

Specifications for revisions to  
PRS/2 and the Victorian Admitted  
Episodes Dataset (VAED) for  
1 July 2006

March 2006

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# Executive Summary

This document details the revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2006. These revisions are summarised below.

1. Changing the format of Site Identifier to be comprised of the three-digit Campus Code plus the existing Site Identifier. The proposal includes:
  - Amend the submission file structure for episode records and transaction types of all records to change from '-2' to '-3'.
  - One new edit.
  - Amend three edits.
2. Add two Barthel Index Score related data items to collect the date of functional assessment on admission and separation. The proposal includes:
  - The date of the functional assessment conducted to determine the patient's Barthel Index Score on Admission.
  - The date of the functional assessment conducted to determine the patient's Barthel Index Score on Separation.
  - Nine new edits.
3. Remove Reason for Critical Care Transfer. This data item ceased being collected as of 1 July 2005. The proposal includes:
  - Remove Reason for Critical Care Transfer data item
  - Remove Critical Care Inter-Hospital Transfer Program
  - Remove one edit table (tabular business rule)
  - Amend four edit tables (tabular business rule)
  - Remove three edits
4. Relocate the Intention to Readmit from the diagnosis record to the episode record to avoid the problems associated with editing between two record types, and therefore reduce hospital workload. The proposal includes:
  - Amend the submission file structure for Episode and Diagnosis records
  - Amend one edit
5. AR-DRG Version and WIES figures/calculations: A new version of AR-DRGs and VicDRGs, and updated WIES calculations and weights will be implemented.
6. New library file for ICD-10-AM/ACHI/ACS Fifth Edition.

# Introduction

## The need for PRS/2 interface modifications

From 1 July 2006, changes to the Victorian Admitted Episodes Dataset (VAED) are necessary to assist Victorian health program monitoring, planning and policy development by the Department of Human Services (DHS).

Comments from hospitals and software suppliers regarding the content of the document *Proposals for Revisions to PRS/2 and the VAED, November 2005* 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 2006.
- 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, 16<sup>th</sup> Edition, July 2006* will be distributed at a later date. Until then, the *VAED Manual, 15<sup>th</sup> Edition, July 2005* (as amended by HDSS Bulletins 98 onwards) together with this document will form the admitted patient data transmission specification for 2006–07.

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

The current *VAED Manual, 15<sup>th</sup> Edition, July 2005* 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) 15th Edition, 1 July 2005*.
  - 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
ACHI	Australian Classification of Health Interventions
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
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

Related to Reason For Critical Care Transfer

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## **Critical Care Inter-Hospital Transfer Program** ***(Deleted)***

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<b>Revision Summary</b> Delete as no longer in VAED scope.
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# Amended/Deleted/New Data Items

## Related to Site Identifier/Campus Code

### **Site Identifier Campus Code (Amended)**

**Revision Summary** Amendment of Site Identifier to become Campus Code, and comprise the Hospital Code plus the existing Site Identifier.

## Specification

**Definition** Indicates the hospital campus where the episode of care was provided.

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

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

**Location** Episode Record

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

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

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

**Code set** Refer to Section 9: *Supplementary Code Lists: Hospitals*.

**Reporting guide** The site identifier for single campus hospitals is 0.  
The Hospital Code plus the Site Identifier. Site Identifier for single campus hospitals is 0.

**Edits**

- 330\* Invalid Site Identifier Campus Code
- 420 Contract/Spoke = Campus / Site Campus Code
- 472 Pall Care, not approved for Palliative Care Program
- 473 Care Type 9, not approved for GEM
- 475 Care Type F or E, not approved for Interim Care
- 477 Funding Arrangement 5, not approved for Rural Patients Initiative
- 478 Funding Arrangement 6, not approved for ESAS
- 520 Accom Type 7, not approved for Medi-hotel
- 521 Accom Type M, no registered MAPU
- 522 Accom Type S, no registered SOU
- 523 CCU Hrs, no Approved CCU
- 524 CCIHT not approved
- 526 ICU Hrs, not approved ICU or NICU
- 527 Accom Type 8, not approved for EMU
- 628 Cannot report for this campus

**Related items** Section 2: *Campus*, and *Hospital*.

Section 9: Code Lists: *Hospitals*.

## Administration

<b><i>Purpose</i></b>	To identify the specific campus of a hospital providing this episode of care, for use in policy and planning development.		
<b><i>Principal data users</i></b>	Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).		
<b><i>Collection start</i></b>	1998-99		
<b><i>Definition source</i></b>	DHS	<b><i>Code set source</i></b>	DHS

Related to Functional Assessment Date

---

## Functional Assessment Date on Admission (a) (New)

## Functional Assessment Date on Separation (b) (New)

<b>Revision Summary</b>	Addition of two new data items to capture the dates of assessment for assignment of Barthel Index Score.
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### Specification

**Definition**

- (a) Date of functional assessment for assignment of Barthel Index Score on admission.
- (b) Date of functional assessment for assignment of Barthel Index Score on separation.

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

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

**Location**                      Sub-Acute Record

**Reported by**                      Public hospitals.

**Reported for**                      Care Types F, E, 2, 6, 7, 9 and K. For Care Type 8, report spaces.

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

**Code set**                      Valid date.

## **Reporting guide**

Reported when a Barthel Index Score is reported, for Interim Care, Rehabilitation and GEM (Care Types F, E, 2, 6, 7, 9 and K).

- (a) The Functional Assessment must be performed on or after the date of admission, but should be within 48 hours of admission.
- (b) The Functional Assessment must be performed on or before the date of separation, but should be on the day the decision is made to cease the episode.  
Where a patient dies in hospital, the Functional Assessment Date on Separation may be reported as spaces.

Statistical separations:

- From episodes with Care Types F, E, 2, 6, 7, K or 9 to episodes with Care Types F, E, 2, 6, 7, K or 9:  
Functional Assessment Date on Separation of the prior episode may be repeated as the Functional Assessment Date on Admission of the subsequent episode.
- From episodes with Care Types F or E to episodes with Care Types F or E (Interim Care NHT to/from Interim Care only):  
Functional Assessment Date on Admission of the prior episode may be repeated as both the Functional Assessment Date on Separation of the prior episode and the Functional Assessment Date on Admission of the subsequent episode.

Editing of data is carried out on the S3 record. If an E3 Update record is submitted with a Care Type change from F, E, 2, 6, 7, 9 or K to Care Type 1, 8, 5x, 0, 4 or U (which does not require Functional Assessment Date on Admission/Separation), the Sub-Acute data will be deleted from the database and a warning edit to this effect will be triggered by the E3 record.

## **Edits**

- (a) 454\* Incompat Fields for Interim Care
  - 618 Invalid Adm Functional Assessment Date
  - 620 Adm Barthel/Functional Assessment Date / Care Type mismatch
  - 622 Functional Assessment Date < 7 days before Adm Date
  - 624 Functional Assessment Date < Adm Date or > 7 days after Adm Date
  - 627 Care Type changed, Sub-Acute data deleted
- (b) 454\* Incompat Fields for Interim Care
  - 619 Invalid Sep Functional Assessment Date
  - 621 Sep Barthel/Functional Assessment Date / Care Type mismatch
  - 625 Functional Assessment Date > 7 days after Sep Date
  - 626 Functional Assessment Date > Sep Date or < 3 days before Sep Date
  - 627 Care Type changed, Sub-Acute data deleted

## **Related items**

Section 3:

- *Barthel Index Score on Admission/Separation*

Section 4:

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

## Administration

<b><i>Purpose</i></b>	To support annual reporting obligation under the Australian Health Care Agreement.
<b><i>Principal data users</i></b>	Sub-Acute Inpatient Services (Metropolitan Health and Aged Care Services, DHS).
<b><i>Collection start</i></b>	2006-07
<b><i>Definition source</i></b>	DHS

Related to Reason For Critical Care Transfer

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## **Reason for Critical Care Transfer (*Deleted*)**

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<b>Revision Summary</b> Delete as no longer in VAED scope.
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## Related to AR-DRG Version and WIES Calculations

# Hospital Generated DRG (*Amended*)

<b>Revision Summary</b>	Change of AR-DRG and Vic DRG versions from 5.0 to 5.1.
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## Specification

**Definition** The DRG (AR-DRG, version 5.0<sup>1</sup> or Vic DRG, version 5.0<sup>1</sup>) generated by the in-house hospital grouper for this episode of care.

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

**Field size** 4 **Layout** ANNA or NNNA or spaces

**Location** Diagnosis Record

**Reported by** Public and private hospitals - **optional**. Otherwise, report spaces in this field.  
Reporting in this field is recommended for hospital quality control, if the hospital has onsite grouping facilities.

**Reported for** Any/all admitted episodes of care. Otherwise, report spaces in this field.

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

**Code set** AR-DRG, version 5.0<sup>1</sup>, or Vic DRG, version 5.0<sup>1</sup>.

**Reporting guide** Report the AR-DRG or Vic DRG version 5.0<sup>1</sup> DRG generated by the hospital for each episode. This field should be automatically reported for all episodes grouped by the hospital.

**Edits** 334 Hosp Generated DRG Not = PRS2 DRG

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

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

## Administration

**Purpose** To enable hospitals to detect differences between their grouping processes and those of DHS.

**Principal data users** Hospital Health Information Managers.

**Collection Start** 1 July 1998 **Version** ~~5 (1 July 2004)~~ 5.1 (1 July 2006)

**Definition source** DHS **Code set source** Commonwealth Department of Health and Aged Care, *Australian Refined Diagnosis Related Groups, version 5.0<sup>1</sup>*, Department of Human Services, *Victoria – Public Hospitals and*

*Mental Health Services Policy and  
Funding Guidelines 2005-2006  
2006-2007.*

## Diagnosis Codes (*Amended*)

<b>Revision Summary</b>	Adoption of ICD-10-AM, Australian Classification of Health Interventions (ACHI—previously volumes 3 and 4 of ICD-10-AM) and Australian Coding Standards (ACS—previously volume 5 of ICD-10-AM) Fifth Editions to meet national reporting requirements.
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### Specification

<b>Definition</b>	At least one (principal diagnosis) and up to 40 ICD-10-AM ( <del>Fourth</del> Fifth Edition) codes reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	8 (x 40)	<b>Layout</b>	AANNNNspacespace Left justify, with trailing spaces.
<b>Location</b>	Diagnosis Record (12) Extra Diagnosis Record (28)		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	DHS ICD-10-AM/ACHI/ACS Library File <del>2005-06</del> 2006-07, available at: <a href="http://www.health.vic.gov.au/hdss/reffiles/2005-06/2006-07/vaed/libfil056.htm">http://www.health.vic.gov.au/hdss/reffiles/2005-06/2006-07/vaed/libfil056.htm</a>		
<b>Reporting guide</b>	<p>Report diagnoses in accordance with <del>ICD-10-AM</del> <i>Australian Coding Standards</i>, the <i>Victorian Additions to Australian Coding Standards</i> and <i>ICD Coding Newsletters</i> issued by DHS. The <i>Victorian Additions to Australian Coding Standards</i> are available at: <a href="http://www.health.vic.gov.au/hdss/icdcoding/index.htm">http://www.health.vic.gov.au/hdss/icdcoding/index.htm</a></p> <p><i>Omit</i> punctuation as shown in ICD-10-AM books (that is, no dot or oblique in codes): for example, ICD-10-AM diagnosis code A00.0 <i>Cholera due to Vibrio cholerae 01, biovar cholerae</i> must be entered as A000.</p> <p>When a code is shown in ICD-10-AM with a symbol (dagger or asterisk), <i>omit</i> the symbol when transmitting to PRS/2.</p> <p>The first character of the field is the prefix: P, A, C or M.</p> <p>In the first diagnosis code field:</p> <ul style="list-style-type: none"> <li>• <i>Character 1</i> must be P.</li> <li>• <i>Next five characters</i> must contain an alpha/numeric code of three, four or five characters (with trailing spaces if required).</li> <li>• <i>Characters 7 and 8</i> must be spaces.</li> </ul> <p>For the remaining thirty nine diagnosis code fields, if a code is present:</p> <ul style="list-style-type: none"> <li>• <i>Character 1</i> must be P, A, C or M.</li> <li>• <i>Next six characters</i> must contain an alpha/numeric code of three, four, five or six characters (with trailing spaces if required).</li> </ul>		

- Character 8 must be a space.

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

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

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

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

### **Effect of prefix A**

A secondary function of the A prefix is to suppress the code description appearing in data extracts provided to TAC and on DRG statements generated by PRS/2 for Work Cover Patients.

### **Edits**

127	Nil Value DRG
160	AR-DRG Grouper GST Code > Zero
186	Neonate MDC But Age >= 28 Days
195	Blank X23
197	Embedded Blank Diag Oper
231	P - Diag Not Prefixed By P
232	Possible Coding or Sequencing Problem
329	Geri Respite - Invalid comb
334	Hosp Generated DRG Not = PRS/2 DRG
351	Illegal Code Format
352	Code Not Found On Code File
353	Code & Age Incompatible
354	Code & Sex Incompatible
355	Invalid Principal Diag - Rejection
355	Invalid Principal Diag - Warning
358	Area Code Restraint
361	External Cause Code Missing
362	Morphology Code Missing
363	External Cause needs Place Code
364	External Cause/Activity Code Mismatch
403	Qual Newborn W/Out Justificat
406	Rehab Type W/Out Rehab PDx
411	Adm Wt < 1000g, No Matching Dx Code
412	Adm Wt 1000-2499g, No Matching Dx Code
413	Adm Wt > 6000g, No Matching Dx Code
426	Y25 Not Accompanied by X23
428	X23 Upd not Accompanied by Y25 Upd
442	NIV Duration for Healthy Newborn
447	Unqual Newborn; Age at Sep > 10 Days
450	Code Incompatible W Female Sex
451	Code Incompat W Male Sex
452	Place/Activity W/Out External Cause Code
453	Wrong PDx for Interim Care
454	Incompat Fields for Interim Care
498	Pall Care without Pall care Diag
525	Diagnosis Code Indicates Boarder Episode
559	Prefix = P, Unusual Code Combination
560	Prefix = P, Unusual Code Combination
561	Prefix = C, Unusual Code Combination
562	Prefix = C, Unusual Code Combination
563	Prefix = A, Unusual Code Combination
564	Prefix = A, Unusual Code Combination
590	Diag Prefix M, Not Morph Code
595	Neoplasm Code Missing
600	Invalid Code

601 Sequencing Error

**Related items**

Section 2: *DRG Classification and Principal Diagnosis*.

Section 3: *Hospital Generated DRG* page 3- 15.

Section 4:

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

## Administration

**Purpose**

To:

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

**Principal data users**

Multiple internal and external data users.

**Collection start**

1979-80

**Definition source**

DHS

**Code set source**

ICD-10-AM Fourth ~~Fourth~~ Fifth Edition

# Procedure Codes (*Amended*)

<b>Revision Summary</b>	Adoption of ICD-10-AM, Australian Classification of Health Interventions (ACHI—previously volumes 3 and 4 of ICD-10-AM) and Australian Coding Standards (ACS—previously volume 5 of ICD-10-AM) Fifth Editions to meet national reporting requirements.
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## Specification

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

<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	8 (x 40)	<b>Layout</b>	NNNNNNN 8th character - A or space. Left justified, trailing spaces.

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

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

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

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

**Code set** DHS ICD-10-AM/ACHI/ACS Library File ~~2005-2006~~ **2006-07**, available at: <http://www.health.vic.gov.au/hdss/reffiles/2005-06/200607/vaed/libfil056.htm>

Where no procedures were performed, report spaces.

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

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

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

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

### Procedures performed under contract at another agency

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

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

### Edits

127	Nil Value DRG
160	AR-DRG Grouper GST Code>Zero
195	Blank X2 <sup>3</sup>
197	Embedded Blank Diag Oper
232	Possible Coding or Sequencing Problem
320	MV Duration But No Procedure Code
334	Hosp Generated DRG Not = PRS/2 DRG
351	Illegal Code Format
352	Code Not found On Code File
353	Code & Age Incompatible
354	Code & Sex Incompatible
358	Area Code Restraint
408	Contract Role 'A' W/Out Proc Flag
409	Proc Flag W/out Contract Role 'A'
428	X2 <sup>3</sup> Upd not Accompanied by Y2 <sup>3</sup> Upd
440	NIV Duration without NIV Proc Code
450	Code Incompatible W Female Sex
451	Code Incompat W Male Sex
596	Same Day ECT: Not in Care Type 4
600	Invalid Code

### Related items

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

Section 3: *Hospital Generated DRG* page 3-15.

Section 4:

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

## Administration

### Purpose

To facilitate:

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

### Principal data users

Multiple internal and external data users.

### Collection start

1979-80

### Definition source

DHS

### Code set source

~~ICD-10-AM Fourth Edition~~ ACHI Fifth Edition

## Amended/Deleted Business Rules

Related to Date of Functional Assessment, and  
Removal of Reason for Critical Care Transfer

### Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K) (Amended)

<b>Revision Summary</b>	Removal of Reason for Critical Care Transfer data items. Addition of Functional Assessment Dates data items.
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If Care Type is 2 *Designated Rehabilitation Program/Unit: Level 1*, 6 *Designated Rehabilitation Program/Unit: Level 2*, 7 *Designated Rehabilitation Program/Unit: Level 3* or K *Non-Designated Rehabilitation Program/Unit* then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Note that the only difference between the four Care Types is Clinical Sub-program.

Field	Valid codes
<b>E23 Episode Record</b>	
Admission Source	S, T, B, N, A, H
Admission Type	S, C, L, O, X
Qualification Status	X
Separation Referral	P, M, L, B, U, C, S, D, G, I, A, K, T, R, X or spaces
Criterion for Admission	B, O, E, C
Mental Health Legal Status	9
Funding Arrangement	1 or space
<b>X23 Diagnosis Record</b>	
Admission weight	Spaces
Duration of MV	Spaces
Reason for Critical Care Transfer	Spaces
Duration of NIV	Spaces
<b>S23 Sub-Acute Record</b>	
Barthel Index Score on Admission	Range 000 to 100
Barthel Index Score on Separation	Range 000 to 100
Functional Assessment Date on Admission	DDMMCCYY
Functional Assessment Date on Separation	DDMMCCYY or spaces
Clinical Sub-program	
If Care Type 2*	02x, 04x, 05x
If Care Type 6, 7, K	Any code from list see section 3
Onset Date	DDMMCCYY
Admission/Re-admission to Rehabilitation	0, 1
RUG ADL on Admission	Spaces
RUG ADL on Separation	Spaces
Source of Referral to Palliative Care	Spaces

**Note:** \* If age at admission is less than 18 years, any Clinical Sub-Program can be used with Care Type 2.

<b>Edits</b>	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  
289 Adm Sc T'fr & Onset = Adm Date  
291 Adm Barthel > Sep Barthel  
305 Adm Rug ADL Present  
306 Sep Rug ADL Present  
341 Source Of Refer To Pal Care Present  
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 Barth  
506 Stat Episode: Rehab also in Next Episode  
507 Stat Episode: Rehab also in Prior Episode

---

618 Invalid Adm Functional Assessment Date  
619 Invalid Sep Functional Assessment Date  
620 Adm Barthel/Functional Assessment Date / Care Type mismatch  
621 Sep Barthel/Functional Assessment Date / Care Type mismatch  
622 Adm Functional Assessment Date < Adm Date  
623 Adm Functional Assessment Date > 7 days after Adm Date  
624 Sep Functional Assessment Date > Sep Date  
625 Sep Functional Assessment Date < 3 days before Sep Date  
627 Care Type changed, Sub-Acute data deleted

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## Care Type: Interim Care Program (F and E) (Amended)

<b>Revision Summary</b>	Removal of Reason for Critical Care Transfer data items. Addition of Functional Assessment Dates data items.
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If Care Type is F *Interim Care Program – Nursing Home Type* or E *Interim Care Program* then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Note that the only differences between the two Care Types is in:

- Account Class and Account Class on Separation

Field	Valid codes
<b>E23 Episode Record</b>	
Admission Type	S, C, L, O, X
Admission Source	S, T, B, N, A, H
Account Class	
If Care Type F	MN, M5, TN, VN, V5
If Care Type E	MP, MA, TA, VX
Accommodation Type	1, 2, 3
Qualification Status	X
Separation Referral	P, M, L, B, U, C, S, D, G, I, A, K, T, R, X or spaces
Account Class on Separation *	
If Care Type F	MN, M5, TN, VN, V5
If Care Type E	MP, MA, TA, VX
Criterion for Admission	O
Intended Duration of Stay	2
Mental Health Legal Status *	9
Funding Arrangement	1 or space
Contract Type	2, 3, 4, 5, 7 or space
<b>X23 Diagnosis Record</b>	
Principal Diagnosis Code *	Z75.11 <i>Person awaiting admission to residential aged care service</i> Z75.12 <i>Person awaiting admission to psychiatric facility/unit</i>
Admission Weight	Spaces
Duration of Stay in ICU	Spaces
Duration of MV	Spaces
Duration of Stay in CCU	Spaces
Reason for Critical Care Transfer	Spaces
Duration of NIV	Spaces
<b>S23 Sub-Acute Record *</b>	
Barthel Index Score on Admission *	Range 000 to 100
Barthel Index Score on Separation *	Range 000 to 100
Functional Assessment Date on Admission	DDMMCCYY
Functional Assessment Date on Separation	DDMMCCYY or spaces
Clinical Sub-Program *	Spaces
Onset Date *	Spaces
Admission/Re-admission to Rehabilitation *	Spaces
RUG ADL on Admission *	Spaces
RUG ADL on Separation *	Spaces

Field	Valid codes
Source of Referral to Palliative Care *	Spaces

\* Field is not checked Edit 454 *Incompat Fields for Interim Care*, as this field is checked by other general edits relating to field, not just in relation to Interim Care.

Edits

- 094 Combination A/C Accom Care Med Suff
  - 251\* Invalid Adm Barthel
  - 252\* Invalid Sep Barthel
  - 258 Sub-Acute: No Sub-Acute Record
  - 268 Inv Comb MHLS and Care Type
  - 305 Adm RugADL Present
  - 306 Sep Rug ADL Present
  - 341 Source Of Refer To Pal Care Present
  - 453 Wrong PDx for Interim Care
  - 454 Incompat Fields for Interim Care
- 
- 618 Invalid Adm Functional Assessment Date
  - 619 Invalid Sep Functional Assessment Date
  - 620 Adm Barthel/Functional Assessment Date / Care Type mismatch
  - 621 Sep Barthel/Functional Assessment Date / Care Type mismatch
  - 622 Adm Functional Assessment Date < Adm Date
  - 623 Adm Functional Assessment Date > 7 days after Adm Date
  - 624 Sep Functional Assessment Date > Sep Date
  - 625 Sep Functional Assessment Date < 3 days before Sep Date
  - 627 Care Type changed, Sub-Acute data deleted

## Account Class: Geriatric Respite (*Amended*)

**Revision Summary**      Removal of Reason for Critical Care Transfer data items.

If Account Class is MR *Geriatric Respite Care* then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Field	Valid codes
<b>E2 Episode Record</b>	
Care Type	4, 9
Medicare Suffix *	Name, C-U
Admission Source	H
Admission Type	C, L, O, X
Transfer Source	Spaces
Accommodation Type	1, 2, 4
Qualification Status	X
Separation Mode	S, D, Z, T, B, N, A, H
Separation Referral	P, M, B, U, C, S, D, G, A, K, T, R, X or spaces
Criterion for Admission	O
Intended Duration of Stay	2
Mental Health Legal Status	9
<b>X2 Diagnosis Record</b>	
Principal Diagnosis	Z75.5 <i>Holiday relief care</i> , or Z74.2 <i>Need for assistance at home and no other household member able to render care</i>
Admission weight	Spaces
Duration of Stay in ICU *	Spaces
Duration of MV *	Spaces
Duration of Stay in CCU	Spaces
Reason for Critical Care Transfer	Spaces
Duration of NIV	Spaces

\* Field is not checked by Edit 329 *Geri Respite – Invalid Comb*, as this field is checked by other general edits relating to the field.

Edits                              329 Geri Respite – Invalid Comb

## Criterion for Admission: Secondary Family Member (*Amended*)

**Revision Summary** Removal of Reason for Critical Care Transfer data items.

If Criterion For Admission is S *Secondary Family Member* then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Field	Valid codes
<b>E2 Episode Record</b>	
Admission Type	C, L, O, X
Admission Source	T, H
Care Type	4
Accommodation Type	1, 2, 3, B
Separation Mode	D, Z, T, B, N, A, H
Mental Health Legal Status	9
<b>X2 Diagnosis Record</b>	
Duration of Stay in ICU	Spaces
Duration of MV	Spaces
Duration of Stay in CCU	Spaces
Reason for Critical Care Transfer	Spaces
Duration of NIV	Spaces

Edit 328 Early Parenting Centre – Invalid Comb

## Reason for Critical Care Transfer: Valid Combinations (*Deleted*)

**Revision Summary** Delete as no longer in VAED scope.

## Editing

### Related to Site Identifier/Campus Code

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## 628 Cannot report for this Campus (*New*)

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<b>Effect</b>	REJECTION
<b>Problem</b>	The transmission file contains records for Campus Codes that cannot be reported by this hospital code.
<b>Remedy</b>	Check the hospital code in the transmission file Header Record and the Campus Code of the E3 record. If you believe that the Campus is approved to be reported under this hospital code, contact the HDSS Help Desk.

Refer to:

- Section 3: *Campus Code*
- Section 9: *Supplementary Code Lists*

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## 078 T–Src/T-Dest Code Matches Hosp (*Amended*)

---

<b>Effect</b>	REJECTION
<b>Problem</b>	The E23 Episode Record's Transfer Source and/or Transfer Destination is the same as the combined Hospital Code and Site Identifier Campus Code of this hospital. Reporting transfers within a campus of a hospital is not permitted.
<b>Remedy</b>	Check Transfer Source and Transfer Destination, amend as appropriate and re-transmit the E23. <ul style="list-style-type: none"><li>• If this record is intended to represent a change of Care Type, amend so that a statistical separation and statistical admission are created.</li></ul>

---

## 330 Invalid Site Identifier Campus Code (*Amended*)

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<b>Effect</b>	REJECTION
<b>Problem</b>	The E23 Episode Record's Site Identifier Campus Code is blank or not valid for this hospital/campus. Every E23 record must contain a valid Site Identifier Campus Code value.
<b>Remedy</b>	Check Site Identifier Campus Code, amend as appropriate and re-transmit the E23.  Refer to: <ul style="list-style-type: none"><li>• Section 3: <i>Site Identifier Campus Code</i>.</li><li>• Section 9: <i>Supplementary Code Lists</i>.</li></ul>

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## 420 Contract/Spoke = Campus/Site (Amended)

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<b>Effect</b>	REJECTION
<b>Problem</b>	The E2 <sup>3</sup> Episode Record's Contract/Spoke Identifier is the same as the Campus Code (a combination of the hospital code in the Header Record) and the Site Identifier (in this episode). In other words, the hospital reporting this episode is claiming to have a contract with itself.
<b>Remedy</b>	Check Contract/Spoke Identifier, amend as appropriate and re-transmit the E2 <sup>3</sup> .

Related to Relocation of Intention to Readmit

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## 192 Invalid Comb Int Readmit/Sep Mode (Amended)

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<b>Effect</b>	FATAL REJECTION
<b>Problem</b>	The X2-Diagnosis E3 Episode Record's Intention to Re-admit is incompatible with the E2-Episode Record's Separation Mode.
<b>Remedy</b>	<p>If this is a new X2, check Separation Mode and Intention to Re-admit, amend as appropriate and re-transmit the E2<sup>3</sup> and/or X2/Y2.</p> <p>If the Separation Mode and/or Intention to Re-admit is amended after the record has been transmitted to PRS/2, this edit can be avoided by transmitting a deletion record to PRS/2, followed by updated E2 and X2/Y2 records.</p> <ul style="list-style-type: none"><li>This combination of data items is incorrect, but is fatal to accommodate the PRS/2 logic in the update process. HDSS will notify each hospital periodically of their episodes that trigger fatal edits. This combination of data items must be amended.</li></ul> <p>Refer to:</p> <ul style="list-style-type: none"><li>Section 4: Business Rules (tabular) <i>Intention to Readmit and Separation Mode</i>.</li></ul>

Related to Reason for Critical Care Transfer

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### **335 Invalid Reason For Crit Care Transfer (Deleted)**

<b>Revision Summary</b>	Delete as Critical Care Inter-Hospital Transfer Program no longer in VAED scope.
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### **336 Invalid Comb For Crit Care Transfer (Deleted)**

<b>Revision Summary</b>	Delete as Critical Care Inter-Hospital Transfer Program no longer in VAED scope.
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### **337 Crit Care Transfer, No ICU/CCU Hrs (Deleted)**

<b>Revision Summary</b>	Delete as Critical Care Inter-Hospital Transfer Program no longer in VAED scope.
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### **524 CCIHT not approved (Deleted)**

<b>Revision Summary</b>	Delete as Critical Care Inter-Hospital Transfer Program no longer in VAED scope.
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## 251 Invalid Adm Barthel (*Amended*)

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**Effect** REJECTION

**Problem** The ~~E2 Episode Record's Care Type is 2, 6, 7 or K Rehabilitation, 9 Geriatric Evaluation and Management or F or E Interim Care but the S23 Sub-Acute Record's Barthel Index Score on Admission is in an invalid format (i.e. not NNN or spaces).~~

**Remedy** Check ~~Care Type (E2) and Barthel Index Score on Admission (S23), amend as appropriate and re-transmit the E2 and/or S23.~~

Refer to:

- Section 3: *Barthel Index Score on Admission.*

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

---

## 252 Invalid Sep Barthel (*Amended*)

---

**Effect** REJECTION

**Problem** The ~~E2 Episode Record's Care Type is 2, 6, 7 or K Rehabilitation, 9 Geriatric Evaluation and Management or F or E Interim Care but the S23 Sub-Acute Record's Barthel Index Score on Separation is in an invalid format (i.e. not NNN or spaces).~~

**Remedy** Check ~~Care Type (E2) and Barthel Index Score on Separation (S23), amend as appropriate and re-transmit the E2 and/or S23.~~

Refer to:

- Section 3: *Barthel Index Score on Separation*

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

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## 618 Invalid Adm Functional Assessment Date (New)

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<b>Effect</b>	REJECTION
<b>Problem</b>	The S3 Sub-Acute Record's <i>Functional Assessment Date on Admission</i> is in an invalid format (ie. Not DDMMCCYY or spaces).
<b>Remedy</b>	Check Functional Assessment Date on Admission, amend as appropriate and re-transmit the S3.  Refer to: <ul style="list-style-type: none"><li>• Section 3: <i>Functional Assessment Date on Admission</i>.</li></ul>

---

## 619 Invalid Sep Functional Assessment Date (New)

---

<b>Effect</b>	REJECTION
<b>Problem</b>	The S3 Sub-Acute Record's <i>Functional Assessment Date on Separation</i> is in an invalid format (ie. Not DDMMCCYY or spaces).
<b>Remedy</b>	Check Functional Assessment Date on Separation, amend as appropriate and re-transmit the S3.  Refer to: <ul style="list-style-type: none"><li>• Section 3: <i>Functional Assessment Date on Separation</i>.</li></ul>

---

## 620 Adm Barthel/Functional Assessment Date / Care Type mismatch (New)

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<b>Effect</b>	REJECTION
<b>Problem</b>	The E3 Episode Record and S3 Sub-Acute Record have an invalid combination of Care Type, Barthel Index Score on Admission and Functional Assessment Date on Admission. This edit will trigger on the S3 record only.
<b>Remedy</b>	Check Care Type (E3), Functional Assessment Date on Admission (S3) and Barthel Index Score on Admission (S3), amend as appropriate and re-transmit the E3 and/or S3.  Refer to: <ul style="list-style-type: none"><li>• Section 3: <i>Barthel Index Score on Admission and Functional Assessment Date on Admission</i>.</li><li>• Section 4: Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)</i>, and <i>Care Type: Interim Care Program (F and E)</i></li></ul>

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## 621 Sep Barthel/Functional Assessment Date / Care Type mismatch (New)

---

<b>Effect</b>	REJECTION
<b>Problem</b>	The E3 Episode Record and S3 Sub-Acute Record have an invalid combination of Care Type, Barthel Index Score on Separation and Functional Assessment Date on Separation. This edit will trigger on the S3 record only.
<b>Remedy</b>	<p>Check Care Type (E3), Functional Assessment Date on Separation (S3), Barthel Index Score on Separation (S3) and Separation Mode (E3), amend as appropriate and re-transmit the E3 and/or S3.</p> <p>Refer to:</p> <ul style="list-style-type: none"><li>• Section 3: <i>Barthel Index Score on Separation and Functional Assessment Date on Separation.</i></li><li>• Section 4: Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type: Interim Care Program (F and E)</i></li></ul>

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## 622 Adm Functional Assessment Date < 7 days before Adm Date (New)

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<b>Effect</b>	REJECTION
<b>Problem</b>	This S3 Sub-Acute Record has a Functional Assessment Date on Admission which is more than 7 days before the Admission Date, and the episode is not a statistical change from Care Type F, E, 2, 6, 7, 9 or K.
<b>Remedy</b>	<p>Check Admission Date (E3) and Functional Assessment Date on Admission (S3), amend as appropriate and re-transmit the E3 and/or S3.</p> <p>Refer to:</p> <ul style="list-style-type: none"><li>• Section 3: <i>Functional Assessment Date on Admission.</i></li></ul>

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## 623 Adm Funct Assess Date < Adm Date or > 7 days after Adm Date (New)

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**Effect** Warning

**Problem** The S3 Sub-Acute Record has a Functional Assessment Date on Admission which is up to seven days before the Admission Date or is more than seven days after the Admission Date. Functional Assessment should occur within two days of admission.

**Remedy** Check Admission Date (E3) and Functional Assessment Date on Admission (S3). Where incorrect, amend as appropriate and re-transmit the E3 and/or S3.

Refer to:

- Section 3: *Functional Assessment Date on Admission.*

---

## 624 Sep Funct Assess Date > 7 days after Sep Date (New)

---

**Effect** REJECTION

**Problem** The S3 Sub-Acute Record has a Functional Assessment Date on Separation which is more than 7 days after the Separation Date and the episode is not a statistical separation to Care Type F, E, 2, 6, 7, 9 or K.

**Remedy** Check Separation Date (E3) and Functional Assessment Date on Separation (S3). Where incorrect, amend as appropriate and re-transmit the E3 and/or S3.

Refer to:

- Section 3: *Functional Assessment Date on Separation.*

---

## 625 Sep Funct Assess Date after Sep Date or < 3 days before Sep Date (New)

---

**Effect** Warning

**Problem** The S3 Sub-Acute Record has a Functional Assessment Date on Separation which is up to seven days after the Separation Date or is more than three days before the Separation Date. Functional Assessment should ideally occur on the day of separation.

**Remedy** Check Separation Date (E3) and Functional Assessment Date on Separation (S3). Where incorrect, amend as appropriate and re-transmit the E3 and/or S3.

Refer to:

- Section 3: *Functional Assessment Date on Separation.*

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## 627 Care Type changed, Sub-Acute data deleted (New)

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<b>Effect</b>	Warning
<b>Problem</b>	Sub-Acute data previously submitted for this Unique Key has been deleted. An E3 record with Care Type F, E, 2, 6, 7, 9, or K and an S3 record have previously been accepted, but this E3 record has Care Type 1, 8, 5x, 0, 4 or U and therefore Sub-Acute data should not be present.
<b>Remedy</b>	<p>If the Care Type was changed in error the E3 and S3 records must be resubmitted with corrected data. If the Care Type was changed intentionally then no further action is required.</p> <p>Refer to:</p> <ul style="list-style-type: none"><li>• Section 4: Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)</i>, and <i>Care Type: Interim Care Program (F and E)</i></li></ul>

# Record Structures

## Episode Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	E23
M	Unique Key	9	3	Hospital-generated Right justified, zero filled
M	Patient Identifier	10	12	Hospital generated Right justified, zero filled
M	Site Identifier Campus Code	4	22	0, 1, 2, 3, 4, 5, 6, 7, 8, 9
M	Medicare Number	11	236	NNNNNNNNNNNN or spaces
M	Medicare Suffix	3	347	AAA or A-A
M	Sex	1	3740	1, 2, 3, 4
M	Marital Status	1	3841	1, 2, 3, 4, 5, 6
M	Date of Birth	8	3942	DDMMCCYY
M	Postcode	4	4750	NNNN Refer to Section 3
M	Locality	22	5154	Refer to Section 3
M	Admission Date	8	7376	DDMMCCYY
M	Admission Time	4	8184	HHMM
M	Admission Type	1	8588	S, Y, M, C, L, O, X
M	Admission Source	1	8689	S, Y, T, B, N, A, H
1	Transfer Source	4	8790	NNNN or spaces Refer to Section 3
	Leave With Permission Days MTD	2	9194	NN or spaces
	Leave With Permission Days Financial YTD	3	9396	NNN or spaces
	Leave With Permission Days Total	3	9699	NNN or spaces
	<b>Status Segment</b> Occurs 7 times			
2	Account Class	2	99102, 112115, 125128, 138141, 151154, 164167, 177180	AA or AN Refer to Field Data item specification
2	Accommodation Type	1	101104, 114117, 127130, 140143, 153156, 166169, 179182	1, 2, 3, 4, 6, 7, 8, B, C, M, S
2	Qualification Status	1	102105, 115118, 128131, 141144, 154157, 167170, 180183	N, U, X

Note	Data Item	Field Size	Record Position	Layout/Code Set
2	Patient Days MTD	2	103-106, 116-119, 129-132, 142-145, 155-158, 168-171, 181-184	Must be present if other Status details are present
2	Patient Days Financial YTD	3	105-108, 118-121, 131-134, 144-147, 157-160, 170-173, 183-186	Must be present if other Status details are present
2	Patient Days Total	4	108-111, 121-124, 134-137, 147-150, 160-163, 173-176, 186-189	Must be present if other Status details are present
3	Separation Date	8	190-193	DDMMCCYY
3	Separation Time	4	198-201	HHMM
3	Separation Mode	1	202	S, D, Z, T, B, N, A, H
1	Transfer Destination	4	203-6	NNNN or spaces Refer to Section 3
4	Separation Referral	4	207-10	F, P, M, L, B, U, C, S, D, G, I, A, K, T, R, X or spaces Left justified, trailing spaces
5	Carer Availability	1	214	1, 2, 3, 4, 5, 6, 7, 8 or space
3	Account Class on Separation	2	212-5	AA or AN Refer to Field specification
3	Accommodation Type on Separation	1	214-7	1, 2, 3, 4, 6, 7, 8, B, C, M, S
M	Care Type	2	215-8	F, E, 1, 2, 6, 7, K, 8, 5x, 9, 0, 3, 4, U Refer to Section 3
M	Country of Birth	4	217-20	NNNN Refer to Section 3
M	Indigenous Status	1	221	2, 5, 6, 7, 8, 9
M 6	Criterion for Admission	1	222-5	B, N, U, O, E, C, S
M	Intended Duration of Stay	1	223-6	1, 2
M	Health Insurance Fund	3	224-7	Refer to Section 3
M	Level of Insurance	1	227-30	1, 3, 8, 6, 9
3	Mental Health Legal Status	1	228-31	1, 2, 9
7	Funding Arrangement	1	229-32	1, 2, 4, 5, 6 or space
8	Contract Type	1	230-3	1, 2, 3, 4, 5, 6, 7 or space
8	Contract Role	1	231-4	A, B or space
9	Contract/Spoke Identifier	4	232-5	NNNN or spaces Refer to Section 3
10	Contract Leave Days - MTD	2	236-9	NN or spaces
10	Contract Leave Days - Financial YTD	2	238-41	NN or spaces

Note	Data Item	Field Size	Record Position	Layout/Code Set
10	Contract Leave Days - Total	2	2403	NN or spaces
	User Flag	1	2425	Optional field, free text
12	Preferred Language	2	2436	NN Refer to Section 3
12	Interpreter Required	1	2458	N Refer to Section 3
13	ACAS Status	1	2469	N or space Refer to Section 3
15	Mental Health Statewide Patient Identifier	10	24750	ODS generated or spaces Refer to Section 3
	Leave Without Permission Days MTD	2	25760	NN or spaces
	Leave Without Permission Days Financial YTD	3	25962	NNN or spaces
14	Leave Without Permission Days Total	3	2625	NNN or spaces
14 16	Palliative Care Patient Days	3	2658	NNN or spaces
3	Intention to Readmit	1	271	0, 1, 2, 3, 4, 9
		Total 267 271		

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

M Mandatory

- 1 Transfer Source: Mandatory if Admission Source = T, else spaces. Transfer Destination: Mandatory if Separation Mode = T, else spaces.
- 2 Mandatory in first Status Segment. In any subsequent Status Segment, if any field is present, then all fields for that segment must be present.
- 3 Mandatory but transmit only when Separation Date is transmitted.
- 4 Mandatory for public hospital if Separation Mode = H but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.
- 5 Carer Availability: Mandatory for public hospitals when Care Type is 1, 2, 6, 7, K, 8, 9, F or E but transmit only when Separation Date is transmitted, else spaces. Private hospitals report a space.
- 6 Criterion for Admission: Code S only for use by Early Parenting Centres.
- 7 Mandatory for all hospitals involved in contracted care, hub and spoke arrangements, or the Healthstreams Program, else space.
- 8 Mandatory for all hospitals involved in contracted care arrangements, else space.
- 9 Mandatory for all hospitals involved in contracted care or Hub and Spoke (only Hub reports) arrangements, else spaces.
- 10 Mandatory for contracting hospitals, in specific instances. Refer to Section 3.
- 12 Mandatory for all public hospitals. Private hospitals report codes or spaces.

- 13 Mandatory for public hospitals when Care Type is 1, 2, 4, 6, 7, K, 8, 9, F or E, and patient age is greater than or equal to 50, and where the episode is not a sameday episode, but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.
- 14 Where a field at the end of a record has a value of space, the record can be ended at the last field where a value is not space(s).
- 15 Mandatory for all public hospitals with an approved Mental Health Service when Care Type is 5x. Private hospitals report spaces.
- 16 Mandatory for all public hospitals when Care Type is 8.

## Diagnosis Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	X23
M	Unique Key	9	3	Hospital generated Right justified, zero filled
1	Diagnosis Code x 12 - each code	8 (8 x 12)	12	ICD-10-AM 4th edition Each left justified, trailing spaces
2	Procedure Code x 12 - each code	8 (8 x 12)	108	ICD-10-AM 4th edition Each left justified, trailing spaces
3	Admission Weight	4	204	In grams, or spaces
<del>M</del>	<del>Intention to Re-admit</del>	<del>4</del>	<del>208</del>	<del>0, 1, 2, 3, 4, 9</del>
<del>98</del>	<del>User Flag</del>	<del>1</del>	<del>2098</del>	<del>Optional field, free text</del>
<del>4</del>	<del>Duration of Stay in Intensive Care Unit</del>	<del>4</del>	<del>2109</del>	<del>0001 to 9999 or spaces</del>
<del>5</del>	<del>Duration of Mechanical Ventilation in ICU</del>	<del>4</del>	<del>2143</del>	<del>0001 to 9999 or spaces</del>
<del>6</del>	<del>Hospital Generated DRG</del>	<del>4</del>	<del>2187</del>	<del>ANNA or NNNA or spaces</del>
<del>7</del>	<del>Duration of Stay in Cardiac/Coronary Care Unit</del>	<del>4</del>	<del>2221</del>	<del>0001 to 9999 or spaces</del>
<del>8</del>	<del>Reason for Critical Care Transfer</del>	<del>4</del>	<del>226</del>	<del>X, E, J, W, Y, F, K, Z or space</del>
<del>98</del>	<del>Duration of Non-Invasive Ventilation</del>	<del>4</del>	<del>2275</del>	<del>00001 to 9999 or spaces</del>
		Total 23028		

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

M Mandatory

1 First diagnosis code is mandatory.

2 Eighth character is F or N for procedures occurring in the contracted hospital when reported by the *contracting* hospital, else space.

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

4 Mandatory for patients cared for in an ICU listed in Section 9, and by hospitals providing contracted services to those listed hospitals, else spaces.

5 Mandatory for patients who received mechanical ventilation in an ICU listed in Section 9, and by hospitals providing contracted services to those listed hospitals, else spaces.

6 Optional but recommended for all hospitals with grouping software; else spaces.

7 Mandatory for patients cared for in a CCU listed in Section 9, and by hospitals providing contracted services to those listed hospitals, else spaces.

~~8 Mandatory for public hospitals participating in the Critical Care Inter-hospital Transfer Program, listed Section 3, else space.~~

98 Where a field at the end of a record has a value of space(s), the record can be ended at the last field where a value is not space(s).

## Sub-Acute Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	S23
M	Unique Key	9	3	Hospital generated Right justified, zero filled
M	Patient Identifier	10	12	Hospital generated Right justified, zero filled
1, 2, 4	Barthel Index Score on Admission	3	22	Range 000 to 100 or spaces
1, 2, 4	Barthel Index Score on Separation	3	25	Range 000 to 100 or spaces
1	Clinical Sub-program	3	28	From code list or spaces
1	Onset Date	8	31	DDMMCCYY or spaces
1	Admission/Re-admission to Rehabilitation	1	39	0, 1 or space
5	User Flag	1	40	Optional field, free text
3 5	RUG ADL on Admission	2	41	Range 00 to 18 or spaces
3 5	RUG ADL on Separation	2	43	Range 00 to 18 or spaces
3 5	Source of Referral to Palliative Care	2	45	Range 01 to 09 or spaces
1, 2, 4	Functional Assessment Date on Admission	8	47	DDMMCCYY or spaces
1, 2, 4	Functional Assessment Date on Separation	8	55	DDMMCCYY or spaces
		Total 462		

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

M Mandatory

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

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

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

4 Mandatory if Care Type = F or E *Interim Care Program*

5 Where a field at the end of a record has a value of space(s), the record can be ended at the last field where a value is not space(s).

**Reported by** Public hospitals.  
 [Private hospitals: Do not report S23s.]

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

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

**Refer to:** 'Data Transmission Scheduling', page 5-#.

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

Field	Rehab Care Type 2, 6, 7 or K	Palliative Care Type 8	GEM Care Type 9	Interim Care Type F, E
Transaction Type	S23	S23	S23	S23
Unique Key	*	*	*	*
Patient Identifier	*	*	*	*
Barthel Index Score on Adm	*	Spaces	*	*
Barthel Index Score on Sep	*	Spaces	*	*
Functional Assessment Date on Admission	*	Spaces	*	*
Functional Assessment Date on Separation	*	Spaces	*	*
Clinical Sub-Program	*	Spaces	Spaces	Spaces
Onset Date	*	Spaces	Spaces	Spaces
Admission / Re-admission	*	Spaces	Spaces	Spaces
RUG ADL on Admission	Spaces	*	Spaces	Spaces
RUG ADL on Separation	Spaces	*	Spaces	Spaces
Source of Referral to Palliative Care	Spaces	*	Spaces	Spaces

### **Other Record File Structures**

The Transaction Types for Extra Diagnosis Record, DVA and TAC Record and Trailer Records will also change as listed below, but otherwise the Record File Structure will not change.

- H2 to H3
- Y2 to Y3
- V2 to V3
- T2 to T3
- U2 to U3

## Reference Files

### Coding Classification and Grouper Versions

For 2006-07, DHS will use AR-DRG Version 5.1 Grouper. It incorporates the fourth edition ICD-10-AM codes. The ADRG and DRG structure is the same as Version 5.0.

Information about AR-DRG Version 5.1 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 5.1 Definitions Manual.

### Hospital Code Table

Updates to the hospital code table during 2006-07 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 2006 will be verified against the ICD-10-AM Fifth edition Library File.

ICD-10-AM/ACHI/ACS Fifth Edition codes will be mapped to ICD-10-AM Fourth Edition codes for grouping purposes.

The ICD-10-AM Fifth edition Library File for 1 July 2006 will be released at a later date. Updates to this file during 2006-07 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 E3 Episode records transmitted to PRS/2 from 1 July 2006.

Updates to the new and existing files during 2006-07 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 2006

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 2006, 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 2006:

- File transmissions with header dates prior to 1 July 2006 must contain records using the 2005–06 format/values (H2, E2, X2, S2, V2, T2, U2).
- File transmissions with header dates of 1 July 2006 and beyond must contain header and trailer records using the 2006–07 format/values (H3, T3, U3).
- File transmissions with header dates of 1 July 2006 and beyond may contain records of patients separated prior to 1 July 2006; if present, those data records must use the 2005–06 format/values.
- File transmissions with header dates of 1 July 2006 and beyond may contain records of unseparated patients (those remaining in on 30 June 2006); if present, those data records must use 2006–07 format/values.
- File transmissions with header dates of 1 July 2006 and beyond must contain records of patients separated on and from 1 July 2006 using the 2006–07 format/values.

## Test Transmissions of New 1 July 2006 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.