

Specifications for revisions to
PRS/2 and the Victorian Admitted
Episodes Dataset (VAED) for
1 July 2007

May 2007

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Executive Summary

This document details the revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2007. These revisions are summarised below.

1. Replacement of ACCSS Country of Birth codeset with SACC Country of Birth codeset.
Change required:
 - i) To support Commonwealth Reporting
 - ii) To bring the VAED in line with the codes used in other DHS data collections.
2. Replacement of current Preferred Language codeset with Australian Standard Classification of Languages (ASCL) codeset.
Change required:
 - i) To support Commonwealth Reporting
 - ii) To bring the VAED in line with the codes used in other DHS data collections.
3. Addition of new Spoke codes to identify dialysis activity performed at 'satellite' sites.
Change required:
To allow reporting of expanded satellite dialysis activity at new sites
4. Addition of new Care Type code value for Paediatric Rehabilitation.
Change required:
To allow Paediatric Rehabilitation data to be separated from other rehabilitation care for program analysis and monitoring.
5. Amendment to DVA number format.
Change required:
 - i) To clarify format definition in user manual
 - ii) To disallow spaces between characters that resulted in rejection of record by DVA.
6. Amend codeset for Level of Insurance and change data item name.
Change required:
To reduce reporting burden on hospitals by removing code values no longer required for analysis and make this data item consistent with the NHDD code set and the minimum requirements for Commonwealth reporting. It will also clarify reporting of 'health' vs 'hospital' insurance.
7. Upgrade to AR-DRG 5.2.
Change required:
For Casemix funding.

Introduction

The need for PRS/2 interface modifications

From 1 July 2007, 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 2006* 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 2007.
- End of financial year considerations.
- Amended, and deleted Supplementary Code Lists.
- Amended file structures.

The *VAED Manual, 17th Edition, July 2007* will be distributed at a later date. Until then, the *VAED Manual, 16th Edition, July 2006* (and subsequent bulletins) together with this document will form the admitted patient data transmission specification for 2007–08.

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

The current *VAED Manual, 16th Edition, July 2006* may be accessed on the Internet at <http://www.health.vic.gov.au/hdss/vaed/index.htm>.

Any questions related to this document may be directed to the HDSS Help Desk on 9096 8141, or HDSS.Help-Desk@dhs.vic.gov.au.

Orientation to this document

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

- New values and definitions relating to existing items appear in boxes
- ~~Redundant values and definitions relating to existing items are struck through.~~
- *[Comments relating only to the proposal document appear in square brackets and italics.]*
- Page numbers representing cross referencing to another section of the VAED Manual are represented by a #.
- Edits that are proposed to change are marked when listed as part of a Data Item or after an Edit Table with a * after the edit number. New proposed edits will be shown with an edit number of ###.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Victorian Admitted Episodes Dataset (VAED) Manual*.
 - Specification:* details the reporting requirements for the item.
 - Administration:* provides additional information including the purpose of the collection of the data item and the source of the code set and definitions.
- Further information such as the background to each proposal is provided.

Abbreviations

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
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
ERC	Expenditure Review Committee
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 Introduction of SACC Country of Birth Codeset

Revision Summary	Introduction of SACC codeset, version 2.03, to meet Commonwealth Reporting requirements, and for consistency with other data collections.
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Country of Birth (*Amended*)

Specification

Definition	The country in which the person was born.		
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: <i>Supplementary Code Lists</i> .		
Reporting guide	Patients born in Australia should be reported under the State in which they were born: code 1100 <i>Australia not otherwise specified</i> should be used as a last resort, when no further details are available. Report the country in which the patient was born, not the country of residence.		
Edits	036 Invalid Country of Birth 069* Newborn From Overseas 228* Unusual Birth Place 234* Aboriginal/Ts Islander But Not Aust Born 392* Recip HCA Account, Not O/Seas Born 571* Acct Recip, Pcode Oseas, Locality not RHCA 574* Postcode Overseas, Locality RHCA, Acct not RHCA		
Related items	Section 9: <ul style="list-style-type: none">Supplementary Code Lists <i>Country of Birth</i>		

Administration

Purpose	To facilitate epidemiological studies.
Principal data users	Multiple internal and external data users.
Collection start	1979-80

Definition source NHDD

Code set source

DHS NHDD SACC Country of Birth, Version 2.03 - DHS modified

Country of Birth Version Flag (*New*)

Specification

Definition	Indicates the version of the Country of Birth codeset being used.		
Datatype	Numeric	Form	Code
Field size	1	Layout	A or space
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	S SACC Country of Birth Codeset		
Reporting guide	The Country of Birth Version Flag is used to confirm the SACC Country of Birth codeset has been implemented for 2007-08. It is intended as a temporary measure for 2007-08 only, to ensure the correct codeset is being used.		
Edits	632 Country of Birth Version Flag not "S"		
Related items	Section 3: <i>Country of Birth</i>		

Administration

Purpose	To confirm codeset version.		
Principal data users	Internal data users.		
Collection start	2007-08		
Definition source	DHS	Code set source	DHS

Related to Introduction of Australian Standard Classification of Languages (ASCL) Preferred Language codeset

Revision Summary	Introduction of ASCL 2 nd Edition codeset to meet Commonwealth Reporting requirements, and for consistency with other data collections.
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Preferred Language (*Amended*)

Specification

Definition	The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.		
Datatype	Numeric	Datatype	Code
Field size	2 [4]	Layout	NN [NNNN] or spaces
Location	Episode Record		
Reported by	Public hospitals (voluntary for private hospitals).		
Reported for	All admitted episodes of care.		
Reported when	The Episode Record is reported.		
Code set	See Section 9: Codes Lists: <i>Preferred Language</i> .		
Reporting guide	This information must: <ul style="list-style-type: none">• Be checked for every admitted patient episode.• Not be set up to a default code on computer systems.• Be collected on, or as soon as possible after, admission. <p>The standard question is: What is [your] [the person's] preferred language?</p> <p>Patient is unable to consent (for example baby, child or elderly): Where a person is not able to consent for themselves (for example baby, child or elderly) then the language of the person who is consenting will be recorded. For example a guardian or someone with enduring power of attorney.</p> <p>07 8000 Other Australian Indigenous languages, nec <i>Includes:</i></p> <ul style="list-style-type: none">• All Australian Indigenous languages not shown separately on the code list.		

98 0002 Not Stated

Includes:

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

Edits

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

Related items

Section 3: *Country of Birth* page 3-, *Indigenous Status* page 3-100, and *Interpreter Required* page 3-105.

Section 9:

- Codes Lists *Preferred Language*.

Administration

Purpose

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

Principal data users

Clinical Governance Unit, DHS

Collection start

2003-04

Definition source

NHDD

Code set source

NHDD; ABS ~~med~~ Aust. Stand. Classification 2nd Edition (2005)

Related to Addition of new Spoke codes to identify dialysis activity performed at 'satellite' sites

Revision Summary	To identify activity performed at satellite sites.
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Contract/Spoke Identifier (*Amended*)

Specification

Definition

This field identifies:

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

Datatype

Numeric

Form

Code

Field size

4

Layout

NNNN or spaces.

Location

Episode Record

Reported by

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

All other sites, report a space in this field.

Reported for

This item is mandatory if Funding Arrangement is:

- 1 *Contract* or
- 2 *Hub/Spoke*

Otherwise, report a space in this field.

Reported when

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

Code set

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

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

Code **Descriptor**

0050	Interim Care Program: Residential aged care facility
0070	Interim Care Program: Supported accommodation
0100	Australian Health Care Agreement (AHCA) - Elective Surgery
0110	National Bowel Cancer Program
0200	Department of Human Services: HIV AIDS

0300	Department of Veterans' Affairs: Veterans' Cardiac Agreement
0311	Brunswick Dialysis Unit
0312	Coburg Dialysis Unit
0313	Broadmeadows Dialysis Unit
0314	Williamstown Hospital Dialysis Unit
0315	Sunshine Hospital Dialysis Unit
0316	Northern Hospital Dialysis Unit
0317	Walwa Bush Nursing Hospital Dialysis Unit
0321	Caulfield General Medical Centre Dialysis Unit
0331	Austin Training Satellite Dialysis Unit
0332	Heidelberg Repatriation Hospital Dialysis Unit
0333	North East Kidney Service
0334	Epping Dialysis Unit
0341	Cranbourne Integrated Care Centre Dialysis Unit
0351	Newcomb Dialysis Unit
0400	Individual contracts with international patients
0500	Transport Accident Commission: Alfred Road Trauma Unit
0600	Department of Human Services: Rural & Remote Health Agency Program
0700	Department of Human Services: Bowen Centre - ARMC
0800	Victorian Maintenance Dialysis Program
0900	St Jude Pacemaker Replacement Program
0910	St Vincent's Lithotripsy Service - Bendigo Hospital
0920	St Vincent's Lithotripsy Service - MMC Clayton
0930	St Vincent's Lithotripsy Service - RCH
0940	St Vincent's Lithotripsy Service - MMC Moorabbin
0950	St Vincent's Lithotripsy Service - West Gippsland Healthcare Group
0960	St Vincent's Lithotripsy Service - Ballarat Hospital
0970	St Vincent's Lithotripsy Service - Geelong Hospital
0980	St Vincent's Lithotripsy Service - Frankston Hospital
0990	St Vincent's Lithotripsy Service - Goulburn Valley Health

Reporting guide

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

0070 Interim Care Program: Supported Accommodation

Includes:

- Supported Residential Service (SRS)

Edits

410	Illegal Comb Fund Arrange & Contract
419	Invalid Contract/Spoke Identifier
420	Contract/Spoke = Campus/Site
456	Contract Leave, No Contract
630	Contract/Spoke Identifier cannot be reported for this campus

Related items

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

Section 4:

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

Administration

Purpose

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

Principal data users

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

Collection start 1999-00

Definition source DHS

***Code set
source*** DHS

Related to Care Type 'P' – Paediatric Rehabilitation

Revision Summary	To identify activity of designated Paediatric Rehabilitation Programs.
-------------------------	--

Care Type (*Amended*)

Specification

Definition The nature of the clinical service provided to an admitted patient during an episode of care.

Datatype Alphanumeric **Form** Code

Field size 2 **Layout** AA or NN or NA
Left justified, trailing spaces.

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:

Code	Descriptor
F	Interim Care Program – Nursing Home Type
E	Interim Care Program
1	NHT/Non-Acute
P	Designated Paediatric Rehabilitation Program/Unit
2	Designated Rehabilitation Program/Unit: Level 1
6	Designated Rehabilitation Program/Unit: Level 2
7	Designated Rehabilitation Program/Unit: Level 3
K	Non-Designated Rehabilitation Program/Unit
8	Palliative Care Program
5x	Approved Mental Health Service or Psychogeriatric Program: <ul style="list-style-type: none">• 5T – Mental Health Nursing Home Type• 5E – Mental Health Secure Extended Care Unit (SECU)• 5K – Child and Adolescent Mental Health Service (CAMHS)• 5G – Acute, Aged Persons Mental Health Service (APMH)• 5S – Acute, Specialist Mental Health Service• 5A – Acute, Adult Mental Health Service
9	Geriatric Evaluation and Management Program
0	Alcohol and Drug Program
4	Other care (Acute) including Qualified newborn
U	Unqualified newborn

Reporting guide

Care Type reported should reflect the treatment the patient receives, not the location of the bed in the facility.

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).

P *Designated Paediatric Rehabilitation Program*

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

Private hospitals: Do not use code P.

2 *Designated Rehabilitation Program/Unit: Level 1*

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

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

Private hospitals: Do not use code 2.

6 *Designated Rehabilitation Program/Unit: Level 2*

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

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

7 *Designated Rehabilitation Program/Unit: Level 3*

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

Private hospitals: Do not use code 7.

K *Non-Designated Rehabilitation Program/Unit*

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

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

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

Private hospitals: Do not use code K.

8 Palliative Care Program

A patient who is admitted to a Palliative Care Program, or a palliative care patient receiving treatment to alleviate pain or symptoms.

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 (Care Types 1, 5T or F) and Palliative Care.

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

5x Approved Mental Health Service or Psychogeriatric Program

A patient who is admitted to, or transferred to, an approved Mental Health Service or Psychogeriatric Program. Use code 5x only if the public hospital's Health Service Agreement and/or Statement of Priorities specifies that the hospital has such an approved Mental Health Service or Psychogeriatric Program.

Private hospitals: Use code 5x only if registered under the Health Services Act 1988 to provide this category of care.

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).

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)

5K Child and Adolescent Mental Health Service (CAMHS)

A patient who is admitted to an approved CAMHS unit.

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

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

Excludes:

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

5S Acute, Specialist Mental Health Service

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

Includes:

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

Excludes: Child and Adolescent Mental Health Service (5K)

5A Acute, Adult Mental Health Service

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

Excludes:

- Community Care Units (Residential)
- Mental Health Nursing Home Type (5T)

9 Geriatric Evaluation and Management Program

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

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

0 Alcohol and Drug Program

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

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

4 Other (Acute) Care including Qualified newborn

Other types of patient:

Includes:

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

Excludes:

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

U Unqualified newborn

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

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

Additional Notes:

Newborns

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

Refer to Sections 2 and 4: *Newborn*.

All other episodes

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

For example:

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

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

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

Edits

094* Combination A/C Accom Care Med Suff

107 Invalid Care Type
 122 Sameday Adm Source/Sep Mode Mismatch
 222 Unqual Newborn; Adm Date Not Birth
 235 Adm Criterion is N But Care Not 4
 250 Deleted – Episode is Sub-Acute
 251 Invalid Adm Barthel
 252 Invalid Sep Barthel
 253* Rehab: Invalid Clin Sub-Prog
 254* Rehab: Invalid Adm/Re-Adm to Rehab
 255* Rehab: Invalid Onset Date
 258* Sub- Acute: No Sub – Acute Record
 260 Invalid Care For Qual
 261 Newborn Care But Age > 9 Days
 262 Invalid Care Type For Newborn
 268 Inv Comb Legal, Care & PFS
 285* Sub-Acute Record not required
 288 Sep Barthel & Sep Mode Incompatible
 289* Adm Sce T'fer & Onset = Adm Date
 290* Stat Adm Sc & Onset = Adm Date
 291 Adm Barthel > Sep Barthel
 292 Sep Barthel Present
 293 Clin Sub-Prog Present
 294 Onset Date Present
 295 Adm/Readmit To Rehab Present
 297 Sep Rug ADL & Sep Mode Incompatible
 298 Adm Barthel Present
 303 Pall Care But Invalid Adm Rug ADL
 304 Pall Care But Invalid Sep Rug ADL
 305* Adm Rug ADL Present
 306* Sep Rug ADL Present
 329 Geri Respite – Invalid Comb
 336 Invalid Comb For Crit Care Transfer
 340 Invalid Source Refer to Pal Care
 341 Source Refer to Pal Care Present
 390* Incompat Care Type, Carer Avail, Age and Sep Mode
 405 Inapplic Clin Prog For Care Type 2
 406* Rehab Care Type W/Out Rehab PDX
 407 Rehab Level 2 or 3 W Low Adm Barthel
 421 Not Separated; Carer Avail Present
 437 NIV Duration for Unqual Newborn
 447 Unqual Newborn; Age at Sep
 448 ICU Stay but Care Type not Acute
 453 Wrong PDx for Interim Care
 454 Incompat Fields for Interim Care
 455 Inconsist Newborn Transferred/Unqual Data
 461 ACAS Status not Required
 463 Accom Type 4, Care Type invalid
 464 Accom Type 7, not Care Type 4
 468 Care Type ≠ 1 or F of 5T, LOS > 365 Days
 471 Care Type 5x, not usual Sep Referral
 472 Pall Care, not approved for Palliative Care Program
 473 Care Type 9, not approved for GEM
 474 Care Type E, LOS > 35 Days
 475 Care Type F or E, not approved for Interim Care
 488 Incompat Care Type/Adm Source Statistical
 489 Incompat Care Type/Sep Mode Statistical
 491 Incompat Fields for ESAS
 492 Incompat Fields for RPI
 498 Pall Care without Pall care Diag
 502* Stat Episode: Care Type same as Next Episode

- 503* Stat Episode: Care Type same as Prior Episode
- 506* Stat Episode: Rehab also in Next Episode
- 507* Stat Episode: Rehab also in Prior Episode
- 528 Stat Episode Pall: Not NHT in Prior Episode
- 529 Stat Episode Pall: Not NHT in Next Episode
- 532 Account Class MA: not 4, 5E, 5K, 5G, 5S, 5A or U
- 533 ACAS Status Code Required
- 535 Care Type 5E, not approved for SECU
- 536 Care Type 5T, not approved for NHT
- 537 Care Type 5K, not approved for CAMHS
- 538 Care Type 5G, not approved for Aged Acute
- 539 Care Type 5S, not approved for Specialist Acute
- 540 Care Type 5A, not approved for Adult Acute
- 541 Care Type K, not approved for Non-Desig Rehab
- 542 MH Acute Adult Care Type But Age < 14 Years
- 543 MH Acute Adult Care Type But Age > 65 Years
- 544 MH APMHS Care Type But Age < 55 Years
- 545 MH CAMHS Care Type But Age < 5 Years
- 546 MH CAMHS Care Type But Age > 19 Years
- 547 MH SECU Care Type But Age < 14 Years
- 548 MH Specialist Acute Care Type But Age < 14 Years
- 575 Care Type 5x, MHSWPI Blank
- 578* MHSWPI Present, not Care Type 5x
- 586 Care Type 2, not approved for Rehab Lvl 1
- 587 Care Type 6, not approved for Rehab Lvl 2
- 588 Care Type 7, not approved for Rehab Lvl 3
- 596 Same Day ECT: Not in Care Type 4
- 597 Mental Health Episode: Sep Mode = S
- 598* Same Day Rehabilitation: Not in Scope
- 599 Carer Availability Not Required
- 607 Care Type Pall Care: Pall Care Pt Days not = Pt Days Total
- 608 Invalid Palliative Care Pt Days
- 620* Adm Barthel/Functional Assessment Date/Care Type mismatch
- 621* Sep Barthel/Functional Assessment Date/Care Type mismatch
- 626 Invalid Combination for Funding Arrangement PHESI
- 631 Care Type P, not approved for Paediatric Rehabilitation

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, Newborn Reporting and Palliative Care Reporting.*
- Business Rules (tabular) *Account Class, Acc Type, Care Type and Medicare Suffix, and Admission Source and Care Type, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type P: Designated Paediatric Rehabilitation Program,* 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 Funding Arrangement: Private Hospitals Elective Surgery Initiative, and Newborns: Criteria for Admission, Qualification Status, Care Type, and Reporting History of Code Changes.*

Section 5: *Status Segments.*

Section 9:

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

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

Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).

Collection start

1995-96

Definition source

DHS

Code set source

DHS

Related to Format of DVA Number

Revision Summary	To align the format of the DVA Number in the VAED with the requirements of the Department of Veterans' Affairs and will make it consistent with other data collections. Please note that in practical terms this may not require a change to software or reporting, however it was drawn to DHS' attention that the existing definition of DVA code was potentially ambiguous and the ambiguity could in certain circumstances result in rejection of a valid DVA code. The only functional change to the format is to disallow spaces between characters.
-------------------------	--

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

Specification

Definition	The Department of Veterans' Affairs file number of the person.		
Datatype	Alphanumeric	Form	Structured Code
Field size	9	Layout	AAAANNNX or AAAANNNXA
Location	DVA and TAC Record (Shared field <i>DVA ID/TAC Claim Number</i>)		
Reported by	Public hospitals only.		
Reported for	Episodes with an Account Class of DVA (V-).		
Reported when	The Episode Record is reported.		
Code set	Obtained from the DVA card, held by those eligible for DVA benefits.		
Reporting guide	Character 1: State identifier. Valid codes: Q, N, V, T, S or W. ACT is included in N (NSW) and NT with S (SA). Characters 2-4: Alphabetic characters may appear in these fields but no alphabetic characters may appear after any numerics in these positions. Characters 5-8: Numeric except last non-space character may be alphabetic. Character 9: Space (veteran), alpha (dependent).		

Layout:**Part 1**

State Identifier. Valid codes: Q, N, V, T, S or W. ACT is included in N (NSW) and NT with S (SA).

Part 2

War Group Code, (Alphanumeric characters) may be up to 3 characters.

Part 3

Serial Number (numeric characters) may be 2 to 6 characters in length.

Part 4 (optional)

Spouse or Dependent Identifier, may be 1 character in length.

~~Edits applied to DVA ID / TAC Claim Number:~~

- ~~• Only alphas, numerics and spaces are permitted.~~
- ~~• Alpha characters must be uppercase.~~
- ~~• A maximum of six numeric characters is permitted.~~
- ~~• Trailing spaces (to the right) are permitted.~~

Valid format (see also above layout and following examples):

- Only alphabetic and numeric characters and spaces are permitted
- Alphabetic characters must be in uppercase
- A maximum of six numeric characters is permitted
- Trailing spaces (to the right) are permitted.
- Spaces between characters are not permitted.

Valid War Codes are available at:

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

Examples of permitted formats: N123456, VX123456, WXX123A, QXXX1B

If a DVA ID / TAC Claim Number that the hospital believes is correct cannot pass these edits, the hospital should refer the problem to their local DVA office.

Edits

180 DVA ID/TAC Claim Number Blank
181* DVA ID/TAC Claim Number Incorrect

Related items

Section 3: *Account Class* on page 3-10.

Administration

Purpose

To facilitate payment by DVA for DVA patients.

These data are held separately to other VAED data to ensure that personal information remains confidential.

Principal data users

Department of Veterans' Affairs.

Collection start

1992-93

Definition source

NHDD

Code set source

DVA

Related to Amendment of codeset for Level of Insurance and change data item name

Revision Summary	To remove unused and unnecessary code values and replace with the NHDD codeset, and clarify reporting of 'health' vs 'hospital' insurance.
-------------------------	--

~~Level of Insurance~~ Hospital Insurance Status (Amended)

Specification

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

Datatype Numeric **Form** Code

Field size 1 **Layout** N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Select the first appropriate category:

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

2	Hospital Insurance
4	No Hospital Insurance
9	Hospital Insurance Status Unknown

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

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

Persons covered by insurance for benefits for ancillary services only are included in 2 *No Hospital Insurance*.

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

newborn baby of the policyholder.

Edits

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

Related items Section 3: *Health Insurance Fund* on page 3-96.

Administration

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

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

Collection start 1990-91

Definition source DHS **Code set source** DHS

Health Hospital Insurance Fund (*Amended*)

Specification

Definition	The patient's hospital insurance fund (if any) <i>regardless</i> of whether the patient elects to be a public or private patient, or is a compensable or ineligible patient.		
Datatype	Alphanumeric	Form	Code
Field size	3	Layout	AAA or NNN
Location	Episode Record		
Reported by	All Victorian hospitals (public and private).		
Reported for	All admitted episodes of care.		
Reported when	The Episode Record is reported.		
Code set	Code	Descriptor – Registered name (may differ from Trading name) <i>[Omitted for brevity]</i>	
	996	Miscellaneous Australian health hospital insurance fund	
	997	Non-Australian health hospital insurance fund	
	998	Patient is insured but will not/cannot specify the fund	
	999	Patient is uninsured/Insurance status unknown	

Reporting guide

Insurance for Ancillary benefits only is not included for the purpose of reporting Hospital Insurance Fund.

The patient's ~~health~~ ~~hospital~~ insurance fund status should in no way be taken to indicate her/his election, nor should it influence that election. ~~Health~~ ~~Hospital~~ Insurance Fund, as reported to the VAED, is not to be used to indicate the source of payment for the patient's treatment. If a patient is covered by a ~~health~~ ~~hospital~~ insurance fund, the code should be recorded regardless of whether the patient plans to utilise the insurance for this admission. This data item is used only to indicate the extent of private health coverage and should not be directly linked to software invoicing systems.

For patients admitted for treatment covered by Department of Veteran Affairs, Transport Accident Commission or Victorian Workcover Authority, record the ~~health~~ ~~hospital~~ insurance fund code if the patient holds private health insurance, regardless of whether the patient intends to claim against their insurance, or record 996, 997, 998 or 999 as appropriate.

Code 996 Miscellaneous Australian ~~health~~ ~~hospital~~ insurance fund should only be used to report a new fund which has not been added to the list of valid codes. It should not be reported when the insurance status of a patient is unknown.

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

~~When assigning code 999, the appropriate code for Level of Insurance is 4 No Hospital Insurance or 9 Hospital Insurance Status Unknown, as appropriate.~~

Notes Relating to Funds:

- Australian Natives' Association and Manchester Unity Independent Order of Oddfellows Friendly Society in Victoria now trade as Australian Unity Friendly Society, registered as Australian Unity Health Limited.
- Mutual Community and HBA are owned and operated by BUPA Australia Health Pty Ltd. In Victoria, BUPA trades as HBA. In SA BUPA, Mutual Community Ltd.
- NRMA Health Pty Limited (which incorporated SGIC and SGIO) have changed their name to MBF Health. This is a subsidiary of MBF Australia Ltd, however they are still trading as a separate health fund (SGI).
- IOOF is no longer a registered health fund in its own right. It merged with NIB.
- IOR has merged with HCF, and changed its name to HCF.

Edits

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

Related items

Section 3: ~~Level of Insurance~~ ~~Hospital Insurance Status~~ on page 3-27.

Administration

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

Hospital Generated DRG (*Amended*)

Specification

Definition	The DRG (AR-DRG, version 5.1 5.2 or Vic DRG, version 5.1 5.2) 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 5.1 5.2, or Vic DRG, version 5.1 5.2.		
Reporting guide	Report the AR-DRG or Vic DRG version 5.1 5.2 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: <i>DRG Classification</i> .		

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 5.2 (1 July 2006 2007)
Definition source	DHS	Code set source	Commonwealth Department of Health and Aged Care, <i>Australian Refined Diagnosis Related Groups, version 5.1 5.2</i> . Department of Human Services, <i>Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2006-2007 2007-2008</i> .

Amended Business Rules (Tabular)

Business Rules

Related to Introduction of Australian Standard Classification of Languages (ASCL) Preferred Language codeset

Interpreter Required and Preferred Language

Valid combinations. Only fields that cannot contain the full code set are listed.

If Interpreter Required is	then Preferred Language must be
1 Yes	00-18, 20-95, 97 <>1201
2 No	00-95, 97 0001, 0003 - 9799
3 Not Stated	96, 98 0002
If Preferred Language is	then Interpreter Required must be
00-18 0001, 0003 - 1200, 1202 - 9799 Refer VAED Manual Section 9 Preferred Language	1, 2
19 1201 English	2
20-95 Refer VAED Manual Section 9 Preferred Language	1, 2
96 0000 Inadequately described	3
97 Non-verbal, so described (including sign languages - eg: Auslan, Makaton)	1, 2
98 0002 Not stated	3

Edits

592 Invalid Comb Int Req/Pref Lang

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

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
E3 E4 Episode Record	
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
X3 X4 Diagnosis Record	
Admission weight	Spaces
Duration of MV	Spaces
Duration of NIV	Spaces
S3 S4 Sub-Acute Record	
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.

Edits	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
	291	Adm Barthel > Sep Barthel
	305	Adm Rug ADL Present
	306	Sep Rug ADL Present
	341	Source Of Refer To Pal Care Present

- 620 Adm Barthel/Functional Assessment Date / Care Type mismatch
- 621 Sep Barthel/Functional Assessment Date / Care Type mismatch
- 627 Care Type changed, Sub-Acute data deleted

Care Type P: Designated Paediatric Rehabilitation Program (New)

If Care Type is P *Designated Paediatric 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
E4 Episode Record	
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
X3 Diagnosis Record	
Admission weight	Spaces
Duration of MV	Spaces
Duration of NIV	Spaces
S4 Sub-Acute Record	
Barthel Index Score on Admission	Spaces
Barthel Index Score on Separation	Spaces
Functional Assessment Date on Admission	Spaces
Functional Assessment Date on Separation	Spaces
Clinical Sub-program	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

- Edits
- 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
 - 305 Adm Rug ADL Present
 - 306 Sep Rug ADL Present
 - 341 Source Of Refer To Pal Care Present
 - 627 Care Type changed, Sub-Acute data deleted

Account Class, Acc Type, Care Type and Medicare Suffix (Amended)

Listed below are the valid reporting combinations for each Account Class.

Note, Accommodation Type 4 *Hospital in the Home*, can only be used for public, private, DVA, TAC and WorkCover patients, unless the Department has notified hospitals that specific funders accept other types of patients for this program.

Account Class	Accom Type	Care Type	Medicare Suffix
Newborn (Transferred and Unqualified)			
NT*	B	U	name, C-U
Public			
MP	1 2 3	E, P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U
MP	1 2 3 6 8 B MS	4, U	name, C-U
MP	4 C	4	name, C-U
MP	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U
MP	7	4	name, C-U
ME	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	N-E
ME	1 2 3 6 8 B MS	4, U	N-E
ME	4 7 C	4	N-E
ME	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	N-E
MR	1 2 4	4	name, C-U
MR	1 2	9	name, C-U
MN	1 2 6 MS	1, 5T	name, C-U, N-E
MN	1 2	F	name, C-U
M5	1 2 6 MS	1, 5T	name, C-U, N-E
M5	1 2	F	name, C-U
MA	1 2 3	E, P, 2, 6, 7, K, 8, 9, 5E, 5K, 5G, 5S, 5A	name, C-U
MA	1 2 3 6 8 B MS	4, U	name, C-U
MA	4 C	4	name, C-U
MA	6 8 MS	P, 2, 6, 7, K, 8, 9, 5K, 5G, 5S, 5A	name, C-U
MA	7	4	name, C-U
MF	1 2 3	E, P, 2, 6, 7, K, 8, 9, 5E, 5K, 5G, 5S, 5A	N-E
MF	1 2 3 6 8 B MS	4, U	N-E
MF	4 C	4	N-E
MF	6 8 MS	P, 2, 6, 7, K, 8, 9, 5K, 5G, 5S, 5A	N-E
MF	7	4	N-E
Private			

Account Class	Accom Type	Care Type	Medicare Suffix
PW	1 2 C	4	name, C-U, N-E
PX	1 2	4	name, C-U, N-E
PY	1 2 C	4	name, C-U, N-E
PA	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PA	1 2 6 8 B MS	4, U	name, C-U, N-E
PA	4 C	4	name, C-U, N-E
PA	6 8 MS	5K, 5G, 5S, 5A	name, C-U, N-E
PA	7	4	name, C-U, N-E
PB	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PB	1 2 6 8 B MS	4, U	name, C-U, N-E
PB	4 C	4	name, C-U, N-E
PB	6 8 MS	5K, 5G, 5S, 5A	name, C-U, N-E
PB	7	4	name, C-U, N-E
PC	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PC	1 2 6 8 B MS	4, U	name, C-U, N-E
PC	4 C	4	name, C-U, N-E
PC	6 8 MS	5K, 5G, 5S, 5A	name, C-U, N-E
PC	7	4	name, C-U, N-E
PD	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PD	1 2 6 8 B MS	4, U	name, C-U, N-E
PD	4 C	4	name, C-U, N-E
PD	6 8 MS	5K, 5G, 5S, 5A	name, C-U, N-E
PD	7	4	name, C-U, N-E
PE	1 2 3	P 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PE	1 2 3 6 8 B MS	4, U	name, C-U, N-E
PE	4 C	4	name, C-U, N-E
PE	6 8 MS	P 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
PE	7	4	name, C-U, N-E
PF	1 2	P 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PF	1 2 6 8 B MS	4, U	name, C-U, N-E
PF	4 C	4	name, C-U, N-E
PF	6 8 MS	P 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
PF	7	4	name, C-U, N-E
PG	1 2 3	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PG	1 2 3 6 B MS	4, U	name, C-U, N-E
PG	6 MS	5K, 5G, 5S, 5A	name, C-U, N-E
PG	7	4	name, C-U, N-E
PG	C	4	name, C-U, N-E
PH	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PH	1 2 6 B MS	4, U	name, C-U, N-E
PH	6 MS	5K, 5G, 5S, 5A	name, C-U, N-E
PH	7	4	name, C-U, N-E
PH	C	4	name, C-U, N-E
PI	1 2 3 6 MS	P 2, 6, 7, K	name, C-U, N-E
PJ	1 2 6 MS	P 2, 6, 7, K	name, C-U, N-E
PK	1 2 6 MS	P 2, 6, 7, K	name, C-U, N-E
PL	1 2 3 4 6 MS	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PM	1 2 4 6 MS	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PN	1 2 4 6 MS	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PO	1 2 3	P 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E

Account Class	Accom Type	Care Type	Medicare Suffix
PO	1 2 3 4 6 8 B C MS	4	name, C-U, N-E
PO	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
PO	7	4	name, C-U, N-E
PP	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PP	1 2 3 4 6 8 B C MS	4	name, C-U, N-E
PP	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
PP	7	4	name, C-U, N-E
PQ	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PQ	1 2 3 4 6 8 B C MS	4	name, C-U, N-E
PQ	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
PQ	7	4	name, C-U, N-E
PR	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PR	1 2 3 4 6 8 B C MS	4	name, C-U, N-E
PR	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
PR	7	4	name, C-U, N-E
PS	1 2 4 6 MS	1, 5T	name, C-U, N-E
PT	1 2 4 6 MS	1, 5T	name, C-U, N-E
PU	1 2 4 6 MS	1, 5T	name, C-U, N-E
PV	1 2 4 6 MS	1, 5T	name, C-U, N-E
DVA			
VX	1 2 3	E, P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U
VX	1 2 3 6 8 B MS	4, U	name, C-U
VX	4 C	4	name, C-U
VX	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U
VX	7	4	name, C-U
VN	1 2 6 MS	1, 5T	name, C-U
VN	1 2	F	name, C-U
V5	1 2 6 MS	1, 5T	name, C-U
V5	1 2	F	name, C-U
Prisoners			
JP	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, P-N
JP	1 2 3 6 8 B MS	4, U	name, P-N
JP	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, P-N
JP	C	4	name, P-N
JN	1 2 6 8 MS	1, 5T	name, P-N
Compensable			
WorkCover			
WC	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E, P-N
WC	1 2 3 6 8 B MS	4, U	name, C-U, N-E, P-N
WC	4	4	name, C-U, N-E, P-N
WC	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E, P-N
WC	7	4	name, C-U, N-E

Account Class	Accom Type	Care Type	Medicare Suffix
WC	C	4	name, C-U
WN	1 2 6 MS	1, 5T	name, C-U, N-E, P-N
TAC			
TA	1 2 3	E, P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E, P-N
TA	1 2 3 6 8 B MS	4, U	name, C-U, N-E, P-N
TA	4	4	name, C-U, N-E, P-N
TA	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E, P-N
TA	7	4	name, C-U, N-E
TA	C	4	name, C-U
TN	1 2	F	name, C-U
TN	1 2 6 MS	1, 5T	name, C-U, N-E, P-N
Services			
AS	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U
AS	1 2 3 6 8 B MS	4, U	name, C-U
AS	4 C	4	name, C-U
AS	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U,
AS	7	4	name, C-U
AN	1 2 6 MS	1, 5T	name, C-U
Seamen			
SS	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
SS	1 2 3 6 8 B MS	4, U	name, C-U, N-E
SS	4 C	4	name, C-U, N-E
SS	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
SS	7	4	name, C-U, N-E
SN	1 2 6 MS	1, 5T	name, C-U, N-E
Common Law			
CL	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
CL	1 2 3 6 8 B MS	4, U	name, C-U, N-E
CL	4 C	4	name, C-U, N-E
CL	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
CL	7	4	name, C-U, N-E
CN	1 2 6 MS	1, 5T	name, C-U, N-E
Other			
OO	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
OO	1 2 3 6 8 B MS	4, U	name, C-U, N-E
OO	4 C	4	name, C-U, N-E
OO	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
OO	7	4	name, C-U, N-E
ON	1 2 6 MS	1, 5T	name, C-U, N-E
Ineligible			
XX	1 2 3	P, 2, 6, 7, K, 8, 9, 0, 5E, 5K, 5G, 5S, 5A	N-E
XX	1 2 3 6 8 B MS	4, U	N-E

Account Class	Accom Type	Care Type	Medicare Suffix
XX	4 C	4	N-E
XX	6 8 MS	P, 2, 6, 7, K, 8, 9, 0, 5K, 5G, 5S, 5A	N-E
XX	7	4	N-E
XN	1 2 6 MS	1, 5T	N-E

* Newborns with an Account Class of NT may change to another Account Class in the second or subsequent status segment. The record will then be subject to the validation rules for the subsequent Account Class, but the Care Type can only be U or 4.

Edits 094 Combination A/C, Accom Care Med Suff
 329 Geri Respite- Invalid Comb
 454 Incompat Fields for Interim Care

Admission Source and Care Type (*Amended*)

Valid combinations. Only fields that cannot contain the full code set are listed.

If Admission Source is	then Care Type must be
S Statistical Admission (change in Care Type within this hospital)	F, E, 1, P, 2, 6, 7, K, 8, 5x, 9, 4
Y Birth Episode	4, U
B Transfer from Transition Care bed based program	F, E, 1, P, 2, 6, 7, K, 8, 5x, 9, 0, 4
N Transfer from Aged Care Residential Facility	F, E, 1, P, 2, 6, 7, K, 8, 5x, 9, 0, 4
A Transfer from Mental Health Residential Facility	F, E, 1, P, 2, 6, 7, K, 8, 5x, 9, 0, 4
If Care Type is	then Admission Source must be
F Interim Care Program – Nursing Home Type	S, T, B, N, A, H
E Interim Care Program	S, T, B, N, A, H
1 NHT/Non-Acute	S, T, B, N, A, H
P Designated Paediatric Rehabilitation	S, T, B, N, A, H
2 Designated Rehab – Level 1	S, T, B, N, A, H
6 Designated Rehab – Level 2	S, T, B, N, A, H
7 Designated Rehab – Level 3	S, T, B, N, A, H
K Non-Designated Rehab Program/Unit	S, T, B, N, A, H
8 Palliative Care Program	S, T, B, N, A, H
5x Approved Mental Health/Psychogeriatric	S, T, B, N, A, H
9 Geriatric Evaluation and Management Program	S, T, B, N, A, H
0 Alcohol and Drug Program	T, B, N, A, H
U Unqualified Newborn	Y, T, H

Edits 488 Incompat Care Type/Adm Source Statistical

Age, Care Type, Carer Availability and Separation Mode *(Amended)*

The edit table applies to Public Hospital episodes only. Private hospitals should report Carer Availability as a space only.

For Care Types 1, P, 2, 6, 7, K, 8, 9, F and E, if an episode has the combination of Separation Mode and Age, then Carer Availability must have one of the codes in the third column:

Separation Mode	Age	Carer Availability
S, D, Z, T, B, N, A	any age	1
H	<8 years	4, 5, 6
H	>7 years	1, 2, 3, 4, 5, 6, 7, 8

Edits 390 Incompat Care Type, Carer Avail, Age and Sep Mode

Care Type and Palliative Care Patient Days *(Amended)*

Care Type	Palliative Care Patient Days
8	001-999
P, 2, 4, 6, 7, K, 9, E	Space or 001-999
0, 1, 5x, F, U	Space

Edits 612 Palliative Care Mismatch

Care Type and Separation Mode (Amended)

Valid combinations. Only fields that cannot contain the full code set are listed.

If Care Type is	then Separation Mode must be
5K Approved Mental Health Service or Psychogeriatric Program – Child and Adolescent Mental Health Service (CAMHS)	S, D, Z, T, A, H
0 Alcohol and Drug Program	D, Z, T, B, N, A, H
U Unqualified Newborn	D, Z, T, H
If Separation Mode is	then Care Type must be
S Statistical Separation (change in Care Type within this hospital)	F, E, 1, P, 2, 6, 7, K, 8, 5x, 9, 4
B Separation/Transfer Transition Care bed based program	F, E, 1, P, 2, 6, 7, K, 8, 5E, 5T, 5G, 5S, 5A, 9, 0, 4
N Separation/Transfer Aged Care Residential Facility	F, E, 1, P, 2, 6, 7, K, 8, 5E, 5T, 5G, 5S, 5A, 9, 0, 4
A Separation/Transfer Mental Health Residential Facility	F, E, 1, P, 2, 6, 7, K, 8, 5x, 9, 0, 4

Edits

489 Incompat Care Type/Sep Mode Statistical

Amended/New Edits

Related to Introduction of SACC Country of Birth Codeset

069 Newborn From Overseas (*Amended*)

Effect

NOTIFIABLE

Problem

The E3 E4 Episode Record's age at admission is zero days but the Country of Birth code is not one of those indicating Australia (~~1100 to 1299~~ 1101-1199).

Remedy

HDSS acknowledges that for a small number of episodes this combination of data items is correct. Check Date of Birth, Country of Birth and Admission Date. Where incorrect, amend as appropriate and re-transmit the E3 E4. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. Where the data has not been corrected or confirmed HDSS will periodically notify each hospital and ask them to do so.

- *This is possible if the baby has been flown in from overseas for emergency treatment on date of birth, or was born in transit by air or sea from overseas.*

228 Unusual Birth Place (*Amended*)

Effect

Warning

Problem

The E3 E4 Episode Record's Country of Birth code indicates unusual birth place:

- 0000 Inadequately described (includes continents not further defined)
- 0001 Born at At sea
- ~~0002 Birth place not elsewhere classified~~
- ~~1700 Antarctic not further defined~~
- ~~1701-1707 Antarctic territories~~
- 1600-1607 Antarctica
- ~~2206 Vatican City, 3103 Holy See~~

Remedy

Check Admission Date, Admission Source and Date of Birth, amend as appropriate, and re-transmit the E3 E4.

- ~~If you have used 0002 Birthplace not elsewhere classified because there is no code for the country, contact the HDSS Help Desk.~~

234 Aboriginal/Ts Island But Not Aust Born (Amended)

Effect

NOTIFIABLE

Problem

The E3 E4 Episode Record's Indigenous Status indicates the patient is of Aboriginal or Torres Strait Islander origin (5, 6 or 7) but the Country of Birth is not one of the codes indicating Australia (~~1100 to 1299~~ 1101-1199).

Remedy

HDSS acknowledges that for a small number of episodes this combination of data items is correct. Check Indigenous Status and Country of Birth. Where incorrect, amend as appropriate and re-transmit the E3 E4. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. Where the data has not been corrected or confirmed HDSS will periodically notify each hospital and ask them to do so.

632 Country of Birth Version Flag Not "S" (New)

Effect

REJECTION

Problem

The E4 Episode Record's Country of Birth Version Flag is not "S", and the separation date is greater than 1 July 2007 or blank.

Remedy

For episodes remaining-in or separated on or after 1 July 2007, the SACC Country of Birth codeset must be used, and the Country of Birth Version Flag must be "S" to confirm the codeset version. If the Country of Birth Version Flag is space, it is assumed the SACC Country of Birth codeset is not being used.

513 Indigenous Status/Preferred Language Mismatch (*Amended*)

Effect

NOTIFIABLE

Problem

The ~~E3~~ **E4** Episode Record's Indigenous Status is 5, 6 or 7 *Indigenous* but Preferred Language is not ~~02, 05, 07, 12, 19, 41, 42, 54, 55, 76, 82, 83, 85, or 97~~ **8xxx Australian Indigenous Languages, 1201 English, 9601 Invented Languages or 97xx Sign Languages**.

Remedy

HDSS acknowledges that for a small number of episodes this combination of data items is correct. Check Indigenous Status and Preferred Language. Where incorrect, amend as appropriate and re-transmit the ~~E3~~ **E4**. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. Where the data has not been corrected or confirmed HDSS will periodically notify each hospital and ask them to do so.

514 Language is Unspecified (*Amended*)

Effect

Warning

Problem

The ~~E3~~ E4 Episode Record's Preferred Language is ~~95-Other languages, nfd,~~
~~96-Inadequately described,~~ or ~~98~~ 0002 Not stated.

Remedy

Check Preferred Language, amend as appropriate, and re-transmit the ~~E3~~ E4.

Related to Addition of new Spoke codes to identify dialysis activity performed at 'satellite' sites

630 Contract/Spoke Identifier cannot be reported for this campus (*New*)

Effect

REJECTION

Problem

The ~~E3~~ E4 Episode Record's Contract/Spoke Identifier cannot be reported for this Campus Code.

Remedy

Check Contract/Spoke Identifier, amend as appropriate and re-transmit the ~~E3~~ E4.

Refer to:

Section 9: Supplementary Code Lists

Related to Care Type 'P' – Paediatric Rehabilitation

For brevity, only those edits where a new edit table applies, or where the addition of Care Type P significantly changes the working of the edit are produced in full. Other edits where the function of the edit is changed only by adding Care Type P to the list of other Care Types checked by the edit (i.e. no special circumstances for Care Type P) are listed in brief below.

- 094 Combination A/C Accom Care Med Suff (*Amended*): Refer to Edit Table *Account Class, Acc Type, Care Type and Medicare Suffix*
- 285 Sub-Acute Record not required (*Amended*): Care Type P added to list of Care Types that require a Sub-Acute record.
- 289 Adm Sce T'fer & Onset = Adm Date (*Amended*): Care Type P added to list of Care Types, i.e. 'The E3 Episode Record's Care Type is P, 2, 6, 7 or K....'
- 290 Stat Adm Sc & Onset = Adm Date (*Amended*): Care Type P added to list of Care Types, i.e. 'The E3 Episode Record's Care Type is P, 2, 6, 7 or K....'
- 305 Adm Rug ADL Present (*Amended*): Care Type P added to list of Care Types, i.e. 'The E3 Episode Record's Care Type is P, 2, 6, 7 or K....'
- 306 Sep Rug ADL Present (*Amended*): Care Type P added to list of Care Types, i.e. 'The E3 Episode Record's Care Type is P, 2, 6, 7 or K....'
- 390 Incompat Care Type, Carer Avail, Age and Sep Mode (*Amended*): As per edit table *Age, Care Type, Carer Availability and Separation Mode*
- 406 Rehab Care Type W/Out Rehab PDX (*Amended*): Care Type P added to list of Care Types, i.e. 'The E3 Episode Record's Care Type is P, 2, 6, 7 or K....'
- 502 Stat Episode: Care Type same as Next Episode (*Amended*): Care Type P to be checked, same as other Care Types.
- 503 Stat Episode: Care Type same as Prior Episode (*Amended*): Care Type P to be checked, same as other Care Types.
- 506 Stat Episode: Rehab also in Next Episode (*Amended*): Care Type P to be checked, same as other Care Types.
- 507 Stat Episode: Rehab also in Prior Episode (*Amended*): Care Type P to be checked, same as other Care Types.
- 578 MHSWPI Present, not Care Type 5x (*Amended*): Care Type P to be checked, same as other Care Types.
- 598 Same Day Rehabilitation: Not in Scope (*Amended*): Care Type P added to list of Care Types, i.e. 'The E3 Episode Record's Care Type is P, 2, 6, 7 or K....'
- 620/621 Adm/Sep Barthel/Functional Assessment Date/Care Type mismatch (*Amended*): Care Type P is added to the list of 'other Care Types' for which Admission/Separation Barthel and Functional Assessment Dates must be spaces. Refer to the new edit table: *Care Type P: Designated Paediatric Rehabilitation Program*.

253 Rehab: Invalid Clin Sub-Prog (*Amended*)

Effect	REJECTION
Problem	The E3 Episode Record's Care Type is P, 2, 6, 7 or K Rehabilitation but the S3 Sub-Acute Record's Clinical Sub-Program is invalid.
Remedy	<p>Check Care Type (E3) and Clinical Sub-Program (S3), amend as appropriate and re-transmit the E3 and/or S3.</p> <p>Refer to:</p> <ul style="list-style-type: none">Section 4: Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)</i>, and <i>Care Type P: Designated Paediatric Rehabilitation Program</i>.

254 Rehab: Invalid Adm/Re-Adm to Rehab (*Amended*)

Effect	REJECTION
Problem	The E3 Episode Record's Care Type is P, 2, 6, 7 or K Rehabilitation but the S3 Sub-Acute Record's Admission/Re-admission to Rehabilitation is invalid.
Remedy	<p>Check Care Type (E3) and Admission/Re-admission to Rehabilitation (S3), amend as appropriate and re-transmit the X3 and/or S3.</p> <p>Refer to:</p> <ul style="list-style-type: none">Section 4: Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)</i>, and <i>Care Type P: Designated Paediatric Rehabilitation Program</i>.

255 Rehab: Invalid Onset Date (*Amended*)

Effect	REJECTION
Problem	<p>The E3 Episode Record's Care Type is P, 2, 6, 7 or K but the S3 Sub-Acute Record's Onset Date is either:</p> <ul style="list-style-type: none">• In an incorrect format, or• Later than the Admission Date, or• Earlier than the Date of Birth.
Remedy	<p>Check Admission Date, Care Type, Date of Birth (E3) and Onset Date (S3), amend as appropriate and re-transmit the E3 and/or S3.</p> <p>Refer to:</p> <ul style="list-style-type: none">• Section 4: Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)</i>, and <i>Care Type P: Designated Paediatric Rehabilitation Program</i>.

258 Sub-Acute: No Sub-Acute Record (*Amended*)

Effect	Warning
Problem	<p>The Public Hospital E3 Episode Record's Care Type is P, 2, 6, 7 or K Rehabilitation, 8 Palliative Care, 9 Geriatric Evaluation and Management Program or F or E Interim Care, and a Separation Date is present, however there has been no S3 Sub-Acute Record accepted for this patient.</p> <p>Triggers for this edit are:</p> <ul style="list-style-type: none">• If Care Type = P, 2, 6, 7 or K, Clinical Sub-Program is not present.• If Care Type = 9, E or F, Barthel Index on Admission is not present.• If Care Type = 8, RUG ADL on Admission is not present.
Remedy	<p>Check Care Type, Separation Date (E3) and all S3 data items (Admission/Readmission to Rehabilitation, Barthel Index Score on Admission and Separation, Clinical Sub-Program, Onset Date, RUG ADL on Admission and Separation and Source of Referral to Palliative Care), amend as appropriate, and re-transmit the E3 and/or S3.</p> <ul style="list-style-type: none">• If Care Type is correct, investigate why no S3 is recorded: if it has been submitted but rejected, amend and re-transmit; if the information is not yet available, ensure the S3 is submitted as soon as possible.• If the patient is not yet separated, delete the Separation Date.

631 Care Type P, not approved for Paediatric Rehabilitation (*New*)

Effect	REJECTION
Problem	The E4 Episode Record's Care Type is P <i>Designated Paediatric Rehabilitation Program/Unit</i> but the Hospital Campus is not approved to provide this level of Rehabilitation Care.
Remedy	<p>Check Care Type, amend as appropriate and re-transmit the E4.</p> <ul style="list-style-type: none">If you believe the Hospital Campus is approved to report this Care Type, contact the HDSS Help Desk. <p>Refer to:</p> <p>Section 9: Supplementary Code Lists: <i>Care Type P: Designated Paediatric Rehabilitation Program.</i></p>

Related to Amendment of codeset for Level of Insurance and change data item name

313 No Fund But Insured (*Amended*)

Effect	REJECTION
Problem	The E3 E4 Episode Record's Health Hospital Insurance Fund is 999 <i>Uninsured</i> but the Level of Insurance is not 6 <i>No hospital insurance</i> or 9 <i>Insurance status-unknown</i> Hospital Insurance Status is 2 <i>Hospital insurance.</i>
Remedy	Check Health Hospital Insurance Fund and Level of Insurance Hospital Insurance Status , amend as appropriate and re-transmit the E3 E4 .

314 Fund But Uninsured (*Amended*)

Effect

REJECTION

Problem

The E3 E4 Episode Record has a valid Health Hospital Insurance Fund but the Level of Insurance Hospital Insurance Status is ~~6 No hospital insurance or 9 Insurance status unknown~~ not 2 Hospital Insurance.

Remedy

Check Health Hospital Insurance Fund and Level of Insurance Hospital Insurance Status, amend as appropriate and re-transmit the E3 E4.

~~315 Fund But Insurance Unknown (*Deleted*)~~

Effect

~~Warning~~

Problem

~~The E3 Episode Record's Health Insurance Fund is valid but the Level of Insurance is 8 Insured but level of insurance unknown.~~

Remedy

~~Check Health Insurance Fund and Level of Insurance, amend as appropriate, and re-transmit the E3.~~

~~232 Possible Coding or Sequencing Problem (Deleted)~~

Effect

Warning

Problem

The X3/Y3 Diagnosis Record has a combination of data causing the case to group to Vic-DRG-5.1:

- ~~901Z Extensive O.R. Procedure Unrelated to Principal Diagnosis~~
- ~~902Z Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis~~
- ~~903Z Prostatic O.R. Procedure Unrelated to Principal Diagnosis~~
- ~~963Z Neonatal Diagnosis Not Consistent W Age/Weight~~

Remedy

Check Admission Date, Date Of Birth, Mental Health Legal Status, Separation Mode (E3), Admission Weight, Diagnosis and Procedure Codes(X3), amend as appropriate, and re-transmit the E3 and/or X3/Y3.

Record Structures Amendments

Episode Record

Episode Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	E3 E4
M	Unique Key	9	3	Hospital-generated Right justified, zero filled
M	Patient Identifier	10	12	Hospital generated Right justified, zero filled
M	Campus Code	4	22	0, 1, 2, 3, 4, 5, 6, 7, 8, 9
M	Medicare Number	11	26	NNNNNNNNNNNN or spaces
M	Medicare Suffix	3	37	AAA or A-A
M	Sex	1	40	1, 2, 3, 4
M	Marital Status	1	41	1, 2, 3, 4, 5, 6
M	Date of Birth	8	42	DDMMCCYY
M	Postcode	4	50	NNNN Refer to Section 3
M	Locality	22	54	Refer to Section 3
M	Admission Date	8	76	DDMMCCYY
M	Admission Time	4	84	HHMM
M	Admission Type	1	88	S, Y, M, C, L, O, X
M	Admission Source	1	89	S, Y, T, B, N, A, H
1	Transfer Source	4	90	NNNN or spaces Refer to Section 3
	Leave With Permission Days MTD	2	94	NN or spaces
	Leave With Permission Days Financial YTD	3	96	NNN or spaces
	Leave With Permission Days Total	3	99	NNN or spaces
	Status Segment Occurs 7 times			
2	Account Class	2	102, 115, 128, 141, 154, 167, 180	AA or AN Refer to Field specification
2	Accommodation Type	1	104, 117, 130, 143, 156, 169, 182	1, 2, 3, 4, 6, 7, 8, B, C, M, S
2	Qualification Status	1	105, 118, 131, 144, 157, 170, 183	N, U, X
2	Patient Days MTD	2	106, 119, 132, 145, 158, 171, 184	Must be present if other Status details are present

Note	Data Item	Field Size	Record Position	Layout/Code Set
2	Patient Days Financial YTD	3	108, 121, 134, 147, 160, 173, 186	Must be present if other Status details are present
2	Patient Days Total	4	111, 124, 137, 150, 163, 176, 189	Must be present if other Status details are present
3	Separation Date	8	193	DDMMCCYY
3	Separation Time	4	201	HHMM
3	Separation Mode	1	205	S, D, Z, T, B, N, A, H
1	Transfer Destination	4	206	NNNN or spaces Refer to Section 3
4	Separation Referral	4	210	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	215	AA or AN Refer to Field specification
3	Accommodation Type on Separation	1	217	1, 2, 3, 4, 6, 7, 8, B, C, M, S
M	Care Type	2	218	F, E, 1, P, 2, 6, 7, K, 8, 5x, 9, 0, 4, U Refer to Section 3
M	Country of Birth	4	220	NNNN Refer to Section 3
M	Indigenous Status	1	224	2, 5, 6, 7, 8, 9
M 6	Criterion for Admission	1	225	B, N, U, O, E, C, S
M	Intended Duration of Stay	1	226	1, 2
M	Health [Hospital] Insurance Fund	3	227	Refer to Section 3
M	Level of Insurance [Hospital Insurance Status]	1	230	1, 3, 8, 6, 9 2, 4, 9
3	Mental Health Legal Status	1	231	1, 2, 9
7	Funding Arrangement	1	232	1, 2, 4, 5, 6 or space
8	Contract Type	1	233	1, 2, 3, 4, 5, 6, 7 or space
8	Contract Role	1	234	A, B or space
9	Contract/Spoke Identifier	4	235	NNNN or spaces Refer to Section 3
10	Contract Leave Days - MTD	2	239	NN or spaces
10	Contract Leave Days - Financial YTD	2	241	NN or spaces
10	Contract Leave Days - Total	2	243	NN or spaces
	User Flag	1	245	Optional field, free text
12	Preferred Language	2 4	246	NN NNNN Refer to Section 3
12	Interpreter Required	1	248 250	N Refer to Section 3
13	ACAS Status	1	249 251	N or space Refer to Section 3
15	Mental Health Statewide Patient Identifier	10	250 252	ODS generated or spaces Refer to Section 3

Note	Data Item	Field Size	Record Position	Layout/Code Set
	Leave Without Permission Days MTD	2	260 262	NN or spaces
	Leave Without Permission Days Financial YTD	3	262 264	NNN or spaces
14	Leave Without Permission Days Total	3	265 267	NNN or spaces
14 16	Palliative Care Patient Days	3	268 270	NNN or spaces
3	Intention to Readmit	1	271 273	0, 1, 2, 3, 4, 9
M	COB Version Flag	1	274	S or space
		Total		
		272		
		274		

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, P, 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.

Sub-Acute Record

Sub-Acute Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	S3 S4
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, 6	Clinical Sub-program	3	28	From code list or spaces
1, 6	Onset Date	8	31	DDMMCCYY or spaces
1, 6	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 62		

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).

6 Mandatory if Care Type = P *Designated Paediatric Rehabilitation Program/Unit*

Reported by Public hospitals.

[Private hospitals: Do not report S3 S4s.]

Reported for Care Types F, E, P, 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	Paed Rehab Care Type P
Transaction Type	S3 S4	S3 S4	S3 S4	S3 S4	S4
Unique Key	*	*	*	*	*
Patient Identifier	*	*	*	*	*
Barthel Index Score on Adm	*	Spaces	*	*	Spaces
Barthel Index Score on Sep	*	Spaces	*	*	Spaces
Functional Assessment Date on Admission	*	Spaces	*	*	Spaces
Functional Assessment Date on Separation	*	Spaces	*	*	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	Spaces
RUG ADL on Separation	Spaces	*	Spaces	Spaces	Spaces
Source of Referral to Palliative Care	Spaces	*	Spaces	Spaces	Spaces

Other Record File Structures

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

- H3 to H4
- X3 to X4
- Y3 to Y4
- V3 to V4
- T3 to T4
- U3 to U4

Additional Changes for 2007-08 (not requiring hospital software modification)

The following revisions are planned for the VAED and may not require changes to internal hospital software systems.

Diagnosis Outstanding Report to become a Control Report

It is intended to incorporate the Diagnosis Outstanding Report as a standard report generated whenever a PRS/2 transmission file is processed. It will list episodes separated up to and before the End Date in the transmission file Header Record, for which a Diagnosis Record (X4) has not been received.

For example, if a transmission file is submitted with Header Dates of 1 July to 23 July 2007, all episodes with a separation date of 23 July 2007 or before, for which a Diagnosis Record (X4) has not been accepted, will be listed on the report.

The Diagnosis Outstanding Report will continue to be available as a Request Report and can be requested for any period.

Reporting Option Changes

The Reporting Option controls the order in which records are listed on the Transmitted Transaction Report produced whenever a PRS/2 transmission file is processed. Currently, the available options are:

0 Full transaction trail: Lists all records in the order they appear in the transmission file. E records are first, followed by S and V records (if applicable) and finally X records.

1 Rejections/notifiabes/warnings/fatals only: Lists only records triggering edits. Accepted records without edits are not listed at all.

2 Edit messages, then full (accepted) transaction trail: Lists records triggering edits first (rejections first, followed by notifiabes/fatals, and then warnings), followed by all records accepted without edits.

It is intended to change Reporting Option 2 to list records triggering edits first, but also to list them in the order in which they appeared in the transmission file. This is because some edits are triggered due to the order they were submitted and therefore if they are listed first it makes diagnosing the cause difficult. For example, if the second admission in a chain of statistical admissions is submitted before the first, it will reject because the first has not yet been processed. But because the rejection will be listed before the accepted record it is impossible to know why the second record has rejected.

It is also intended to remove Reporting Option 1 as this option does not provide an audit trail of submissions to PRS/2. It makes reconciliation problems difficult to resolve and, since the option is set when the file is transmitted, cannot be reversed after the fact, i.e. a report cannot be produced retrospectively containing all submitted records.

To minimise changes required to hospital software systems, if a '1' is reported in this field it will be defaulted to '2'.

WIES Values for Each Episode

It is intended to print the WIES value on each Diagnosis (X4) record, where the episode has qualified for WIES funding. This will assist hospitals in identifying discrepancies between PRS/2 and inhouse figures.

Admission weight

AR-DRG Version 5.1 accepts an admission weight between 100 grams and 399 grams for episodes reported with any of the following diagnosis codes:

P07.01 Extremely low birth weight 499 g or less

P07.21 Extreme immaturity, less than 24 completed weeks

P07.22 Extreme immaturity, 24 or more completed weeks but less than 28 completed weeks

Therefore it is intended that PRS/2 no longer assigns an admission weight of 400 grams to episodes with an admission weight between 125 and 399 grams for grouping purposes and to allow an admission weight as low as 100 grams to be reported.

The following Data Definition has been amended:

Admission Weight (*Amended*)

Specification

Definition The birth weight of the live baby, or the weight of the neonate or infant (under one year of age) on the date admitted, if this is different from the date of birth.

Datatype Numeric **Form** Quantitative value

Field size 4 **Layout** NNNN or spaces.
Right justify, leading zeros.

Location Diagnosis Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted patients under 1 year of age.

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

Code set Valid weight in grams, 0125-0100-9999. If Admission Weight is not required, transmit spaces, not zeros.

Reporting guide Admission Weight is required for all infants under 1 year of age at admission (that is, admitted on a date earlier than the infant's first birthday).

Where the admission starts on the day of birth, the birth weight is the Admission Weight.

~~As the grouper accepts an admission weight range of 400 to 9999 grams, episodes reported to PRS/2 with an Admission Weight of between 125 and 399 grams will be assigned an admission weight of 400 grams (by PRS/2) for the purpose of grouping to the appropriate VIC-DRG5.~~

If Admission Weight is unknown or heavier than 9999, and the patient is aged greater than 27 days, use 9999.

The remainder of this section is unchanged

Edit 232 Possible coding or sequencing problem

Feedback received indicates that there is limited value in having this edit trigger on the PRS/2 report therefore it is intended to remove this edit. Hospitals can generate Request Report 02 DRGs for Review to identify episodes grouping to a range of nil value/problem DRGs.

End of Financial Year Considerations

Method for Reporting 'Remaining Ins' on 30 June 2007

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 2007, the header dates of a transmission will determine the format and values reported.

The following data rules apply for PRS/2 data transmissions before and after 1 July 2007:

- File transmissions with header dates prior to 1 July 2007 must contain records using the 2006–07 format/values (H3, E3, X3, Y3, S3, V3, T3, U3).
- File transmissions with header dates of 1 July 2007 and beyond must contain header and trailer records using the 2007–08 format/values (H4, T4, U4).
- File transmissions with header dates of 1 July 2007 and beyond may contain records of patients separated prior to 1 July 2007; if present, those data records must use the 2006–07 format/values.
- File transmissions with header dates of 1 July 2007 and beyond may contain records of unseparated patients (those remaining in on 30 June 2007); if present, those data records must use 2007–08 format/values.
- File transmissions with header dates of 1 July 2007 and beyond must contain records of patients separated on and from 1 July 2007 using the 2007–08 format/values.

Test Transmissions of New 1 July 2007 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. The facilities manager 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, the facilities manager 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 the facilities manager (One Response Network) 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, the facilities manager 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 the facilities manager.

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

Staff at 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 the facilities manager will be able to request their test reports to be produced in an electronic format.