

**Proposals for Revisions
to PRS/2 and the
Victorian Admitted Episodes Dataset
(VAED)**

Department of Human Services

December 2001

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Executive Summary

This document details the proposed revisions to the Victorian Admitted Episodes Dataset (VAED) for 1 July 2002. These proposed revisions are summarized below.

1. New name for DVA Record (*DVA and TAC Record*) and inclusion of two new data items (*TAC Claim Number* and *Date of Accident*) to support direct billing of compensable Transport Accident Commission episodes of care.
2. Inclusion of a new data item (*Duration of Continuous Positive Airways Pressure*) in Diagnosis Record to (potentially) provide an indicator of severity for patients having Continuous Positive Airways Pressure (CPAP).
3. Two new Care Types to support reporting of admissions to the Interim Care Program. Sub-Acute data is required for these Care Types.
4. Two new Account Class codes to enable consistent reporting of admissions of prisoners. This will support a planned review of prisoner billing, as well as ongoing funding of prisoner admissions.
5. Changed alignment of data within the Patient Identifier field to enable consistency of reporting between DHS data sets and comparison of records between these collections.

This document details the above proposals and describes the consultation process that will assist in the development and possible introduction of these revisions to PRS/2 and the VAED.

Introduction

The VAED Proposals Consultation Process

Each year the Department of Human Services (DHS) reviews the data elements and format of PRS/2 and the Victorian Admitted Episodes Dataset (VAED). This review seeks to ensure that the admitted patient collection supports the Department's national reporting obligations, and assists DHS planning and policy development.

This document is being distributed to all Victorian hospitals, to patient management system suppliers known to have Victorian clients, and to a range of industry bodies. It outlines *proposals* for changes to PRS/2 and the VAED, as at the time of its release in December 2001. This should not be regarded as a complete list of changes to be made for 2002–2003. Items in this publication cannot be guaranteed to change or to change in the form suggested here; nor does the absence of an item from this publication indicate it will not change from 1 July 2002. Confirmed changes will be published in the document '*Specification for Revisions to PRS/2 and the VAED for 1 July 2002*', which will be published in January/February 2002.

Timelines for release of the *Proposals for Revisions* and *Specifications for Revisions* have been brought forward to allow inclusion of these revisions in the developed specifications for the patient administration system replacement projects presently underway in Victoria.

There are a number of proposals for changes to the VAED outlined in this document. It is expected that release of these proposals will stimulate discussion within the health industry. **Prompt feedback is sought on these proposals.** Hospitals and software suppliers should review this document and assess the feasibility of the proposals. All are invited to provide written feedback to the Department by completing the proforma provided with this document, and forwarding it to the Department as indicated, **no later than Monday 10 December 2001.**

There will be a **summary presentation** of these proposals during the **HDSS Forum** to be conducted on **Thursday 13 December 2001**. Responses to feedback received from hospitals and software suppliers during the feedback period will be addressed at this forum. If you have any questions or comments, it is important to notify these prior to the forum, as question time will only be available at the forum if time permits.

Constructive suggestions are welcomed, both for dealing with the proposed changes identified in this document, and of other alterations to PRS/2 and the VAED, to improve their utility for hospitals.

Orientation to this Document

As this document provides 'proposals' for revisions, there are a few features that require explanation:

- New values and definitions relating to existing items appear in boxes
- The text is divided into the categories of 'Specification' and 'Administration'.
Specification – details the reporting requirements for the item.
Administration – provides additional information including the purpose of the collection of the data item and the source of the code set and definitions.
- Further information such as the background to each proposal is provided.

Abbreviations

DHS	Department of Human Services
DVA	Department of Veterans Affairs
HDSS	Health Data Standards and Systems
NICU	Neonatal Intensive Care Unit
PRS/2	Patient Reporting System, Version 2
TAC	Transport Accident Commission
VAED	Victorian Admitted Episodes Dataset
WIES	Weighted Inlier Equivalent Separations

Proposed Revisions

Proposal one—Transport Accident Commission (TAC)

It is proposed to Revise the title of the DVA Record (V2) to be the *DVA and TAC Record*, to be reported for all episodes with an Account Class for DVA (V-) or TAC (T-).

Incorporated into this proposal, is the collection of two new data items:

- TAC Claim Number, and
- Date of Accident.

These data items to be reported for all TAC patients (that is, patients with a TAC Account Class) admitted to public hospitals.

TAC Claim Number can be collected in the field currently used to report the DVA Number (actual content of field to depend on the patient's Account Class).

A new field in the V2 record is required for Date of Accident.

Proposed by Candice Charles
Transport Accident Commission
Phone 9664 6042

Implementation Date 1 July 2002

Background In 2000 – 2001 the TAC received approximately 8,200 paper-based accounts for admitted patients, and paid almost \$30M to 100 Victorian public hospitals.

For 2002 – 2003 the TAC are proposing that DHS provide electronic data to TAC in a similar manner to DVA data. Payment would be made to the DHS, which in turn will transfer funds to the hospitals.

Provision of the TAC Claim Number and Date of Accident enables TAC to identify eligible patients for prompt payment.

TAC Claim Number

Specification

<i>Definition</i>	The Transport Accident Commission's claim number for the person.		
<i>Datatype</i>	Alphanumeric	<i>Form</i>	Code
<i>Field size</i>	9	<i>Layout</i>	DDMMCCYY
<i>Location</i>	DVA and TAC Record (Shared field <i>DVA Number</i> and <i>TAC Claim Number</i>)		
<i>Reported by</i>	Public hospitals.		
<i>Reported for</i>	Episodes with an Account Class of TAC (T-).		
<i>Reported when</i>	The Episode Record is reported.		
<i>Code set</i>	Obtained from the TAC, allocated to those eligible for TAC benefits. C–U <i>Claim number unavailable</i> should be reported when the persons TAC Claim Number is not known by the hospital.		
<i>Reporting guide</i>	<i>Characters 1-2</i> : Financial year of claim acceptance. <i>Characters 4-8</i> : Numeric characters allocated by TAC. <i>Character 9</i> : Space Examples of permitted formats: 9812345, 5412345		
<i>New edits required</i>	### TAC Claim Number is invalid (blank, in future, other) ### Year of accident incompatible with TAC Claim number		
<i>Edits requiring modification</i>	All cross edits for V2/E2 validation		
<i>Related items</i>	Date of Accident, Account Class		

Date of Accident

Specification

<i>Definition</i>	The date of the transport accident causing the person to require hospitalisation.		
<i>Datatype</i>	Numeric	<i>Form</i>	Date
<i>Field size</i>	8	<i>Layout</i>	DDMMCCYY
<i>Location</i>	DVA and TAC Record		
<i>Reported by</i>	Public hospitals.		
<i>Reported for</i>	Episodes with an Account Class of TAC (T-).		
<i>Reported when</i>	The Episode Record is reported.		
<i>Reporting guide</i>	Report unknown Date of Accident as 01011901.		
<i>New edits required</i>	### Invalid Date of Accident (blank, invalid format, future date) ### Year of accident incompatible with TAC Claim number		
<i>Edits requiring modification</i>	Cross edits for V2/E2 validation		

Administration

<i>Purpose</i>	To enable TAC payment of relevant episodes of care.
<i>Principal data users</i>	Transport Accident Commission
<i>Collection start</i>	2002 – 2003
<i>Definition source</i>	TAC

DVA and TAC Record

DVA and TAC Record—Revised File Structure

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	V2
M	Unique Key	6	3	A/N	Hospital generated.
M	Patient Identifier	8	9	A/N	Hospital generated Left justified, trailing blanks
M	DVA / TAC Claim Number	9	17	A/N	Refer to editing rules for these items
M	Surname	20	26	A/N	Refer to PRS/2 Manual Section 3
M	Given Name(s)	12	46	A/N	Refer to PRS/2 Manual Section 3
1	Admission Date	8	58	N	DDMMCCYY
1	Separation Date	8	66	N	DDMMCCYY
2	Date of Accident	8	74	N	DDMMCCYY
	User Flag	1	82	A/N	Optional field, free text or space
	Filler	158	83	A/N	Spaces
		Total:240			

All alpha characters must be uppercase. All numeric fields right justified and zero filled.

M Mandatory

1 These dates must match those in the corresponding Episode Record.

2 **Mandatory for episodes with Account Class of TAC (T-).**

Reported by Public hospitals.

[Private hospitals: Do not report V2s.]

Reported for Admitted patient episodes with an Account Class of DVA (V-) or TAC (T-).

Reported when The Episode Record is reported (each time).

Reporting guide **General**

The DVA and TAC Record allows hospitals to report the necessary additional information about a DVA or TAC patient to facilitate payment for the episode.

Field

DVA
(Account Class V-)
TAC
(Account Class T-)

Transaction Type

V2

V2

Unique Key

*

*

Patient Identifier

*

*

DVA Number / TAC Claim Number

DVA Number

TAC Claim Number

Surname

*

*

Given Name(s)

*

*

Admission Date

Separation Date

*

*

*

*

Date of Accident

Spaces

*

User Flag

Correction/Update

To correct a DVA and TAC Record, re-transmit the entire DVA and TAC Record (together with the Episode Record), including the corrections. This will overwrite the existing record held by PRS/2.

Deletion

To delete a DVA and TAC Record, re-transmit the DVA and TAC Record with the DVA or TAC number filled with 9s. If the deletion is submitted after the DVA and TAC Record has been sent the record will be flagged as cancelled but will remain on the file available to the Department.

If the Episode Record is deleted, the DVA and TAC Record will automatically be deleted. Re-transmitting the Episode Record alone will not re-generate the DVA and TAC Record. The DVA and TAC Record must also be re-transmitted.

Data Items

Per PRS/2 Manual 11th Edition, 1 July 2001.

Editing

The following rules apply to DVA and TAC data:

- If, in this transmission, there is an Episode Record with Account Class V- or Account Class T-, then there must be a V2 with the same Unique Key in this transmission.
- If, in this transmission, there is a DVA and TAC Record, then there must be an Episode Record with Account Class V- DVA or Account Class T- TAC, with the same Unique Key in this transmission.

- If a DVA and TAC Record sent in this transmission fails the edits, then the corresponding Episode Record in this transmission will also be rejected.
- If an Episode Record with Account Class V- or Account Class T- *sent* in this transmission fails the edits, then the corresponding DVA and TAC Record in this transmission will also be rejected.

These rules imply:

- When sending an updated Episode Record, even though a V2 had been successful in an earlier transmission, the DVA and TAC Record must be sent again.
- When sending an updated DVA and TAC Record (to correct information in a previously accepted DVA and TAC Record), even though an Episode Record had been successful in an earlier transmission, the Episode Record must be sent again.
- When sending an Episode Record deletion for the DVA or TAC patient, do not send an Episode Record for the same Unique Key in this transmission.
- When sending a DVA and TAC Record deletion, do not send a V2 for the same Unique Key in this transmission.

The Episode and DVA and TAC Records of DVA and TAC patients are subject to a Transaction Matching process before the Transmitted Transaction process.

The Transaction Match process:

- Verifies for presence of one E2 and one V2 for any Unique Key
- Checks Admission and Separation Dates for consistency between the E2 and V2
- Edits V2s for validity
- Rejects the pairs of records which fail these checks

Proposal two—Duration of Continuous Positive Airways Pressure (CPAP)

It is proposed to Create a new data item to collect the Duration of Continuous Positive Airways Pressure (CPAP) for all patients undergoing CPAP while admitted to hospital.

Proposed by Steve Gillett
Funding Policy Unit, Department of Human Services
Phone 9616 7297

Implementation Date 1 July 2002

Background During early 1999, DHS undertook a review of Neonatal Intensive Care funding. The consultants recommended that DHS develop a series of severity indicators for neonates (Recommendation 2); review existing problem lists (Recommendation 8) and introduce a payment for CPAP (Recommendation 10). DHS deferred this work until after the introduction of version 4 DRGs.

As an interim measure DHS modified the 2001 – 2002 funding formula to include mechanical ventilation copayments for neonates. These copayments were to compensate Neonatal Intensive Care Units (NICUs) for treating the most costly babies, until a better indicator of severity could be developed.

The introduction of a CPAP based payments within WIES requires the collection of the number hours that patients undergo CPAP. Initially, data will be analysed to determine the appropriateness and scope of a potential CPAP copayments, allowing for the potential to modify the payment formula for 2003-2004. However, if sufficient retrospective data can be provided to allow earlier analyses, funding changes could be introduced for 2002 – 2003.

It is also worth noting that the Commonwealth Department of Health and Aged Care has received submissions for the incorporation of CPAP DRGs within version 5 of ARDRGs. DHS believes that creating separate CPAP DRGs is a sub-optimal solution for funding the most severely ill patients. The availability of CPAP data for adults would also enable DHS to explore the other funding/classification options for non-neonates.

Duration of Continuous Positive Airways Pressure (CPAP)

Specification

<i>Definition</i>	Total duration of Continuous Positive Airways Pressure (CPAP) in hours, provided during this episode of care.		
<i>Datatype</i>	Numeric	<i>Form</i>	Quantitative value
<i>Field size</i>	4	<i>Layout</i>	NNNN or spaces. Right justified and zero-filled.
<i>Location</i>	Diagnosis Record		
<i>Reported by</i>	Public hospitals providing CPAP to admitted patients. [Otherwise, report spaces.]		
<i>Reported for</i>	Episodes where CPAP is provided. [Otherwise, report spaces.]		
<i>Reported when</i>	A Separation Date is reported in the Episode Record.		
<i>Code set</i>	A number in the range 0001 to 9999.		
<i>Reporting guide</i>	<p>If the patient has more than one period of CPAP during this episode, the total duration of all such periods is reported.</p> <p>Duration is reported in hours, measured to the nearest completed hour (rounded up). All CPAP hours (regardless of location within the hospital) are counted. Includes patients on being weaned from CPAP by cycling on and off CPAP.</p> <p>Duration of CPAP should be reported whenever CPAP is provided.</p> <p>Episodes with a reported Duration of CPAP will most likely include a reported ICD-10-AM procedure code for CPAP. If no CPAP code present, a code for continuous ventilatory support should be present.</p> <p>A patient who receives CPAP in Hospital B during a contracted service episode has the duration of that CPAP reported by Hospital B; Hospital A also reports the CPAP hours received in Hospital B in</p>		

addition to any CPAP hours the patient received at Hospital A.

New edits required ### CPAP procedure code and duration mismatch.

Administration

Purpose To facilitate the evaluation of the perceived need for a co-payment on specified DRGs. DHS has been advised that CPAP hours represent a sound and clinically valid surrogate for illness severity.

Principal data users Financial Analysis and Purchasing Branch (Acute Health, DHS).

Collection start 2002 – 2003

Definition source DHS

Diagnosis Record

Diagnosis Record—Revised File Structure

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	X2
M	Unique Key	6	3	A/N	Hospital generated
1	Diagnosis Code x 12 - each code	8 (8 x 12)	9	A/N	ICD-10-AM 2 nd edition Each left justified, trailing spaces
2	Procedure Code x 12 - each code	8 (8 x 12)	105	A/N	ICD-10-AM 2 nd edition Each left justified, trailing spaces
3	Admission weight	4	201	N	In grams, or spaces
M	Intention to Re-admit	1	205	A/N	0,1,2,3,4,9
	User Flag	1	206	A/N	Optional field, free text
4	Duration of Stay in Intensive Care Unit	4	207	N	0001 to 9999 or spaces
5	Duration of Mechanical Ventilation in ICU	4	211	N	0001 to 9999 or spaces
6	Hospital Generated DRG	4	215	A/N	ANNA or NNNA or spaces
7	Duration of Stay in Coronary/Cardiac Care Unit	4	219	N	0001 to 9999 or spaces
8	Reason for Critical Care Transfer	1	223	A/N	X,E,J,W,Y,F,K,Z or space
9	Duration of CPAP	4	224	N	0001 to 9999 or spaces
	Filler	13	228	A/N	Spaces
		Total: 240			

All alpha characters uppercase. All numeric fields right justified with leading zeros.

M Mandatory

1 First diagnosis code is mandatory.

2 Eighth character is F or N for procedures provided by *contracting* hospital, else space.

3 Mandatory if patient aged <365 days at admission, else spaces.

4 Mandatory for patients cared for in an ICU listed in PRS/2 Manual Section 4, and by hospitals providing contracted services to those listed hospitals, else spaces.

- 5 Mandatory for patients who received mechanical ventilation in an ICU listed in PRS/2 Manual Section 4, and by hospitals providing contracted services to those listed hospitals, else spaces.
- 6 Optional but recommended for all hospitals with grouping software; else spaces.
- 7 Mandatory for patients cared for in a CCU listed in PRS/2 Manual Section 4, and by hospitals providing contracted services to those listed hospitals, else spaces.
- 8 Mandatory for public hospitals participating in the Critical Care Inter-hospital Transfer Program, listed PRS/2 Manual Section 3, else space.
- 9 Mandatory for all patients who received continuous positive airways pressure (CPAP), including contracted episodes.

Reported by All Victorian hospitals (public and private).

Reported for All admitted patient episodes of care.

Reported when A Separation Date is reported in the Episode Record.

Reporting guide Per PRS/2 Manual, 11th Edition, July 2001.

Proposal three—Interim Care Program

It is proposed to Create two new Care Types for patients admitted to the Interim Care Program.

A Sub-Acute Record will be required for all patients admitted to the Interim Care Program using the new Care Type codes.

Proposed by Basia Sudbury
Sub-Acute Unit, Department of Human Services
Phone 9616 7948

Implementation Date 1 July 2002

Background For 2002 – 2003 DHS has negotiated with five metropolitan health services to provide Interim Care, a strategy to improve patient ‘flow’. The five auspice services are Northern Health, Eastern Health, Southern Health, Melbourne Health and the Sisters of Charity.

There will be a continuing need for this program beyond the pilot period.

During 2002 – 2003, the five Health Services only may report the Interim Care Program Care types. Thereafter, the program may be further developed to allow other Health Services to offer Interim Care.

The treatment goal of the Interim Care Program is to provide an appropriate level of multi-disciplinary care to patients who are waiting to gain access to a residential care facility or a similarly supported setting. Appropriate care includes maintaining a patient’s functional status and actively working with the patient and their family/carer to find appropriate accommodation.

Patients admitted to Interim Care:

- a. Have completed their acute or sub-acute episode of care
- b. Have been assessed and recommended by an ACAS for residential care
- c. Are suitable for immediate placement if a residential care place is available, and
- d. Are unlikely to improve during an extended period of convalescence.

Care Type

Specification

Definition The nature of the clinical service provided to an admitted patient during an episode of care.

Datatype Alphanumeric *Form* Code

Field size 1 *Layout* A or N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted patient episodes of care.

Reported when The Episode Record is reported.

Code set Select the first appropriate category:

Code ***Descriptor***

D	Interim Care Program – Nursing Home Type
E	Interim Care Program
1	Nursing Home Type/Non-Acute
2	Designated Rehabilitation Program/Unit: Level 1
6	Designated Rehabilitation Program/Unit: Level 2
7	Designated Rehabilitation Program/Unit: Level 3
8	Palliative Care Program
5	Approved Mental Health Service or Psychogeriatric Program
9	Geriatric Evaluation and Management Program
0	Alcohol and Drug Program
3	Family choice: Awake Attendant Care
4	Other care (Acute) including Qualified newborn
U	Unqualified newborn

D Interim Care Program – Nursing Home Type (NHT)

This Care Type occurs only for patients admitted under the Interim Care program who have been designated NHT.

NHT

Defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner certifies under section 3B that the patient is in need of acute care.

Such a patient will have been assessed by an Aged Care Assessment Service and will hold a 2624 certificate (formerly NH5 Form).

E Interim Care Program

This Care Type occurs only for patients admitted under the Interim Care program who have not been designated NHT.

Such a patient will have been assessed by an Aged Care Assessment Service and will hold a 2624 certificate (formerly NH5 Form) before 35 days of continuous hospitalisation.

1 NHT/Non-Acute

This Care Type occurs after an admitted patient has been designated NHT or Non-Acute:

NHT

Defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner certifies under section 3B that the patient is in need of acute care.

Non-Acute

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). If this patient had not been a compensable/ineligible patient, they would be deemed to be a Nursing Home Type patient.

Such a patient may or may not have been assessed by an Aged Care Assessment Service and may or may not hold a 2624 certificate (formerly NH5 Form).

2 Designated Rehabilitation Program or Unit: Level 1 (Public hospitals only)

A patient who is admitted to, or transferred to, a designated

Rehabilitation Program/Unit Level 1. Use code 2 only if the public hospital's Health Service Agreement specifies the hospital to have such a designated unit.

Private hospitals: Do not report this code.

6 *Designated Rehabilitation Program or Unit: Level 2*

A patient who is admitted to, or transferred to, a designated Rehabilitation Program/Unit Level 2. Use code 6 only if the public hospital's Health Service Agreement specifies the hospital to have such a designated unit.

Private hospitals: Use code 6 only if registered under the Health Services Act 1988 to provide this category of care.

7 *Designated Rehabilitation Program or Unit: Level 3 (Public hospitals only)*

A patient who is admitted to, or transferred to, a designated Rehabilitation Program/Unit Level 3. Use code 7 only if the public hospital's Health Service Agreement specifies the hospital to have such a designated unit.

Private hospitals: Do not use code 7.

8 *Palliative Care Program*

A patient who is admitted to a Palliative Care Program.

Public hospitals: Code 8 may be used only for patients admitted to a Palliative Care Program (provided in a recognised palliative care unit or under the supervision of a palliative care specialist, being a medical officer, or physician). This program excludes Nursing Home Type/Non-Acute patients. Only admitted patient services funded by the Aged Care Program 113 may report a statistical change to Palliative Care Program. In hospitals funded only by the Acute Program 111, a change from acute care to palliation does not cause a statistical separation but continues the acute care episode.

Private hospitals: If the hospital considers it operates a similar program and wishes to identify episodes of care using code 8, they may.

5 *Approved Mental Health Service or Psychogeriatric Program*

A patient who is admitted to, or transferred to, an approved Mental Health Service or Psychogeriatric Program. Use code 5 only if the public hospital's Health Service Agreement specifies the hospital to have such an approved Mental Health Service or Psychogeriatric Program.

Private hospitals: Use code 5 only if registered under the Health Services Act 1988 to provide this category of care.

9 Geriatric Evaluation and Management Program

A patient who is admitted to, or transferred, to a Geriatric Evaluation and Management Program. Use code 9 only if the public hospital's Health Service Agreement specifies the hospital to have a Geriatric Evaluation and Management Program. This program excludes Nursing Home Type/Non-Acute patients.

Private hospitals: If the hospital considers it operates a similar program and wishes to identify episodes of care using code 9, they may.

0 Alcohol and Drug Program

A patient who is admitted to an Alcohol and Drug Program. Use code 0 only if the patient receives treatment by a specialist physician for an alcohol or drug related condition that is the principal diagnosis. Report this Care Type on admission but not for a change of Care Type following another episode of care.

Private hospitals: If the hospital considers it operates a similar program and wishes to identify episodes of care using code 0, they may.

3 Family Choice: Awake Attendant Care

A patient who is admitted to, or transferred to, an authorised Family Choice Program where the child receives overnight awake attendant care in the home. Report code 3 only if the public hospital is authorised under this Program (Royal Children's Hospital only).

4 Other (Acute) Care including Qualified newborn

Other types of patient:

Includes:

- Same day and acute (except psychiatric).
- Geriatric respite care.
- Newborn who has been a Qualified newborn for some or all of the duration of this episode.

Excludes:

- Patients admitted to designated units and programs covered by other Care Type codes.
- Newborn who has been an Unqualified newborn for the entire duration of this stay (use code U).

U Unqualified newborn

A newborn who has been an Unqualified newborn for the entire duration of this episode.

Excludes: A newborn who has had any period as a Qualified newborn during this episode (use code 4).

Additional Notes

See PRS/2 Manual, 11th Edition, 1 July 2001

<i>Existing Edits</i>	Per PRS/2 Manual, 11 th Edition, July 2001 (relevant edits will be amended to incorporate new Care Type codes).
<i>New Edits required</i>	Cross-edits between sub-acute data items and Interim Care Program Care Type (see <i>Sub-Acute Record</i> below).

Administration

Purpose

To distinguish various types of care in order to:

- Apply the appropriate funding formula to the episode.
- Group episodes to facilitate analysis.

Principal data users

Financial Analysis and Purchasing Branch (Acute Health, DHS).
Sub-Acute Unit (Acute Health, DHS).

Collection start

1995-1996

Definition source

DHS

*Code set
source*

DHS

Sub-Acute Record

Sub-Acute Record—Revised file structure

No te	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	S2
M	Unique Key	6	3	A/N	Hospital generated
M	Patient Identifier	8	9	A/N	Hospital generated Left justified, trailing blanks
1,2 <u>4</u>	Barthel Index Score on Admission	3	17	A/N	Range 000 to 100 or spaces
1,2 <u>4</u>	Barthel Index Score on Separation	3	20	A/N	Range 000 to 100 or spaces
1	Clinical Sub-program	3	23	A/N	From code list or spaces
1	Onset date	8	26	N	DDMMCCYY or spaces
1	Admission/Re-admission to Rehabilitation	1	34	A/N	0, 1 or space
	User Flag	1	35	A/N	Optional field, free text
	Filler	2	36	A/N	Spaces
3	RUG ADL on Admission	2	38	A/N	Range 00 to 18 or spaces
3	RUG ADL on Separation	2	40	A/N	Range 00 to 18 or spaces
3	Source of Referral to Palliative Care	2	42	A/N	Range 01 to 09 or spaces
	Filler	197	44	A/N	Spaces
		Total:240			

All alpha characters uppercase. All numeric fields right justified and zero filled.

M Mandatory

1 Mandatory if Care Type = 2, 6 or 7 *Designated Rehabilitation Program/Unit*

2 Mandatory if Care Type = 9 *Geriatric Evaluation and Management Program*

3 Mandatory if Care Type = 8 *Palliative Care Program*

4 Mandatory if Care Type = C or N *Interim Care Program*

Reported by Public hospitals.
[Private hospitals: Do not report S2s.]

Reported for Care Types C, N, 2, 6, 7, 8, and 9 only.

Reported when A Separation Date is reported in the Episode Record.
Refer to: 'Data Transmission Scheduling', Section 5 of the PRS/2 Manual.

Reporting guide **General**

The data items collected in the Sub-Acute Record are needed for the support and further development of casemix classifications for sub-acute patients.

Field	Rehabilitation Care Type 2, 6, 7	Palliative Care Type 8	GEM Care Type 9	Interim Care Care Type N, C
Transaction Type	S2	S2	S2	S2
Unique Key	*	*	*	*
Patient Identifier	*	*	*	*
Barthel Index Score on Admis	*	Spaces	*	*
Barthel Index Score on Sep	*	Spaces	*	*
Clinical Sub- Program	*	Spaces	Spaces	Spaces
Onset Date	*	Spaces	Spaces	Spaces
Admission/ Re-admission	*	Spaces	Spaces	Spaces
RUG ADL on Admission	Spaces	*	Spaces	Spaces
RUG ADL in Separation	Spaces	*	Spaces	Spaces
Source of Referral to Palliative Care	Spaces	*	Spaces	Spaces

Data Items

Per PRS/2 Manual, 11th Edition, 1 July 2001.

Proposal four—Prisoners

It is proposed to Amend the code set for Account Class to enable reporting of two new Account Class codes for Prisoners.

Proposed by Milena Canil
Department of Human Services
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Implementation Date 1 July 2002

Background The Department has become aware of some disparities between hospitals in the reporting of admissions for prisoners. It is essential that reporting of admissions of Prisoners is accurate to ensure that hospitals obtain appropriate levels of funding from the appropriate source.

In 2002, DHS intends to conduct a review of funding and billing procedures for prisoner admissions. It is intended that the outcome of this review will assist hospitals to accurately bill the Department of Justice for prisoner admissions. Reporting of accurate data regarding prisoner admissions will be essential to this review and the ongoing success of billing for these patients.

Account Class (a)

Account Class on Separation (b)

Specification

- Definition**
- (a) The agency/individual chargeable for this episode, and associated sub-categories, for this episode of care, including changes to this item during the episode.
 - (b) The agency/individual chargeable for this episode, and associated sub-categories, on the last (counted) patient day.

Datatype Alphanumeric *Form* Code

Field size 2 *Layout* AA or AN

- Location**
- (a) Status Segments of the Episode Record.
 - (b) Episode Record.

Reported by All Victorian hospitals (public and private).

Reported for All admitted patient episodes of care.

- Reported when**
- (a) The Episode Record is reported.
 - (b) Once the Separation Date is reported in the Episode Record.

Code set *Code* *Descriptor*

Public (Acute Care)

MP	Eligible (no charge)
ME	Ineligible: hospital exempt (no charge)
MR	Geriatric respite care
MN	Public NHT - without NH5
M5	Public NHT - with NH5

MA Reciprocal Health Care Agreement

Private

PA Advanced surgery 1 (1-14 days)
PB Advanced surgery 2 (15+ days)
PC Surgery (1-14 days)
PD Surgery 2 (15+ days)
PE Medical 1 (1-14 days)
PF Medical 2 (15+ days)
PG Obstetric 1 (1-14 days)
PH Obstetric 2 (15+ days)
PI Rehabilitation 1 (1-49 days)
PJ Rehabilitation 2 (50-65 days)
PK Rehabilitation 3 (66+ days)
PL Psychiatric 1 (1-42 days)
PM Psychiatric 2 (43-65 days)
PN Psychiatric 3 (66+ days)
PO Same Day (Band 1)
PP Same Day (Band 2)
PQ Same Day (Band 3)
PR Same Day (Band 4)
PS Private NHT - with general care-without NH5
PT Private NHT-with general care-with NH5
PU Private NHT-with extensive care-without NH5
PV Private NHT-with extensive care-with NH5

Department of Veterans' Affairs

VX Department of Veterans' Affairs (DVA)
VN Department of Veterans Affairs NHT-without NH5
V5 Department of Veterans' Affairs NHT-with NH5

Prisoners

JP Prisoner
JN Non-Acute

Compensable

WC	Victorian WorkCover Authority (VWA)
WN	Non-Acute
TA	Transport Accident Commission (TAC)
TN	Non-Acute
AS	Armed Services
AN	Non-Acute
SS	Seamen
SN	Non-Acute
CL	Common Law Recoveries
CN	Non-Acute
OO	Other compensable
ON	Non-Acute

Ineligible

XX	Ineligible non-Australian residents (not exempted from fees)
XN	Non-Acute

Reporting guide

For newborns, report the same Account Class as their mother.

MP *Public/Medicare Patient*

An eligible person who, on admission to a recognised hospital or a private hospital for services provided under contract, or as soon as possible thereafter, elects to be treated as a public patient and in respect of whom the recognised hospital provides comprehensive care including all necessary medical, nursing and diagnostic services and, if they are available at the recognised hospital, dental and paramedical services, by means of its own staff or by other agreed arrangements, provided these services are provided without charge to the eligible person. (Refer PRS/2 Manual Section 2 *Medicare Eligibility Status – Eligible Person*).

Includes: Persons holding a current Interim Medicare Card.

Excludes: Persons holding an expired Interim Medicare Card (report XX *Ineligible*)

A person admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient's treatment.

ME *Ineligible: Hospital Exempt*

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 has determined that no fee be charged; or
- Who has been declared a safe haven resident and whose treatment is provided or arranged by a designated hospital.

MR *Geriatric Respite Care Patient*

A patient admitted for geriatric respite care. After 35 days of continuous hospitalisation, the patient can be classified as a NHT patient.

MN *Public Nursing Home Type Patient*

A patient as defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation, the patient is classified as a NHT patient unless a medical practitioner certifies under section 3B 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.

Nursing Home Type patients can be of the following types:

- Public
- Private with general care
- Private with extensive care
- DVA with general care
- DVA with extensive care.

If a NHT patient is out of a hospital for seven days or less and is readmitted, the count of days continues (the days out of hospital are not added). If a NHT patient is out of hospital for more than seven consecutive days, the patient is admitted again as an acute patient.

M5 *Public NH5 Patient*

A NHT patient who has been assessed by an Aged Care Assessment Team and has an approved NH5 Form 'Application for Nursing Home Admission'.

MA *Reciprocal Health Care Agreement Patient*

A visitor to Australia who is ordinarily resident in a country with which Australia has a reciprocal health care agreement (RHCA), for necessary medical treatment (but only as a public patient), 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. Refer to PRS/2 Manual Section 2: *Medicare Eligibility Status: Eligible Person*.

P - *Private Patient*

A person who elects in writing to be treated (in a public or private hospital) as an admitted patient by a medical practitioner of their own choice and to be responsible for paying the charges referred to in clause 57 of the 1999 Australian Health Care Agreement.

Includes:

- A patient on whose behalf election has been made by another person with patient's express or implied consent.
- A patient admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient's treatment.

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

V- Department of Veterans' Affairs Patient

An eligible person whose charges for this episode of care are met by the Department of Veterans' Affairs (DVA). A gold card holder is automatically eligible as a veteran but a white card holder's eligibility must be established at the time of admission or on the next business day if the patient is admitted over a weekend (contact Department of Veterans' Affairs, State office, telephone (03) 9284 6111 or fax (03) 9284 6440. If DVA does not accept responsibility, then normal patient election applies.

Public hospitals: If the first character of the patient's Account Class is V, a DVA Record must be transmitted every time the Episode Record is transmitted.

J- Prisoner

An eligible person who is an admitted patient and is currently in the custody of Correctional Services in Victoria.

-- Compensable Patient

An eligible person who is an admitted patient and who is entitled under a law that is or was in force in Victoria, other than Veterans' Affairs legislation, to the payment of, or who has been paid compensation for, damages or other benefits (including a payment in settlement of a claim for compensation, damages, or other benefits) in respect of the injury, illness or disease for which he/she is receiving hospital services.

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 Health Care Agreement states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria.'

- N Compensable Non-Acute Patient

A person who 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 patient, would be deemed to be a Nursing Home Type patient.

XX Ineligible Patient

A person who is an admitted patient but who is not eligible for Medicare and therefore not exempted from fees.

Includes: Persons holding expired Interim Medicare Cards (these patients should be billed for services).

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

XN *Ineligible Non-Acute Patient*

A person who 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 an ineligible patient, would be deemed to be a Nursing Home Type patient.

Reporting guide Per PRS/2 Manual, 11th Edition, 1 July 2001

Edits Per PRS/2 Manual, 11th Edition, July 2001 (relevant edits will be amended to incorporate new Account Class codes).

New edits required ### Inconsistent Prisoner Data
Episodes for prisoners must use the following combination for these data items.

Data item

Value and description

Account Class

JP *Prisoner* or

JN *Prisoner Non-Acute*

Medicare Suffix

P-N *Prisoner*

Medicare Number

Blank

Administration

Purpose (a) To:

- Distinguish between broad categories (public, private, DVA, compensable).
- Identify patients with DVA account classes (for accounting purposes).

- Identify certain compensable patients (so DRG Statements are raised).
 - Verify other fields (such as Care Type, Accommodation Type) for consistency.
- (a) To identify the Account Class of a patient at separation:
- For use in summary analyses.
 - To place patients into broad account categories for reporting to the Commonwealth.

Principal data users Purchasing Policy Unit (Acute Health, DHS)
 Department of Veterans' Affairs (DVA)
 Transport Accident Commission (TAC)
 WorkCover

Collection start 1979-1980

Definition source DHS *Code set source* DHS

Proposal five—Patient Identifier

It is proposed to Change the alignment of the reported Patient Identifier within the Patient Identifier field. DHS requires the Patient Identifier to be right justified and the field zero filled, not allowing blanks or spaces anywhere within the field.

Proposed by Mark Gill
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Implementation Date 1 July 2002

Background In accordance with the program to standardise DHS data collections, and to facilitate future linkage and comparison of these data, this item must be right justified and zero filled for all separations on and after 1 July 2002.

Patient Identifier

Specification

Definition A patient identifier, unique to this hospital or campus (patient's record number/unit record number).

Datatype Alphanumeric ***Form*** Code

Field size 8

<i>Layout</i> XXXXXXXX Right justified, zero filled.
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Location Episode Record
Sub-Acute Record
DVA Record

Reported by Victorian hospitals (public and private).

<i>Reported for</i>	All admitted patient episodes of care.
<i>Reported when</i>	The Episode Record, Sub-Acute Record or DVA is reported.
<i>Code set</i>	Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.
<i>Reporting guide</i>	<p>If multiple campuses transmit to PRS/2 in a single file, the Patient Identifier must be unique to the hospital. If the campuses transmit data separately to PRS/2, the Patient Identifier must be unique to each campus.</p> <p>All newborns must have their own Patient Identifier. This cannot be the newborn's mother's Patient Identifier but could be the mother's Patient Identifier with a prefix or suffix.</p>
<i>Edits</i>	Per PRS/2 Manual, 11 th Edition, July 2001.

<i>Edits requiring amendment</i>	029	Invalid Patient Identifier – Amend to disallow reporting of blanks or spaces anywhere within this field.
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Administration

<i>Purpose</i>	To enable relevant episodes to be updated and provide the potential for episodes to be linked across patient settings.		
<i>Principal data users</i>	Automated PRS/2 processes.		
<i>Collection start</i>	1979-1980		
<i>Definition source</i>	DHS	<i>Code set source</i>	Individual hospitals