

## ***Section 3: Data Definitions***



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# Introduction

This section provides the specifications for each data item collected during an admitted episode of care, and later transmitted to PRS/2.

Additional items that are included in PRS/2 transmissions, such as trailer record statistics and fillers, are specified in Section 5, along with the file structures of each Transaction Record.

Additional items are derived from items transmitted in PRS/2. These are referenced in Section 2 for information only. Some of these derived items are listed in the Transmitted Transaction reports (such as the DRG); others are used in edits, including age and length of stay.

## Format

Information about each data item is presented in the following structured format:

## Data Item Name

### Specification

<b>Definition</b>	A statement that expresses the essential nature of a data item and its differentiation from all other data items.
<b>Datatype</b>	The type of symbol, character or other designation used to represent a data item, that is: <ul style="list-style-type: none"><li>• Alpha/numeric - A field on which calculations are not performed.</li><li>• Numeric - A field on which calculations may be performed.</li></ul>
<b>Form</b>	Name or description of the form of representation for the data item such as: date, code (code set), or quantitative value.
<b>Field size</b>	The maximum number of characters accommodated by this field.
<b>Layout</b>	The layout of characters for the data item, expressed by a character string representation. Examples include: 'DDMMCCYY' for dates, 'N' for a 1-digit numeric value, spaces or blank, and 'A' for a 1-character alpha value, spaces or blank. 'X' for spaces, apostrophes, hyphens, alphas or numerics.
<b>Location</b>	The Transaction Record in which this item is transmitted to PRS/2. For example, the Episode Record.
<b>Reported by</b>	The requirement for this data item to be collected by public hospitals only, or public <i>and</i> private hospitals (includes day procedure centres).
<b>Reported for</b>	The specific circumstances when this item must be reported. For example: Carer Availability is reported when the Care Type for the episode is 1, 2, 6, 7, K, 8, 9, F or E.
<b>Recorded when</b>	The stage in the episode/data submission cycle when this data item is to be reported to PRS/2. For example: Sub Acute data items are reported following the transmission of a Separation Date in the Episode Record, not before.
<b>Code set</b>	The set of representations of permissible values for the data item, according to the form, layout, datatype and field size.
<b>Reporting guide</b>	Additional comments or advice on reporting the item.

<b><i>Edits</i></b>	A list of edits (edit numbers and long descriptors) that relate to this data item.
<b><i>Related items</i></b>	A list of related data items, Business Rule Tables, Concept Definitions and Supplementary Code Lists that affect the assignment of a code in this data item.

## **Administration**

<b><i>Purpose</i></b>	The main reason/s for the collection of this data item.
<b><i>Principal data users</i></b>	Identifies the primary user/s of the data collected.
<b><i>Collection start</i></b>	The year the collection of this data item commenced.
<b><i>Definition source</i></b>	Identifies the authority that defined this data item.
<b><i>Code set source</i></b>	Identifies the authority that developed the code set for this data item.

# Definitions

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## ACAS Status

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### Specification

<b>Definition</b>	The type of involvement of the Aged Care Assessment Service (ACAS) in patient separation.														
<b>Datatype</b>	Numeric	<b>Form</b>	Code												
<b>Field size</b>	1	<b>Layout</b>	N or space												
<b>Location</b>	Episode Record														
<b>Reported by</b>	Public hospitals  Private hospitals – Optional. If the private hospital chooses not to report these data items, report spaces in the field.														
<b>Reported for</b>	Episodes with Care Type 1, 2, 4, 6, 7, 8, 9, F, E and K. <i>And</i> Where the patient's age is equal to or greater than 50, <i>And</i> Where the episode is not a same day episode.  For Care Types 0, 3, 5x and U, report spaces in this field.														
<b>Reported when</b>	A Separation Date is reported in the Episode Record.														
<b>Code set</b>	Select the first appropriate category:  <table><thead><tr><th><b>Code</b></th><th><b>Descriptor</b></th></tr></thead><tbody><tr><td>1</td><td>ACAS Assessment completed during this episode</td></tr><tr><td>2</td><td>ACAS Assessment incomplete: referral to Sub-acute services</td></tr><tr><td>3</td><td>ACAS Assessment incomplete: other reason</td></tr><tr><td>4</td><td>ACAS Consultation only during this episode</td></tr><tr><td>5</td><td>No ACAS involvement during this episode</td></tr></tbody></table>			<b>Code</b>	<b>Descriptor</b>	1	ACAS Assessment completed during this episode	2	ACAS Assessment incomplete: referral to Sub-acute services	3	ACAS Assessment incomplete: other reason	4	ACAS Consultation only during this episode	5	No ACAS involvement during this episode
<b>Code</b>	<b>Descriptor</b>														
1	ACAS Assessment completed during this episode														
2	ACAS Assessment incomplete: referral to Sub-acute services														
3	ACAS Assessment incomplete: other reason														
4	ACAS Consultation only during this episode														
5	No ACAS involvement during this episode														
<b>Reporting guide</b>	This information should be noted in the patient's health record by staff members or by ACAS.  <b>1 ACAS Assessment completed during this episode</b> Use code 1 if the patient has received a comprehensive assessment by a member of the ACAS of their physical, medical, psychological, social and restorative care needs with a recommendation for the patient's long term care setting and all the relevant paperwork completed (for example, 2624 certificate completed and signed if required).														

## **2 ACAS Assessment incomplete: referral to Sub-acute services**

Use code 2 if the patient was seen by the ACAS who referred the patient to sub-acute services (for example, GEM or rehabilitation) at this hospital or another campus/hospital.

*Excludes* when the assessment was not completed because the patient:

- Required further acute care to become medically stable (use 3).
- Began an assessment that was completed in a subsequent statistical episode (use 3).
- Died (use 3).
- Left against medical advice (use 3).

## **3 ACAS Assessment incomplete: other reason**

Use code 3 if the patient was seen by the ACAS but a final care plan and long term care setting recommendation could not be made.

*Includes* when the assessment was not completed because the patient:

- Required further acute care to become medically stable.
- Began an assessment that was completed in a subsequent statistical episode.
- Died.
- Left against medical advice

*Excludes* when the assessment was not completed because the patient:

- Was referred to sub-acute services (eg GEM or rehabilitation)(use 2)

## **4 ACAS Consultation only during this episode**

Use code 4 if the ACAS were consulted, or gave advice to the Hospital staff (discharge planner, social worker) about a patient's discharge and long term care setting and care plan options, but did not conduct a full assessment.

## **5 No ACAS involvement during this episode**

Use code 5 if ACAS had no involvement with the patient.

*Includes:*

- Patient referred to ACAS for a home-based assessment (record this in Separation Referral).

### **Edits**

460	Invalid ACAS Status
461	ACAS Status not Required
462	Incompat ACAS Status and Sep Referral
533	ACAS Status Code Required

### **Related items**

Section 3: *Separation Referral* page 3-149.

## **Administration**

### **Purpose**

Assist in measuring demand, and for planning of future services.

### **Principal data users**

Co-ordinated and Home Care Unit (Rural and Regional Health and Aged Care Services, DHS)

### **Collection start**

2003-04

### **Definition source**

DHS

### **Code set source**

DHS

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## Accommodation Type (a)

## Accommodation Type on Separation (b)

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### Specification

**Definition** (a) The accommodation type or types occupied by the patient during their admission, including changes to this item during the episode.  
(b) The accommodation type occupied by the patient on their last (counted) patient day.

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

**Field size** 1 **Layout** N or A

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

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

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

**Reported when** (a) The Episode Record is reported. Any changes in Accommodation Type are reported in new Status Segments.  
(b) Once the Separation Date is reported in the Episode Record.

**Code set** For data items (a) and (b), select the first appropriate category:

<b>Code</b>	<b>Descriptor</b>
4	In the Home (Hospital - HITH)
7	Ward Based/Medi-Hotel combination
8	Emergency Medical Unit
S	Short Stay Observation Unit
M	Medical Assessment and Planning Unit
6	Emergency Department accommodation
C	Nursery accommodation: NICU/SCN
B	Other nursery accommodation or mother's bedside (rooming in)
3	Same Day accommodation
2	Overnight accommodation: single room
1	Overnight accommodation: shared room

**Reporting guide** **4 In the Home (Hospital - HITH)**  
Approved care in accommodation outside the hospital.

*Includes:*

- Under the Hospital in the Home (HITH) program, if the public hospital's Health Service Agreement and/or Statement of Priorities specifies the hospital is participating in this program. HITH services can only be provided to public, private, DVA, TAC and WorkCover patients.

*Excludes:*

- Accommodation in a Medi-Hotel (use code 7).

### **7 Ward Based/Medi-Hotel combination**

For multi-day stay patients, where the patient receives treatment in a traditional hospital setting (ward) during the day and resides in the hospital's Medi-Hotel overnight.

*Includes:*

- Accommodation in same day facilities during the day.
- Where the patient is cared for in the Medi-Hotel by someone not arranged for, provided by, or paid for by the hospital, such as a relative or other carer.

*Excludes:*

- Accommodation In the Home (HITH) (use code 4).

### **8 Emergency Medical Unit**

Accommodation within an approved Emergency Medical Unit (EMU), often located near the Emergency Department.

EMUs concentrate on admissions for general medical conditions in one geographical area to streamline the care planning processes. Planned length of stay in the Emergency Medical Unit may be up to 48 hours prior to transfer to another ward or discharge home (majority of patients). The clinical management of these patients is jointly managed by Emergency Department physicians and general physicians.

*Excludes:*

- Medical Assessment and Planning Unit (use code M).
- Short Stay Observation Unit (use code S).

### **S Short Stay Observation Unit**

Accommodation within an approved Short Stay Observation Unit (SOU). The facility may be in, adjacent to, or remote from the Emergency Department.

SOU is a designated unit that is specifically staffed and equipped to provide observation care and treatment for emergency patients who have an expected length of stay between 4 and 24 hours.

*Includes:*

- General and specific Short Stay Observation Units, for example chest pain units.

*Excludes:*

- Short stay facilities designated specifically for elective surgical and radiological procedures
- Medical Assessment and Planning Unit admissions (use code M).
- Emergency Medical Unit admissions (use code 8).

### **M Medical Assessment and Planning Unit**

Accommodation within an approved Medical Assessment and Planning Unit (MAPU). MAPUs concentrate on admissions for general medical conditions in one geographical area to streamline the care planning processes. Planned length of stay in the Medical Assessment and Planning Unit may be up to 48 hours prior to transfer to another Accommodation Type (ward) or separation home.

*Excludes:*

- Short Stay Observation Unit (use code S).
- Emergency Medical Unit (use code 8).

### **6 Emergency Department accommodation**

Patient accommodation provided in the Emergency Department.

### **C Nursery accommodation: NICU/SCN**

Accommodation provided to any infant in a facility approved by the Commonwealth Minister for the purpose of provision of neonatal intensive or special care.

### **B Other nursery accommodation or mother's bedside (rooming in)**

Accommodation provided to any infant in a postnatal ward, either in a nursery that is not an approved NICU or SCN or by its mother's bedside (that is 'rooming in').

For infants in paediatric wards, report code 1, 2 or 3 as appropriate.

### **3 Same Day accommodation**

Same day bed or accommodation such as a renal dialysis chair, regardless of whether this bed/chair is in a single or shared room.

#### *Excludes:*

- Where a same day patient is accommodated in a ward or bed not designated as a same day ward/bed either because the hospital has no such designated accommodation or because that accommodation is full.

### **2 Overnight accommodation: single room**

Sole occupation of a room intended for the overnight accommodation of a single patient but only when the patient has requested single accommodation.

#### *Includes:*

- Where the patient has requested single accommodation and occupies a room intended for single occupancy but her newborn is rooming-in.
- Where a same day patient is accommodated in a ward/bed not designated as a same day ward/bed either because the hospital has no such designated accommodation or because that accommodation is full.

#### *Excludes:*

- Where the patient is the only person occupying a room intended for shared occupancy, such as the isolation of a patient for medical reasons, or where there is no available shared room (use code 1).
- Where the patient occupies a single room but has not requested single accommodation (use code 1).

### **1 Overnight accommodation: shared room**

Occupation of a room intended for the overnight accommodation of more than one patient.

#### *Includes:*

- Where the patient is the only person occupying a room intended for shared occupancy.
- Where the patient and her rooming-in newborn are the only people occupying a room intended for occupancy by more than one adult patient.
- Where the patient has not requested single accommodation but occupies a single room because of a clinical decision.
- Where a same day patient accommodated in a ward/bed not designated as a same day ward/bed either because the hospital has no such designated accommodation or because that accommodation is full.

## Edits

- (a)
- 076 Not Sufficient Fields First Status
  - 077 Not Sufficient Fields Other Status
  - 084 Invalid Accom Type
  - 094 Combination A/C Accom Care Med Suff
  - 117 Sep Accom Type Not In A Status Seg
  - 240 Newborn Accom But Over 4 Months
  - 329 Geri Respite - Invalid Comb
  - 431 Newborn But Not Newborn Accom
  - 432 MAPU or SOU >48 Hours
  - 434 NICU/SCN Accom But Unqual Newborn
  - 454 Incompat Fields for Interim Care
  - 463 Accom Type 4, Care Type invalid
  - 464 Accom Type 7, not Care Type 4
  - 520 Accom Type 7, not approved for Medi-hotel
  - 521 Accom Type M, no registered MAPU
  - 522 Accom Type S, no registered SOU
  - 527 Accom Type 8, not approved for EMU
  - 602 Newborn Accom But Over 12 Months
- (b)
- 106 Invalid Sep Accom
  - 108 Field(s) Missing From Sep
  - 117 Sep Accom Type Not In A Status Seg
  - 401 Accom Type On Sep – Emerg, Not Same Day
  - 455 Inconsist Newborn Transferred/Unqual Data

## Related items

Section 2: *Admitted Patient, Hospital in the Home, Intensive Care Unit, Medicare Eligibility Status – Eligible Person, Medicare Eligibility Status – Ineligible Person, and Medi-Hotel.*

Section 4:

- Business Rules (non-tabular) *Medi-Hotel.*
- Business Rules (tabular) *Account Class, Acc Type, Care Type and Medicare Suffix, and Account Class: Geriatric Respite, and Care Type: Interim Care Program (F and E), and Criterion for Admission: Secondary Family Member.*

Section 5: *Status Segments.*

Section 9:

- Code Lists: *Emergency Medical Unit (EMU): Accommodation Type 8, and Medical Assessment and Planning Units (MAPU): Accommodation Type M, and Neonatal Intensive Care Units and Special Care Nurseries: Accommodation Type C, and Short Stay Observation Units: Accommodation Type S, and Ward Based/Medi-Hotel Combination: Accommodation Type 7.*

## Administration

<b>Purpose</b>	For analysis of patient movement during an episode.		
<b>Principal data users</b>	Multiple internal and external data users		
<b>Collection start</b>	1991-92		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

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## Account Class (a)

## Account Class on Separation (b)

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### Specification

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

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

**Field size**                      2                      **Layout**                      AA or AN

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

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

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

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

**Code set**

<b>Code</b>	<b>Descriptor</b>
<b>Unqualified Newborns (Not Birth Episode)</b>	
NT	Newborn (Unqualified, Not birth episode)
<b>Public (Acute Care) Patient</b>	
MP	Public: Eligible
ME	Ineligible: hospital exempt
MR	Geriatric respite care
MN	Public NHT - without NH5
M5	Public NHT - with NH5
MA	Reciprocal Health Care Agreement

**Private Patient**

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

**Department of Veterans' Affairs Patient**

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

**Compensable Patient**

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

**Ineligible**

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

## **Reporting guide**

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

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

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

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

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

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

### **MP *Public: Eligible***

An eligible person who, on admission to a recognised hospital or a private hospital for services provided under contract, or as soon as possible thereafter, elects to be treated as a public patient. The hospital provides comprehensive care including all necessary medical, nursing and diagnostic services and, if available, dental and paramedical services, by means of its own staff or by other agreed arrangements, without charge to the patient.

#### *Includes:*

- Persons holding a current Interim Medicare Card.

#### *Excludes:*

- Persons holding an expired Interim Medicare Card (report XX *Ineligible*)
- A person admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient's treatment.

### **ME *Ineligible: Hospital Exempt***

An ineligible non-Australian resident:

- Specifically referred to Australia for hospital services not available in the patient's own country and for whom the Secretary of the Department has determined that no fee be charged; or
- Who has been declared a safe haven resident and whose treatment is provided or arranged by a designated hospital.

### **MR *Geriatric Respite Care***

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

**MN Public NHT – without NH5**

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

*For example:*

- Professional attention for an acute phase of the patient's condition; or
- Active rehabilitation; or
- Continued management, for medical reasons, as an admitted patient.

Nursing Home Type patients can be of the following types:

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

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

**M5 Public NHT – with NH5**

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

**MA Reciprocal Health Care Agreement**

A visitor to Australia who is ordinarily resident in a country with which Australia has a Reciprocal Health Care Agreement (RHCA), admitted for necessary medical treatment (but only as a public patient), as is clinically necessary for the diagnosis, alleviation or care of the condition requiring attention, on terms no less favourable than would apply to a resident.

**P - Private Patient**

A person who elects in writing to be treated (in a public or private hospital) as an admitted patient by a medical practitioner of their own choice and to be responsible for paying the charges referred to in clause 49 of the 1999 Australian Health Care Agreement.

*Includes:*

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

Clause 49 of the *Australian Health Care Agreement* states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria'.

**V.- Department of Veterans' Affairs Patient**

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

Public hospitals: If the first character of the patient's Account Class is V, a S2 DVA and TAC Record must be transmitted every time the Episode Record is transmitted.

**- - Compensable Patient**

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

This category includes workers compensation, transport accident, criminal injury and common law cases and members of the Defence Forces and seamen with personnel entitlements.

Clause 49 of the Australian Health Care Agreement states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria.'

**- N Compensable Non-Acute Patient**

A person who has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not a compensable patient, would be deemed to be a Nursing Home Type patient.

**J- Prisoner Patient**

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

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

**XX Ineligible Non-Australian Resident Patient**

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

*Includes:*

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

Clause 49 of the *Australian Health Care Agreement* states 'Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria'.

**XN Ineligible Non-Australian Resident - Non-Acute Patient**

A person who has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not an ineligible patient, would be deemed to be a Nursing Home Type patient.

**Public hospitals:**

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

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

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

**Private Patients:**

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

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

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

The fee charged to a private patient will depend upon:

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

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

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

**Private hospitals:**

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

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

**Contracted patients:**

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

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

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

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

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

PO PP PQ PR

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

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

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

PS PT PU PV VN V5

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

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

WC TA AS SS CL OO XX

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

**Edits**

- (a)
- 076 Not Sufficient Fields First Status
  - 077 Not Sufficient Fields Other Status
  - 083 Invalid Account Class
  - 094 Combination A/C Accom Care Med Suff
  - 111 Same Day A/C Stat Not The Only Status
  - 113 Same Day Status: Total Pt Days Not 1
  - 116 Sep A/C Class Not In A Status Seg
  - 222 Unqual Newborn; Adm Date Not Birth
  - 324 Incompat ICU Hrs, A/C Class
  - 325 Incompat MV Hrs, Acct Class
  - 329 Geri Respite - Invalid comb
  - 372 Episode Deletion: Multiple Epis Trans
  - 374 Episode DVA/TAC: No 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
  - 382 Epis Not DVA/TAC: Multiple V2 Trans
  - 391 Recip HCA Account, Not O/Seas P/Code
  - 392 Recip HCA Account, Not O/Seas Born
  - 393 Recip HCA Account, Indig Stat A or TI
  - 454 Incompat Fields for Interim Care
  - 491 Incompat Fields for ESAS
  - 492 Incompat Fields for RPI
  - 532 Account Class MA: not 4, 5E, 5K, 5G, 5S, 5A or U
  - 571 Acct Recip, Pcode Oseas, Locality Not RHCA
  - 572 Postcode Overseas, Account Not Recip, or Inelig
  - 573 Postcode Overseas, Account Public
  - 574 Postcode Overseas, Locality RHCA, Acct Not RHCA
  - 603 CCU Account Class, No CCU Hours
  - 604 ICU Account Class, No ICU Hours
  - 605 Priv Pt, CCU Hours, no CCU Account Class
  - 606 Priv Pt, ICU Hours, no ICU Account Class
  - 615 HDU Account Class, no approved ICU
  - 616 ICU Account Class, no approved ICU
  - 617 CCU Account Class, no approved CCU
- (b)
- 105 Invalid Sep Account Class
  - 108 Field(s) missing From Sep
  - 116 Sep A/C Class Not In A Status Seg
  - 454 Incompat Fields for Interim Care
  - 455 Inconsist Newborn Transferred/Unqual Data

**Related Items**

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

Section 4:

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

Section 5: *Status Segments.*

## Administration

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

**Principal data users** Financial Strategy Unit (Metropolitan Health and Aged Care Services, DHS)  
 Department of Veterans' Affairs (DVA)  
 Transport Accident Commission (TAC)  
 WorkCover (VWA)

**Collection start** 1979-80

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

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

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

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

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

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

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

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# Admission Date

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## Specification

**Definition** Date on which an admitted patient commences an episode of care (formal or statistical).

**Datatype** Numeric **Form** Date

**Field size** 8 **Layout** DDMMCCYY

**Location** Episode Record  
DVA and TAC Record

**Reported by** All Victorian hospitals (public and private).  
  
Private hospitals: Do not report a DVA and TAC Record.

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

**Reported when** The Episode Record or DVA and TAC Record is reported.

**Code set** Valid date.

### Reporting guide

#### Admission of Birth Episode

For the first episode of a Newborn, the Admission Date will be the Date of Birth, except in the unusual circumstance where the newborn is born before arrival at this hospital, and where the birth occurs just before midnight and the newborn arrives at this hospital after midnight.

#### Admission from Non-admitted Services

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care. For example, when a patient is admitted from the Emergency Department, then the admission time is the time treatment was started in the Emergency Department. That is, when the patient was first treated by a nurse or doctor, whichever comes first, rather than the time the decision is taken to admit the patient. In this context, 'treatment' includes commencement of baseline observations by a nurse and assessment of the patient by a doctor.

#### Statistical Admissions

Statistical admissions must have an Admission Date equalling the previous episode's Separation Date. Statistical separations and admissions cannot occur over midnight.

**Edits**

026	Zero Sep; Existing Not Discharged
027	Adm Record; Overlaps Existing
028	Prior Adm; No Sep Date
035	Invalid Date of Birth
038	Invalid Adm Date
039	Invalid Adm Date; > Header
057	Incompat Adm Type/Age
061	Married – Age Not Within Range

062 Duplicate Pt ID, Adm Date Time, Diff. Unique  
 063 Prior Not Discharged  
 064 Duplicate Pt ID, Date Time  
 069 Newborn From Overseas  
 074 Invalid Age For Criterion  
 080 Sex Indeterminate Age < 90 Days  
 102 Sep Date < Adm Date  
 112 Calc Los + Leave Not = Adm/Sep  
 115 Adm Time Not < Sep Time  
 122 Sameday Adm Source/Sep Mode Mismatch  
 127 Nil Value DRG  
 160 AR-DRG Grouper GST Code > Zero  
 178 Trans Adm Not Same As Episode  
 186 Neonate MDC But Age > = 28 days  
 187 Adm Weight Too Low  
 188 Adm Weight Too High  
 189 Age < 1 Year But Adm Weight Missing  
 190 Adm Wt Present But Not Aged < 1 Year  
 215 Sex Indeterminate But Age > 9 Days  
 222 Unqual Newborn; Adm Date Not Birth  
 226 Adm Date Before Birth Date  
 227 Age Calculated As 120 Years & Over  
 232 Possible Coding or Sequencing Problems  
 240 Newborn Accom But Over 4 Months  
 245 Adm Wt > = 9Kg But Age > = 5 Mth  
 255 Rehab: Invalid Onset Date  
 261 Newborn Care Type But Age > 9 days  
 262 Invalid Care Type For Newborn  
 289 Adm Sc T'fer & Onset = Adm Date  
 290 Stat Adm Sc, & Onset = Adm Date  
 322 ICU/CCU Stay > Total Stay  
 323 MV Duration > Total Stay  
 329 Geri Respite Invalid Comb  
 353 Code & Age Incompatible  
 390 Incompat Care Type, Carer Avail, Age and Sep Mode  
 397 Sep Referral Postnatal, Incompat Age/Sex  
 401 Accom Type On Sep - Emerg, Not Same Day  
 431 Newborn But Not Newborn Accom  
 438 NIV Duration > Total Stay  
 440 NIV Duration without NIV Proc Code  
 447 Unqual Newborn; Age at Sep > 10 Days  
 454 Incompat Fields for Interim Care  
 461 ACAS Status not Required  
 465 Adm Duration < 15 Mins  
 467 Adm Wt < 1000g, LOS < 28 Days, Sep Mode ≠ T or D  
 468 Care Type ≠ 1 or F, LOS > 365 Days  
 474 Care Type E, LOS > 35 Days  
 479 Incompat Adm Source/Age  
 480 Incompat Adm Source/Age < 15  
 481 Incompat Adm Source/Age < 55  
 486 Incompat Age/Crit for Adm  
 487 Incompat Age/Qual Stat  
 493 Incompat Sep Mode/Age < 15  
 494 Incompat Sep Mode/Age < 55  
 504 Stat Episode: Next Episode > 1 Minute Apart  
 505 Stat Episode: Previous Episode > 1 Minute Apart  
 518 Medicare Code = 0, Age > 6 Months  
 519 Medicare Code = 0, Age > 12 Months  
 533 ACAS Status Code Required  
 542 MH Acute Adult Care Type But Age < 14 Years  
 543 MH Acute Adult Care Type But Age > 65 Years  
 544 MH APMHS Care Type But Age < 55 Years

- 545 MH CAMHS Care Type But Age < 5 Years
- 546 MH CAMHS Care Type But Age > 19 Years
- 547 MH SECU Care Type But Age < 14 Years
- 548 MH Specialist Acute Care Type But Age < 14 Years
- 549 Type B Crit for Adm, LOS >1
- 550 Type C Crit for Adm, LOS >1
- 551 Type C Crit for Adm, LOS >4 hrs
- 552 Type E Crit for Adm, LOS >1
- 553 Type E Crit for Adm, LOS <4 hrs
- 554 Date of Accident > Adm Date
- 596 Same Day ECT: Not in Care Type 4
- 598 Same Day Rehabilitation: Not in Scope
- 602 Newborn Accom But over 12 Months
- 615 HDU Account Class, no approved ICU/CCU
- 616 ICU Account Class, no approved ICU
- 617 CCU Account Class, no approved CCU

**Related items**

Section 2: *Age, Length of Stay, Overnight or Multi-day Stay Patient, and Same Day Patient.*

Section 3: *Date of Birth* on page 3-69.

Section 4:

- Business Rules (non-tabular) *DRG Classification* and *Length of Stay.*
- Business Rules (tabular) *Admission Source and Age, and Admission Type and Age, and Age and Criterion For Admission, and Age and Qualification Status, and Carer Availability and Separation Mode, and Criterion for Admission, Age, Admission Type, Admission Source, Qualification Status.*

## Administration

**Purpose**

To enable (for data validation purposes) 'patient days' (patient's length of stay) and normal leave days to be balanced with the difference between Admission Date and Separation Date.

To enable calculation of age.

**Principal data users**

Multiple internal and external data users.

**Collection start**

1979-80

**Definition source**

NHDD

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# Admission/Re-Admission to Rehabilitation

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## Specification

<b>Definition</b>	Indicates whether this is the first or subsequent rehabilitation episode for a particular injury/condition.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N or space
<b>Location</b>	Sub-Acute Record		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Care Types 2, 6, 7 and K. For Care Types 8, 9, F and E, report a space.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	
	0	First rehabilitation admission	
	1	Re-admission for rehabilitation	
<b>Reporting guide</b>	<b>0 First rehabilitation admission</b> Patient's current admission is their first rehabilitation episode for this condition.		
	<b>1 Re-admission for rehabilitation</b> Patient's current admission is a re-admission for rehabilitation for this condition.		
<b>Edits</b>	254	Rehab - Invalid Adm/Re-Adm to Rehab	
	258	Sub-Acute: No Sub-Acute Record	
	295	Adm/Readmit To Rehab Present	
	454	Incompat Fields for Interim Care	
<b>Related items</b>	Section 2: <i>Rehabilitation Care</i> .		
	Section 4:		
	<ul style="list-style-type: none"><li>Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)</i>, and <i>Care Type: Interim Care Program (F and E)</i>.</li></ul>		

## Administration

<b>Purpose</b>	To support and further develop casemix classifications for sub-acute episodes of care.		
<b>Principal data users</b>	Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).		
<b>Collection start</b>	1995-96		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

---

# Admission Source

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## Specification

**Definition** Describes where the patient was residing or living prior to the commencement of an episode of care.

**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>
S	Statistical Admission (change in Care Type within the hospital)
Y	Birth episode
T	Transfer from acute hospital/extended care/rehabilitation/geriatric centre
B	Transfer from Transition Care bed based program
N	Transfer from aged care residential facility
A	Transfer from mental health residential facility
H	Admission from private residence/accommodation

**Reporting guide** **S Statistical Admission (change in Care Type within this hospital)**  
Assign this code when a new episode of care has commenced within the same hospital stay on the same hospital campus.

*Includes:*

- Statistical admission to Palliative Care (Care Type 8) only if the change is from Nursing Home Type (Care Types F, 1 or 5T).

*Excludes:*

- Change from or to Unqualified newborn (Care Type U) as a Statistical Separation or a Statistical Admission. Changes between Qualified and Unqualified status of newborns is recorded in Status Segments using the Qualification Status field. Refer to Section 4: *Newborn*.
- Change between Rehabilitation Program/Units: Levels 2, 6, or 7 Care Types (2, 6, 7).
- Change from Palliative Care (Care Type 8) as a Statistical Separation Admission, unless the change is from or to Nursing Home Type (Care Types F, 1 or 5T).

**Y Birth episode**

Admission of newborn at or directly after birth.

*Excludes* second or subsequent admissions in the newborn period:

- Newborns admitted after the birth episode, while still nine (9) days old or less (use code T or H).

**T *Transfer from acute hospital / extended care / rehabilitation / geriatric centre***

Admission to this hospital, directly from another acute hospital, extended care, rehabilitation or geriatric centre, regardless of whether the patient was admitted or not at the transferring hospital. Requires a Transfer Source code.

*Includes:*

- Public and private acute, extended care and mental health admitted patient units.

*Excludes:*

- Transition Care bed based program (use code B).
- Aged care residential facilities (use code N).
- Mental health residential facility (use code A).

**B *Transfer from Transition Care bed based program***

Admission to hospital directly from a Transition Care bed based program. Does not require a Transfer Source code.

*Excludes:*

- Home-based Transition Care.

**N *Transfer from aged care residential facility***

Admission to hospital directly from an aged care residential facility (includes nursing home and hostel). Does not require a Transfer Source code.

*Excludes:*

- Transition Care bed based program (use code B).
- Mental health aged care residential facility (use code A).

**A *Transfer from mental health residential facility***

Transfer from mental health residential facility (includes psychogeriatric nursing homes and community care units) (Rehabilitation/Continuing Care/Other Care) funded by Mental Health Services. Only mental health residential facilities listed in Section 9 apply to this code. Does not require a Transfer Source code.

*Includes:*

- Mental health aged care residential facility.

*Excludes:*

- Mental health admitted patient units (use code T).

**H *Private Residence/Accommodation***

Place of residence immediately prior to admission.

*Includes:*

- Home or home of relative or friend.
- Supported residential facilities.
- Special accommodation houses.
- Training centres for intellectually disabled persons.
- Prison.
- Forensic hospital (Thomas Embling).
- Juvenile detention centre.
- Armed forces base camp/hospital.
- Homeless (shelters, half way houses).

*Excludes:*

- Transition Care bed based program (use code B).
- Aged care residential facility (use code N).
- Mental health residential facility (use code A).

## Edits

041	Invalid Adm Source
051	Transfer Source Blank
056	Incompatible Adm Type/Source
122	Sameday Adm Source/Sep Mode Mismatch
289	Adm Sc T'fer & Onset = Adm Date
290	Stat Adm Sc & Onset Date = Adm Date
328	Early Parenting Centre – Invalid Comb
329	Geri Respite – Invalid Comb
336	Invalid comb For Crit Care Transfer
423	Invalid Comb Fund/Contract/Transfer
454	Incompat Fields for Interim Care
479	Incompat Adm Source/Age
480	Incompat Adm Source/Age <15
481	Incompat Adm Source/Age <55
482	Incompat Adm Source/Crit for Adm
483	Incompat Adm Source/Qual Stat
488	Incompat Care Type/Adm Source Statistical
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
499	Stat Admission: No Prev Episode
501	Stat Episode: Adm Source ≠ Sep Mode Prev Episode
503	Stat Episode: Care Type same as Prior Episode
505	Stat Episode: Previous Episode > 1 Minute Apart
507	Stat Episode: Rehab also in Prior Episode
509	Stat Episode: Sep Mode ≠ Adm Source Next Episode
510	Stat Sep Mode: No Subsequent Episode
528	Stat Episode Pall: Not NHT in Prior Episode

## Related items

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

Section 3: *Transfer Source*, page 3-163.

Section 4:

- Business Rules (non-tabular) *Episode of Care, Newborn and Transfer.*
- Business Rules (tabular) *Account Class: Geriatric Respite, and Admission Source and Admission Type, and Admission Source and Age, and Admission Source and Care Type, and Admission Source and Criterion For Admission, and Admission Source and Qualification Status, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type: Interim Care Program (F and E), and Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode, and Criterion for Admission, Age, Admission Type, Admission Source, Qualification Status, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative, and Reasons for Critical Care Transfer: Valid Combinations.*

## Administration

<b>Purpose</b>	To analyse patient movement.		
<b>Principal data users</b>	Multiple internal and external data users.		
<b>Collection start</b>	1979-80		
<b>Definition source</b>	NHDD	<b>Code set source</b>	DHS

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# Admission Time

---

## Specification

<b>Definition</b>	Time at which an admitted patient commences an episode of care.		
<b>Datatype</b>	Numeric	<b>Form</b>	(24 Hour) Time
<b>Field size</b>	4	<b>Layout</b>	HHMM
<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>	A valid 24-hour time (not 0000 or 2400).		
<b>Reporting guide</b>	For a <b>formal admission</b> , the Admission Time is the time at which patient was admitted (at the admission desk), the time of birth, or the time care commenced in the Emergency Department (see below).		

For a **statistical admission** (Care Type change), a dummy Admission Time is acceptable to enable the times to be automatically recorded. Care Type changes could be recorded as occurring at midday. The Admission Time must be one minute later than the Separation Time of the preceding episode (for example, if Separation Time of the earlier episode was made to be 1200, Admission Time of the new episode would be 1201).

### Midnight

Following international convention, midnight is either 2359 of preceding date or 0001 of following date (0000 and 2400 are not accepted).

### Newborns

- For newborns born in this hospital, the Admission Time is the time of birth.
- For newborns born before arrival or transferred to this hospital from another, the Admission Time is time of arrival at this hospital.

### Admission from Non-admitted Services

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care. For example, when a patient is admitted from the Emergency Department, then the Admission Time is the time treatment was started in the Emergency Department. That is, when the patient was first treated by a nurse or doctor, whichever comes first, rather than the time the decision is taken to admit the patient. In this context, 'treatment' includes commencement of baseline observations by a nurse and assessment of the patient by a doctor.

<b>Edits</b>	027	Adm Record; Overlaps Existing
	040	Invalid Adm Time
	062	Duplicate Pt ID, Adm Date Time, Diff Unique
	064	Duplicate Pt ID, Date Time
	115	Adm Time Not < Sep Time
	322	ICU/CCU Stay > Total Stay
	323	MV Duration > Total Stay
	438	NIV Duration > Total Stay
	465	Adm Duration < 15 Mins
	504	Stat Episode: Next Episode > 1 Minute Apart
	505	Stat Episode: Previous Episode > 1 Minute Apart
	551	Type C Crit for Adm, LOS >4 hrs
	553	Type E Crit for Adm, LOS <4 hrs

**Related items**                    Section 3: *Admission Date* page 2-19.

## **Administration**

**Purpose**                                To enable the exact Length of Stay to be determined.

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

**Collection start**                    1990-91

**Definition source**                NHDD

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# Admission Type

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## Specification

**Definition** The category of admission (patient characteristic) relating to this episode of care.

**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>
S	Statistical admission (change in Care Type within this hospital)
Y	Birth episode
M	Maternity
C	Emergency admission through Emergency Department at this hospital
L	Admission – from the Waiting List
O	Other emergency admission
X	Other admission

**Reporting guide** **S Statistical admission (change in Care Type within this hospital)**  
Used for statistical admissions.

**Y Birth episode**  
Admission of newborn at or directly after birth.

*Excludes* second or subsequent admissions in the newborn period:

- Newborns admitted after the birth episode, while still nine (9) days old or less (use code C, L, O or X).

**M Maternity**  
Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy.

### **C    *Emergency admission through Emergency Department at this hospital***

Admission of an emergency patient, arising from presentation at the Emergency Department of this hospital.

Use of this code is not limited to those facilities that report to the Victorian Emergency Minimum Dataset (VEMD).

*Includes:*

- Threatened miscarriage before 20 weeks.

*Excludes:*

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).

### **L    *Admission – from the Waiting List***

Admission of a patient currently on the waiting list for elective medical or surgical treatment as an admitted patient. Waiting list patients include only those elective admissions for whom names, addresses and other necessary details are held by the hospital on a specific list prepared from a written request for admission from the patient's doctor.

Use of this code is not limited to those facilities that report elective surgery waiting list data to the Elective Surgery Information System (ESIS).

*Includes:*

- Non-elective admissions managed through the use of a 'waiting list', for example rehabilitation episodes.

### **O    *Other emergency admission***

Admission of an emergency patient, not arising from presentation at the Emergency Department at this hospital.

*Includes:*

- GP-referred admission or self-referral for acute illness (such as unstable diabetes, CCF, pneumonia, asthma attack) directly for emergency admission.
- Threatened miscarriage before 20 weeks.
- Emergency admission to a hospital without a formal Emergency Department.
- Admission from Outpatient Department where patient is an emergency patient.

*Excludes:*

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).

### **X    *Other admission***

Routine or elective admission regardless of expected length of stay, where the patient is not recorded on the waiting list.

*Includes:*

- Planned admission for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.
- Admission from Outpatient Department where patient is an elective patient.
- Follow-up admission following a previous emergency admission or presentation.

<b>Edits</b>	052	Invalid Adm Type
	056	Incompatible Adm Type/Source
	057	Incompat Adm Type/Age
	059	Maternity - Not Female
	328	Early Parenting Centre – Invalid Comb
	329	Geri Respite - Invalid Comb
	336	Invalid Comb For Crit Care Transfer
	454	Incompat Fields for Interim Care
	455	Inconsist Newborn Transferred/Unqual Data
	466	Adm Type L & Newborn Qual Status
	484	Incompat Adm Type/Crit for Adm
	485	Incompat Adm Type/Qual Stat
	491	Incompat Fields for ESAS
	492	Incompat Fields for RPI

**Related items** Section 2: *Admission, Geriatric Respite, Newborn, and Urgency of Admission.*

Section 4:

- Business Rules (non-tabular) *Newborn.*
- Business Rules (tabular) *Account Class: Geriatric Respite, and Admission Source and Admission Type, and Admission Type and Age, and Admission Type and Criterion For Admission, and Admission Type and Qualification Status, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type: Interim Care Program (F and E), and Criterion for Admission, Age, Admission Type, Admission Source, Qualification Status, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative, and Reasons for Critical Care Transfer: Valid Combinations.*

## Administration

<b>Purpose</b>	To:		
		<ul style="list-style-type: none"> <li>• Distinguish between emergency and non-emergency admissions.</li> <li>• Monitor admissions from the Waiting List.</li> <li>• Identify data for maternity and birth episodes.</li> </ul>	
<b>Principal data users</b>	Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).		
<b>Collection start</b>	1979-80		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

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# Admission Weight

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## Specification

<b>Definition</b>	The birth weight of the live baby, or the weight of the neonate or infant (under one year of age) on the date admitted, if this is different from the date of birth.		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	4	<b>Layout</b>	NNNN or spaces. Right justify, leading zeros.
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted patients under 1 year of age.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	Valid weight in grams, 0125-9999. If Admission Weight is not required, transmit spaces, not zeros.		
<b>Reporting guide</b>	<p>Admission Weight is required for all infants under 1 year of age at admission (that is, admitted on a date earlier than the infant's first birthday).</p> <p>Where the admission starts on the day of birth, the birth weight is the Admission Weight.</p> <p>As the grouper accepts an admission weight range of 400 to 9999 grams, episodes reported to PRS/2 with an Admission Weight of between 125 and 399 grams will be assigned an admission weight of 400 grams (by PRS/2) for the purpose of grouping to the appropriate VIC-DRG5.</p> <p>If Admission Weight is unknown or heavier than 9999, and the patient is aged greater than 27 days, use 9999.</p>		
<b>Edits</b>	<p>127 Nil Value DRG</p> <p>160 AR-DRG Grouper GST Code &gt; Zero</p> <p>187 Adm Weight Too Low</p> <p>188 Adm Weight Too High</p> <p>189 Age &lt; 1 Year But Adm Weight Missing</p> <p>190 Adm Wt Present But Not Aged &lt; 1 Year</p> <p>232 Possible Coding or Sequencing Problem</p> <p>245 Adm Wt &gt;= 9kg But Age &lt;= 5 Mth</p> <p>329 Geri Respite – Invalid Comb</p> <p>334 Hosp Generated DRG Not = PRS/2 DRG</p> <p>411 Adm Wt &lt; 1000g, No Matching Dx Code</p> <p>412 Adm Wt is 1000-2499g, No Matching Dx Code</p> <p>413 Adm Wt &gt; 6000g, No Matching Dx Code</p> <p>454 Incompat Fields for Interim Care</p> <p>467 Adm Wt &lt;1000g, LOS &lt; 28 Days, Sep Mode ≠ T or D</p> <p>534 Invalid Adm Weight</p>		

**Related items**

Section 3: *Admission Date* on page 3-19, and *Date of Birth* on page 3-69.

Section 4:

- Business Rules (non-tabular) *DRG Classification*.
- Business Rules (tabular) *Account Class: Geriatric Respite*, and *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, and *Care Type: Interim Care Program (F and E)*.

## Administration

**Purpose**

To:

- Monitor the Admission Weight of patients <1 year of age. Weight is an important indicator of pregnancy outcome, is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants.
- To enable accurate grouping in DRG systems.

**Principal data users**

Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).

**Collection start**

1993-94

**Definition source**

DHS

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## Barthel Index Score on Admission (a)

## Barthel Index Score on Separation (b)

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### Specification

<b>Definition</b>	(a) Barthel Index Score, as assessed on admission. (b) Barthel Index Score, as assessed on separation.		
<b>Datatype</b>	Numeric	<b>Form</b>	Score
<b>Field size</b>	3	<b>Layout</b>	NNN or spaces. Right justified with leading zeros.
<b>Location</b>	Sub-Acute Record		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Care Types F, E, 2, 6, 7, 9 and K. For Care Type 8, report spaces.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	Report a score in the range 000-100, using the following table:		

## Barthel Index

	Can do without aids	Can do with aids	Can do with help of someone else	Cannot do at all
<b>Self Care Index</b>				
Drinking from a cup	4	2	0	0
Eating	6	3	0	0
Dressing upper body	5	5	3	0
Dressing lower body	5	5	2	0
Putting on brace or artificial limb	0	0	-2	0 (if not applicable)
Grooming	5	5	0	0
Washing or bathing	4	4	0	0
Controlling urination	10	10	5 (accidents)	0
Controlling bowel movements	10	10	5 (accidents)	0
Care of perineum/ clothes at toilet	4	4	2	0
<b>Mobility Index</b>				
Getting in and out of chair	15	15	7	0
Getting on and off toilet	6	5	3	0
Getting in and out of shower/bath	1	1	0	0
Walking 50 yards on the level	15	15	10	0
Walking up/down one flight of stairs	10	10	5	0
<b>If not walking</b>				
Propelling or pushing wheelchair	15	5	0	0
<b>TOTAL</b> (out of 100)				

### **Reporting guide**

Assessment of Barthel Indexes is required at admission and separation for all S2 Records (excluding Palliative Care) except when:

- Reporting an S2 record because this has started statistically after an episode for which a Separation Barthel had been reported – the Separation Barthel of that previous episode can be repeated as this episode's Admission Barthel.
- Reporting an S2 record because the episode is ending statistically before another Interim Care episode - the Admission Barthel of this episode can be repeated as this episode's Separation Barthel.

- (a) The Barthel Index on Admission should be assessed within 48 hours of admission.
- (b) The Barthel Index on Separation should be assessed on the day on which the decision is taken to cease the Care Type.
  - The Barthel Index on Separation for patients who die in hospital is 000.

- Edits**
- (a) 251 Invalid Adm Barthel
  - 258 Sub-Acute: No Sub-Acute Record
  - 291 Adm Barthel > Sep Barthel
  - 298 Adm Barthel Present
  - 407 Rehab Level 2 or 3 W Low Adm Barthel
  - 454 Incompat Fields for Interim Care
  
  - (b) 252 Invalid Sep Barthel
  - 258 Sub-Acute: No Sub-Acute Record
  - 288 Sep Barthel & Sep Mode Incompatible
  - 291 Adm Barthel > Sep Barthel
  - 292 Sep Barthel Present
  - 454 Incompat Fields for Interim Care

- Related items**
- Section 4:
- Business Rules (tabular), *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, and *Care Type: Interim Care Program (F and E)*.

## Administration

**Purpose** To support and further develop casemix classifications for sub-acute episodes of care.

**Principal data users** Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).

**Collection start** 1995-96

**Definition source** DHS **Code set source** Barthel Index

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# Carer Availability

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## Specification

<b>Definition</b>	A record of whether a person, such as a family member, friend or neighbour has been identified as providing regular on-going care or assistance, not linked to a formal service.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N or space
<b>Location</b>	Episode Record		
<b>Reported by</b>	Public hospitals.  Private hospitals: Report a space in this field.		
<b>Reported for</b>	Admitted episodes with a Care Type of 1, 2, 6, 7, K, 8, 9, F, or E.  For all other Care Types, report a space in this field.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	
	1	Carer not needed/not applicable	
	2	Lives alone, has a carer	
	3	Lives alone, has no carer	
	4	Lives with another, has no carer	
	5	Lives with another, has a resident carer	
	6	Lives with another, has a non-resident carer	
	7	Lives in a mutually dependent situation	
	8	Missing or not recorded	
<b>Reporting Guide</b>	Support provided by a carer excludes (for VAED purposes) <i>formal</i> services such as delivered meals or home help, persons arranged by formal services such as volunteers, and funded group housing or similar services.  Availability infers carer willingness and ability to undertake the caring role and can apply when there are several carers. Where a potential carer is not prepared to undertake the role, or when their capacity to carry out necessary tasks is minimal, then the patient must be reported as not having an <i>informal</i> carer.  Where there are several carers, a decision should be taken as to which of these is the main or primary carer and report accordingly.		

**1 Carer not needed/not applicable**

Person able to self care and/or their therapeutic regime does not require the input of an informal carer, or reporting in this field is not applicable because this is a statistical separation, or the patient has been transferred to another hospital, left against medical advice or died.

*Includes:*

- Those circumstances where it may be inappropriate for a carer at home to undertake a complex medical procedure requiring a high level of nursing skill.
- Person who is discharged to supported accommodation or other care facility that will provide the formal care required.

*Excludes:*

- Circumstances where a relative or friend is available but is unwilling or unable to undertake a carer role (report 3 or 4).
- Children under eight years of age (report 4, 5 or 6), unless the patient has been statistically separated, transferred to another hospital, left against medical advice or died.

**2 Lives alone, has a carer**

Person lives alone and has an informal carer who is able and willing to attend to the person's recuperative needs on an ongoing basis.

**3 Lives alone, has no carer**

Person lives alone and does not have an informal carer willing and/or able to visit for the purpose of assisting with care on an arranged and regular basis.

**4 Lives with another, has no carer**

Person does not live alone but the co-resident/s is/are unable or unwilling to provide the care needed and there is no other external informal carer available.

**5 Lives with another, has a resident carer**

Household where the person lives with another who is willing and able to provide the care required for recuperation.

*Excludes:*

- Person whose potential co-resident carer is mutually dependent (7).

**6 Lives with another, has a non-resident carer**

Person does not live alone but the co-resident/s is/are unable and/or unwilling to provide the care needed, but there is an external informal carer who is willing and able to provide this care.

**7 Lives in a mutually dependent situation**

Households where the service recipient and another person are mutually dependent. The critical aspect of such households is that if either member becomes unavailable for any reason, the other is either at high risk or unable to remain at home.

**8 Missing or not recorded**

Insufficient information to determine Carer Availability.

**Edits**

- 108 Field(s) Missing From Sep
- 390 Incompat Care Type, Carer Avail, Age and Sep Mode
- 421 Not Separated; Carer Avail Present
- 491 Incompat Fields for ESAS
- 492 Incompat Fields for RPI
- 591 Invalid Carer Availability
- 599 Carer Availability Not Required

**Related items** Section 3: *Separation Mode* on page 3-145.

Section 4:

- Business Rules (tabular) *Carer Availability and Separation Mode*, and *Funding Arrangement: Elective Surgery Access Service*, and *Funding Arrangement: Rural Patients Initiative*.

## Administration

**Purpose** To enable monitoring of the impact of Carer Availability on separation timing and use of ambulatory services, to support policy development and planning.

**Principal data users** Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).

**Collection start** 1999-00

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

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# Care Type

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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>	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.		
<b>Code set</b>	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
K	Non-Designated Rehabilitation Program/Unit
8	Palliative Care Program
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
4	Other care (Acute) including Qualified newborn
U	Unqualified newborn

## **Reporting guide**

### **F Interim Care Program —Nursing Home Type**

Use this Care Type only for a patient admitted to a unit designated to provide Interim Care and who has been classified as NHT.

#### **NHT**

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

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

Private hospitals: Do not use code F.

#### *Excludes:*

- NHT/Non-Acute (1)
- Approved Mental Health Service or Psychogeriatric Program Mental Health Nursing Home Type (5T).

### **E Interim Care Program**

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

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

Private hospitals: Do not use code E.

### **1 NHT/Non-Acute**

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

#### **NHT**

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

#### **Non-Acute**

The patient has been in one or more hospitals (public and private) for a continuous period of more than 35 days (with a maximum break of seven consecutive days). If this patient had not been a compensable/ineligible patient, they would be deemed to be a Nursing Home Type patient.

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

#### *Excludes:*

- Interim Care Program – Nursing Home Type (F)
- Approved Mental Health Service or Psychogeriatric Program Mental Health Nursing Home Type (5T).

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

A patient who is admitted to, or transferred to, a designated Rehabilitation Program/Unit Level 1. Use code 2 only if:

- The public hospital's Health Service Agreement and/or Statement of Priorities specifies that the hospital has such a designated unit.
- The rehabilitation episode directly follows the acute care episode in which the principal diagnosis is a spinal cord injury or head injury, or an amputation has been performed.

Private hospitals: Do not use code 2.

## **6 Designated Rehabilitation Program/Unit: Level 2**

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

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

## **7 Designated Rehabilitation Program/Unit: Level 3**

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

Private hospitals: Do not use code 7.

## **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.

## **8 Palliative Care Program**

A patient who is admitted to a Palliative Care Program.

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

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

**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 and/or Statement of Priorities 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.

*Excludes:*

- Mental Health Nursing Home Type (5T)
- 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 2624 certificate (formerly NH5 Form).

*Excludes:*

- Interim Care Program – Nursing Home Type (F)
- NHT/Non-Acute (1).

**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 (5K)

**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 (5T)

**9 Geriatric Evaluation and Management Program**

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

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

**0 Alcohol and Drug Program**

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

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

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

Other types of patient:

*Includes:*

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

*Excludes:*

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

**U Unqualified newborn**

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

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

## **Additional Notes:**

### **Newborns**

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

Refer to Sections 2 and 4: *Newborn*.

### **All other episodes**

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

For example:

- If the patient is admitted to Acute care (Care Type 4) but later is transferred to an Approved Mental Health Service, the Care Type changes to Care Type 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 F, 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 Legal, Care & PFS
285	Sub-Acute Record not required
288	Sep Barthel & Sep Mode Incompatible
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  
 390 Incompat Care Type, Carer Avail, Age and Sep Mode  
 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 of 5T, LOS >365 Days  
 471 Care Type 5x, not usual Sep Referral  
 472 Pall Care, 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  
 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  
 532 Account Class MA: not 4, 5E, 5K, 5G, 5S, 5A or U  
 533 ACAS Status Code Required  
 535 Care Type 5E, not approved for SECU  
 536 Care Type 5T, not approved for NHT  
 537 Care Type 5K, not approved for CAMHS  
 538 Care Type 5G, not approved for Aged Acute  
 539 Care Type 5S, not approved for Specialist Acute  
 540 Care Type 5A, not approved for Adult Acute  
 541 Care Type K, not approved for Non-Desig Rehab  
 542 MH Acute Adult Care Type But Age < 14 Years  
 543 MH Acute Adult Care Type But Age > 65 Years  
 544 MH APMHS Care Type But Age < 55 Years  
 545 MH CAMHS Care Type But Age < 5 Years  
 546 MH CAMHS Care Type But Age > 19 Years  
 547 MH SECU Care Type But Age < 14 Years  
 548 MH Specialist Acute Care Type But Age < 14 Years  
 575 Care Type 5x, MHSWPI Blank  
 578 MHSWPI Present, not Care Type 5x  
 586 Care Type 2, not approved for Rehab Lvl 1  
 587 Care Type 6, not approved for Rehab Lvl 2  
 588 Care Type 7, not approved for Rehab Lvl 3

- 596 Same Day ECT: Not in Care Type 4
- 597 Mental Health Episode: Sep Mode = S
- 598 Same Day Rehabilitation: Not in Scope
- 599 Carer Availability Not Required
- 607 Care Type Pall Care: Pall Care Pt Days not = Pt Days Total
- 608 Invalid Palliative Care Pt Days

**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 and Non-Designated Rehabilitation Programs (2, 6, 7 and K), 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 Care Type 2: Rehabilitation Program: Level 1, and Care Type 5A: Mental Health Service and Psychogeriatric Program – Acute, Adult Mental Health Service, and Care Type 5E: Mental Health Service and Psychogeriatric Program – Mental Health Secure Extended Care Unit (SECU), and Care Type 5G: Mental Health Service and Psychogeriatric Program – Acute, Aged Persons Mental Health Service (APMH), and Care Type 5K: Mental Health Service and Psychogeriatric Program – Child and Adolescent Mental Health Service (CAMHS), and Care Type 5S: Mental Health Service and Psychogeriatric Program – Acute, Specialist Mental Health Service, and Care Type 5T: Mental Health Service and Psychogeriatric Program – Mental Health Nursing Home Type, and Care Type 6: Rehabilitation Program: Level 2, and Care Type 7: Rehabilitation Program: Level 3, and Care Type 8 and Palliative Care Patient Days: Palliative Care Program, and Care Type 9: Geriatric Evaluation and Management (GEM) Program, and Care Type F and E: Interim Care Program, and Care Type K: Non-Designated Rehabilitation Program/Unit.*

## Administration

<b>Purpose</b>	To distinguish various types of care in order to: <ul style="list-style-type: none"> <li>• Apply the appropriate funding formula to the episode.</li> <li>• Group episodes to facilitate analysis.</li> </ul>		
<b>Principal data users</b>	Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS). Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).		
<b>Collection start</b>	1995-96		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

---

# Clinical Sub-Program

---

## Specification

<b>Definition</b>	The diagnosis, based on the body system manifesting the reason for rehabilitation.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	3	<b>Layout</b>	NNN Right justify, leading zero.
<b>Location</b>	Sub-Acute Record		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Care Types 2, 6, 7 and K. For Care Types 8, 9, F and E, report spaces.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		

### Code set

<b>Code</b>	<b>Descriptor</b>
010	<b>Stroke</b>
020	<b>Head Injury</b>

### Neurological

031	Multiple sclerosis
032	Parkinsonism
033	Polyneuropathy
034	Guillain-Barre
039	Other neurological

### Spinal Cord

041	Paraplegia incomplete
042	Paraplegia complete
043	Quadriplegia incomplete C1-4
044	Quadriplegia incomplete C5-8
045	Quadriplegia complete C1-4
046	Quadriplegia complete C5-8
049	Other spinal cord

### Amputation of Limb

051	Upper extremity above elbow <i>Includes:</i> shoulder disarticulation
052	Upper extremity below elbow <i>Includes:</i> hand and/or finger(s) alone double upper extremity of finger(s) alone
053	Single lower extremity above knee <i>Includes:</i> hip disarticulation
054	Single lower extremity below knee <i>Includes:</i> foot and/or toe(s) alone
055	Double lower extremity above knee <i>Includes:</i> hip(s) disarticulation
056	Double lower extremity above/ below knee <i>Includes:</i> hip disarticulation feet and/or toes alone
057	Double lower extremity below knee <i>Includes:</i> feet and/or toes alone

059 Multiple limbs  
*Includes:* lower and upper extremities  
double shoulder disarticulation  
double upper extremities, includes both hands but excludes  
if only fingers of both hands [052]

**Arthritis**

061 Rheumatoid  
062 Osteoarthritis  
069 Other arthritis

**Pain**

071 Neck pain  
072 Back pain  
073 Extremity pain  
079 Other pain

**Orthopaedic**

081 Post hip fracture  
082 Post femur (shaft) fracture  
083 Post pelvic fracture  
084 Post major multiple fracture  
085 Post hip replacement  
086 Post knee replacement  
089 Other orthopaedic  
090 Cardiac

**Pulmonary**

101 Chronic obstructive pulmonary disease  
109 Other pulmonary

110 **Burns**

120 **Musculoskeletal**

**Major Multiple Trauma**

131 Brain and spinal cord  
132 Brain and multiple fracture/amputation  
133 Spinal cord and multiple fracture/amputation  
139 Other major multiple trauma  
140 Other Disabling Impairment

150 **Other Geriatric Management**

**Reporting guide**

Clinical Sub-Program should be assigned by the treating clinician.  
Sub-program assignment must be supported by the appropriate ICD-10-AM  
codes reported in the X2/Y2 Diagnosis/Extra Diagnosis Records.

**Edits**

253 Rehab Invalid Clin Sub-Prog  
258 Sub-Acute: No Sub-Acute Record  
293 Clin Sub-Prog Present  
405 Inapplic Clin Prog For Care Type 2  
454 Incompat Fields for Interim Care

**Related items**

Section 2: *Rehabilitation Care*.

Section 4:

- Business Rules (tabular) *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, and *Care Type: Interim Care Program (F and E)*.

## Administration

<b><i>Purpose</i></b>	To support and further develop casemix classifications for sub-acute episodes of care.		
<b><i>Principal data users</i></b>	Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).		
<b><i>Collection start</i></b>	1995-96		
<b><i>Definition source</i></b>	DHS	<b><i>Code set source</i></b>	DHS

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# Contract Leave Days Financial Year-To-Date

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## Specification

<b>Definition</b>	The number of days during this episode of care that the patient was out of hospital on 'contract leave' in the financial year being reported (includes the month being reported).		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	2	<b>Layout</b>	NN or spaces Right justified and zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases and providers of contracted care).  All other sites, report spaces in this field.		
<b>Reported for</b>	Episodes where: <ul style="list-style-type: none"><li>• Funding Arrangement is 1 <i>Contract</i> and</li><li>• Contract Type is 2 <i>Contract Type ABA</i>, 3 <i>Contract Type AB</i> or 5 <i>Contract Type BA</i> and</li><li>• Contract Role A <i>Hospital A</i>.</li></ul> Contract leave is not reported where a patient goes on contract leave and returns on the same day.		
<b>Reported when</b>	This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.		
<b>Code set</b>	A valid number equal to or greater than month-to-date contract leave days.  The minimum valid number is 01. If there are no Contract Leave Days to report, transmit spaces, not zeros.		
<b>Reporting guide</b>	Contracted Leave Days are included in Patient Days.  The method of calculating Contract Leave Days is consistent with method of calculating leave with or without permission days.  Contract Leave Days Financial Year-To-Date must be equal to or greater than Contracted Leave Days Month-To-Date and equal to or less than Contract Leave Days Total.		
<b>Edits</b>	278 Contract Lve YTD Not Num/Blank 282 Contract Lve YTD < MTD 284 Contract Lve Total < YTD 456 Contract Leave, No Contract		

**Related items**

Section 2: *Contracted Care, Leave With Permission, Leave Without Permission and Patient Day.*

Section 3: *Contract Leave Days Month-To-Date* page 3-52, *Contract Leave Days Total* page 3-54, *Patient Days Financial Year-To-Date* page 3-122, *Patient Days Month-To-Date* page 3-123, and *Patient Days Total* page 3-124.

Section 4:

- Business Rules (non-tabular) *Contracted Care* and *Length of Stay*.
- Business Rules (tabular) *Contracting: Contract Fields, Contract Leave and Funding Arrangement*, and *Contracting: Funding Arrangement and Contract Fields*.

## Administration

<b><i>Purpose</i></b>	To identify days (in this financial year to date) a patient was on contract leave from this hospital (not on leave with or without permission).
<b><i>Principal data users</i></b>	Funding Policy Section (Metropolitan Health and Aged Care Services, DHS).
<b><i>Collection start</i></b>	1996-97
<b><i>Definition source</i></b>	DHS

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# Contract Leave Days Month-To-Date

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## Specification

<b>Definition</b>	The number of days during this episode of care that the patient was out of hospital on 'contract leave' 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 and zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases and providers of contracted care).  All other sites, report a space in this field.		
<b>Reported for</b>	Episodes where: <ul style="list-style-type: none"><li>• Funding Arrangement is 1 <i>Contract</i> and</li><li>• Contract Type is 2 <i>Contract Type ABA</i>, 3 <i>Contract Type AB</i> or 5 <i>Contract Type BA</i> and</li><li>• Contract Role A <i>Hospital A</i>.</li></ul> Contract leave is not reported where a patient goes on contract leave and returns on the same day.		
<b>Reported when</b>	This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.		
<b>Code set</b>	A valid number less than or equal to the number of month-to-date patient days.  The minimum valid number is 01. If there are no Contract Leave Days to report, transmit spaces, not zeros.		
<b>Reporting guide</b>	Contracted Leave Days are included in Patient Days.  Method of calculating Contract Leave Days is consistent with method of calculating leave with or without permission days.  Contract Leave Days Month-To-Date must be equal to or less than Contracted Leave Days Financial Year-To-Date and Contract Leave Days Total.		
<b>Edits</b>	277 Contract Lve MTD Not num/blank 282 Contract Lve YTD < MTD 283 Contract Lve Total < MTD 456 Contract Leave, No Contract		

**Related items**

Section 2: *Contracted Care, Leave With Permission, Leave Without Permission and Patient Day.*

Section 3: *Contract Leave Days Financial Year-To-Date* page 3-50, *Contract Leave Days Total* page 3-54, *Patient Days Financial Year-To-Date* page 3-122, *Patient Days Month-To-Date* page 3-123, and *Patient Days Total* page 3-124.

Section 4:

- Business Rules (non-tabular) *Contracted Care and Leave.*
- Business Rules (tabular) *Contracting: Contract Fields, Contract Leave and Funding Arrangement, and Contracting: Funding Arrangement and Contract Fields.*

## Administration

**Purpose** To identify days (in this month to date) that a patient was on contract leave from this hospital (not on leave with or without permission).

**Principal data users** Funding Policy Section (Metropolitan Health and Aged Care Services, DHS).

**Collection start** 1996-97

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

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# Contract Leave Days Total

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## Specification

<b>Definition</b>	The total number of days during this episode of care that the patient was out of hospital on 'contract leave', including days from the previous financial year(s).		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	2	<b>Layout</b>	NN or spaces Right justified and zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases and providers of contracted care).  All other sites, report a space in this field.		
<b>Reported for</b>	Episodes where: <ul style="list-style-type: none"><li>• Funding Arrangement is 1 <i>Contract</i> and</li><li>• Contract Type is 2 <i>Contract Type ABA</i>, 3 <i>Contract Type AB</i> or 5 <i>Contract Type BA</i> and</li><li>• Contract Role A <i>Hospital A</i>.</li></ul> Contract leave is not reported where a patient goes on contract leave and returns on the same day.		
<b>Reported when</b>	This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.		
<b>Code set</b>	A valid number equal to or greater than financial year-to-date contract leave days.  The minimum valid number is 01. If there are no Contract Leave Days to report, transmit spaces, not zeros.		
<b>Reporting guide</b>	Contracted Leave Days are included in Patient Days.  Method of calculating Contract Leave Days is consistent with method of calculating leave with or without permission days.  Contract Leave Days Total must be equal to or greater than Contracted Leave Days Month-To-Date and Contract Leave Days Year-To-Date.		
<b>Edits</b>	279 Contract Lve Total Not num/Blank 283 Contract Lve Total < MTD 284 Contract Lve Total < YTD 456 Contract Leave, No Contract		

**Related items**

Section 2: *Contracted Care, Leave With Permission, Leave Without Permission and Patient Day.*

Section 3: *Contract Leave Days Financial Year-To-Date* page 3-50, *Contract Leave Days Month-To-Date* page 3-52, *Patient Days Financial Year-To-Date* page 3-122, *Patient Days Month-To-Date* page 3-123, and *Patient Days Total* page 3-124.

Section 4:

- Business Rules (non-tabular) *Contracted Care* and *Length of Stay*.
- Business Rules (tabular) *Contracting: Contract Fields, Contract Leave and Funding Arrangement*, and *Contracting: Funding Arrangement and Contract Fields*.

## Administration

**Purpose** To identify the total days that a patient was on contract leave from this hospital (not on leave with or without permission).

**Principal data users** Funding Policy Section (Metropolitan Health and Aged Care Services, DHS).

**Collection start** 1996-97

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

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# Contract Role

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## Specification

<b>Definition</b>	Identifies whether the hospital is the purchaser of hospital care (contracting hospital) or the provider of an admitted or non-admitted service (contracted hospital).		
<b>Datatype</b>	Alpha	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	A or space.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchasers and providers of contracted care).  All other sites, report a space in this field.		
<b>Reported for</b>	Episodes where Funding Arrangement is 1 <i>Contract</i> .  If Funding Arrangement is <i>not</i> 1, report a space in this field.		
<b>Reported when</b>	This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.		
<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	
	A	Hospital A (purchasing hospital)	
	B	Hospital B (service provider hospital)	
<b>Reporting guide</b>	<b>A Hospital A (purchasing hospital)</b> This hospital is the contracting (purchasing) hospital.  <b>B Hospital B (service provider hospital)</b> This hospital is the contracted (service provider) hospital.		
<b>Edits</b>	408	Contract Role 'A' W/Out Proc Flag	
	409	Proc Flag W/Out Contract Role 'A'	
	410	Illegal Comb Fund Arrange & Contract	
	418	Invalid Contract Role	
	423	Invalid Comb Fund Arrange, Contract/Transfer	
	456	Contract Leave, No Contract	
<b>Related items</b>	Section 2: <i>Contracted Care, Leave Without Permission and Leave - Contract</i> .  Section 4: <ul style="list-style-type: none"><li>• Business Rules (non-tabular) <i>Contracted Care and Leave</i>.</li><li>• Business Rules (tabular) <i>Contracting: Contract Fields, Contract Leave and Funding Arrangement</i>, and <i>Contracting: Funding Arrangement and Contract Fields</i>, and <i>Contracting: Funding Arrangement, Contract Type, Contract Role with Admission Source and Separation Mode</i>.</li></ul>		

## Administration

**Purpose** To identify the role that the reporting hospital has taken in this contract arrangement (purchaser or provider):

- To make a public hospital casemix payment to the contracting hospital.
- To avoid counting the same episode twice (for epidemiological and planning purposes).

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

**Collection start** 1999-00

**Definition source** NHDD **Code set source** NHDD

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# Contract/Spoke Identifier

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## Specification

**Definition** This field identifies:

- The public or private hospital or day procedure centre involved in contracted care arrangements with this hospital (as purchaser *or* provider of contracted care).
- The *Spoke* hospital in a Hub and Spoke arrangement for this episode (the Spoke hospital does not report the episode less a multi-day stay).
- The exact nature of the contract involving an external purchaser.
- A non-hospital contracted to provide Interim Care services

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

**Field size** 4 **Layout** NNNN or spaces.

**Location** Episode Record

**Reported by** Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchasers and providers of contracted care).

All other sites, report a space in this field.

**Reported for** This item is mandatory if Funding Arrangement is:  
1 *Contract* or  
2 *Hub/Spoke*

Otherwise, report a space in this field.

**Reported when** This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

**Code set** Report the relevant Hospital Campus Code (refer to Section 9: Code Lists: *Hospitals*), which identifies the other party to the contracted service arrangement, with the following exception:

- When the Funding Arrangement is 1 *Contract* and the Contract Type 1 *Contract Type B* or 7 *Contract Type (A)*, report the code from the list below that identifies the external purchaser/program relevant to the episode of care.

<b>Code</b>	<b>Descriptor</b>
0050	Interim Care Program: Residential aged care facility
0070	Interim Care Program: Supported accommodation
0100	Australian Health Care Agreement (AHCA) - Elective Surgery
0110	National Bowel Cancer Program
0200	Department of Human Services: HIV Aids
0300	Department of Veterans Affairs: Veterans Cardiac Agreement
0400	Individual contracts with international patients
0500	Transport Accident Commission: Alfred Road Trauma Unit
0600	Department of Human Services: Rural & Remote Health Agency Program
0700	Department of Human Services: Bowen Centre - ARMC
0800	Victorian Maintenance Dialysis Program
0900	St Jude Pacemaker Replacement Program
0910	St Vincent's Lithotripsy Service - Bendigo Hospital

0920	St Vincent's Lithotripsy Service - MMC Clayton
0930	St Vincent's Lithotripsy Service - RCH
0940	St Vincent's Lithotripsy Service - MMC Moorabbin
0950	St Vincent's Lithotripsy Service - West Gippsland Healthcare Group
0960	St Vincent's Lithotripsy Service - Ballarat Hospital
0970	St Vincent's Lithotripsy Service - Geelong Hospital
0980	St Vincent's Lithotripsy Service - Frankston Hospital
0990	St Vincent's Lithotripsy Service - Goulburn Valley Health

**Reporting guide** Codes 0050 and 0070 *Interim Care Program* shall only be used with Contract Type 7 *Contract Type (A)*.

**0070 Interim Care Program: Supported Accommodation**

*Includes:*

- Supported Residential Service (SRS)

**Edits**

410	Illegal Comb Fund Arrange & Contract
419	Invalid Contract/Spoke Identifier
420	Contract/Spoke = Campus/Site
456	Contract Leave, No Contract

**Related items** Section 2: *Contracted Care, Leave – Contract, Leave Without Permission and Hub and Spoke.*

Section 4:

- Business Rules (non-tabular) *Contracted Care and Hub and Spoke.*
- Business Rules (tabular) *Contracting: Contract Fields, Contract Leave and Funding Arrangement, and Contracting: Funding Arrangement and Contract Fields.*

## Administration

**Purpose** To enable monitoring of health services provided under contract in Victoria.

**Principal data users** Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).

**Collection start** 1999-00

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

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# Contract Type

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## Specification

**Definition** Describes the contract arrangement between the contractor and the contracted hospital/facility. Contract Types are distinguished by the physical movement of the patient between the contracting (where applicable) and contracted hospitals.

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

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

**Location** Episode Record

**Reported by** Victorian public and private hospitals involved in contracted care arrangements (purchases and providers of contracted care).

All other sites, report a space in this field.

**Reported for** Episodes where the Funding Arrangement is 1 *Contract*. For all other episodes, report a space in this field.

**Reported when** This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	Contract Type B
	2	Contract Type ABA
	3	Contract Type AB
	4	Contract Type (A)B
	5	Contract Type BA
	6	Contract Type A(B)
	7	Contract Type (A)

**Reporting guide** The contracting (purchasing) hospital (or authority) is termed Hospital **A**.

The contracted (service provider) hospital is termed Hospital **B**.

Contract Types are described by the sequence of the **A** and **B** characters, representing the movement of the patient between the contracting and contracted entities. Brackets indicate the patient was not physically present in one of either the contracting or contracted hospital. For example, (A) means the patient was not physically present in the contracting hospital.

**1 Contract Type B**

A (health authority/other external purchaser) contracts **B** (hospital) for admitted service.

**2 Contract Type ABA**

Patient admitted by Hospital **A**.

Hospital **A** contracts Hospital **B** for admitted or non-admitted patient service.

Patient returns to Hospital **A** on completion of service by Hospital **B**.

### **3 Contract Type AB**

Patient admitted by Hospital **A**.

Hospital A contracts Hospital **B** for admitted or non-admitted patient service.

Patient does *not* return to Hospital A on completion of service by Hospital B.

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

Patient is *not* present in the Contracting Hospital (**A**) at any time during the episode.

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

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

### **5 Contract Type BA**

Hospital A contracts Hospital **B** for an admitted patient service following which the patient moves to Hospital **A** for the remainder of the care.

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

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

Hospital B provides the service at Hospital A.

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

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

### **7 Contract Type (A)**

Hospital **A** contracts a residential aged care facility or supported accommodation to provide Interim Care.

Patient not present in the Contracting Hospital (**A**) for some or any time during the episode.

#### **Edits**

410 Illegal Comb Fund Arrange & Contract  
417 Invalid Contract Type  
423 Invalid Comb Fund/Contract/Transfer  
454 Incompat Fields for Interim Care  
456 Contract Leave, No Contract

#### **Related items**

Section 2: *Contracted Care, Leave – Contract and Leave Without Permission.*

Section 4:

- Business Rules (non-tabular) *Contracted Care*
- Business Rules (tabular) *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.*

## Administration

<b>Purpose</b>	To identify the type of contract arrangement (if any) that applies to this episode, to make a link (if appropriate) to the record reported by the other party to the contract arrangement.		
<b>Principal data users</b>	Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).		
<b>Collection start</b>	1999-00		
<b>Definition source</b>	NHDD	<b>Code set source</b>	NHDD

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# Country of Birth

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## Specification

<b>Definition</b>	The country in which the person was born.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	4	<b>Layout</b>	NNNN
<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 Section 9: <i>Code Lists</i> .		
<b>Reporting guide</b>	Patients born in Australia should be reported under the State in which they were born: code 1100 <i>Australia not otherwise specified</i> should be used as a last resort, when no further details are available.		
<b>Edits</b>	036 Invalid Country of Birth 069 Newborn From Overseas 228 Unusual Birth Place 234 Aboriginal/Ts Islander But Not Aust Born 392 Recip HCA Account, Not O/Seas Born		
<b>Related items</b>	Section 9: <ul style="list-style-type: none"><li>• Code Lists <i>Country of Birth</i></li></ul>		

## Administration

<b>Purpose</b>	To facilitate epidemiological studies.		
<b>Principal data users</b>	Multiple internal and external data users.		
<b>Collection start</b>	1979-80		
<b>Definition source</b>	NHDD	<b>Code set source</b>	DHS

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# Criterion For Admission

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## Specification

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

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

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

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

### **N Qualified newborn**

Any newborn who is:

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

### **U Unqualified newborn**

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

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

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

#### *Includes:*

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

#### *Excludes:*

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

#### *Examples:*

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

### **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, (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 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 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.

### **Edits**

072	Invalid Criterion for Adm
074	Invalid Age For Criterion
235	Adm Crit N But Care Not 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
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
549	Type B Crit for Adm, LOS >1
550	Type C Crit for Adm, LOS >1
551	Type C Crit for Adm, LOS >4 hrs
552	Type E Crit for Adm, LOS >1
553	Type E Crit for Adm, LOS <4 hrs

**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 and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, and *Care Type: Interim Care Program (F and E)*, and *Criterion for Admission, Age, Admission Type, Admission Source, Qualification Status, and Criterion for Admission and Newborn Qualification Status (1<sup>st</sup> Status Segment)*, and *Criterion for Admission and Qualification Status*, and *Criterion for Admission: Secondary Family Member*, and *Funding Arrangement: Elective Surgery Access Service*, and *Funding Arrangement: Rural Patients Initiative*, and *Newborns: Criteria for Admission, Qualification Status, Care Type, and Reasons for Critical Care Transfer: Valid Combinations*.

## Administration

**Purpose**

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

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

**Principal data users**

Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).

**Collection start**

1993-94

**Definition source**

Commonwealth

**Code set source**

DHS

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# Date of Accident

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## Specification

<b>Definition</b>	The date of the transport accident causing the person to require hospitalisation.		
<b>Datatype</b>	Numeric	<b>Form</b>	Date
<b>Field size</b>	8	<b>Layout</b>	DDMMCCYY
<b>Location</b>	DVA and TAC Record		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Episodes with an Account Class of TAC (T-).		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Episodes with an Account Class of DVA (V-): blank. Episodes with an Account Class of TAC (T-): A valid date.		
<b>Reporting guide</b>	For all episodes with an Account Class of TAC (T-), Date of Accident must not be blank.  For the majority of episodes with an Account Class of TAC (T-), Date of Accident should not be: <ul style="list-style-type: none"><li>• Later than the Admission Date</li><li>• Prior to the Date of Birth</li></ul> Report unknown Date of Accident as 01011901		
<b>Edits</b>	444 Invalid Date of Accident 445 Dt of Accid Incompat W TAC Claim Nbr – Fatal 446 Dt of Accid Incompat W TAC Claim Nbr - Warning 554 Date of Accident > Admission Date 555 Date of Accident < Date of Birth		
<b>Related items</b>	Section 3: <i>Account Class</i> on page 3-9.		

## Administration

<b>Purpose</b>	To enable TAC payment of relevant episodes of care. <i>Date of Accident</i> is used in the matching process to link hospital admissions to TAC claims.  These data are held separately to other VAED data to ensure that personal information remains confidential.		
<b>Principal data users</b>	Transport Accident Commission		
<b>Collection start</b>	2002—03		
<b>Definition source</b>	TAC		

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# Date of Birth

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## Specification

<b>Definition</b>	The date of birth of the person.		
<b>Datatype</b>	Numeric	<b>Form</b>	Date
<b>Field size</b>	8	<b>Layout</b>	DDMMCCYY
<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>	A valid date.		
<b>Reporting guide</b>	The Date of Birth must be on or before Date of Admission.  Century (CC) can only be 18, 19 or 20.  If unknown, estimate the year of birth and enter 0000 [zeros] in DDMM and the estimated year in CCYY. Date 00MMCCYY will not be accepted.		

**Edits**

035 Invalid Date of Birth  
057 Incompat Adm Type/Age  
061 Married – Age Not Within Range  
069 Newborn From Overseas  
074 Invalid Age For Criterion  
080 Sex Indeterminate Age > 90  
127 Nil Value DRG  
160 AR-DRG Grouper GST Code> Zero  
186 Neonate MDC But Age>= 28 Days  
187 Adm Weight Too Low  
188 Adm Wt Too High  
189 Age < 1 Year But Adm Weight Missing  
190 Adm Wt Present But Not Aged < 1 Year  
215 Sex Indeterminate But Age >= 90 Days  
222 Unqual Newborn; Adm Date Not Birth  
232 Possible Coding or Sequencing Problem  
226 Adm Date Before Date of Birth  
227 Age Calculated As 120 Yrs & Over  
240 Newborn Accom But Over 4 Months  
245 Adm Wt >= 9kg But Age is <= 5 Mth  
255 Rehab: Invalid Onset Date  
261 Newborn Care Type But Age > 9 Days  
262 Invalid Care Type For Newborn  
329 Geri Respite - Invalid comb  
353 Code & Age Incompatible  
390 Incompat Care Type, Carer Avail, Age and Sep Mode  
397 Sep Referral Postnatal, Incompatible Age/Sex  
431 Newborn But Not Newborn Accom  
440 NIV Duration without NIV Proc Code  
447 Unqual Newborn; Age at Sep > 10 Days  
461 ACAS Status not Required  
467 Adm Wt <1000g, LOS < 28 Days, Sep Mode ≠ T or D  
479 Incompat Adm Source/Age  
480 Incompat Adm Source/Age <15  
481 Incompat Adm Source/Age <55  
486 Incompat Age/Crit for Adm  
487 Incompat Age/Qual Stat  
493 Incompat Sep Mode/Age <15  
494 Incompat Sep Mode/Age <55  
518 Medicare Code = 0, Age > 6 Months  
519 Medicare Code = 0, Age > 12 Months  
533 ACAS Status Code Required  
542 MH Acute Adult Care Type But Age < 14 Years  
543 MH Acute Adult Care Type But Age > 65 Years  
544 MH APMHS Care Type But Age < 55 Years  
545 MH CAMHS Care Type But Age < 5 Years  
546 MH CAMHS Care Type But Age > 19 Years  
547 MH SECU Care Type But Age < 14 Years  
548 MH Specialist Acute Care Type But Age < 14 Years  
555 Date of Accident < Date of Birth  
579 MHSWPI Valid, no Matching DOB  
602 Newborn Accom but Over 12 Months

**Related items**

Section 2: *Age*.

Section 3: *Admission Date*, page 3-19.

Section 4:

- Business Rules (non-tabular) *DRG Classification*.
- Business Rules (tabular) *Admission Source and Age*, and *Admission Type and Age*, and *Age and Criterion For Admission*, and *Age and Qualification Status*, and *Carer Availability and Separation Mode*, and *Criteria for Admission, Age, Admission Type, Admission Source, Qualification Status*.

## Administration

**Purpose**

To:

- Enable calculation of 'age at admission' (difference between Date of Birth and Admission Date) that is used in the allocation of DRGs and for analysis of service utilisation, need for services and epidemiological studies.
- Verify other fields (such as diagnosis and procedure codes) for consistency with calculated age.

**Principal data users**

Multiple internal and external data users.

**Collection start**

1979-80

**Definition source**

NHDD

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# Diagnosis Codes

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## Specification

<b>Definition</b>	At least one (principal diagnosis) and up to 40 ICD-10-AM (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 2005-06, available at: <a href="http://www.health.vic.gov.au/hdss/reffiles/2005-06/vaed/libfil05.htm">http://www.health.vic.gov.au/hdss/reffiles/2005-06/vaed/libfil05.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://www.health.vic.gov.au/hdss/icdcoding/index.htm">http://www.health.vic.gov.au/hdss/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 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> <p>The first character of the field is the prefix: P, A, C or M.</p> <p>In the first diagnosis code field:</p> <ul style="list-style-type: none"><li>• <i>Character 1</i> must be P.</li><li>• <i>Next five characters</i> must contain an alpha/numeric code of three, four or five characters (with trailing spaces if required).</li><li>• <i>Characters 7 and 8</i> must be spaces.</li></ul> <p>For the remaining thirty nine diagnosis code fields, <i>if</i> a code is present:</p> <ul style="list-style-type: none"><li>• <i>Character 1</i> must be P, A, C or M.</li><li>• <i>Next six characters</i> must contain an alpha/numeric code of three, four, five or six characters (with trailing spaces if required).</li><li>• <i>Character 8</i> must be a space.</li></ul>		

### **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://www.health.vic.gov.au/hdss/icdcoding/index.htm>

### **Effect of prefix A**

A secondary function of the A prefix is to suppress the code description appearing in data extracts provided to TAC and on DRG statements generated by PRS2 for Work Cover Patients.

### **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
358	Area Code Restraint
361	External Cause Code Missing
362	Morphology Code Missing
363	External Cause needs Place 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
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
559	Prefix = P, Unusual Code Combination
560	Prefix = P, Unusual Code Combination
561	Prefix = C, Unusual Code Combination
562	Prefix = C, Unusual Code Combination
563	Prefix = A, Unusual Code Combination
564	Prefix = A, Unusual Code Combination
590	Diag Prefix M, Not Morph Code
595	Neoplasm Code Missing
600	Invalid Code

**Related items**

Section 2: *DRG Classification* and *Principal Diagnosis*.

Section 3: *Hospital Generated DRG* page 3- 93.

Section 4:

- Business Rules (non-tabular) *DRG Classification*
- Business Rules (tabular) *Account Class: Geriatric Respite*, and *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, and *Care Type: Interim Care Program (F and E)*.

## 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 data users.

**Collection start**

1979-80

**Definition source**

DHS

**Code set  
source**

ICD-10-AM Fourth Edition

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# Duration of Mechanical Ventilation in ICU

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## 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.		
<b>Code set</b>	A number in the range 0001 to 9999.		
<b>Reporting guide</b>	<p>If the patient has more than one period of MV in ICU 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 MV hours provided in an ICU are counted:</p> <ul style="list-style-type: none"><li>• Where a patient is intubated and MV starts in an operating theatre, for the purposes of the Duration of MV field, the <i>counting of the duration of MV commences when the patient enters the ICU.</i></li><li>• Where MV starts in ICU, continues while the patient is in an operating theatre and on the patient's return to ICU, the <i>count of duration should be suspended for the time the patient is out of the ICU.</i></li><li>• Where a patient receives MV in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.</li></ul> <p>Refer to the <i>ICD Coding Newsletter</i>, August 2002, page 4 for a comparison of reporting this field and <i>coding MV.</i></p> <p>Duration of MV is edited against Duration of Stay in ICU.</p> <p>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.</p>		
<b>Edits</b>	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	
	454	Incompat Fields for Interim Care	

**Related items**

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

Section 3: *Duration of Stay in Intensive Care Unit* page 3-82.

Section 4:

- Business Rules (tabular) *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, 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**

Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).

**Collection start**

1996-97

**Definition source**

DHS

**Code set source**

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# Duration of Non-invasive Ventilation (NIV)

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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		

**Reported by** Optional for public and private hospitals providing NIV in an approved Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN) or Intensive Care Unit (ICU).

Otherwise, report spaces.

**Reported for** Episodes of care for patients receiving NIV in a NICU and/or SCN and/or ICU. Otherwise, report spaces.

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

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

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

### Counting duration of NIV

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

### Calculation is in four stages:

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

### **1 Counting non-intermittent NIV**

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

### **2 Counting intermittent NIV**

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

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

### **3 Counting Contracted NIV hours**

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

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

### **4 Summing and rounding above calculations**

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

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

#### **Edits**

328 Early Parenting Centre – Invalid Comb  
329 Geri Respite – Invalid Comb  
435 Invalid NIV Duration  
437 NIV Duration for Unqual Newborn  
438 NIV Duration > Total Stay  
440 NIV Duration without NIV Proc Code  
442 NIV Duration for Healthy Newborn  
454 Incompat Fields for Interim Care  
583 NIV Duration High

#### **Related items**

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

Section 3: *Duration of Stay in Intensive Care Unit* on page 3-82.

Section 4:

- Business Rules (tabular) *Account Class: Geriatric Respite*, and *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, and *Care Type: Interim Care Program (F and E)*, and *Criterion for Admission: Secondary Family Member*.

## Administration

<b><i>Purpose</i></b>	To evaluate the need for a co-payment on specified DRGs. Although the preliminary evaluation has not resulted in a co-payment, this item remains to facilitate further evaluation if deemed necessary.
<b><i>Principal data users</i></b>	Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).
<b><i>Collection start</i></b>	2002-03
<b><i>Definition source</i></b>	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

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## Specification

<b>Definition</b>	Total duration of stay (hours) in an approved Cardiac/Coronary Care Unit (CCU), 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 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 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>	322 ICU/CCU Stay > Total Stay 328 Early Parenting Centre – Invalid Comb 333 Invalid CCU Stay 337 Crit Care Transfer, No ICU/CCU Hrs 454 Incompat Fields for Interim Care 523 CCU Hrs, no Approved CCU 582 CCU Duration High 603 CCU Account Class, No CCU Hours 605 Priv Pt, CCU Hours, No CCU Account Class		

**Related items**

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

Section 3: *Duration of Mechanical Ventilation in ICU* page 3-75, and *Duration of Non-invasive Ventilation (NIV)* page 3-77.

Section 4:

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

## Administration

**Purpose**

To facilitate a co-payment on specified DRGs.

**Principal data users**

Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).

**Collection start**

1998-99

**Definition source**

DHS

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# Duration of Stay in Intensive Care Unit

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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 0001 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 448 ICU Stay but Care Type not Acute 454 Incompat Fields for Interim Care 526 ICU Hrs, no approved ICU or NICU 604 ICU Account Class, No ICU Hours 606 Priv Pt, ICU Hours, No ICU Account Class		

- Related items**
- Section 2: *Intensive Care Unit and Time of Death.*
  - Section 3: *Duration of Mechanical Ventilation in ICU* page 3-75
  - Section 4:
    - Business Rules (tabular) *Care Type: Interim Care Program (F and E), and Criterion for Admission: Secondary Family Member.*

## **Administration**

- Purpose** To facilitate a co-payment on specified DRGs.
- Principal data users** Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).
- Collection start** 1996-97
- Definition source** DHS

---

# DVA ID / TAC Claim Number (Where Account Class is V- DVA)

---

## Specification

<b>Definition</b>	The Department of Veterans' Affairs file number of the person.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	9	<b>Layout</b>	AAAANNX or AAAANNXA
<b>Location</b>	DVA and TAC Record (Shared field <i>DVA ID/TAC Claim Number</i> )		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Episodes with an Account Class of DVA (V-).		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Obtained from the DVA card, held by those eligible for DVA benefits.		
<b>Reporting guide</b>	<p><i>Character 1:</i> State identifier. Valid codes: Q, N, V, T, S or W. ACT is included in N (NSW) and NT with S (SA).</p> <p><i>Characters 2-4:</i> Alphabetic characters may appear in these fields but no alphabetic characters may appear after any numerics in these positions.</p> <p><i>Characters 5-8:</i> Numeric except last non-space character may be alphabetic.</p> <p><i>Character 9:</i> Space (veteran), alpha (dependent).</p> <p>Edits applied to DVA ID / TAC Claim Number:</p> <ul style="list-style-type: none"><li>• Only alphas, numerics and spaces are permitted.</li><li>• Alpha characters must be uppercase.</li><li>• A maximum of <i>six</i> numeric characters is permitted.</li><li>• Trailing spaces (to the right) are permitted.</li></ul> <p>Examples of permitted formats: N123456, VX123456, WXX123A, QXXX1B</p> <p>If a DVA ID / TAC Claim Number that the hospital believes is correct cannot pass these edits, the hospital should refer the problem to their local DVA office.</p>		
<b>Edits</b>	180	DVA ID/TAC Claim Number Blank	
	181	DVA ID/TAC Claim Number Incorrect	
<b>Related items</b>	Section 3: <i>Account Class</i> on page 3-9.		

## Administration

<b><i>Purpose</i></b>	To facilitate payment by DVA for DVA patients.		
	These data are held separately to other VAED data to ensure that personal information remains confidential.		
<b><i>Principal data users</i></b>	Department of Veterans' Affairs.		
<b><i>Collection start</i></b>	1992-93		
<b><i>Definition source</i></b>	NHDD	<b><i>Code set source</i></b>	DVA

---

# DVA ID / TAC Claim Number (Where Account Class is T- TAC)

---

## Specification

<b>Definition</b>	The Transport Accident Commission Claim Number of the person, relating to this hospital admission.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	9	<b>Layout</b>	YYXXXXX
<b>Location</b>	DVA and TAC Record (Shared field <i>DVA ID/TAC Claim Number</i> )		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Episodes with an Account Class of TAC (T-).		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Obtained from the TAC, allocated to those eligible for TAC benefits. C—U <i>Claim number unavailable</i> should be reported when the persons TAC Claim Number is not known by the hospital.		
<b>Reporting guide</b>	<i>Characters 1-2:</i> Financial year of claim acceptance. <i>Characters 3-7:</i> Numeric characters allocated by TAC. <i>Characters 8-9:</i> Spaces  Examples of permitted formats: 9812345, 5412345  Hospitals wishing to obtain TAC Claim Numbers can contact TAC on: 1300 654 329 (Choose option 2: Service Provider to a TAC Customer).		
<b>Edits</b>	180 DVA ID/TAC Claim Number Blank 181 DVA ID/TAC Claim Number Incorrect 445 Dt of Accid Incompat W TAC Claim Nbr – Fatal 446 Dt of Accid Imcompat W TAC Claim Nbr - Warning		
<b>Related items</b>	Section 3: <i>Account Class</i> on page 3-9, and <i>Date of Accident</i> on page 3-68.		

## Administration

<b>Purpose</b>	To facilitate payment by TAC for TAC patients.  These data are held separately to other VAED data to ensure that personal information remains confidential.		
<b>Principal data users</b>	Transport Accident Commission.		
<b>Collection start</b>	2002—03		
<b>Definition source</b>	TAC	<b>Code set source</b>	TAC

---

# Funding Arrangement

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## Specification

<b>Definition</b>	Identifies the specific funding arrangement, if any, which applies to this episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N or space
<b>Location</b>	Episode Record		
<b>Reported by</b>	<ul style="list-style-type: none"><li>Any Victorian public and private hospital involved in contracted care arrangements with another hospital (purchasers and providers of contracted care).</li><li>Any Victorian public and private hospital involved in hub and spoke arrangements with another hospital.</li><li>Any Victorian public or private hospital treating a patient identified as a Coordinated Care Trial patient.</li><li>Any Victorian public hospital involved in the Rural Patients Initiative program.</li><li>Any Victorian public hospital involved in the Elective Surgery Access Service program (ESAS).</li></ul> <p>All other circumstances, report a space in this field.</p>		
<b>Reported for</b>	<p>Episodes where an admitted service is provided under contract, hub and spoke, Coordinated Care Trial arrangements, Rural Patients Initiative or Elective Surgery Access Service (ESAS).</p> <p>Otherwise, report a space in this field.</p>		
<b>Reported when</b>	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	
	4	Coordinated Care Trial	
	5	Rural Patients Initiative	
	6	Elective Surgery Access Service	
<b>Reporting guide</b>	<b>1 Contract</b>	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).	
	<b>2 Hub and Spoke</b>	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.)	
	<b>4 Coordinated Care Trial</b>	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
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 3-56, *Contract/Spoke Identifier* on page 3-58, and *Contract Type* on page 3-60.

Section 4:

- Business Rules (non-tabular) *Contracted Care* and *Hub and Spoke*.
- Business Rules (tabular) *Care Type: Designated Rehabilitation Program (2, 6, and 7)*, 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

Multiple internal and external data users.

### Collection start

1996-97

### Definition source

DHS

**Code set  
source**

DHS

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# Given Name(s)

---

## 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>	15	<b>Layout</b>	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 Invalid Given Name 556 Given Name Unusual Length		
<b>Related items</b>	Section 3: <i>Account Class</i> page 3-9 and <i>Surname</i> page 3-159.		

## 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>	-

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# Health Insurance Fund

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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.

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

**Field size** 3 **Layout** AAA or NNN

**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 – Registered name (may differ from Trading name)</b>
	ACA	ACA Health Benefits Fund
	AMA	AMA Health Fund Limited
	AHM	Australian Health Management Group
	AUF	Australian Unity Health Limited (see notes)
	CBH	CBHS Friendly Society
	CDH	Cessnock District Health Benefits Fund
	CPS	Credicare Health Fund
	AHB	Defence Health Limited
	YMH	Federation Health
	GMH	Geelong Medical and Hospital Benefits Association Limited
	GMF	Goldfields Medical Fund (Inc.)
	FAI	Grand United Corporate Health Limited
	GUF	Grand United Health Fund Pty Ltd
	HBF	HBF Health Funds Inc
	HCI	Health Care Insurance Ltd
	HIF	Health Insurance Fund of WA
	SPS	Health Partners Inc
	HHB	Healthguard Health Benefits Fund Limited
	HBA	Hospital Benefits Association Limited (see notes)
	HCF	Hospitals Contribution Fund of Australia Ltd, The
	LHS	Latrobe Health Services, Inc.
	LHM	Lysaght Peoplecare
	MUI	Manchester Unity Australia Ltd
	SGI	MBF Health Pty Ltd (see notes)
	MBP	Medibank Private Limited
	MBF	Medical Benefits Fund of Australia Ltd
	MDH	Mildura District Hospital Fund
	MCL	Mutual Community Ltd (see notes)
	NMH	National Mutual Health Insurance (see notes)
	NHB	Navy Health Ltd
	NIB	NIB Health Funds Limited
	PWA	Phoenix Health Fund Ltd
	MIM	Queensland Country Health Limited
	QTU	Queensland Teachers Union Health Fund Ltd
	RTE	Railway & Transport Health Fund Ltd

RBH	Reserve Bank Health Society
SPE	South Australian Police Employees' Health Fund Incorporated
SLM	St Luke's Medical & Hospital Benefits Association Limited
NTF	Teacher's Federation Health Limited
TFS	Transport 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)
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

### **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.

- When assigning code 999, the appropriate code for Level of Insurance is 6 *No hospital insurance (includes ancillary cover only)* or 9 *Insurance status unknown*, as appropriate.

If a patient is covered by a health insurance fund, the code should be recorded regardless of whether the patient plans to utilise the insurance for this admission. This data item is used to indicate the extent of private health coverage, and should not be used to indicate patient election or for billing purposes.

For patients admitted for treatment covered by Department of Veteran Affairs, Transport Accident Commission or Victorian Workcover Authority, record the health insurance fund code if the patient holds private health insurance, or else record 996, 997, 998 or 999.

#### *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 and HBA are owned and operated by BUPA Australia Health Pty Ltd. In Victoria, BUPA trades as HBA. In SA BUPA, Mutual Community Ltd.
- Transition Benefits Fund Pty Ltd ceased operation on 31 March 2002.
- NRMA Health Pty Limited (which incorporated SGIC and SGIO) have changed their name to MBF Health. This is a subsidiary of MBF Australia Ltd, however they are still trading as a separate health fund (SGI).
- IOOF is no longer a registered health fund in its own right. It merged with NIB.
- IOR has merged with HCF, and changed its name to HCF.
- 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 Funds Inc.

### **Edits**

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

### **Related items**

Section 3: *Level of Insurance* on page 3-107.

## Administration

<b>Purpose</b>	To monitor patterns of hospital insurance usage to inform health policy and planning.		
<b>Principal data users</b>	Funding Policy Section (Metropolitan Health and Aged Care Services, DHS).		
<b>Collection start</b>	1996-97		
<b>Definition source</b>	DHS	<b>Code set source</b>	Part 6 (Registered Health Benefits Organization), Schedule 7, <i>National Health Act 1995</i> . 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: <a href="http://www.phiac.gov.au/healthfunds/list.html">http://www.phiac.gov.au/healthfunds/list.html</a> This site provides contact details for all Funds.

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# Hospital Generated DRG

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## Specification

<b>Definition</b>	The DRG (AR-DRG, version 5.0 or Vic DRG, version 5.0) generated by the in-house hospital grouper for this episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	4	<b>Layout</b>	ANNA or NNNA or spaces
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	Public and private hospitals - <b>optional</b> . Otherwise, report spaces in this field.  Reporting in this field is recommended for hospital quality control, if the hospital has onsite grouping facilities.		
<b>Reported for</b>	Any/all admitted episodes of care. Otherwise, report spaces in this field.		
<b>Reported when</b>	The Separation Date is reported in the Episode Record.		
<b>Code set</b>	AR-DRG, version 5.0, or Vic DRG, version 5.0.		
<b>Reporting guide</b>	Report the AR-DRG or Vic DRG version 5.0 DRG generated by the hospital for each episode. This field should be automatically reported for all episodes grouped by the hospital.		
<b>Edits</b>	334 Hosp Generated DRG Not = PRS2 DRG		
<b>Related items</b>	Section 2: <i>DRG Classification</i> .  Section 4: <ul style="list-style-type: none"><li>• Business Rules (non-tabular) <i>DRG Classification</i>.</li></ul>		

## Administration

<b>Purpose</b>	To enable hospitals to detect differences between their grouping processes and those of DHS.		
<b>Principal data users</b>	Hospital Health Information Managers.		
<b>Collection Start</b>	1 July 1998	<b>Version</b>	5 (1 July 2004)
<b>Definition source</b>	DHS	<b>Code set source</b>	Commonwealth Department of Health and Aged Care, <i>Australian Refined Diagnosis Related Groups, version 5.0</i> . Department of Human Services, <i>Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2005-2006</i> .

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# Indigenous Status

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## Specification

**Definition** An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.

**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>
	2	Not indigenous - <i>Not</i> Aboriginal or Torres Strait Islander origin
	5	Indigenous - Aboriginal but not Torres Strait Islander origin
	6	Indigenous - Torres Strait Islander but not Aboriginal origin
	7	Indigenous - Aboriginal and Torres Strait Islander origin
	8	Question unable to be asked
	9	Patient refused to answer

**Reporting guide** A person of Aboriginal descent is a person descended from the original inhabitants of Australia.

The Torres Strait Islands are the islands directly to the north of Cape York, between Cape York and New Guinea.

In Victoria, the community of Torres Strait Island people is small and the community of people of Aboriginal and Torres Strait Island people is smaller again, therefore code 6 Indigenous-Torres Strait Islander but not Aboriginal origin and code 7 Indigenous-Aboriginal and Torres Strait Islander origin would not be widely used.

Code 8 *Question unable to be asked* should only be used under the following circumstances:

- When the patient's medical condition prevents the question of Indigenous Status being asked; or
- In the case of an unaccompanied child who is too young to be asked their Indigenous Status.

This information must be collected for every admitted patient episode and updated each time the patient represents to the hospital for admission.

Systems must not be set up to input a default code.

Rather than asking every patient about his or her indigenous status, first ask the patient. "Were you born in Australia?":

- If No, the patient should be asked, "What country were you born in?"
- If Yes, the patient should be asked, "Are you of Aboriginal or Torres Strait Islander origin?"

If the patient answers Yes to being of Aboriginal or Torres Strait Islander origin, then ask further questions to record correctly the person's indigenous status.

#### **Patient is baby or child**

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

For further information refer to the Principles of recording Aboriginal Status in Victoria, available on the internet at:

<http://www.health.vic.gov.au/koori/>

<b>Edits</b>	070	Invalid Indigenous Status
	234	Aboriginal/Ts Island But Not Aust Born
	393	Recip HCA Account, Indig Stat A Or TI
	495	Incompat Sep Referral and Indigenous Status
	513	Indigenous Status/Preferred Language Mismatch

**Related items** Section 2: *Country of Birth*, page 3-63, and *Preferred Language* page 3-129.

## **Administration**

**Purpose** To:

- Enable planning and service delivery, and monitoring of indigenous health at state and national level.
- Facilitate application of specific funding arrangements.

**Principal data users** Koori Health Unit (Public Health, DHS).  
Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).

**Collection start** 1987-88

<b>Definition source</b>	NHDD	<b>Code set source</b>	NHDD (DHS modified)
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# Intended Duration of Stay

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## Specification

**Definition** The intention of the responsible clinician at the time of the patient's admission to hospital, to discharge the patient either on the day of admission or a subsequent date.

**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	Intended same day
	2	Intended overnight (or longer)

**Reporting guide** The intended duration of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital. This should not be altered after admission, regardless of the actual duration of the episode.

**Edits**

307	Invalid Intended Duration
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
329	Geri Respite – Invalid Comb
454	Incompat Fields for Interim Care

**Related items** Section 4:

- Business Rules (tabular) *Account Class: Geriatric Respite*, and *Care Type: Interim Care Program (F and E)*.

## Administration

**Purpose** To provide clinical indicator data.

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

**Collection start** 1996-97

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

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# Intention to Re-Admit

---

## Specification

<b>Definition</b>	The intention of the responsible clinician, at the time of the patient's separation from hospital, to re-admit the patient within 28 days.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N
<b>Location</b>	Diagnosis 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 Separation Date is reported in the Episode Record.		
<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	
	Select the first appropriate category:		
	0	Not applicable	
	1	Re-admission planned to this hospital within 28 days <i>and</i> booking arranged	
	2	Re-admission planned to this hospital within 28 days <i>but no</i> booking yet arranged	
	3	Re-admission planned to another acute hospital within 28 days <i>and</i> booking arranged	
	4	Re-admission planned to another acute hospital within 28 days <i>but no</i> booking yet arranged	
	9	No plan to re-admit within 28 days	
<b>Reporting guide</b>	For <b>statistical</b> separations, and for patients who have been transferred, died, or left against medical advice, code 0 (zero) indicates <i>not applicable</i> .		
	For <b>formal</b> separations, this information should be recorded by the patient's treating medical practitioner at the time of separation to indicate whether or not there is an <i>intention</i> on the part of the medical practitioner that the patient would be admitted within 28 days either to this hospital or to another acute hospital.		
	Intention to re-admit may be for treatment of a condition related to the one for which the patient was originally hospitalised <i>or for another reason</i> .		

## **0 Not applicable**

### *Includes:*

- Patient statistically separated (Separation Mode S).
- Died in hospital (Separation Mode D).
- Patient who left hospital at own risk against medical advice (Separation Mode Z).
- Patient transferred directly to another acute hospital, extended care, rehabilitation or geriatric centre (Separation Mode T), even though arrangements may have been made to re-admit the patient back to this hospital.

### *Excludes:*

- Patients who go to an aged care residential facility.
- Patients separated to a Transition Care bed based program

## **1, 2, 3 and 4 Re-admission planned**

### *Includes:*

- Patient whose re-admission is planned to this or another acute hospital within 28 days with or without a booking.
- Antenatal patient whose dates or medical condition indicate the birth could be within 28 days.

### *Excludes:*

- Separation Modes S, D, Z or T (use code 0 *Not applicable*).

## **9 No plan to re-admit within 28 days**

### *Includes:*

- Patient whose only plan is for an appointment for a *non-admitted* (outpatient) occasion of service.
- Patient whose medical practitioner has *no plan* to re-admit but expects the patient, of the patient's own accord, may re-present at this or another hospital within 28 days because of debility, habit or a chronic condition.

### *Excludes:*

- Antenatal patient whose dates or medical condition indicate the birth could be within 28 days (classify to appropriate *re-admission planned* code).
- Separation Modes S, D, Z or T (use code 0 *Not applicable*).

### **Edits**

- 191 Invalid Intention to Readmit
- 192 Invalid Comb Int. Readmit/Sep Mode
- 193 Not Separated – Intent Readmit

### **Related items**

Section 3: *Separation Mode* on page 3-145.

### Section 4:

- Business Rules (tabular) *Intention to Readmit and Separation Mode*

## **Administration**

### **Purpose**

To:

- Calculate rate of unplanned readmissions.
- Provide clinical indicator data.

### **Principal data users**

Multiple internal and external data users

### **Collection start**

1996-97

### **Definition source**

DHS

**Code set  
source**

DHS

---

# Interpreter Required

---

## Specification

**Definition** The patient's need for an interpreter, as perceived by the patient or person consenting for the patient.

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

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

**Location** Episode Record

**Reported by** Public hospitals (voluntary for private hospitals).

**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	Yes
	2	No
	3	Not Stated

**Reporting guide** Preferred Language to be asked before Interpreter Required.

If the Preferred language is English, Interpreter Required can be assumed to be 2 *No*.

This data item must:

- Be checked for every admitted patient episode.
- Not be set up to input a default code on computer systems.
- Be collected on, or as soon as possible after, admission.

The standard question is:

[Do you] [Does the person] [Does (name)] require an interpreter?

The provision of the question 'Do you require an interpreter?' is asked to determine patient need for an interpreter, not the capacity of the hospital to provide an interpreter.

**1 Yes**

Use code 1 if the patient indicates they need an interpreter.

**2 No**

Use code 2 if the patient indicates they do not need an interpreter.

*Includes:*

- Where the Preferred Language is English.

**3 Not Stated**

Use code 3 if neither Yes nor No can be accurately ascertained.

*Includes:*

- Where the Preferred Language is 98 *Not Stated*.
- Some instances where the Preferred Language is 95 *Other Languages, nfd* or 96 *Inadequately described*.

**Patient is unable to consent (eg baby, child or elderly):**

Where a person is not able to consent for themselves (eg baby, child or elderly) then the need for an interpreter is recorded for the person who is consenting. For example a guardian or someone with enduring power of attorney.

**Edits**

517 Invalid Interpreter Required  
 592 Invalid Comb Int Req/Pref Lang

**Related items** Section 3: *Country of Birth* page 3-63, *Indigenous Status* page 3-94, and *Preferred Language* page 3-129.

## Administration

**Purpose** For planning and to form the basis for future funding allocation for Culturally and Linguistically Diverse (CALD) hospital service provision.

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

**Collection start** 2003-04

<b>Definition source</b>	DHS	<b>Code set source</b>	DHS
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---

# Leave With Permission Days Financial Year-To-Date

---

## Specification

<b>Definition</b>	The number of days during this episode of care that the patient was out of hospital 'on leave with permission' 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 leave with permission 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 With Permission Days Financial Year-To-Date must be equal to or greater than Leave With Permission Days Month-To-Date and equal to or less than Leave With Permission Days Total.		
<b>Edits</b>	047 Leave W Perm Days YTD Not Numeric or Blank 053 Leave W Perm YTD< MTD 055 Leave W Perm Tot<YTD 224 Newborn With Leave		
<b>Related items</b>	Section 2: <i>Leave With Permission</i> and <i>Leave Without Permission</i> .  Section 3: <i>Leave With Permission Days Month-To-Date</i> page 3-102, and <i>Leave With Permission Days Total</i> page 3-103.		

## 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>	1990-91
<b>Definition source</b>	DHS

---

# Leave With Permission Days Month-To-Date

---

## Specification

<b>Definition</b>	The number of days during this episode of care that the patient was out of hospital 'on leave with 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 with 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 With Permission Days Month-To-Date must be equal to or less than Leave With Permission Days Financial Year-To-Date and Leave With Permission Days Total.		
<b>Edits</b>	047 Leave W Perm Days YTD Not Numeric or Blank 053 Leave W Perm YTD< MTD 055 Leave W Perm Tot<YTD 224 Newborn With Leave		
<b>Related items</b>	Section 2: <i>Leave With Permission</i> and <i>Leave Without Permission</i> .  Section 3: <i>Leave With Permission Days Financial Year-To-Date</i> page 3-101, and <i>Leave With Permission Days Total</i> page 3-103.		

## 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>	1990-91
<b>Definition source</b>	DHS

---

# Leave With Permission Days Total

---

## Specification

<b>Definition</b>	The total number of days during this episode of care that the patient was out of hospital 'on leave with 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.
<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 with permission.		
<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 With Permission Days Total must be equal to or greater than Leave With Permission Days Month-To-Date and Leave With Permission Days Financial Year-To-Date.		
<b>Edits</b>	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		
<b>Related items</b>	Section 2: <i>Leave With Permission</i> and <i>Leave Without Permission</i> .  Section 3: <i>Leave With Permission Days Financial Year-To-Date</i> page 3-101, and <i>Leave With Permission Days Month-To-Date</i> page 3-102.		

## Administration

<b>Purpose</b>	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.
<b>Principal data users</b>	Automated PRS/2 processes.
<b>Collection start</b>	1990-91
<b>Definition source</b>	DHS

---

# Leave Without Permission Days Financial Year-To-Date

---

## Specification

<b>Definition</b>	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).		
<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 leave without permission 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 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.		
<b>Edits</b>	224 Newborn With Leave 566 Leave W/O Perm Days YTD Not Numeric or Blank 568 Leave W/O Perm YTD< MTD 570 Leave W/O Perm Tot<YTD		
<b>Related items</b>	Section 2: <i>Leave With Permission</i> and <i>Leave Without Permission</i> .  Section 3: <i>Leave Without Permission Days Month-To-Date</i> page 3-105, and <i>Leave Without Permission Days Total</i> page 3-106.		

## 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

---

# Leave Without Permission Days Month-To-Date

---

## Specification

<b>Definition</b>	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 565 Leave W/O Perm Days MTD Not Numeric or Blank 568 Leave W/O Perm YTD < MTD 569 Leave W/O Perm Tot < MTD		
<b>Related items</b>	Section 2: <i>Leave With Permission and Leave Without Permission</i> .  Section 3: <i>Leave Without Permission Days Financial Year-To-Date</i> page 3-104, and <i>Leave Without Permission Days Total</i> page 3-106.		

## 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

---

# Leave Without Permission Days Total

---

## Specification

<b>Definition</b>	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.
<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.		
<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 Total must be equal to or greater than Leave Without Permission Days Month-To-Date and Leave Without Permission Days Financial Year-To-Date.		
<b>Edits</b>	112 Calc Los + Leave Not = Adm/Sep 224 Newborn With Leave 567 Leave W/O Perm Days Tot Not Numeric or Blank 569 Leave W/O Perm Tot < MTD 570 Leave W/O Perm Tot < YTD		
<b>Related items</b>	Section 2: <i>Leave With Permission</i> and <i>Leave Without Permission</i> .  Section 3: <i>Leave Without Permission Days Financial Year-To-Date</i> page 3-104, and <i>Leave Without Permission Days Month-To-Date</i> page 3-105.		

## 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

---

# Level of Insurance

---

## Specification

**Definition** The patient's level of hospital insurance, regardless of whether they elect to be a public or private patient, or are a compensable or ineligible patient.

**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.

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

<b>Code</b>	<b>Descriptor</b>
1	Insured with a health fund: hospital insurance with exclusions
3	Insured with a health fund: full hospital insurance
8	Insured but level of hospital insurance unknown
6	No hospital insurance (includes ancillary cover only)
9	Insurance status unknown

**Reporting guide** Any arrangement a patient has with their health insurance company to pay an 'excess' in the event of making a claim, has no relevance to assigning the code. Such an arrangement does *not* mean the patient has health insurance with exclusions.

A health insurance policy with 'exclusions' does not provide cover for a particular admitted patient service/s. When a patient holds such a policy, report 1 *Insured with a health fund: hospital insurance with exclusions*.

It cannot be assumed that a mother's level of insurance will apply to her newborn baby. In particular, single insurance cover does not provide for a newborn baby of the policyholder.

**Edits**

044	Invalid Level of Insurance Code
313	No Fund But Insured
314	Fund But Uninsured
315	Fund But Insurance Unknown

**Related items** Section 3: *Health Insurance Fund* on page 3-90.

## Administration

<b><i>Purpose</i></b>	To monitor patterns of hospital insurance usage to inform health policy and planning.		
<b><i>Principal data users</i></b>	Funding Policy Section (Metropolitan Health and Aged Care Services, DHS).		
<b><i>Collection start</i></b>	1990-91		
<b><i>Definition source</i></b>	DHS	<b><i>Code set source</i></b>	DHS

---

# Locality

---

## Specification

<b>Definition</b>	Geographic location (suburb/town/locality for Australian residents, country for overseas residents) 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>	AAAAAAAAAAAAAAAAAAAAAAAAAA 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 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 must be blank if the Postcode is 1000 or 9988. Where the Postcode is 8888 (overseas), report the 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.		
<b>Edits</b>	058	Invalid Postcode/Locality	
	571	Acct Recip, Pcode Oseas, Locality Not RHCA	
	574	Postcode Overseas, Locality RHCA, Acct Not RHCA	
<b>Related items</b>	Section 3: <i>Postcode</i> page 3-127.  Section 4: Business Rules (tabular) <i>Locality/Postcode</i> .		

## Administration

<b>Purpose</b>	To enable calculation (with Postcode field) of the patient's appropriate Statistical Local Area (SLA) which enables: <ul style="list-style-type: none"><li>• Analysis of service utilisation and need for services.</li><li>• Identification of patients living outside Victoria for purposes of cross-border funding.</li><li>• Identification of patients living outside Australia for the Reciprocal Health Care Agreement (RHCA).</li></ul>		
<b>Principal data users</b>	Automated PRS/2 processes.  Multiple internal and external users.		
<b>Collection start</b>	1990-91		
<b>Definition source</b>	DHS	<b>Code set source</b>	ABS National Locality Index (Cat. No. 1252)(DHS modified)

---

# Marital Status

---

## Specification

<b>Definition</b>	Current marital status of the person.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N
<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</b>	
	1	Never married	
	2	Widowed	
	3	Divorced	
	4	Separated	
	5	Currently married (including defacto)	
	6	Not stated/inadequately described	
<b>Reporting guide</b>	Report the current marital status of the person.		
<b>Edits</b>	034	Invalid Marital Status	
	061	Married - Age Not Within Range	
<b>Related items</b>	-		

## Administration

<b>Purpose</b>	To facilitate social and epidemiological studies.		
<b>Principal data users</b>	Multiple internal and external users.		
<b>Collection start</b>	1979-80		
<b>Definition source</b>	NHDD	<b>Code set source</b>	NHDD

# Medicare Number

## Specification

<b>Definition</b>	Personal identifier allocated by the Health Insurance Commission to eligible persons under the Medicare scheme.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	11	<b>Layout</b>	NNNNNNNNNN or spaces (all zeros are invalid).
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	<p>Public hospitals: All patients except in the circumstances covered under Medicare Suffix.</p> <p>Private hospitals: All contracted patients and for all other patients, where possible. The exceptions are covered under Medicare Suffix.</p>		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	The patient's Medicare Number and Code, issued by the Health Insurance Commission.		
<b>Reporting guide</b>	<p>Valid:</p> <ul style="list-style-type: none"> <li>• First character can only be a: 2, 3, 4, 5, or 6</li> <li>• Numeric or all blanks</li> <li>• Check digit (ninth character) is the remainder of the following equation:  <math display="block">[(1\text{st digit} * 1) + (2\text{nd digit} * 3) + (3\text{rd digit} * 7) + (4\text{th digit} * 9) + (5\text{th digit} * 1) + (6\text{th digit} * 3) + (7\text{th digit} * 7) + (8\text{th digit} * 9)] / 10</math> </li> </ul> <p>Invalid:</p> <ul style="list-style-type: none"> <li>• Special characters (for example, \$, #)</li> <li>• Alphabetic characters</li> <li>• Zero-filled (if the Medicare Number is not available or not applicable, the Medicare Number must be left blank)</li> </ul>		

<b>Medicare</b>	
	3256112837
Medicare Code	1 Jane A Citizen
	2 John A Citizen
	Valid to 08/04

Medicare Number from the Medicare card, the eleventh character being the Medicare Code (the number printed on the Medicare Card, to the left of the printed name of the patient).

For newborns who have not yet been added to the family Medicare Card, and therefore have no Medicare Code, report zero (0) as the eleventh character in this field, with the mother's /family's Medicare Number reported in the first ten characters.

<b>Edits</b>	030	Invalid Medicare Number
	415	Suffix 'BAB'; Medicare Last Not Zero
	518	Medicare Code = 0, Age > 6 Months
	519	Medicare Code = 0, Age > 12 Months

**Related items**      Section 2: *Medicare Eligibility Status – Eligible Person*, and *Medicare Eligibility Status – Ineligible Person*.

Section 3: *Medicare Suffix*, page 3-114.

## Administration

**Purpose**      To:

- Assist in monitoring continuity of care across hospitals.
- Ensure eligibility for publicly funded health care.

**Principal data users**      Funding Policy Unit (Metropolitan Health and Aged Care Services, DHS).

**Collection start**      1979-80

**Definition source**      NHDD      **Code set source**      Health Insurance Commission

---

# Medicare Suffix

---

## Specification

**Definition** First three characters of patient's first given name (as it appears on the persons Medicare card).

**Datatype** Alphanumeric **Form** Abbreviation/Code

**Field size** 3 **Layout** XXX or A-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** The first 3 characters of the patient's first given name.

Characters permitted:

- *Upper case* alphas
- Space as second and third characters
- Space as third character
- Hyphen *or* apostrophe as second character *or* hyphen *or* apostrophe as third character.

If Medicare Number is unavailable or the patient is not eligible for a Medicare Number, leave the Medicare Number blank (not zero-filled) and enter the appropriate suffix:

<b>Code</b>	<b>Descriptor</b>
C-U	Card unavailable/Not applicable
N-E	Not eligible for Medicare
P-N	Prisoner

### Reporting guide

#### Unnamed neonate

For unnamed neonate where the family has a Medicare Number: use mother's/family's Medicare Number with zero (0) as the eleventh character and with suffix BAB.

### Edits

031	Blank Medicare Suffix
032	Invalid Medicare Suffix
094	Comb A/C Accom Care Med Suff
329	Geri Respite – Invalid Comb
415	Suffix 'Bab'; Medicare Last Not Zero
454	Incompat Fields for Interim Care

### Related items

Section 2: *Medicare Eligibility Status – Eligible Person*, and *Medicare Eligibility Status – Ineligible Person*.

Section 3: *Medicare Number* on page 3-112.

Section 4:

- Business Rules (tabular) *Account Class, Acc Type, Care Type and Medicare Suffix* and *Account Class: Geriatric Respite*.

## Administration

**Purpose**

To:

- Assist in monitoring continuity of care across hospitals.
- Ensure eligibility for publicly funded health care.

**Principal data users**

Funding Policy Unit (Metropolitan Health and Aged Care Services, DHS).

**Collection start**

1979-80

**Definition source**

DHS

**Code set  
source**

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# Mental Health Legal Status

---

## Specification

**Definition** Whether a person is treated on an involuntary basis under the relevant State mental health legislation, at any time during an admitted episode of care.

Involuntary patients are persons who are detained in hospital under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

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

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	Involuntary for all or part of this episode
	2	Not involuntary <i>at any time</i> during this episode
	9	Not applicable

**Reporting guide** **Private hospitals**  
Report code 9 *Not applicable* for all patients as private hospitals are not proclaimed to provide services for involuntary patients.

**Public hospitals**  
Patients in Care Type 5x *Approved Mental Health Service or Psychogeriatric Program* in public hospitals whose care is funded by Mental Health Services:

- Report either code 1 *Involuntary* or code 2 *Not involuntary*.
- Only hospitals with Approved Mental Health Services can report codes 1 or 2. Where a patient is treated under contract at such an Approved Mental Health Service (as Hospital B in a contracted service arrangement), only the contract service provider (Hospital B) should report codes 1 or 2; the contracting hospital (Hospital A) should report code 9 *Not applicable* for the contracted component of that episode.

Patients in Care Type 1 *NHT/Non-Acute* in public hospitals whose care is funded by Mental Health Services:

- Report code 9 *Not applicable*.

Patients in all Care Types, other than Care Type 5x *Approved Mental Health Service or Psychogeriatric Program*, in public hospitals:

- Report code 9 *Not applicable*.
- Where a patient is treated under contract at an Approved Mental Health Service, that hospital (Hospital B) should report codes 1 or 2 (*Involuntary* and *Not involuntary*); the contracting hospital (Hospital A) should report code 9.

<b>Edits</b>	108	Field(s) are Missing From Sep
	232	Possible Coding or Sequencing Problem
	265	Mental Health Status - Not Separated
	266	Invalid Legal Status
	268	Inv Comb Legal, Status, Care & PFS
	329	Geri Respite – Invalid Comb
	334	Hospital Generated DRG Not = PRS/2 DRG
	454	Incompat Fields for Interim Care
	491	Incompat Fields for ESAS
	492	Incompat Fields for RPI

- Related items**      Section 4:
- Business Rules (non-tabular) *DRG Classification*
  - Business Rules (tabular) *Account Class: Geriatric Respite, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type: Interim Care Program (F and E), and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative.*

## Administration

<b>Purpose</b>	To enable grouping into AR-DRG v5.0.		
<b>Principal data users</b>	Automated PRS/2 processes.		
<b>Collection start</b>	1996-97		
<b>Definition source</b>	NHDD	<b>Code set source</b>	DHS

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# Mental Health Statewide Patient Identifier

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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>	ODS generated.		
<b>Reporting guide</b>	Report the primary Mental Health Statewide Patient Identifier for all mental health episodes of care (Care Types 5x).		
<b>Edits</b>	575 Care Type 5x, MHSWPI Blank 576 Invalid MHSWPI 577 MHSWPI not on ODS 578 MHSWPI Present, not Care Type 5x 579 MHSWPI Valid, no Matching DOB 580 MHSWPI Valid, no Matching Sex 581 MHSWPI Valid, Secondary on ODS		
<b>Related items</b>	Section 9: <ul style="list-style-type: none"><li>Code Lists: Care Type <i>Care Type 5A: Mental Health Service and Psychogeriatric Program – Acute, Adult Mental Health Service</i>, and Care Type <i>5E: Mental Health Service and Psychogeriatric Program – Mental Health Secure Extended Care Unit (SECU)</i>, and Care Type <i>5G: Mental Health Service and Psychogeriatric Program – Acute, Aged Persons Mental Health Service (APMH)</i>, and Care Type <i>5K: Mental Health Service and Psychogeriatric Program – Child and Adolescent Mental Health Service (CAMHS)</i>, and Care Type <i>5S: Mental Health Service and Psychogeriatric Program – Acute, Specialist Mental Health Service</i>, and Care Type <i>5T: Mental Health Service and Psychogeriatric Program – Mental Health Nursing Home Type</i>.</li></ul>		

## Administration

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

---

# Onset Date

---

## Specification

<b>Definition</b>	Date of admission for the acute episode for care, relating to an injury or disease condition, for which the person has now been admitted for a subsequent rehabilitation episode of care.		
<b>Datatype</b>	Numeric	<b>Form</b>	Date
<b>Field size</b>	8	<b>Layout</b>	DDMMCCYY, or spaces.
<b>Location</b>	Sub-Acute Record		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Episodes with Care Type 2, 6, 7 or K. For Care Types 8, 9, F and E, report spaces in this field.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	Valid date.		
<b>Reporting guide</b>	Onset Date must be equal to or earlier than the Admission Date, and after the Date of Birth.  The Admission Date of the acute episode should be obtained from the acute hospital where the acute episode occurred.  If the patient is admitted to rehabilitation directly from the community, this field should match the date of admission in the Episode Record.		
<b>Edits</b>	255 Rehab: Invalid Onset Date 258 Sub-Acute: No Sub-Acute Record 289 Adm Sc is T'fer & Onset = Adm Date 290 Stat Adm Sc & Onset = Adm Date 294 Onset Date Present 454 Incompat Fields for Interim Care		
<b>Related items</b>	Section 2: <i>Rehabilitation Care</i> .  Section 4: <ul style="list-style-type: none"><li>• Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)</i>, and <i>Care Type: Interim Care Program (F and E)</i>.</li></ul>		

## Administration

<b>Purpose</b>	To enable measurement of the time elapsed since the initial acute episode, to support and further develop casemix classifications for sub-acute episodes.
<b>Principal data users</b>	Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).
<b>Collection start</b>	1995-96
<b>Definition source</b>	DHS

---

# Palliative Care Patient Days

---

## Specification

<b>Definition</b>	The total number of patient days for which the patient received palliative care under an approved palliative care program during the whole episode of care, excluding leave days.		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	3	<b>Layout</b>	NNN or spaces
<b>Location</b>	Episode Record		
<b>Reported by</b>	Public Hospitals		
<b>Reported for</b>	Episodes with Care Type 2, 4, 6, 7, K, 8, 9 and E, where the hospital campus is approved for Palliative Care.  [For Care Types 0, 1, 5x, F and U, report spaces in this field.]  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 of 001 to 999.		
<b>Reporting guide</b>	Approved Palliative Care Patient Days is reported for patients treated under approved programs, as defined by the Continuing Care unit. An approved program is one funded specifically for the delivery of palliative care to patients in approved beds or units by suitably qualified staff. The list of public hospitals authorised to report this data item is the same as those eligible to report a Care Type of 8.  A day should be reported as a Palliative Care Patient Day when the Palliative care program was primarily responsible for the patients care.  Palliative Care Patient Days must be equal to or less than Patient Days Total.  Where Palliative Care Patient Days is greater than zero, the Diagnosis Code Z51.5 <i>Palliative Care</i> must be present in the Diagnosis Code string.		
<b>Edits</b>	472	Pall Care, not approved for Palliative Care Program	
	498	Pall Care without Pall Care Diag	
	609	Pall Care Pt Days > Patient Days Total	
	612	Palliative Care mismatch	
	613	Pall Care Diag no Pall Care (at approved campus)	

- Related items**
- Section 2: *Episode of Care, Leave With Permission, Palliative Care and Patient Day.*
- Section 3: *Care Type, page 3-39, Diagnosis Code, page 3-72, and Patient Days Total, page 3-124.*
- Section 4:
- Business Rules (non-tabular) *Palliative Care*
  - Business Rules (tabular) *Care Type and Palliative Care Patient Days*
- Section 9:
- *Care Type 8 and Palliative Care Patient Days: Palliative Care Program.*

## Administration

<b>Purpose</b>	To measure the demand for palliative care services for:		
	<ul style="list-style-type: none"> <li>• Planning of palliative care services</li> <li>• Managing funding arrangements for palliative care services</li> </ul>		
<b>Principal data users</b>	Continuing Care and Clinical Service Development, (Metropolitan Health and Aged Care Services, DHS).		
<b>Collection start</b>	2005-06		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

---

# Patient Days Financial Year-To-Date

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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> leave with and without permission 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 Contacted Leave Days.  Patient Days Financial Year-To-Date must be equal to or greater than Patient Days Month-To-Date and equal to or less than Patient Days Total.		
<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		
<b>Related items</b>	Section 2: <i>Contracted Care and Patient Day</i> .  Section 3: <i>Contract Leave Days Financial Year-To-Date</i> page 3-50, <i>Contract Leave Days Month-To-Date</i> page 3-52, <i>Contract Leave Days Total</i> page 3-54, <i>Patient Days Month-To-Date</i> page 3-123, and <i>Patient Days Total</i> page 3-124.  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>	To enable hospitals to reconcile YTD days reported each month.
<b>Principal data users</b>	Automated PRS/2 processes.
<b>Collection start</b>	1983-84
<b>Definition source</b>	DHS

---

# Patient Days Month-To-Date

---

## Specification

<b>Definition</b>	The number of patient days the person has accrued during the current month <i>excluding</i> 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.)		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	2	<b>Layout</b>	NN 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 31.		
<b>Reporting guide</b>	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		
<b>Related items</b>	Section2: <i>Contract Care</i> and <i>Patient Day</i> .  Section 3: <i>Contract Leave Days Financial Year-To-Date</i> page 3-50, <i>Contract Leave Days Month-To-Date</i> page 3-52, <i>Contract Leave Days Total</i> page 3-54 <i>Patient Days Financial Year-To-Date</i> page 3-122, and <i>Patient Days Total</i> page 3-124.  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>	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

---

# Patient Days Total

---

## Specification

<b>Definition</b>	The total number of patient days the person has accrued during the whole episode of care to date <i>excluding</i> leave with and without permission 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>	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 Contacted Leave Days.		

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

<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
	607	Care Type Pall Care: Pall Care Pt Days not = Pt Days Total
	609	Pall Care Pt Days > Patient Days Total

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

Section 3: *Contract Leave Days Financial Year-To-Date* page 3-50, *Contract Leave Days Month-To-Date* page 3-52, *Contract Leave Days Total* page 3-54, *Patient Days Financial Year-To-Date* page 3-122, and *Patient Days Month-To-Date* page 3-123.

Section 4:

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

Section 5: *Status Segments*.

## Administration

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

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# Patient Identifier

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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>	10	<b>Layout</b>	XXXXXXXXXX Right justified, zero filled.
<b>Location</b>	Episode Record Sub-Acute Record DVA and TAC Record		
<b>Reported by</b>	Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	The Episode Record, Sub-Acute Record or DVA and TAC Record is reported.		
<b>Code set</b>	Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.		
<b>Reporting guide</b>	If multiple campuses transmit to PRS/2 in a single file, the Patient Identifier must be unique to the hospital. If the campuses transmit data separately to PRS/2, the Patient Identifier must be unique to each campus.  All newborns must have their own Patient Identifier. This cannot be the newborn's mother's Patient Identifier but could be the mother's Patient Identifier with a prefix or suffix.		
<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		
<b>Related items</b>	-		

## Administration

<b>Purpose</b>	To enable relevant episodes to be updated and provide the potential for episodes to be linked across patient settings.		
<b>Principal data users</b>	Automated PRS/2 processes.		
<b>Collection start</b>	1979-80		
<b>Definition source</b>	DHS	<b>Code set source</b>	Hospitals

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# Postcode

---

## Specification

**Definition** Postcode or 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 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 four digit country code 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**

058	Invalid Postcode/Locality
391	Recip HCA Account, Not O/Seas P/Code
571	Acct Recip, Pcode Oseas, Locality Not RHCA
572	Postcode Overseas, Account Not Recip, or Inelig
573	Postcode Overseas, Account Public
574	Postcode Overseas, Locality RHCA, Acct Not RHCA

**Related items** Section 3: *Locality*, page 3-109.

Section 4:

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

## Administration

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

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# Preferred Language

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## Specification

**Definition** The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.

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

**Field size** 2 **Layout** NN or spaces

**Location** Episode Record

**Reported by** Public hospitals (voluntary for private hospitals).

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

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

**Code set** See Section 9: Codes Lists: *Preferred Language*.

**Reporting guide** This information must:

- Be checked for every admitted patient episode.
- Not be set up to a default code on computer systems.
- Be collected on, or as soon as possible after, admission.

The standard question is:

What is [your] [the person's] preferred language?

**Patient is unable to consent (for example baby, child or elderly):**

Where a person is not able to consent for themselves (for example baby, child or elderly) then the language of the person who is consenting will be recorded. For example a guardian or someone with enduring power of attorney.

**07 Australian Indigenous languages, NEC**

*Includes:*

- All Australian Indigenous languages not shown separately on the code list.

**98 Not Stated**

*Includes:*

- Patients who are not able to respond to this question during their admission (for example unconscious).
- Child unaccompanied by an adult, who is too young to identify preferred language in relation to the ability to consent.
- This question on the form was not filled in, or filled in correctly and cannot be verified throughout the admission.

**Edits**

511	Invalid Preferred Language
513	Indigenous Status/Preferred Language Mismatch
514	Language is Unspecified
592	Invalid Comb Int Req/Pref Lang

**Related items** Section 3: *Country of Birth* page 3-63, *Indigenous Status* page 3-94, and *Interpreter Required* page 3-99.

Section 9:

- Codes Lists *Preferred Language*.

## Administration

**Purpose** For planning and to form the basis for future funding allocation for Culturally And Linguistically Diverse (CALD) hospital service provision.

**Principal data users** Clinical Governance Unit, DHS

**Collection start** 2003-04

**Definition source** NHDD **Code set source** NHDD; ABS mod Aust. Stand. Classification

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# Procedure Codes

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## Specification

**Definition** Up to 40 ICD-10-AM 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 2005-2006, available at:  
<http://www.health.vic.gov.au/hdss/reffiles/2005-06/vaed/libfil05.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://www.health.vic.gov.au/hdss/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.

<b>Edits</b>	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
	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
	440	NIV Duration without NIV Proc Code
	450	Code Incompatible W Female Sex
	451	Code Incompat W Male Sex
	596	Same Day ECT: Not in Care Type 4
	600	Invalid Code

**Related items** Section 2: *Contracted Care, DRG Classification and Procedure.*

Section 3: *Hospital Generated DRG* page 3-93.

Section 4:

- Business Rules (non-tabular) *Contracted Care and DRG Classification.*

## Administration

**Purpose** To facilitate:

- Epidemiological studies and other research.
- Grouping for casemix purposes.

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

**Collection start** 1979-80

**Definition source** DHS **Code set source** ICD-10-AM Fourth Edition

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# Qualification Status

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## Specification

<b>Definition</b>	Qualification status indicates whether each patient day within a newborn episode of care is either qualified or unqualified.		
<b>Datatype</b>	Alpha	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	A
<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>	<b>Code</b>	<b>Descriptor</b>	
	N	Qualified newborn	
	U	Unqualified newborn	
	X	Not applicable	
<b>Reporting guide</b>	<p>Status Segments are used to record changes between Qualified and Unqualified status for newborns and the duration of these periods (Patient Days).</p> <p>For all other admitted patients, a single Qualification Status code (X) is recorded, indicating newborn qualification status is not relevant to this patient.</p> <p><b>N      <i>Qualified newborn</i></b> A newborn who, for the patient days being recorded in this Status Segment, meets at least one of the following criteria to be a 'Qualified Newborn'.</p> <ul style="list-style-type: none"><li>• Admitted to facilities approved by the Commonwealth Minister for the provision of special care in designated neonatal intensive care units (NICUs) and designated special care nurseries (SCNs), or</li><li>• Is the second or subsequent live born of a multiple birth, or</li><li>• Remains in hospital after their mother is separated from hospital, or</li><li>• Is admitted to hospital without their mother.</li></ul> <p><b>U      <i>Unqualified newborn</i></b> A newborn who, for the patient days being recorded in this Status Segment, does not meet any of the qualifications to be a 'Qualified Newborn'.</p> <p><b>X      <i>Not applicable</i></b> An admitted patient other than a newborn.</p>		

An example of how changes of a newborn's Qualification Status are recorded:

Event	Date	Hospital's data records:
Birth of a single liveborn. Baby needs Special Care Nursery	1.9.2004	Admission details for newborn. Status Segment <i>Qualified</i>
Baby improves; transferred to ward	2.9.2004	New Status Segment <i>Unqualified</i>
Baby worsens; transferred back to SCN	3.9.2004	New Status Segment <i>Qualified</i>
Baby improves; transferred back to ward	4.9.2004	New Status Segment <i>Unqualified</i>
Mother and baby both go home	6.9.2004	Separation details for mother, baby

**Edits**

- 076 Not Sufficient Fields First Status
- 077 Not Sufficient Other Status
- 098 Invalid Qual Type
- 224 Newborn With Leave
- 241 Illegal Qual Stat Combination N & Y
- 242 Illegal Qual Stat Combination U & X
- 243 Unqual Newborn But Total Days > 9
- 260 Invalid Care For Qual
- 329 Geri Respite – Invalid Comb
- 403 Qual Newborn W/Out Justificat
- 434 NICU/SCN Accom But Unqual Newborn
- 454 Incompat Fields for Interim Care
- 466 Adm Type L & Newborn Qual Status
- 483 Incompat Adm Source/Qual Stat
- 485 Incompat Adm Type/Qual Stat
- 487 Incompat Age/Qual Stat
- 490 Incompat Crit For Adm/Qual Stat
- 491 Incompat Fields for ESAS
- 492 Incompat Fields for RPI

**Related items**

Section 2: *Acute Care, Criterion for Admission, Episode of Care, Newborn, Qualification (Newborn) and Sub-Acute Care.*

Section 3: *Care Type*, page 3-39.

Section 4:

- Business Rules (non-tabular) *Episode of Care* and *Newborn*.
- Business Rules (tabular) *Account Class: Geriatric Respite*, and *Admission Source and Qualification Status*, and *Admission Type and Qualification Status*, and *Age and Qualification Status*, and *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, 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 *Funding Arrangement: Elective Surgery Access Service*, and *Funding Arrangement: Rural Patients Initiative*, and *Newborns: Criteria for Admission, Qualification Status, Care Type*.

Section 5: *Status Segments*.

## Administration

**Purpose** To enable removal of unqualified newborn days, and episodes where the newborn is unqualified for the entire length of stay, to satisfy reporting requirements under the AHCA.

**Principal data users** Australian Institute of Health & Welfare.

**Collection start** 1995-96

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

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# Reason for Critical Care Transfer

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## Specification

**Definition** The reason a patient was transferred to another hospital for the provision of critical care.

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

**Field size** 1 **Layout** A or space

**Location** Diagnosis Record

**Reported by** Data item inactivated for 2005-06.

Hospitals do not report this item for 2005-06.

**Reported if** This hospital is participating in the Critical Care Inter-Hospital Transfer (CCIHT) Program and admits (*receives*) a patient for provision of critical care following their transfer from another hospital  
*and*  
The patient receives care in the ICU or CCU during the admission.  
*or*  
This hospital is participating in the Critical Care Inter-Hospital Transfer (CCIHT) Program and transfers (*sends*) an admitted patient to another hospital (public or private) for the provision of critical care.

Otherwise, report a space in this field.

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

**Code set** Hospitals that *receive* a patient following their transfer from another hospital for the provision of critical care, report the first appropriate value from:

<b>Code</b>	<b>Descriptor</b>
X	Transfer from acute hospital - Speciality not available at sending hospital
E	Transfer from acute hospital - ICU bed not available at sending hospital
J	Transfer from acute hospital - CCU bed not available at sending hospital
W	Other reason for transfer from acute hospital for critical care

Hospitals that *send* an admitted patient to another hospital for the provision of critical care report the first appropriate value from:

<b>Code</b>	<b>Descriptor</b>
Y	Transfer to acute hospital - Speciality not available at this hospital
F	Transfer to acute hospital - ICU bed not available at this hospital
K	Transfer to acute hospital - CCU bed not available at this hospital
Z	Other reason for transfer to acute hospital for critical care

**Reporting guide** **Sent and Received**  
Where, in a single episode, a patient was received by this hospital for the provision of critical care and sent by this hospital to another hospital for the provision of critical care, report the sending code only for this episode.

**Receiving: X, Sending: Y Specialty not available**

An inter-hospital transfer of a patient:

- From a hospital without an ICU to a hospital with an ICU, for treatment in ICU.
- From a hospital to a hospital listed below, for the listed specialty/condition.

Hospital	Specialties/Conditions
The Alfred Hospital	Major burns, heart-lung transplant, pre-transplant mechanical cardiac supports, hyperbaric treatment.
Austin & Repatriation Medical Centre	Spinal injury, liver transplant, weaning beds of Intensive Care Patients in the Victoria Respiratory Support Service (VRSS).
The Alfred or Royal Melbourne Hospital	Bone marrow transplant or complication of a bone marrow transplant

- From a hospital with a level 1, 2 or rural ICU to a hospital with level 3 ICU for neurology/neurosurgery, cardiac surgery or thoracic surgery, or treatment for major trauma.
- From Box Hill or Frankston Hospital to a hospital with level 3 ICU for neurology/neurosurgery, cardiac surgery.
- From the Western Hospital to a hospital with level 3 ICU for cardiac surgery.
- From a hospital without a CCU to a hospital with CCU, for treatment in CCU.
- From a hospital with a level 2 cardiac care service to a hospital with level 3 or level 4 cardiac care service for consideration or provision of angiography, angioplasty, cardiac surgery, assist device or electrophysiology.
- From St Vincent's to a hospital with level 4 cardiac care service for electrophysiology.
- From a hospital without the clinician responsible for the patient's original and on-going treatment to a hospital for on-going care by the original treating clinician.
- From a hospital without a requested or clinically needed specialist to one with a requested or clinically needed specialist.

**Receiving: E, Sending: F ICU bed not available**

An inter-hospital transfer of a patient to a hospital with an ICU for treatment in the ICU, outside the circumstances listed under X, Y.

*Includes an inter-hospital transfer of a patient:*

- From a hospital where the service, speciality or procedure is usually provided but the ICU bed, facilities, equipment or staff (medical/nursing/ancillary) are not available for the care of this patient. To the original sending hospital's ICU for recovery ('Down transfer').

**Receiving: J, Sending: K CCU bed not available**

An inter-hospital transfer of a patient to a hospital with a CCU for treatment in the CCU, outside the circumstances listed under X, Y.

*Includes an inter-hospital transfer of a patient:*

- From a hospital where the service, specialty or procedure is usually provided but the CCU bed, facilities, equipment or staff (medical/nursing/ancillary) are not available for the care of this patient. To the original sending hospital's CCU for recovery ('Down transfer').

**Receiving: W Other reason for transfer**

An inter-hospital transfer of a patient:

- But not to an ICU or CCU. However, the patient later spends time in the receiving hospital's ICU or CCU. (The sending hospital does not report a Reason for Critical Care Transfer in this instance.)
- For the provision of critical care in ICU/CCU when the sending hospital is able to provide the care required. Reasons for an inter-hospital transfer in this circumstance include:
  - Transfer to a hospital closer to home
  - Transfer to a hospital due to family convenience

**Sending: Z Other reason for transfer**

An inter-hospital transfer of a patient for the provision of critical care in ICU/CCU when the sending hospital is able to provide the care required.

*Includes an inter-hospital transfer of a patient:*

- To a hospital closer to home
- To a hospital due to family convenience

**Edits**

- 329 Geri Respite – Invalid Comb
- 335 Invalid Reason For Crit Care Transfer
- 336 Invalid Comb For Crit Care Transfer
- 454 Incompat Fields for Interim Care
- 524 CCIHT not approved

**Related items**

Section 2: *Cardiac/Coronary Care Unit, Critical Care Inter-Hospital Transfer Program, and Intensive Care Unit.*

Section 3: *Duration of Stay in Cardiac/Coronary Care Unit* page 3-80, and *Duration of Stay in Intensive Care Unit* page 3-82.

Section 4:

- Business Rules (tabular) *Account Class: Geriatric Respite, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and k), and Care Type: Interim Care Program (F and E), and Criterion for Admission: Secondary Family Member, and Reasons for Critical Care Transfer: Valid Combinations.*

Section 9:

- Code Lists: *Critical Care Inter-Hospital Transfer (CCIHT) Program: Participating Hospitals*

## Administration

**Purpose**

To provide data to support the Critical Care Inter-Hospital Transfer (CCIHT) component of the Hospital Access Program (HAP).

**Principal data users**

**Collection start** 1998-99

**Definition source**

DHS

**Code set source**

DHS

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## RUG ADL on Admission (a)

## RUG ADL on Separation (b)

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### Specification

<b>Definition</b>	RUG ADL (Resource Utilisation Group Activities of Daily Living): (a) As assessed on admission. (b) As assessed on separation.		
<b>Datatype</b>	Numeric	<b>Form</b>	Score
<b>Field size</b>	2	<b>Layout</b>	NN or spaces Right justify, leading zeros.
<b>Location</b>	Sub-Acute Record		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Episodes with Care Type 8. For Care Types 2, 6, 7, K, 9, F and E, report spaces in this field.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	Cumulative Score, out of 18. On admission, a minimum score of 04 must be reported. Refer to the RUG ADL Score Table following.		
<b>Reporting guide</b>	Record what the person actually does, not what they are capable of doing; that is, record the lowest performance of the assessment period.  If the person dies in hospital, record a score of 00 for the Separation RUG ADL.  On the score sheet, do not leave any spaces blank. It is essential that each data collector knows what behaviours and/or tasks are contained within each item and have a 'working knowledge' of the scale.		

### RUG ADL Score

RUG Item	Score	Definition
<b>Bed Mobility</b>		Ability to move in bed after the transfer into bed has been completed.
Independent supervision	1	Able to readjust position in bed, and perform own pressure area relief, through spontaneous movement around bed or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.
Limited assistance	3	Able to readjust position in bed, and perform own pressure area relief, with the assistance of one person.
Other than two persons	4	Requires the use of a hoist or other assistive device to readjust position in bed and provide pressure relief. Still requires the assistance of one person for task.
Two or more persons physical assist	5	Requires 2 or more assistants to readjust position in bed, and perform pressure area relief.

RUG Item	Score	Definition
<b>Toileting</b>		Includes mobilising to the toilet, adjustment of clothing before and after toileting and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes. If level of assistance differs between voiding and bowel movement, record the lower performance.
Independent/ supervision	1	Able to mobilise to toilet, adjusts clothing, cleans self, adjusts clothing, has no incontinence or soiling of clothing. All tasks are performed independently or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.
Limited assistance	3	Requires hands-on assistance of one person for one or more of the tasks.
Other than two persons physical assist	4	Requires the use of a catheter/uridome/urinal and/or colostomy/bedpan/commode chair and/or insertion of enema/ suppository. Requires assistance of one person for management of the device.
Two or more persons physical assist	5	Requires two or more assistants to perform any step of the task.
<b>Transfer</b>		Includes the transfer in and out of bed, bed to chair, in and out of shower/tub. Record the lowest performance of the day/night.
Independent/ supervision	1	Able to perform all transfers independently or with prompting of carer. No hands-on assistance required. May be independent with the use of a device.
Limited assistance	3	Requires hands-on assistance of one person to perform any transfer of the day/night.
Other than two persons physical assist	4	Requires use of a device for any of the transfers performed in the day/night. Requires only one person plus a device to perform the task.
Two or more persons physical assist	5	Requires 2 or more assistants to perform any transfer of the day/night.
<b>Eating</b>		Includes the tasks of cutting food, bringing food to mouth and chewing and swallowing food. Does not include preparation of the meal.
Independent/ supervision	1	Able to cut, chew and swallow food, independently or with supervision, once meal has been presented in the customary fashion. No hands-on assistance required. If individual relies on parenteral or gastrostomy feeding that he/she administers him/herself then Score 1.
Limited assistance	2	Requires hands on assistance of one person to set up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet).
Extensive assistance/ total dependence/ tube fed	3	Person needs to be fed meal by assistant, or the individual does not eat or drink full meals by mouth but relies on parenteral/ gastrostomy feeding and does not administer feeds by him/herself.
<b>TOTAL</b>		<b>(Score out of 18)</b>

**Edits**

- (a) 258 Sub-Acute: No Sub-Acute Record  
303 Pal Care But Invalid Adm RUG ADL  
305 Adm RUG ADL Present  
454 Incompat Fields for Interim Care
- (b) 258 Sub-Acute: No Sub-Acute Record  
297 Sep RUG ADL & Sep Mode Incompatible  
304 Pall Care But Invalid Sep RUG ADL  
306 Sep RUG ADL Present  
454 Incompat Fields for Interim Care

**Related items** Section 2: *Palliative Care*.

Section 4:

- Business Rules (tabular) *Care Type: Designated and non-Designated Rehabilitation Programs (2, 6, 7 and K)*, and *Care Type: Interim Care Program (F and E)*.

## Administration

**Purpose** To support and further develop casemix classifications for sub-acute episodes of care.

**Principal data users** Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).

**Collection start** 1996-97

**Definition source** DHS **Code set source** RUG ADL

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# Separation Date

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## Specification

<b>Definition</b>	Date on which an admitted patient completes an episode of care.		
<b>Datatype</b>	Numeric	<b>Form</b>	Date
<b>Field size</b>	8	<b>Layout</b>	DDMMCCYY
<b>Location</b>	Episode Record DVA and TAC 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 of care is completed.		
<b>Code set</b>	A valid date.		
<b>Reporting guide</b>	The Separation Date must be on or after the Admission Date.		

If no other separation details are submitted (patient not yet separated), zero-filled Separation Date is accepted.

The Separation Date may relate to a formal or statistical separation.

### **Statistical Separations**

Statistical Separation must have a Separation Date equalling the next episode's Admission Date. Statistical separations and admissions cannot occur over midnight.

**Edits**

026	Zero Sep; Existing not Discharged
027	Adm Record; Overlaps Existing
028	Prior Adm; No Sep Date
063	Prior Not Discharged
065	Original Deleted Upd Sep < Cutoff
066	Sep Date Prior to Cutoff Date
101	Invalid Sep Date
102	Sep Date < Adm Date
108	Field(s) are missing From Sep
112	Calc Los +Leave Not = Adm/Sep
115	Adm Time Not < Sep Time
119	Sep Time - No Sep Date
122	Sameday Adm Source/ Sep Mode Mismatch
127	Nil Value DRG
160	AR-DRG Grouper GST Code > Code
179	Trans Sep Not Same As Episode
193	Not Separated – Intent Readmit
196	X2 Record Epis. Not Separated
258	Sub – Acute: No Sub Acute Record
259	Invalid Rehab/Subac – Episode Sep Date
265	Mental Health Status - Not Separated
322	ICU/CCU Stay > Total Stay
323	MV Duration > Total Stay
352	Code Not Found On Code File
388	Sep Referral - Episode Not Separated
401	Accom Type On Sep – Emerg, Not Same Day
421	Not Separated; Carer Avail Present
424	Not Separated: Fund Arr S/Be Spaces
438	NIV Duration >Total Stay
461	ACAS Status not Required
465	Adm Duration < 15 Mins
467	Adm Wt <1000g, LOS <28 Days, Sep Mode ≠ T or D
468	Care Type ≠ 1 or F, LOS >365 Days
474	Care Type E, LOS > 35 Days
504	Stat Episode: Next Episode > 1 Minute Apart
505	Stat Episode: Previous Episode > 1 Minute Apart
533	ACAS Status Code Required
549	Type B Crit for Adm, LOS >1
550	Type C Crit for Adm, LOS >1
551	Type C Crit for Adm, LOS >4 hrs
552	Type E Crit for Adm, LOS >1
553	Type E Crit for Adm, LOS <4 hrs
593	Invalid Sep Date; > Header
596	Same Day ECT: Not in Care Type 4
598	Same Day Rehabilitation: Not in Scope

**Related items**

Section 2: *Length of Stay, Overnight or Multi-day Stay Patient, and Same Day Patient.*

Section 4:

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

## Administration

<b><i>Purpose</i></b>	To enable validation of patient days and to enable an episode of care to be placed into month and year of separation: <ul style="list-style-type: none"><li>• For counting purposes.</li><li>• To check codes in the record against the valid codes for that year.</li></ul>
<b><i>Principal data users</i></b>	Automated PRS/2 processes.
<b><i>Collection start</i></b>	1979-80
<b><i>Definition source</i></b>	NHDD

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# Separation Mode

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## Specification

**Definition** Status at separation of the person, and place to which the person is released (where applicable).

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

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	S	Statistical Separation (change in Care Type within this hospital)
	D	Death
	Z	Left against medical advice
	T	Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre
	B	Separation and transfer to Transition Care bed based program
	N	Separation and transfer to aged care residential facility
	A	Separation and transfer to mental health residential facility
	H	Separation to private residence/accommodation

**Reporting guide** **S Statistical Separation (change in Care Type within this hospital)**  
Assign this code when a new episode of care (change in Care Type) occurs within the same hospital stay.

*Includes:*

- Statistical separation from Palliative Care (Care Type 8) only if the change is to Nursing Home Type (Care Type F, 1, 5T).

*It is not permissible to:*

- Change to Alcohol and Drug Program Care Type following another episode of care (for public hospitals).
- Change between Rehabilitation Program/Units: Levels 1, 2 or 3 Care Types (2, 6 or 7).
- Change from or to Unqualified newborn (Care Type U) as a Statistical Separation or a Statistical Admission. Changes between Qualified and Unqualified status of newborns is recorded in Status Segments using the Qualification Status field. Refer to Section 2: *Newborns*.
- Change to Palliative Care (Care Type 8) as a Statistical Admission, unless the change is from Nursing Home Type (Care Type F, 1, 5T).

**D Death**  
Died in hospital.

**Z *Left against medical advice***

Patient absconds or leaves against medical advice, at own risk. This Separation Mode is significant in the allocation of some DRGs.

*Includes:*

- Newborns taken from the hospital against medical advice.

**T *Separation and transfer to other acute hospital/extended care/rehabilitation/ geriatric centre***

Separation and transfer to another hospital, regardless of whether the patient is to be admitted at the receiving hospital. Requires a Transfer Destination code.

*Includes:*

- Unqualified newborn being transferred to another hospital.
- Public and private acute, extended care and mental health admitted patient units.

*Excludes:*

- Transition Care bed based program (use code B).
- Aged care residential facilities (use code N).
- Mental health residential units (use code A).

**B *Separation and transfer to Transition Care bed based program***

Separation and transfer directly to a Transition Care bed based program. Does not require a Transfer Destination code.

*Excludes:*

- Home-based Transition Care (use code H and Separation Referral Code T).

**N *Separation and transfer to aged care residential facility***

Separation and transfer to an aged care residential facility (includes nursing home and hostel). Does not require a Transfer Destination code.

*Includes:*

- Patient returning to the aged care residential facility in which they live.

*Excludes:*

- Transition Care bed based program (use code B).
- Mental health aged care residential facility (use code A).

**A *Separation and transfer to mental health residential facility***

Separation and transfer to mental health residential facility (includes psychogeriatric nursing home and community care unit) funded by Mental Health Services. Does not require a Transfer Destination code.

*Includes:*

- Patient returning to the mental health residential facility in which they live.
- Mental health aged care residential facility.

*Excludes:*

- Mental health admitted patient units (use code T).

## **H Separation to private residence/accommodation**

Place of residence immediately following separation. Requires a Separation Referral code.

### *Includes:*

- Home or home of relative or friend.
- Supported residential facilities.
- Special accommodation houses.
- Training centres for intellectually disabled persons.
- Prison.
- Forensic hospital (Thomas Embling)
- Juvenile detention centre.
- Armed forces base camp.
- Homeless (shelters, half way houses).
- A patient in Accommodation Type 4 *In The Home (Hospital – HITH)* in private accommodation or residential facility who, on separation, remains in the same private accommodation.
- Home-based Transition Care.

### *Excludes:*

- Transition Care bed based program (use code B).
- Aged care residential facility (use code N).
- Mental health residential facility (use code A).

### **Edits**

103	Invalid Sep Mode
108	Fields(s) Missing From Sep
109	Trans Dest Not Blank
110	Invalid Transfer Type
122	Sameday Adm Source/ Sep Mode Mismatch
127	Nil Value DRG
160	AR-DRG Grouper GST Code Zero
192	Invalid Comb Int. Readmit Sep Mode
232	Possible Coding or Sequencing Problem
288	Sep Barthel & Sep Mode Incompatible
291	Adm Barthel > Sep Barthel
297	Sep Rug ADL & Sep Mode Incompatible
328	Early Parenting Centre – Invalid Comb
329	Geri Respite – Invalid Comb
334	Hosp Generated DRG Not = PRS/2 DRG
336	Invalid Comb For Crit Care Transfer
390	Incompat Care Type, Carer Avail, Age and Sep Mode
394	Sep Mode Home, No Sep Referral
395	Sep Mode Not Home, Sep Referral Present
397	Sep Referral Postnatal, Incompat Age/Sex
423	Invalid Comb Fund/ Contract /Transfer
454	Incompat Fields for Interim Care
467	Adm Wt <1000g, LOS < 28 Days, Sep Mode ≠ T or D
471	Care Type 5x, not usual Sep Referral
489	Incompat Care Type/Sep Mode Statistical
493	Incompat Sep Mode/Age <15
494	Incompat Sep Mode/Age <55
501	Stat Episode: Adm Source ≠ Sep Mode Prev Episode
502	Stat Episode: Care Type same as Next Episode
504	Stat Episode: Next Episode > 1 Minute Apart
506	Stat Episode: Rehab also in Next Episode
509	Stat Episode: Sep Mode ≠ Adm Source Next Episode
510	Stat Sep Mode: No Subsequent Episode
529	Stat Episode Pall: Not NHT in Next Episode
597	Mental Health Episode: Sep Mode = S

**Related items**

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

Section 3: *Transfer Source*, page 3-163.

Section 4:

- Business Rules (non-tabular) *DRG Classification, Episode of Care and Transfer.*
- Business Rules (tabular) *Account Class: Geriatric Respite, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type: Interim Care Program (F and E), and Care Type and Separation Mode, and Carer Availability and Separation Mode, and Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode, and Criterion for Admission: Secondary Family Member, and Intention to Readmit and Separation Mode, and Reasons for Critical Care Transfer: Valid Combinations.*

**Administration****Purpose**

To:

- Distinguish between formal and statistical separations.
- Study service patterns - Care Type changes, transfers.
- Assist in the allocation of DRGs.

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

**Collection start** 1979-80

**Definition source** NHDD

**Code set source** DHS

**Mapping between Separation Mode and the Grouper Mode of Separation:**

Separation Mode (PRS/2)		Mode of Separation (NHDD and Grouper)	
D	Death	8	Died
Z	Left against medical advice	6	Left against medical advice
T	Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre	1	Discharge/transfer to an(other) acute hospital
B	Separation and transfer to Transition Care bed based program	4	Discharge/transfer to other health care accommodation
N	Separation and transfer to aged care residential facility	2	Discharge/transfer to a Residential Aged Care Service
A	Separation and transfer to mental health residential facility	4	Discharge/transfer to other health care accommodation
H	Separation to private residence/accommodation	9	Other (includes to usual residence)
S	Statistical separation (change in Care Type within this hospital)	5	Statistical discharge-type change

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# Separation Referral

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## Specification

**Definition** Clinical care and support services arranged by the hospital to meet the person's recuperative needs when discharged to private accommodation or home.

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

**Field size** 4 **Layout** AAAA or spaces  
Left justified, trailing spaces.

**Location** Episode Record

**Reported by** Public hospitals.

Private hospitals – Optional. If the private hospital chooses not to report these data, report spaces in this field.

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

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

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

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

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

Unless a specific service has been arranged, use code X *No referral or support*

*services arranged before discharge.*

**F *Domiciliary postnatal care, arranged before discharge***

Mother discharged, with domiciliary postnatal care arranged before discharge to her own home or home of relative or friend or other private accommodation\*. Domiciliary care includes that provided by the hospital and by home nursing services.

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

**P *Post Acute Care Program services, arranged before discharge***

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

For more information about Post Acute Program Services refer to *Victoria—Public Hospitals and Mental Health Services Policy and Funding Guidelines 2005-2006* and <http://www.health.vic.gov.au/pac/>

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

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

*Excludes:*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Includes:*

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

**T Referral to Transition Care home based program, arranged before discharge**

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

*Excludes:*

- Bed-based Transition Care (use code R and Separation Mode code B).

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

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

*Includes:*

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

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

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

**Notes:**

\*Private accommodation comprises:

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

*Includes:*

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

**Edits**

329 Geri Respite – Invalid Comb  
 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 5x, not usual Sep Referral  
 495 Incompat Sep Referral and Indigenous Status  
 584 Sep Referral I, not approved for Interim Care

**Related items**

Section 3: *Separation Mode* on page 3-145.

## Section 4:

- Business Rules (tabular) *Account Class: Geriatric Respite*, and *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, 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>	Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, 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

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# Separation Time

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## Specification

**Definition** The time at which a patient completes an episode of care.

**Datatype** Numeric **Form** Time

**Field size** 4 **Layout** HHMM

**Location** Episode Record

**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** A valid 24-hour time (not 0000 or 2400).

**Reporting guide** For a **formal separation**, the Separation Time is the time at which patient presents at the discharge office/desk. For patients who leave against medical advice, Separation Time is the time of last patient contact. For patients who die in hospital, Separation Time is the time of death (that is, brain death).

For a **statistical separation**, (Care Type change), a dummy Separation Time is acceptable to enable the times to be automatically recorded. Care Type changes could be recorded as occurring at midday. The Separation Time must be one minute earlier than the Admission Time of the following episode (for example, if Separation Time of the earlier episode was made to be 1200, Admission Time of the new episode would be 1201).

### Midnight

Following international convention, midnight is either 2359 of preceding date or 0001 of following date (0000 and 2400 are not accepted).

**Edits**

027	Adm Record; Overlap Existing
108	Fields(s) Missing From Sep
114	Invalid Sep Time
115	Adm Time Not < Sep Time
119	Sep Time - No Sep Date
322	ICU/CCU Stay > Total Stay
323	MV Duration > Total Stay
438	NIV Duration > Total Stay
465	Adm Duration < 15 Mins
504	Stat Episode: Next Episode > 1 Minute Apart
505	Stat Episode: Previous Episode > 1 Minute Apart
551	Type C Crit for Adm, LOS >4 hrs
553	Type E Crit for Adm, LOS <4 hrs

**Related items** Section 2: *Time of Death*.

## Administration

<i>Purpose</i>	To enable the exact Length of Stay to be determined.
<i>Principal data users</i>	Multiple internal and external data users.
<i>Collection start</i>	1993-94
<i>Definition source</i>	DHS

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# Sex

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## Specification

<b>Definition</b>	The sex of the person.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N
<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</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.

<b>Edits</b>	033	Invalid Sex
	059	Maternity - Not Female
	080	Sex Indeterminate, age < 90 days
	127	Nil Value DRG
	160	AR-DRG Grouper GST Code>Zero
	215	Sex Indeterminate But Age>= 90 days
	354	Code & Sex Incompatible
	397	Sep Referral Postnatal, Incompat Age/Sex
	450	Code Incompatible W Female Sex
	451	Code Incompat W Male Sex
	580	MHSWPI Valid, no Matching Sex
	585	Sex Code Intersexual

**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 data users.

**Collection start** 1979-80

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

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# Site Identifier

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## Specification

<b>Definition</b>	Indicates the hospital campus where the episode of care was provided.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N
<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 Section 9: <i>Code Lists: Hospitals</i> .		
<b>Reporting guide</b>	The site identifier for single campus hospitals is 0.		
<b>Edits</b>	330 Invalid Site Identifier 420 Contract/Spoke = Campus / Site 472 Pall Care, not approved for Palliative Care Program 473 Care Type 9, not approved for GEM 475 Care Type F or E, not approved for Interim Care 477 Funding Arrangement 5, not approved for Rural Patients Initiative 478 Funding Arrangement 6, not approved for ESAS 520 Accom Type 7, not approved for Medi-hotel 521 Accom Type M, no registered MAPU 522 Accom Type S, no registered SOU 523 CCU Hrs, no Approved CCU 524 CCIHT not approved 526 ICU Hrs, not approved ICU or NICU 527 Accom Type 8, not approved for EMU		
<b>Related items</b>	Section 2: <i>Campus, and Hospital</i> .  Section 9: • Code Lists: <i>Hospitals</i> .		

## Administration

<b>Purpose</b>	To identify the specific campus of a hospital providing this episode of care, for use in policy and planning development.		
<b>Principal data users</b>	Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).		
<b>Collection start</b>	1998-99		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

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# Source of Referral to Palliative Care

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## Specification

<b>Definition</b>	The source of the person's referral to the DHS Palliative Care Program.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	2	<b>Layout</b>	NN Right justified, leading zero.
<b>Location</b>	Sub-Acute Record		
<b>Reported by</b>	Public hospitals.		
<b>Reported for</b>	Episodes with Care Type 8. For Care Types 2, 6, 7, K, 9, F or E, report spaces.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	Select the first appropriate category:		
	<b>Code</b>	<b>Descriptor</b>	
	01	Community Sector - GP	
	02	Community Sector - Specialist	
	03	Community Sector - Self, Carer, Other (eg family member, neighbour)	
	04	Community Sector - Community Based Agency	
	05	Hospital - Public - Admitted patient	
	06	Hospital - Private - Admitted patient	
	07	Hospital - Outpatient - Non-admitted patient	
	08	Residential Care - Nursing Home/Hostel	
	09	Other	
<b>Reporting guide</b>	-		
<b>Edits</b>	258	Sub-Acute: No Sub-Acute Record	
	340	Invalid Source Of Refer to Pal Care	
	341	Source Of Refer To Pal Care Present	
	454	Incompat Fields for Interim Care	
<b>Related items</b>	Section 2: <i>Palliative Care</i> .		
	Section 4:		
	<ul style="list-style-type: none"><li>Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)</i>, and <i>Care Type: Interim Care Program (F and E)</i>.</li></ul>		

## Administration

<b>Purpose</b>	To inform policy and planning decisions.		
<b>Principal data users</b>	Cancer and Palliative Care Unit (Metropolitan Health and Aged Care Services, DHS).		
<b>Collection start</b>	1998-99		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

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# Surname

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## Specification

<b>Definition</b>	The surname of the DVA or TAC patient.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Name
<b>Field size</b>	25	<b>Layout</b>	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.  The first character must be an alpha character.		
<b>Edits</b>	161 Invalid Surname 557 Surname Unusual Length		
<b>Related items</b>	Section 3: <i>Account Class</i> page 3-9 and <i>Given Name(s)</i> page 3-89.		

## 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>	-

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# Transfer Destination

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## Specification

<b>Definition</b>	Identification of the hospital campus to which a person is transferred, following separation from this hospital campus.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	4	<b>Layout</b>	NNNN or spaces
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	Admitted episodes where the Separation Mode is T <i>Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centres</i> .  Otherwise, report spaces.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	Refer to the Hospital Code Table 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>Hospital identifier for Victorian hospitals</b> Refer to Section 9: <i>Code Lists: Hospitals</i> .		

## Hospital identifier for interstate and overseas hospitals

Compile a code according to the following convention:

### **First character:**

9 for all interstate and overseas hospitals

### **Second character:** state/overseas identifier

0 Queensland  
1 New South Wales  
2 Tasmania  
3 South Australia  
4 Western Australia  
5 ACT  
6 Northern Territory  
7 New Zealand  
8 Other overseas

### **Third character:** hospital type

0 Major specialist/teaching  
1 Other public acute  
2 Extended care  
3 Private  
5 Psychiatric (public only)  
6 Rehabilitation (public only)  
9 Other healthcare accommodation (eg early parenting centres)

### **Fourth character:**

7 for all interstate and overseas hospitals

Thus, an *extended care hospital* in *New South Wales* would be coded 9127.

Unknown Transfer Destination code is 9999

## **Reporting guide**

### **Prison Hospitals and Armed Forces Hospitals**

These are not generally recognised as hospitals by the Australian Government Department of Health and Ageing, and therefore separation to such facilities is not an inter-hospital transfer (use Separation Mode H *Separation to private accommodation or home*).

## **Edits**

078 T- Srce T- Dest Code Matches Hosp  
109 Transfer Dest Not Blank  
110 Invalid Transfer Type  
336 Invalid Comb For Crit Care Transfer

## **Related items**

Section 2: *Transfer*.

Section 4:

- Business Rules (non-tabular) *Transfer*.
- Business Rules (tabular) *Reasons for Critical Care Transfer: Valid Combinations*.

Section 9:

- Code Lists: *Hospitals*.

## Administration

<b><i>Purpose</i></b>	Study of transfer patterns.		
<b><i>Principal data users</i></b>	Health Policy Analysis and Reporting (Metropolitan Health and Aged Care Services, DHS).		
<b><i>Collection start</i></b>	1999-00		
<b><i>Definition source</i></b>	DHS	<b><i>Code set source</i></b>	DHS

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# Transfer Source

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## Specification

<b>Definition</b>	Identification of the hospital campus the person has been transferred from, following separation from that hospital.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	4	<b>Layout</b>	NNNN or spaces
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	Admitted episodes where the Admission Source is T <i>Transfer from acute hospital/extended care/rehabilitation/geriatric centres</i> .  Otherwise, report spaces.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Refer to the Hospital Code Table 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>Hospital identifier for Victorian hospitals</b> Refer to Section 9: <i>Code Lists: Hospitals</i> .		

## Hospital identifier for interstate and overseas hospitals

Compile a code according to the following convention:

### First character:

9 for all interstate and overseas hospitals

### Second character: state/overseas identifier

0 Queensland  
1 New South Wales  
2 Tasmania  
3 South Australia  
4 Western Australia  
5 ACT  
6 Northern Territory  
7 New Zealand  
8 Other overseas

### Third character: hospital type

0 Major specialist/teaching  
1 Other public acute  
2 Extended care  
3 Private  
5 Psychiatric (public only)  
6 Rehabilitation (public only)  
9 Other healthcare accommodation (eg early parenting centres)

### Fourth character:

7 for all interstate and overseas hospitals

Thus, an *extended care hospital* in *New South Wales* would be coded 9127.

Unknown Transfer Source code is 9999

## Reporting guide

### Prison Hospitals and Armed Forces Hospitals

These are not generally recognised as hospitals by the Australian Government Department of Health and Ageing, and therefore admission from such facilities is not an inter-hospital transfer (use Admission Source *Z Other formal admission source*).

## Edits

042 Invalid Transfer Source  
051 Transfer Source Not Blank  
078 T- Srce/ T- Dest Code Matches Hosp  
329 Geri Respite – Invalid Comb  
336 Invalid Comb For Crit Care Transfer

## Related items

Section 2: *Transfer*.

Section 4:

- Business Rules (non-tabular) *Transfer*.
- Business Rules (tabular) *Account Class: Geriatric Respite, and Reasons for Critical Care Transfer: Valid Combinations*.

Section 9:

- Code Lists: *Hospitals*.

## Administration

<i>Purpose</i>	Study of transfer patterns.		
<i>Principal data users</i>	Health Policy Analysis and Reporting (Metropolitan Health and Aged Care Services, DHS).		
<i>Collection start</i>	1979-80		
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

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# Unique Key

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## Specification

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

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

**Field size** 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 there is a 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.

**Edits**

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
169	No Corresponding Episode
192	Diagnoses Delete: No Record On File
248	Tran Pt ID Not Same As Episode Or Subac
249	No Sub – Acute To Delete
259	Invalid Rehab/Subac- Episode Sep Date
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
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.