

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

March 2004

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# Executive Summary

The PRS/2 transmission specification for 2004–05 comprises the *VAED Manual, 13<sup>th</sup> Edition, 1 July 2003* and edit changes notified in HDSS Bulletins 63 onwards, together with amendments detailed in this document and the Appendices to be released at a later time.

For 2004-05 there are five new fields and some important enhancements have been made to existing data items. However many of the changes listed in this document do not modify the “content”, but are merely name, reference, or format changes.

## ICD-10-AM New Edition

ICD-10-AM Fourth Edition will supersede ICD-10-AM Third Edition, effective from 1 July 2004. This biannual update ensures clinical currency and enables Victoria to meet national reporting requirements. Minor reference changes to reflect this upgrade have been made to data items *Diagnosis Codes* and *Procedure Codes*.

## Leave

To ensure congruency between the VAED and the CMI/ODS for Mental Health patients, and to allow absconded patients to be reported in the same way across all Care Types, the following enhancements have been made:

- Three new data items have been introduced - *Leave Without Permission Days (Financial Year-To-Date, Month-To-Date, Total)*.
- Three existing data items have been renamed from *Leave [Normal] Days (Financial Year-To-Date, Month-To-Date, Total)* to *Leave With Permission Days (Financial Year-To-Date, Month-To-Date, Total)*.

To reflect the addition and modification of the above data items:

- Minor reference changes have been made to data items *Patient Days (Financial Year-To-Date, Month-To-Date, Total)*, concept definitions *Leave Without Permission* and *Length of Stay*, and business rule *Length of Stay*.
- Concept definition *Leave [Normal]* has been renamed to *Leave With Permission*.

## Locality/Postcode

To ensure the patient's country of residence is captured for overseas residents, and to achieve an exact match between locality and postcode for interstate residents:

- Business rule (non-tabular) *Locality/Postcode* has been modified accordingly.
- Reporting guides and code sets have been modified accordingly for data items *Locality* and *Postcode*.

## Mental Health

- To enable Mental Health outcome measures to be appended onto a VAED extract, which will form the basis for submissions to the Commonwealth NMDS and NOCC, a new data item, *Mental Health Statewide Patient Identifier* has been introduced.
- To enable the identification of Mental Health specific programs, and Acute, Nursing Home Type and Sub-Acute patient days, additional *Care Type* codes have been added and the field size has been lengthened.

## Rehabilitation Care

To enable the identification of patients admitted to a public hospital with a non-designated rehabilitation program:

- Concept definition *Rehabilitation Care* has been modified.
- A new code has been added to the *Care Type* data item.

### Other Amended Data Items

- To enable the identification of same day admissions justified by extended medical treatment only, a new code has been added to the *Criterion For Admission* code set. The hierarchy has also been amended in this data item.
- To enable identification of patients discharged to Home based Interim Care and Alcohol and Drug Treatment Services, two new codes have been added to the *Separation Referral* code set.
- The *Sex* data item has been updated, in line with changes for the NHDD 13<sup>th</sup> Edition. The data item contains enhanced guidelines for capturing the sex of a person and a new code has been added for patients who identify as Intersex.
- The code to capture the superseded Healthstreams Program has been deleted in *Funding Arrangement*.
- To meet system and matching requirements for DVA and TAC, field sizes for *Given Name* and *Surname* have been lengthened.
- To achieve congruency between the VAED, VEMD and ESIS collections, field sizes for *Patient Identifier* and *Unique Key* have been lengthened. In addition, the lengthening of *Unique Key* will accommodate sites that have greater than 999,999 admitted episodes.
- To enable unique identification of concepts and in accordance with advice received from the Private Health Insurance Administration Council, the *Health Insurance Fund* code set has been revised slightly.
- In line with reporting guides, the valid minimum reporting values have been modified for *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*.

### Amended File Structures

- The *Number of Available Beds* field has been deleted from the Header Record (H2), as it is collected via AIMS.
- To enable electronically connected hospitals to receive their PRS/2 reports electronically, two new fields have been added to the Header Record (H2), *Reporting Type Control* and *Reporting Type Request*.
- To enable hospitals to order up to six Request Reports, two new fields have been added to the Header Record (H2), *6<sup>th</sup> Request - Report Code* and *Report Parameter*.
- All fillers have been removed from all record file structures, resulting in the position of certain data items altering.
- File structures have been modified accordingly to accommodate new, modified and deleted data items, modified code sets and field sizes, data item name and reference changes, removal of filler records and relocation of record positions.

### Reference Files

Information is provided for:

- Coding Classification and Grouper Versions.
- Hospital Code Table.
- ICD-10-AM Library File.
- Postcode/Locality/SLA File.
- Preferred Language.

### End of Financial Year Consideration

Information is provided in relation to:

- Method for Reporting 'Remaining Ins' on 30 June 2004.
- Test Transmissions of New 1 July 2004 Software.

Edits and edit tables will be revised according to the changes listed above, as well as for other data quality and reporting purposes. These are presented in Appendix A, which is a separate document, and will be issued at a later date.

# Introduction

## The need for PRS/2 interface modifications

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From 1 July 2004, changes to the Victorian Admitted Episodes Dataset (VAED) are necessary to assist Victorian health program monitoring, planning and policy development by the Department of Human Services (DHS).

Comments from hospitals and software suppliers regarding the content of the document *Proposals for Revisions to PRS/2 and the VAED, November 2003* have been taken into account and where possible, suggestions have been accommodated.

## Distribution and components of this document

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This document has been distributed to all Victorian hospitals, software suppliers known to have Victorian clients, and to a range of industry bodies and DHS staff. It provides the following information:

- Amended, deleted and new concept definitions, data items and business rules
- Amended file structures
- Reference files to be updated for 1 July 2004
- End of Financial Year Consideration

An additional document will be released in April 2004, *Specification for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2004, Appendix A*, that will include new, amended and deleted edits and edit tables.

The *VAED Manual, 14<sup>th</sup> Edition, July 2004* will be distributed at a later date. Until then, the *VAED Manual, 13<sup>th</sup> Edition, July 2003* (as amended by HDSS Bulletins 63 onwards) together with this document, and Appendix A, will form the admitted patient data transmission specification for 2004–05.

Victorian hospitals are required to arrange for their software to be modified in accordance with the revised specifications.

The current *VAED Manual, 13<sup>th</sup> Edition, July 2003* may be accessed on the Internet at <http://hdss.health.vic.gov.au/vaed/index.htm>.

Any questions related to this document may be directed to the HDSS Help Desk on 9616 8141, or [PRS2.Help-Desk@dhs.vic.gov.au](mailto:PRS2.Help-Desk@dhs.vic.gov.au).

## Orientation to this document

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

- New values and definitions relating to *existing* items appear in boxes. Where the entire concept definition or data item is new this will appear in the normal layout without the boxes.
- ~~Redundant values and definitions relating to existing items are struck through.~~
- *[Comments relating to the specification document only appear in square brackets and italics.]*
- Page numbers representing cross referencing to another section of the *VAED Manual* that are not represented in this document 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 specification is provided.
- New edits can be identified in this document by the three hash symbols printed to the left of the edit descriptor. Amended edits can be identified by the asterisk printed beside the relevant edit number and descriptor. New and amended edits will be detailed in Appendix A, which is to be released separately.

## Abbreviations

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ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
AIMS	Agency Information Management System
AR-DRG	Australian Refined Diagnosis Related Group
ASCCSS	Australian Standard Classification of Countries for Social Statistics
ATSI	Aboriginal and Torres Strait Islanders
BiPAP	Bi-level Positive Airway Pressure
CCU	Coronary/Cardiac Care Unit
CMI	Client Management Interface
CPAP	Continuous Positive Airway Pressure
DHS	Department of Human Services
DRG	Diagnosis Related Group
DVA	Department of Veteran Affairs
ESAS	Elective Surgery Access Service
ESIS	Elective Surgery Information Systems
GEM	Geriatric Evaluation and Management
HDSS	Health Data Standards and Systems
HITH	Hospital In The Home
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive Care Unit
IMV	Intermittent Mandatory Ventilation
MHSW PI	Mental Health Statewide Patient Identifier
MTD	Month To Date
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
RITH	Rehabilitation In The Home
SCN	Special Care Nursery
TAC	Transport Accident Commission
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
YTD	Year To Date

## Symbols

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

# Amended Concept Definitions

## Leave Related

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### Leave ~~With Permission~~ ~~[Normal]~~ (Amended)

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**Revision Summary** To rename [Normal] Leave to Leave With Permission.

**Definition**

~~[Normal]~~ Leave with permission occurs when an overnight or multi-day patient leaves the hospital temporarily with the approval of the hospital and/or treating medical practitioner, with the intention that the patient will return within seven days to continue the current treatment.

Leave with permission excludes Contract Leave.

**Guide for use**

No patient day charges are raised, nor patient days counted, while the patient is on ~~[normal]~~ leave with permission.

*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]~~ leave with permission 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.

Unless the patient is on contract or ~~normal~~ leave with permission, 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]~~ leave with permission 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~~ leave ~~with permission~~ 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 Hospital in the Home patient does not receive any admitted type services on a particular date, this day should be recorded as a ~~normal~~ leave ~~with permission~~ day.

Newborns are not permitted to go on ~~normal~~ 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 2-5, *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: *Leave With Permission Days Financial Year-To-Date* ~~Normal~~, *Leave With Permission Days Month-To-Date* ~~Normal~~, and *Leave With Permission Days Total* ~~Normal~~.

---

## Leave Without Permission (*Amended*)

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<b>Revision Summary</b>	To add a change for the reporting guidelines for involuntary Mental Health patients.
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**Definition** Where a patient absconds or leaves against medical advice.

**Guide for use** As it is still the intention of the medical practitioner that the patient return within seven days to continue the current treatment, follow ~~normal~~ leave ~~with permission~~ guidelines and reporting. 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).

**Refer to:**

- Section 2: *Length of Stay* page 2-5, *Leave* ~~Normal~~ ~~With Permission~~ page 2-#, *Overnight or Multi-day Stay Patient* page 2-#, *Same Day Patient* page 2-#.
- Section 3: *Admission Date*, *Patient Days Financial Year-To-Date*, *Patient Days Month-To-Date*, *Patient Days Total*, and *Separation Date*.
- Section 4: Business Rules (non-tabular) *Contracted Care* and *Length of Stay*.

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## Length of Stay (*Amended*)

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<b>Revision Summary</b> To rename [Normal] Leave to Leave With Permission.
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**Definition**

The length of stay of an admitted patient is measured in patient days. A same day patient should be allocated a length of stay of one patient day. The length of stay of an overnight or multi-day stay patient is calculated by subtracting the Admission Date from the Separation Date and deducting total ~~[normal]~~ leave ~~with and~~ ~~without permission~~ days. Total contracted patient days are included in length of stay.

**Refer to:**

- Section 2: *Leave - Contract* page 2-#, *Leave* ~~[Normal]~~ *With Permission* page 2-3, *Leave Without Permission* page 2-4, *Overnight or Multi-day Stay Patient* page 2-#, and *Same Day Patient* page 2-#.
- Section 3: *Admission Date*, *Patient Days Financial Year-To-Date*, *Patient Days Month-To-Date*, *Patient Days Total*, and *Separation Date*.
- Section 4: Business Rules (non-tabular) *Contracted Care* and *Length of Stay*.

## Rehabilitation Care (*Amended*)

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<b>Revision Summary</b>	To add a new type of rehabilitation care for public hospitals with non-designated Rehabilitation Programs/Units.
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**Definition** Care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by periodic assessment using a recognised functional assessment measure.

**Guide for use** The DHS Rehabilitation Program excludes Nursing Home Type/Non-Acute patients and Geriatric Evaluation and Management patients.

The Department defines three levels of designated rehabilitation programs. The RITH service provides continuation of these three levels, rather than an additional level. In addition to the three levels, rehabilitation may be provided in a non-designated rehabilitation program serving a specified geographical area.

### **Level 1**

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

### **Level 2**

Care in a public or private hospital in a designated Level 2 Rehabilitation Program/Unit. Level 2 are rehabilitation programs that fully meet the criteria for designation as set out in the document Designation of Rehabilitation Programs, November 1993.

### **Level 3**

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

### **Non-Designated**

Care in a public hospital in a non-designated Rehabilitation Program/ Unit. Non-Designated rehabilitation programs are where services are provided on the basis that rehabilitation type care is being delivered in a geographical area requiring the provision of such a service and where the agency is currently not seeking formal designation as a rehabilitation program. This rehabilitation type care is being delivered out of WIES funding.

**Refer to:**

- Section 2: *Rehabilitation in the Home*, and *Sub-Acute Care* page.
- Section 3: *Care Type* and *Clinical Sub-Program*.
- Section 4: Business Rules (non-tabular) *Rehabilitation in the Home*.
- Section 4: Business Rules (tabular) *Care Type 2, 6, 7, ~~or J~~ or K: Designated Rehabilitation Programs*.
- Section 5: *Sub-Acute Record*.
- Section 9: Code Lists: Hospitals *Care Type 2, 6, 7 or J: Designated Rehabilitation Programs* and *Care Type K: Non-Designated Rehabilitation Program*.

# Amended/New Data Items

## Care Type

### **Background**

Currently it is not possible to identify Mental Health related patient days as either:

- Acute types of care
- Nursing Home Type
- Sub-Acute Secure Extended Care

The Care Type codeset has been lengthened from one to two characters to enable identification of these patient days and specific programs under Care Type 5x *Approved Mental Health Service or Psychogeriatric Program*.

A new code has also been added to the Care Type codeset to enable the identification of non-designated rehabilitation programs provided in a specified geographical area. This type of care is not currently formally designated as a rehabilitation program, and episodes are WIES funded.

This new type of care is currently a pilot rehabilitation program and is only for use by Western District Health Service and Portland District Health.

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## Care Type (*Amended*)

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<b>Revision Summary</b>	Lengthen the Care Type field size to accommodate the expansion of Mental Health related codes.  Add a new code to the codeset to capture episodes admitted to a non-designated rehabilitation program/unit.
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### **Specification**

<b>Definition</b>	The nature of the clinical service provided to an admitted patient during an episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	4 2	<b>Layout</b>	AA or NN or NA Left justified, trailing spaces.
<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:

<b>Code</b>	<b>Descriptor</b>
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
K	Non-Designated Rehabilitation Program/Unit
8	Palliative Care Program
5	<del>Approved Mental Health Service or Psychogeriatric Program</del>
5x	Approved Mental Health Service or Psychogeriatric Program: <ul style="list-style-type: none"> <li>• 5E – Mental Health Secure Extended Care Unit (SECU)</li> <li>• 5T – Mental Health Nursing Home Type</li> <li>• 5K – Child and Adolescent Mental Health Service (CAMHS)</li> <li>• 5G – Acute, Aged Persons Mental Health Service (APMH)</li> <li>• 5S – Acute, Specialist Mental Health Service</li> <li>• 5A – Acute, Adult Mental Health Service</li> </ul>
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**

**[Reporting guides relating to other values remain the same as per the VAED Manual 13<sup>th</sup> Edition]**

**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.

*Excludes:* Approved Mental Health Service or Psychogeriatric Program Mental Health Nursing Home Type (5T).

**K *Non-Designated Rehabilitation Program/Unit***

A patient who is admitted to, or transferred to, a non-designated Rehabilitation Program/Unit. Use code K only if the public hospital has approval from the Sub-Acute Program to run this program.

The program involves the provision of admitted patient services; where:

- The patient will be monitored by an identified medical leader responsible for admission assessment and care plan development; and
- The patient will have an appointed case manager; and
- The agency will provide a medium to high intensity program with allied health interventions.

Private hospitals: Do not use code K.

~~**5 *Approved Mental Health Service or Psychogeriatric Program***~~

~~A patient who is admitted to, or transferred to, an approved Mental Health Service or Psychogeriatric Acute 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.~~

**5x *Approved Mental Health Service or Psychogeriatric Program***

A patient who is admitted to, or transferred to, an approved Mental Health Service or Psychogeriatric Program. Use code 5x 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 5x only if registered under the Health Services Act 1988 to provide this category of care.

**5E *Mental Health Secure Extended Care Unit (SECU)***

This Care Type occurs when a patient is admitted to an approved unit designed to accommodate persons who require active clinical care in the secure/safe environment of a locked ward, often with the intention of longer term (extended) care.

*Includes:*

- Austin - Bunjil House SECU
- Ballarat - Queen Elizabeth Campus SECU
- Bendigo - Vahland SECU
- Dandenong - Wirringga SECU
- Latrobe Regional - Flynn SECU
- Sunshine - Mid West SECU

*Excludes:*

- Mental Health Nursing Home Type (NHT)
- Community Care Units (CCU) including Vahland CCU
- Aged Person's Mental Health Nursing Homes (APMHNH)
- Psychogeriatric Nursing Homes (PGNH)

**5T Mental Health Nursing Home Type**

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.

Such a patient may or may not have been assessed by an Aged Psychiatric Assessment and Treatment Team (APATT) or an Aged Care Assessment Service (ACAS) and may or may not have an approved NH5 Form.

**5K Child and Adolescent Mental Health Service (CAMHS)**

A patient who is admitted to an approved CAMHS unit.

**5G Acute, Aged Persons Mental Health Service (APMH)**

A patient who is admitted to an approved APMH (Psychogeriatric) unit.

*Excludes:*

- Aged Person's Mental Health Nursing Home (APMHNH)
- Psychogeriatric Nursing Home (PGNH)

**5S Acute, Specialist Mental Health Service**

A patient who is admitted to an approved Specialist Mental Health Service.

*Includes:*

- Brain Disorder Unit
- Eating Disorders Unit
- Forensic Unit
- Mother and Baby Unit
- Neurological Unit

*Excludes:* Child and Adolescent Mental Health Service

**5A Acute, Adult Mental Health Service**

A patient who is admitted to an approved Adult Mental Health Service.

*Excludes:*

- Community Care Units (Residential)
- Mental Health Nursing Home Type

**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 5X, 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 or 5T), 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 MHLS & Care Type
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 Ivalid 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 or 5T, LOS >365 Days
  - 469 Care Type 2, 6, 7 or J, not approved for Rehab
  - 470\* Care Type 5x, 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
- |   |
|---|
| ### MH SECU Care Type But Age < 14 Years <i>[Notifiable]</i>              |
| ### MH CAMHS Care Type But Age < 5 Years <i>[Notifiable]</i>              |
| ### MH CAMHS Care Type But Age > 19 Years <i>[Notifiable]</i>             |
| ### MH APMHS Care Type But Age < 55 Years <i>[Notifiable]</i>             |
| ### MH Specialist Acute Care Type But Age < 14 Years <i>[Notifiable]</i>  |
| ### MH Acute Adult Care Type But Age < 14 Years <i>[Notifiable]</i>       |
| ### MH Acute Adult Care Type But Age > 65 Years <i>[Notifiable]</i>       |
| ### Care Type K, not approved for Non-Designated Rehab <i>[Rejection]</i> |

**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 5x: 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

## Criterion For Admission

### **Background**

In August 2003 an updated *DHS Hospital Admission Policy 2003-04* (available at: <http://hdss.health.vic.gov.au/>) 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.

Further work is being undertaken in 2003-04 to further clarify, and to possibly introduce changes in Admission Policy, which may have funding implications in 2004-05.

In order to better monitor adherence to the Admission Policy, 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).

---

## Criterion For Admission (*Amended*)

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<b>Revision Summary</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).  Change in Criterion for Admission hierarchy (C placed further down the hierarchy).
-------------------------	---

### **Specification**

**Definition** The criterion that has been met, to justify the patient's admission.

**Datatype** Alpha **Form** Code

**Field size** 1 **Layout** A

**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:

<b>Code</b>	<b>Descriptor</b>
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 [ <i>Change in position in hierarchy</i> ]
S	Secondary family member

## **Reporting guide**

The reference to the *Commonwealth Day Only Procedures Manual* relates to the *Day Only Procedures Manual* [November] 1999 and *Day Only Procedures Manual Supplement* [Type B and C Lists] 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)

<http://www.health.gov.au/privatehealth/providers/dayonly/>

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'.

*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.

*Includes:* Patients undergoing a Type C Professional Attention Procedure where it is intended that they will also receive Extended Medical Treatment.

### **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.

*Excludes:* Patients undergoing a Type C Professional Attention Procedure where it is intended that they will also receive Extended Medical Treatment.

### **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.

#### **Note**

The Procedure Codes in the ICD-10-AM fourth edition library file can be used as a guide for determining whether the procedure falls into Type A, B or C.

Type A procedures are defined by the Commonwealth as professional attention normally requiring admitted overnight hospital stays.

## 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 [Warning]  
### Type B Crit for Adm with Type C Proc Code Only [Warning]  
### Type C Crit for Adm with Type A Proc Code [Notifiable]  
### Type C Crit for Adm with Type B Proc Code [Notifiable]  
### Type C Crit for Adm w/o Type C Proc Code [Warning]  
### Type E Crit for Adm with Type A 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 C Crit for Adm, LOS >4 hrs [Warning]  
### Type E Crit for Adm, LOS >1 [Warning]  
### Type E Crit for Adm, LOS <4 hrs [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

<b>Purpose</b>	To prompt the hospital to consider the eligibility of the patient for admission, to identify: <ul style="list-style-type: none"><li>• Any patient admitted for procedures listed on the Commonwealth's 'Day Only Bands' list.</li><li>• Any patient with special circumstances requiring admission (rather than treatment as an ambulatory patient).</li><li>• Any person treated in an Early Parenting Centre not meeting the requirements to be admitted (to omit such episodes from reporting to the Commonwealth).</li></ul>		
<b>Principal data users</b>	Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).		
<b>Collection start</b>	1993-94		
<b>Definition source</b>	Commonwealth	<b>Code set source</b>	DHS

# Funding Arrangement

## **Background**

The Healthstreams program has been superseded by the new - "Small Rural Health Services Funding and Accountability Approach". 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 facility under this new approach will automatically be identified.

---

## Funding Arrangement (*Amended*)

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<b>Revision Summary</b>	Removal of Funding Arrangement Code 3 <i>Healthstreams</i> from the codeset.
-------------------------	--

## Specification

**Definition** Identifies the specific funding arrangement, if any, that applies to this episode of care.

**Datatype** Alphanumeric **Form** Code

**Field size** 1 **Layout** N or space

**Location** Episode Record

**Reported by**

- Any Victorian public and private hospital involved in contracted care arrangements with another hospital (purchasers and providers of contracted care).
- Any Victorian public and private hospital involved in hub and spoke arrangements with another hospital.
- ~~Any Victorian public hospital involved in the Healthstreams program.~~
- Any Victorian public or private hospital treating a patient identified as a Coordinated Care Trial patient.
- Any Victorian public hospital involved in the Rural Patients Initiative program.
- Any Victorian public hospital involved in the Elective Surgery Access Service program (ESAS).

All other circumstances, report a space in this field.

**Reported for** Episodes where an admitted service is provided under contract, hub and spoke, ~~Healthstreams~~, Coordinated Care Trial arrangements, Rural Patients Initiative or Elective Surgery Access Service (ESAS).

Otherwise, report a space in this field.

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

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	Contract
	2	Hub and spoke
	3	<del>Healthstreams</del>
	4	Coordinated Care Trial
	5	Rural Patients Initiative

**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
- ~~476 Funding Arrangement 3, not approved for Healthstreams~~
- 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

**Purpose**

To:

- Identify whether a specific funding arrangement applies to this episode.
- Facilitate health services planning and monitoring.

**Principal data users**

Financial Analysis and Purchasing Branch, Metropolitan Health & Aged Care, DHS (Contract; Hub and Spoke)

~~Rural Specialist Services Grant (Healthstreams)~~

Quality and Care Continuity (Coordinated Care Trial and Elective Surgery Access Service)

Rural & Regional Health Services (Rural Patients Initiative)

**Collection start**

1996-97

**Definition source**

DHS

**Code set source**

DHS

# Given Name and Surname

## Background

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.

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. The Electronic Data Exchange process for TAC originally requested 25 characters for Given Name and 25 characters for Surname. The field sizes for these data items will be increased to meet the DVA HOTSPUR information system requirements that will still provide sufficient data for the TAC matching process.

The layout for each data item has also been modified to ensure the first character of the data item is an alpha character.

---

## Given Name (*Amended*)


---

<b>Revision Summary</b>	Lengthen field size to meet the system and matching requirements for DVA and TAC. Modify the layout to ensure the first character is an alpha character.
-------------------------	--

## 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>	42 <sup>15</sup>	<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.		
<b>Code set</b>	-		
<b>Reporting guide</b>	The given name/s of the patient.  Permitted characters: A to Z (uppercase), space, apostrophe, hyphen.  The first character must be an alpha character.		
<b>Edits</b>	162* Blank Invalid Given Name ### Given Name Unusual Length [Notifiable]		
<b>Related items</b>	Section 3: Account Class page 3-# and Surname page 3-26.		

## Administration

<b>Purpose</b>	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.		
<b>Principal data users</b>	Department of Veterans' Affairs and Transport Accident Commission.		
<b>Collection start</b>	1992-93		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS 

# Surname (*Amended*)

<b>Revision Summary</b>	Lengthen field size to meet the system and matching requirements for DVA and TAC. Modify the layout to ensure the first character is an alpha character.
-------------------------	--

## Specification

<b>Definition</b>	The surname of the DVA or TAC patient.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Name
<b>Field size</b>	20 <input type="text" value="25"/>	<b>Layout</b>	<input type="text" value="AAAAAAAAAAAAAAAAAAAAA"/> <input type="text" value="XXXXXXXXXXXXXXXXXXXXXXXXXXXX"/>
<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.		
<b>Reporting guide</b>	Surname of the person.		
	Permitted characters: A to Z (uppercase), space, apostrophe, hyphen.		
	<input type="text" value="The first character must be an alpha character."/>		
<b>Edits</b>	161* <input type="text" value="Blank"/> <input type="text" value="Invalid"/> Surname <input type="text" value="### Surname Unusual Length [Notifiable]"/>		
<b>Related items</b>	Section 3: <i>Account Class</i> page 3-# and <i>Given Name(s)</i> page 3-24.		

## Administration

<b>Purpose</b>	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.		
<b>Principal data users</b>	Department of Veteran's Affairs and Transport Accident Commission.		
<b>Collection start</b>	1992-93		
<b>Definition source</b>	DHS	<b>Code set source</b>	-

# Health Insurance Fund

## **Background**

Health Insurance Fund code 888 *Miscellaneous health insurance fund or Patient is insured but will not/cannot specify the Fund* currently incorporates two different concepts. This code will be removed from the codeset and replaced with three new codes to enable identification of:

- *Miscellaneous Australian health insurance fund*
- *Non-Australian health insurance fund*
- *Patient is insured but will not/cannot specify the fund*

In addition, a notifiable edit will be implemented to trigger when a hospital reports the miscellaneous Australian health insurance fund code. This will require the hospital to advise DHS the name of the miscellaneous fund to ensure that the health insurance fund listing is better maintained and accurately reflects any new additions.

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## Health Insurance Fund (*Amended*)

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<b>Revision Summary</b>	Removal of one code that incorporates more than one concept and replace with three new codes to enable unique identification of concepts. Refine the code set in accordance with the latest advice received from the Private Health Insurance Administrative Council.
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## Specification

**Definition** The patient's hospital insurance fund (if any) *regardless* 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>	<b>Code</b>	<b>Descriptor – Registered name (may differ from Trading name)</b>
	ACA	ACA Health Benefits Fund
	AHB	Defence Health Limited
	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 <del>(in AXA group)</del>
HBF	<del>Hospital Benefits Fund of Western Australia, Limited, The</del> HBF Health Funds Inc
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 Limited
MCL	Mutual Community Ltd <del>(in AXA group)</del>
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	<del>New South Wales</del> Teacher's Federation Health Society Limited
PWA	Phoenix Health Fund Ltd
QTU	Queensland Teachers Union Health Society Fund Ltd
RBH	Reserve Bank Health Society
RTE	<del>Railway &amp; Transport Employees' Friendly Society Health Fund</del> Health Fund Ltd
SGI	<del>NRMA Health Pty Limited (incorporating SGIC and SGIO)</del>
SLM	St Luke's Medical & Hospital Benefits Association Limited
SPE	South Australian Police Employees' Health Fund Incorporated
SPS	Health-Partners Inc
TFS	Transport Friendly Society Health Pty Ltd
UAD	United Ancient Order of Druids Friendly Society Limited
UAF	United Ancient Order of Druids Registered Friendly Society Grand Lodge of NSW
WDH	Western District Health Fund Ltd (Westfund)
YMH	Federation Health
888	<del>Miscellaneous health insurance fund or</del> Patient is insured but will not/cannot specify the Fund (note 2)
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 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 hospital 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, registered as Australian Unity Health Limited.
- Mutual Community is owned and operated by BUPA Australia Health Pty Ltd National Mutual. In Victoria, Mutual Community trades as HBA. In NT as Territory Mutual. In SA as Mutual Community Ltd.
- Transition Benefits Fund Pty Ltd ceased operation on 31 March 2002.
- NRMA Health Pty Limited have changed their name to MBF Health. This is a subsidiary of MBF Australia Ltd.
- The following funds have changed their registered names:
  - \* New South Wales Teacher's Federation Health Society to Teacher's Federation Health Limited.
  - \* Transport Friendly Society to Transport Health Pty Ltd.
  - \* Hospital Benefits Fund of Western Australia, Limited to HBF Health Health Funds Inc.

## 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]

## 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.

# ICD-10-AM Diagnosis and Procedure Codes

## Background

ICD-10-AM Fourth Edition will be adopted in Victoria to ensure the national reporting requirements are met. This edition will be effective from 1 July 2004.

## Diagnosis Codes (*Amended*)

<b>Revision Summary</b>	Update ICD-10-AM references from Third to Fourth Edition.
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## Specification

<b>Definition</b>	At least one (principal diagnosis) and up to 40 ICD-10-AM ( <del>Third</del> Fourth 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> 2004-2005, 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 <del>enter</del> cholerae</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>		

The first character of the field is the prefix: P, A, C or M.

In the first diagnosis code field:

- *Character 1* must be P.
- *Next five characters* must contain an alpha/numeric code of three, four or five characters (with trailing spaces if required).
- *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/icdencoding/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

### Prefix = P, Unusual Code Combination [Notifiable]  
 ### Prefix = P, Unusual Code Combination [Warning]  
 ### Prefix = C, Unusual Code Combination [Notifiable]  
 ### Prefix = C, Unusual Code Combination [Warning]  
 ### Prefix = A, Unusual Code Combination [Notifiable]  
 ### Prefix = A, Unusual Code Combination [Warning]

[The ICD-10-AM Fourth Edition Library File will have an additional column from which these edits will be run].

**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**

**Purpose**

To:

- Facilitate epidemiological studies and other research.
- Identify episodes containing specified codes for co-payments.
- Facilitate 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

---

# Procedure Codes (*Amended*)

---

<b>Revision Summary</b>	Update ICD-10-AM references from Third to Fourth Edition.
-------------------------	---

## Specification

**Definition** Up to 40 ICD-10-AM ~~Third~~ Fourth Edition codes reflecting the interventions used for the diagnosis and/or treatment of ill health during this episode of care.

**Datatype** Alphanumeric **Form** Code

**Field size** 8 (x 40) **Layout** NNNNNNN 8<sup>th</sup> character - A or space.  
Left justified, trailing spaces.

**Location** Diagnosis Record (12)  
Extra Diagnosis Record (28)

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

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

**Reported when** 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.

*[The ICD-10-AM Fourth Edition Library File will have an additional column from which the new edits for Criterion for Admission against Type A, B and C procedure codes will be run. This list can also be used by hospitals as a guide as which procedures are designated as Type B and C.]*

### 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 [Warning]  
### Type B Crit for Adm with Type C Proc Code Only [Warning]  
### Type C Crit for Adm with Type A Proc Code [Notifiable]  
### Type C Crit for Adm with Type B Proc Code [Notifiable]  
### Type C Crit for Adm w/o Type C Proc Code [Warning]  
### Type E Crit for Adm with Type A Proc Code [Notifiable]  
### Type E Crit for Adm with Type B 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

<b>Purpose</b>	To facilitate: <ul style="list-style-type: none"><li>• Epidemiological studies and other research.</li><li>• 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> <span style="border: 1px dashed black; padding: 0 2px;">Fourth</span> Edition

## Leave

### Background

This specification 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.

---

## Leave **With Permission** Days Financial Year-To-Date ~~[Normal]~~ (Amended)

---

<b>Revision Summary</b>	To reflect the amendment of [Normal] Leave to Leave With Permission.
-------------------------	--

### Specification

<b>Definition</b>	The number of days during this episode of care that the patient was out of hospital on <del>normal</del> leave <b>with permission</b> in the financial year being reported (includes the month being reported).		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	3	<b>Layout</b>	NNN or spaces. Right justified, zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	Episodes where there was a period of <del>normal</del> leave <b>with permission</b> for the financial year-to-date.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	A valid number complying with the business rules.		
<b>Reporting guide</b>	Leave <b>With Permission</b> Days Financial Year-To-Date <del>[Normal]</del> must be equal to or greater than Leave <b>With Permission</b> Days Month-To-Date <del>[Normal]</del> and equal to or less than Leave <b>With Permission</b> Days Total <del>[Normal]</del> .		
<b>Edits</b>	047* Leave <b>W Perm</b> Days YTD Not Numeric or Blank 053* Leave <b>W Perm</b> YTD < MTD 055* Leave <b>W Perm</b> Tot < YTD <b>224*</b> Newborn With Leave		
<b>Related items</b>	Section 2: Leave <b>With Permission</b> <del>—Normal</del> and Leave Without Permission.  Section 3: Leave <b>With Permission</b> Days Month-To-Date <del>[Normal]</del> page 3-37, and Leave <b>With Permission</b> Days Total <del>[Normal]</del> page 3-38.		

## Administration

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

---

## Leave ~~[Normal]~~ **With Permission** Days Month-To-Date **[Normal]** (Amended)

---

<b>Revision Summary</b>	To reflect the amendment of <del>[Normal]</del> Leave to Leave With Permission.
-------------------------	---

## Specification

<b>Definition</b>	The number of days during this episode of care that the patient was out of hospital 'on <del>[normal]</del> leave' <b>with permission</b> in the month being reported (month-to-date).		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	2	<b>Layout</b>	NN or spaces. Right justified, zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	Episodes where there was a period of <del>normal</del> leave <b>with permission</b> for the month.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	A valid number complying with the business rules.		
<b>Reporting guide</b>	Leave <b>With Permission</b> Days Month-To-Date <del>[Normal]</del> must be equal to or less than Leave <b>With Permission</b> Days Financial Year-To-Date <del>[Normal]</del> and Leave <b>With Permission</b> Days Total <del>[Normal]</del> .		
<b>Edits</b>	046* Leave <b>W Perm</b> Days MTD Not Numeric or Blank 053* Leave <b>W Perm</b> YTD < MTD 054* Leave <b>W Perm</b> Tot < MTD <b>224*</b> Newborn With Leave		

**Related items** Section 2: Leave ~~With Permission~~ ~~Normal~~ and Leave Without Permission.

Section 3: ~~Interpreter Required~~ Leave With Permission Days Financial Year-  
~~To-Date~~ page 3-36, and Leave ~~With Permission~~ Days Total ~~Normal~~ page  
3-38.

## Administration

**Purpose** 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.

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

**Collection start** 1990-91

**Definition source** DHS

---

## Leave ~~With Permission~~ Days Total ~~Normal~~ (Amended)

---

<b>Revision Summary</b>	To reflect the amendment of <del>Normal</del> Leave to Leave With Permission.
-------------------------	---

## Specification

**Definition** The total number of days during this episode of care that the patient was out of hospital 'on ~~normal~~ leave ~~with permission~~', including days from the previous financial year/s.

**Datatype** Numeric **Form** Quantitative value

**Field size** 3 **Layout** NNN or spaces.  
Right justified, zero filled.

**Location** Episode Record

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

**Reported for** Episodes where there was a period of ~~normal~~ leave ~~with permission~~.

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

**Code set** A valid number complying with the business rules.

**Reporting guide** Leave ~~With Permission~~ Days Total ~~Normal~~ must be equal to or greater than Leave ~~With Permission~~ Days Month-To-Date ~~Normal~~ and Leave ~~With Permission~~ Days Financial Year-To-Date ~~Normal~~.

**Edits**

- 049\* Leave ~~W Perm~~ Days Tot Not Numeric or Blank
- 054\* Leave ~~W Perm~~ Tot < MTD
- 055\* Leave ~~W Perm~~ Tot < YTD
- 112\* Calc Los + Leave Not = Adm/Sep
- 224\* Newborn With Leave

**Related items** Section 2: Leave ~~With Permission~~ ~~Normal~~ and Leave Without Permission.

Section 3: ~~Interpreter Required~~ Leave With Permission Days Financial Year-To-Date page 3-36, Leave ~~With Permission~~ Days Month-To-Date ~~Normal~~ page 3-37.

## Administration

**Purpose** 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.

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

**Collection start** 1990-91

**Definition source** DHS

---

## Leave Without Permission Days Financial Year-To-Date (New)

---

### Specification

**Definition** The number of days during this episode of care that the patient was out of hospital 'on leave without permission' in the financial year being reported (includes the month being reported).

**Datatype** Numeric **Form** Quantitative value

**Field size** 3 **Layout** NNN or spaces.  
Right justified, zero filled.

**Location** Episode Record

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

**Reported for** Episodes where there was a period of leave without permission for the financial year-to-date.

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

**Code set** A valid number complying with the business rules.

**Reporting guide** Leave Without Permission Days Financial Year-To-Date must be equal to or greater than Leave Without Permission Days Month-To-Date and equal to or less than Leave Without Permission Days Total.

**Edits** 224\* Newborn With Leave  
### Leave W/O Perm Days YTD Not Numeric or Blank [Rejection]  
### Leave W/O Perm YTD < MTD [Rejection]  
### Leave W/O Perm Tot < YTD [Rejection]

**Related items** Section 2: *Leave With Permission* and *Leave Without Permission*.  
 Section 3: *Leave Without Permission Days Month-To-Date* page 3-40, and *Leave Without Permission Days Total* page 3-41.

## Administration

**Purpose** To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of leave days) against the difference between Admission Date and Separation Date.

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

**Collection start** 2004-05

**Definition source** DHS

## Leave Without Permission Days Month-To-Date (New)

### Specification

**Definition** The number of days during this episode of care that the patient was out of hospital 'on leave without permission' in the month being reported (month-to-date).

<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	2	<b>Layout</b>	NN or spaces. Right justified, zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	Episodes where there was a period of leave without permission for the month.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	A valid number complying with the business rules.		
<b>Reporting guide</b>	Leave Without Permission Days Month-To-Date must be equal to or less than Leave Without Permission Days Financial Year-To-Date and Leave Without Permission Days Total.		
<b>Edits</b>	224* Newborn With Leave ### Leave W/O Perm Days MTD Not Numeric or Blank [Rejection] ### Leave W/O Perm YTD < MTD [Rejection] ### Leave W/O Perm Tot < MTD [Rejection]		

**Related items** Section 2: *Leave With Permission* and *Leave Without Permission*.

Section 3: *Leave Without Permission Days Financial Year-To-Date* page 3-39, and *Leave Without Permission Days Total* page 3-41.

## Administration

**Purpose** To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of leave days) against the difference between Admission Date and Separation Date.

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

**Collection start** 2004-05

**Definition source** DHS

---

## Leave Without Permission Days Total (New)

---

### Specification

**Definition** The total number of days during this episode of care that the patient was out of hospital 'on leave without permission', including days from the previous financial year/s.

<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	3	<b>Layout</b>	NNN or spaces. Right justified, zero filled.

**Location** Episode Record

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

**Reported for** Episodes where there was a period of leave without permission.

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

**Code set** A valid number complying with the business rules.

**Reporting guide** Leave Without Permission Days Total must be equal to or greater than Leave Without Permission Days Month-To-Date and Leave Without Permission Days Financial Year-To-Date.

**Edits**

- 112\* Calc Los + Leave Not = Adm/Sep
- 224\* Newborn With Leave
- ### Leave W/O Perm Days Tot Not Numeric or Blank [Rejection]
- ### Leave W/O Perm Tot<MTD [Rejection]
- ### Leave W/O Perm Tot< YTD [Rejection]

**Related items** Section 2: *Leave With Permission* and *Leave Without Permission*.

Section 3: *Leave Without Permission Days Financial Year-To-Date* page 3-39, and *Leave Without Permission Days Month-To-Date* page 3-40.

## Administration

<b>Purpose</b>	To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of leave days) against the difference between Admission Date and Separation Date.
<b>Principal data users</b>	Automated PRS/2 processes.
<b>Collection start</b>	2004-05
<b>Definition source</b>	DHS

---

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

---

<b>Revision Summary</b>	To reflect the amendment of [Normal] Leave to Leave With Permission, and the addition of three new data items relating to Leave Without Permission.
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## Specification

<b>Definition</b>	The number of patient days the person has accrued during the current financial year-to-date <i>excluding</i> <del>[normal]</del> leave <u>with and without permission</u> days (includes the month being reported). (Total of patient days recorded in each of the status segments.)		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	3	<b>Layout</b>	NNN Right justified, zero filled.
<b>Location</b>	Status Segments of the 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>	A number in the range 01 to 366.		
<b>Reporting guide</b>	Patient Days includes Contracted 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.		
<b>Edits</b>	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 3-43, and *Patient Days Total* page 3-44.

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

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

**Revision Summary**            To reflect the amendment of [Normal] Leave to Leave With Permission, and the addition of three new data items relating to Leave Without Permission.

## Specification

**Definition**                            The number of patient days the person has accrued during the current month *excluding* ~~[normal]~~ leave [with and without permission] 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.)

**Datatype**                            Numeric                                **Form**                                Quantitative value

**Field size**                            2    **Layout**                                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.

<b>Edits</b>	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 3-44.*

Section 4:

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

Section 5: *Status Segments.*

## Administration

<b>Purpose</b>	To enable hospitals to reconcile MTD days reported each month.
<b>Principal data users</b>	Automated PRS/2 processes.
<b>Collection start</b>	1983-84
<b>Definition source</b>	DHS

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## Patient Days Total (*Amended*)

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<b>Revision Summary</b>	To reflect the amendment of [Normal] Leave to Leave With Permission, and the addition of three new data items relating to Leave Without Permission.
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## Specification

<b>Definition</b>	The total number of patient days the person has <u>accrued during the whole episode of care to date <i>excluding</i> <del>[normal]</del> leave <u>with and without permission</u> days (includes the month being reported). (Total of patient days recorded in each of the status segments.)</u>		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	4	<b>Layout</b>	NNNN Right justified, zero filled.
<b>Location</b>	Status Segments of the 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>	A number in the range 0001 to 9999.
<b>Reporting guide</b>	Patient Days includes Contracted Leave Days.  Patient Days Total must be equal to or greater than Patient Days Month-To-Date and Patient Days Financial Year-To- Date.
<b>Edits</b>	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
<b>Related items</b>	Section 2: <i>Contracted Care and Patient Day.</i>  Section 3: <i>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 3-43.</i>  Section 4: <ul style="list-style-type: none"> <li>• Business Rules (non-tabular) <i>Length of Stay.</i></li> </ul> Section 5: <i>Status Segments.</i>

## Administration

<b>Purpose</b>	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>
<b>Principal data users</b>	Multiple internal and external users.
<b>Collection start</b>	1979-80
<b>Definition source</b>	DHS

## Locality

### **Background**

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 quality of data reported for overseas episodes, required for the Reciprocal Health Care Agreement (RCHA), the Locality Reporting Guide will be refined to ensure that when a postcode of 8888 (overseas) is reported, a valid four digit country code is entered in the Locality field to indicate the country of residence.

A new 'Postcode/Locality' reference file, created specifically for editing (does not contain SLA data), will be posted to <http://www.health.vic.gov.au/hdss/reffiles/index.htm>.

An updated 'Postcode/Locality/SLA' reference file, in its existing format, will also be available at <http://www.health.vic.gov.au/hdss/reffiles/index.htm>, for hospitals to access for their own purposes.

Note: Both files will incorporate each country of residence code, derived from the ASCCSS List, against a multiple listing of overseas postcodes

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## Locality (*Amended*)

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<b>Revision Summary</b>	Refine the Reporting Guide to require a four digit code to be reported in the Locality field when a postcode of 8888 (overseas) is entered, to accurately indicate the country of residence.
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### **Specification**

<b>Definition</b>	Geographic location (suburb/town/locality <span style="border: 1px solid black; padding: 2px;">for Australian residents, country for overseas residents</span> ) 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://www.health.vic.gov.au/hdss/reffiles/index.htm">http://www.health.vic.gov.au/hdss/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 country the patient lives in in Locality. The four digit country code must be one that corresponds with a code listed against 8888 (overseas) in the Postcode/Locality reference file.

**Edits** 058\* Invalid Postcode/Locality  
 ### Postcode Overseas, Locality RHCA, Acct Not RHCA [Notifiable]  
 ### Acct Recip, Pcode Oseas, Locality Not RHCA [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) (DHS modified)

## Postcode (Amended)

<b>Revision Summary</b>	Refine the Code set to ensure a four digit code is reported in the Locality field when a postcode of 8888 (overseas) is entered, to indicate the country of residence.
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## 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.

**Code set** Refer to the Postcode/Locality/SLA reference file available from:  
<http://www.health.vic.gov.au/hdss/reffiles/index.htm>

Other codes for use in this field:

<b>Code</b>	<b>Descriptor</b>
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

**Reporting guide** The Australia Post listing of postcodes and localities is available from:  
[www.auspost.com.au](http://www.auspost.com.au)

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.

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 *residential* address. PRS/2 will *reject* non-residential Postcodes (such as mail delivery centres).

For newborns, use the postcode of mother's residential address.

**Edits**

037	Invalid Postcode
058*	Invalid Postcode/Locality
391	Recip HCA Account, Not O/Seas P/Code
###	Postcode Overseas, Account Public [ <i>Notifiable</i> ]
###	Postcode Overseas, Account Not Recip, or Inelig [ <i>Warning</i> ]
###	Postcode Overseas, Locality RHCA, Acct Not RHCA [ <i>Notifiable</i> ]
###	Acct Recip, Pcode Oseas, Locality Not RHCA [ <i>Rejection</i> ]

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

Section 4:

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

## Administration

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

- Analyses 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).
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**Principal data users** Multiple internal and external users.

**Collection start** 1979-80

<b>Definition source</b>	DHS	<b>Code set source</b>	Australia Post (DHS modified)
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# Mental Health

## **Background**

### **Care Type**

The Care Type codeset has been lengthened from one to two characters to enable identification of patient days and specific programs under Care Type 5x *Approved Mental Health Service or Psychogeriatric Program* for:

- Acute types of care
- Nursing Home Type
- Sub-Acute Secure Extended Care

See 'Care Type', page 8.

### **Mental Health Statewide Patient Identifier (MHSW PI)**

Outcome Measurement in Mental Health is a major Commonwealth and State initiative. To promote better clinical outcomes for patients and better planning for mental health services.

Mental Health Outcome measurement is currently only collected in the Mental Health Client Management Interface (CMI) system, whereas the Victorian Admitted Episode Dataset (VAED) is a more developed and refined data set that is used as the basis for the Victorian component of the Admitted Episode National Minimum Data Set (NMDS).

The inclusion of the Mental Health Statewide Patient Identifier (MHSW PI) for all Mental Health episodes will enable the outcome measures to be appended onto a VAED extract which will form the basis for submission to the Commonwealth NMDS and National Outcome and Casemix Collection (NOCC).

The encryption of the MHSW PI at DHS will ensure patient privacy at the Commonwealth level. The Commonwealth require the identifier reported in the NOCC extract to 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 Patient Identifier enables this continuity across the data sets. In addition, the introduction of the Mental Health Statewide Patient Identifier into general hospital systems is a step in moving towards a more complete and refined data collection system.

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## **Mental Health Statewide Patient Identifier (*New*)**

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### **Specification**

<b>Definition</b>	The client identifier, unique to the client for approved Mental Health Service and Psychogeriatric Programs.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	10	<b>Layout</b>	NNNNNNNNNN or spaces Right justified, zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian public hospitals with an approved Mental Health Service.  Private hospitals: Report spaces in this field.		
<b>Reported for</b>	All mental health admitted episodes of care.		
<b>Reported when</b>	The episode record is reported.		

<b>Code set</b>	RAPID-generated.
<b>Reporting guide</b>	Report the Mental Health Statewide Patient Identifier for all mental health episodes of care (Care Types 5x).
<b>Edits</b>	### Invalid MHSWPI [ <i>Rejection</i> ] ### MHSWPI Present, not Care Type 5x [ <i>Rejection</i> ] ### Care Type 5x, MHSWPI Blank [ <i>Rejection</i> ]
<b>Related items</b>	Section 9: <ul style="list-style-type: none"> <li>Code Lists: Care Type <i>Care Type 5x: Approved Mental Health Service and Psychogeriatric Programs.</i></li> </ul>

## Administration

<b>Purpose</b>	To enable management of clients and their associated data.		
<b>Principal data users</b>	Mental Health Branch		
<b>Collection start</b>	2004-05		
<b>Definition source</b>	DHS	<b>Code set source</b>	RAPID generated

## Patient Identifier

### **Background**

To achieve consistency and facilitate data linkage between the VAED, VEMD and ESIS data collections, the Patient Identifier field size will be lengthened from an eight 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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<b>Revision Summary</b>	Lengthen the Patient Identifier field size.
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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 <input type="text" value="10"/>	<b>Layout</b>	XXXXXXXXXX <input type="text" value="XX"/> 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.		

<b>Edits</b>	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
	531	Same UK, diff Pt ID

**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

## Reporting zero versus null

### **Background**

The codeset for the following data items is currently specified as a valid number in the range 0000 to 9999. Where there is no duration recorded in these data items, spaces, rather than zeros are to be transmitted to PRS/2. Problems with data analysis arise when a combination of spaces and zeros are reported, due to their different meanings and mathematical properties.

The valid minimum value in the reporting range will be amended from 0000 to 0001 for:

- Duration of Mechanical Ventilation in ICU
- Duration of Non-invasive Ventilation (NIV)
- Duration of Stay in Cardiac/Coronary Care Unit
- Duration of Stay in Intensive Care Unit

In response to feedback regarding these changes, hospitals that enter zero in this field as a means of confirming the episode has been checked for any reported duration, may continue to do so. In these instances, the software must be modified to ensure that when zeros are reported in these fields, during the extraction process, these values are mapped to a space for transmitting to PRS/2.

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## **Duration of Mechanical Ventilation in ICU (Amended)**

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<b>Revision Summary</b>	Refine the minimum value in the reporting range.
-------------------------	--

### **Specification**

<b>Definition</b>	Total duration of Mechanical Ventilation (MV) in hours, provided in an approved Intensive Care Unit (ICU), during this episode of care.		
<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>	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.		
<b>Reported for</b>	Episodes where MV is provided in such an 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 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 2002, page 24 4 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
  - 328 Early Parenting Centre – Invalid Comb
  - 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 3-59.

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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<b>Revision Summary</b>	Refine the minimum value in the reporting range.
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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>	<p>Reporting is <b>MANDATORY</b> for public hospitals providing NIV to patients while admitted to an approved:</p> <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> <p>Reporting is <b>OPTIONAL</b> for:</p> <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> <p>Otherwise, report spaces.</p>		
<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.		
<b>Code set</b>	A number in the range 0000 (4 spaces, blanks or null) 0001 to 9999.		

**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).

Refer to the *ICD Coding Newsletter*, August 2002, page 4 for a comparison of reporting this field and *coding MV*.

<b>Edits</b>	328	Early Parenting Centre – Invalid Comb
	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 High [Notifiable]

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

Section 3: *Duration of ICU Stay in Intensive Care Unit* on page 3-59.

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)

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

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<b>Revision Summary</b>	Refine the minimum value in the reporting range.
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## 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

<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>	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.																		
<b>Reported for</b>	Episodes where time is spent in such a CCU. Otherwise, report spaces.																		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.																		
<b>Code set</b>	A number in the range 0000 0001 to 9999.																		
<b>Reporting guide</b>	<p>If patient has more than one period in CCU 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).</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 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.</p>																		
<b>Edits</b>	<table border="0"> <tr> <td>322</td> <td>ICU/CCU Stay &gt; Total Stay</td> </tr> <tr> <td>328</td> <td>Early Parenting Centre – Invalid Comb</td> </tr> <tr> <td>333</td> <td>Invalid CCU Stay</td> </tr> <tr> <td>337</td> <td>Crit Care Transfer, No ICU/CCU Hrs</td> </tr> <tr> <td>344</td> <td>Invalid comb For Family Choice</td> </tr> <tr> <td>454</td> <td>Incompat Fields for Interim Care</td> </tr> <tr> <td>523</td> <td>CCU Hrs, no Approved CCU</td> </tr> <tr> <td>###</td> <td>CCU Duration High [Notifiable]</td> </tr> </table>			322	ICU/CCU Stay > Total Stay	328	Early Parenting Centre – Invalid Comb	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 Duration High [Notifiable]
322	ICU/CCU Stay > Total Stay																		
328	Early Parenting Centre – Invalid Comb																		
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 Duration High [Notifiable]																		

**Related items**

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

Section 3: *Duration of Mechanical Ventilation in ICU* page 3-53, and *Duration of Non-invasive Ventilation (NIV)* page 3-55.

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

<b>Purpose</b>	To facilitate a co-payment on specified DRGs.
<b>Principal data users</b>	Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).
<b>Collection start</b>	1998-99
<b>Definition source</b>	DHS

---

# Duration of Stay in Intensive Care Unit (Amended)

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<b>Revision Summary</b>	Refine the minimum value in the reporting range.
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## Specification

<b>Definition</b>	Total duration of stay (hours) in an approved Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU), during this episode of care.		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	4	<b>Layout</b>	NNNN or spaces. Right-justified, zero-filled.
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	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.		
<b>Reported for</b>	Episodes where time is spent in such an ICU/NICU. Otherwise, report spaces.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	A valid number in the range 0000 <span style="border: 1px dashed black; padding: 0 2px;">0001</span> to 9999.		
<b>Reporting guide</b>	<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>		

<b>Edits</b>	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
	328	Early Parenting Centre – Invalid Comb
	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 3: *Duration of Mechanical Ventilation in ICU* page 3-53.

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

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

## Separation Referrals

### **Background**

Two new codes will be added to the Separation Referral codeset to enable identification of patients discharged to:

- 1) Home based Interim Care; and
  - 2) Alcohol and Drug Treatment Service
- 
- 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 at DHS 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, and are referred on to an alcohol and drug treatment service.

The addition of a Separation Referral code for alcohol and drug use requires the modification of existing code M *Referral to a community rehabilitation centre arranged before discharge* to exclude alcohol and drug treatment services.

---

## Separation Referral (*Amended*)

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<b>Revision Summary</b>	Add two new codes to the codeset.
-------------------------	-----------------------------------

### **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.		
<b>Reported for</b>	Episodes where the Separation Mode is H <i>Separation to private residence/accommodation</i> . For all other Separation Modes, report spaces in this field.		
<b>Reported when</b>	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:

**Code    Descriptor**

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**

**[Reporting guides relating to other values remain the same as per the VAED Manual 13<sup>th</sup> Edition]**

**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\*.

**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. Patients admitted to these hospitals, regardless of their Care Type during the admission, may be discharged from their admitted patient stay to receive home-based Interim Care.

**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.

**Edits**

- ~~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 I, not approved for Interim Care [Rejection]

**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

<b>Purpose</b>	To monitor discharge planning processes to inform policy and planning.		
<b>Principal data users</b>	Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).		
<b>Collection start</b>	1999-00 (Formerly a sub-set of Separation Mode)		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

# Sex

## 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, including those for capturing the sex of person’s whose sex may change during their lifetime.

## Sex (Amended)

<b>Revision Summary</b>	Add a new code to the codeset. In addition, the data item contains enhanced guidelines for capturing the sex of a person.
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## Specification

**Definition** Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.

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

**Field size** 1 **Layout** 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.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	Male
	2	Female
	3	Indeterminate
	4	Intersex

**Reporting guide** 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).

The term 'intersex' refers to a person, who, because of a genetic condition was born with reproductive organs or sex chromosomes that are not exclusively male or female and who identifies as being neither male nor female. Excludes: transgender, transsexual and chromosomally indeterminate individuals who identify with a particular sex (male or female).

Code 3 *Indeterminate* should be used for infants with ambiguous genitalia, where the biological sex, even following genetic testing, cannot be determined. Code 3 can only be assigned for infants aged less than 90 days.

Codes 3 *Indeterminate* and 4 *Intersex* should not generally be used on data collection forms completed by the respondent. They should only be used if the person or respondent volunteers that the person is intersexual or where it 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.~~

**Edits**

- 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
- 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 Intersexual [Notifiable]

**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).

## Unique Key

### **Background**

To achieve consistency between the VAED, VEMD and ESIS data collections, and to accommodate sites that have greater than 999,999 admitted episodes, the Unique Key field size will be lengthened from a six to a nine character, right justified, zero filled field.

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## Unique Key (*Amended*)

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<b>Revision Summary</b>	Lengthen the Unique Key field size.
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### **Specification**

**Definition** A unique identifier specific to an individual admitted patient episode of care.

**Datatype** Alphanumeric **Form** Code

**Field size** 6 9 **Layout** XXXXXXXXX  
Right justified, zero filled.

**Location** Episode Record  
Diagnosis Record  
Extra Diagnosis Record  
Sub-Acute Record  
DVA and TAC Record

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

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

**Reported when** Any of the above record types is reported.

**Code set** Hospital-generated.

**Reporting guide** The Unique Key can be computer-generated or have specific relevance at the hospital.

A Unique Key *should not* be changed. If in exceptional circumstances you need to alter the number (eg mis-punched) the original episode would have to be deleted and re-submitted with a new Unique Key.

Do *not* re-use a Unique Key; a Unique Key must *not* be re-assigned to another episode for the same patient or to another patient.

<b>Edits</b>	005	Deletion Record - No Match Found
	026	Zero Sep; Existing Not Discharged
	027	Adm Record; Overlaps Existing
	028	Prior Adm; No Sep Date
	060	Unique Key Blank
	062	Duplicate Pt ID, Adm Date Time, Diff Unique
	063	Prior Not Discharged
	064	Duplicate Pt ID, Date Time
	129	Diagnoses Delete: No Record On File
	169	No Corresponding Episode
	<del>171</del>	<del>No DVA &amp; TAC Record To Delete</del>
	248	Tran Pt ID Not Same As Episode Or Subac
	249	No Sub – Acute To Delete
	259	Invalid Rehab/Subac- Episode Sep Date
	<del>370</del>	<del>DVA/TAC Deletion: Episode Deletion</del>
	371	Episode Deletion: DVA/TAC Trans Present
	372	Episode Deletion: Multiple Epis Trans
	374	Episode DVA/TAC V2 Transaction
	375	Episode DVA/TAC: V2 Trans Rejected
	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
	<del>381</del>	<del>Epis Not DVA/TAC: V2 Present &amp; Rejected</del>
	382	Epis Not DVA/TAC: Multiple V2 Trans
	383	V2 Trans: No Episode Trans
	384	V2 Trans: Multiple Episode Trans
	531	Same UK, diff Pt ID

**Related items** -

## Administration

**Purpose** To enable data records (E2, X2, Y2, S2, V2) to be amalgamated into a single record for each episode of care, for editing and reporting purposes.

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

**Collection start** 1990-91

**Definition source** DHS **Code set source** Hospital-generated.

# Amended Business Rules

## Leave Related

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### Length of Stay (*Amended*)

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**Revision Summary** To reflect the amendment of [Normal] Leave to Leave With Permission, and the addition of three new data items relating to Leave Without Permission.

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.

**Guide for use**

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

- Retrospective: Separation Date minus Admission Date minus Total ~~[normal]~~ leave ~~[with and without permission]~~ 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]~~ leave ~~[with and without permission]~~ days must equal the number of days elapsed between Admission Date and Separation Date.
- 2 For any given date, either a patient day (including a contract leave day) or a ~~[normal]~~ leave day ~~[with and without permission]~~ may be counted, but not both.
- 3 Patient days are not accrued when the patient is out of the hospital on ~~[normal]~~ leave ~~[with and without permission]~~, 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~~ Leave Days (With and Without Permission), and Hence Calculating LOS

- 7 A same day patient cannot go on either contract leave or ~~normal~~ leave (with and without permission). A same day patient is one who has completed their course of treatment and is separated on the same day.
- 8 A period of contract or ~~normal~~ leave (with or without permission) starting and ending on the same date is not counted as a contract leave day or a ~~normal~~ leave with our without permission day. To count a contract leave day or a ~~normal~~ leave day (with or without permission), the patient must be out of the hospital overnight.
- 9 A period of ~~normal~~ leave (with or without permission) cannot exceed seven days. If a patient does not return to the hospital to continue this episode of care within seven days of starting ~~normal~~ leave (with or without permission), the patient is considered to have been separated on the date he/she started ~~normal~~ leave. 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).
- 10 Count the day of going on contract leave or ~~normal~~ leave (with or without permission) as a contract leave day or a ~~normal~~ leave day (with or without permission) respectively. Count the day of returning from contract leave or ~~normal~~ leave (with or without permission) 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 (with or without permission), count this day as a patient day.
  - When, on the same date, a patient returns from contract leave and again goes on contract leave, count this day as a contract leave day.
  - When, on the same date, a patient returns from ~~normal~~ leave (with or without permission), is assessed as fit to continue on leave and again goes on ~~normal~~ leave (with or without permission), count this day as a ~~normal~~ leave day.
  - When, on the same date, a patient returns from ~~normal~~ leave (with or without permission), receives treatment, investigation and/or observation, and again goes on ~~normal~~ leave (with or without permission), 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~~ leave (with or without permission) and is separated, do not count this day as either a contract leave day or a ~~normal~~ leave day or as a patient day.
  - When, on the same date, a patient goes on contract leave and is separated from the contracted hospital, do not count this day as either a contract leave day or as a patient day.

#### Refer to:

- Section 2: Leave - Contract, Leave ~~Normal~~ (With Permission), 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.

## Locality

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### Locality/Postcode (*Amended*)

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<b>Revision Summary</b>	Edit 058 changed to ensure: <ol style="list-style-type: none"><li>1. The capture of the patient's country of residence when a postcode of 8888 (overseas) is reported.</li><li>2. An exact match between locality and postcode for interstate residents.</li></ol>
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The validity of the Locality and Postcode combination is checked against the reference file. Reject (Edit 058) records if there is not an exact match for both Locality and Postcode, including the following editing on the Locality and Postcode data items apply:

- ~~1 Accept if the Locality is blank and the Postcode is 1000 or 8888 or 9988.~~  
~~Accept if the Locality is not blank and the Postcode is 8888.~~  
~~Reject (Edit 058) If the Locality is blank and the Postcode is not 1000 or 8888 or 9988.~~  
~~Reject (Edit 058) If the Locality is not blank and the Postcode is 1000 or 9988.~~

If Postcode is 8888 and Locality is between 0000 and 1299.  
If Postcode is 8888 and Locality is not a valid country code from the  Postcode/Locality reference file.

- ~~2 Reject (Edit 037 058) if Postcode is not valid, that is not in the Postcode/Locality/SLA reference file.~~

- ~~3 Check validity of the Locality and Postcode combination against the reference file:  
Reject (Edit 058) records of Victorian residents (postcode commences with 3) if there is not an exact match for both Locality and Postcode.~~

~~All other (non-Victorian residents) records will be:~~

- ~~Accepted if there is an exact match for both Locality and Postcode.~~
- ~~Accepted if there is a match on Postcode and part of the Locality. This routine will look for the best fit for the Locality, with a minimum requirement that there is a match on the first three letters.~~
- ~~Rejected (Edit 058) if neither of the above apply.~~

# Amended File Structures

## Number of Available Beds

The number of available beds is also collected via the AIMS A3 - Average Available Beds return form.

To reduce duplicate data entry, these data will only be collected through AIMS and the data item removed from the PRS/2 Header Record.

## PRS/2 Electronic Reports

From 1 July 2004, hospitals that are electronically connected to Allegiance Systems will have the option of receiving their PRS/2 reports electronically. Hospitals may receive their reports in the following ways:

- Electronic only; or
- Paper only (default option); or
- Electronic and paper.

The DHS hospital reference table will be enhanced so that non-electronically connected hospitals only receive reports on paper, regardless of the selection entered.

Paper based reports will continue to be produced in the current format, however electronic reports containing all information currently included in the paper based reports, will be produced in a tab-delimited file format. This will enable hospitals to import the data into the software application of choice and utilise the data as desired. Electronic reports will be available for pickup on the RSCA server at Allegiance Systems once the file has been processed. Hospitals will not be advised when an electronic report is available, they will need to check manually.

Two new fields will be added to the Header Record (H2) to enable this function to occur. The selection in the Reporting Type field (*Reporting Type Control*) will apply to all of the following Control and Reconciliation Reports:

- Front Cover
- Transmitted Transactions Report
- User Reconciliation Report
- Separations and Outstanding Records for Period
- Sub-Acute Separations and Outstanding Sub-Acute Records for the Period
- Census Report
- Episodes Containing 'ITH' Days for the Period
- Back Cover
- Hospital Activity and WIES Report

WorkCover Admitted Patient VIC-DRG Statements are excluded however, and will continue to be produced on paper only, regardless of the selection entered by the hospital. If hospitals elect to receive their reports electronically only, they can arrange with Allegiance Systems to have WorkCover statements despatched via courier or post.

The second Reporting Type field (*Reporting Type Request*) will apply to all Request Reports. Therefore, if the hospital selects the electronic only report option, and two request reports, such as Diagnoses Outstanding and the Census Report, these would both be produced electronically.

If no selection is entered, reports will be produced in the default paper only type.

## Report Requests (Header Record - H2)

From 1 July 2004, the number of Report Requests will be increased from five (5) to six (6). The Header Record (H2) will be modified accordingly.

## Record Fillers (All Records – H2, E2, X2, Y2, S2, V2)

All fillers will be removed from all record file structures. This will result in the position of certain data items changing. Refer to Amended File Structures on page 72.

## Header Record (H2)

## Header Record File Structure (*Amended*)

<b>Revision Summary</b>	<p>Additions to accommodate the new data items of Reporting Type Control, Reporting Type Request, and 6<sup>th</sup> Report Request.</p> <p>Deletion of data item Number of Available Beds.</p> <p>Removal of Filler data items and relocation of data item record positions accordingly.</p>
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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
+	<del>Number of Available Beds</del>	<del>4</del>	<del>22</del>	<del>N</del>	<del>NNNN</del>
	Reporting Option	1	<del>26</del> 22	A/N	Space, 0, 1, 2
	Reporting Type Control	1	23	A/N	Space, E, P, B
	<del>Filler</del>	<del>2</del>	<del>27</del>	<del>A/N</del>	<del>Spaces</del>
	Reporting Type Request	1	24	A/N	Space, E, P, B
	<i>Report Requests</i>				Refer to Section 6
	1 <sup>st</sup> request				
	Report Code	2	<del>29</del> 25	A/N	
	Report Parameter	12	<del>31</del> 27	A/N	
	2 <sup>nd</sup> request				
	Report Code	2	<del>43</del> 39	A/N	
	Report Parameter	12	<del>45</del> 41	A/N	
	3 <sup>rd</sup> request				
	Report Code	2	<del>57</del> 53	A/N	
	Report Parameter	12	<del>59</del> 55	A/N	
	4 <sup>th</sup> request				
	Report Code	2	<del>71</del> 67	A/N	
	Report Parameter	12	<del>73</del> 69	A/N	
	5 <sup>th</sup> request				
	Report Code	2	<del>85</del> 81	A/N	
	Report Parameter	12	<del>87</del> 83	A/N	

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
	6 <sup>th</sup> request				
	Report Code	2	95	A/N	
	Report Parameter	12	97	A/N	
	Filler	139	99	A/N	Spaces
	Software Version/Edition Identifier	3	238 109	A/N	Optional field, free text, or spaces
		Total 240 111			

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

M Mandatory

1—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.

**Reporting Type Control**

Select the type of report you wish for the Transmission Control and Reconciliation Report for this transmission.

Note: Only applicable for hospitals that are electronically connected to Allegiance Systems. Hospitals that are not connected, report a space.

Report your choice in this field as follows:

- E Electronic only
- P Paper only
- B Electronic and paper

Option P is printed if this field is left blank.

**Filter**

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

**Reporting Type Request**

Select the type of report you wish for the Request Report/s for this transmission.

Note: Only applicable for hospitals that are electronically connected to Allegiance Systems. Hospitals that are not connected, report a space.

Report your choice in this field as follows:

- E Electronic only
- P Paper only
- B Electronic and paper

Option P is printed if this field is left blank.

---

**Report Requests**

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

**Filter**

~~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)

### Episode Record File Structure (*Amended*)

<b>Revision Summary</b>	<p>Additions to accommodate the new data items of Mental Health Statewide Patient Identifier and Leave Without Permission Days (MTD, Financial YTD, and Total).</p> <p>Amendments to a number of code sets: Care Type, Criterion for Admission, Funding Arrangement, Separation Referral, and Sex.</p> <p>Amendments to Unique Key, Patient Identifier and Care Type data items to accommodate increase in field size lengths.</p> <p>Amendment of Normal Leave Days to Leave With Permission Days.</p> <p>Removal of Filler data items and relocation of data item record positions accordingly.</p>
-------------------------	---

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	E2
M	Unique Key	6 9	3	A/N	Hospital-generated Right justified, zero filled
M	Patient Identifier	8 10	9 12	A/N	Hospital generated Right justified, zero filled
M	Site Identifier	1	17 22	A/N	0, 1, 2, 3, 4, 5, 6, 7, 8, 9
M	Medicare Number	11	18 23	N	NNNNNNNNNNNN or spaces
M	Medicare Suffix	3	29 34	A/N	AAA or A-A
M	Sex	1	32 37	A/N	1, 2, 3, 4
M	Marital Status	1	33 38	A/N	1, 2, 3, 4, 5, 6
M	Date of Birth	8	34 39	N	DDMMCCYY
M	Postcode	4	42 47	N	NNNN Refer to Section 3
M	Locality	22	46 51	A/N	Refer to Section 3
M	Admission Date	8	68 73	N	DDMMCCYY
M	Admission Time	4	76 81	N	HHMM
M	Admission Type	1	80 85	A/N	S, Y, M, C, L, O, X
M	Admission Source	1	81 86	A/N	S, Y, T, N, A, H
1	Transfer Source	4	82 87	A/N	NNNN or spaces Refer to Section 3
	Normal Leave With Permission Days MTD	2	86 91	N	NN or spaces
	Normal Leave With Permission Days Financial YTD	3	88 93	N	NNN or spaces
	Normal Leave With Permission Days Total	3	91 96	N	NNN or spaces

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
	<b>Status Segment</b> Occurs 7 times				
2	Account Class	2	<del>94, 107,</del> <del>120, 133,</del> <del>146, 159,</del> <del>172</del> 99, 112, 125, 138, 151, 164, 177	A/N	AA or AN Refer to Field specification
2	Accommodation Type	1	<del>96, 109,</del> <del>122, 135,</del> <del>148, 161,</del> <del>174</del> 101, 114, 127, 140, 153, 166, 179	A/N	1, 2, 3, 4, 6, 7, 8, B, C, M, S
2	Qualification Status	1	<del>97, 110,</del> <del>123, 136,</del> <del>149, 162,</del> <del>175</del> 102, 115, 128, 141, 154, 167, 180	A/N	N, U, X
2	Patient Days MTD	2	<del>98, 111,</del> <del>124, 137,</del> <del>150, 163,</del> <del>176</del> 103, 116, 129, 142, 155, 168, 181	N	Must be present if other Status details are present
2	Patient Days Financial YTD	3	<del>100, 113,</del> <del>126, 139,</del> <del>152, 165,</del> <del>178</del> 105, 118, 131, 144, 157, 170, 183	N	Must be present if other Status details are present
2	Patient Days Total	4	<del>103, 116,</del> <del>129, 142,</del> <del>155, 168,</del> <del>181</del> 108, 121, 134, 147, 160, 173, 186	N	Must be present if other Status details are present
3	Separation Date	8	<del>185</del> 190	N	DDMMCCYY
3	Separation Time	4	<del>193</del> 198	N	HHMM
3	Separation Mode	1	<del>197</del> 202	A/N	S, D, Z, T, N, A, H
1	Transfer Destination	4	<del>198</del> 203	A/N	NNNN or spaces Refer to Section 3

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
4	Separation Referral	4	202 207	A/N	F, P, M, L B, U, C, S, D, G, I, A, K, R, X or spaces Left justified, trailing spaces
5	Carer Availability	1	206 211	A/N	1, 2, 3, 4, 5, 6, 7, 8 or space
3	Account Class on Separation	2	207 212	A/N	AA or AN Refer to Field specification
3	Accommodation Type on Separation	1	209 214	A/N	1, 2, 3, 4, 6, 7, 8, B, C, M, S
M	Care Type	4 2	210 215	A/N	F, E, 1, 2, 6, 7, J, K, 8, 5, 9, 0, 3, 4, U Refer to Section 3
M	Country of Birth	4	211 217	A/N	NNNN Refer to Section 3
M	Indigenous Status	1	215 221	A/N	2, 5, 6, 7
M 6	Criterion for Admission	1	216 222	A/N	B, C, N, U, O, E, C, S
M	Intended Duration of Stay	1	217 223	A/N	1, 2
M	Health Insurance Fund	3	218 224	A/N	Refer to Section 3
M	Level of Insurance	1	221 227	A/N	1, 3, 8, 6, 9
3	Mental Health Legal Status	1	222 228	A/N	1, 2, 9
11	Filler	4	223	A/N	Space
7	Funding Arrangement	1	224 229	A/N	1, 2, 3, 4, 5, 6 or space
8	Contract Type	1	225 230	A/N	1, 2, 3, 4, 5, 6, 7 or space
8	Contract Role	1	226 231	A/N	A, B or space
9	Contract/Spoke Identifier	4	227 232	A/N	NNNN or spaces Refer to Section 3
10	Contract Leave Days - MTD	2	231 236	N	NN or spaces
10	Contract Leave Days - Financial YTD	2	233 238	N	NN or spaces
10	Contract Leave Days - Total	2	235 240	N	NN or spaces
	User Flag	1	237 242	A/N	Optional field, free text
12	Preferred Language	2	238 243	N	NN Refer to Section 3
12	Interpreter Required	1	240 245	N	N Refer to Section 3
13 14	ACAS Status	1	241 246	N	N or space Refer to Section 3
15	Mental Health Statewide Patient Identifier	10	247	A/N	RAPID generated or spaces Refer to Section 3
	Leave Without Permission Days MTD	2	257	N	NN or spaces
	Leave Without Permission Days Financial YTD	3	259	N	NNN or spaces
14	Leave Without Permission Days Total	3	262	N	NNN or spaces
		Total 241 264			

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~~ <sup>and</sup> 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 with an approved Mental Health Service when Care Type is 5x. Private hospitals report spaces.

## Diagnosis Record (X2)

# Diagnosis Record File Structure (*Amended*)

Revision Summary
<p>Amendments to a number of code sets: Duration of Stay in Intensive Care Unit, Duration of Mechanical Ventilation in ICU, Duration of Stay in Cardiac/Coronary Care Unit, and Duration of Non-invasive Ventilation (NIV).</p> <p>Amendments to Diagnosis and Procedure code sets to reflect update from ICD-10-AM Third Edition to Fourth Edition.</p> <p>Amendment to Unique Key data item to accommodate increase in field size length.</p> <p>Removal of Filler data items and relocation of data item record positions accordingly.</p>

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	X2
M	Unique Key	69	3	A/N	Hospital generated Right justified, zero filled
1	Diagnosis Code x 12 - each code	8 (8 x 12)	912	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)	105 108	A/N	ICD-10-AM 3 <sup>rd</sup> -4 <sup>th</sup> edition Each left justified, trailing spaces
3	Admission Weight	4	201 204	N	In grams, or spaces
M	Intention to Re-admit	1	205 208	A/N	0, 1, 2, 3, 4, 9
10	User Flag	1	206 209	A/N	Optional field, free text
4 10	Duration of Stay in Intensive Care Unit	4	207 210	N	00001 to 9999 or spaces
5 10	Duration of Mechanical Ventilation in ICU	4	211 214	N	00001 to 9999 or spaces
6 10	Hospital Generated DRG	4	215 218	A/N	ANNA or NNNA or spaces
7 10	Duration of Stay in Cardiac/Coronary Care Unit	4	219 222	N	00001 to 9999 or spaces
8 10	Reason for Critical Care Transfer	1	223 226	A/N	X, E, J, W, Y, F, K, Z or space
9 10	Duration of Non-Invasive Ventilation	4	224 227	N	00001 to 9999 or spaces
<del>10</del>	<del>Filler</del>	<del>13</del>	<del>228</del>	<del>A/N</del>	<del>Spaces</del>
		Total 240230			

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)

# Extra Diagnosis Record File Structure (*Amended*)

<b>Revision Summary</b>	Amendments to Diagnosis and Procedure code sets to reflect update from ICD-10-AM Third Edition to Fourth Edition.
	Amendment to Unique Key data item to accommodate increase in field size length.
	Relocation of data item record positions accordingly.

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	Y2
M	Unique Key	69	3	A/N	Hospital generated Right justified, zero filled
	Diagnosis Code (13 to 25)	8 (8 x 13)	9-12	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)	113-116	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)	217-220	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)	337-340	A/N	ICD-10-AM 3 <sup>rd</sup> -4 <sup>th</sup> edition Each left justified and with trailing spaces
		Total 456-459			

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*)

<b>Revision Summary</b>	Amendments to Unique Key and Patient Identifier data items to accommodate increase in field size lengths.
	Removal of Filler data items and relocation of data item record positions accordingly.

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	S2
M	Unique Key	<del>6</del> 9	3	A/N	Hospital generated Right justified, zero filled
M	Patient Identifier	<del>8</del> 10	<del>9</del> 12	A/N	Hospital generated Right justified, zero filled
1, 2, 4	Barthel Index Score on Admission	3	<del>17</del> 22	A/N	Range 000 to 100 or spaces
1, 2, 4	Barthel Index Score on Separation	3	<del>20</del> 25	A/N	Range 000 to 100 or spaces
1	Clinical Sub-program	3	<del>23</del> 28	A/N	From code list or spaces
1	Onset Date	8	<del>26</del> 31	N	DDMMCCYY or spaces
1	Admission/Re-admission to Rehabilitation	1	<del>34</del> 39	A/N	0, 1 or space
5	User Flag	1	<del>35</del> 40	A/N	Optional field, free text
<del>5</del>	<del>Filler</del>	<del>2</del>	<del>36</del>	<del>A/N</del>	<del>Spaces</del>
3 5	RUG ADL on Admission	2	<del>38</del> 41	A/N	Range 00 to 18 or spaces
3 5	RUG ADL on Separation	2	<del>40</del> 43	A/N	Range 00 to 18 or spaces
3 5	Source of Referral to Palliative Care	2	<del>42</del> 45	A/N	Range 01 to 09 or spaces
<del>5</del>	<del>Filler</del>	<del>197</del>	<del>44</del>	<del>A/N</del>	<del>Spaces</del>
		Total <del>240</del> 46			

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*, or K *Non-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, K, 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, <del>or J</del> or K	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 File Structure (*Amended*)

<b>Revision Summary</b>	Amendments to Unique Key, Patient Identifier, Surname and Given Name data items to accommodate increase in field size lengths.
	Removal of Filler data items and relocation of data item record positions accordingly.

Note	Data Item	Field Size	Record Position	Datatype	Layout/Code Set
M	Transaction Type	2	1	A/N	V2
M	Unique Key	6 9	3	A/N	Hospital generated Right justified, zero filled
M	Patient Identifier	8 10	9 12	A/N	Hospital generated Right justified, zero filled
M	DVA ID / TAC Claim Number	9	17 22	A/N	Refer to Section 3
M	Surname	20 25	26 31	A/N	Refer to Section 3
M	Given Name(s)	12 15	46 56	A/N	Refer to Section 3
1	Admission Date	8	58 71	N	DDMMCCYY
1	Separation Date	8	66 79	N	DDMMCCYY
2 3	Date of Accident	8	74 87	N	DDMMCCYY or spaces
3	User Flag	1	82 95	A/N	Optional field, free text or space
<del>3</del>	<del>Filler</del>	<del>158</del>	<del>83</del>	<del>A/N</del>	<del>Spaces</del>
		Total: 240 95			

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.~~

## Reference Files

### Coding Classification and Grouper Versions

For 2004-05, DHS will map ICD-10-AM Fourth Edition codes to ICD-10-AM Third Edition codes for input to the AR-DRG Version 5.0 Grouper.

Information about AR-DRG Version 5.0 can be found on the website of the Commonwealth Department of Health and Ageing (<http://www.health.gov.au/casemix/ardrg1.htm>), and in the Australian Refined Diagnosis Related Groups Version 5.0 Definitions Manual.

### Hospital Code Table

Updates to the hospital code table during 2004-05 will again be published in the HDSS Bulletin, with the web version being amended accordingly at:  
<http://www.health.vic.gov.au/hdss/reffiles/index.htm>

This reference file is used for reporting in the following PRS/2 fields:  
*Hospital Code, Site Identifier, Transfer Source, Transfer Destination, Contract/Spoke Identifier.*

### ICD-10-AM Library File

Separations on or after 1 July 2004 will be verified against the ICD-10-AM Version 4 Library File. Version-4 of ICD-10-AM will be implemented in Victoria for separations on or after 1 July 2004.

The ICD-10-AM Version 4 Library File will be released at a later date. It is intended to add additional data items to allow editing in relation to Criterion for Admission (Procedures) and Prefixes (Diagnoses). Updates to this file during 2004-05 will again be published in the HDSS Bulletin, with the web version being amended accordingly at:  
<http://www.health.vic.gov.au/hdss/reffiles/index.htm>

### Postcode/Locality/SLA File

A new postcode/locality file will be applied to all E2 Episode records transmitted to PRS/2 from 1 July 2004. This file, created in a different format that is better suited for editing and not containing SLA data, contains valid combinations of postcode and locality for Australian and overseas (8888) postcodes in accordance with the Locality and Postcode specifications on pages 46 and 47.

An updated 'Postcode/Locality/SLA' reference file, in its existing format, available at <http://www.health.vic.gov.au/hdss/reffiles/index.htm>, will be for hospitals to access for their own purposes.

Updates to the new and existing files during 2004-05 will again be published in the HDSS Bulletin, with the web version being amended accordingly at:  
<http://www.health.vic.gov.au/hdss/reffiles/index.htm>

Note: Both files will incorporate each country of residence code, derived from the ASCCSS List, against a multiple listing of overseas postcodes

## Preferred Language

The Preferred Language codeset has been modified, following a recent analysis that revealed a significant number of episodes being reported with Preferred Language codes 95 *Other languages, nfd*, 96 *Inadequately described*, or 98 *Not stated*. The enhanced Preferred Language Code List should decrease the amount of episodes reported to these codes.

## Preferred Language (*Amended*)

This classification is specified in the NHDD and is a modification of the 2-digit level Australian Standard Classification of Languages (ABS) classification.

### **Code Preferred Language**

93	African Indigenous Language (Includes Bantu, Hausa, Masai & Zulu)
00	Afrikaans
01	Albanian
02	Alyawarr (Alyawarra)
89	Amharic (Language of Ethiopia and Surrounding Nations)
03	Arabic (including Lebanese see Note 1)
04	Armenian
05	Arrernte (Aranda)
06	Assyrian (including Aramaic)
07	Australian Indigenous languages, NEC
08	Bengali
09	Bisaya
10	Bosnian
11	Bulgarian
12	Burarra
13	Burmese
14	Cantonese
15	Cebuano
16	Croatian
17	Czech
18	Danish
19	English (including Scottish)
20	Estonian
21	Fijian
22	Finnish
23	French
24	German (including Austrian and Viennese)
25	Gilbertese (including Kiribati)
26	Greek
27	Gujarati
28	Hakka
29	Hebrew
30	Hindi
31	Hmong (including Meo)
32	Hokkien (including Taiwanese)
33	Hungarian (including Magyar)

### **Code Preferred Language**

34	Indonesian (Bahasa Indonesian)
94	Indonesian Dialects (includes Balinese, Javanese, Sumatran and Sundanese)
35	Irish (including Gaelic)
36	Italian (including Abruzzan, Calabrian, Roman, Sardinian and Sicilian)
37	Japanese (including Nippon)
38	Kannada
39	Khmer (including Cambodian and Kampuchean)
40	Korean
41	Kriol
87	Kurdish
42	Kuurinji (Gurindji)
43	Lao
44	Latvian
45	Lithuanian
46	Macedonian
47	Malay (including Bahasa Malaysian)
48	Maltese
49	Mandarin
50	Mauritian Creole
91	Nepalese/Nepali
51	Netherlandic (including Belgian, Dutch and Flemish)
52	Norwegian
53	Persian (including Dari and Farsi)
54	Pintupi
55	Pitjantjatjara
56	Polish
57	Portuguese (including Brasilian)
58	Punjabi
88	Pushtu and Afghan
59	Romanian (including Moldavian)
60	Russian (including Belorussian and Georgian)
61	Samoan
62	Serbian
63	Sinhalese (including Ceylonese)

**Code Preferred Language**

64	Slovak
65	Slovene
66	Somali
67	Spanish (including Chilian, Mexican and Peruvian)
68	Swahili
69	Swedish
70	Tagalog (including Filipino and Philippino)
71	Tamil
72	Telugu
73	Teochew
74	Thai (including Siamese)
92	Tibetan
75	Timorese
76	Tiwi
77	Tongan

**Code Preferred Language**

78	Turkish
79	Ukranian
80	Urdu
90	Tartar and Mongolian (includes Uzbek and Kirghiz)
81	Vietnamese
82	Walmajarri (Walmadjari)
83	Warlpiri
84	Welsh
85	Wik-Mungkan
86	Yiddish
95	Other languages, nfd
96	Inadequately described
97	Non verbal, so described (including sign languages eg: Auslan, Makaton)
98	Not stated

**Guide for Use**

Code 07: All Australian Indigenous languages not shown separately on the code list.

Code 96: Insufficient information is provided.

Code 97: All non-verbal means of communication, including sign languages.

Code 98: No information is provided.

**Note 1**

Arabic includes indigenous languages of the following countries (not an exclusive listing):

Algeria	Kuwait	Qatar
Bahrain	Lebanon	Saudi Arabia
Egypt	Libya	Syria
Eritrea	Morocco	Tunisia
Iraq	Oman	United Arab Emirates
Kingdom of Jordan	Palestine	Yemen

# End of Financial Year Consideration

## Method for Reporting 'Remaining Ins' on 30 June 2004

In summary, the Separation Date of an episode will determine the format and values to be reported for data records. For patients remaining in hospital on 30 June 2004, the header dates of a transmission will determine the format and values reported.

These arrangements are explained further and reinforced under the headings of 'General Rules' and 'Specific Rules'.

### **General Rules**

The following data rules apply for PRS/2 data transmissions before and after 1 July 2004:

- File transmissions with header dates prior to 1 July 2004 must contain records using the 2003-2004 format/values.
- File transmissions with header dates of 1 July 2004 and beyond must contain records using the 2004–2005 format/values.
- File transmissions with header dates of 1 July 2004 and beyond may contain records of patients separated prior to 1 July 2004 which must use the 2003-2004 format/values.
- File transmissions with header dates of 1 July 2004 and beyond may contain records of unseparated patients (those remaining in on 30 June 2004); which must use 2004–2005 format/values.

### **Specific Rules: E2 (Episode Record)**

- An Episode Record (E2) for patients remaining in hospital on 30 June 2004 must be transmitted by the final June 2004 data transmission. This Episode Record must use the PRS/2 format/values applying for 2003-2004, and will have the Separation Date and associated fields blank.
- Once the Separation Date is added to the record (accompanied with associated fields required on separation), the fields associated with the admission must comply with the 2004-2005 code set/edits.

### **Important notes**

The PRS/2 logic means that for *episodes admitted on or before 30 June 2004, and separated on or after 1 July 2004*:

- Applicable episodes will need to capture Mental Health Statewide Patient Identifier and Leave Without Permission Days data items.
- Mental Health episodes will need to have the Care Type amended to either 5E, 5T, 5K, 5G, 5S or 5A.
- Rehabilitation episodes in a non-designated Rehabilitation Program/Unit will need to have the Care Type amended to K.

Also, as it is the Separation Date which determines which codeset is valid, hospitals and software suppliers are reminded that the new codesets relating to admission data items *need to be valid for episodes admitted before 1 July 2004*.

Hospitals have three options for processing the above:

- Soon after 30 June 2004, systematically update the 'remaining in' episodes to add in applicable data items. However, if this is completed while the hospital is still transmitting 2003-2004 Header Dates (that is, June 2004), then the large majority of 'remaining ins' will reject.
- Wait until the Separation Date is added, and add/amend data items at this time (if not, they will reject on submission to PRS/2).
- A combination of the other two options.

Non-adherence to any of the above rules will cause the transaction/transmission to reject.

Hospitals need to take steps to ensure accurate information is reported on patients who are remaining in on 30 June 2004. The action required will vary according to the information already collected from/about patients, and the in-house system capabilities at each hospital.

## Test Transmissions of New 1 July 2004 Software

The Department of Human Services recognises that software suppliers can experience difficulties making the 1 July revisions to their programs and that distributing untested programs to clients is unsatisfactory. It can also be difficult for hospitals to resolve problems caused by using untested software. Allegiance Systems will therefore be making a test facility available to software suppliers and encourages all suppliers to test new programs before using them to send live data to the VAED via PRS/2.

After making the necessary programming changes to meet the revised requirements, each software supplier can send up to two tests in public hospital format and two in private hospital format, without charge. If the Department approves additional testing, Allegiance Systems will provide this service at a charge (price on application).

For each test use a Hospital Code of '500', the code for *dummy hospital* as used by Allegiance Systems. Where data is being supplied electronically, the file must have a filename of 'prs2test'. Where data is being supplied via diskette, the diskette must be externally labelled 'Supplier test' and whether the program is in public hospital or private hospital format and, if not from a hospital, with the name of the software supplier.

For second or subsequent tests, Allegiance Systems requires advice as to whether or not previous test(s) are to be deleted before this test is run.

Turnaround time will depend on workload at Allegiance Systems.

Allegiance Systems will handle Control Reports produced for each test as follows:

- If Allegiance Systems knows the identity of the pilot hospital, the Control Reports will be sent to that hospital *unless that hospital has provided Allegiance Systems with written authorisation to send reports elsewhere* (a fax on letterhead is sufficient).
- If Allegiance Systems does not know the identity of the pilot hospital, Control Reports will be sent to the software supplier.
- Staff at Allegiance Systems and the Department will, if requested, assist in identifying problems. However, there is no approval process for testing 1 July updates. Once the supplier and/or the hospital is satisfied that the new software meets the specifications as defined by the Department, live transmissions can commence.
- Hospitals that are electronically connected to Allegiance Systems will be able to request their test reports to be produced in an electronic format.