

Specifications for revisions to  
PRS/2 and the Victorian Admitted  
Episodes Dataset (VAED) for  
1 July 2005

March 2005

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# Executive Summary

This document details the revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2005. These revisions are summarised below.

1. Removal of a code from the Care Type codeset, as Rehabilitation In The Home (RITH) is no longer considered to be within the scope of the VAED. Removal of associated Concept Definition, and amendments to other data items to remove references to RITH.
2. New Concept Definition for Transition Care, and new codes in three data items (Admission Source, Separation Mode and Separation Referral) to capture admissions from and separations and referrals to bed-based and home-based Transition Care.
3. A new data item to capture Palliative Care Patient Days in approved palliative care programs.
4. Amendment of the newborn Accommodation Types to remove the reference to age less than three months.
5. Amendment of reporting requirements for Duration of Non-Invasive Ventilation (NIV) to be optional for all episodes.
6. Amendment of the Indigenous Status data item through the addition of two new codes.
7. Three new private Account Classes.
8. Edit concept name change to distinguish between the two types of notifiable edits.
9. Updated reference files, including: ICD-10-AM Library File (edit parameters only), Hospital Code Table and Postcode/Locality Reference File.
10. Addition of a new concept to the library file to indicate codes that may sometimes be followed by a morphology code, and the removal of two redundant concepts.

# Introduction

## The need for PRS/2 interface modifications

From 1 July 2005, changes to the Victorian Admitted Episodes Dataset (VAED) are necessary to assist Victorian health program monitoring, planning and policy development by the Department of Human Services (DHS).

Comments from hospitals and software suppliers regarding the content of the document *Proposals for Revisions to PRS/2 and the VAED, December 2004* have been taken into account and where possible, suggestions have been accommodated. Items presented in the *Proposals for revisions to PRS/2 and the VAED* may be altered from their initial presentation in that document. Additionally, there are items in this document that have not been presented in the *Proposals* documentation.

## Distribution and components of this document

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

- Amended, deleted and new concept definitions, data items and business rules.
- Reference files to be updated for 1 July 2005.
- End of financial year considerations.

Appendix A of this document includes:

- Amended, deleted and new edits and edit tables.
- Amended, and deleted Supplementary Code Lists.
- Amended file structures.

The *VAED Manual, 15<sup>th</sup> Edition, July 2005* will be distributed at a later date. Until then, the *VAED Manual, 14<sup>th</sup> Edition, July 2004* (as amended by HDSS Bulletins 80 onwards) together with this document, and Appendix A, will form the admitted patient data transmission specification for 2005–06.

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

The current *VAED Manual, 14<sup>th</sup> Edition, July 2004* may be accessed on the Internet at <http://hdss.health.vic.gov.au/vaed/index.htm>.

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

## Orientation to this document

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

- New values and definitions relating to existing items appear in boxes. Where the entire concept definition or data item is new this will appear in the normal layout without the boxes.
- Redundant values and definitions relating to existing items are ~~struck through~~.
- *[Comments relating to the specification document only appear in square brackets and italics.]*
- Page numbers representing cross referencing to another section of the *VAED Manual* that are not represented in this document are represented by a #.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Victorian Admitted Episodes Dataset (VAED) 14th Edition, 1 July 2004*.
  - Specification*: details the reporting requirements for the item.
  - Administration*: provides additional information including the purpose of the collection of the data item and the source of the code set and definitions.
- Further information such as the background to each specification is provided.
- Amended edits can be identified by the asterisk printed beside the relevant edit number and descriptor.

## Abbreviations

ABS	Australian Bureau of Statistics
AHCA	Australian Health Care Agreement
AIHW	Australian Institute of Health and Welfare
AIMS	Agency Information Management System
AR-DRG	Australian Refined Diagnosis Related Group
DHS	Department of Human Services
HDSS	Health Data Standards and Systems
HITH	Hospital In The Home
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive Care Unit
NHDD	National Health Data Dictionary
NICU	Neonatal Intensive Care Unit
NIV	Non-invasive Ventilation
NMDS	National Minimum Data Set
PRS/2	Patient Reporting System, Version 2
RITH	Rehabilitation In The Home
SCN	Special Care Nursery
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VICC	Victorian ICD Coding Committee
WIES	Weighted inlier Equivalent Separations

## Symbols

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

# Amended/New/Deleted Concept Definitions Rehabilitation In The Home (RITH) Related

## Hospital in the Home (HITH) (*Amend*)

<b>Revision Summary</b>	Remove reference to Rehabilitation In The Home (RITH), as this concept is no longer considered to be within the scope of the VAED.
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**Definition** Provision of care to hospital admitted patients in their place of residence as a substitute for traditional hospital accommodation. Place of residence may be permanent or temporary.

**Guide for use** Place of residence includes residential facilities such as nursing homes, hostels or other forms of supported accommodation. Medi-hotels are excluded, no services are provided while the patient resides there.

Hospital in the Home (HITH) services might include treatment of orthopaedic conditions or the administration of intra-venous therapies. The use of HITH is voluntary for the patient. For a patient, the service might be a combination of hospital and home-based care or replace hospital care completely.

A public hospital must be designated in its Health Service Agreement to provide HITH services.

Currently, HITH is limited to public, private, DVA, TAC and WorkCover patients. However, a hospital must apply for eligibility to treat private patients under HITH. Details regarding this are outlined in the following circulars:

- HBF 740 PH 474 Guidelines for Approved Outreach Services under the Health Legislation Amendment Act (No 1) 2001.
- HBF 747 PH 481 Amendment to Guidelines for the Establishment and Implementation of the Private Sector Outreach Services and other general information.

These circulars include the following:

- Facilities seeking to provide outreach [hospital in the home] services to private patients will be required to gain Federal Ministerial approval. Only those services that have been approved will be covered by hospital table health insurance and reinsurance arrangements (where eligible).
- Public hospital, private hospital and day facilities wishing to offer an approved outreach service are invited to make an application to the Private Health Industry Branch, Commonwealth Department of Health and Aged Care.

For the Hospital in the Home program, movement between ward accommodation and 'Hospital in the Home' accommodation is reported in the Status Segments within the same episode. ~~(Note that the Rehabilitation in the Home program treats accommodation changes differently).~~

Patients receiving care under this program must meet one of the minimum criteria for admission, as HITH represents a substitute for acute admitted patient care provided in a traditional hospital setting.

**Refer to:**

- Section 2: *Medi-Hotel page 2-#, Non-Admitted Patient page 2-#, and Rehabilitation in the Home page 2-8.*
- Section 3: *Accommodation Type.*
- Section 4: *Rehabilitation in the Home.*

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## Rehabilitation in the Home (*Delete*)

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<b>Revision Summary</b>	Delete as this concept is no longer considered to be within the scope of the VAED.
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### Transition Care (*New*)

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<b>Revision Summary</b>	New Concept Definition to support reporting of new codes in Admission Source, Separation Mode and Separation Referral.
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**Definition** Transition Care is a jointly funded program between the Department of Human Services and the Department of Health and Ageing which targets:

‘older people at the conclusion of a hospital episode who require more time and support in a non hospital environment to complete their restorative process, optimise their functional capacity and finalise and access their longer term care arrangements’

**Guide for use** Services provided include:

- Those that further improve functioning thereby improving the person’s capacity for independent living; to
- Those that actively maintain the individual’s functioning while assisting them and their family/carers make appropriate long-term care arrangements.

Services may be provided in a bed-based environment or at the older person’s home.

Eligible older people will be separated from hospital.

**Refer to:**

- Section 3: *Admission Source, Separation Mode and Separation Referral.*

## Amended/New Data Items

### Accommodation Type Related (Newborns)

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## Accommodation Type (a) (Amend)

## Accommodation Type on Separation (b) (Amend)

<b>Revision Summary</b>	Removal of references to Rehabilitation In The Home (RITH). Removal of references to 'less than 3 months' in the newborn accommodation types.
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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) ( <del>Rehabilitation - RITH</del> )
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 ( <del>aged &lt;3 months</del> )
B	Other nursery accommodation or mother's bedside (rooming in, <del>aged &lt;3 months</del> )
3	Same Day accommodation
2	Overnight accommodation: single room
1	Overnight accommodation: shared room

**4 *In the Home (Hospital - HITH)***~~(*Rehabilitation - RITH*)~~

Approved care in accommodation outside the hospital.

*Includes:*

- Under the Hospital in the Home (HITH) program, if the public hospital's Health Service Agreement specifies the hospital is participating in this program. HITH services can only be provided to public, private, DVA, TAC and WorkCover patients.
- ~~Conducted by a Hospital with a designated Rehabilitation Unit, or Geriatric Evaluation and Management (GEM) Program, where the providing care in the home has been agreed to by the Sub-Acute Unit.~~

*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)~~(RITH)~~(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 S).

### **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 (~~aged < 3 months~~)**

Accommodation provided to any infant ~~aged less than 3 months at admission~~ 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, aged < 3 months~~)**

Accommodation provided to any infant ~~aged less than 3 months at admission~~ 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 3 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
  - ~~439 NIV Proc Code W/Out Duration in NICU/SCN~~
  - 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 and Rehabilitation In The Home.~~*

Section 4:

- Business Rules (non-tabular) *Medi-Hotel and Rehabilitation in the Home.*
- 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: Other Information *Emergency Medical Unit (EMU): Approved for Accommodation Type 8, and Hospital in the Home Program: Participating Hospitals, and Medical Assessment and Planning Units (MAPU): Approved for Accommodation Type M, and Neonatal Intensive Care Units and Special Care Nurseries: Approved for Accommodation Type C, and Short Stay Observation Units: Approved for Accommodation Type S, and Ward Based/Medi-Hotel Combination: Approved for Accommodation Type 7.*

## Administration

**Purpose**

For analysis of patient movement during an episode.

**Principal data users**

Continuity Unit (Metropolitan Health & Aged Care, DHS)

Hospital Demand Management (Metropolitan Health & Aged Care, DHS)

Neonatal Services Advisory Committee

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

**Collection start**

1991-92

**Definition source**

DHS

**Code set source**

DHS

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## Account Class (a)

## Account Class on Separation (b)

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**Revision Summary**      Creation of three new private Account Classes to allow changes in the *Fees and Charges for Acute Health Services in Victoria: A Handbook for Public Hospitals*.

### 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.

<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	2	<b>Layout</b>	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 this 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 a sample '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.

After admission and initial election, patient election status can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to:

- Patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;
- Patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health professional; and
- Patients whose social circumstances change while in hospital (for example loss of job).

**Private hospitals and day procedure centres:**

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.

Use the following as a guide to assigning Account Class in private hospitals and day procedure centres:

For 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 |
- (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** Purchasing Policy Unit (Metropolitan Health & Aged Care, DHS)  
 Department of Veterans' Affairs (DVA)  
 Transport Accident Commission (TAC)  
 WorkCover (VWA)

**Collection start** 1979-80

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

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

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

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

AIMS Statistics Category	Account Classes
Private – Acute (both Separations and Patient Days)	PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN, PO, PP, PQ, PR, PW, PX, PY, 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

## Duration of Non-Invasive Ventilation (NIV)

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

<b>Revision Summary</b>	Change the reporting requirements for Duration of Non-invasive Ventilation (NIV) from mandatory for public hospitals providing NIV to patients while admitted to an approved Level 3 nursery/Neonatal Intensive Care Unit (NICU) or Level 2 nursery/Special Care Nursery (SCN), to optional.
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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** Reporting is ~~MANDATORY~~ for public hospitals providing NIV to patients while admitted to an approved:

- ~~Level 3 nursery/Neonatal Intensive Care Unit (NICU) or~~
- ~~Level 2 nursery/Special Care Nursery (SCN).~~

Reporting is ~~OPTIONAL~~ for:

- ~~Public hospitals providing NIV to patients while admitted to an approved Intensive Care Unit (ICU)~~
- ~~Private hospitals providing NIV in an approved NICU or SCN or ICU.~~

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*.

<b>Edits</b>	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
	<del>439 NIV Proc Code W/Out Duration in NICU/SCN</del>
	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-#.

Section 4:

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

## Administration

**Purpose** To evaluate the need for a co-payment on specified DRGs. ~~DHS has been advised that NIV hours represent a sound and clinically valid surrogate for illness severity.~~ Although the preliminary evaluation has not resulted in a co-payment, this item remains to facilitate further evaluation if deemed necessary.

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

**Collection start** 2002-03

**Definition source** Australian and New Zealand Neonatal Network (amended: in PRS/2, NIV via nasopharyngeal intubation is reported in Duration of MV in ICU field)

# Indigenous Status

## Indigenous Status (*Amend*)

<b>Revision Summary</b>	Add to new codes to the codeset.
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### Specification

**Definition** An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Island 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 answered/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. ~~It must not be one of the hospital's patient master index items.~~

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 ~~child's mother or father~~. 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/>

**Edits**

- 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*, ~~and~~ page 3-#, and *Preferred Language*, ~~on~~ page 3-#.

## 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).  
 Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).

**Collection start**

1987-88

**Definition source**

NHDD

**Code set source**

NHDD (DHS modified)

## Palliative Care Patient Days (*New*)

<b>Revision Summary</b>	Addition of a new data item to capture days the patient was the primary responsibility of an approved Palliative Care Program.
-------------------------	--

### Specification

**Definition** 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.

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

**Field size** 3 **Layout** NNN or spaces

**Location** Episode Record

**Reported by** Public Hospitals

**Reported for** Episodes with Care Type 1, 2, 4, 6, 7, K, 8, 9, F and E, where the hospital campus is approved for Palliative Care.

[For Care Types 0, 5x and U, report spaces in this field.]

Otherwise, report spaces.

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

**Code set** A number in the range of 001 to 999.

**Reporting guide** 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 the Care Type is 8 Palliative Care Program, the number of Palliative Care Patient Days must equal Patient Days Total.

Where Palliative Care Patient Days is greater than zero, the Diagnosis Code Z51.5 Palliative Care must be present in the Diagnosis Code string.

**Edits**

607	Care Type Pall Care: Pall Care Pt Days not = Pt Days Total
608	Invalid Palliative Care Pt Days
609	Pall Care Pt Days > Patient Days Total
610	Pall Care Pt Days without Pall Care Diag
611	Pall Care Diag without Pall Care Pt Days at approved site

498\* Pall Care without Pall Care Diag

**Related items**

Section 2: Concept definitions *Episode of Care*, *Leave With Permission*, *Palliative Care* and *Patient Day*.

Section 3: *Care Type*, page 3-#, *Diagnosis Code*, page 3-#, and *Patient Days Total*, page 3-#.

Section 4:

- Business Rules (non-tabular) *Palliative Care*

Section 9:

- *Palliative Care Units Approved for Care Type 8 and Palliative Care Patient Days*.

## Administration

**Purpose**

To measure the demand for palliative care services for:

- Planning of palliative care services
- Managing funding arrangements for palliative care services

**Principal data users**

Continuing Care, DHS.

**Collection start**

2005-06

**Definition source**

DHS

**Code set source**

DHS

## Rehabilitation in the Home Related

### Admission Source (*Amend*)

<b>Revision Summary</b>	Addition of a code for transfer from Transition Care (bed-based). Removal of references to Rehabilitation In The Home.
-------------------------	---

### 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
C	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).
- ~~Admissions to Care Type J Designated Rehabilitation Program/Unit- Home-based substitution from other rehabilitation Care Types (2, 6, 7).~~

*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 C).
- Aged care residential facilities (use code N).
- Mental health residential facility (use code A).

**C 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 C).
- 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).
- Transition Care homed based program

### *Excludes:*

- Transition Care bed based program (use code C).
- 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-#.

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, J 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>	Access Unit (Metropolitan Health & Aged Care, DHS).		
<b>Collection start</b>	1979-80		
<b>Definition source</b>	NHDD	<b>Code set source</b>	DHS

## Care Type (*Amend*)

<b>Revision Summary</b>	Remove code for Rehabilitation In The Home (no longer in the scope of the VAED).
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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.		

**Code set**

Select the first appropriate category:

<b>Code</b>	<b>Descriptor</b>
F	Interim Care Program – Nursing Home Type
E	Interim Care Program
1	NHT/Non-Acute
2	Designated Rehabilitation Program/Unit: Level 1
6	Designated Rehabilitation Program/Unit: Level 2
7	Designated Rehabilitation Program/Unit: Level 3
J	<del>Designated Rehabilitation Program/Unit: Home-based substitution</del>
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 specifies that the hospital has such a designated unit.
- The rehabilitation episode directly follows the acute care episode in which the principal diagnosis is a spinal cord injury or head injury, or an amputation has been performed.

Private hospitals: Do not use code 2.

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

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

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

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

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

Private hospitals: Do not use code 7.

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

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

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

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

**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 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 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 Care Type 8, not approved for Palliative Care Program  
 473 Care Type 9, not approved for GEM  
 474 Care Type E, LOS > 35 Days  
 475 Care Type F or E, not approved for Interim Care  
 488\* Incompat Care Type/Adm Source Statistical  
 489 Incompat Care Type/Sep Mode Statistical  
 491\* Incompat Fields for ESAS  
 492\* Incompat Fields for RPI  
 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  
~~589 Care Type J, not approved for Rehab Home~~  
 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

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

## Administration

### **Purpose**

To distinguish various types of care in order to:

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

### **Principal data users**

Financial Analysis and Purchasing Branch (Metropolitan Health & Aged Care, DHS).  
Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).

### **Collection start**

1995-96

### **Definition source**

DHS

### **Code set source**

DHS

# Separation Mode (*Amend*)

<b>Revision Summary</b>	Addition of one code for separation and transfer to Transition Care (bed-based). Removal of references to Rehabilitation In The Home.
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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
	C	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:*

- ~~Separations to RITH where hospitals are reporting a rehabilitation episode under the CRAFT model and part of the care is delivered in a home setting (Care Type J).~~
- 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 C).
- Aged care residential facilities (use code N).
- Mental health residential units (use code A).

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

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

*Excludes:*

- Home-based Transition Care (use Separation Referral 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 C).
- 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)(Rehabilitation – RITH)* in private accommodation or residential facility who, on separation, remains in the same private accommodation.

### *Excludes:*

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

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-J 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 research 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
C	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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## Admission Source (*Amend*)

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See page 32.

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## Separation Mode (*Amend*)

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See page 44.

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## Separation Referral (*Amend*)

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<b>Revision Summary</b>	Addition of a code for referral to a Transition Care home based program.
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### Specification

<b>Definition</b>	Clinical care and support services arranged by the hospital to meet the person's recuperative needs when discharged to private accommodation or home.		
<b>Datatype</b>	Alpha	<b>Form</b>	Code
<b>Field size</b>	4	<b>Layout</b>	AAAA or spaces Left justified, trailing spaces.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Public hospitals.  Private hospitals – Optional. If the private hospital chooses not to report these data, report spaces in this field.		
<b>Reported for</b>	Episodes where the Separation Mode is H <i>Separation to private residence/accommodation</i> . For all other Separation Modes, report spaces in this field.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		

**Code set**

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

<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. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

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

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

Discharge, with provision of Post Acute Care Program services arranged before discharge to own home or home of relative or friend or other private accommodation\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

For more information about Post Acute Program Services refer to *Victoria—Public Hospitals and Mental Health Services Policy and Funding Guidelines 2004-2005* 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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

*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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

**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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

**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. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

**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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

**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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

**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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

**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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

**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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

**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. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

**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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

*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 Separation Mode C)

**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\*. ~~Unless a specific service has been arranged, use code X No referral or support services arranged before discharge.~~

*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 3-48.

## Section 4:

- Business Rules (tabular) *Account Class: Geriatric Respite*, and *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7-J 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>	Sub-Acute Unit (Metropolitan Health & Aged Care, DHS).		
<b>Collection start</b>	1999-00 (Formerly a sub-set of Separation Mode)		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

## Amended/Deleted Business Rules

### Palliative Care (Business Rules (non-tabular))

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## Palliative Care (Business Rules (non-tabular) *Amend*)

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<b>Revision Summary</b>	To incorporate information relating to the new data item, Palliative Care Patient Days.
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**Guide for use** The Palliative Care Type and Palliative Care Patient Days are only reported to the VAED for patients admitted to ~~designated~~ approved programs.

When a patient is deemed to require palliative care during a non-Palliative Care Type episode (with or without Palliative Care Patient Days), a Diagnosis Code of Z51.5 *Palliative Care* must be included in the Diagnosis Code string to denote the component of palliation.

Change from or to Palliative Care (Care Type 8) as a statistical separation or a statistical admission is prohibited, unless the change is from or to Nursing Home Type (Care Types F, 1 or 5T).

**Refer to:**

- Section 2: *Episode of Care*.
- Section 3: *Care Type*.
- Section 5: *Sub-Acute Record*.
- Section 9:
  - Code Lists: Care Type *Care Type 8: Approved Palliative Care Units*.

### Rehabilitation In The Home (RITH)(Business Rules (non-tabular))

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## Rehabilitation in the Home (RITH) (Business Rules (non-tabular) *Delete*)

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<b>Revision Summary</b>	Delete as no longer in VAED scope.
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## Reference Files

### Coding Classification and Grouper Versions

For 2005-06, DHS will map ICD-10-AM Fourth Edition codes to ICD-10-AM Third Edition codes for input to the AR-DRG Version 5.0 Grouper.

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

### Hospital Code Table

Updates to the hospital code table during 2004-05 will again be published in the HDSS Bulletin, with the web version being amended accordingly at:

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

This reference file is used for reporting in the following PRS/2 fields:

*Hospital Code, Site Identifier, Transfer Source, Transfer Destination, Contract/Spoke Identifier.*

### ICD-10-AM Library File

Separations on or after 1 July 2004 have been verified against the ICD-10-AM Fourth edition Library File. This will continue for 2005-06, however a new library file will be implemented in Victoria, with changes to the edits relating to many of the codes, for separations on or after 1 July 2005.

A revised specification of the ICD-10-AM Fourth edition Library File for 1 July 2005 is included in the Appendix of this document. This incorporates a new concept within column N to indicate diagnosis codes that may sometimes be followed by a morphology code, and the removal of two concepts in column L related to the deletion of edit 449.

The ICD-10-AM Fourth edition Library File for 1 July 2005 will be released at a later date. Updates to this file during 2005-06 will again be published in the HDSS Bulletin, with the web version being amended accordingly at:

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

### Postcode/Locality

A new (updated) postcode/locality file will be applied to all E2 Episode records transmitted to PRS/2 from 1 July 2004.

Updates to the new and existing files during 2004-05 will again be published in the HDSS Bulletin, with the web version being amended accordingly at:

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

# End of Financial Year Considerations

## Method for Reporting 'Remaining Ins' on 30 June 2005

In summary, the Separation Date of an episode will determine the format and values to be reported for data records. For patients remaining in hospital on 30 June 2005, the header dates of a transmission will determine the format and values reported.

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

### **General Rules**

The following data rules apply for PRS/2 data transmissions before and after 1 July 2005:

- File transmissions with header dates prior to 1 July 2005 must contain records using the 2004-05 format/values.
- File transmissions with header dates of 1 July 2005 and beyond must contain records using the 2005-06 format/values.
- File transmissions with header dates of 1 July 2005 and beyond may contain records of patients separated prior to 1 July 2005 which must use the 2004-05 format/values.
- File transmissions with header dates of 1 July 2005 and beyond may contain records of unseparated patients (those remaining in on 30 June 2005); which must use 2005-06 format/values.

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

- An Episode Record (E2) for patients remaining in hospital on 30 June 2005 must be transmitted by the final June 2005 data transmission. This Episode Record must use the PRS/2 format/values applying for 2004-05, and will have the Separation Date and associated fields blank.
- Once the Separation Date is added to the record (accompanied with associated fields required on separation), the fields associated with the admission must comply with the 2005-06 code set/edits.

### **Important notes**

The PRS/2 logic means that for *episodes admitted on or before 30 June 2005, and separated on or after 1 July 2005*, applicable episodes will need to capture the Palliative Care Patient Days data item.

Patients who remain admitted under Care Type *J Rehabilitation In The Home* (RITH) on 30 June 2005 should be separated that day (as from 1 July 2005, these episodes will not be in the scope of the VAED).

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

Hospitals need to take steps to ensure accurate information is reported on patients who are remaining in on 30 June 2005. The action required will vary according to the information already collected from/about patients, and the in-house system capabilities at each hospital.

## Test Transmissions of New 1 July 2005 Software

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

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

Where data is being supplied electronically, the file must have a filename of 'prs2test'. Where data is being supplied via diskette, the diskette must be externally labelled 'Supplier test' and whether the program is in public hospital or private hospital format and, if not from a hospital, with the name of the software supplier. Contact Mantrack before transmitting a test file to ensure the file is processed appropriately and the test system is configured to receive your file.

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

Turnaround time will depend on workload at Mantrack.

Mantrack will send Control Reports produced for each test to the hospital and will only send to an alternate address (such as the software supplier) on receipt of written authorisation on hospital letterhead.

Staff at Mantrack and the Department will, if requested, assist in identifying problems. However, there is no approval process for testing 1 July updates. Once the supplier and/or the hospital is satisfied that the new software meets the specifications as defined by the Department, live transmissions can commence.

Hospitals that send electronically to Mantrack will be able to request their test reports to be produced in an electronic format.