

## *Definitions*

# Contents

|   |           |
|---|-----------|
| <b>Definitions</b> .....  | <b>3</b>  |
| <b>Definitions Related to Facilities</b> .....                        | <b>4</b>  |
| Hospital.....   | 4         |
| Health Care Network .....   | 4         |
| Network Component Hospital .....                                      | 4         |
| Campus .....  | 4         |
| Intensive Care Unit .....   | 5         |
| Adult Intensive Care Unit—Level 3.....                                | 5         |
| Adult Intensive Care Unit—Level 2.....                                | 6         |
| Adult Intensive Care Unit—Level 1 .....                               | 6         |
| Paediatric Intensive Care Unit .....                                  | 6         |
| Neonatal Intensive Care Unit—Level 3.....                             | 7         |
| Cardiac/Coronary Care Unit.....                                       | 7         |
| Hospital in the Home .....  | 7         |
| Critical Care Inter-Hospital Transfer Program .....                   | 8         |
| <b>Definitions Related to Patients</b> .....                          | <b>9</b>  |
| Patient .....   | 9         |
| Admitted Patient .....  | 9         |
| Same Day Patient.....   | 9         |
| Overnight or Multi-day Stay Patient .....                             | 10        |
| Patient Categories .....  | 10        |
| Eligible Person .....   | 10        |
| Types of Eligible Patient.....  | 12        |
| Ineligible Person.....  | 14        |
| Types of Ineligible Patient .....                                     | 14        |
| Non-Admitted Patient.....   | 14        |
| Live Birth.....   | 15        |
| Newborn .....   | 15        |
| Neonate.....  | 16        |
| Boarder.....  | 16        |
| Indigenous Status: Aboriginal or Torres Strait Islander Persons ..... | 16        |
| <b>Definitions Related to Episodes</b> .....                          | <b>18</b> |
| Admission .....   | 18        |
| Criteria for Admission .....  | 18        |
| Criteria for Admission—Reporting to the VAED .....                    | 19        |
| Change to Planned Treatment .....                                     | 19        |
| Cancelled Treatment.....  | 19        |
| Admission from Emergency Department.....                              | 20        |
| Parentcraft .....   | 20        |
| Criteria for Admission - Values .....                                 | 20        |
| Criteria for Admission - Guide for Use .....                          | 21        |
| Episodes of Care .....  | 22        |
| Separation .....  | 25        |
| Donor Organ Procurement .....   | 25        |

|  |           |
|--|-----------|
| <b>Definitions Related to Counting Days .....</b>  | <b>27</b> |
| Patient Days .....   | 27        |
| Length of Stay .....   | 27        |
| Rules for Counting Patient Days, Contract Leave Days and [Normal] Leave Days and for<br>Determining Length of Stay ..... | 27        |
| <b>Definitions Related to Leave .....</b>  | <b>29</b> |
| Contract Leave .....   | 29        |
| Normal Leave .....   | 29        |
| Reporting Same Day Contract Leave or [Normal] Leave .....  | 30        |
| <b>Definitions Related to Sub-Acute Geriatric Admitted Services: Streams of Care.....</b>                                | <b>31</b> |
| Geriatric Evaluation and Management Program (GEM).....   | 31        |
| Designated Rehabilitation Program .....  | 31        |
| Palliative Care Program.....   | 32        |
| Geriatric Respite.....   | 32        |
| Nursing Home Type/Non-Acute.....   | 33        |
| <b>Definitions Related to Clinical Coding and DRGS.....</b>  | <b>34</b> |
| Principal Diagnosis .....  | 34        |
| Procedures .....   | 34        |
| DRG Classification.....  | 34        |
| DRG Classification System for Victorian Hospitals, 1999–2000 .....   | 34        |
| DRG Cost Weights.....  | 35        |
| DRG Cost Weights for Victorian Hospitals, 1999–2000.....   | 35        |
| <b>Definitions Related to Contracted Hospital Care .....</b>   | <b>36</b> |
| Recording Contracted Care .....  | 36        |
| Scope of Contracted Care .....   | 36        |
| Contract Leave .....   | 37        |
| Identification of Contracted Episodes of Care .....  | 37        |
| Identification of Procedures Performed under Contract .....  | 37        |
| Types of Contracted Hospital Care .....  | 38        |
| 1 Contract Type B .....  | 38        |
| 2 Contract Type ABA.....   | 38        |
| 3 Contract Type AB.....  | 38        |
| 4 Contract Type (A)B.....  | 38        |
| 5 Contract Type BA .....   | 38        |
| 6 Contract Type A(B).....  | 39        |
| AIMS Reporting .....   | 39        |
| <b>Definitions Related to Non-Admitted Patient Services .....</b>  | <b>40</b> |
| Occasion of Service.....   | 40        |
| Encounters .....   | 41        |

# *Definitions*

This section provides a summary of definitions for hospitals in Victoria. These definitions are based wherever possible on the *National Health Data Dictionary* produced by the Australian Institute of Health and Welfare and endorsed under the authority of the Australian Health Ministers' Advisory Council. The definitions are relevant to the AIMS data collection, Victorian Admitted Episodes Dataset (VAED) and PRS/2. They are reproduced in the *PRS/2 Manual* with additional notes relevant to the VAED.

The Definitions are grouped under the following sections:

- Facilities
- Patients
- Episodes
- Counting Days
- Leave
- Sub-Acute Geriatric Admitted Services: Streams of Care
- Clinical Coding and DRGs
- Contracted Hospital Care
- Non-Admitted Patient Services

## ***Definitions Related to Facilities***

### **Hospital**

A hospital is a health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.

- A hospital thus defined may be located at one physical site or may be a multi-campus hospital.
- For the purposes of these definitions, hospital includes satellite units managed and staffed by the hospital and private homes used for service provision under the Hospital in the Home program.
- The definition includes public hospitals, denominational hospitals, metropolitan hospitals and privately operated hospitals as defined in the *Health Services Act 1988*.
- The definition includes private hospitals and day procedure centres registered under the Health Services Act 1988. Private hospitals are required to maintain separate registrations for each site.
- Nursing homes and hostels which are now approved under the *Aged Care Act 1997* (Commonwealth) are *excluded* from the definition, as are supported residential services registered under the Health Services Act 1988.

### **Health Care Network**

Health Care Network is the term used to describe a metropolitan hospital as defined in the Health Services Act 1988, and encompasses previously existing hospitals whose incorporation has now been cancelled.

### **Network Component Hospital**

Network Component Hospital (formerly called Aggregated Hospital) refers to a former hospital in the metropolitan area of Melbourne whose incorporation has been cancelled and now forms part of a health care network.

### **Campus**

A campus is a physically distinct site owned or occupied by a hospital on which the hospital regularly provides treatment and/or care to patients. This definition includes:

- a satellite work unit, such as a dialysis unit or community rehabilitation centre, which may be physically separated from the hospital main site, is managed and staffed by the hospital, and provides treatment and/or care to patients;
- a nursing home, hostel or day centre managed and staffed by the hospital and funded by Aged Care Services; or
- that part of a facility that is leased or occupied by the hospital even though the whole of the facility is administered by another hospital.

**For the purposes of reporting to the VAED:**

A *single campus (network component) hospital* provides admitted patient services at one location, through a combination of overnight stay beds and day stay facilities, or day stay facilities only.

A *multi-campus (network component) hospital* has two or more locations providing admitted patient services, where the locations:

- are separated by land (other than public road) not owned, leased or used by that (network component) hospital or its network;
- have the same management at the hospital/network component hospital level;
- each have overnight stay facilities. A separate location (see first dot point) providing day only services, such as a satellite dialysis unit, is considered to be part of a campus; and
- are not private homes. Private homes, where Hospital in the Home services are provided, are considered to be part of a campus.

The Department holds that, as a general principle, VAED reporting should identify activity at each campus.

- Any *Public hospital* not currently reporting on this basis, or intending to change from single to multi-campus or vice versa, should discuss this with the Acute Health Division of the Department before proceeding.
- Any *Private hospital* operating beds off-site should discuss reporting requirements with the Acute Health Division of the Department.

**Intensive Care Unit**

This definition is taken from the Australian Council on Healthcare Standards' (ACHS) Intensive Care Unit Guidelines (draft) of January 1996:

An intensive care unit (ICU) is a designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

There are five different types and levels of ICU the details of which are listed below:

- Adult intensive care—level 3, level 2, level 1
- Paediatric intensive care
- Neonatal intensive care—level 3.

As defined, ICUs do not include Special Care Nurseries, Coronary Care Units, High Dependency Units, Intensive Nursing Units or Stepdown Units.

**Adult Intensive Care Unit—Level 3****Nature of Facility**

A level 3 adult ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period. It must be a tertiary

referral centre for intensive care patients and have extensive back up laboratory and clinical service facilities to support this tertiary referral role.

#### **Care Process**

A level 3 adult ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardiovascular monitoring for an indefinite period. These types of service are illustrative of the nature of care provided in a level 3 adult ICU but are not exhaustive of the possibilities.

#### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

#### ***Adult Intensive Care Unit—Level 2***

##### **Nature of Facility**

A level 2 adult ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support.

##### **Care Process**

A level 2 adult ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardiovascular monitoring for a period of at least several days. These types of service are illustrative of the nature of care provided in a level 2 adult ICU but are not exhaustive of the possibilities.

##### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

#### ***Adult Intensive Care Unit—Level 1***

##### **Nature of Facility**

A level 1 adult ICU must be a separate and self-contained facility in the hospital capable of providing basic multi-system life support usually for less than a 24-hour period.

##### **Care Process**

A level 1 adult ICU must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours. These types of service are illustrative of the nature of care provided in a level 1 adult ICU but are not exhaustive of the possibilities.

##### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

#### ***Paediatric Intensive Care Unit***

##### **Nature of Facility**

A paediatric ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period. It must be a tertiary

referral centre for children needing intensive care and have extensive backup laboratory and clinical service facilities to support this tertiary role.

### **Care Process**

A paediatric ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardiovascular monitoring for an indefinite period to infants and children less than 16 years of age. These types of service are illustrative of the nature of care provided in a paediatric ICU but are not exhaustive of the possibilities.

### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

### **Neonatal Intensive Care Unit—Level 3**

#### **Nature of facility**

A level 3 neonatal ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period.

#### **Care Process**

A neonatal ICU must be capable of providing mechanical ventilation and invasive cardiovascular monitoring. These types of service are illustrative of the nature of care provided in a neonatal ICU but are not exhaustive of the possibilities.

#### **Clinical Standards and Staffing Requirements**

An ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

### **Cardiac/Coronary Care Unit**

A Cardiac/Coronary Care Unit (CCU) is defined as a designated ward of a hospital which is specifically staffed and equipped to provide observation, care and treatment to patients with acute cardiac problems such as acute myocardial infarction and unstable angina and who may have undergone interventional procedures from which recovery is possible. The CCU provides special facilities and utilises the expertise and skills of medical, nursing and other staff trained and experienced in the management of these conditions.

*(Definition from Ministerial Review of Coronary Care Services in Victoria - December 1996).*

### **Hospital in the Home**

*Hospital in the Home* services are defined as acute health care services provided to people living in the community, in their own homes or in residential facilities such as nursing homes, hostels or other forms of supported accommodation. Hospital in the Home (HITH) services might include the treatment of orthopaedic conditions or the administration of intra-venous therapies. The use of HITH services is voluntary for the patient. For a patient the service might be a combination of hospital and home-based care or replace hospital care completely.

A public hospital must be *designated* in its *Health Service Agreement* to provide HITH services.

As at 1 July 1999, HITH is limited to public, DVA, TAC and WorkCover patients because insurers and the Commonwealth have not yet permitted private patients to be treated under this program. A private patient must *not* be reclassified to public in order to be treated under this program.

In the VAED, Hospital in the Home is indicated in the field *Accommodation Type*. Moving between ward accommodation and Hospital in the Home accommodation is indicated by starting a new *Status Segment* within the *same* episode and does *not* represent a new episode following a formal separation or a statistical separation (the concept of separation is covered under *Admission*).

Acute Health Services HITH episodes are included in the casemix funding program. Aged Care HITH episodes are included in the Aged Care funding formula. Patients receiving care under this program must meet one of the minimum criteria for admission, with the care provided representing a substitute for acute admitted patient care.

Hospital in the Home patients are reported on the AIMS Form 111 S1 (Acute Health Admitted Patients), Form 113/S1 (Aged Care Admitted Patients) and Form 113/S4 (Aged Care Streams of Care).

## **Critical Care Inter-Hospital Transfer Program**

The Critical Care Inter-Hospital Transfer (CCIHT) Program started on 1 July 1998 to provide a financial incentive for Health Care Networks/hospitals to better manage their critical care bed availability, plan for peaks in demand and keep the need for acute inter-hospital transfers to a minimum.

Participating hospitals receiving a transferred patient report who subsequently spends time in the ICU or CCU report the reason for the transfer in the *Reason for Critical Care Transfer* field in the Diagnosis X2 record.

## ***Definitions Related to Patients***

### **Patient**

A patient is a person for whom a hospital accepts responsibility for treatment and/or care.

There are two categories of patient:

- *admitted* patient
- *non-admitted* patient.

Boarders (see *Boarder*, page 16) are not patients.

### **Admitted Patient**

An admitted patient is a person who has been assessed by the treating clinician as meeting at least one of the minimum criteria for admission and who undergoes the hospital's formal or statistical admission process as either a same-day, overnight or multi-day stay patient.

The term *admitted patient* is synonymous with the term *inpatient* as used in hospitals.

*The definition of admission* is on page 18. *The criteria for admission* are stated and explained on page 18.

The decision to admit a patient (rather than to treat them as an outpatient or Emergency Department patient) should be made by a medical practitioner and cannot be delegated to administrative staff or automated. Thus Resident and Senior Medical Staff, Nursing Staff and personnel involved in the admission procedure within hospitals, including staff of the Admission Office, Medical Records Department and Hospital Information Systems Department, need to be fully acquainted with the content of this document.

For statistical purposes, patients are *counted* as either same-day or overnight/multi-day stay patients *retrospectively*. It does not depend on the intention at admission.

### **Same Day Patient**

A same day patient is a patient who is admitted and separated on the same day.

- A same day patient may be either a booked or an emergency patient.
- A patient *cannot* be both a same day patient and an overnight or multi-day stay patient *at the one hospital*. Thus emergency treatment provided to a patient who is subsequently classified as an overnight or multi-day stay patient in the *same hospital* shall be regarded as part of the overnight or multi-day stay patient episode of care.
- The category of *same day* is determined retrospectively; that is, it is not based on the intention to admit and separate on the same date. Rather, a patient is deemed to have been a same day patient if, in retrospect, it can be seen that the patient was admitted to,

and separated from, the hospital on the same date. Therefore, patients who die, transfer to another hospital or leave of their own accord on their first day in the hospital are *included*. Booked same day patients who are subsequently required to stay in hospital for one night or more are *excluded*.

## Overnight or Multi-day Stay Patient

An overnight or multi-day stay patient is a patient who is admitted and stays a minimum of one night in the hospital.

- The category of *overnight or multi-day stay* is determined retrospectively; that is, it is not based on the intention to admit for one night or more.
- A patient is deemed to have been an overnight stay patient if, in retrospect, it can be seen that the patient was admitted to, and separated from, the hospital on different dates. Therefore, a booked same day patient who is subsequently required to stay in hospital for one night or more is an *overnight patient*. A patient who dies, is transferred to another hospital or leaves of their own accord on their first day in the hospital is a same day patient even if the intention at admission was that they remain in hospital at least overnight.
- Unless a patient is on contract leave, an overnight or multi-day stay patient in one hospital *cannot* be concurrently an *overnight or multi-day stay patient* in *another* hospital.

See also *Length of Stay*, page 27 and *Leave*, page 29.

## Patient Categories

Changes in Medicare eligibility criteria are advised by circular as and when advice is received from the Commonwealth Department of Health and Aged Care. Patient categories are identified in the VAED through the *Account Class* in the Episode Record. Refer to the PRS/2 Manual for specific details.

### **Eligible Person**

An *eligible person* means:

- a person who resides in Australia and whose stay in Australia is not subject to any limitation as to time imposed by law; but
  - does not include a foreign diplomat or family (except where eligibility is expressly granted to such persons by the terms of a reciprocal health care agreement); or
- persons visiting Australia who are ordinarily resident in Finland, Italy, Malta, the Netherlands, New Zealand, the Republic of Ireland, Sweden or the United Kingdom as they are covered by reciprocal health care agreements (RHCA). However, persons from Malta and Italy are covered for six months only; or
- a person or a class of persons declared eligible by the Commonwealth Minister of Health and Aged Care.

### **Australian Resident**

An *Australian resident* is a person who *resides* in Australia and fulfils one of the following criteria:

- is an Australian citizen
- holds an entry permit not being a temporary entry permit
- holds a return endorsement or resident return visa
- has been granted refugee status, or
- is the holder of a valid temporary entry permit with an application for permanent residence, and
  - has a spouse, parent or child who is the holder of a permanent entry permit, or
  - has authorisation to work.

### **Eligible Overseas Representative**

An *eligible overseas representative* is the head, a member of diplomatic or consular staff or a member of their family, of a diplomatic mission of a country with which Australia has a reciprocal health care agreement (RHCA) except New Zealand. This is full Medicare eligibility and is not limited to immediately necessary medical treatment. Such persons will be issued with a Medicare care endorsed 'Visitor RHCA'.

### **Reciprocal Health Care Agreements**

Visitors to Australia who are ordinarily resident in a country with which Australia has a reciprocal health care agreement and provides for *immediately necessary treatment* but only as a public patient, for such medical treatment as is clinically necessary for the diagnosis, alleviation or care of the condition requiring attention, on terms no less favourable than would apply to a resident. The RHCA countries are:

- Finland
- Italy (six month limit)
- Malta (six month limit)
- the Netherlands
- New Zealand (see note 2 below)
- Republic of Ireland
- Sweden
- the United Kingdom.

Note:

- 1 Persons from Italy and Malta are limited to the first six months of their visit only, except where a continuing course of treatment starts before and extends over the six month limit.
- 2 New Zealand diplomats or their families are not included in the Australian/New Zealand RHCA and are therefore *not* eligible persons.
- 3 Students holding student visas from a country with which Australia has a RHCA are *not* eligible but should register with the Overseas Student Health Cover administered by Medibank Private.

### **Persons Declared Eligible by the Minister**

The Commonwealth Minister for Health and Aged Care also has a discretionary power to make persons eligible for Medicare. Such persons are eligible for, and generally will hold a Medicare card.

### **Types of Eligible Patient**

An eligible patient is further categorised as a Public, Private, Department of Veterans' Affairs, Nursing Home Type or Compensable patient.

#### **Public Patient**

A public patient is:

- an eligible person who receives or elects to receive a public hospital service free of charge or
- an eligible public patient whose treatment is contracted to a private hospital.

#### **Private Patient**

A private patient is:

- an eligible person who elects to be treated as a private patient in a public hospital and elects to be responsible for paying hospital fees as well as the professional fees raised by any treating medical or dental practitioner; or
- an eligible person who chooses to be admitted to a private hospital and elects to be responsible for paying all hospital fees as well as the professional fees raised by any treating medical or dental practitioner.

Includes a patient on whose behalf election has been made by another person with the patient's express or implied consent.

Clause 57 of the Australian Healthcare Agreement states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria'.

#### **Department of Veterans' Affairs (DVA) Patient**

An eligible person entitled to comprehensive medical and allied health treatment for all medical conditions at the expense of the Department of Veterans' Affairs.

#### **Nursing Home Type (NHT) Patient**

A patient as defined in section 3 of *Commonwealth Health Insurance Act 1973*: after 35 days continuous hospitalisation, the patient *must* be classified as a NHT patient unless a medical practitioner certifies under section 3(B)(1) that the patient is in need of acute care. For example:

- professional attention for an acute phase of the patient's condition; or
- active rehabilitation; or
- continued management, for medical reasons, as an admitted patient.

A patient *cannot* be designated NHT before 35 days continuous hospitalisation (with a maximum break of seven consecutive days) even if an approved NH5 form, *Application for Nursing Home Admission* has been signed.

If a NHT patient is out of hospital (other than for contracted services) for seven days or less and is re-admitted, the patient continues to be a NHT patient.

If a NHT patient is out of hospital (other than for contracted services) for more than seven consecutive days, the patient would be admitted again as an acute patient, not a NHT patient.

If a NHT patient is out of one hospital for contracted services of any duration at another hospital, it is likely that the second hospital would sign a 3B certificate thereby ending the period of NHT care. In that event, the count towards 35 days continuous hospitalisation (with a maximum break of seven consecutive days) starts again so, if the patient returns to the original hospital or another hospital, the patient would continue to be an acute patient unless/until the patient had again had 35 days of continuous hospitalisation (with a maximum break of seven consecutive days) and no 3B certificate had been signed, in which case the patient would again become a NHT patient.

If a NHT patient is out of one hospital for contracted services of any duration at another hospital, and that second hospital continues to classify the patient as NHT, when the patient returns to the original hospital or another hospital, either immediately or after a period of not more than seven days, the patient continues to be a NHT patient unless a 3B certificate is then signed, ending that NHT period, and commencing a further period of at least 35 acute days, as described above.

For statistical reporting, NHT patients can be of the following types:

- Public
- Private:
  - Private
    - with general care
    - with extensive care
  - Department of Veterans' Affairs
    - with general care
    - with extensive care.

A patient who has been assessed by an Aged Care Assessment Service may hold an *approved* NH5 'Application for Nursing Home Admission' Form. Whilst NH5 forms are not limited to NHT patients (for example, a patient may have an approved NH5 form while an acute patient), NHT patients are the only patient type which are further categorised as NH5 or non-NH5.

### **Compensable Patient**

An eligible person who has received, or has established a right to receive, payment by way of compensation or damages (including payment in settlement of a claim for compensation or damages) under a law that is, or was in force in a State or States (other than Veterans' Affairs legislation) in respect of the injury, illness or disease for which he/she is receiving hospital care and treatment. This category includes workers compensation, transport accident, criminal injury and common law cases and members of the Defence Forces and seamen with personnel entitlements.

Clause 57 of the Australian Healthcare Agreement states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria'.

Under current legislation, compensable patients cannot be categorised as Nursing Home Type. However, where a compensable patient would otherwise have been classed as a Nursing Home Type patient, they are deemed to be Non-Acute compensable.

### ***Ineligible Person***

A person who is not eligible under Medicare, generally:

- a person who does not fit into one of the categories of eligibility listed above;
- a visitor to Australia from a country with which Australia has a reciprocal health care agreement who elects to be treated as a private patient; or
- a foreign diplomat, or a member of their family, of a country with which Australia does not have a reciprocal health care agreement.

Clause 57 of the Australian Healthcare Agreement states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria'.

Note: An asylum seeker who has a valid temporary entry visa and is an applicant for a protection visa and has either work rights or a spouse, parent or child who is a permanent Australian resident, is eligible to apply for a Medicare card and is therefore an *eligible* person once they have their Medicare card.

### ***Types of Ineligible Patient***

An ineligible patient is further categorised as exempt or non-exempt.

#### **Exempt Patient**

An ineligible non-Australian resident specifically referred to Australia for hospital services not available in the patient's own country and for whom the Secretary of the Department of Human Services has determined that no fee be charged.

#### **Non-Exempt Patient**

An ineligible patient not exempted from fees by the Secretary of the Department of Human Services.

Under current legislation non-exempt ineligible patients cannot be categorised as Nursing Home Type. However, where a non-exempt ineligible patient would otherwise have been classed as a Nursing Home Type patient, they are deemed to be Non-Acute ineligible.

### **Non-Admitted Patient**

A person who receives direct treatment and/or care within emergency departments or other designated clinics within the hospital but who is not formally admitted at the time when the care is provided. The term *non-admitted patient* is synonymous with the term *non-inpatient* as used by hospitals.

Records for *non-admitted patients* should *not* be transmitted to the VAED.

Patients admitted to the designated Hospital in the Home program should be counted as *admitted* patients.

## Live Birth

A live birth is defined by the World Health Organisation (WHO) to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy who, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

## Newborn

A newborn baby is a live birth who is nine days old or less, at the time of admission. The formula for calculating age is Date of Admission minus Date of Birth. For example:

- Is baby born on 1<sup>st</sup> of month a *newborn* on the 10<sup>th</sup> of the month?  
10-1=9 then Baby *is* a newborn
- Is baby born on 1<sup>st</sup> of month a *newborn* on the 11<sup>th</sup> of the month?  
11-1=10 then Baby *is not* a newborn.

All newborns:

- must be recorded in the VAED
- (in public hospitals) are paid by Casemix
- must have the same account class as their mother
- can have a different level of insurance from their mother, and
- cannot go on (normal) leave or contract leave.

At admission, a newborn may be either qualified or unqualified or a boarder:

- If the newborn meets one of criteria for Qualified Newborn, then the newborn is admitted as Qualified (Criterion for Admission).
- If the newborn does *not* meet one of criteria for *Qualified Newborn* there are two possibilities:
  - Either this admission started with the birth, in this hospital, of the newborn or the baby has not previously been admitted to another hospital.  
*Then the newborn is admitted as Unqualified (Criterion for Admission), or*
  - The baby has previously been admitted to another hospital.  
*Then the newborn is a Boarder (so do not report to the VAED or to AIMS).*

As stated in Department Circular 17/1995, stillborns are not to be reported to the VAED.

Diagnosis and procedure coding of newborns must be according to the *Victorian Additions to the Australian Coding Standards*, effective 1 July 1998.

## Neonate

In the *National Health Data Dictionary*, for perinatal purposes, a neonate is defined as being less than 28 days old.

However, the critical factor for admitted patients is treatment of babies for grouping purposes. DRG software allocates neonates to MDC 15 if the patient's age at admission is less than 29 days. Using the formula for calculating age as 'Date of Admission minus Date of Birth':

- Is baby born on 1<sup>st</sup> of month a *neonate* on the 29<sup>th</sup> of the month?  
29-1=28 therefore baby *is* a neonate
- Is baby born on 1<sup>st</sup> of month a *neonate* on 30<sup>th</sup> of the month?  
30-1=29 therefore Baby *is not* a neonate.

Babies under 365 days of age at admission whose admission weight is less than 2500 grams are also grouped to MDC 15.

## Boarder

A boarder is not a patient: a boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

- A boarder thus defined is *not admitted* to the hospital and therefore must *not* be counted in the Department of Human Services AIMS returns as an admitted patient, nor should data relating to boarders be transmitted to the VAED. However, the hospital, for its own purposes, may wish to record boarders in its in-house system; if so, the hospital's interface must be able to identify boarders and exclude them from transmission to the VAED and to AIMS.
- A boarder who subsequently receives clinical treatment at the health care facility shall be classified as a patient in accordance with the definition of Admission (see *Admission*, page 18).
- An unqualified newborn remaining in hospital when he/she becomes ten days old becomes a boarder.

A newborn baby is a boarder in a second or subsequent stay in hospital that starts within the first nine days of life, if it does not meet the Criteria for Admission as a qualified newborn. That is, a newborn may have no more than one episode where he/she is an unqualified newborn.

## Indigenous Status: Aboriginal or Torres Strait Islander Persons

The indigenous status of a patient is determined by patient self-identification. An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the

community with which he/she is associated (Department of Aboriginal Affairs, Constitutional Section, 1981).

This information must be collected for every admitted patient and it *must* be collected at every admission. It must *not* be one of the hospital's patient master index items. A response must be entered at each admission and the system must *not* be set up to default to a code.

Rather than ask every patient about their indigenous status, first ask "Were you born in Australia?"

- If No, ask the patient "What country were you born in?" (and omit the indigenous status question).
- If Yes, ask the patient "Are you of Aboriginal or Torres Strait Islander origin?"

If the patient is a baby or child, the parent or guardian should be asked about the indigenous status of the child's mother or father. If the mother of a newborn baby has not identified as being of Aboriginal or Torres Strait Islander descent, hospital staff should *not* assume the baby is non-Aboriginal; the father may be of Aboriginal or Torres Strait Islander descent.

The Koori Health Unit issues a booklet that hospital staff will find useful: *Are you of Aboriginal or Torres Strait Islander Origin? Information for Hospital Staff who are responsible for collecting information on Patients who are admitted to Hospital or Patients who attend the Emergency Department* (this publication is also available on: [www.dhs.vic.gov.au/ahs1/prs2/infoshee.htm](http://www.dhs.vic.gov.au/ahs1/prs2/infoshee.htm)).

## *Definitions Related to Episodes*

### **Admission**

An admission is the administrative process which signifies the start of an admitted patient episode of care. An admission may be *formal* or *statistical*.

- **Formal admission**

The administrative process by which a hospital records the start of treatment and/or care and accommodation of an admitted patient.

- **Statistical admission on care type change**

The administrative process by which a hospital records the start of any episode of care, subsequent to the initial episode of care (which started with a formal admission), within a single hospital stay. For details of Care Types reported to the VAED, refer to Episodes of Care, page 22.

The mandatory VAED data item *Admission Source* records whether the admission is statistical or formal. An *admitted patient* is defined on page 9.

### **Criteria for Admission**

Before a patient can be admitted, they must meet at least one of the minimum criteria for admission. These were initially drawn from the 1993 Medicare Agreement, which in turn were based upon criteria for the admission of private patients for day only procedures, most recently detailed in the Commonwealth publication *Same Day Procedures Manual*, August 1996. Since then they have been adapted to incorporate the admission of *all* newborns, in accordance with the National Health Data Dictionary (Admitted patient). In the minimum criteria for admission stated below, the reference to Same Day Procedures Manual means the updated version contained on the Internet:  
([www.health.gov.au:80/pubs/circfin1/circulars/dayonly.pdf](http://www.health.gov.au:80/pubs/circfin1/circulars/dayonly.pdf)).

Before a patient can be admitted, at least one of the following criteria must be met:

- **The patient is to receive a Same-day Surgical and Diagnostic Services as specified in Band 1A, 1B, 2, 3 and 4** as specified in the Same Day Procedures Manual;

or

- **The patient is to receive a Type C Professional Attention Procedure** as specified in the Same Day Procedures Manual. In these cases the medical record must contain documentation from the medical practitioner which justifies the admission on the grounds of the medical condition of the patient or other special circumstances that relate to the patient (for example, remote location, no-one at Home to care for the patient);

or

- **The patient is nine days old or less at the time of admission (newborn).** All newborn days are further divided into categories of qualified and unqualified for the Australian Healthcare Agreement and health insurance benefit purposes.
  - A newborn day is *qualified* if the newborn meets at least one of the following criteria:
    - i is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient; or
    - ii is admitted to a facility approved by the Commonwealth Minister for the purpose of provision of intensive or special care; or
    - iii is admitted to or remains in hospital without their mother.
  - A newborn day is *unqualified* if the newborn does not meet any of the criteria described above;

or

- **The patient, following a clinical decision, is expected to require overnight or multi-day hospitalisation.**

### **Criteria for Admission—Reporting to the VAED**

The specific criterion under which each patient is admitted does not have an impact on casemix funding.

Criterion for Admission must be reported at admission for *all* admitted patients (see page 18 for details of the field *Criterion for Admission*). If the care intended to be provided to a patient does not meet any of the criteria for admission, then the patient should not be admitted and the episode not reported to the VAED. Hospitals are responsible for ensuring that appropriate procedures and records are maintained to facilitate accurate reporting and to justify the admission. The list of criteria for admission on the previous page is complete. There are no other criteria for admission. For example:

- Care provided to a patient in a non-admitted hospital setting over an extended period of time does not in itself constitute (conversion to) an admission. A patient in non-admitted care may only be admitted once at least one of the admission criteria is met.
- Under these criteria, the fact that a procedure is undertaken in an operating suite does not, in itself, justify admission.

### ***Change to Planned Treatment***

Where a patient's condition requires a different course than that planned at admission, the hospital must retain on the VAED the original Criterion for Admission. For example, a newborn who changes Qualification Status must retain their original Criterion for Admission code (N or U).

### ***Cancelled Treatment***

There will be occasions where a patient who is admitted subsequently has their planned treatment cancelled and is separated on the same day:

- If the admission could be justified as extended medical treatment (see Guide of Use Type C, page 21 ) and supporting documentation is provided, the episode should remain and

be reported to the VAED. Note: even though this assessment needs to be made, the original criterion for admission should not be changed.

- If the admission could *not* be justified as extended medical treatment, the admission should be cancelled.

The level of same-day admissions involving cancelled procedures will be continually monitored.

### ***Admission from Emergency Department***

When a patient is admitted from the Emergency Department, then the admission time is the time treatment was started in the Emergency Department. That is, when the patient was first treated by a nurse or doctor, whichever comes first. The Emergency Department occasion of service is counted in these circumstances.

### ***Parentcraft***

*Parentcraft* describes the type of care provided by Early Parenting Centres but similar care may be provided by other hospitals. In regard to parentcraft care and treatment, only those family members who satisfy the minimum criteria should be admitted. Whilst mother, father, baby and siblings may attend the hospital, normally only one member of the family should be admitted. In some instances, admission of two or more family members may be justified where they are affected by separate problems; or where problems affect more than one member, such as breastfeeding difficulties, where care and treatment are required for both mother and baby.

### **Criteria for Admission - Values**

For the purposes of reporting Criteria for Admission to the VIMD, report the first category which is appropriate to the patient:

B = Day Only Bands 1A, 1B, 2, 3 and 4

C = Type C Professional Attention Procedures with Certification

N = Qualified newborn

U = Unqualified newborn

O = Patient expected to require hospitalisation for minimum of one night

For example, if the patient is admitted for a Day Only Band 1A procedure, but, because there will be no one at home to care for the patient that night, the management plan at admission is that the patient will remain overnight, the Criterion for Admission code selected should be B.

There is an additional Criterion for Admission code available only to Early Parenting Centres to identify episodes which are not reported to the Commonwealth.

## **Criteria for Admission - Guide for Use**

### **B Day Only Bands 1A, 1B, 2, 3 and 4**

It is expected that the majority of Type B procedures will (and should) occur in an admitted patient setting and be reported to the VIMD accordingly. For example, it has consistently been agreed that patients should always be admitted for each episode involving renal dialysis.

Code B is the correct code for patients who meet Criterion B but stay in hospital overnight, whether that overnight stay was planned or unplanned at the time of admission.

For the purpose of VIMD reporting, there is no significance in, nor requirement to, separately identify the various bands. They are included in the definition for the purpose of highlighting the consistency with the classification of private patients by hospitals for health insurance claim purposes.

When a private patient is admitted for a Type B intervention but stays overnight, the relevant section of the 'Private Patient Hospital Claim Form' must be completed. As advised in Circular 6/1998, the Commonwealth are phasing out the use of form 1830 which was formerly used for certification purposes.

### **C Type C Professional Attention Procedures with Certification**

#### ***Type C Exclusion List***

The exclusion list of procedures (the 'Type C Exclusion List') identifies services which would be normally be undertaken on a non-admitted basis (outpatient, accident and emergency) and not normally accepted as same day admissions. However, if the patient's medical condition or other special circumstances justify admission, they can be admitted. This list overrides the general criteria listed under the definition of the bands.

The Commonwealth Department of Health and Family Services regularly updates the items included in the Same Day Procedure Manual. Circulars containing these updates are distributed to hospitals regularly. They can also be accessed on the following internet address: <http://www.health.gov.au/pubs/circfinl/spcintst.htm>

Code C is the correct code for patients who meet Criterion C but stay in hospital overnight, whether that stay was planned or unplanned at the time of admission.

#### ***Extended Medical Treatment - Emergency, and Non-Emergency***

It is acknowledged that the non-surgical component of day admissions is not well addressed in the Same Day Procedures Manual. In order to establish some consistency in data collection between hospitals, admission should be based on: the appropriateness to admit the patient as determined by a clinician; and

- medical treatment involving constant nursing care and treatment under the supervision of a medical practitioner for a period of no less than four hours, excluding waiting time (note this is only a guideline - alone it does not provide justification for an admission; a clinical decision to admit is required and must be adequately documented).

### **Certification**

Whilst the Type C Exclusion List identifies services which will not normally be accepted as same day admissions, there will be occasions when patient admission for the provision of Type C services is warranted on the grounds of the medical condition or other special circumstances that relate to the patient. These details must be documented.

- **For privately insured patients:**

The attending medical practitioner should complete the relevant section of the 'Private Patient Hospital Claim Form'. As advised in Circular 6/1998, the Commonwealth are phasing out the use of form 1830 which was formerly used for certification purposes.

- **For patients other than privately insured patients:**

The Department no longer requires completion of a pro-forma. However, documented justification of the admission for Type C procedures on clinical grounds must be included in the medical record. Audits of medical records will be conducted for the purpose of ensuring that Type C services provided in an admitted patient setting are warranted.

### **N Qualified newborn**

Code N should be recorded if the newborn is qualified at the time of admission. While the Qualification Status may subsequently change to unqualified, the Criterion for Admission and the Care Type should not be changed. See the table summarising this.

### **U Unqualified newborn**

Code U should be recorded if the newborn is unqualified at the time of admission. If the Qualification Status subsequently changes to qualified, the original Care Type should be changed, but the Criterion for Admission should remain as originally recorded. See the table summarising this.

### **O The patient, following a clinical decision, is expected to require overnight or multi-day hospitalisation**

This category involves the admission of patients with the expectation, at the time of admission, that the patient requires overnight or multi-day hospitalisation (this hospitalisation may be provided by a subsequent hospital to which the patient is transferred).

This category is therefore intended to cover the critically ill patient who presents to the emergency department but dies within a few hours despite intensive resuscitative treatment and the patient who needs resource intensive emergency stabilisation for a short period, prior to transfer to another hospital.

Thus criterion Code O is not altered if the patient dies, is transferred or is discharged on the same day.

The decision to admit to this category must be made on the basis of clinical appropriateness, and it is not intended that such a decision be determined simply by the duration of the stay.

## **Episodes of Care**

There are a number of types of care which a hospital can provide for admitted patients. An overnight or multi-day stay patient may receive more than one type of care during the period

of hospitalisation: the period of hospitalisation is then broken into Episodes of Care, one for each type of care (Care Type).

An Episode of Care refers to a phase of treatment and is designed to reflect the changing diagnosis and/or treatment of the patient. The Episode of Care ends when the Care Type changes or the patient separates from hospital.

There are some exceptions to this general rule:

- (*Public Hospitals Only*). A newborn may change Qualification Status during an Episode of Care. This change is also reflected by *correcting* the Care Type. A qualified newborn receives Acute Care; an unqualified newborn receives Unqualified Newborn Care; a newborn who has been both qualified and unqualified during a single episode is reported as Acute Care for that episode.
- A patient cannot have two changes of Care Type on the one day (that is, start the day as one Care Type, become another Care Type, and then revert to the original Care Type or transfer to a third Care Type). PRS/2s editing prevents such a sequence: to accept it would result in a single day being double-counted as a patient day (once in the same day episode and once as the admission day of the following episode). This circumstance most commonly occurs when a patient is treated as an Acute patient (Care Type) for a day in the middle of another Care Type episode (the same day episode should not be reported to the VAED). Where the patient reverts to the original Care Type, continue the original episode. Where the patient is transferred to a third Care Type, statistically end the original episode and start an episode for the third Care Type.
- In general, public hospitals may use the Palliative Care Type only on admission, if the patient receives palliative care under the supervision of a palliative care specialist or physician; that is, public hospitals may not change to Palliative Care Type following another Episode of Care; the original episode must continue. The only exception to this rule is for transfer between funding sources; that is, if the patient is being transferred to Palliative Care Type funded by the Aged Care Program from another Care Type.
- Public hospitals may use the Alcohol and Drug Care Type only on admission; it is not for use following another Episode of Care.

The following Care Types are distinguished in the VAED:

- *Rehabilitation—Level 1*: Care in a public hospital in a designated Level 1 Rehabilitation Program/Unit.\*

Level 1 rehabilitation is for use by designated specialty programs providing rehabilitation following spinal cord injury, head injury or amputation and where the rehabilitation episode directly follows the acute care episode in which the injury is the principal diagnosis.

- *Rehabilitation—Level 2*: Care in a public or private hospital in a designated Level 2 Rehabilitation Program/Unit.\*

Level 2 are rehabilitation programs that fully meet the criteria for designation as set out in the document *Designation of Rehabilitation Programs*, November 1993.

- *Rehabilitation—Level 3:* Care in a public hospital in a designated Level 3 Rehabilitation Program/Unit.\*

Level 3 rehabilitation programs are where interim/transitional designation is provided based on agreed patient days where the minimum rehabilitation designation criteria were not met but geographical or other considerations require the continued provision of interim services pending improved service provision or the development of service capacity in other agencies.

- *Palliative Care:* Care in a public or private hospital where the patient receives palliative care under the supervision of a palliative care specialist or physician.

In general, public hospitals may use this Care Type on admission (not for change of Care Type following another Episode of Care) if the patient receives palliative care under the supervision of a palliative care specialist or physician. However, where palliative care services are funded by the Aged Care Program, Palliative Care may also be used for a change of Care Type.

- *Mental Health or Psychogeriatric:* Care in an approved mental health service or psychogeriatric program in a public or private hospital registered to provide psychiatric care.\*
- *Geriatric Evaluation and Management:* Care in a public or private hospital in a Geriatric Evaluation and Management Program.\* A geriatric evaluation and management program is sub-acute care of chronic or complex conditions associated with aging, cognitive dysfunction, chronic illness or disability.

*Alcohol and Drug:* Care in a public or private hospital where the patient receives treatment by a specialist physician for an alcohol and drug related condition that is the principal diagnosis. Public hospitals may use this Care Type on admission but not for a change of Care Type following another Episode of Care.

- *Nursing Home Type (NHT) and Non-Acute:*
  - NHT is when the patient has been in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days (or as specified in legislation) and the patient does not have a current Acute Care Certificate issued under section 3B or a determination under section 3A of the Commonwealth Health Insurance Act.
  - Under current legislation, compensable and ineligible patients cannot be categorised as NHT. However, where such a patient has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not a compensable/ineligible patient, would be deemed to be a Nursing Home Type patient, then these patients are deemed to be Non-Acute.

Both NHT and Non-Acute are Care Type 1.

- **Acute Care and Day Surgery, including Qualified Newborn**  
Acute care type refers to an admitted patient episode which does not meet the criteria for classification as any other Care Type. Newborn episodes during which the baby has been classed as a qualified newborn are included in this Care Type.
- **Unqualified Newborn**  
Care Type to be used for a newborn who has been an unqualified newborn for the entire duration of this episode (public hospitals only).
- \* These categories can only be used if the public hospital's Health Service Agreement specifies the hospital to have such a designated unit/program or, in the case of mental health care or specialist rehabilitation, if the private hospital is registered under the Health Services Act 1988 for this category of care. For all other Care Types, if the private hospital considers it is operating a similar program in the private sector and wishes to identify episodes of care using the Care Types specified in this document, the hospital should contact the HDSS Help Desk regarding the use of these Care Type codes.

## Separation

The process whereby a same day patient or an overnight or multi-day stay patient completes an episode of care.

A separation may be either *formal* or *statistical*.

**Formal.** The administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient. This will be because:

- the patient is discharged to private accommodation or other residence;
- the patient is transferred to other health care accommodation;
- the patient dies;
- the patient leaves against medical advice; or
- the patient fails to return from [normal] leave *within seven days* and is therefore discharged, effective from the first day of leave. (This limit does *not* apply to contract leave.)

**Statistical.** The administrative process by which a hospital records the completion of treatment and/or care and accommodation following a change of Care Type (transfer between Care Types) occurring within the one hospital stay (for example, transfer from acute to Nursing Home Type care or transfer from acute to rehabilitation in a designated rehabilitation program).

## Donor Organ Procurement

Donor organs for transplant are procured in two circumstances:

- From a patient already admitted to the hospital who dies:
  - Such a patient's time of separation is the official time of death (being brain death).

- Therefore, the count of hours in ICU reported to the VAED must cease at official separation, and the ICD-10-AM codes for the *procuring* procedures must not be reported to the VAED.
- From a person who is declared dead on arrival at the hospital:
  - Such a person cannot be admitted.
  - Therefore *no* episode can be reported to the VAED.

The costs incurred by the procuring hospital fall outside the casemix system. However, any hospital (public and private) procuring organs for transplant is eligible to claim reimbursement from funds specifically allocated by the Department, based on calculations of the cost of:

- maintaining the potential organ donor in an ICU bed immediately before donor organ procurement
- costs associated with in-house theatre staff
- additional operating theatre costs

Currently, reimbursements are:

- \$800 for procuring kidneys only
- \$2,090 for procuring multiple organs

Claims should be submitted to the Quality Unit, Acute Health Division, Department of Human Services.

## ***Definitions Related to Counting Days***

### **Patient Days**

A *patient day* means a day or part of a day that a patient is admitted to receive hospital treatment. The patient day is the unit of measurement for the length of stay of an episode of care.

The term *patient day* is synonymous with the term *bed day* as used in hospitals.

PRS/2 does not calculate length of stay from admission and separation dates. It sums all Status Segment Total Patient Day fields transmitted by the hospital. However, PRS/2 performs some logical checks.

### **Length of Stay**

The length of stay (LOS) of an episode is the sum of all patient days accrued by a patient within that episode of care. The unit of counting for LOS is *patient day*. For the purpose of calculating LOS, contract leave days are treated as patient days.

### ***Rules for Counting Patient Days, Contract Leave Days and [Normal] Leave Days and for Determining Length of Stay***

There are two possible methods for calculating length of stay:

- *Retrospective*: Separation Date minus Admission Date minus Total [Normal] leave days; and
- *Progressive*: Sum of patient days (including contract leave days) accrued to date.

By whichever method, the result *must* be the same for an individual patient episode.

### ***Both methods of calculating LOS have some fundamental principles***

- 1 The sum of patient days (including contract leave days) and [normal] leave days must equal the number of days elapsed between Admission Date and Separation Date.
- 2 For any given date, either a patient day (including a contract leave day) or a [normal] leave day may be counted, but *not* both.
- 3 Patient days are *not* accrued when the patient is out of the hospital on [normal] leave, regardless of whether a bed is 'being held' for the patient during his/her absence. Contract leave days are effectively treated as patient days and included in Length of Stay.
- 4 For patients admitted and separated on different dates: count one patient day for date of admission; count no patient day for date of separation.
- 5 For patients admitted and separated on the same date: count one patient day; no leave days; and LOS = 1 day.
- 6 A period of absence starting and ending on the same date is *not* counted as leave.

**Some Specific Guidelines for Counting Patient Days, Contract Leave Days and [Normal] Leave Days, and Hence Calculating LOS**

- 7 A same day patient cannot go on either contract leave or [normal] leave. A same day patient is one who has completed their course of treatment and is separated on the same day.
- 8 A period of contract or [normal] leave starting and ending on the same date is not counted as a contract leave day or a [normal] leave day. To count a contract leave day or a [normal] leave day, the patient must be out of the hospital overnight.
- 9 A period of [normal] leave cannot exceed seven days. If a patient does not return to the hospital to continue this episode of care within seven days of starting [normal] leave, the patient is considered to have been separated on the date he/she started [normal] leave.
- 10 Count the day of going on contract leave or [normal] leave as a contract leave day or a [normal] leave day respectively. Count the day of returning from contract leave or [normal] leave as a patient day.
- 11 Notwithstanding point 10 above:
  - When, on the same date, a patient is admitted and goes on contract leave or [normal] leave, count this day as a patient day.
  - When, on the same date, a patient returns from contract leave and again goes on contract leave, count this day as a contract leave day.
  - When, on the same date, a patient returns from [normal] leave, is assessed as fit to continue on leave and again goes on [normal] leave, count this day as a [normal] leave day.
  - When, on the same date, a patient returns from [normal] leave, receives treatment, investigation and/or observation, and again goes on [normal] leave, count this day as a patient day.
  - When, on the same date, a patient returns from contract leave or [normal] leave and is separated, do not count this day as either a contract leave day or a [normal] leave day or as a patient day.
  - When, on the same date, a patient goes on contract leave and is separated from the contracted hospital, do not count this day as either a contract leave day or as a patient day.

**Some Specific Guidelines for Counting Qualified and Unqualified Days:**

- 12 For newborns, count the day of changing from being unqualified to qualified as a qualified day. Count the day of changing from being qualified to unqualified as an unqualified day.
- 13 Notwithstanding point 12 above, when, on the same date, a newborn has *more than one* change of qualification status, starting as unqualified, becoming qualified, then changing back to unqualified, count the day as a qualified day.

## ***Definitions Related to Leave***

There are two types of leave.

- Contract leave
- [Normal] leave

Counting days and reporting are dependent on the type of leave.

### ***Contract Leave***

Contract leave is a period spent as an admitted patient at a contracted (service provider) hospital, during an episode where the patient is also admitted to the contracting (purchasing) hospital. (A special section covers Contracted Hospital Care in detail on page 36).

Contract leave days are reported only by the contracting (purchasing) hospital, and are treated as patient days and included in the length of stay at that hospital. There is no limit to the duration of contract leave. Patients commencing a period of contract leave are *not* separated.

### ***Normal Leave***

Normal leave occurs when an overnight or multi-day patient leaves the hospital temporarily with the approval of the hospital and/or treating medical practitioner with the intention that the patient will return *within seven days* to continue the current treatment. No patient day charges are raised, nor patient days counted, while the patient is on normal leave. Periods of normal leave are *not* counted as separations.

If the absence is planned to be greater than seven days or if the patient fails to return within seven days:

- The patient should be formally separated, effective from the date of leaving the hospital; this is counted as a *formal* separation. If the patient later returns to the hospital and is admitted, a new Episode Record is started; this is counted as a *formal* admission.
- Unless the patient is on contract leave, an overnight/multi-day stay patient in one hospital cannot concurrently be an overnight/multi-day stay patient in another hospital. Such a patient must be separated from one hospital and admitted to the other hospital on each occasion of transfer.

Where it is intended that a patient return to the hospital within seven days for a related but different procedure (for example, a coronary angiogram is to be followed by heart surgery), the patient should be separated and re-admitted.

Where it is intended that a patient return to the hospital within seven days for a regular Type B procedure (dialysis, chemotherapy, plasmapheresis, etc), the patient should be separated and re-admitted.

However, where it is intended that a patient return to the hospital at regular intervals of not more than seven days for a series of non-Type B procedures, the patient is:

- a multi-day patient on leave between treatments; and
- not a same day patient, even if the patient does not stay overnight in the hospital.

In such cases, documented justification for the admission must be provided (that is, to justify admitted care rather than non-admitted care).

### **Reporting Same Day Contract Leave or [Normal] Leave**

A period of absence starting and ending on the same date is *not* counted as leave but the patient *must* be recorded as absent in his/her medical record. The patient *may* be recorded as absent in the hospital's computer system; however, the system *must not* report that day's leave to PRS/2 *nor* (if [normal] leave) deduct a patient day in other reporting (refer to *Length of Stay*, page 27).

## ***Definitions Related to Sub-Acute Geriatric Admitted Services: Streams of Care***

These Streams of Care definitions apply to sub-acute geriatric admitted patient services purchased by the Aged Care Program.

### ***Geriatric Evaluation and Management Program (GEM)***

A Geriatric Evaluation and Management Program is sub-acute care of chronic or complex conditions associated with aging, cognitive dysfunction, chronic illness or disability. These conditions require admission for review, treatment and management by a geriatrician and multi-disciplinary team for a defined episode of care.

The GEM client group are usually older people with complex, chronic or multiple health care conditions requiring treatment and stabilisation of those conditions and/or medical review for future treatment options or service planning.

The GEM Program excludes Nursing Home Type/Non-Acute patients and patients awaiting placement in residential care. If a GEM patient is in hospital for more than 35 days with a maximum break of seven consecutive days, an Acute Care Certificate is needed if the GEM episode is to continue.

Patients admitted to this program are recorded in PRS/2 as Care Type 9 *Geriatric Evaluation and Management Program*.

### ***Designated Rehabilitation Program***

Rehabilitation is defined as the process of restoring a disabled person to his/her fullest physical, mental and social capability through the combined and coordinated use of medical, physical, educational and vocational measures so as to achieve optimum functional independence.

The Rehabilitation Program excludes Nursing Home Type/Non-Acute patients and Geriatric Evaluation and Management patients.

The Department defines three levels of rehabilitation program:

#### **Level 1**

For use by programs that have been designated under the criteria set out in the document *Designation for Rehabilitation Programs*, November 1993 and that provide specialty rehabilitation programs for patients in the spinal cord, head injury and amputee sub-program areas, directly following the acute episode where the injury was the principal diagnosis.

#### **Level 2**

General rehabilitation programs that have been designated under the criteria set out in the document *Designation for Rehabilitation Programs*, November 1993.

### **Level 3**

Transitional designation for use by programs that have not fully met the criteria for designation as a rehabilitation program but geographical or other considerations require interim designation to be provided conditional on improvements being achieved or the transfer of services to other facilities.

Rehabilitation patients are recorded in PRS/2 according to the level of designation of the program as:

- Level 1: Care Type 2
- Level 2: Care Type 6
- Level 3: Care Type 7

### ***Palliative Care Program***

Palliative Care is defined as end stage management and symptom control provided with palliative care physician support, linked to community palliative care services and to an acute facility. Palliative care is a comprehensive program providing coordinated medical, nursing and allied health support to address physical, spiritual and psychosocial needs.

The palliative care client group are people of any age who have been diagnosed as having a terminal illness; have a progressively deteriorating condition; and have a life expectancy of six months or less, or have difficulty coping with the prospect of a shortened life expectancy.

The Palliative Care Program excludes Nursing Home Type/Non-Acute patients.

Palliative Care patients are recorded in PRS/2 as Care Type 8 *Palliative Care Program*.

### ***Geriatric Respite***

Geriatric Respite is admission for care and support of a person in a stable, pre-assessed condition requiring accommodation, clinical and nursing care to provide relief for carers.

Geriatric Respite includes both planned and unplanned respite:

- Planned geriatric respite care is provided for a planned or booked admission of a person in order to provide relief for carers.
- Unplanned respite provides accommodation and care when an emergency or crisis has occurred, including an episode of ill health for the carer.

In both cases, the patient does not require assessment or clinical care over and above that which would normally have been provided in the usual place of residence.

The program excludes Nursing Home Type/Non-Acute patients and patients awaiting placement in residential care. Geriatric respite is not available to residents of residential care facilities.

On admission, Geriatric Respite Care patients are recorded in PRS/2 as Care Type 4 *Other Care (Acute)* and Admission Type G *Geriatric Respite Admission*. Public hospitals may use this combination only on admission, as a statistical transfer to geriatric respite is not valid.

### ***Nursing Home Type/Non-Acute***

This group includes Nursing Home Type patients, patients with an NH5 certificate and non-acute patients and is defined as a program to maintain current levels of functional independence in patients awaiting transfer to residential care.

A Nursing Home Type (NHT) patient is defined in section 3 of the Commonwealth Health Insurance Act 1973: after 35 days continuous hospitalisation, the patient is classified as an NHT patient unless a medical practitioner certifies under section 3(B)(1) that the patient is in need of acute care. For example:

- professional attention for an acute phase of the patient's condition; or
- active rehabilitation; or
- continued management, for medical reasons as an admitted patient.

A patient cannot be designated NHT before 35 days continuous hospitalisation (with a maximum break of seven consecutive days) even if an approved NH5 form, *Application for Nursing Home Admission* has been signed.

If a NHT patient is out of hospital (other than for contracted services) for seven days or less and is re-admitted, the patient continues to be a NHT patient.

If a NHT patient is out of hospital (other than for contracted services) for more than seven consecutive days, the patient would be admitted as an acute patient, not a NHT patient.

NHT patients are recorded in PRS/2 as Care Type 1 *NHT/Non-Acute*.

### **Non-Acute Compensable Patient and Non-Acute Ineligible Patient**

Under current legislation, compensable and ineligible patients cannot be categorised as Nursing Home Type. However, where such a patient has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not a compensable/ineligible patient would be deemed to be a Nursing Home Type patient, then these patients are deemed to be Non-Acute.

Non-Acute patients are recorded in PRS/2 as Care Type 1 *NHT/Non-Acute*.

## ***Definitions Related to Clinical Coding and DRGS***

### **Principal Diagnosis**

The Principal Diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).

The principal diagnosis must be determined in accordance with the Australian Coding Standards. It is derived from and must be substantiated by clinical documentation.

### **Procedures**

Record procedures undertaken in accordance with the Australian Coding Standards. The order of codes should be determined using the following hierarchy.

- Procedure performed for treatment of the principal diagnosis.
- Procedure performed for treatment of an additional diagnosis.
- Diagnostic/exploratory procedure related to the principal diagnosis.
- Diagnostic/exploratory procedure related to an additional diagnosis.

### **DRG Classification**

The term DRG refers to the Diagnosis Related Group classification system which clusters patients into groups which are clinically coherent and similar in use of resources. The concept of clinical coherence requires that the patient characteristics included in the definition of each DRG relate to a common organ system or aetiology (cause of disease), and that a specific medical specialty should typically provide care to the patients in that DRG.

A patient can be allocated to only one DRG for an episode of care. Allocation occurs on the basis of information contained in the patient's discharge abstract. A DRG is assigned by computer software using codes for:

- the principal diagnosis;
- procedures undertaken for surgical cases;
- the presence or absence of other diseases or comorbidities and complications; and
- other variables such as age, sex and discharge status and, for neonates, admission weight.

Further details of grouping logic and methodology are contained in the *Australian National Diagnosis Related Groups Definitions Manual, version 3.1*

### ***DRG Classification System for Victorian Hospitals, 1999–2000***

The Department of Human Services will use Australian National Diagnosis Related Groups (AN-DRGs), v3.1, for grouping VAED data in 1999–2000. There are 667 DRGs in Version 3.1.

AN-DRG v3.1 is based on the first edition of the Australian Version of the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) coding system for diagnoses and procedures. However, since 1 July 1998, Victorian hospitals have reported using ICD-10-AM (Australian Modification) and these codes are mapped back to ICD-9-CM for grouping purposes.

### ***DRG Cost Weights***

A relative measure of the average cost of care for patients in the DRG.

Patients in those DRGs assigned a high cost weight are expected to require more costly care than those assigned a low cost weight. Thus, cases in a DRG with a cost weight of 2.0 would, on average, cost twice as much to treat as for cases in a DRG that has a cost weight of 1.0. The cost weight for a DRG represents a statistical average of actual costs with a certain level of variability. Within the same DRG there are still some variations between individual patients in the level of resources used, but these variations are predictable.

### ***DRG Cost Weights for Victorian Hospitals, 1999–2000***

In 1999–2000, the casemix funding formula in Victoria will be based on the 1998–99 *Victorian Cost Weights Study* of 1997–98 activity.

Full details of the Victorian casemix-based funding formula for public hospitals are contained in *Victoria—Public Hospitals Policy and Funding Guidelines 1999–2000* ([www.dhs.vic.gov.au/ahs/pfg9920](http://www.dhs.vic.gov.au/ahs/pfg9920)).

## ***Definitions Related to Contracted Hospital Care***

### **Recording Contracted Care**

Accurate recording of contracted care in both public and private hospitals is essential because:

- Funding arrangements require that the DRG assigned to a patient accurately reflects the total treatment provided, even where part of the treatment was provided under contract.
- Funding arrangements require that potential double payments are identified and avoided; the case payment will apply only to the contracting hospital and not the contracted hospital.
- Unidentified duplication in the reporting of separations, patient days and procedures must be avoided to enable accurate analyses as required for funding, casemix, resource use and epidemiological purposes.
- The Commonwealth Department of Health and Aged Care requires details of contracted public patients attending private hospitals to be reported, under the Australian Healthcare Agreement.

### **Scope of Contracted Care**

Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contractor) and a provider of an admitted or non-admitted service (contracted hospital). Such an agreement can be formal or informal, written or verbal.

Related contracted hospital care data items should only be completed where services are provided which represent *some, but not all* of the contacted hospital's total services. That is, it is not necessary to complete contracted hospital care data items where *all* of the hospital services are contracted by a health authority, for example, privately owned and/or operated public hospitals such as New Latrobe Regional Hospital.

To be in scope, contracted care must involve *all* of the following:

- A purchaser, which can be a public or private hospital, or a health authority (Department of Human Services or a Health Region) or another external purchaser. Examples of other external agencies purchasing hospital care include the Transport Accident Commission (for the Alfred Road Trauma Unit), Department of Veterans' Affairs (for the Veterans' cardiac agreement) and international patients entered into individual contracts.
- A contracted hospital, which can be a public or private hospital or day procedure centre.
- The contractor making full payment to the contracted hospital for the contracted service. Thus, services provided to a patient in a separate facility during their episode of care, where the *patient* is directly responsible for payment of this additional service, are not considered contracted services for the purposes of PRS/2 reporting.

- The patient being physically present in the contracted hospital for the provision of the contracted service. Thus, pathology or other investigations performed at another location on specimens gathered at the contracting hospital would *not* be considered contracted services for the purposes of PRS/2 reporting.

## Contract Leave

Contract leave is a period spent as an admitted patient at a contracted (service provider) hospital, during an episode where the patient is also admitted to the contracting (purchasing) hospital.

Contract leave days are reported only by the contracting (purchasing) hospital and are treated as patient days and included in length of stay at that hospital. In PRS/2, contract leave days for the episode are reported in three Contract Leave Days fields: Month-to-date, Financial Year-to-date, and Total. There is no limit to the duration of contract leave.

Patients going on contract leave are *not* separated.

## Identification of Contracted Episodes of Care

In PRS/2, reporting1 (*Contract*) in the *Funding Arrangement* field identifies episodes involving contracted care. The following fields are then used:

- The type of contract involved is reported in the *Contract Type* field.
- The role of the hospital (contracting or contracted) is reported in the *Contract Role* field.
- The nature of the contract involving an external purchaser, or the other hospital involved in a contracted care or hub and spoke arrangement, is reported in the *Contract/Spoke Identifier* field.

## Identification of Procedures Performed under Contract

The contracting (purchasing) hospital is termed Hospital A.  
The contracting (service provider) hospital is termed Hospital B.

In PRS/2, procedures performed *at another hospital under contract to this hospital* are recorded by both hospitals, but flagged in the *contracting hospital only* (Hospital A). Hospital A reports a flag in the eighth character of the (ICD-10-AM) codes relating to procedures performed under contract by Hospital B.

Flags used by Hospital A are:

- Character F on procedures performed by Hospital B on an admitted basis.
- Character N on procedures performed by Hospital B on a non-admitted basis.

See the PRS/2 Manual for further details.

Allocation of diagnosis and procedure codes should not be affected by the contract status of an episode: the *Australian Coding Standards*, including the *Victorian Additions to the Australian Coding Standards*, should be applied when coding all episodes. In particular,

procedures that would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (that is, not a recognised hospital) should be coded if appropriate but should not be flagged as contracted hospital procedures.

## **Types of Contracted Hospital Care**

The contracting (purchasing) hospital is termed Hospital A.  
The contracting (service provider) hospital is termed Hospital B.

Six contract types are identified by the sequence of alpha characters, representing the movement of the patient between the contracting (A) and contracted (B) hospitals.

### **1 Contract Type B**

A (health authority/other external purchaser) contracts B (hospital) for admitted service. External purchaser agencies include, but are not limited to:

- Department of Veterans' Affairs: Veterans' Cardiac Agreement
- Transport Accident Commission: Alfred Road Trauma Unit
- individual contracts with international patients.

*Hospitals that believe they have a similar contract should contact the Department to discuss reporting arrangements.*

### **2 Contract Type ABA**

Patient admitted by Hospital A.  
Hospital A contracts Hospital B for admitted or non-admitted patient service.  
Patient returns to Hospital A on completion of service by Hospital B.

### **3 Contract Type AB**

Patient admitted by Hospital A.  
Hospital A contracts Hospital B for admitted or non-admitted patient service.  
Patient does *not* return to Hospital A on completion of service by Hospital B.

### **4 Contract Type (A)B**

Patient *not* present in the Contracting Hospital A at any time during the episode.  
Hospital A contracts Hospital B for the *whole* admitted patient service.

An (A)B contract type cannot occur between two public hospitals unless approved by the Department. Where two public hospitals enter into a contract, the contracting hospital must admit and provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).

### **5 Contract Type BA**

Hospital A, which does not initially admit the patient, contracts Hospital B for an admitted patient service following which the patient is transferred to and admitted by Hospital A.

## **6 Contract Type A(B)**

Hospital A contracts Hospital B for the *whole* admitted patient service.

Hospital B provides the service at Hospital A.

Patient *not* present in the Contracted Hospital (B) at any time during the episode.

An A(B) contract type cannot occur between two public hospitals unless approved by the Department. Where two public hospitals enter into a contract, the contracting hospital must admit and provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).

See the PRS/2 Manual for recording contract patient services on PRS/2.

## **AIMS Reporting**

The following summarises reporting AIMS requirements under various contracted patient scenarios:

### **Contracted Non-Admitted Service:**

- If the contracting hospital arranges for an admitted patient to receive an occasion of service as a non-admitted patient at another hospital, and the patient returns on the same day, neither hospital reports an occasion of service on AIMS Form S2. There is no effect on the separations and patient days reported on the contracting hospital's AIMS Form S1.

### **Contracted admitted service:**

- If the contracting hospital arranges for an admitted patient to be treated as a same day admitted patient by another hospital, and the patient returns on the same day, the patient will not be recorded as being on contract leave from the contracting hospital. This will have no effect on the separations and patient days reported on the contracting hospital's AIMS Form S1. The contracted hospital will also admit and separate the patient as usual and report a same day episode on its AIMS Form S1 (if a public hospital) or its AIMS Form P1 (if a private hospital).
- If the patient does return to the contracting hospital but not on the same day, the absence is recorded as a period of contract leave, regardless of whether the absence was more or less than seven days. The contracting hospital reports only one separation, dated when the patient is finally separated from the contracting hospital. The contracted hospital will also report a separation when the patient leaves that hospital. The contract leave days will be included in the contracting hospital's length of stay, in order to derive the appropriate case payment (inlier/outlier length of stay).
- If the patient does not return to the contracting hospital at all, the contracting hospital reports the Separation Date as the date the patient actually left the contracted hospital. The days between leaving the contracting hospital and leaving the contracted hospital are recorded by the contracting hospital as contracted leave days. The contracted hospital reports the episode as another separation and the duration of the stay as patient days.

## ***Definitions Related to Non-Admitted Patient Services***

### **Occasion of Service**

An occasion of service is any examination(s), consultation(s), treatment(s) or other service(s) provided to a non-admitted patient in *each functional unit* of a health service establishment on each occasion such service(s) is (are) provided.

### **Counting Occasions of Service**

An occasion of service occurs when one or more services are provided to a non-admitted patient by a particular functional unit or department of a hospital. Each set of related diagnostic tests or services for the one patient on one occasion, consists of one occasion of service. For example, three blood tests performed for the one patient on one visit to the hospital would count as one occasion of service.

Services provided by different departments in the hospital represent different occasions of service; thus, if a patient receives an x-ray and a blood test to assist with diagnosis of the same problem, this would count as two occasions of service.

Occasions of service may occur on campus or off campus. However, occasions of service are not intended to include telephone conversations with, or about, the patient.

Services provided to non-admitted patients of another hospital, such as pathology or allied health services, should only be counted if the hospital is not reimbursed for these services by the other hospital.

From 1 July 1999, non-admitted patient services provided to eligible veterans and war widow(er)s are to be reported on the Acute Health non-admitted patient returns (Forms 111/S2, 111/S8 and 111/S9). This information is required for implementation of the new funding arrangements with the Department of Veterans' Affairs. Other Programs of the Department have made alternative arrangements for collecting DVA data.

Services provided to non-admitted patients by medical practitioners or other health professionals on a private basis should not be counted. Services provided on a private basis involve patients being charged directly by the private practitioner or in the private practitioner's name; this includes all services which attract Medicare benefits and services provided to compensable patients.

### **Business Units and Privatised Services**

'Privatised services' refers to services provided by a separately incorporated body which may or may not be owned by the hospital/network.

The term 'business unit' refers to a unit which:

- is not a separate legal entity and is under the control of the hospital Board of Management;
- maintains a separate identity within the hospital and a separate set of accounts;
- does not (directly) receive any income from the Department of Human Services; and

- is reimbursed by the hospital from the Operating Fund for any services 'purchased' for public patients.

It is anticipated that business units and privatised services will provide services to private patients on a fee-for-service basis, or to public patients referred by the hospital. Services provided to privately referred non-admitted patients on a fee-for-service basis should not be counted as occasions of service on the Form S2.

Where a public non-admitted patient is referred to a business unit or privatised service by the hospital, these services should be counted as occasions of service by the hospital on the appropriate Form S2. The hospital would pay for the service provided to the referred public patient and no claims should be made for Medicare or Veterans' Affairs benefits. Payment by the hospital should be based on an agreed fee-for-service, such as the rates provided in the CMBS Schedule. Where payment for services by the hospital is in kind, such as by provision of accommodation, power, cleaning services, administrative services, etc., the value of the in kind services should be made explicit, and the transfer of chargings between Operating and Specific Purpose Accounts should occur at the end of each month.

### **Group Session**

A service provided to a group of non-admitted patients or clients rather than to individuals. Each group session is to be counted *once only*, irrespective of the number of patients/clients in the group or the number of staff providing services.

### **Encounters**

Encounters refer to a visit to one of the 45 VACS categories. For funding, resource weights have been developed that incorporate encounters based not only on the clinic visit but associated ancillary services provided to a patient over a defined period. The period over which bundling occurs is a 'window' of thirty (30) days either side of the visit.