# Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Author</th>
<th>Change reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/07/2011</td>
<td>1.0</td>
<td>Julie Brophy</td>
<td>Initial Draft.</td>
</tr>
<tr>
<td>30/07/2011</td>
<td>2.0</td>
<td>Julie Brophy</td>
<td>Updated to include revised S&amp;W descriptions and VMO category removed. Order resorted to include Principles and Definitions and Guidelines sections.</td>
</tr>
<tr>
<td>28/07/2011</td>
<td>3.0</td>
<td>Julie Brophy</td>
<td>Updated to include section on linking ancillary services.</td>
</tr>
<tr>
<td>29/07/2011</td>
<td>3.1</td>
<td>Julie Brophy</td>
<td>Updated to include expanded definition of Service Location, Date of Service and Episode Number Format</td>
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<tr>
<td>8/8/2011</td>
<td>3.2</td>
<td>Julie Brophy</td>
<td>Inclusion of data validations section</td>
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<td>17/8/2011</td>
<td>3.3</td>
<td>Julie Brophy</td>
<td>Updated AH definition</td>
</tr>
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<td>9/9/2011</td>
<td>3.4</td>
<td>Julie Brophy</td>
<td>Updated to include medical indemnity and depreciation guidelines</td>
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<tr>
<td>15/9/2011</td>
<td>3.5</td>
<td>Julie Brophy</td>
<td>Updated to reflect changes to reporting of Radiotherapy episodes</td>
</tr>
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<td>22/09/2011</td>
<td>3.6</td>
<td>Funding System Development</td>
<td>Updated with minor amendments, formatting fixed</td>
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## Glossary of Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHPCS</td>
<td>Australian Hospital Patient Costing Standards</td>
</tr>
<tr>
<td>CCOA</td>
<td>Common Chart of Accounts</td>
</tr>
<tr>
<td>CCSAA</td>
<td>Clinical Costing Standards Association of Australia</td>
</tr>
<tr>
<td>CCU</td>
<td>Critical Care Unit</td>
</tr>
<tr>
<td>CMBS</td>
<td>Commonwealth Medical Benefits Schedule</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>ESSU</td>
<td>Emergency Short Stay Unit</td>
</tr>
<tr>
<td>GL</td>
<td>General Ledger</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HEN</td>
<td>Home Enteral Nutrition</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>OP</td>
<td>Outpatient</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Schedule</td>
</tr>
<tr>
<td>S&amp;W</td>
<td>Salaries and Wages</td>
</tr>
<tr>
<td>VACS</td>
<td>Victorian Ambulatory Classification System</td>
</tr>
<tr>
<td>VAED</td>
<td>Victorian Admitted Episodes Dataset</td>
</tr>
<tr>
<td>VCCUG</td>
<td>Victorian Clinical Costing User Group</td>
</tr>
<tr>
<td>VCDC</td>
<td>Victorian Cost Data Collection</td>
</tr>
<tr>
<td>VEMD</td>
<td>Victorian Emergency Dataset</td>
</tr>
<tr>
<td>VINAH</td>
<td>Victorian Non-admitted Health Minimum Dataset</td>
</tr>
<tr>
<td>VMO</td>
<td>Visiting Medical Officer</td>
</tr>
<tr>
<td>VRMDS</td>
<td>Victorian Radiotherapy Minimum Dataset</td>
</tr>
</tbody>
</table>
Purpose

This document provides guidance to health services in the costing and reporting of 2010-11 patient level cost data to the Victorian Cost Data Collection (VCDC). The aim is for the reported cost data to:

- comply with the VCDC File Specifications;
- comply with the Australian Hospital Patient Costing Standards (AHPCS) V2 - excluding standards relating to Depreciation (DEP 1.001, 1A.001,1B.001,1C.001 1D.001 and 1E.001), Teaching (SCP 2A.002) and Research (SCP 2B.001); and
- be used for benchmarking and best practice improvement initiatives.

This document has been developed by the Department of Health (DH) in consultation with the Victorian Clinical Costing User Group (VCCUG) which is a sub-committee of the Clinical Costing Standards Association of Australia (CCSAA).
Costing Principles

Full Activity Costing
Health services must allocate 100% of General Ledger (GL) operating expenses in the costing process. Costs must be allocated to patient episodes, or where no feeder data exists, a ‘dummy’ patient episode. The level of the dummy episode created will be dependant on the cost breakdown available. For example, if a health service provides several sub-acute ambulatory services to patients, they may wish to create just one dummy episode per period (i.e. year, month or quarter depending on costing practices) to allocate all the costs for providing these services. Alternatively they may have a greater level of GL information that allows the site to allocate some costs for different types of services provided. Examples of services are physiotherapy and social work.

Teaching & Research
All operating expenses relating to teaching and research activities are to be allocated as indirect costs for reporting of 2010-11 cost data. Cost should first be allocated to the most appropriate cost area within the costing system (e.g. medical units for teaching and training undertaken by medical staff) and then allocated to episodes using the most appropriate cost allocation. The following table outlines the preferred cost allocation methods for the most common types of cost incurred with teaching, training and research activities.

Table 1: Allocation methods for Teaching and Research

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Allocation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>S&amp;W Medical</td>
<td>Medical EFT</td>
</tr>
<tr>
<td>S&amp;W Nursing</td>
<td>Nursing EFT</td>
</tr>
<tr>
<td>S&amp;W Allied Health</td>
<td>Allied Health EFT</td>
</tr>
<tr>
<td>S&amp;W Other</td>
<td>Other EFT</td>
</tr>
<tr>
<td>MS/GS</td>
<td>Expenditure</td>
</tr>
</tbody>
</table>

Overhead Cost Area
The following cost areas are defined as Overhead costs under Australian Hospital Patient Costing Standards (AHPCS) but may be able to be allocated using direct cost allocation methods:
- Interpreters
- Central Sterile Supply Services
- Chaplaincy
- Ambulance
- Patient Transport
- Porters & Orderlies
- Patient Accommodation
- Meals

The 2010-11 Victorian Health Services Mapping of Cost Areas to AHPCS and CCSAA Cost Outputs provide the dhCostArea prefix to be used for both direct and indirect cost areas within costing systems. (Note: Indirect cost areas will not appear in the VCDC output as they are allocated across direct cost areas)
Linking of Ancillary Services
Ancillary services such as diagnostic imaging, pathology and pharmacy should be linked to an existing episode of care. Examples of episodes of care include an emergency presentation, an inpatient admission or a specialist consultation. Ideally, linking of services to an episode of care should occur in source systems and not in the costing system. However if the costing system is used, then the location where the service was ordered, should take precedence over where the service was delivered.

If date alone is used to link services, then the rules should generally follow the preference of linking to an emergency episode, followed by an admitted episode and finally a non-admitted episode. Ancillary services ordered and/or provided within 30 days before or after a specialist non-admitted consultation can be linked to the consultation. In linking to a non-admitted episode, health services need to ensure that it is a relevant non-admitted episode (see examples below). This may necessitate excluding certain types of episodes from the linking process. Where the funding source of these services is known, they should be linked to an episode of the same funding type. For example, public funded ancillary services should only be linked to a public non-admitted consultation.

Matching of other services to the relevant episode should therefore consider the type of service. For example:

- Chemotherapy drugs dispensed prior to admission should be linked to a relevant admitted episode and not to an unrelated non-admitted presentation.
- Radiotherapy treatment should be linked to a non-admitted radiotherapy episode and not to a non-admitted medical consultation.
- Allied health practitioners do not generally order diagnostic investigations or prescribe medication and they should therefore be excluded from the linking process.
- Visiting nursing services should not generally attract diagnostic or pharmacy services.

Depreciation
Reporting of depreciation costs is not mandatory for 2010-11 activity.

Medical Indemnity
Medical indemnity costs should be included in costs reported to VCDC for 2010-11 activity. It is recommended that costs should be allocated to medical cost areas as indirect costs based on medical EFT or medical salary and wages expenditure. However if health services can identify more specific cost allocations methods then these should be applied.
Definitions & Guidelines

Episode Program Definitions

The episode program identifies the type of cost episode reported. The following categories are applicable. The reference value of identifying keys has also been defined to ensure that costing data can be linked to other reportable datasets such as the Victorian Admitted Episodes Dataset (VAED), the Victorian Emergency Minimum Dataset (VEMD), the Victorian Non-admitted Health Minimum Dataset (VINAH) and the Victorian Radiotherapy Minimum Dataset (VRMDS).

Table 2: Episode Program Values and Key Definitions

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
<th>Episode Key (ekey)</th>
<th>DH Unique Key (dhKey)</th>
<th>Encounter ID (encounter)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Admitted</td>
<td>CCS Unique Key</td>
<td>VAED Unique Key</td>
<td>N/A</td>
</tr>
<tr>
<td>B</td>
<td>Boarders</td>
<td>CCS Unique Key</td>
<td>N/A</td>
<td>IP CCS Unique Key*</td>
</tr>
<tr>
<td>C</td>
<td>Community Health</td>
<td>CCS Unique Key</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>E</td>
<td>Emergency Department</td>
<td>CCS Unique Key</td>
<td>VEMD Unique Key</td>
<td>IP CCS Unique Key*</td>
</tr>
<tr>
<td>N</td>
<td>Non-Admitted</td>
<td>CCS Unique Key</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Mental Health</td>
<td>CCS Unique Key</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>O</td>
<td>Organ Procurement</td>
<td>CCS Unique Key</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>R</td>
<td>Radiotherapy</td>
<td>CCS Unique Key</td>
<td>VRMDS Unique Key</td>
<td>IP CCS Unique Key*</td>
</tr>
</tbody>
</table>

* = Where applicable  
CCS Unique Key = Clinical Costing System Unique Key

A – Admitted Episodes

Episode Program A is valid for all care types reported to the Victorian Admitted Episode Dataset (VAED).

B – Boarders

Episode Program B is valid for hospital boarders who are receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. Hospital boarders are not admitted to the hospital and not reported to the VAED. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Minimal costs should be allocated to boarders reflecting only the cost of food and/or accommodation provided to them.

C – Community Health

Episode Program C is valid for services provide by health services and funded by the Department of Health’s Community Health Care program area funding. This includes the following areas (Victorian Health Services Policy and Funding Guidelines 2010-1, Highlights, page 77, http://www.health.vic.gov.au/pfg/):

- Diabetes Self Management
- Community Health
- Aboriginal Promotion and Chronic Care
- Family Planning
- Family and Reproductive Rights Education Program
- Primary Health
- Women’s Health
- Integrated Chronic Disease Management
- Refugee Health Services
- Healthy Mothers Healthy Babies
- Children’s Weight Management

**E – Emergency**

Episode Program E is used to recognise that each patient presentation to an Emergency Department (ED) should have an associated emergency cost episode reflecting the cost of services and care while in the ED.

The following examples provide guidance on the linking of services and costs to admitted and emergency episodes.

**Example 1: Patient presentation to ED, treated and sent home or transferred to another facility.**

<table>
<thead>
<tr>
<th>Episodes Created</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEMD</td>
</tr>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

**Example 2: Patient presentation to ED, treated and subsequently admitted to a ward.**

<table>
<thead>
<tr>
<th>Episodes Created</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEMD</td>
</tr>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>
Example 3: Patient presentation to ED, admitted for treatment in ED, subsequently discharged home.

![Diagram of ED arrival, admit, and depart times]

<table>
<thead>
<tr>
<th>Episodes Created</th>
<th>VEMD</th>
<th>VAED</th>
<th>Costing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y</td>
<td>Y</td>
<td>E – All costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A – No Costs</td>
</tr>
</tbody>
</table>

Example 4: Patient presentation to ED, admitted for treatment to an Emergency Short Stay Unit (ESSU), subsequently transferred to a ward.

![Diagram of ED, ESSU, and Ward arrival, admit, and depart times]

<table>
<thead>
<tr>
<th>Episodes Created</th>
<th>VEMD</th>
<th>VAED</th>
<th>Costing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y</td>
<td>Y</td>
<td>E - Cost up to ED Departure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A – Cost from ED Departure</td>
</tr>
</tbody>
</table>

Example 5: Admitted to a ward for treatment, treated in ED on discharge from ward.

![Diagram of Ward and ED arrival, admit, and depart times]

<table>
<thead>
<tr>
<th>Episodes Created</th>
<th>VEMD</th>
<th>VAED</th>
<th>Costing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y</td>
<td>Y</td>
<td>E – Cost after discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A – Cost up to discharge</td>
</tr>
</tbody>
</table>
Example 6: Presents to ED during HITH admission

<table>
<thead>
<tr>
<th>Episodes Created</th>
<th>Costing</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEMD</td>
<td>VAED</td>
</tr>
<tr>
<td>Y x 2</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N - Non-admitted

 Episode Program N must be used for all service events that is currently or will be reported to the Victorian Integrated Non-Admitted Health Minimum Dataset (VINAH). This includes the following:

- Sub-Acute Ambulatory Services
- Hospital Admission Risk Program
- Post Acute Care
- Community Palliative Care
- Family Choice
- Victorian HIV Service
- Victorian Respiratory Support Service
- Medihotel*
- Specialist Outpatients – Medical & AH – public and CMBS billed**
- Victorian Perinatal Data Collection
- Transition Care Program
- Residential In-Reach
- Hospital Based Palliative Care Consultancy Team

*If the cost is part of an episode that is or will be reportable to VINAH then these costs must be reported under Program N. However, if the cost of medihotels forms a part of an episode that is reported to the VAED then these costs must be reported under Program A.

**Funding source type will be used by DH to determine the funding stream for Specialist Clinics Outpatients (OP). For example MV Public Eligible = VACS funded Outpatients and QM Private Clinic = MBS funded Outpatients. For valid funding source types refer to VINAH Manual 2011-12 (VINAH v7), Section 3-17 ‘Contact Account Class’.
All episodes reported under Program N must also report an Episode Program Stream code. Where an appropriate Episode Program Stream code is unavailable ‘9999’ should be used. If ‘9999’ is used for the Episode Program Stream, the clinic field should be populated with a description that is meaningful to the health service.

Episode Program N should also be used to report the following:
- Unlinked services. Some examples include pharmacy, pathology and imaging services.
- Private patient clinics that are operated by the health service
- Home and Community Care (HACC) funded services. For example visiting nursing services.
- Services provide to patient in their homes. For example Home Enteral Nutrition (HEN) services.

**M - Mental Health**

Episode Program M is valid for mental health services that cannot be classified under other episode programs. An example is non-admitted services provided by a mental health unit. The following hierarchy should be followed in considering whether an episode belongs to Episode Program M.

**Flow Diagram 1: Allocation of Episode Program = Mental Health (M)**

```
Flow Diagram 1: Allocation of Episode Program = Mental Health (M)

Mental Health Service
  ↓
  Pt in ED
    ↓
    Yes
      ↓
      Episode Program = E
    No
      ↓
      Pt Admitted
        ↓
        Yes
          ↓
          Episode Program = A
        No
          ↓
          OP Clinic
            ↓
            Yes
              ↓
              Episode Program = N
            No
              ↓
              Episode Program = M
```

**O - Organ Procurement**

Episode Program O is valid for services relating to Organ procurement (posthumous), which is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead. Costs allocated to these episodes should reflect procedures undertaken including mechanical ventilation and tissue procurement. These patients are not admitted to the hospital but should be registered by the hospital.
R – Radiotherapy

Episode Program R is valid for episodes that relate to the provision of radiotherapy services, including treatment and consultations.

Costs to be allocated to these episodes include the following service events with provision of each type of service event to an individual patient generating a separate cost episode.

Consultations

- Medical – is the provision of specialist consultations by a Radiation Oncologist or multi-disciplinary team. The initial consultations will usually result in the prescribing of a course of radiotherapy treatment. During treatment, patients are also reviewed regularly by the Radiation Oncologist. Post treatment, further consultation will be provided to the patient to review their progress and outcomes. Ancillary services (e.g. diagnostic imaging, pathology, pharmacy) provided within 30 days either side of the consultation is considered a component of the consultation service event.

- Nursing – includes scheduled consultations by a registered nurse or nurse practitioner. It should be noted that VACS (Specialist Outpatients) funded consultations must be reported as Episode Program Stream N.

- Allied Health – includes scheduled consultations provided by allied health practitioners but excluded VACS (Specialist Outpatients) funded consultations. It should be noted that VACS funded consultations should be reported as Episode Program Stream N.

Planning – includes the processes involved in creating a treatment plan from the Radiation Oncologist’s prescription and simulation stages.

- Simulation – includes the processes for establishing a treatment volume and patient position, documenting appropriate measurements and applying tattoos to the patient. It is performed either using a ‘treatment simulator’ or a CT scanner.

- Dosimetry – includes the processes for measurement and calculation of the dose of radiation for the radiotherapy treatment.

- Mould room - the production of positioning masks, tissue substitutes and specialised shielding for many different treatment areas.

Treatment – is the use of radiation to destroy cells administered by either external beam therapy or internally.

- External beam – is the delivery of megavoltage or kilo voltage treatment.

- Brachytherapy – is the use of radioactive sources that are inserted directly into, or immediately adjacent to tumours.

A course of radiotherapy involves:

- A prescription by a Radiation Oncologist outlining the anatomical region/site(s) to be treated, fractionation, and total dose to be delivered; and

- All phases of radiotherapy delivered for the management of a single disease entity relating to a decision to treat.

The DH Unique Key (dhKey) reported to the VCDC for Radiotherapy episodes should reflect the Course ID reported to the VRMDS for treatment (MVT, KVY, brachytherapy), planning (simulation, dosimetry and mould room) service events. A DH Unique Key (i.e. Course ID) is not required for consultations as many of these may be provided independent of treatment, but should be provided if known.

Treatment provided to inpatients (including brachytherapy) should generate a radiotherapy episode and not be ‘bundled’ to the admitted episode for reported to the VCDC.
Episode Number Format

Unlinked Services
Where episode numbers must be created for services that do not link to existing episodes, the following format for the episode number is to be applied and reported as the episode key to the VCDC. Service Areas are to reflect the type of feeder extract that generates the episode.

Service Area-UR-Date (YYYYMMDD)

i.e. PATH-123456-20110701

The dhKey for these episodes must be populated with UNLINKED.

Table 3: Service Areas

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH</td>
<td>Allied Health</td>
</tr>
<tr>
<td>DIAG</td>
<td>Diagnostic Imaging</td>
</tr>
<tr>
<td>PATH</td>
<td>Pathology</td>
</tr>
<tr>
<td>PRO</td>
<td>Procedure Suite</td>
</tr>
<tr>
<td>PHAR</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>RT</td>
<td>Radiotherapy</td>
</tr>
<tr>
<td>OTH</td>
<td>Other</td>
</tr>
</tbody>
</table>

Aggregated Episodes
Where patient level feeder data is not available, cost should be allocated to a single ‘dummy’ episode. For example, community health services may not be able to provide patient level data, but the cost of operating the service can be identified. A cost area for this service should be created within the costing system and the costs should be allocated through the costing process to a ‘dummy’ episode. This practice will also allow for the allocation of indirect costs to the cost area.

The following format of episode keys should be used to create and report such episodes.
YYYYMM-AREA (Note: the date will be the last month of the processing period. If processing annually this will be June e.g. 201106).

Examples are provided below:

Table 4: Service Areas

<table>
<thead>
<tr>
<th>episodeKey</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>201106-PAC</td>
<td>2010-11 Post Acute Care</td>
</tr>
<tr>
<td>201106-CHS</td>
<td>2010-11 Community Health Services</td>
</tr>
<tr>
<td>201106-MH</td>
<td>2010-11 Mental Health Services</td>
</tr>
<tr>
<td>201106-MEDIHOTEL</td>
<td>2010-11 Medihotel</td>
</tr>
<tr>
<td>201106-INTERIMCARE</td>
<td>201-11 Interim Care (Care Type F)</td>
</tr>
</tbody>
</table>

The dhKey for these episodes must be populated with UNALLOCATED.
**Cost Areas**

As part of the costing process health services must map general ledger (GL) costs to a cost area within their costing system. Depending on the software application that is being used, this can also be referred to as the cost centre, department or cost output. To enable consistent reporting of cost outputs, health services are required to prefix these cost areas with an alphanumeric code that can be interpreted consistently for reporting purposes. A mapping of these prefixes to the Australian Hospital Patient Costing Standards (AHPCS) and the Clinical Costing Standards Association of Australia (CCSAA) cost outputs has been provided on the VCDC website (http://www.health.vic.gov.au/hdss/vcdc/index.htm).

Cost area prefixes and descriptions have been used from the Victorian Common Chart of Accounts (CCOA) to allow greater correlation between the GL and costing systems. However, some additional cost areas have been added ensure that Commonwealth reporting requirements can be met. This includes the Birth Centre cost area (Table 5). In this instance, any cost record reported to DH with a dhCostArea code of A0250 will be mapped to the cost centre ‘BirthCentre’ for Commonwealth reporting and will subsequently be rolled up to the ‘Clinical’ cost group for APHCS cost bucket reporting. This cost centre will also be mapped to the ‘Nursing’ cost bucket for reporting in Victoria against the CCSAA cost outputs.

Some cost centre ranges from the CCOA have also been ‘split’ to allow for a distinction between medical and surgical clinical unit costs for reporting against CCSAA cost outputs. An example is gynaecology (Table 5).

Provision has also been provided for cost areas that are defined by the AHPCS as ‘Overhead’ but may be allocated using direct cost allocations methods and therefore appear as cost outputs. An example of this is ambulance costs (Table 5). Ambulance costs may be allocated indirectly. However, if these costs are allocated using direct patient allocation methods and appear in the cost outputs to DH then the costs will be mapped to ‘GenWard’ costs for Commonwealth reporting and the ‘Nursing’ cost output for CCSAA reporting. In either instance, the prefix on the cost area in the costing system should be P0448.

**Table 5: Mapping of Cost Areas to AHPCS and CCSAA Cost Outputs**

<table>
<thead>
<tr>
<th>dhCostArea Code</th>
<th>Alpha</th>
<th>Numeric</th>
<th>Description</th>
<th>Final or Overhead</th>
<th>Code</th>
<th>Group</th>
<th>CCSAA Direct or Indirect</th>
<th>Service Cost Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0152</td>
<td>0200</td>
<td>Coronary Care</td>
<td>Final</td>
<td>CCU</td>
<td>Critical</td>
<td>D</td>
<td>CCU</td>
</tr>
<tr>
<td>A</td>
<td>0250</td>
<td></td>
<td>Birth Centre</td>
<td>Final</td>
<td>BirthCentre</td>
<td>Clinical</td>
<td>D</td>
<td>Nursing</td>
</tr>
<tr>
<td>A</td>
<td>5452</td>
<td>5576</td>
<td>Gynaecology</td>
<td>Final</td>
<td>Gynaecology</td>
<td>Clinical</td>
<td>D</td>
<td>Med Non Surg</td>
</tr>
<tr>
<td>A</td>
<td>5477</td>
<td>5500</td>
<td>Gynaecology - Surgical</td>
<td>Final</td>
<td>Gynaecology</td>
<td>Clinical</td>
<td>D</td>
<td>Med Surg</td>
</tr>
<tr>
<td>P</td>
<td>0448</td>
<td></td>
<td>Ambulance</td>
<td>OtherOhds</td>
<td>PatTransport</td>
<td>Overhead</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>0448</td>
<td></td>
<td>Ambulance</td>
<td>Final</td>
<td>GenWard</td>
<td>Clinical</td>
<td>D</td>
<td>Nursing</td>
</tr>
</tbody>
</table>

**Account Type**

An account type is a group of general ledger expenditure account codes defined by an input type (rather than function as defined by a cost centre) that describe resources being use by a cost centre.

The following are defined for use in reporting of 2010-11 cost data to DH.
Table 6: DH Account Types

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood*</td>
<td>Blood Products</td>
</tr>
<tr>
<td>DeprecB*</td>
<td>Depreciation - Building</td>
</tr>
<tr>
<td>DeprecE*</td>
<td>Depreciation - Equipment</td>
</tr>
<tr>
<td>GS</td>
<td>Goods &amp; Services</td>
</tr>
<tr>
<td>Hotel</td>
<td>Hotel Services</td>
</tr>
<tr>
<td>Imag</td>
<td>Imaging</td>
</tr>
<tr>
<td>Lease</td>
<td>Leases</td>
</tr>
<tr>
<td>MS</td>
<td>Medical Supplies</td>
</tr>
<tr>
<td>OnCosts</td>
<td>Labour On Costs</td>
</tr>
<tr>
<td>Path</td>
<td>Pathology</td>
</tr>
<tr>
<td>PharmNPBS</td>
<td>Pharmacy - Non PBS or S100 reimbursed</td>
</tr>
<tr>
<td>PharmPBS</td>
<td>Pharmacy - PBS reimbursed</td>
</tr>
<tr>
<td>PharmS100</td>
<td>Pharmacy - Section 100 reimbursed</td>
</tr>
<tr>
<td>Pros</td>
<td>Prosthesis</td>
</tr>
<tr>
<td>PtTransport</td>
<td>Patient Transport</td>
</tr>
<tr>
<td>SWAdmin</td>
<td>Salary &amp; Wages Administration</td>
</tr>
<tr>
<td>SWAdminOc</td>
<td>Salary &amp; Wages Administration On Costs</td>
</tr>
<tr>
<td>SWAH</td>
<td>Salary &amp; Wages Allied Health</td>
</tr>
<tr>
<td>SWAHOc</td>
<td>Salary &amp; Wages Allied Health On Costs</td>
</tr>
<tr>
<td>SWHMO</td>
<td>Salary &amp; Wages Hospital Medical Officers</td>
</tr>
<tr>
<td>SWHMOOc</td>
<td>Salary &amp; Wages Hospital Medical Officers On Costs</td>
</tr>
<tr>
<td>SWHotel</td>
<td>Salary &amp; Wages Hotel</td>
</tr>
<tr>
<td>SWHotelOc</td>
<td>Salary &amp; Wages Hotel On Costs</td>
</tr>
<tr>
<td>SWMed</td>
<td>Salary &amp; Wages Medical</td>
</tr>
<tr>
<td>SWMedOc</td>
<td>Salary &amp; Wages Medical On Costs</td>
</tr>
<tr>
<td>SWMedSup</td>
<td>Salary &amp; Wages Medical Support</td>
</tr>
<tr>
<td>SWMedSupOc</td>
<td>Salary &amp; Wages Medical Support On Costs</td>
</tr>
<tr>
<td>SWNurs</td>
<td>Salary &amp; Wages Nursing</td>
</tr>
<tr>
<td>SWNursOc</td>
<td>Salary &amp; Wages Nursing On Costs</td>
</tr>
<tr>
<td>SWOther</td>
<td>Salary &amp; Wages Other</td>
</tr>
<tr>
<td>SWOtherOc</td>
<td>Salary &amp; Wages Other On Costs</td>
</tr>
<tr>
<td>SWSess</td>
<td>Salary &amp; Wages Sessional Medical Staff</td>
</tr>
<tr>
<td>SWSessOc</td>
<td>Salary &amp; Wages Sessional Medical Staff On Costs</td>
</tr>
</tbody>
</table>

* Not mandatory for 2010-11 cost data reporting
A mapping of Victorian CCOA Account Codes to DH Account Types has been provided on the VCDC website (http://www.health.vic.gov.au/hdss/vcdc/index.htm). The table also identifies how the DH Account Types will be reported to the Commonwealth under the AHPCS rollup.

The following provides further clarification on definitions of reportable Account Types in accordance to the Australian Hospital Patient Costing Standards, V2.0

**Salary & Wages**

Salary and wages are the main forms of payments made to an employee. Generally, they are considered as payments:

a) made to an individual

b) made as remuneration for services and

c) provided under a contract of service (employment contract).

Salaries and wages include ordinary hours worked, penalty rates, overtime, professional development, and allowances (e.g. district/remote, on-call, living out, uniform and laundry). On-costs are excluded.

All salary and wages need to be allocated to one of the following ten categories.

1. **Nursing**

   Nursing salary and wages includes the following categories of staff:
   
   • Registered Nurses;
   • Enrolled Nurses;
   • Establishment Based Student Nurses and
   • Trainee/pupil nurse.

2. **Medical Officers (non VMO or HMOs)**

   Medical Officers salary and wages are incurred by Medical Officers employed by the health service.

3. **Hospital Medical Officers (HMOs)**

   Medical salary and wages includes the following categories of staff employed by a health service:
   
   • Specialist and General Practice Medical Officers;
   • Registrar;
   • Residents and
   • Interns.

4. **Sessional Clinicians**

   Sessional Clinicians’ salary and wages are incurred by Clinicians employed by the health service on a sessional or Visiting Medical Officers (VMO) basis. VMOs are defined as a medical practitioners appointed by the health service to provide medical services for hospital (public) patients in an honorary, sessional or fee-for-service basis.

5. **Allied Health**

   Allied Health salary and wages includes qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, technical and therapeutic services. This account type should also include diagnostic and health professionals whose duties are primarily or partly of an administrative nature. Exclusions to this definition are Medical Scientists, Medical Imaging Technologists/Radiographers, Medical Physicists, Nuclear Medical Technologists, Pharmacists, and Radiation Therapists who are identified as Medical Support.
Staff must be registered or working towards registration and must have current practicing certificate with an applicable registered body or training towards registration under the direct supervision of the relevant diagnostic or allied health professional.

Allied health is a collective term for a wide range of tertiary qualified health professionals, other than medical and nursing, including but not limited to:

- Art /Music Therapists
- Audiologists
- Clinical Psychologists
- Dentists
- Dieticians/Nutritionists
- Occupational Therapists
- Orthoptists
- Orthotists/Prosthetists
- Pharmacists (Community/Hospitals)
- Physiotherapists
- Podiatrists
- Radiation Therapists
- Social Workers
- Speech Pathologists

6. Medical Support

This category includes Medical Scientists, Medical Imaging Technologists/Radiographers, Medical Physicists, Nuclear Medical Technologists, Pharmacists and Radiation Therapists.

7. Hotel and Allied Services

This category includes staff engaged in the provision of hotel services that support the provision of care to patients including cleaning, domestic, catering and laundry staff. It also encompasses staff engaged in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions and are not allocated as an overhead cost. This category includes attendants, assistants or home assistants, home companions, family aides, ward helpers, ward assistants, assistants in nursing and Aboriginal Health Workers.

8. Administrative and Clerical Staff

This category includes staff engaged in administrative and clerical duties including ward clerks and administrative staff.

9. Other Salary & Wages

This category includes staff salary and wages costs that cannot be allocated to any one specific category above. Agency and external contract staff expenses that are not defined by a specific pay type should also be grouped to this category.

On Costs

On costs are long service leave, leave loading, payroll tax, workers compensation payments (excluding premiums that are a goods and services cost) and redundancy payments.

Goods and Services

Goods are defined as items of merchandise, finished products, supplies or raw materials. In some cases, the term is extended to cover all inventory items or assets such as cash, supplies, and fixed assets.
Services are defined as labor performed by an individual or organisation on behalf of others. It is the provision of services for which payment is received from a client.

Goods and Services also include Repairs and Maintenance costs and are defined as the costs incurred:

- to bring an asset back to an earlier condition or to keep the asset operating at its present condition;
- on existing non-current assets that maintain the usefulness of an asset; or
- on repairs and maintenance of assets that are to be expensed in the Operating Statement.

**Medical Supplies**

Medical and surgical supplies, includes medical and surgical equipment, medical instruments and medical aides.

Medical surgical supplies are items that:

- are usually disposable in nature; and or
- cannot withstand repeated use by more than one individual; and or
- are primarily and customarily used to serve a clinical purpose; and or
- generally are not useful to a person in the absence of illness and injury; and or
- may be ordered and used by clinical staff.

Medical and surgical supplies include external prosthetics such as prosthetic legs, external breast prostheses, prosthetic eyes, wigs and other such devices.

It also includes dressings, minor surgical instruments, medical gases, disposable medical supplies, x-ray supplies, medical and surgical appliances such as splints, crutches and wheelchairs.

In addition, includes items of medical equipment, surgical instruments and patient appliances which have a life of less than one year.

Supplies that cannot be classified under these definitions should be classified under goods and services.

**Pharmaceuticals**

**PBS reimbursed pharmaceuticals**

A "pharmaceutical benefit" within the meaning of the Act refers to:

(a) An item which is listed in the Schedule of Pharmaceutical Benefits; or

(b) An item, which is listed in the Schedule of Pharmaceutical Benefits and is supplied by an approved supplier under Part 7 of the NHA subject to subsidy

**S100 reimbursed pharmaceuticals**

Section 100/high cost drugs’ criteria for inclusion of drugs in the program can be summarised as follows:

- Ongoing specialist medical supervision required.
- Treatment of chronic medical conditions; not acute episodes of inpatient treatment (includes out patient, day patient and discharge medication).
- Highly specialised drugs
- Marketing approval in Australia for approved indications.
- High unit cost and identifiable patient target group.
PBS non-reimbursed pharmaceuticals

Non-PBS drugs are prescribed when a patient's clinical condition does not match the restriction on the Schedule of Pharmaceutical Benefits. A non-PBS prescription is written using a PBS prescription form. However, the drug must be identified as "Non-PBS" on the prescription.

This category also includes the purchase, production, distribution, supply and storage of drug products and clinical pharmacy services of all drugs that are not reimbursed by PBS or S100.

Prostheses

The term 'Prostheses,' includes surgically implanted prostheses, human tissue and other medical devices. Implanted prostheses include cardiac pacemakers and defibrillators, cardiac stents, hip and knee replacements and intraocular lenses, as well as human tissues such as human heart valves, corneas, bone (part and whole) and muscle tissue.

Criteria for listing on the Prostheses List

Products meeting all of the following criteria are eligible for consideration for inclusion on the Prostheses List:

- The product must be included or being considered for inclusion on the Australian Register of Therapeutic Goods; and
- The product must be provided to a person as part of an episode of hospital treatment or hospital-substitute treatment; and
- A Medicare benefit must be payable in respect of the professional service associated with the provision of the product (or the provision of the product is associated with podiatric treatment by an accredited podiatrist); and
- The product should be:
  a. surgically implanted in the patient and be purposely designed to:
     i. replace an anatomical body part; or
     ii. combat a pathological process; or
     iii. modulate a physiological process; and
  b. essential to and specifically designed as an integral single-use aid for implanting a product that is only suitable for use with the patient in whom that product is implanted; or
  c. critical to the continuing function of the surgically implanted product and is only suitable for use by the patient in whom that product is implanted; and
- The product has been compared to alternate products on the Prostheses List or alternate treatments and:
  a. have been assessed as being, at least, of similar clinical effectiveness; and
  b. the cost of the product is relative to its clinical effectiveness.

Pathology

Pathology costs are goods and services used in the provision of a pathology service and consumables. These costs can also be the actual cost as billed by a provider and is defined, but not limited, to the following:

- Animal Testing
- Autopsy
- Clinical Biochemistry
- Cytogenetics
- Cytology
- Forensic
- General Pathology
- Genetics
- Haematology (laboratory)
- Histopathology
- Immunology (laboratory)
- Microbiology
- Mortuary
- Pharmacology
- Specimen collection services
- Toxicology

Imaging

Imaging cost are goods and services used in the provision of an imaging service. These costs can also be the actual cost as billed by a provider and is defined, but not limited, to the following:

- Angiography
- Computed Tomography (CT)
- General Imaging
- Echo Cardiogram
- Mammography
- Magnetic Resonance Imaging (MRI)
- Nuclear Medicine
- Positron Emission Tomography (PET)
- Plain X-ray (including films and contrast)
- Ultrasound

Hotel

Hotel costs include the following:

- Cleaning products and services
- Linen and laundry services
- Food services (patients)
- General hotel services

Blood

These costs are defined as the:

- Blood products that are used or intended for use for human therapeutic or diagnostic purposes and that:
  a. consist of human blood or components of human blood; or
b. are derived from human blood; or
   - Blood-related products that are used or intended for use for human therapeutic or diagnostic purposes and that:
     a. are alternative, analogued or complementary to the use of blood products; and
     b. are regarded as blood-related products for the National Blood Agreement; or
   - Services, equipment or procedures that are regarded as blood-related services for the National Blood Agreement and that:
     a. are used in the collection, supply or use of blood products or blood-related products; or
     b. are alternatives to the use of blood products or blood-related products; or
     c. reduce the need for blood products or blood-related products; or
     e. otherwise affect the demand or supply of blood products or blood-related products.

**Lease**
Lease costs are related to an agreement whereby the lessor conveys to the lessee in return for a payment or series of payments the right to use an asset for an agreed period of time.

**Depreciation**
These costs are related to the systematic allocation of the depreciable amount of an asset over its useful life.
- **Building Depreciation** - Includes fixed fit out such as items fitted to the building. Examples include lights and partitions.
- **Equipment Depreciation** - Includes non fixed building fit out including facility fit out items such as theatre tables, moveable furniture, and chemotherapy chairs etc.

**Service Location**
The service location is to be reported for all cost records to identify where the service was ordered (e.g. diagnostic, pharmacy and ancillary services) or delivered (e.g. ward bed days). Ideally the feeder system data should identify the location of where the service was ordered from. If this is not possible, then a match of the location of the patient on the date of service can be used.

Two levels of specificity can be reported. Reporting at level one is mandatory for 2010-11 cost records, with level two optional.

**Table 7: Service Location Codes – Level 1**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Inpatient</td>
</tr>
<tr>
<td>200</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>300</td>
<td>Non-Admitted</td>
</tr>
<tr>
<td>400</td>
<td>Community Health</td>
</tr>
</tbody>
</table>
Table 8: Service Location Codes – Level 2

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>Ward</td>
</tr>
<tr>
<td>102</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>103</td>
<td>Coronary Care Unit</td>
</tr>
<tr>
<td>104</td>
<td>High dependency Unit</td>
</tr>
<tr>
<td>105</td>
<td>Neonatal Intensive Care Unit</td>
</tr>
<tr>
<td>106</td>
<td>Special Care Nursery</td>
</tr>
<tr>
<td>107</td>
<td>Operating Room</td>
</tr>
<tr>
<td>108</td>
<td>Specialist Procedure Suite</td>
</tr>
<tr>
<td>109</td>
<td>Hospital in the Home</td>
</tr>
<tr>
<td>200</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>301</td>
<td>Specialist Consultation Suite</td>
</tr>
<tr>
<td>302</td>
<td>Other Procedure Suite</td>
</tr>
<tr>
<td>303</td>
<td>Private Practice</td>
</tr>
<tr>
<td>304</td>
<td>Radiotherapy Service</td>
</tr>
<tr>
<td>305</td>
<td>Post natal Domiciliary Nursing Service</td>
</tr>
<tr>
<td>306</td>
<td>Other Domiciliary Nursing Service</td>
</tr>
<tr>
<td>307</td>
<td>Medihotel</td>
</tr>
<tr>
<td>400</td>
<td>Community Health</td>
</tr>
</tbody>
</table>

**Date of Service**

A date of service (ddMMyyyy) is the data of when services are provided to a patient within an episode of care. For admitted episodes, the date of service is only required for the first date of any service in each specific location and should only change if the location changes. If a patient presents to ICU twice within an admitted episode, then cost records should be reported separately for each stay in ICU.

Ideally the feeder system data should identify the date of when the service was ordered (or delivered for services that do not require ordering (e.g. bed days)). If this is not possible, then the service date (e.g. test date) or the date that the service was provided to the patient (e.g. reporting date) should be used.
Data Validations

The following validations will be applied to data submitted to the VCDC. Data failing the validations will generate an error or warning report to health services.

General validations

The following validations apply for all episodes:

1. the sum of the (indirectCost + directCost) for each cost area (DH cost area) should be > zero
   \textbf{ACTION:} if not true then flag as error (E1)

2. the sum (indirectCost + directCost) of all records for an episode should have a cost > zero
   \textbf{ACTION:} if not true then flag as error (E2)

Admitted data validations

The following validations only apply to admitted episodes:

3. If the episode has a length of stay of 1 day where the admission date=separation date (i.e. same day episode):
   - the separation mode is a death or transfer (VAED.SEPMODE= ‘D’, ‘T’), then the total cost (sum of indirectCost + directCost for all records in an episode) should be >$40
   - all other separation modes should have a total cost >$50
   \textbf{ACTION:} if not true then flag as error (E3)

4. If the episode has a length of stay (LOS) of 1 day and is a duration of < 24:00 hours and the admission date is not the same as the separation date (i.e. overnight stay):
   - the separation mode is a death or transfer (VAED.SEPMODE= ‘D’, ‘T’) and the total cost (sum of indirectCost + directCost for all records in an episode) should be > $40
   - all other separation modes should have a total cost >$50
   \textbf{ACTION:} if not true then flag as error (E4)

5. If the episode has a length of stay of > 1 day and is a duration of >24:00 hours and the admission date is not the same as the separation date (i.e. overnight stay):
   - the vicdrg of the corresponding financial year is ‘P66D’ or ‘P67D’ then the per diem (sum of all records for an episode directCost + indirectCost /los)cost should be >$50
   - all other vicdrg of the corresponding financial year
   - the separation mode is a death or transfer should have a per diem cost > $70
   - all other separation modes should have a per diem cost >$100
   \textbf{ACTION:} if not true then flag as error (E5)

6. The sum of all records for an episode directCost + indirectCost should be < $200,000
   \textbf{ACTION:} if not true flag as warning (E6)

7. If the vicdrg of the corresponding financial year is valid (as per prescribed list) and not blank, then
   - The per diem cost of episodes should be < 5 times the per diem average of the prior year
   \textbf{ACTION:} if not true then flag as warning (E7)
8 If the care type is sub-acute (either ‘2’, ‘6’, ‘7’, ‘K’, ‘J’, ‘P’) 
- the vicdrg of the corresponding year is valid (as per prescribed list) then the per diem cost should be < $3,000 
- the per diem cost should be > $100

**ACTION:** if not true then flag as warning (E8)

9 If the ICU hours is > 0 the sum of the (indirectCost + directCost) where CCSAA Service Cost Group = ICU should be >0

**ACTION:** if not true then flag as error (E9)

10 If the ICU hours is = 0 the sum of the (indirectCost + directCost) where CCSAA Service Cost Group = ICU should = 0

**ACTION:** if not true then flag as error (E10)

11 If the CCU hours is > 0 the sum of the (indirectCost + directCost) where CCSAA Service Cost Group =CCU should be >0

**ACTION:** if not true then flag as error (E11) and review

12 If the CCU hours is = 0 the sum of the (indirectCost + directCost) where CCSAA Service Cost Group =CCU should = 0

**ACTION:** if not true then flag as error (E12)

13 If the DRG is Surgical (second character of the vicdrg of the corresponding year is either a ‘0’, ‘1’, ‘2’, ‘3’, ‘4’ or ‘5’) and 
- the sum of (indirectCost + directCost) where CCSAA Service Cost Group =(TheatreOR and TheatreNonOR) = 0 and

**AND**
- then the sum of (indirectCost + directCost) where CCSAA Service Cost Group =(MedSurg and MedNonSurg) should >$50,

**ACTION:** if not true then flag as warning (E13)

14 If the episode is flagged with a E13 warning then check to see if any of the procedure code is from either blocks ‘1331’, ‘1909’ or ‘1912’ of Australian Classification of Health Interventions. (refer to provided table of anaesthetic procedure codes).

**ACTION:** if true flag as warning (E14)

15 If the episode procedure code is contained in the ‘prosthesis list’ table, then episode must contain a record with a dhAccountType =Prosthesis AND directCost >0

**ACTION:** if true flag as warning (E15)

**Non-admitted data validations**

16 The following validations only apply to non-admitted data (episode program stream 1-9999)

- If the sum of (indirectCost + directCost) for all records in an episode is > $3,000

**ACTION:** if true flag as warning (E16)

17 If the sum of (indirectCost + directCost) for all records in an episode is < $5
**ACTION**: if true flag as warning (E17)