

Proposals for revisions to PRS/2  
and the Victorian Admitted  
Episodes Dataset (VAED) for  
1 July 2004

November 2003

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Melbourne, Victoria

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# Executive Summary

This document details the proposed revisions to the Victorian Admitted Episodes Dataset (VAED) for 1 July 2004. These proposed revisions are summarised below.

1. Deletion of Number of Available Beds field from the PRS/2 Header Record.
2. Simplification of *Account Class* data item where data can be readily captured through other data items.
3. Addition of a new *Criterion For Admission* code, to separately capture admissions that are justified by extended medical treatment only (previously included in Type C).
4. Deletion of *Funding Arrangement* code for the Healthstreams program as this data is captured at a hospital level, rather than at an episode level.
5. Change in field sizes for *Given Name* and *Surname* data items to meet the system and matching requirements for DVA and TAC.
6. Addition of a data item (*HARP Patient Flag*) to identify patients participating in the Hospital Admissions Risk Program (HARP).
7. Refine the *Health Insurance Fund* codeset to ensure only one concept covered in each code and improve data quality.
8. Adopt the fourth edition of ICD-10-AM.
9. Change the name of [*Normal*] *Leave* data item to *Other Leave*, and incorporate leave without permission. Minor changes to Leave reporting requirements have also been proposed.
10. Refine the *Locality* data item Reporting Guide to improve data quality for episodes reported with an overseas postcode.
11. Addition of two new Mental Health related *Care Type* codes to enable identification of nursing home type/non-acute and secure extended care episodes.
12. Addition of a new data item (*Mental Health Statewide Patient Identifier*) to collect the Mental Health Statewide Unit Record Number for all Mental Health episodes.
13. Amend the *Patient Identifier* data item to ensure that Patient Identifiers are reported as 10 characters.
14. Changes to the reporting range for data items *Duration of Mechanical Ventilation in ICU*, *Duration of Non-invasive Ventilation (NIV)*, *Duration of Stay in Cardiac/Coronary Care Unit*, and *Duration of Stay in Intensive Care Unit* to ensure that where there is no duration in any of these data items, it is reported as spaces, not zeros.
15. Addition of two new codes to the *Separation Referral* data item to enable identification of patients discharged to Home based Interim Care and Alcohol and Drug Treatment Services.
16. Add a new code to the *Sex* data item to provide guidelines for capturing the sex of a person's whose sex may change during their lifetime.
17. Update on DHS Admission Policy.
18. That PRS/2 Control Reports to be produced electronically.

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 November 2003. This should not be regarded as a complete list of changes to be made for 2004–2005. 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 2004. Confirmed changes will be published in the document '*Specification for Revisions to PRS/2 and the VAED for 1 July 2004*', which will be published in February 2004.

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, by **Wednesday 3 December 2003**.

There will be a **summary presentation** of these proposals during the **HDSS Forum** to be conducted on **Friday 5 December 2003**. If you have any questions or comments, it is important to forward these promptly, as responses to feedback will be provided at the forum, where question time may be limited.

There will be further opportunity to provide written comment following the forum.

## 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
- ~~Redundant values and definitions relating to existing items are struck through.~~
- [Comments relating to the proposal document only appear in square brackets and italics.]
- Page numbers representing cross referencing to another section of the VAED Manual are represented by a #.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Victorian Admitted Episodes Dataset (VAED 13<sup>th</sup> Edition, 1 July 2003)*.
  - 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

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
AHCA	Australian Health Care Agreement
AIHW	Australian Institute of Health and Welfare
AIMS	Agency Information Management System
ALOS	Average Length of Stay
CMI	Client Management Interface
DHS	Department of Human Services
DVA	Department of Veteran's Affairs
ED	Emergency Department
ESIS	Elective Surgery Information System
HARP	Hospitals Admission Risk Program
HDSS	Health Data Standards and Systems
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
MHSW UR	Mental Health Statewide Unit Record
NHDC	National Health Data Committee
NHDD	National Health Data Dictionary
NHT	Nursing Home Type
NICU	Neonatal Intensive Care Unit
NIV	Non-invasive Ventilation
NMDS	National Minimum Data Set
NOCC	National Outcome and Casemix Collection
ODS	Operational Data Store
PRS/2	Patient Reporting System, Version 2
TAC	Transport Accident Commission
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VHIRS	Victorian Health Information Reporting System
WIES	Weighted inlier Equivalent Separations

## Symbols

<	Less than
>	Greater than
=	Equal to
≠	Not equal to
&	And

# Proposed data item deletion

## Proposal 1 - Header Record: Number of Available Beds

<b>It is proposed to</b>	Remove this field from the PRS/2 Header Record.
<b>Proposed by</b>	Amanda Muggivan, Health Data Standards and Systems (HDSS) Department of Human Services Phone: 9616 7535, Email: <a href="mailto:Amanda.Muggivan@dhs.vic.gov.au">Amanda.Muggivan@dhs.vic.gov.au</a>
<b>Implementation Date</b>	1 July 2004
<b>Background</b>	<p>The number of available beds is also collected via the AIMS A3 - Average Available Beds return.</p> <p>To reduce duplicate data entry, it is proposed to continue collecting these data through AIMS and remove the requirement from the PRS/2 Header Record.</p>

# Proposed revisions/additions to data items

## Proposal 2 - Account Classes

It is proposed to	Refine the Account Class codeset.
Proposed by	Amanda Muggivan, Health Data Standards and Systems (HDSS) Department of Human Services Phone: 9616 7535, Email: <a href="mailto:Amanda.Muggivan@dhs.vic.gov.au">Amanda.Muggivan@dhs.vic.gov.au</a>
Implementation Date	1 July 2004
Background	A review of the Account Class data item has revealed that this codeset may potentially be simplified. It is proposed to: <ul style="list-style-type: none"><li>• Remove Nursing Home Type (NHT) Account Class codes as these episodes can be identified through Care Type;</li><li>• Remove Geriatric Respite Account Class code as these episodes can be identified through the ICD-10-AM diagnosis code; and</li><li>• Collate Private Surgical and Obstetric Account Classes in accordance with Hospital Circular 14/2003, available at: <a href="http://www.dhs.vic.gov.au/ahs/circular/circ1403.htm">www.dhs.vic.gov.au/ahs/circular/circ1403.htm</a>.</li></ul>

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## Account Class (a) (*Amended*)

## Account Class on Separation (b) (*Amended*)

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### Specification

<i>Definition</i>	(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.		
<i>Datatype</i>	Alphanumeric	<i>Form</i>	Code
<i>Field size</i>	2	<i>Layout</i>	AA or AN
<i>Location</i>	(a) Status Segments of the Episode Record. (b) Episode Record.		
<i>Reported by</i>	All Victorian hospitals (public and private).		
<i>Reported for</i>	All admitted episodes of care.		
<i>Reported when</i>	(a) The Episode Record is reported. (b) Once the Separation Date is reported in the Episode Record.		

## Code set

<i>Code</i>	<i>Descriptor</i>
<b>Unqualified Newborns (Not Birth Episode)</b>	
NT	Newborn (Unqualified, Not birth episode)

**Public (Acute Care) Patient**

MP <input type="checkbox"/> MH	Public: Eligible
ME	Ineligible: hospital exempt
MR	<del>Geriatric respite care</del>
MN	<del>Public NHT without NH5</del>
M5	<del>Public NHT with NH5</del>
MA	Reciprocal Health Care Agreement

**Private Patient**

PA	Advanced surgery 1 (1-14 days)
PB	Advanced surgery 2 (15+ days)
PC	<del>Surgery (1-14 days)</del>
PD	<del>Surgery 2 (15+ days)</del>
PE	<del>Medical 1 (1-14 days)</del>
PF	<del>Medical 2 (15+ days)</del>
PG	<del>Obstetric 1 (1-14 days)</del>
PH	<del>Obstetric 2 (15+ days)</del>
PW	Surgery/Obstetrics 1-14 days
PX	Surgery/Obstetrics 15+ days
PY	Other (Medical) 1-14 days
PZ	Other (Medical) 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	<del>Private NHT with general care without NH5</del>
PT	<del>Private NHT with general care with NH5</del>
PU	<del>Private NHT with extensive care without NH5</del>
PV	<del>Private NHT with extensive care with NH5</del>

**Department of Veterans' Affairs Patient**

VX <input type="checkbox"/> VA	Department of Veterans' Affairs (DVA)
VN	<del>Department of Veterans Affairs NHT without NH5</del>
V5	<del>Department of Veterans' Affairs NHT with NH5</del>

**Compensable Patient**

WC <input type="checkbox"/> WA	Victorian WorkCover Authority (VWA)
WN	<del>Victorian WorkCover Authority (VWA) Non Acute</del>
TA <input type="checkbox"/> TC	Transport Accident Commission (TAC)
TN	<del>Transport Accident Commission (TAC) Non Acute</del>
AS <input type="checkbox"/> AR	Armed Services
AN	<del>Armed Services Non Acute</del>
SS <input type="checkbox"/> SM	Seamen
SN	<del>Seamen Non Acute</del>
CL <input type="checkbox"/> CR	Common Law Recoveries
CN	<del>Common Law Recoveries Non Acute</del>
OO <input type="checkbox"/> OC	Other compensable
ON	<del>Other compensable Non Acute</del>
JP <input type="checkbox"/> JR	Prisoner

JN Prisoner Non-Acute

**Ineligible**

~~XX XI~~ Ineligible non-Australian residents (not exempted from fees)

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

*Reporting guide*

Newborns are expected to have the same Account Class as their mother for the birth episode. In certain circumstances in public hospitals, the mother may be public and the baby private, or the mother private and the baby public. For example:

- Where the mother does not have private insurance and elects for the baby to be treated as private and pay all expenses; and
- Where the mother has single private insurance and elects to be private, the baby can be a public patient.

Where the newborn is unqualified and it is not the birth episode, report Account Class NT.

**NT *Newborn (Unqualified, Not birth episode)***

A newborn (under 10 days old at admission), admitted subsequent to the birth episode (where the Account Class should be the same as the mother's) who does not meet the criteria for a qualified newborn. Usually these babies are transferred from another hospital.

Note: The newborn may have been reported as qualified or unqualified at a prior hospital.

**MP MH *Public: Eligible***

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. The hospital provides comprehensive care including all necessary medical, nursing and diagnostic services and, if available, dental and paramedical services, by means of its own staff or by other agreed arrangements, without charge to the patient.

*Includes:*

- Persons holding a current Interim Medicare Card.

*Excludes:*

- Persons holding an expired Interim Medicare Card (report ~~XX XI~~ *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*~~

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

~~MN — *Public NHT — without NH5*~~

~~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 formally separated. If the patient later returns to the hospital, the patient is formally admitted as an acute patient.~~

~~M5 — *Public NHT — with NH5*~~

~~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***

A visitor to Australia who is ordinarily resident in a country with which Australia has a Reciprocal Health Care Agreement (RHCA), admitted 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.

**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~~ **VA** *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 S2 DVA and TAC Record must be transmitted every time the Episode Record is transmitted.

- - *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.~~

~~J~~ **JR** *Prisoner Patient*

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

- Prisoners may be transferred to a public hospital for treatment on an admitted or non-admitted basis. Funding for these services is not provided by the Commonwealth through the Australian Health Care Agreement. Hence, DHS does not recognise these patients for casemix or VACS payments. Funding for prisoners' health care is provided to prison authorities by the Department of Justice and prison authorities are responsible for meeting all costs incurred by hospitals in the treatment of such patients.
- Hospitals are required to bill 'Australian Correctional Management' directly.

~~XX XI~~ **Ineligible Non-Australian Resident 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'.

~~XXN~~ **~~Ineligible Non-Australian Resident – 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.~~

**Public hospitals:**

Report the patient's Account Class according to the *Fees and Charges for Acute Health Services in Victoria - A Handbook for Public Hospitals* document, available at:

<http://www.health.vic.gov.au/feesman/index.htm>

The patient elects to be treated as a Public or Private patient, or may be eligible for DVA or a compensable class, or may be ineligible. Refer to above document for the correct wording for the 'Form of Election for Admission to Public Hospital'.

**Private Patients:**

Within each broad Account Class, categorisation of patients is a medical decision and is performed by medical staff at the hospital or the referring medical practitioner; patients cannot elect to be charged as a particular Account Class as this will depend on what surgery, if any, is performed and complexity of the care.

Fees depend on whether the patient has been an admitted patient in any hospital within the seven days before this admission. Previous hospitalisation may alter the patient's length of stay classification.

Private patients specify on the election form whether they wish to be accommodated in a single room.

The fee charged to a private patient will depend upon:

- Patient account classification and length of stay.
- Type of accommodation.

Initial election cannot be changed except for the following 'unseen circumstances':

- A change in medical circumstances, ie patients who are admitted for a particular procedure but are found to have co-morbidities not evident at admission, or develop complications.
- A change in social circumstances, ie change in income status resulting in an ability to pay (loss of job, or bankruptcy).

**Private hospitals:**

Record patient account class as 'best fit' account class according to the *Fees and Charges for Acute Health Services in Victoria - A Handbook for Public Hospitals* document.

Because of the many patient account options used in private hospitals, and the limited applicability of the comparatively small range of Account Classes offered in PRS/2, private hospitals and day procedure centres are not required to supply comprehensive Account Class data. Only the following broad categories apply:

**Contracted patients:**

Use the appropriate Account Class from the range of valid codes. Where public patients are admitted under contract, use code ~~MP~~ MH.

A patient admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient's treatment is not considered to be a public patient. These patients should be reported using an appropriate private account class.

If a patient is admitted as fee-paying but is unable/unwilling to pay their account and the fee is written off, the original Account Class should be used (for example, ~~PE, PC,~~ PW, PY). Do not change the Account Class to a Medicare no-charge category.

~~Private acute patients need only be identified as such. Further detail (for example, the distinction between Advanced Surgery, Surgery, Medical, etc) is not required except that same day cases need to be identified as such without detail as to Band.~~

For all private acute same day patients, use any code respectively, from the following list:

~~PO PP PQ PR~~

For all private acute overnight/multi-day patients, use a code starting with P, with any valid combination of second character, from the following list:

~~PA PB PC PD PE PF PG PH PI PJ PK PL  
PM PN PW PX PY PZ~~

~~Nursing Home Type patients (Private and Department of Veterans' Affairs) must be classed to the existing range of codes:~~

~~PS PT PU PV VN V5~~

~~However, accurate specification of general or extensive care level or NH5 status is not required for private hospital NHT or Department of Veterans' Affairs NHT patients.~~

Compensable or Ineligible patients should be identified as such, including detail of the relevant funder. These patients need only be classified to the following level of detail:

~~WC TA AS SS CL OO XX  
WA TC AR SM CR OC XI~~

~~There is no requirement to use the codes with second character N.~~

**Edits**

- (a) 076 Not Sufficient Fields First Status  
077 Not Sufficient Fields Other Status  
083 Invalid Account Class  
094 Combination A/C Accom Care Med Suff  
111 Same Day A/C Stat Not The Only Status  
113 Same Day Status: Total Pt Days Not 1  
116 Sep A/C Class Not In A Status Seg  
165 DVA/TAC; No DVA & TAC Record  
172 Flagged Deleted Episode is DVA/TAC  
173 Flagged Deleted Episode Not DVA or TAC  
174 Deleted Episode is DVA/TAC  
222 Unqual Newborn; Adm Date Not Birth  
324 Incompat ICU Hrs, A/C Class  
325 Incompat MV Hrs, Acct Class  
~~329 Geri Respite Invalid comb~~  
344 Invalid Comb For Family Choice  
372 Episode Deletion: Multiple Epis Trans  
374 Episode DVA/TAC: No V2 Transaction  
375 Episode DVA/TAC: V2 Trans Rejected  
376 Episode DVA/TAC: V2 Deletion Trans  
377 Episode DVA/TAC: Multiple E2 Trans  
378 Episode DVA/TAC: Multiple V2 Trans  
379 Epis Not DVA/TAC: V2 Trans Present  
380 Epis Not DVA/TAC: V2 Trans: Multiple E2s  
381 Epis Not DVA/TAC: V2 Present & Rejected  
382 Epis Not DVA/TAC: Multiple V2 Trans  
391 Recip HCA Account, Not O/Seas P/Code  
392 Recip HCA Account, Not O/Seas Born  
393 Recip HCA Account, Indig Stat A or TI  
454 Incompat Fields for Interim Care  
491 Incompat Fields for ESAS  
492 Incompat Fields for RPI
- (b) 105 Invalid Sep Account Class  
108 Field(s) missing From Sep  
116 Sep A/C Class Not In A Status Seg  
454 Incompat Fields for Interim Care  
455 Inconsist Newborn Transferred/Unqual Data  
### Priv Sep A/C Class LOS ≠ LOS [Notifiable]

**Related Items**

Section 2: *Boarder, Medicare Eligibility Status - Eligible Person, Medicare Eligibility Status - Ineligible Person, and Newborn.*

Section 4:

- Business Rules (non-tabular) *Newborn.*
- Business Rules (tabular) *Account Class, Acc Type, Care Type and Medicare Suffix and Account Class: Geriatric Respite, and Care Type: Family Choice, and Care Type: Interim Care Program (F and E), and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative.*

Section 5: *Status Segments.*

## 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.
- (b) 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 (Metropolitan Health & Aged Care, DHS)  
 Department of Veterans' Affairs (DVA)  
 Transport Accident Commission (TAC)  
 WorkCover (VWA)

**Collection start** 1979-80

**Definition source** DHS **Code set source** DHS

## Account Classes on Separation mapped to the Separation Patient Type Code (derived item)

Account Class on Separation (first character of Account Class)	Separation Patient Type
M	H Public
P	P Private
V	V DVA
W, T, A, S, C, O	S Compensable
X	X Ineligible

## Account Classes mapped to AIMS Trailer Record fields - Private Hospitals and Day Procedure Centres

AIMS Statistics Category	Account Classes
Private - Acute (both Separations and Patient Days)	PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN, PO, PP, PQ, PR, PW, PX, PY, PZ, VX, VA
Private - Nursing Home Type (both Separations and Patient Days)	PS, PT, PU, PV, VN, V5
Compensable (both Separations and Patient Days)	JP, JN, WC, WN, TA, TN, AS, AN, SS, SN, CL, CN, OO, ON, WA, TC, AR, SM, CR, OC, JR
Ineligible (both Separations and Patient Days)	XX, XN, XI
Public - Under Contract (both Separations and Patient Days)	MP, MH
Private - Same Day	PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN, PO, PP, PQ, PR, PS, PT, PU, PV, PW, PX, PY, PZ, VX, VN, V5, VA
Compensable - Same Day	JP, JN, WC, WN, TA, TN, AS, AN, SS, SN, CL, CN, OO, ON, WA, TC, AR, SM, CR, OC, JR
Ineligible - Same Day	XX, XN, XI
Public - Under Contract - Same Day	MP, MH

## Account Classes mapped to AIMS Trailer Record fields - Public Hospitals

AIMS Statistics Category	Account Classes
Public - Acute (both Separations and Patient Days)	MP, MH, ME, MR, MA
Private - Acute (both Separations and Patient Days)	PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN, PO, PP, PQ, PR, PW, PX, PY, PZ, VX, VA
Compensable - Acute (both Separations and Patient Days)	JP, WC, TA, AS, SS, CL, OO JR, WA, TC, AR, SM, CR, OC
Ineligible - Acute (both Separations and Patient Days)	XX, XI
Public NHT - NH5 (both Separations and Patient Days)	M5
Public NHT - Non NH5 (both Separations and Patient Days)	MN
Private NHT - NH5 (both Separations and Patient Days)	PT, PV, V5
Private NHT - Non NH5 (both Separations and Patient Days)	PS, PU, VN
Compensable - Non Acute (both Separations and Patient Days)	JN, WN, TN, AN, SN, CN, ON
Ineligible - Non Acute (both Separations and Patient Days)	XN
Public - Same Day	MP, MH, ME, MN, M5, MA, MR
Private - Same Day	PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN, PO, PP, PQ, PR, PS, PT, PU, PV, PW, PX, PY, PZ, VX, VN, V5, VA
Compensable - Same Day	JP, JM, WC, WN, TA, TN, AS, AN, SS, SN, CL, CN, OO, ON JR, WA, TC, AR, SM, CR, OC
Ineligible - Same Day	XX, XN, XI

## Proposal 3 - Criteria for Admission

<b>It is proposed to</b>	Create an additional Criterion For Admission, to separately capture same day admissions that are justified by extended medical treatment only (previously included under Type C).
<b>Proposed by</b>	Catherine Perry, Health Data Standards and Systems Department of Human Services Phone: 9616 6928, Email: <a href="mailto:Catherine.Perry@dhs.vic.gov.au">Catherine.Perry@dhs.vic.gov.au</a>
<b>Implementation Date</b>	1 July 2004
<b>Background</b>	<p>In August 2003 an updated <i>DHS Hospital Admission Policy 2003-04</i> (available at: <a href="http://hdss.health.vic.gov.au/">http://hdss.health.vic.gov.au/</a>) was released. Although this should not have resulted in any changes in practice in hospitals, it is clear that this is the case in many organisations.</p> <p>Further work is being undertaken in 2003-04 to further clarify, and to possibly introduce changes in Admission Policy for 2004-05, which may also result in changes in WIES targets and other funding mechanisms, for some sites, in 2004-05.</p> <p>DHS would like to be able to separately identify same day episodes that are justified by extended medical treatment only (not Type B or C procedures).</p> <p>Changes relating to Admission Policy are discussed later in this document, starting page 89.</p>

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## Criterion For Admission (*Amended*)

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### Specification

<b>Definition</b>	The criterion that has been met, to justify the patient's admission.		
<b>Datatype</b>	Alpha	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	A
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	The Episode Record is reported.		

**Code set**

Select the first appropriate category:

<i>Code</i>	<i>Descriptor</i>
B	Day Only Bands 1A, 1B, 2, 3 and 4
N	Qualified newborn
U	Unqualified newborn
O	Patient expected to require hospitalisation for minimum of one night
E	Extended Medical Treatment
C	Type C Professional Attention Procedures
S	Secondary family member

**Reporting guide**

The reference to the *Commonwealth Day Only Procedures Manual* relates to the *Day Only Procedures Manual 1999* and *Day Only Procedures Manual Supplement 1 May 2003* documents, which are available at:  
[http://www.health.gov.au/privatehealth/providers/dayonly/daymbs\\_nov2001.htm](http://www.health.gov.au/privatehealth/providers/dayonly/daymbs_nov2001.htm)

The original Criterion for Admission must not be changed, even where a patient's condition requires a different course than that planned at admission. For example, a newborn who changes Qualification Status must retain their original Criterion for Admission code (N or U), and Criterion O is not altered if the patient dies, is transferred or is discharged on the same day.

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

Admission for Day Only surgical and diagnostic services as specified in Bands 1A, 1B, 2, 3 and 4 but excluding uncertified Type C Professional Attention Procedures of the Health Insurance Basic Table, as defined in subsection 4(1) of the Commonwealth National Health Act. Refer to the Commonwealth's *Day Only Procedures Manual*.

**N Qualified newborn**

Any newborn who is:

- Admitted within the first nine days of life to facilities approved by the Commonwealth Minister for the provision of special care in designated neonatal intensive care units and designated special care nurseries, or
- Is the second or subsequent live born of a multiple birth, or
- Remains in hospital after their mother is separated from hospital, or
- Is admitted to hospital without their mother.

**U Unqualified newborn**

Any newborn who, at time of admission, does not meet any of the criteria for admission as a Qualified newborn (N).

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

This category involves the admission of patients with the expectation, at the time of admission, that the patient requires overnight or multi-day hospitalisation.

*Includes:*

- Critically ill patients and patients with traumatic injuries who present to the Emergency Department, but die within a few hours, despite intensive resuscitative treatment.
- Critically ill patients and patients with traumatic injuries who need resource intensive emergency stabilisation for a short period, prior to transfer to another hospital.

*Excludes:*

- Patients, who at the time of admission are expected to be separated on the same day without being transferred to another hospital. The interventions received may satisfy a Criterion for Admission as a Same Day patient (Type B or C). If not, the patient would be a non-admitted patient.
- Patients who are transferred without stabilisation or work-up. These patients would not be admitted.

*Examples:*

- A patient arrives at the hospital with multiple injuries resulting from a car accident and receives emergency stabilisation prior to transfer to another hospital. The first hospital reports an admitted patient, with Criteria for Admission O.
- A patient presents with a headache and baseline observations deteriorate over time. Following diagnosis, the patient is transferred to another facility for treatment. The first hospital reports an admitted patient, with Criteria for Admission B.

**E Extended Medical Treatment**

Admission for Type E Extended Medical Treatment. The patient's medical record must contain clinical documentation that indicates the treatment provided to the patient justified admission, and that continuous active management exceeded four hours.

*For privately insured patients:*

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

*For patients other than privately insured patients:*

- Documented justification of the admission for extended medical treatment on clinical grounds must be included in the medical record. Audits of medical records may be conducted for the purpose of ensuring that treatment of such patients in an admitted patient setting is warranted.

### **C Type C Professional Attention Procedures**

Admission for Type C Professional Attention Procedures as specified in the Health Insurance Basic Table, as defined in subsection 4(1) of the National Health Act, (~~includes~~ ~~excludes~~ extended emergency or non-emergency medical treatment which should be reported as E). The patient's medical record must contain clinical documentation that indicates that the admission was necessary on the grounds of the medical condition of the patient, or other special circumstances that relate to the patient (for example, remote location or no-one at home to care for the patient).

*For privately insured patients:*

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

*For patients other than privately insured patients:*

- Documented justification of the admission for Type C procedures/~~extended medical treatment~~ on clinical grounds must be included in the medical record. Audits of medical records may be conducted for the purpose of ensuring that treatment of such patients in an admitted patient setting is warranted.

### **S Secondary Family Member**

A person who does not meet any of the Criterion for Admission categories but is accompanying a patient who is admitted. Code S must be used for all such persons.

Only Early Parenting Centres can report this category.

### **Edits**

072	Invalid Criterion for Adm
074	Invalid Age For Criterion
217	Newborn Adm Crit But Age >9 Days
235	Adm Crit N But Care N 4
308	Adm Crit O But Int'd Same Day
309	Adm Crit B & Int'd Overnight
310	Adm Crit C Int'd Overnight
311	Adm Crit N & Int'd Same Day
312	Adm Crit U Int'd Same Day
328	Early Parenting Centre -Invalid comb
329	Geri Respite - Invalid Comb
336	Invalid Comb For Crit Care Transfer
344	Invalid Comb For Family Choice
454	Incompat Fields for Interim Care
455	Inconsist Newborn Transferred/Unqual Data
482	Incompat Adm Source/Crit for Adm
484	Incompat Adm Type/Crit for Adm
486	Incompat Age/Crit for Adm
490	Incompat Crit For Adm/Qual Stat
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
###	Type B Crit for Adm w/o Type B Proc Code [Notifiable]
###	Type C Crit for Adm with Type B Proc Code [Notifiable]
###	Type E Crit for Adm with Type B Proc Code [Notifiable]
###	Type B Crit for Adm, LOS >1 [Warning]
###	Type C Crit for Adm, LOS >1 [Warning]
###	Type E Crit for Adm, LOS >1 [Warning]

**Related items** Section 2: *Criterion for Admission, Neonate, Newborn, and Overnight or Multi-day Stay.*

Section 4:

- Business Rules (non-tabular) *Contracted Care* and *DRG Classification*.
- Business Rules (tabular) *Account Class: Geriatric Respite*, and *Admission Source and Criterion For Admission*, and *Admission Type and Criterion For Admission*, and *Age and Criterion For Admission*, and *Care Type: Designated Rehabilitation Program (2, 6, 7 and J)*, and *Care Type: Family Choice*, and *Care Type: Interim Care Program (F and E)*, and *Criterion for Admission, Age, Admission Type, Admission Source, Qualification Status, and Criterion for Admission and Newborn Qualification Status (1<sup>st</sup> Status Segment)*, and *Criterion for Admission and Qualification Status*, and *Criterion for Admission: Secondary Family Member*, and *Funding Arrangement: Elective Surgery Access Service*, and *Funding Arrangement: Rural Patients Initiative*, and *Newborns: Criteria for Admission, Qualification Status, Care Type, and Reasons for Critical Care Transfer: Valid Combinations*.

## Administration

**Purpose** To prompt the hospital to consider the eligibility of the patient for admission, to identify:

- Any patient admitted for procedures listed on the Commonwealth's 'Day Only Bands' list.
- Any patient with special circumstances requiring admission (rather than treatment as an ambulatory patient).
- Any person treated in an Early Parenting Centre not meeting the requirements to be admitted (to omit such episodes from reporting to the Commonwealth).

**Principal data users** Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).

**Collection start** 1993-94

**Definition source** Commonwealth **Code set source** DHS

## Proposal 4 - Funding Arrangement

It is proposed to	Remove Funding Arrangement Code 3 <i>Healthstreams</i> from the codeset.
Proposed by	Amanda Muggivan, Health Data Standards and Systems (HDSS) Department of Human Services Phone: 9616 7535, Email: <a href="mailto:Amanda.Muggivan@dhs.vic.gov.au">Amanda.Muggivan@dhs.vic.gov.au</a>
Implementation Date	1 July 2004
Background	The Healthstreams program has been superseded by the Small Rural Health Services Project. As this program is an attribute of the reporting site, it is not required to be collected for each episode, as all patients admitted to a designated Healthstreams/Small Rural Health Services Project facility will automatically be identified under this program. Therefore it is proposed to remove Funding Arrangement Code 3 <i>Healthstreams</i> from the codeset.

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## Funding Arrangement (*Amended*)

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### Specification

<i>Definition</i>	Identifies the specific funding arrangement, if any, that applies to this episode of care.		
<i>Datatype</i>	Alphanumeric	<i>Form</i>	Code
<i>Field size</i>	1	<i>Layout</i>	N or space
<i>Location</i>	Episode Record		
<i>Reported by</i>	<ul style="list-style-type: none"><li>• Any Victorian public and private hospital involved in contracted care arrangements with another hospital (purchasers and providers of contracted care).</li><li>• Any Victorian public and private hospital involved in hub and spoke arrangements with another hospital.</li><li>• <del>Any Victorian public hospital involved in the Healthstreams program.</del></li><li>• Any Victorian public or private hospital treating a patient identified as a Coordinated Care Trial patient.</li><li>• Any Victorian public hospital involved in the Rural Patients Initiative program.</li><li>• Any Victorian public hospital involved in the Elective Surgery Access Service program (ESAS).</li></ul> <p>All other circumstances, report a space in this field.</p>		
<i>Reported for</i>	Episodes where an admitted service is provided under contract, hub and spoke, <del>Healthstreams</del> , Coordinated Care Trial arrangements, Rural Patients Initiative or Elective Surgery Access Service (ESAS).  Otherwise, report a space in this field.		
<i>Reported when</i>	A Separation Date is reported in the Episode Record.		

<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>
	1	Contract
	2	Hub and spoke
	<del>3</del>	<del>Healthstreams</del>
	4	Coordinated Care Trial
	5	Rural Patients Initiative
	6	Elective Surgery Access Service

### *Reporting guide*

#### **1 Contract**

Patient receiving contracted hospital care under an agreement between a purchaser of hospital care (contractor) and a provider of an admitted or non-admitted service (contracted hospital).

#### **2 Hub and Spoke**

Patient receiving a specialist service at another hospital site (spoke) under a hub and spoke arrangement. This hospital is the hub hospital. (Any service provided at a spoke hospital is reported by the hub hospital only.)

#### ~~**3 Healthstreams**~~

~~Patient receiving admitted patient services under Healthstreams. (The majority of services provided under Healthstreams do not involve admitted patient services.)~~

~~Private hospitals: Do not use code 3.~~

#### **4 Coordinated Care Trial**

Patient identified as a Coordinated Care Trial patient.

#### **5 Rural Patients Initiative**

Admission under the Rural Patients Initiative. Use code 5 only if the public hospital has been allocated resources through the Rural Patients Initiative.

Private hospitals: Do not use code 5.

#### **6 Elective Surgery Access Service (ESAS)**

Admission under the Elective Surgery Access Service (ESAS). Use code 6 only if the public hospital has been allocated resources through the Elective Surgery Access Service.

Private hospitals: Do not use code 6.

### *Edits*

108	Field(s) Missing From Sep
410	Illegal Comb Fund Arrang & Contract
416	Invalid Fund Arrangement
423	Invalid Comb Funding/Contract/Transfer
424	Not Separated: Fund Arr S/Be Spaces
454	Incompat Fields for Interim Care
456	Contract Leave, No Contract
<del>476</del>	<del>Funding Arrangement 3, not approved for Healthstreams</del>
477	Funding Arrangement 5, not approved for Rural Patients Initiative
478	Funding Arrangement 6, not approved for ESAS
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
523	CCU Hrs, no Approved CCU
524	CCIHT not approved
526	ICU Hrs, no approved ICU or NICU

- Related items**
- Section 2: *Contracted Care* and *Hub and Spoke*.
- Section 3: *Contract Role* on page 3-#, *Contract/Spoke Identifier* on page 3-#, and *Contract Type* on page 3-#.
- Section 4:
- Business Rules (non-tabular) *Contracted Care* and *Hub and Spoke*.
  - Business Rules (tabular) *Care Type: Designated Rehabilitation Program (2, 6, 7 and J)*, and *Care Type: Interim Care Program (F and E)*, and *Contracting: Contract Fields, Contract Leave and Funding Arrangement*, and *Contracting: Funding Arrangement and Contract Fields*, and *Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode*, and *Funding Arrangement: Elective Surgery Access Service*, and *Funding Arrangement: Rural Patients Initiative*.

## Administration

<b>Purpose</b>	To:		
		<ul style="list-style-type: none"> <li>• Identify whether a specific funding arrangement applies to this episode.</li> <li>• Facilitate health services planning and monitoring.</li> </ul>	
<b>Principal data users</b>	Financial Analysis and Purchasing Branch, Metropolitan Health & Aged Care, DHS (Contract; Hub and Spoke)		
	<del>Rural Specialist Services Grant (Healthstreams)</del>		
	Quality and Care Continuity (Coordinated Care Trial and Elective Surgery Access Service)		
	Rural & Regional Health Services (Rural Patients Initiative)		
<b>Collection start</b>	1996-97		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

## Proposal 5 - Given Name and Surname

<b>It is proposed to</b>	Lengthen field sizes of Given Name and Surname data items to meet the system and matching requirements for DVA and TAC.
<b>Proposed by</b>	<b>Anthony La Sala, Performance Reporting and Analysis Unit</b> Department of Human Services Phone: 9616 7474, Email: <a href="mailto:Anthony.LaSala@dhs.vic.gov.au">Anthony.LaSala@dhs.vic.gov.au</a>
<b>Implementation Date</b>	1 July 2004
<b>Background</b>	<p>Given Name and Surname are reported to PRS/2 in order to facilitate payment by Department of Veteran Affairs (DVA) and Transport Accident Commission (TAC) for relevant episodes of care. These data are held separately to other VAED data to ensure confidentiality is maintained.</p> <p>DVA have recently implemented a new information system (HOTSPUR). The requirements of this system specify 15 characters for the Given Name and 24 characters for the Surname.</p> <p>The Electronic Data Exchange process for TAC originally requested 25 characters for Given Name and 25 characters for Surname.</p> <p>It is proposed to increase the above field sizes as follows:</p> <ul style="list-style-type: none"><li>• Given Name – from 12 to 15 characters.</li><li>• Surname – from 20 to 25 characters.</li></ul> <p>These field size increases will meet the DVA HOTSPUR information system requirements and whilst Given Name will not be lengthened to 25 characters, this will still provide sufficient data for the TAC matching process.</p> <p>It is also proposed to modify the layout for each data item to ensure the first character of the data item is an alpha character.</p>

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## Given Name(s) (*Amended*)

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### Specification

<b>Definition</b>	The given name/s of the DVA or TAC patient.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Name
<b>Field size</b>	12-15	<b>Layout</b>	XXXXXXXXXXXXX XXXXXXXXXXXXXXXXXX
<b>Location</b>	DVA and TAC Record		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Admitted episodes with an Account Class of V- DVA or T- TAC.		
<b>Reported when</b>	The Episode Record is reported.		

<i>Code set</i>	-
<i>Reporting guide</i>	The given name/s of the patient.  <div style="border: 1px solid black; padding: 2px;">Given Name must be a minimum of 2 characters in length.</div> Permitted characters: A to Z (uppercase), space, apostrophe, hyphen.
<i>Edits</i>	162 <del>Blank</del> <div style="border: 1px solid black; padding: 2px;">Invalid</div> Given Name <div style="border: 1px solid black; padding: 2px;">### Invalid Length Given Name [Rejection]</div>
<i>Related items</i>	Section 3: <i>Account Class</i> page 3-# and <i>Surname</i> page 3-#.

## Administration

<i>Purpose</i>	To facilitate payment by DVA and TAC for relevant episodes of care.  These data are held separately to other VAED data to ensure that personal information remains confidential.		
<i>Principal data users</i>	Department of Veterans' Affairs and Transport Accident Commission.		
<i>Collection start</i>	1992-93		
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

## Surname (*Amended*)

### Specification

<i>Definition</i>	The surname of the DVA or TAC patient.		
<i>Datatype</i>	Alphanumeric	<i>Form</i>	Name
<i>Field size</i>	2025	<i>Layout</i>	<div style="border: 1px solid black; padding: 2px;"> AAAAAAAAAAAAAAAAAAAAAAAAA-  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X </div>
<i>Location</i>	DVA and TAC Record		
<i>Reported by</i>	Public hospitals.		
<i>Reported for</i>	Admitted episodes with an Account Class of V- <i>DVA</i> or T- <i>TAC</i> .		
<i>Reported when</i>	The Episode Record is reported.		
<i>Reporting guide</i>	Surname of the person.  <div style="border: 1px solid black; padding: 2px;">Surname must be a minimum of 2 characters in length.</div> Permitted characters: A to Z (uppercase), space, apostrophe, hyphen.		
<i>Edits</i>	161 <del>Blank</del> <div style="border: 1px solid black; padding: 2px;">Invalid</div> Surname <div style="border: 1px solid black; padding: 2px;">### Invalid Length Surname [Rejection]</div>		

*Related items* Section 3: *Account Class* page 3-# and *Given Name(s)* page 3-#.

## Administration

*Purpose* To facilitate payment by DVA and TAC for relevant episodes of care.  
These data are held separately to other VAED data to ensure that personal information remains confidential.

*Principal data users* Department of Veteran's Affairs and Transport Accident Commission.

*Collection start* 1992-93

*Definition source* DHS *Code set source* -

## Proposal 6 - HARP Data Item

<b>It is proposed to</b>	Add a new data item to the VAED collection to identify patients participating in the Hospital Admissions Risk Program (HARP).
<b>Proposed by</b>	Sue Daly, Hospital Demand Management Department of Human Services Phone: 9616 8021, Email: <a href="mailto:Sue.Daly@dhs.vic.gov.au">Sue.Daly@dhs.vic.gov.au</a>
<b>Implementation Date</b>	1 July 2004
<b>Background</b>	<p>The Hospital Admissions Risk Program (HARP) commenced in 2001-02 and is a prevention strategy to reduce the avoidable use of Victorian public hospitals through decreasing Emergency Department (ED) presentations and hospital separations. HARP aims to do this through funding initiatives to better manage the treatment of people with chronic and complex conditions. Project examples that HARP focuses on are patients with disease conditions such as chronic obstructive pulmonary disease, congestive heart failure, diabetes, and asthma.</p> <p>The importance of this program has been highlighted with a recurrent funding of \$50m annually, hence the ability to analyse HARP related data is vital in evaluating it as a funding program. With this data, it will be possible to:</p> <ul style="list-style-type: none"><li>• Identify the cohort of HARP patients.</li><li>• Analyse their hospitalisations (admission/readmission rate and pattern, bed days and average length of stay, and primary and related diagnoses).</li><li>• Analyse their use of emergency departments (presentations/re-presentations, and diagnoses)</li><li>• Assess HARP as a funding program, by evaluating the outcomes for these patients (decreased average length of stay (ALOS), decreased presentations/admissions, and admissions for other conditions).</li><li>• Determine the direction for the future and the level at which HARP should be funded.</li></ul>

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## HARP Patient Flag (*New*)

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### Specification

<b>Definition</b>	Identifies a patient registered to a Hospital Admissions Risk Program (HARP)		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	A or space
<b>Location</b>	Episode Record		
<b>Reported by</b>	Victorian Public Hospitals participating in HARP.		
	Otherwise, report spaces.		
<b>Reported for</b>	All admitted episodes of care.		

<i>Reported when</i>	This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.		
<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>	
	Y	Yes	
	N	No	
<i>Reporting guide</i>	Report Code Y <i>Yes</i> if a patient admitted to a Victorian public hospital participating in HARP is assigned to a HARP project either: <ul style="list-style-type: none"> <li>• At the time of admission; or</li> <li>• Is assigned to a HARP project during the admission.</li> </ul> Report Code N <i>No</i> if a patient admitted to a Victorian public hospital participating in HARP is not assigned to a HARP project.		
<i>Edits</i>	### Invalid HARP Patient Flag [ <i>Rejection</i> ] ### HARP Patient Flag but Campus Not Approved [ <i>Rejection</i> ]		
<i>Related items</i>	Section 9: <ul style="list-style-type: none"> <li>• Code Lists: Other Information <i>Hospital Admissions Risk Program: Approved for HARP Patient Flag.</i></li> </ul>		

## Administration

<i>Purpose</i>	To provide patient episode level data to support the evaluation of the Hospital Admissions Risk Program (HARP) component of the Hospital Demand Management Strategy		
<i>Principal data users</i>	Hospital Demand Management Unit (Metropolitan Health & Aged Care, DHS)		
<i>Collection start</i>	2004-05		
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

## Proposal 7 - Health Insurance Fund Codes

It is proposed to	Refine the codeset by deleting one code that currently includes more than one concept and creating three new codes to improve data quality.
Proposed by	Greg O'Connell, Health Data Standards and Systems Department of Human Services Phone: 9616 7327, Email: <a href="mailto:Gregory.O'Connell@dhs.vic.gov.au">Gregory.O'Connell@dhs.vic.gov.au</a>
Implementation Date	1 July 2004
Background	<p>Health Insurance Fund code 888 <i>Miscellaneous health insurance fund or Patient is insured but will not/cannot specify the Fund</i> currently includes two different concepts.</p> <p>It is proposed to replace this code with three new codes to enable identification of:</p> <ul style="list-style-type: none"><li>• <i>Miscellaneous Australian health insurance fund</i></li><li>• <i>Non-Australian health insurance fund</i></li><li>• <i>Patient is insured but will not/cannot specify the fund</i></li></ul> <p>It is proposed to implement a notifiable edit that will be triggered when a hospital reports the miscellaneous Australian health insurance fund code. This will ensure that the hospital advises DHS the name of the miscellaneous fund to ensure that the health insurance fund listing is better maintained and accurately reflects any new health insurance funds.</p>

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## Health Insurance Fund (*Amended*)

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### Specification

<b>Definition</b>	The patient's hospital insurance fund (if any) <i>regardless</i> of whether the patient elects to be a public or private patient, or is a compensable or ineligible patient.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	3	<b>Layout</b>	AAA or NNN
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Code	Descriptor – <i>Registered name (may differ from Trading name)</i>	
	ACA	ACA Health Benefits Fund	
	AHB	Defence Health	
	AHM	Australian Health Management Group	
	AMA	AMA Health Fund Limited	
	AUF	Australian Unity Health Limited	

CBH	CBHS Friendly Society
CDH	Cessnock District Health Benefits Fund
CPS	Credicare Health Fund
FAI	Grand United Corporate Health Limited
GUF	Grand United Health Fund Pty Ltd
GMF	Goldfields Medical Fund (Inc.)
GMH	Geelong Medical and Hospital Benefits Association Limited
HBA	Hospital Benefits Association Limited (in AXA group)
HBF	Hospital Benefits Fund of Western Australia, Limited, The
HCF	The Hospitals Contribution Fund of Australia, Ltd
HCI	Health Care Insurance Ltd
HHB	Healthguard Health Benefits Fund Limited
HIF	Health Insurance Fund of WA
IOF	IOOF Health Services Ltd
IOR	IOR Australia Pty Ltd
LHM	Lysaght Peoplecare
LHS	Latrobe Health Services, Inc.
MBF	Medical Benefits Fund of Australia Ltd
MBP	Medibank Private
MCL	Mutual Community Ltd (in AXA group)
MDH	Mildura District Hospital Fund
MIM	Queensland Country Health Limited
MUI	Manchester Unity Australia Ltd
NHB	Navy Health Ltd
NIB	NIB Health Funds Limited
NMH	National Mutual Health Insurance (in AXA group)
NTF	New South Wales Teacher's Federation Health Society
PWA	Phoenix Health Fund Ltd
QTU	Queensland Teachers Union Health Society
RBH	Reserve Bank Health Society
RTE	Railway & Transport Employees' Friendly Society Health Fund
SGI	NRMA Health Pty Limited (incorporating SGIC and SGIO)
SLM	St Luke's Medical & Hospital Benefits Association
SPE	South Australian Police Employees' Health Fund Incorporated
SPS	Health Partners
TFS	Transport Friendly Society
UAD	United Ancient Order of Druids
UAF	United Ancient Order of Druids Registered Friendly Society Grand Lodge of NSW
WDH	Western District Health Fund Ltd (Westfund)
YMH	Federation Health
<del>888</del>	<del>Miscellaneous health insurance fund or Patient is insured but will not/cannot specify the Fund (note 2)</del>
996	Miscellaneous Australian health insurance fund
997	Non-Australian health insurance fund
998	Patient is insured but will not/cannot specify the fund
999	Patient is uninsured/Insurance status unknown (note 3)

### Reporting guide

The patient's health insurance fund status should in no way be taken to indicate her/his election, nor should it influence that election.

- Do *not* use this code 998 to indicate TAC, WorkCover or DVA; record the patient's health insurance fund or code 999, if the patient is uninsured.
- When assigning code 999, the appropriate code for Level of Insurance is 6 No health insurance (includes ancillary cover only) or 9 Insurance status unknown, as appropriate.

#### Notes Relating to Funds:

- Australian Natives' Association and Manchester Unity Independent Order of Oddfellows Friendly Society in Victoria now trade as Australian Unity Friendly Society.
- Mutual Community is owned and operated by National Mutual. In Victoria, Mutual Community trades as HBA. In NT as Territory Mutual.
- Transition Benefits Fund Pty Ltd ceased operation on 31 March 2002.

### Edits

264 Blank /Invalid Health Insurance Fund  
313 No Fund But Insured  
314 Fund But Uninsured  
315 Fund But Insurance Unknown

### Misc Health Insurance Fund [Notifiable]

### TAC, WorkCover or DVA But HIF 998 [Rejection]

### Related items

Section 3: *Level of Insurance* on page 3-#.

## Administration

### Purpose

To monitor patterns of hospital insurance usage to inform health policy and planning.

### Principal data users

Purchasing and Policy Unit (Metropolitan Health & Aged Care, DHS).

### Collection start

1996-97

### Definition source

DHS

### Code set source

Part 6 (Registered Health Benefits Organization), Schedule 7, *National Health Act 1995*. Note that an error in this Schedule has been corrected here: the Fund incorrectly named 'Eastern District Health Fund Ltd' is shown here correctly as 'Western District Health Fund Ltd'.  
Current definitive list of registered health benefits organisations:  
<http://www.phiac.gov.au/healthfunds/list.html>  
From this site, you can find contact details for all Funds.

## Proposal 8 - ICD-10-AM 4<sup>th</sup> Edition

It is proposed to	Adopt the 4 <sup>th</sup> edition of ICD-10-AM.
Proposed by	Catherine Perry, Health Data Standards and Systems Department of Human Services Phone: 9616 6928, Email: <a href="mailto:Catherine.Perry@dhs.vic.gov.au">Catherine.Perry@dhs.vic.gov.au</a>
Implementation Date	1 July 2004
Background	This allows Victoria to meet national reporting requirements.

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## Diagnosis Codes (*Amended*)

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### Specification

<b>Definition</b>	At least one (principal diagnosis) and up to 40 ICD-10-AM ( <del>Third</del> <b>Fourth</b> Edition) codes reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	8 (x 40)	<b>Layout</b>	AANNNNspacespace Left justify, with trailing spaces.
<b>Location</b>	Diagnosis Record (12) Extra Diagnosis Record (28)		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	DHS ICD-10-AM Library File <del>2003-2004</del> <b>2004-2005</b> , available at: <a href="http://hdss.health.vic.gov.au/reffiles/2003-04/vaed/libfil03.htm">http://hdss.health.vic.gov.au/reffiles/2003-04/vaed/libfil03.htm</a> <a href="http://hdss.health.vic.gov.au/reffiles/2004-05/vaed/libfil04.htm">http://hdss.health.vic.gov.au/reffiles/2004-05/vaed/libfil04.htm</a>		
<b>Reporting guide</b>	<p>Report diagnoses in accordance with ICD-10-AM <i>Australian Coding Standards</i> and the <i>Victorian Additions to Australian Coding Standards</i>. The <i>Victorian Additions to Australian Coding Standards</i> are available at: <a href="http://hdss.health.vic.gov.au/icdcoding/index.htm">http://hdss.health.vic.gov.au/icdcoding/index.htm</a></p> <p><i>Omit</i> punctuation as shown in ICD-10-AM books (that is, no dot or oblique in codes): for example, ICD-10-AM diagnosis code A00.0 <i>Cholera due to Vibrio cholerae 01, biovar eltor</i> must be entered as A000.</p> <p>When a code is shown in ICD-10-AM with a symbol (dagger or asterisk), <i>omit</i> the symbol when transmitting to PRS/2.</p> <p>The first character of the field is the prefix: P, A, C or M.</p> <p>In the first diagnosis code field:</p> <ul style="list-style-type: none"><li>• <i>Character 1</i> must be P.</li><li>• <i>Next five characters</i> must contain an alpha/numeric code of three, four or five characters (with trailing spaces if required).</li></ul>		

- *Characters 7 and 8* must be spaces.

For the remaining thirty nine diagnosis code fields, *if* a code is present:

- *Character 1* must be P, A, C or M.
- *Next six characters* must contain an alpha/numeric code of three, four, five or six characters (with trailing spaces if required).
- *Character 8* must be a space.

#### Morphology codes (where first character is M)

Submit without punctuation (oblique) and with M prefix: for example MM80703

#### Prefixes: Definitions for P, A, C, M

Refer to the *Victorian Additions to the Australian Coding Standards*, available at: <http://hdss.health.vic.gov.au/icdcoding/index.htm>

#### Effect of prefix A

If the patient's Account Class causes the production of a DRG Statement (TAC and WorkCover), the code prefix A will suppress printing of the code rubric on the DRG Statement.

#### Edits

127	Nil Value DRG
160	AR - DRG Grouper GST Code > Zero
186	Neonate MDC But Age >= 28 Days
195	Blank X2
197	Embedded Blank Diag Oper
231	P - Diag Not Prefixed By P
232	Possible Coding or Sequencing Problem
329	Geri Respite - Invalid comb
334	Hosp Generated DRG Not = PRS/2 DRG
351	Illegal Code Format
352	Code Not Found On Code File
353	Code & Age Incompatible
354	Code & Sex Incompatible
355	Invalid Principal Diag - Rejection
355	Invalid Principal Diag - Warning
356	Non Specific Code
358	Area Code Restraint
361	External Cause Code Missing
362	Morphology Code Missing
363	External Cause needs Place Code
364	External Cause needs Activity Code
365	Ext Cause needs POO & Activity Code
403	Qual Newborn W/Out Justificat
406	Rehab Type W/Out Rehab PDx
411	Adm Wt < 1000g, No Matching Dx Code
412	Adm Wt 1000-2499g, No Matching Dx Code
413	Adm Wt > 6000g, No Matching Dx Code
426	Y2 Not Accompanied by X2
428	X2 Upd not Accompanied by Y2 Upd
442	NIV Duration for Healthy Newborn
447	Unqual Newborn; Age at Sep > 10 Days
449	Notifiable Infectious Disease Coded
450	Code Incompatible W Female Sex
451	Code Incompat W Male Sex
452	Place/Activity W/Out External Cause Code
453	Wrong PDx for Interim Care
454	Incompat Fields for Interim Care
498	Pall Care without Pall care Diag
525	Diagnosis Code Indicates Boarder Episode

- Related items**
- Section 2: *DRG Classification and Principal Diagnosis*.
  - Section 3: *Hospital Generated DRG page 3-#*.
  - Section 4:
    - Business Rules (non-tabular) *DRG Classification*
    - Business Rules (tabular) *Account Class: Geriatric Respite, and Care Type: Designated Rehabilitation Program (2, 6, 7 and J), and Care Type: Interim Care Program (F and E)*.
  - Section 9:
    - Code Lists: Other Information *Notifiable Infectious Disease ICD-10-AM Codes*

## Administration

<b>Purpose</b>	To: <ul style="list-style-type: none"> <li>• Facilitate epidemiological studies and other research.</li> <li>• Identify episodes containing specified codes for co-payments.</li> <li>• Facilitate grouping for casemix purposes.</li> </ul>		
<b>Principal data users</b>	Multiple internal and external research users.		
<b>Collection start</b>	1979-80		
<b>Definition source</b>	DHS	<b>Code set source</b>	ICD-10-AM <del>Third</del> <b>Fourth</b> Edition

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## Procedure Codes (*Amended*)

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### Specification

<b>Definition</b>	Up to 40 ICD-10-AM <del>Third</del> <b>Fourth</b> Edition codes reflecting the interventions used for the diagnosis and/or treatment of ill health during this episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	8 (x 40)	<b>Layout</b>	NNNNNNN 8 <sup>th</sup> character - A or space. Left justified, trailing spaces.
<b>Location</b>	Diagnosis Record (12) Extra Diagnosis Record (28)		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		

**Code set** DHS ICD-10-AM Library File ~~2003-2004~~ 2004-2005, available at:  
<http://hdss.health.vic.gov.au/reffiles/2003-04/vaed/libfil03.htm>  
<http://hdss.health.vic.gov.au/reffiles/2004-05/vaed/libfil04.htm>

Where no procedures were performed, report spaces.

**Reporting guide** *Character 1-7* must contain a numeric code of seven characters.

*Character 8* must be F, N or space.

Report procedures undertaken during this episode of care in accordance with the ICD-10-AM *Australian Coding Standards* and the *Victorian Additions to Australian Coding Standards*. The *Victorian Additions to Australian Coding Standards* are available at: <http://hdss.health.vic.gov.au/icdcoding/index.htm>

*Omit* punctuation as shown in ICD-10-AM books (no dash in codes); for example, ICD-10-AM procedure code 40903-00 *Neuroendoscopy* must be entered 4090300. Do not transmit Block numbers.

**Procedures performed under contract at another agency**

Procedures performed *at another hospital under contract to this hospital* are recorded by both hospitals (where the episode is admitted by both hospitals), but flagged in the *contracting* hospital only, by use of a flag in the eighth character allocated for each procedure code.

- 'F' indicating the procedure was performed at another hospital on an admitted basis.
- 'N' indicating the procedure was performed at another hospital on a non-admitted basis.

**Edits**

127	Nil Value DRG
160	AR-DRG Grouper GST Code>Zero
195	Blank X2
197	Embedded Blank Diag Oper
232	Possible Coding or Sequencing Problem
320	MV Duration But No Procedure Code
334	Hosp Generated DRG Not = PRS/2 DRG
351	Illegal Code Format
352	Code Not found On Code File
353	Code & Age Incompatible
354	Code & Sex Incompatible
356	Non Specific Code
358	Area Code Restraint
408	Contract Role 'A' W/Out Proc Flag
409	Proc Flag W/out Contract Role 'A'
428	X2 Upd not Accompanied by Y2 Upd
439	NIV Proc Code W/Out Duration in NICU/SCN
440	NIV Duration without NIV Proc Code
450	Code Incompatible W Female Sex
451	Code Incompat W Male Sex
###	Type B Crit for Adm w/o Type B Proc Code [Notifiable]
###	Type C Crit for Adm with Type B Proc Code [Notifiable]
###	Type E Crit for Adm with Type B Proc Code [Notifiable]
###	Type E Crit for Adm with Type C Proc Code [Notifiable]

- Related items*
- Section 2: *Contracted Care, DRG Classification and Procedure.*
  - Section 3: *Hospital Generated DRG page 3-#.*
  - Section 4:
    - Business Rules (non-tabular) *Contracted Care and DRG Classification.*

## Administration

- Purpose* To facilitate:
- Epidemiological studies and other research.
  - Grouping for casemix purposes.
- Principal data users* Multiple internal and external research users.
- Collection start* 1979-80
- Definition source* DHS *Code set source* ICD-10-AM ~~Third~~ Fourth Edition

## Proposal 9 - Leave

**It is proposed to** Change the name of [Normal] Leave to Other Leave. This wording is used to differentiate leave from Contract Leave. Other leave incorporates both leave with permission (excluding Contract Leave), and leave without permission.

Additionally, there are some minor changes to Leave reporting requirements.

**Proposed by** Catherine Perry, Health Data Standards and Systems  
Department of Human Services  
Phone: 9616 6928, Email: [Catherine.Perry@dhs.vic.gov.au](mailto:Catherine.Perry@dhs.vic.gov.au)

**Implementation Date** 1 July 2004

**Background** This proposal allows for congruency between the information reported on the VAED, and the Client Management Interface (CMI)/ Operational Data Store (ODS), for Mental Health patients, and allows for absconded patients to be reported the same way across all Care Types. This is in line with reporting requirements of the Office of the Chief Psychiatrist.

Additionally, this provides software suppliers with the opportunity to review the current calculation of Leave days, which is known to be incorrect in many systems, particularly in relation to the dot points under point 11 in the Business Rules.

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## **Other Leave [~~Normal~~] (Concept Definition Amended)**

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**Definition** [~~Normal~~] Other leave occurs either (i) when an overnight or multi-day patient leaves the hospital temporarily with the approval of the hospital and/or treating medical practitioner, with the intention that the patient will return within seven days to continue the current treatment, or (ii) where a patient absconds or leaves against medical advice and returns within seven days for continuation of the current treatment.

**Guide for use** No patient day charges are raised, nor patient days counted, while the patient is on [~~Normal~~] Other leave.

*Examples where leave should be recorded are:*

- Patient presents to hospital for induction of labour, sent home, to return when in established labour. Patient returns the next morning. Patient should only have one episode for this period. If the induction meets Criteria for Admission, the patient should be placed on leave whilst at home, as she is expected to return within seven days for continuing care.
- Rehabilitation patient leaves on the 24 December to return on the 26 December, so that they can spend Christmas in the care of their family.

Persons going on ~~Normal~~ Other leave are not separated unless the patient fails to return within seven days. If so, the patient should be formally separated, effective from the date of leaving the hospital. If the patient later returns to the hospital, a new episode is started and the patient is formally admitted. The exception to this is:

- Where the patient is an involuntary Mental Health patient, in which case the Leave Without Permission can be up to 12 months (as determined by the Mental Health Act 1988).

Unless the patient is on contract or ~~normal~~ other leave, an overnight or multi-day stay patient in one hospital campus cannot concurrently be a patient in another hospital campus. Such a patient must be separated from one hospital campus and admitted to the other hospital campus on each occasion of transfer.

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

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

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

In such cases, documentation to justify the admission must be provided (that is, why it is not non-admitted care).

A period of absence starting and ending on the same date is not counted as ~~normal~~ other leave but the patient must be recorded as absent in his/her medical record. The patient may be recorded as absent in the hospital's computer system; however, the system must not report a day's leave to PRS/2 nor deduct a patient day in other reporting.

Where a patient absconds or leaves against medical advice, it is still the intention of the medical practitioner that the patient return within seven days to continue the current treatment. As this circumstance is a subset of Other Leave, all of the guidelines apply.

Where a Hospital in the Home patient does not receive any admitted type services on a particular date, this day should be recorded as an ~~Normal~~ Other leave day.

Newborns are not permitted to go on ~~normal~~ other leave; they should be separated.

Where a patient is separated, then deteriorates and returns to the hospital and is subsequently re-admitted, this should be recorded as two separate episodes, even where both episodes occur on the same day.

**Refer to:**

- Section 2: *Length of Stay page 2-#, Newborn page 2-#, Nursing Home Type/Non-Acute Care page 2-#, Overnight or Multi-day Stay Patient page 2-#, Patient Day page 2-#, and Separation page 2-#.*
- Section 3: *Other Leave Days Financial Year-To-Date ~~Normal~~, Other Leave Days Month-To-Date ~~Normal~~, and Other Leave Days Total ~~Normal~~.*

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## Leave Without Permission (Concept Definition *Delete*)

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## Length of Stay (Business Rules: Non-Tabular *Amended*)

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### *Guide for use*

In practice, there are two methods for calculating length of stay:

- Retrospective: Separation Date minus Admission Date minus Total ~~normal~~ other leave days; and
- Progressive: sum of patient days (including contract leave days) accrued to date.

By whichever method, the result must be the same at the conclusion of an individual patient episode.

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

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

## Some Specific Guidelines for Counting Patient Days, Contract Leave Days and ~~Normal~~ Other Leave, and Hence Calculating LOS

- 7 A same day patient cannot go on either contract leave or ~~normal~~ other leave. A same day patient is one who has completed their course of treatment and is separated on the same day.
- 8 A period of contract or ~~normal~~ other leave starting and ending on the same date is not counted as a contract leave day or an ~~normal~~ other leave day. To count a contract leave day or an ~~normal~~ other leave day, the patient must be out of the hospital overnight.
- 9 A period of ~~normal~~ other leave cannot exceed seven days. If a patient does not return to the hospital to continue this episode of care within seven days of starting ~~normal~~ other leave, the patient is considered to have been separated on the date he/she started ~~normal~~ other leave. The exception to this is when an involuntary Mental Health patient absconds. In this case, up to 12 months leave may be recorded, as determined by the Mental Health Act 1988.
- 10 Count the day of going on contract leave or ~~normal~~ other leave as a contract leave day or an ~~normal~~ other leave day respectively. Count the day of returning from contract leave or ~~normal~~ other leave as a patient day.
- 11 Notwithstanding point 10 above:
  - When, on the same date, a patient is admitted and goes on contract leave or [normal] leave, count this day as a patient day.
  - When, on the same date, a patient returns from contract leave and again goes on contract leave, count this day as a contract leave day.
  - When, on the same date, a patient returns from ~~normal~~ other leave, is assessed as fit to continue on leave and again goes on ~~normal~~ Other leave, count this day as an ~~normal~~ other leave day.
  - When, on the same date, a patient returns from ~~normal~~ other leave, receives treatment, investigation and/or observation, and again goes on ~~normal~~ other leave, count this day as a patient day. *[Known by HDSS not how some PAS's count this day. This scenario needs to be treated differently to the previous dot point].*
  - When, on the same date, a patient returns from contract leave or ~~normal~~ other leave and is separated, do not count this day as either a contract leave day or an ~~normal~~ other leave day or as a patient day.
  - When, on the same date, a patient goes on contract leave and is separated from the contracted hospital, do not count this day as either a contract leave day or as a patient day.

### Refer to:

- Section 2: Leave - Contract, ~~Other~~ Leave ~~Normal~~, Leave Without Permission, Length of Stay, Overnight or Multi-Day Stay patient, and Same Day Patient.
- Section 3: Admission Date, Patient Days Financial Year-To-Date, Patient Days Month-To-Date, Patient Days Total, and Separation Date.

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## ~~Other~~ Leave Financial Year-To-Date ~~Normal~~ (Amended)

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### Specification

#### Definition

The number of days during this episode of care that the patient was out of hospital 'on ~~normal~~ other leave' in the financial year being reported (includes the month being reported).

<i>Datatype</i>	Numeric	<i>Form</i>	Quantitative value
<i>Field size</i>	3	<i>Layout</i>	NNN or spaces. Right justified, zero filled.
<i>Location</i>	Episode Record		
<i>Reported by</i>	All Victorian hospitals (public and private).		
<i>Reported for</i>	Episodes where there was a period of <del>normal</del> <b>Other</b> leave for the financial year-to-date.		
<i>Reported when</i>	The Episode Record is reported.		
<i>Code set</i>	A valid number complying with the business rules.		
<i>Reporting guide</i>	<b>Other</b> Leave Days Financial Year-To-Date <del>{Normal}</del> must be equal to or greater than <b>Other</b> Leave Days Month-To-Date <del>{Normal}</del> and equal to or less than <b>Other</b> Leave Days Total <del>{Normal}</del> .		
<i>Edits</i>	047 Leave Days YTD Not Numeric or Blank 053 Leave YTD < MTD 055 Leave Tot < YTD		
<i>Related items</i>	Section 2: <del><b>Other</b> Leave — Normal and Leave Without Permission.</del>  Section 3: <del><b>Other</b> Leave Days Month-To-Date {Normal}</del> page 3-#, and <del><b>Other</b> Leave Days Total {Normal}</del> page 3-#.		

## Administration

<i>Purpose</i>	To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of normal leave days) against the difference between Admission Date and Separation Date.		
<i>Principal data users</i>	Automated PRS/2 processes.		
<i>Collection start</i>	1990-91		
<i>Definition source</i>	DHS		

## **Other** Leave Days Month-To-Date ~~{Normal}~~ (Amended)

## Specification

<i>Definition</i>	The number of days during this episode of care that the patient was out of hospital 'on <del>{normal}</del> <b>other</b> leave' in the month being reported (month-to-date).		
<i>Datatype</i>	Numeric	<i>Form</i>	Quantitative value
<i>Field size</i>	2	<i>Layout</i>	NN or spaces. Right justified, zero filled.
<i>Location</i>	Episode Record		

<i>Reported by</i>	All Victorian hospitals (public and private).
<i>Reported for</i>	Episodes where there was a period of <del>normal</del> <b>Other</b> leave for the month.
<i>Reported when</i>	The Episode Record is reported.
<i>Code set</i>	A valid number complying with the business rules.
<i>Reporting guide</i>	<b>Other</b> Leave Days Month-To-Date <del>{Normal}</del> must be equal to or less than <b>Other</b> Leave Days Financial Year-To-Date <del>{Normal}</del> and <b>Other</b> Leave Days Total <del>{Normal}</del> .
<i>Edits</i>	046 Leave Days MTD Not Numeric or Blank 053 Leave YTD < MTD 054 Leave Tot < MTD
<i>Related items</i>	Section 2: <b>Other</b> Leave — <del>Normal and Leave Without Permission</del> .  Section 3: <i>Interpreter Required</i> page 3-#, and <b>Other</b> Leave Days Total <del>{Normal}</del> page 3-#.

## Administration

<i>Purpose</i>	To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of normal leave days) against the difference between Admission Date and Separation Date.
<i>Principal data users</i>	Automated PRS/2 processes.
<i>Collection start</i>	1990-91
<i>Definition source</i>	DHS

## **Other** Leave Days Total ~~{Normal}~~ (*Amended*)

## Specification

<i>Definition</i>	The total number of days during this episode of care that the patient was out of hospital 'on <del>normal</del> <b>Other</b> leave', including days from the previous financial year/s.		
<i>Datatype</i>	Numeric	<i>Form</i>	Quantitative value
<i>Field size</i>	3	<i>Layout</i>	NNN or spaces. Right justified, zero filled.
<i>Location</i>	Episode Record		
<i>Reported by</i>	All Victorian hospitals (public and private).		
<i>Reported for</i>	Episodes where there was a period of normal leave.		
<i>Reported when</i>	The Episode Record is reported.		

<i>Code set</i>	A valid number complying with the business rules.
<i>Reporting guide</i>	<b>Other</b> Leave Days Total <del>{Normal}</del> must be equal to or greater than <b>Other</b> Leave Days Month-To-Date <del>{Normal}</del> and <b>Other</b> Leave Days Financial Year-To-Date <del>{Normal}</del> .
<i>Edits</i>	049 Leave Days Tot Not Numeric or Blank 054 Leave Tot<MTD 055 Leave Tot< YTD 112 Calc Los + Leave Not = Adm/Sep 224 Newborn With Leave
<i>Related items</i>	Section 2: <b>Other</b> Leave — <del>Normal and Leave Without Permission</del> .  Section 3: <i>Interpreter Required</i> page 3-#, and <b>Other</b> Leave Days Month-To-Date <del>{Normal}</del> page 3-40.

## Administration

<i>Purpose</i>	To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of normal leave days) against the difference between Admission Date and Separation Date.
<i>Principal data users</i>	Automated PRS/2 processes.
<i>Collection start</i>	1990-91
<i>Definition source</i>	DHS

## Patient Days Financial Year-To-Date (*Amended*)

### Specification

<i>Definition</i>	The number of patient days the person has accrued during the current financial year-to-date <i>excluding</i> <del>{normal}</del> <b>Other</b> leave days (includes the month being reported). (Total of patient days recorded in each of the status segments.)		
<i>Datatype</i>	Numeric	<i>Form</i>	Quantitative value
<i>Field size</i>	3	<i>Layout</i>	NNN Right justified, zero filled.
<i>Location</i>	Status Segments of the Episode Record.		
<i>Reported by</i>	All Victorian hospitals (public and private).		
<i>Reported for</i>	All admitted episodes of care.		
<i>Reported when</i>	The Episode Record is reported.		
<i>Code set</i>	A number in the range 01 to 366.		
<i>Reporting guide</i>	Patient Days includes Contacted Leave Days.  Patient Days Financial Year-To-Date must be equal to or greater than Patient Days Month-To-Date and equal to or less than Patient Days Total.		

**Edits**

076	Not Sufficient Fields First Status
077	Not Sufficient Fields Other Status
087	Pt Days YTD Not Numeric Or Blank
091	Pt Days YTD <MTD
093	Pt Days Total< YTD

**Related items** Section 2: *Contracted Care and Patient Day.*

Section 3: *Contract Leave Days Financial Year-To-Date page 3-#, Contract Leave Days Month-To-Date page 3-#, Contract Leave Days Total page 3-#, Patient Days Month-To-Date page 3-44, and Patient Days Total page 3-45.*

Section 4:

- Business Rules (non-tabular) *Length of Stay.*

Section 5: *Status Segments.*

## Administration

**Purpose** To enable hospitals to reconcile YTD days reported each month.

**Principal data users** Automated PRS/2 processes.

**Collection start** 1983-84

**Definition source** DHS

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# Patient Days Month-To-Date (*Amended*)

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## Specification

**Definition** The number of patient days the person has accrued during the current month *excluding* [normal] [other] leave days, where current month refers to the month nominated by the Header start and end dates. (Total of patient days recorded in each of the status segments.)

<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	2	<b>Layout</b>	NN Right justified, zero filled.

**Location** Status Segments of the Episode Record.

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted episodes of care.

**Reported when** The Episode Record is reported.

**Code set** A number in the range 01 to 31.

**Reporting guide** Patient Days includes Contacted Leave Days.

Patient Days Month-To-Date must be equal to or less than Patient Days Financial Year-To-Date and Patient Days Total.

**Edits**

- 076 Not Sufficient Fields First Status
- 077 Not Sufficient Fields Other Status
- 086 Pt Days MTD Not Numeric Or Blank
- 091 Pt Days YTD<MTD
- 092 Pt Days Total<MTD

**Related items** Section2: *Contract Care and Patient Day.*

Section 3: *Contract Leave Days Financial Year-To-Date page 3-#, Contract Leave Days Month-To-Date page 3-#, Contract Leave Days Total page 3-#, Patient Days Financial Year-To-Date page 3-42, and Patient Days Total page 3-45.*

Section 4:

- Business Rules (non-tabular) *Length of Stay.*

Section 5: *Status Segments.*

## Administration

**Purpose** To enable hospitals to reconcile MTD days reported each month.

**Principal data users** Automated PRS/2 processes.

**Collection start** 1983-84

**Definition source** DHS

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# Patient Days Total (*Amended*)

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## Specification

**Definition** The total number of patient days the person has accrued during the whole episode of care to date *excluding* [normal] [other] leave days (includes the month being reported). (Total of patient days recorded in each of the status segments.)

**Datatype** Numeric **Form** Quantitative value  
**Field size** 4 **Layout** NNNN  
Right justified, zero filled.

**Location** Status Segments of the Episode Record.

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted episodes of care.

**Reported when** The Episode Record is reported.

**Code set** A number in the range 0001 to 9999.

**Reporting guide** Patient Days includes Contacted Leave Days.

Patient Days Total must be equal to or greater than Patient Days Month-To-Date and Patient Days Financial Year-To- Date.

**Edits**

- 076 Not Sufficient Fields First Status
- 077 Not Sufficient Fields Other Status
- 089 Pt Days Tot < Not Numeric Or Blank
- 092 Pt Days Total < MTD
- 093 Pt Days Total <YTD
- 096 Total Days Can't Be Zero
- 112 Calc LOS + Leave Not = Adm /Sep
- 113 Same Day Status: Total Pt Days Not 1
- 243 Unqual Newborn But Total Days > 9
- 432 MAPU or SOU > 48 Hours

**Related items** Section 2: *Contracted Care and Patient Day.*

Section 3: *Contract Leave Days Financial Year-To-Date page 3-#, Contract Leave Days Month-To-Date page 3-#, Contract Leave Days Total page 3-#, Patient Days Financial Year-To-Date page 3-42, and Patient Days Month-To-Date page 3-44.*

Section 4:

- Business Rules (non-tabular) *Length of Stay.*

Section 5: *Status Segments.*

## Administration

<i>Purpose</i>	Major measure of resource use. Also identifies whether episode is: <ul style="list-style-type: none"><li>• An inlier or outlier for the appropriate DRG.</li><li>• Same day or one day or multi day.</li></ul>
<i>Principal data users</i>	Multiple internal and external users.
<i>Collection start</i>	1979-80
<i>Definition source</i>	DHS

## Proposal 10 – Locality

<b>It is proposed to</b>	Refine the Locality field Reporting Guide to improve data quality for episodes reported with an overseas postcode.
<b>Proposed by</b>	Greg O’Connell, Health Data Standards and Systems (HDSS) Department of Human Services Phone: 9616 7327, Email: <a href="mailto:Gregory.O’Connell@dhs.vic.gov.au">Gregory.O’Connell@dhs.vic.gov.au</a>
<b>Implementation Date</b>	1 July 2004
<b>Background</b>	<p>The Locality data item currently specifies that when a postcode of 8888 (overseas) is entered, the country name must be reported utilising free text. To improve the data quality reported for overseas episodes, required for the Reciprocal Health Care Agreement (RCHA), it is proposed to refine the Reporting Guide to ensure that when a postcode of 8888 (overseas) is reported, a four digit country code is entered in the Locality field to indicate the country of residence.</p> <p>The ‘Postcode/Locality/SLA’ reference file, available at: <a href="http://www.health.vic.gov.au/hdss/reffiles/index.htm">http://www.health.vic.gov.au/hdss/reffiles/index.htm</a>, will be modified to incorporate each country of birth code, derived from the Country of Birth Code List, against a multiple listing of postcode 8888 (overseas). Therefore, if a postcode of 8888 (overseas) is entered, a valid four digit country code must be entered in the Locality field.</p>

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## Locality (*Amended*)

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### Specification

<b>Definition</b>	Geographic location (suburb/town/locality <u>for Australian residents, country for overseas residents</u> ) of usual residence of the person ( <i>not</i> postal address).		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Name
<b>Field size</b>	22	<b>Layout</b>	AAAAAAAAAAAAAAAAAAAAA Left justified.
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Refer to the Postcode/Locality/SLA reference file available from: <a href="http://hdss.health.vic.gov.au/reffiles/index.htm">http://hdss.health.vic.gov.au/reffiles/index.htm</a> .		
<b>Reporting guide</b>	Australia Post web-site listing of postcodes and localities is available from: <a href="http://www.auspost.com.au">www.auspost.com.au</a>		
	The DHS file excludes non-residential postcodes listed in the Australia Post file. Common variations of locality spellings, as used in Melway references and the Australian Bureau of Statistics National Locality Index (Cat. No. 1252), are included in the DHS file.		

Locality may be blank if the Postcode is 1000 or 9988. Where the Locality Postcode is 8888 (overseas), report the country name valid four digit country code in Locality. The country code must be one that corresponds with a code against the listing of 8888 (overseas) codes in the Postcode/Locality/SLA reference file, available at: <http://www.health.vic.gov.au/hdss/reffiles/index.htm>

**Edits** 058 Invalid Postcode/Locality  
### Postcode Overseas, Country Invalid [Rejection]

**Related items** Section 3: Postcode page 3-##.  
Section 4: Business Rules (tabular) Locality/Postcode

## Administration

**Purpose** To enable calculation (with Postcode field) of the patient's appropriate Statistical Local Area (SLA) which enables:

- Analysis of service utilisation and need for services.
- Identification of patients living outside Victoria for purposes of cross-border funding.
- Identification of patients living outside Australia for the Reciprocal Health Care Agreement (RHCA).

**Principal data users** Automated PRS/2 processes.  
Multiple internal and external users.

**Collection start** 1990-91

**Definition source** DHS **Code set source** ABS National Locality Index (Cat. No. 1252)

## Postcode (*Amended*)

### Specification

**Definition** Postcode of locality in which the person usually *resides* (*not* postal address).

**Datatype** Numeric **Form** Code

**Field size** 4 **Layout** NNNN

**Location** Episode Record

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted episodes of care.

**Reported when** The Episode Record is reported.

<i>Code set</i>	<p>Refer to the Postcode/Locality/SLA reference file available from:  <a href="http://hdss.health.vic.gov.au/reffiles/index.htm">http://hdss.health.vic.gov.au/reffiles/index.htm</a></p> <p>Other codes for use in this field:</p> <table border="0"> <thead> <tr> <th style="text-align: left;"><i>Code</i></th> <th style="text-align: left;"><i>Descriptor</i></th> </tr> </thead> <tbody> <tr> <td>1000</td> <td>No fixed abode</td> </tr> <tr> <td>8888</td> <td>Overseas (Report the <span style="border: 1px solid black; padding: 0 2px;">four digit</span> country name <span style="border: 1px solid black; padding: 0 2px;">code</span> in the Locality field.)</td> </tr> <tr> <td>9988</td> <td>Unknown</td> </tr> </tbody> </table>	<i>Code</i>	<i>Descriptor</i>	1000	No fixed abode	8888	Overseas (Report the <span style="border: 1px solid black; padding: 0 2px;">four digit</span> country name <span style="border: 1px solid black; padding: 0 2px;">code</span> in the Locality field.)	9988	Unknown
<i>Code</i>	<i>Descriptor</i>								
1000	No fixed abode								
8888	Overseas (Report the <span style="border: 1px solid black; padding: 0 2px;">four digit</span> country name <span style="border: 1px solid black; padding: 0 2px;">code</span> in the Locality field.)								
9988	Unknown								
<i>Reporting guide</i>	<p>The Australia Post listing of postcodes and localities is available from:  <a href="http://www.auspost.com.au">www.auspost.com.au</a></p> <p>From the Australia Post list, non-residential postcodes are excluded and common variations of locality spellings, as used in Melway references and the Australian Bureau of Statistics National Locality Index (Cat. No. 1252), are included.</p> <p>The hospital may collect the patient's postal address for its own purposes. However, for transmission to PRS/2, the Postcode must represent the patient's <i>residential</i> address. PRS/2 will <i>reject</i> non-residential Postcodes (such as mail delivery centres).</p> <p>For newborns, use the postcode of mother's residential address.</p>								
<i>Edits</i>	<table border="0"> <tr> <td>037</td> <td>Invalid Postcode</td> </tr> <tr> <td>058</td> <td>Invalid Postcode/Locality</td> </tr> <tr> <td>391</td> <td>Recip HCA Account, Not O/Seas P/Code</td> </tr> </table>	037	Invalid Postcode	058	Invalid Postcode/Locality	391	Recip HCA Account, Not O/Seas P/Code		
037	Invalid Postcode								
058	Invalid Postcode/Locality								
391	Recip HCA Account, Not O/Seas P/Code								

*Related items*      Section 3: *Locality*, page 3-##.

Section 4:

- Business Rules (tabular) *Locality/Postcode*.

## Administration

<i>Purpose</i>	<p>To enable calculation (with Locality field) of the patient's appropriate Statistical Local Area (SLA) which enables:</p> <ul style="list-style-type: none"> <li>• Analyses of service utilisation and need for services.</li> <li>• Identification of patients living outside Victoria for purposes of cross-border funding.</li> </ul>		
<i>Principal data users</i>	Multiple internal and external users.		
<i>Collection start</i>	1979-80		
<i>Definition source</i>	DHS	<i>Code set source</i>	Australia Post (DHS modified)

## Proposal 11 - Mental Health Related Items

It is proposed to	<ol style="list-style-type: none"><li>1. Add two new Mental Health related Care Types to the codeset.</li><li>2. Add a new data item to collect the Mental Health Statewide Unit Record Number for all Mental Health episodes.</li></ol>
Proposed by	<p>Phil Barelli, Service Monitoring and Review Unit, Mental Health Branch Department of Human Services Phone: 9616 8799, Email: <a href="mailto:Phil.Barelli@dhs.vic.gov.au">Phil.Barelli@dhs.vic.gov.au</a></p>
Implementation Date	1 July 2004
Background	<p>Currently it is not possible to distinguish between the following Mental Health related patient days:</p> <ul style="list-style-type: none"><li>• Acute</li><li>• Non-Acute/Nursing Home Type</li><li>• Sub-Acute Secure Extended Care</li></ul> <p>It is proposed to add two new Care Types to enable these patient days to be identified.</p> <p>Outcome Measurement in Mental Health (NOCC) is a major Commonwealth and State initiative. It is pivotal in efforts to promote better clinical outcomes for patients and in better planning for mental health services.</p> <p>The Victorian Admitted Episode Database (VAED) is regarded as a more developed and refined data set and is the basis for the Victorian component of the Admitted Episode National Minimum Data Set (NMDS). However Mental Health Outcome measurement is currently collected in the Mental Health Client Management Interface (CMI) system and not entered into general hospital systems and subsequently through to the VAED.</p> <p>The inclusion of the Mental Health Statewide Unit Record Number (MHSW UR) for all Mental Health episodes will enable the outcome measures to be appended onto a VAED extract which then forms the basis for the Commonwealth NMDS and NOCC.</p> <p>The encryption of the MHSW UR at DHS will provide additional security of patient privacy at the Commonwealth level. The Commonwealth requires that the identifier reported in the NOCC extract be in encrypted form and identical to that used in supplying unit record data for the Admitted and later for Ambulatory and Community Residential NMDS. The inclusion of the Mental Health Statewide Unit Record Number enables this continuity across the data sets. Also, the Mental Health Branch recognises the problems of double data entry and the introduction of the Mental Health Statewide Unit Record Number into local data systems is a step in moving towards a more complete and refined data collection system.</p> <p>The MHSW UR would not be available to researchers through the Victorian Health Information Reporting System (VHIRS) Helpdesk. It is to be entered and transmitted only with Mental Health Care Type episodes. Mental Health Statewide Unit Record Number should be considered as 'admission specific'. This will maximise patient confidentiality and privacy.</p>

# Care Type (*Amended*)

## 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 episodes of care.

**Reported when** The Episode Record is reported.

**Code set** Select the first appropriate category:

<i>Code</i>	<i>Descriptor</i>
F	Interim Care Program – Nursing Home Type
E	Interim Care Program
1	NHT/Non-Acute
2	Designated Rehabilitation Program/Unit: Level 1
6	Designated Rehabilitation Program/Unit: Level 2
7	Designated Rehabilitation Program/Unit: Level 3
J	Designated Rehabilitation Program/Unit: Home-based substitution
8	Palliative Care Program
P	Approved Mental Health Service or Psychogeriatric Program – Secure Extended Care
M	Approved Mental Health Service or Psychogeriatric Program – NHT/Non-Acute
5	Approved Mental Health Service or Psychogeriatric Program <b>Acute</b>
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

**Reporting guide** **F Interim Care Program –Nursing Home Type**  
Use this Care Type only for a patient admitted to a unit designated to provide Interim Care and who has been classified as 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).

Private hospitals: Do not use code F.

**E *Interim Care Program***

Use this Care Type only for a patient admitted to a unit designated to provide Interim Care and who has not been classified as 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.

Private hospitals: Do not use code E.

**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 Team and may or may not have an approved NH5 Form.

**2 *Designated Rehabilitation Program/Unit: Level 1***

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 that the hospital has such a designated unit.
- The rehabilitation episode directly follows the acute care episode in which the principal diagnosis is a spinal cord injury or head injury, or an amputation has been performed.

Private hospitals: Do not use code 2.

**6 *Designated Rehabilitation Program/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 that the hospital has 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/Unit: Level 3***

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 that the hospital has such a designated unit.

Private hospitals: Do not use code 7.

**J *Designated Rehabilitation Program/Unit: Home-based substitution***

A patient who is admitted to, or transferred to, a designated Rehabilitation Program with the Accommodation Type of 4 *In the Home (Hospital - HITH)(Rehabilitation- RITH)*. Use code J only if:

- The public hospital's Health Service Agreement specifies that the hospital has such a designated unit, and
- The public hospital has approval from the Sub-Acute Program to run a bed substitution Rehabilitation in the Home program, and
- The approved service will provide medium to high intensity program with allied health interventions equivalent to the traditional ward based admitted environment, and
- A 24-hour duty of care is presumed and the public hospital must fund any brokerage services as part of the inpatient funded episode, and
- The Rehabilitation Physician or Geriatrician should monitor the patient for the length of the bed substitution episode. If the GP is involved in the service, he/she must be contracted by the health service.

Private hospitals: Do not use code J.

**8 *Palliative Care Program***

A patient who is admitted to a Palliative Care Program.

Public hospitals: Code 8 must only be used on formal admission, if the patient receives palliative care under the supervision of a palliative care specialist or physician. A statistical change is permitted when a patient changes between Nursing Home Type and Palliative Care.

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

**P *Approved Mental Health Service or Psychogeriatric Program – Secure Extended Care***

A patient who is admitted to, or transferred to, an approved Mental Health Service or Psychogeriatric Program, and who has been designated as Secure Extended Care.

Use code P only if the public hospital's Health Service Agreement specifies that the hospital has such an approved Mental Health Service or Psychogeriatric Program.

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

**M *Approved Mental Health Service or Psychogeriatric Program – NHT/Non-Acute***

A patient who is admitted to, or transferred to, an approved Mental Health Service or Psychogeriatric Program, and who 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 Team or an Aged Persons Assessment and Treatment Team and may or may not have an approved NH5 Form.

Use code M only if the public hospital's Health Service Agreement specifies that the hospital has such an approved Mental Health Service or Psychogeriatric Program.

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

**5 *Approved Mental Health Service or Psychogeriatric Program - Acute***

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 that the hospital has 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 that the hospital has a Geriatric Evaluation and Management Program. This program excludes Nursing Home Type/Non-Acute patients.

Private hospitals: If the hospital 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: Use if the hospital operates a similar program and wishes to identify episodes of care as such.

### **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).

Private hospitals: Do not use code 3.

### **4 Other (Acute) Care including Qualified newborn**

Other types of patient:

*Includes:*

- Same day and acute (except mental health).
- 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 Types.
- Newborn who has been an Unqualified newborn for the entire duration of this stay (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 (4).

#### **Additional Notes:**

##### **Newborns**

In a single episode, a newborn may change between being Qualified and Unqualified with such changes being recorded in the (Status Segment) Qualification Status field. Care Type may need updating if a newborn changes from being Unqualified to Qualified.

Refer to Sections 2 and 4: *Newborn*.

### All other episodes

For all other episodes, if the Care Type changes during the episode, the date of that change must be reported in the Separation Date field and other Separation Status details completed; then a new Episode Record must be started (that is, a statistical separation and a statistical admission).

For example:

- If the patient is admitted to Acute care (Care Type 4) but later is transferred to an Approved Mental Health Service, the Care Type changes to Care Type 5, therefore the earlier Episode Record should be completed and a new Episode Record should be started.
- If the patient is admitted to one of the acute Care Types and after 35 days is deemed to require only NHT care (Care Type 1), the earlier Episode Record should be completed and a new Episode Record should be started.

This is summarised in Sections 2 and 4: *Episode of Care*, which also describes some circumstances when a new episode is not started.

A new Episode Record requires Diagnosis and Procedure Codes specific to that episode and therefore a separate DRG identified. The Separation Mode in the earlier Episode Record indicates the episode is being completed not because the patient has gone home, died or been transferred but because the Care Type has changed. The Admission Source of the new Episode Record indicates the new episode is starting not because the patient has been formally admitted but because the Care Type has changed.

### Edits

094	Combination A/C Accom Care Med Suff
107	Invalid Care Type
122	Sameday Adm Source/Sep Mode Mismatch
222	Unqual Newborn; Adm Date Not Birth
235	Adm Criterion is N But Care Not 4
250	Deleted – Episode is Sub-Acute
251	Invalid Adm Barthel
252	Invalid Sep Barthel
253	Rehab: Invalid Clin Sub-Prog
254	Rehab: Invalid Adm/Re-Adm to Rehab
255	Rehab: Invalid Onset Date
258	Sub- Acute: No Sub – Acute Record
260	Invalid Care For Qual
261	Newborn Care But Age > 9 Days
262	Invalid Care Type For Newborn
268	Inv Comb Legal, Care & PFS
285	Sub-Acute Record not required
289	Adm Sce T'fer & Onset = Adm Date
290	Stat Adm Sc & Onset = Adm Date
291	Adm Barthel > Sep Barthel
292	Sep Barthel Present
293	Clin Sub-Prog Present
294	Onset Date Present
295	Adm/Readmit To Rehab Present
297	Sep Rug ADL & Sep Mode Incompatible
298	Adm Barthel Present
303	Pall Care But Invalid Adm Rug ADL
304	Pall Care But Invalid Sep Rug ADL
305	Adm Rug ADL Present
306	Sep Rug ADL Present
329	Geri Respite – Invalid Comb
336	Invalid Comb For Crit Care Transfer
340	Invalid Source Refer to Pal Care
341	Source Refer to Pal Care Present

344 Invalid Comb For Family Choice  
390 Invalid Carer Availability  
399 Incompat Sep Mode & Carer Availability  
400 Child, Incompatible Carer Availability  
405 Inapplic Clin Prog For Care Type 2  
406 Rehab Care Type W/Out Rehab PDX  
407 Rehab Level 2 or 3 W Low Adm Barthel  
421 Not Separated; Carer Avail Present  
437 NIV Duration for Unqual Newborn  
447 Unqual Newborn; Age at Sep  
448 ICU Stay but Care Type not Acute  
453 Wrong PDX for Interim Care  
454 Incompat Fields for Interim Care  
455 Inconsist Newborn Transferred/Unqual Data  
461 ACAS Status not Required  
463 Accom Type 4, Care Type invalid  
464 Accom Type 7, not Care Type 4  
468 Care Type ≠ 1 or F, LOS >365 Days  
469 Care Type 2, 6, 7 or J, not approved for Rehab  
470 Care Type 5, M or P, not approved for Mental Health  
471 Care Type 5, not usual Sep Referral  
472 Care Type 8, not approved for Palliative Care Program  
473 Care Type 9, not approved for GEM  
474 Care Type E, LOS > 35 Days  
475 Care Type F or E, not approved for Interim Care  
488 Incompat Care Type/Adm Source Statistical  
489 Incompat Care Type/Sep Mode Statistical  
491 Incompat Fields for ESAS  
492 Incompat Fields for RPI  
496 MH Care Type But Age ≤ 5 years  
497 MV Duration But Care Type Not Acute  
498 Pall Care without Pall care Diag  
502 Stat Episode: Care Type same as Next Episode  
503 Stat Episode: Care Type same as Prior Episode  
506 Stat Episode: Rehab also in Next Episode  
507 Stat Episode: Rehab also in Prior Episode  
528 Stat Episode Pall: Not NHT in Prior Episode  
529 Stat Episode Pall: Not NHT in Next Episode

**Related items**

Section 2: *Acute Care, Admission, Admitted Patient, Episode of Care, Geriatric Evaluation and Management Program, Interim Care Program, Newborns, Nursing Home Type/Non-Acute Care, Palliative Care, Rehabilitation Care and Sub-Acute Care.*

Section 4:

- Business Rules (non-tabular) *Episode of Care, Interim Care Program, Newborn and Palliative Care.*
- Business Rules (tabular) *Account Class, Acc Type, Care Type and Medicare Suffix, and Admission Source and Care Type, and Care Type: Designated Rehabilitation Program (2, 6, 7 and J), and Care Type: Family Choice, and Care Type: Interim Care Program (F and E), and Care Type and Separation Mode, and Carer Availability and Separation Mode, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative, and Newborns: Criteria for Admission, Qualification Status, Care Type, and Reasons for Critical Care Transfer: Valid Combinations.*

Section 5: *Status Segments.*

Section 9:

- Code Lists: *Care Type Approved for Care Type 2, 6 or 7: Designated Rehabilitation Programs, and Care Type 5, M or P: Mental Health Service and Psychogeriatric Programs, and Care Type 8: Approved Palliative Care Program, and Care Type 9 Approved: Geriatric Evaluation and Management (GEM) Program, and Care Type F and E: Approved Interim Care Program.*

## 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 (Metropolitan Health & Aged Care, DHS).  
Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).

**Collection start**

1995-96

**Definition source**

DHS

**Code set source**

DHS

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# Mental Health Statewide Patient Identifier (*New*)

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## Specification

<i>Definition</i>	The client identifier, unique to the client for Victorian Public Mental Health agencies.		
<i>Datatype</i>	Alphanumeric	<i>Form</i>	Code
<i>Field size</i>	8	<i>Layout</i>	NNNNNNNN or spaces
<i>Location</i>	Episode Record		
<i>Reported by</i>	All Victorian public hospitals with an approved Mental Health Service.		
<i>Reported for</i>	All admitted episodes of care.		
<i>Reported when</i>	The episode record is reported.		
<i>Reporting guide</i>	Report the Mental Health Statewide Patient Identifier for all mental health episodes of care (Care Types P, M and 5).		
<i>Edits</i>	### Care Type P, M or 5, Invalid MHSPI [ <i>Rejection</i> ] ### MHSPI Present, not Care Type P, M or 5 [ <i>Rejection</i> ]		
<i>Related items</i>	Section 9: <ul style="list-style-type: none"><li>Code Lists: Care Type Care Type 5, M or P: Mental Health Service and Psychogeriatric Programs.</li></ul>		

## Administration

<i>Purpose</i>	To enable management of clients and their associated data.		
<i>Principal data users</i>	Mental Health Branch		
<i>Collection start</i>	01 July 2004		
<i>Definition source</i>	DHS	<i>Code set source</i>	RAPID generated

## Proposal 12 – Patient Identifier

<b>It is proposed to</b>	Lengthen the field size of the Patient Identifier data item to be consistent with the Victorian Emergency Minimum Dataset (VEMD) and Elective Surgery Information Systems (ESIS) collections.
<b>Proposed by</b>	Greg O’Connell, Health Data Standards and Systems Department of Human Services Phone: 9616 7327, Email: <a href="mailto:Gregory.O’Connell@dhs.vic.gov.au">Gregory.O’Connell@dhs.vic.gov.au</a>
<b>Implementation Date</b>	1 July 2004
<b>Background</b>	The current VAED specification for the Patient Identifier data item is an eight character, right justified, zero filled field. To achieve consistency and facilitate data linkage between the VAED, VEMD and ESIS data collections, it is proposed to lengthen the Patient Identifier data item field size to a ten character, right justified, zero filled field.  Note: Linkage is undertaken for data quality reasons or to produce statewide, non-identifiable statistics.

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## Patient Identifier (*Amended*)

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### Specification

<b>Definition</b>	An identifier, unique to a patient within this hospital or campus (patient’s record number/unit record number).		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	8 10	<b>Layout</b>	XXXXXXXXXX Right justified, zero filled.
<b>Location</b>	Episode Record Sub-Acute Record DVA and TAC Record		
<b>Reported by</b>	Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	The Episode Record, Sub-Acute Record or DVA and TAC Record is reported.		
<b>Code set</b>	Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.		
<b>Reporting guide</b>	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.  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.		

<i>Edits</i>	026	Zero Sep; Existing Not Discharged
	027	Adm Record; Overlaps Existing
	028	Prior Adm; No Sep Date
	029	Invalid Pt ID
	062	Duplicate Pt ID, Adm Date Time, Diff Unique
	063	Prior Not Discharged
	064	Duplicate Pt ID, Date Time
	248	Tran Pt ID Not Same As Episode Or Sub Ac
	499	Stat Admission: No Prev Episode
	510	Stat Sep Mode: No Subsequent Episode

*Related items* -

## Administration

*Purpose* To enable relevant episodes to be updated and provide the potential for episodes to be linked across patient settings.

*Principal data users* Automated PRS/2 processes.

*Collection start* 1979-80

*Definition source* DHS *Code set source* Hospitals

## Proposal 13 - Reporting zero versus null

It is proposed to	Amend the reporting range for the following data items: <ul style="list-style-type: none"><li>• Duration of Mechanical Ventilation in ICU</li><li>• Duration of Non-invasive Ventilation (NIV)</li><li>• Duration of Stay in Cardiac/Coronary Care Unit</li><li>• Duration of Stay in Intensive Care Unit</li></ul>
Proposed by	Greg O'Connell, Health Data Standards and Systems Department of Human Services Phone: 9616 7327, Email: <a href="mailto:Gregory.O'Connell@dhs.vic.gov.au">Gregory.O'Connell@dhs.vic.gov.au</a>
Implementation Date	1 July 2004
Background	The layout for these data items is specified as a four character numeric field or spaces. The codeset is specified as a valid number in the range 0000 to 9999. Where there is no duration in the above data items, this should be reported as spaces, not zeros.

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## Duration of Mechanical Ventilation in ICU (Amended)

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### Specification

<i>Definition</i>	Total duration of Mechanical Ventilation (MV) in hours, provided in an approved Intensive Care Unit (ICU), 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 and private hospitals with an approved ICU, as listed in Section 9, and hospitals contracting with a hospital with an approved ICU.  Otherwise, report spaces.		
<i>Reported for</i>	Episodes where MV is provided in such an ICU. Otherwise, report spaces.		
<i>Reported when</i>	A Separation Date is reported in the Episode Record.		

**Code set** A number in the range 0000 0001 to 9999.

**Reporting guide** If the patient has more than one period of MV in ICU during this episode, the total duration of all such periods is reported.

Duration is reported in hours, measured to the nearest completed hour (rounded up). Only MV hours provided in an ICU are counted:

- Where a patient is intubated and MV starts in an operating theatre, for the purposes of the Duration of MV field, the *counting of the duration of MV commences when the patient enters the ICU.*
- Where MV starts in ICU, continues while the patient is in an operating theatre and on the patient's return to ICU, the *count of duration should be suspended for the time the patient is out of the ICU.*
- Where a patient receives MV in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.

Refer to the *ICD Coding Newsletter*, August 2000, page 24 for a comparison of reporting this field and *coding MV.*

Duration of MV is edited against Duration of Stay in ICU.

A patient who receives MV in an ICU in Hospital B during a contracted service episode has the duration of that MV reported by Hospital B; Hospital A also reports the MV hours received in Hospital B in addition to any MV hours the patient received in an ICU at Hospital A.

- Edits**
- 317 Invalid MV Duration
  - 318 MV Duration >ICU Stay
  - 319 MV Duration But No ICU Stay
  - 320 MV Duration But No Proc Code
  - 323 MV Duration >Total Stay
  - 325 Incompat MV Hrs, A/C Class
  - 344 Invalid Comb For Family Choice
  - 454 Incompat Fields for Interim Care
  - 497 MV Duration But Care Type Not Acute

**Related items** Section 2: *Intensive Care Unit and Time of Death.*

Section 3: *Duration of Stay in Intensive Care Unit page 3-#.*

Section 4:

- *Business Rules (tabular) Care Type: Designated Rehabilitation Program (2, 6, 7 and J), and Care Type: Family Choice, and Care Type: Interim Care Program (F and E), and Criterion for Admission: Secondary Family Member.*

## Administration

**Purpose** To facilitate a co-payment on specified DRGs. MV hours represent a sound and clinically valid surrogate for illness severity.

**Principal data users** Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).

**Collection start** 1996-97

**Definition source** DHS **Code set source** -

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# Duration of Non-invasive Ventilation (NIV) (Amended)

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## Specification

**Definition** Total number of hours of non-invasive ventilatory assistance given via any route other than intubation or tracheostomy, provided to patients in an approved Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN) or Intensive Care Unit (ICU).

By far the most common is Continuous Positive Airway Pressure (CPAP). Duration of the following, less common, methods of ventilatory assistance should also be reported in this field:

- Bi-level Positive Airway Pressure (BiPAP)
- Intermittent Positive Pressure Breathing (IPPB), and/or
- Intermittent Mandatory Ventilation (IMV)

<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	4	<b>Layout</b>	NNNN or spaces. Right justified and zero-filled
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	Reporting is <b>MANDATORY</b> for public hospitals providing NIV to patients while admitted to an approved: <ul style="list-style-type: none"><li>• Level 3 nursery/Neonatal Intensive Care Unit (NICU) or</li><li>• Level 2 nursery/Special Care Nursery (SCN).</li></ul> Reporting is <b>OPTIONAL</b> for: <ul style="list-style-type: none"><li>• Public hospitals providing NIV to patients while admitted to an approved Intensive Care Unit (ICU)</li><li>• Private hospitals providing NIV in an approved NICU or SCN or ICU.</li></ul> Otherwise, report spaces.		
<b>Reported for</b>	Episodes of care for patients receiving NIV in a NICU and/or SCN and/or ICU. Otherwise, report spaces.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		

**Code set** A number in the range 0000 (4 spaces, blanks or null) 0001 to 9999.

**Reporting guide** **Respiratory support by intubation and/or tracheostomy**  
If CPAP, BiPAP, IPPB or IMV is performed by intubation or tracheostomy in an ICU or NICU, this duration should be reported in *Duration of Mechanical Ventilation in ICU*, and not *Duration of Non-invasive Ventilation*.

**Counting duration of NIV**

- All NIV hours given in NICU, SCN and/or ICU are counted.
- Reference below to '24-hour period' means 'midnight to midnight'.
- Where the NIV starts in an operating theatre, for the purpose of the Duration of NIV field, the *counting of the duration of NIV starts when the patient enters the NICU or SCN or ICU*.
- Where NIV starts in NICU or SCN or ICU, continues while the patient is in an operating theatre and on the patient's return to NICU, SCN or ICU, the *count of the duration should be suspended for the time the patient is out of the NICU or SCN or ICU*.

**Calculation is in four stages:**

- 1 Counting non-intermittent NIV
- 2 Counting intermittent NIV
- 3 Counting Contracted NIV hours (if any)
- 4 Summing and rounding above calculations

**1 Counting non-intermittent NIV**

If the patient has more than one period of non-intermittent NIV during this episode, sum the duration of all such periods.

**2 Counting intermittent NIV**

If a patient is electively cycling on and off NIV (usually only for NICU/SCN patients):

- If NIV was given for *four or more hours* in the 24-hour period between midnight and midnight, count this as 24 hours.
- If NIV was given for *less than four hours* in the 24-hour period between midnight and midnight, count the actual number of hours.

**3 Counting Contracted NIV hours**

When a patient receives NIV provided in a NICU, SCN or ICU in Hospital B during a contracted service episode:

- Hospital B reports the duration of NIV calculated according to these rules;
- Hospital A also includes the NIV hours received in Hospital B in addition to any NIV hours the patient received at Hospital A, each calculated according to these rules.

**4 Summing and rounding above calculations**

Sum the resulting figures for non-intermittent and intermittent NIV (including any Contracted hours). Then round to the nearest completed hour (round up).

**Edits**

329	Geri Respite – Invalid Comb
344	Invalid Comb For Family Choice
435	Invalid NIV Duration
437	NIV Duration for Unqual Newborn
438	NIV Duration > Total Stay
439	NIV Proc Code W/Out Duration in NICU/SCN
440	NIV Duration without NIV Proc Code
442	NIV Duration for Healthy Newborn
454	Incompat Fields for Interim Care
###	NIV Duration > 100 days [Notifiable]

- Related items**      Section 2: *Intensive Care Unit* and *Time of Death*.
- Section 3: *Duration of ICU* on page 3-#.
- Section 4:
- Business Rules (tabular) *Account Class: Geriatric Respite*, and *Care Type: Designated Rehabilitation Program (2, 6, 7 and J)*, and *Care Type: Family Choice*, and *Care Type: Interim Care Program (F and E)*, and *Criterion for Admission: Secondary Family Member*.

## Administration

- Purpose**      To evaluate the need for a co-payment on specified DRGs. DHS has been advised that NIV hours represent a sound and clinically valid surrogate for illness severity.
- Principal data users**      Financial Analysis and Purchasing Branch (Acute Health, DHS).
- Collection start**      2002-03
- Definition source**      Australian and New Zealand Neonatal Network (amended: in PRS/2, NIV via nasopharyngeal intubation is reported in Duration of MV in ICU field)

## Duration of Stay in Cardiac/Coronary Care Unit (Amended)

### Specification

- Definition**      Total duration of stay (hours) in an approved Cardiac/Coronary Care Unit (CCU), during this episode of care.
- Datatype**      Numeric      **Form**      Quantitative value
- Field size**      4      **Layout**      NNNN or spaces.  
Right justified and zero filled.
- Location**      Diagnosis Record
- Reported by**      Public and private hospitals with an approved CCU, as listed in Section 9, and hospitals contracting with a hospital with an approved CCU.  
  
Otherwise, report spaces.
- Reported for**      Episodes where time is spent in such a CCU. Otherwise, report spaces.
- Reported when**      A Separation Date is reported in the Episode Record.
- Code set**      A number in the range 0000 0001 to 9999.

**Reporting guide** If patient has more than one period in CCU during this episode, the total duration of all such periods is reported.

Duration is reported in hours, measured to the nearest completed hour (rounded up).

Where a hospital has a combined ICU/CCU, the duration of stay is reported in *either* the ICU field *or* the CCU field, not both. However, where a patient receives *mechanical ventilation* or *non-invasive ventilation* in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.

A patient admitted to a CCU in Hospital B during a contracted service episode has the duration of that CCU stay reported by Hospital B; Hospital A also reports the hours spent in CCU in Hospital B in addition to any hours spent in CCU at Hospital A.

**Edits**

322	ICU/CCU Stay > Total Stay
333	Invalid CCU Stay
337	Crit Care Transfer, No ICU/CCU Hrs
344	Invalid comb For Family Choice
454	Incompat Fields for Interim Care
523	CCU Hrs, no Approved CCU
###	CCU Stay > 50 days [Notifiable]

**Related items**

Section 2: *Cardiac/Coronary Care Unit and Time of Death.*

Section 3: *Duration of Mechanical Ventilation in ICU page 3-#, and Duration of Non-invasive Ventilation (NIV) page 3-#.*

Section 4:

- **Business Rules (tabular)** *Account Class: Geriatric Respite, and Care Type: Family Choice, and Care Type: Interim Care Program (F and E), and Criterion for Admission: Secondary Family Member.*

## Administration

**Purpose** To facilitate a co-payment on specified DRGs.

**Principal data users** Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).

**Collection start** 1998-99

**Definition source** DHS

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# Duration of Stay in Intensive Care Unit (Amended)

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## Specification

<i>Definition</i>	Total duration of stay (hours) in an approved Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU), 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, zero-filled.
<i>Location</i>	Diagnosis Record		
<i>Reported by</i>	Public and private hospitals with an approved ICU/NICU, as listed in Section 9, and hospitals contracting with a hospital with an approved ICU.  Otherwise, report spaces.		
<i>Reported for</i>	Episodes where time is spent in such an ICU/NICU. Otherwise, report spaces.		
<i>Reported when</i>	A Separation Date is reported in the Episode Record.		
<i>Code set</i>	A valid number in the range 0000 <span style="border: 1px solid black; padding: 0 2px;">0001</span> to 9999.		
<i>Reporting guide</i>	<p>If patient has more than one period in ICU/NICU 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). Only the time in the ICU/NICU is counted, not time, for example, in an operating theatre.</p> <p>Where a hospital has a combined ICU/CCU, the duration of stay is reported in <i>either</i> the ICU field <i>or</i> the CCU field, not both. However, where a patient receives <i>mechanical ventilation</i> or <i>non-invasive ventilation</i> in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.</p> <p>A patient admitted to an ICU/NICU in Hospital B during a contracted service episode has the duration of that ICU/NICU stay reported by Hospital B; Hospital A also reports the hours spent in ICU/NICU in Hospital B in addition to any hours spent in ICU/NICU at Hospital A.</p>		
<i>Edits</i>	316 Invalid ICU Duration 318 MV Duration >ICU Stay 319 MV But No ICU Stay 322 ICU/ CCU Stay > Total Stay 324 Incompat ICU Hrs, A/C Class 337 Crit Care Transfer, No ICU/CCU Hrs 344 Invalid Comb For Family Choice 448 ICU Stay but Care Type not Acute 454 Incompat Fields for Interim Care 526 ICU Hrs, no approved ICU or NICU		

- Related items*                    Section 2: *Intensive Care Unit* and *Time of Death*.
- Section 4:
- Business Rules (tabular) *Care Type: Family Choice*, and *Care Type: Interim Care Program (F and E)*, and *Criterion for Admission: Secondary Family Member*.

## Administration

- Purpose*                                To facilitate a co-payment on specified DRGs.
- Principal data users*            Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).
- Collection start*                    1996-97
- Definition source*                 DHS

## Proposal 14 - Separation Referrals

<b>It is proposed to</b>	Add two codes to the Separation Referral codeset to enable identification of patients discharged to: 1) Home based Interim Care; and 2) Alcohol and Drug Treatment Service
<b>Proposed by</b>	1) <b>Leanne Butler, Continuing Care</b> Department of Human Services Phone: 9616 1332, Email: <a href="mailto:Leanne.Butler@dhs.vic.gov.au">Leanne.Butler@dhs.vic.gov.au</a>  2) <b>Mandy Keating, Drugs Policy and Services</b> Department of Human Services Phone: 9637 4467, Email: <a href="mailto:Mandy.Keating@dhs.vic.gov.au">Mandy.Keating@dhs.vic.gov.au</a>
<b>Implementation Date</b>	1 July 2004
<b>Background</b>	1) Patients admitted to a campus approved to provide Interim Care, regardless of their Care Type during the admission, may be discharged from their admitted patient stay to receive Home based Interim Care. Addition of this Separation Referral code will enable the Continuing Care Unit to identify such patients and their demographics.  2) Alcohol and drug use is an ever increasing problem within our society. A large number of patients attend hospitals each year with an alcohol and drug related problem. The addition of a Separation Referral code to identify these patients will endeavour to reduce the demand for alcohol and drug related admissions.  The addition of a Separation Referral code for alcohol and drug use requires the modification of existing code M <i>Referral to a community rehabilitation centre arranged before discharge</i> to exclude alcohol and drug treatment services.

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## Separation Referral (*Amended*)

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### Specification

<b>Definition</b>	Clinical care and support services arranged by the hospital to meet the person's recuperative needs when discharged to private accommodation or home.		
<b>Datatype</b>	Alpha	<b>Form</b>	Code
<b>Field size</b>	4	<b>Layout</b>	AAAA or spaces Left justified, trailing spaces.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Public hospitals.  Private hospitals – Optional. If the private hospital chooses not to report these data, report spaces in this field.		

**Reported for** Episodes where the Separation Mode is H *Separation to private residence/accommodation*. For all other Separation Modes, report spaces in this field.

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

**Code set** Select up to four options from list. Do not repeat codes. If more than four referrals have been made, select the first four listed:

<b>Code</b>	<b>Descriptor</b>
F	Domiciliary postnatal care, arranged before discharge
P	Post Acute Care Program services, arranged before discharge
M	Referral to a community rehabilitation centre arranged before discharge
L	Alcohol and drug treatment service, arranged before discharge
B	Community palliative care support, arranged before discharge
U	Home nursing support, arranged before discharge
C	Mental health community services, arranged before discharge
S	Referral to private psychiatrist, arranged before discharge
D	Psychiatric disability support services, arranged before discharge
G	Referral to general practitioner, arranged before discharge
I	Home based Interim Care, arranged before discharge
A	Referral to Aged Care Assessment Service (ACAS), arranged before discharge
K	Referral to Aboriginal and Torres Strait Islander (ATSI), arranged before discharge
R	Other clinical care and/or support services, arranged before discharge
X	No referral or support services arranged before discharge

**Reporting guide** In arranging the referral of a patient to these services, the hospital would expect to receive confirmation from the referred provider of their preparedness to accept responsibility for delivering the required services to the patient upon discharge.

**F *Domiciliary postnatal care, arranged before discharge***  
Mother discharged, with domiciliary postnatal care arranged before discharge to her own home or home of relative or friend or other private accommodation\*. Domiciliary care includes that provided by the hospital and by home nursing services. Unless a specific service has been arranged, use code X *No referral or support services arranged before discharge*.

Code *not* for use for the baby's Separation Mode: unless a specific service (with another code) has been arranged for the baby, baby's code would be X *No referral or support services arranged before discharge*.

**P *Post Acute Care Program services, arranged before discharge***  
Discharge, with provision of Post Acute Care Program services arranged before discharge to own home or home of relative or friend or other private accommodation\*.

For more information about Post Acute Program Services refer to *Victoria—Public Hospitals and Mental Health Services Policy and Funding Guidelines 2003-2004* and <http://www.health.vic.gov.au/pac/>.

**M Referral to a community rehabilitation centre, arranged before discharge**

Discharge, with referral to community rehabilitation centre (formerly known as day hospital) arranged before discharge to own home or home of relative or friend or other private accommodation\*.

*Excludes:*

- Discharge, with referral to alcohol and drug treatment service (use code L).

**L Referral to alcohol and drug treatment service, arranged before discharge**

Discharge, with referral to alcohol and drug treatment service, arranged before discharge to own home or home of relative or friend or other private accommodation\*.

**B Community palliative care support, arranged before discharge**

Discharge, with community palliative care service support arranged before discharge to own home or home of relative or friend or other private accommodation\*.

**U Home nursing support, arranged before discharge**

Discharge, with home nursing support arranged before discharge to own home or home of relative or friend or other private accommodation\*. Home nursing support includes that provided by the hospital and by district nursing services.

**C Mental health community services, arranged before discharge**

Discharge, with mental health community services arranged before discharge to own home or home of relative or friend or other private accommodation\*.

**S Referral to private psychiatrist, arranged before discharge**

Discharge, with referral to a private psychiatrist arranged before discharge to own home or home of relative or friend or other private accommodation\*.

**D Psychiatric disability support services, arranged before discharge**

Discharge, with referral to psychiatric disability support services arranged before discharge to own home or home of relative or friend or other private accommodation\*.

**G Referral to general practitioner, arranged before discharge**

Discharge, with referral to general practitioner arranged before discharge to own home or home of relative or friend or other private accommodation\*.

**I Home based Interim Care, arranged before discharge**

Discharge, with referral to Home based Interim Care arranged before discharge to own home or home of relative or friend or other private accommodation\*.

Only public hospitals approved to provide Interim Care Programs (Care Types F and E *Interim Care Program*) are permitted to report this code.

**A Referral to Aged Care Assessment Service (ACAS), arranged before discharge**

Discharge, with referral to Aged Care Assessment Service (ACAS) arranged before discharge to own home or home of a relative or friend or other private accommodation.

**K *Referral to Aboriginal and Torres Strait Islander (ATSI) service, arranged before discharge***

Discharge, with referral to an Aboriginal and Torres Strait Islander (ATSI) service arranged before discharge to own home or home of a relative or friend or other private accommodation\*.

*Includes:*

- Services provided by the local Aboriginal co-operative
- Designated Koori HACC services
- Designated Koori Alcohol and Drug Services

**R *Other clinical care and/or support services, arranged before discharge***

Discharge, with other clinical care and support service arranged before discharge to own home or home of relative or friend or other private accommodation\*.

*Includes:*

- Discharge to residential care facility if patient was admitted from a *less* supportive form of accommodation, such as a private home.
- Discharge of newborn to foster care.
- Any service not under the other values for this field (for example, outpatient appointment, specialist appointment, meals on wheels, home maintenance services, private community care and services, community health services, private allied health services, maternal and child health services).

**X *No referral or support services, arranged before discharge***

No referral or support services arranged before discharge to own home or home of relative or friend or other private accommodation\*.

**Notes:**

\*Private accommodation comprises:

- Supported residential facilities, special accommodation houses, half-way houses, training centres for intellectually disabled persons, prisons, prison and armed forces hospitals.

*Includes:*

- A patient treated under the HITH program in private accommodation or residential facility who, on separation, remains in the same private accommodation.
- A newborn discharged with his/her mother.

<i>Edits</i>	108	Fields(s) Missing From Sep
	329	Geri Respite – Invalid Comb
	344	Invalid Comb For Family Choice
	387	Sep Referral Not Left Justified
	388	Sep Referral - Episode Not Separated
	389	Invalid Sep Referral
	394	Sep Mode Home, No Sep Referral
	395	Sep Mode not Home, Sep Referral Present
	396	Sep Referral, No Refer Plus Other Ref
	397	Sep Referral Postnatal, Incompatible Age/ Sex
	398	Sep Referral, Duplicates
	454	Incompat Fields for Interim Care
	462	Incompat ACAS Status and Sep Referral
	471	Care Type 5, not usual Sep Referral
	495	Incompat Sep Referral and Indigenous Status
	###	Sep Referral Interim Care, not approved for Interim Care <i>[Rejection]</i>

*Related items* Section 3: *Separation Mode* on page 3-#.

Section 4:

- Business Rules (tabular) *Account Class: Geriatric Respite, and Care Type: Designated Rehabilitation Program (2, 6, 7 and J), and Care Type: Family Choice, and Care Type: Interim Care Program (F and E).*

## Administration

*Purpose* To monitor discharge planning processes to inform policy and planning.

*Principal data users* Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).

*Collection start* 1999-00 (Formerly a sub-set of Separation Mode)

*Definition source* DHS *Code set source* DHS

## Proposal 15 - Sex

It is proposed to	Add a new code for intersex and provide guidelines for capturing the sex of a person's whose sex may change during their lifetime.
Proposed by	Catherine Perry, Health Data Standards and Systems Department of Human Services Phone: 9616 6928, Email: <a href="mailto:Catherine.Perry@dhs.vic.gov.au">Catherine.Perry@dhs.vic.gov.au</a>
Implementation Date	1 July 2004
Background	The National Health Data Committee (NHDC) has updated the Sex data item in the National Health Data Dictionary to incorporate the concept of "intersex" into the data element, and to provide more appropriate reporting guidelines for capturing the sex of person's whose sex may change during their lifetime.

---

## Sex (Amended)

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### Specification

<i>Definition</i>	The sex of the person.												
<i>Datatype</i>	Numeric	<i>Form</i>	Code										
<i>Field size</i>	1	<i>Layout</i>	N										
<i>Location</i>	Episode Record												
<i>Reported by</i>	All Victorian hospitals (public and private).												
<i>Reported for</i>	All admitted episodes of care.												
<i>Reported when</i>	The Episode Record is reported.												
<i>Code set</i>	<table border="1"><thead><tr><th><i>Code</i></th><th><i>Descriptor</i></th></tr></thead><tbody><tr><td>1</td><td>Male</td></tr><tr><td>2</td><td>Female</td></tr><tr><td>3</td><td>Indeterminate</td></tr><tr><td>4</td><td>Intersex</td></tr></tbody></table>	<i>Code</i>	<i>Descriptor</i>	1	Male	2	Female	3	Indeterminate	4	Intersex		
<i>Code</i>	<i>Descriptor</i>												
1	Male												
2	Female												
3	Indeterminate												
4	Intersex												
<i>Reporting guide</i>	Enumeration of sex should be inferred or accepted as reported by the respondent, as at the time of the admission. That is, it is usually unnecessary and may be inappropriate or even offensive to ask a person their sex. Sex may be inferred from other cues such as observation, relationship to respondent, or first name.												

A person's sex may change during their lifetime as a result of procedures known alternatively as Sex change, Gender reassignment, Transsexual surgery, Transgender reassignment or Sexual reassignment. Throughout this process, which may be over a considerable period of time, sex could be recorded as either Male or Female.

In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate

ICD-10-AM code(s) that clearly identify that the person is undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (for example, where the patient has prostate or ovarian cancer).

Codes 3 and 4 should not generally be used on data collection forms completed by the respondent. It should only be used if the person or respondent volunteers that the person is intersex or where it otherwise becomes clear during the collection process that the individual is neither male nor female. For infants with ambiguous sexual genitalia, the biological sex as determined at birth, possibly following genetic testing, is recorded. Only where this cannot be determined during the episode of care should 'Indeterminate' be assigned.

<b>Edits</b>	033 Invalid Sex
	059 Maternity - Not Female
	080 Sex Indeterminate, age < 90 days
	127 Nil Value DRG
	160 AR- DRG Grouper GST Code>Zero
	215 Sex Indeterminate But Age>= 90 days [ <i>Changed to become Notifiable</i> ]
	354 Code & Sex Incompatible
	397 Sep Referral Postnatal, Incompat Age/Sex
	450 Code Incompatible W Female Sex
	451 Code Incompat W Male Sex
	### Sex Code Intersex [ <i>Notifiable</i> ]

**Related items** Section 2: *Age and DRG Classification*.

- Section 4:
- Business Rules (non-tabular) *DRG Classification*.

## Administration

**Purpose** To enable:

- Analyses of service utilisation, need for services and epidemiological studies.
- Verification of other fields (such as diagnosis and procedure codes) for consistency.
- To assist in the allocation of DRGs.

**Principal data users** Multiple internal and external research users.

**Collection start** 1979-80

**Definition source** ABS **Code set source** NHDD (DHS modified).

# Changes in Record Structures

## Header Record (H2)

## Header Record (*Amended*)

### Header Record File Structure

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	H2
M	Hospital Code	3	3	A/N	NNN
M	Start Date	8	6	N	DDMMCCYY
M	End Date	8	14	N	DDMMCCYY
±	Number of Available Beds Filler	4	22	N	NNNN Spaces
	Reporting Option	1	26	A/N	Space, 0, 1, 2
	Filler	2	27	A/N	Spaces
	<i>Report Requests</i>				Refer to Section 6
	1 <sup>st</sup> request				
	Report Code	2	29	A/N	
	Report Parameter	12	31	A/N	
	2 <sup>nd</sup> request				
	Report Code	2	43	A/N	
	Report Parameter	12	45	A/N	
	3 <sup>rd</sup> request				
	Report Code	2	57	A/N	
	Report Parameter	12	59	A/N	
	4 <sup>th</sup> request				
	Report Code	2	71	A/N	
	Report Parameter	12	73	A/N	
	5 <sup>th</sup> request				
	Report Code	2	85	A/N	
	Report Parameter	12	87	A/N	
	Filler	139	99	A/N	Spaces
	Software Version/Edition Identifier	3	238	A/N	Optional field, free text, or spaces
		Total 240			

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

M Mandatory

± Mandatory in transmissions with end of month file date

*Reported by* All Victorian hospitals (public and private).

*Reported for* All PRS/2 data transmissions.

*Reported when* A file is transmitted to PRS/2.

*Reporting guide*

**General**

The Header Record identifies the source of the PRS/2 transmission file, the period of time the file relates to, and facilitates report requests.

**Data Items**

**Transaction Type**

The value identifying the Header Record is 'H2'.

**Hospital Code**

The Hospital Code for this hospital. HDSS will advise new hospitals of their code.

**Start Date**

A valid date, one day greater than the End Date in the Header Record of the previous transmission (except where the transmission has the same Start and End Dates as the previous transmission).

**End Date**

A valid date greater than this Header Record's Start Date but less than, or equal to, the end of month date (being the last day of the month of the Header Record's Start Date).

~~**Number of Available Beds**~~

~~For each end of month transmission, report the average number of available beds during the month (including weekends and public holidays), calculated as the sum of the available beds on each day of the month, divided by the number of days in the month.~~

~~The available beds on each day are calculated by adding together the occupied beds at midnight, unoccupied but staffed beds at midnight, and day procedure beds that were staffed and available that day.~~

~~This statistic is not altered by the reporting arrangements for contracted services: neither hospital (Hospital A nor Hospital B) in a contract service arrangement should adjust this calculation to include (exclude) beds purchased (sold) under contracted arrangements.~~

**Reporting Option**

Select the format you wish for the Transmission Control and Reconciliation Report for this transmission.

Report your choice in this field as follows:

- 0 Full transaction trail
- 1 Warnings/rejections only
- 2 Edit messages, then full (accepted) transaction trail

It is strongly recommended that one of the two full transaction trail reporting options (either 0 or 2), be selected. Option 0 is printed if this field is left blank.

**Filler**

Spaces must be reported in this field (field not presently in use).

**Report Requests**

Up to five Request Reports may be ordered in the Header Record. Refer to Section 6 for details on ordering these reports.

**Filler**

Spaces must be reported in this field (field not presently in use).

**Software Version/Edition Number**

Report the version/edition of software being used by this hospital. Otherwise report spaces.

## Episode Record (E2)

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## Episode Record (*Amended*)

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### Episode Record File Structure

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	E2
M	Unique Key	6	3	A/N	Hospital-generated
M	Patient Identifier Filler	8	9	A/N	Hospital-generated Right justified, zero filled Spaces
M	Site Identifier	1	17	A/N	0, 1, 2, 3, 4, 5, 6, 7, 8, 9
M	Medicare Number	11	18	N	NNNNNNNNNNNN or spaces
M	Medicare Suffix	3	29	A/N	AAA or A-A
M	Sex	1	32	A/N	1, 2, 3, 4
M	Marital Status	1	33	A/N	1, 2, 3, 4, 5, 6
M	Date of Birth	8	34	N	DDMMCCYY
M	Postcode	4	42	N	NNNN Refer to Section 3
M	Locality	22	46	A/N	Refer to Section 3
M	Admission Date	8	68	N	DDMMCCYY
M	Admission Time	4	76	N	HHMM
M	Admission Type	1	80	A/N	S, Y, M, C, L, O, X
M	Admission Source	1	81	A/N	S, Y, T, N, A, H
1	Transfer Source	4	82	A/N	NNNN or spaces Refer to Section 3
	<del>Normal</del> Other Leave Days MTD	2	86	N	NN or spaces
	<del>Normal</del> Other Leave Days Financial YTD	3	88	N	NNN or spaces
	<del>Normal</del> Other Leave Days Total	3	91	N	NNN or spaces
	Status Segment Occurs 7 times				
2	Account Class	2	94, 107, 120, 133, 146, 159, 172	A/N	AA or AN Refer to Field specification
2	Accommodation Type	1	96, 109, 122, 135, 148, 161, 174	A/N	1, 2, 3, 4, 6, 7, 8, B, C, M, S
2	Qualification Status	1	97, 110, 123, 136, 149, 162, 175	A/N	N, U, X

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
2	Patient Days MTD	2	98, 111, 124, 137, 150, 163, 176	N	Must be present if other Status details are present
2	Patient Days Financial YTD	3	100, 113, 126, 139, 152, 165, 178	N	Must be present if other Status details are present
2	Patient Days Total	4	103, 116, 129, 142, 155, 168, 181	N	Must be present if other Status details are present
3	Separation Date	8	185	N	DDMMCCYY
3	Separation Time	4	193	N	HHMM
3	Separation Mode	1	197	A/N	S, D, Z, T, N, A, H
1	Transfer Destination	4	198	A/N	NNNN or spaces Refer to Section 3
4	Separation Referral	4	202	A/N	F, P, M, <u>L</u> , B, U, C, S, D, G, <u>I</u> , A, K, R, X or spaces Left justified, trailing spaces
5	Carer Availability	1	206	A/N	1, 2, 3, 4, 5, 6, 7, 8 or space
3	Account Class on Separation	2	207	A/N	AA or AN Refer to Field specification
3	Accommodation Type on Separation	1	209	A/N	1, 2, 3, 4, 6, 7, 8, B, C, M, S
M	Care Type	1	210	A/N	0, 1, 2, 3, 4, <u>P</u> , <u>M</u> , 5, 6, 7, 8, 9, U, F, E, J
M	Country of Birth	4	211	A/N	NNNN Refer to Section 3
M	Indigenous Status	1	215	A/N	2, 5, 6, 7
M 6	Criterion for Admission	1	216	A/N	B, C, N, U, O, <u>E</u> , S
M	Intended Duration of Stay	1	217	A/N	1, 2
M	Health Insurance Fund	3	218	A/N	Refer to Section 3
M	Level of Insurance	1	221	A/N	1, 3, 8, 6, 9
3	Mental Health Legal Status	1	222	A/N	1, 2, 9
11	Filler	1	223	A/N	Space
7	Funding Arrangement	1	224	A/N	1, 2, 3, 4, 5, 6 or space
8	Contract Type	1	225	A/N	1, 2, 3, 4, 5, 6, 7 or space
8	Contract Role	1	226	A/N	A, B or space
9	Contract/Spoke Identifier	4	227	A/N	NNNN or spaces Refer to Section 3
10	Contract Leave Days - MTD	2	231	N	NN or spaces
10	Contract Leave Days - Financial YTD	2	233	N	NN or spaces
10	Contract Leave Days - Total	2	235	N	NN or spaces
	User Flag	1	237	A/N	Optional field, free text
12	Preferred Language	2	238	N	NN Refer to Section 3
12	Interpreter Required	1	240	N	N Refer to Section 3

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
13 14	ACAS Status	1	241	N	N or space Refer to Section 3
M	Patient Identifier	10	243	A/N	Hospital generated Right justified, zero filled
15	HARP Patient Flag	1	244	A/N	A or space
16	Mental Health Statewide Patient Identifier	8	245	A/N	NNNNNNNN or spaces Refer to Section 3
		Total 241 252			

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

M Mandatory

- 1 Transfer Source: Mandatory if Admission Source = T, else spaces. Transfer Destination: Mandatory if Separation Mode = T, else spaces.
- 2 Mandatory in first Status Segment. In any subsequent Status Segment, if any field is present, then all fields for that segment must be present.
- 3 Mandatory but transmit only when Separation Date is transmitted.
- 4 Mandatory for public hospital if Separation Mode = H but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.
- 5 Carer Availability: Mandatory for public hospitals when Care Type is 1, 2, 6, 7, J, 8, 9, F or E but transmit only when Separation Date is transmitted, else spaces. Private hospitals report a space.
- 6 Criterion for Admission: Code S only for use by Early Parenting Centres.
- 7 Mandatory for all hospitals involved in contracted care and hub and spoke arrangements, ~~or the Healthstreams Program~~, else space.
- 8 Mandatory for all hospitals involved in contracted care arrangements, else space.
- 9 Mandatory for all hospitals involved in contracted care or Hub and Spoke (only Hub reports) arrangements, else spaces.
- 10 Mandatory for contracting hospitals, in specific instances. Refer to Section 3.
- 11 Must be spaces.
- 12 Mandatory for all public hospitals. Private hospitals report codes or spaces.
- 13 Mandatory for public hospitals when Care Type is 1, 2, 4, 6, 7, J, 8, 9, F or E, and patient age is greater than or equal to 50, and where the episode is not a sameday episode, but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.
- 14 Where a field at the end of a record has a value of space, the record can be ended at the last field where a value is not space(s).

15 Mandatory for all public hospitals participating in Hospital Admissions Risk Program (HARP).
---

16 Mandatory for all public hospitals with an approved Mental Health Service when Care Type is P, M or 5.
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## Diagnosis Record (X2)

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## Diagnosis Record (*Amended*)

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### Diagnosis Record 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 3 <sup>rd</sup> -4 <sup>th</sup> edition Each left justified, trailing spaces
2	Procedure Code x 12 - each code	8 (8 x 12)	105	A/N	ICD-10-AM 3 <sup>rd</sup> -4 <sup>th</sup> 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
10	User Flag	1	206	A/N	Optional field, free text
4 10	Duration of Stay in Intensive Care Unit	4	207	N	0000 <sub>1</sub> to 9999 or spaces
5 10	Duration of Mechanical Ventilation in ICU	4	211	N	0000 <sub>1</sub> to 9999 or spaces
6 10	Hospital Generated DRG	4	215	A/N	ANNA or NNNA or spaces
7 10	Duration of Stay in Coronary/Cardiac Care Unit	4	219	N	0000 <sub>1</sub> to 9999 or spaces
8 10	Reason for Critical Care Transfer	1	223	A/N	X, E, J, W, Y, F, K, Z or space
9 10	Duration of Non-Invasive Ventilation	4	224	N	0000 <sub>1</sub> to 9999 or spaces
10	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 occurring in the contracted hospital when reported by the *contracting* hospital, else space.

3 Mandatory if patient aged <1 year at admission, else spaces.

4 Mandatory for patients cared for in an ICU listed in Section 9, 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 Section 9, 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 Section 9, 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 Section 3, else space.
- 9 Mandatory for all patients who receive non-invasive ventilation (NIV) in a public hospital NICU and/or SCN as listed in Section 9, and by hospitals that have contracted services from those listed hospitals, else spaces. Includes public contracted episodes. Optional for patients treated in private hospitals who received NIV in a SCN; and for patients treated in public or private hospitals who receive NIV in an ICU listed in Section 9, and by hospitals that have contracted services from those listed hospitals, else spaces.
- 10 Where a field at the end of a record has a value of space(s), the record can be ended at the last field where a value is not space(s). Additionally, where there are filler spaces at the end of the record, hospitals have the option of removing the 'filler' spaces from the file.

## Extra Diagnosis Record (Y2)

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## Extra Diagnosis Record (*Amended*)

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### Extra Diagnosis Record File Structure

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	Y2
M	Unique Key	6	3	A/N	Hospital generated
	Diagnosis Code (13 to 25)	8 (8 x 13)	9	A/N	ICD-10-AM 3 <sup>rd</sup> -4 <sup>th</sup> edition Each left justified and with trailing spaces
1 2	Procedure Code (13 to 25)	8 (8 x 13)	113	A/N	ICD-10-AM 3 <sup>rd</sup> -4 <sup>th</sup> edition Each left justified and with trailing spaces
2	Diagnosis Code (26 to 40)	8 (8 x 15)	217	A/N	ICD-10-AM 3 <sup>rd</sup> -4 <sup>th</sup> edition Each left justified and with trailing spaces
1 2	Procedure Code (26 to 40)	8 (8 x 15)	337	A/N	ICD-10-AM 3 <sup>rd</sup> -4 <sup>th</sup> edition Each left justified and with trailing spaces
		Total 456			

M Mandatory

- 1 Eighth character is F or N for procedures occurring in the contracted hospital when reported by the *contracting* hospital, else space.
- 2 Where a field at the end of a record has a value of space(s), the record can be ended at the last field where a value is not space(s). Additionally, where there are filler spaces at the end of the record, hospitals have the option of removing the 'filler' spaces from the file.

## Sub-Acute Record (S2)

# Sub-Acute Record File Structure (*Amended*)

### Sub-Acute Record File Structure

Note	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 Filler	8	9	A/N	Hospital generated Right justified, zero filled Spaces
1, 2, 4	Barthel Index Score on Admission	3	17	A/N	Range 000 to 100 or spaces
1, 2, 4	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
5	User Flag	1	35	A/N	Optional field, free text
5	Filler	2	36	A/N	Spaces
3 5	RUG ADL on Admission	2	38	A/N	Range 00 to 18 or spaces
3 5	RUG ADL on Separation	2	40	A/N	Range 00 to 18 or spaces
3 5	Source of Referral to Palliative Care	2	42	A/N	Range 01 to 09 or spaces
M	Patient Identifier	10	44	A/N	Hospital generated Right justified, zero filled
5	Filler	197 187	44 54	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, 7 or J *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 = F or E *Interim Care Program*

5 Where a field at the end of a record has a value of space(s), the record can be ended at the last field where a value is not space(s). Additionally, where there are filler spaces at the end of the record, hospitals have the option of removing the 'filler' spaces from the file.

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

**Reported for** Care Types F, E, 2, 6, 7, J, 8, and 9 only.

**Reported when** A Separation Date is reported in the Episode Record.  
 Refer to: 'Data Transmission Scheduling', page 5-#.

**Reporting guide** General  
 The data items collected (marked with an \* in the table below) in the Sub-Acute Record are needed for the support and further development of casemix classifications for sub-acute patients.

Field	Rehab Care Type 2, 6, 7 or J	Palliative Care Type 8	GEM Care Type 9	Interim Care Type F, E
Transaction Type	S2	S2	S2	S2
Unique Key	*	*	*	*
Patient Identifier	*	*	*	*
Barthel Index Score on Adm	*	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 on Separation	Spaces	*	Spaces	Spaces
Source of Referral to Palliative Care	Spaces	*	Spaces	Spaces

**Correction**

To correct a Sub-Acute Record, re-transmit the entire Sub-Acute Record, including the corrections. This will overwrite the existing record held by PRS/2.

Re-transmitting the Sub-Acute Record causes the Episode Record to be re-edited.

**Deletion**

To delete a Sub-Acute Record, re-transmit Sub-Acute Record containing all 9s in the Clinical Sub-Program.

If an Episode Record is deleted, the Sub-Acute Record will automatically be deleted. Re-transmitting the Episode Record alone will not re-generate the Sub-Acute Record; the Sub-Acute Record must also be re-transmitted.

A record can be deleted and re-transmitted in the same transmission so long as the hospital sequences the deletion first.

**Data Items**

**Transaction Type**

The value identifying the Sub-Acute Record is 'S2'.

**User Flag**

This field has been added at the suggestion of a software supplier. Hospitals can use the field for data management purposes, perhaps to flag certain types of records, such as corrections.

The content of this field will be printed in PRS/2 Control Reports, when and where the Sub-Acute Record is printed.

Filler

Spaces must be reported in this field (field not presently in use).

## DVA and TAC Record (V2)

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## DVA and TAC Record (*Amended*)

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### DVA and TAC Record 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 Filler	8	9	A/N	Hospital generated Right justified, zero filled Spaces
M	DVA ID / TAC Claim Number	9	17	A/N	Refer to Section 3
M	Surname Filler	20	26	A/N	Refer to Section 3 Spaces
M	Given Name(s) Filler	12	46	A/N	Refer to Section 3 Spaces
1	Admission Date	8	58	N	DDMMCCYY
1	Separation Date	8	66	N	DDMMCCYY
2 3	Date of Accident	8	74	N	DDMMCCYY or spaces
3	User Flag	1	82	A/N	Optional field, free text or space
M	Patient Identifier	10	83	A/N	Hospital generated Right justified, zero filled
M	Surname	25	93	A/N	Refer to Section 3
M	Given Name	15	118	A/N	Refer to Section 3
3	Filler	158 108	83 133	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 This date cannot be later than the Admission Date. Mandatory if Account Class = T- TAC, else spaces.

3 Where a field at the end of a record has a value of space(s), the record can be ended at the last field where a value is not space(s). Additionally, where there are filler spaces at the end of the record, hospitals have the option of removing the 'filler' spaces from the file.

## Other proposed changes

### Proposal 16 - Admission Policy

<b>It is proposed to</b>	<p>Change the scope of the VAED to:</p> <ul style="list-style-type: none"><li>• Include all Secure Extended Care episodes (currently only some in the State are being reported), and episodes from Forensic Care.</li></ul> <p>Clarify the reporting guidelines for Medi-Hotel.</p>
<b>Proposed by</b>	<p>Catherine Perry, Health Data Standards and Systems Department of Human Services Phone: 9616 6928, Email: <a href="mailto:Catherine.Perry@dhs.vic.gov.au">Catherine.Perry@dhs.vic.gov.au</a></p>
<b>Implementation Date</b>	<p>1 July 2004</p>
<b>Background</b>	<p>In August 2003 an updated <i>DHS Hospital Admission Policy 2003-04</i> (available at: <a href="http://hdss.health.vic.gov.au/">http://hdss.health.vic.gov.au/</a>) was released. Although this should not have resulted in any changes in practice in hospitals, it is clear that this is the case in many organisations.</p> <p>Further review of the DHS Admission Policy is currently being undertaken. This is taking into consideration many variables including the Australian Health Care Agreement (AHCA), Commonwealth guidelines, National reporting requirements, and funding implications at a State and Health Service level.</p> <p>Comments relating to <i>DHS Hospital Admission Policy 2003-04</i>, or any other matter relating to Hospitals Admissions, should be forwarded for consideration.</p>

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# Medi-Hotel Business Rule (*Amended*)

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**Guide for use** The following guidelines shall be met when reporting Medi-hotel admitted episodes:

1. Where the use of the Medi-hotel involves care/service/treatment during the day that resembles traditional admitted care, the patient should be admitted.
2. For Medi-hotel, movement between ward accommodation and the Medi-hotel accommodation is reported in the Status Segments within the same episode, excluding notes listed in 4. The Accommodation Type shown for each patient day shall be:
  - 1 *Overnight accommodation: shared room* or 2 *Overnight accommodation: single room* where the patient remains in a traditional hospital setting at midnight;
  - 7 *Ward Based/Medi-Hotel combination* when a patient is in a traditional hospital setting during the day and in a Medi-hotel at midnight.

For example, where a patient is admitted to a shared hospital ward on the 1 July 2003, moves to the Medi-hotel at 1700 on the 4 July 2003, and returns to the traditional hospital setting at 0900 on the 5 July 2003 where they are discharged at 1600, the Accommodation Type for the first three patient days is 2 *Overnight accommodation: single room*; and the Accommodation Type for the last patient day is 7 *Ward Based/Medi-Hotel combination*.

3. The use of Medi-hotel should be recorded as leave in the following circumstances:
  - Where the patient receives two or more consecutive days of non-admitted services (not a substitute for traditional admitted care), with an intervening night in the Medi-hotel, and the patient receives admitted patient care both directly before and after this period.
  - Where the patient receives no care for two to seven consecutive days, with an intervening night(s) in the Medi-hotel, and the patient receives admitted patient care both directly before and after this period.
4. The use of Medi-hotel should not be recorded as part of an admitted episode in the following circumstances:
  - Where the patient is receiving only non-admitted services on the first day(s), or no services (for example, a night in Medi-hotel to facilitate an 07:00 Admission Time), the patient should be admitted on the day they first received admitted services.
  - Where the patient is receiving only non-admitted services on the last day(s), the patient should be separated at the time they left the admitted services area (to go to the Medi-hotel).

Hospitals, for their own purposes, may wish to record these times in their in-house systems: if so, the hospital's interface must identify and exclude these times from transmission to the VAED.

**Refer to:**

- Section 2: *Criteria for Admission, Hospital in the Home, Medi-Hotel and Patient Day.*
- Section 3: *Accommodation Type.*

## Proposal 17 - PRS/2 Electronic Reports

<b>It is proposed to</b>	Create an option for sites to receive PRS/2 Control Reports electronically.
<b>Proposed by</b>	<b>Sofie Ioannidis, Manager, Decision Support &amp; Casemix Analysis Unit</b> Mercy Hospital for Women Phone: 9270 2474, Email: <a href="mailto:SIoannidis@mercy.com.au">SIoannidis@mercy.com.au</a>
<b>Implementation Date</b>	1 July 2004
<b>Background</b>	<p>The current process of receiving PRS/2 reports in a paper-based format does not enable sites to effectively utilise this data.</p> <p>The advantages in receiving electronic PRS/2 reports particularly relate to the ability to manipulate and analyse data specifically to the site requirements and needs. Such uses of the data include:</p> <ul style="list-style-type: none"><li>• Reconciliation with electronic data provided by the DHS Performance Reporting &amp; Analysis Unit;</li><li>• Identification of particular trends and areas of concern, such as WIES variances;</li><li>• Clinical costing; and</li><li>• Enhanced identification and analysis of PRS/2 edit messages</li></ul> <p>In addition, electronic reports provide the added bonus of saving considerable amounts of paper.</p> <p>It is proposed that the current data provided in the PRS/2 paper based reports be issued to sites electronically in a file format suitable for sites to effectively utilise. It is proposed that this feature is optional, and sites still retain the choice to receive their reports in the current paper based format.</p>