not equivalent to HLTADM006 Undertake complex clinical coding.

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 HLTCCD007 Undertake moderately complex clinical coding

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>