

Section 4: Business Rules

Contents

SECTION 4: BUSINESS RULES	1
INTRODUCTION	1
BUSINESS RULES (NON-TABULAR)	2
Contracted Care	2
Episode of Care	8
Geriatric Respite	9
Hub and Spoke	10
Interim Care Program and Contracting Arrangements	11
Leave	12
Length of Stay	13
Medi-hotel Reporting	15
Newborn Reporting	16
Palliative Care Reporting	19
Reporting history of code changes	20
Transfer Reporting	22
BUSINESS RULES (TABULAR)	23
Account Class, Acc Type, Care Type and Medicare Suffix	23
Account Class: Geriatric Respite	27
Account Class: Newborn, Unqualified, Not Birth Episode	28
Admission Source and Admission Type	28
Admission Source and Age	29
Admission Source and Care Type	29
Admission Source and Criterion For Admission	30
Admission Source and Qualification Status	30
Admission Type and Age	31
Admission Type and Criterion For Admission	31
Admission Type and Qualification Status	32
Age and Criterion For Admission	32
Age and Qualification Status	33
Age, Care Type, Carer Availability and Separation Mode	33
Care Type and Palliative Care Patient Days	33
Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)	34
Care Type: Designated Paediatric Rehabilitation Program (P)	35
Care Type: Interim Care Program (F and E)	36
Care Type and Separation Mode	37
Contracting: Contract Fields, Contract Leave and Funding Arrangement	38
Contracting: Funding Arrangement and Contract Fields	39
Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode	41
Criterion for Admission and Newborn Qualification Status (1 st Status Segment)	42
Criterion for Admission and Qualification Status	42
Criterion for Admission: Secondary Family Member	43
Funding Arrangement: Elective Surgery Access Service	43
Funding Arrangement: Private Hospital Elective Surgery Initiative	44
Funding Arrangement: Rural Patients Initiative	44
Intention to Readmit and Separation Mode	45
Interpreter Required and Preferred Language	46
Locality/Postcode	46
Newborns: Criteria for Admission, Qualification Status, Care Type	49

Introduction

This section provides consolidated information about topics that involve two or more data items. It is split into two sections depending on the primary format of the information: tabular or non-tabular.

The non-tabular section provides references to other sections of the Manual where appropriate. The majority of information in the tabular section is referenced in one or more edits, which are listed under each table.

Business Rules (non-tabular)

Contracted Care

Guide for use Related contracted hospital care data items should only be completed where contracted services are provided which represent some, but not all of the hospital's total services. That is, it is not necessary to complete contracted hospital care data items where all of the hospital services are contracted by a health authority, for example, privately owned and/or operated public hospitals such as Mildura Base Hospital.

Note: The contract between Department of Human Services and Department of Veterans' Affairs does not allow hospitals to sub-contract private hospitals to provide services to eligible persons whose charges for this episode of care are met by the Department of Veterans' Affairs.

Identification of Contracted Episodes of Care

In PRS/2, reporting 1 *Contract* in the Funding Arrangement field identifies episodes involving contracted care. The following fields are then reported:

- The type of contract involved is reported in the Contract Type field.
- The role of the hospital (contracting or contracted) is reported in the Contract Role field.
- The nature of the contract involving an external purchaser, or the other hospital involved in a contracted care or hub and spoke arrangement, is reported in the Contract/Spoke Identifier field.

Identification of Procedures Performed under Contract

The contracting (purchasing) hospital is termed Hospital A.

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

Brackets indicate the patient is not present in the hospital.

In PRS/2, procedures performed at another hospital under contract to this hospital are recorded by both hospitals, but flagged only by the contracting hospital: Hospital A reports a flag in the eighth character of the (ICD-10-AM) codes relating to procedures performed under contract by Hospital B.

Flags used by Hospital A are:

- Character F on procedures performed by Hospital B on an admitted basis.
- Character N on procedures performed by Hospital B on a non-admitted basis.

Allocation of Diagnosis and Procedure Codes should not be affected by the contract status of an episode: the Australian Coding Standards, including the Victorian Additions to the Australian Coding Standards, should be applied when coding all episodes. In particular, procedures that would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (that is, not a recognised hospital) should be coded if appropriate but should not be flagged as contracted hospital procedures.

Contract Leave

Contract leave is a period spent as an admitted patient at a contracted (service provider) hospital, during an episode where the patient is also admitted to the contracting (purchasing) hospital.

Contract leave days are reported only by the contracting (purchasing) hospital and are treated as patient days and included in the length of stay at that hospital. In PRS/2, contract leave days for the episode are reported in three Contract Leave Days fields: Month-to-date, Financial Year-to-date, and Total. There is no limit to the duration of contract leave.

Patients going on contract leave are not separated.

Types of Contracted Hospital Care

Seven contract types are identified by the sequence of alpha characters, representing the movement of the patient between the contracting and contracted hospitals.

1 Contract Type B

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

Examples include:

- Department of Human Services: HIV Aids
- St Vincent's Lithotripsy Service
- Individual contracts with international patients

Hospitals that believe they have a similar contract should contact the Department to discuss reporting arrangements.

2 Contract Type ABA

Patient admitted by Hospital **A**.

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

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

3 Contract Type AB

Patient admitted by Hospital **A**.

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

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

4 Contract Type (A)B

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

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

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

5 Contract Type BA

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

6 Contract Type A(B)

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

Hospital B provides the service at Hospital **A**.

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

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

7 Contract Type (A)

Hospital A contracts with a residential aged care facility or supported accommodation for provision of Interim Care.

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

PRS/2 Reporting for Contracted Hospital Care

The contracting (purchasing) hospital is termed Hospital **A**.

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

Brackets indicate the patient is not present in the hospital.

Responsibility for exchange of information:

The contracting (purchasing) hospital (Hospital **A**) is responsible for ensuring that the contracted (service provider) hospital/facility (Hospital **B**/facility) provides adequate information for inclusion in the patient's record at Hospital **A** to:

- (i) enable ongoing patient care at Hospital **A** and
- (ii) support the diagnosis and procedure codes reported to the VAED by Hospital **A**.

These seven types of contracted hospital care should be recorded in the following ways:

1 Contract Type B

B records:

- Funding Arrangement code 1 *Contract*.
- Contract Type code 1 *Contract Type B*.
- Contract Role code B *Hospital B*.
- Contract/Spoke Identifier.

2 Contract Type ABA

A records:

- Admission Date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 2 *Contract Type ABA*.
- Contract Role code A *Hospital A*.
- Contract/Spoke Identifier (Campus code) of Hospital **B**.
- Contracted Leave Days: report difference between date patient leaves **A** for treatment by **B** and date patient returns to **A**. If patient is not admitted by **B**, Contract Leave is nil.
- Diagnosis and Procedure Codes: include any additional diagnoses identified by **B**, and procedures provided by **B** each with relevant contract procedure flag (F or N) (see *Responsibility for exchange of information* above).
- Separation Date: being date patient left **A** after returning from **B**.
- Length of stay is Separation Date minus Admission Date minus Total [normal] Leave days; thus contract leave days are effectively treated as patient days and included in Length of Stay.

If admitted by B, B records:

- Admission Date, being date of commencement of care at **B**.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 2 *Contract Type ABA*.
- Contract Role code B *Hospital B*.
- Contract/Spoke Identifier (Campus code) of Hospital **A**.
- Admission Source code T: requires Transfer Source code.
- Transfer Source: Contracting Hospital **A**.
- Diagnosis and Procedure Codes: only relating to care provided by **B**.
- Separation Date: actual date separated from **B**.
- Separation Mode code T: requires Transfer Destination code.
- Transfer Destination: Contracting Hospital **A**.

3 Contract Type AB

A records: (irrespective of the original intention for the patient to return or not):

- Admission Date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 3 *Contract Type AB*.
- Contract Role code A *Hospital A*.
- Contract/Spoke Identifier (Campus code) of Hospital **B**.
- Contracted Leave Days: report difference between date patient leaves **A** for treatment by **B** and date patient separated from **B**.
- If patient not admitted by **B**, contract leave is nil.
- Diagnosis and Procedure Codes: include any additional diagnoses identified by **B**, and procedures provided by **B** each with relevant contract procedure flag (F or N) (see *Responsibility for exchange of information* above).
- Separation Date: report actual date patient separated from **B** if admitted by **B**, or date separated from **A** if not admitted by **B**.
- Separation Mode code T: requires Transfer Destination code.
- Transfer Destination: Contracted Hospital **B**.
- Length of stay is Separation Date minus Admission Date minus Total [normal] *Leave* days; thus contract leave days are effectively treated as patient days and included in Length of Stay.

If admitted by B, B records:

- Admission Date, being date of commencement of care at **B**.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 3 *Contract Type AB*.
- Contract Role code B *Hospital B*.
- Contract/Spoke Identifier (Campus code) of Hospital **A**.
- Admission Source code T: requires Transfer Source code.
- Transfer Source: Contracting Hospital **A**.
- Diagnosis and Procedure Codes: only relating to care provided by **B**.
- Separation Date: actual date separated from **B**.

4 Contract Type (A)B

A records:

- Admission Date: actual date admitted by **B**.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 4 *Contract Type (A)B*.
- Contract Role code A *Hospital A*.
- Contract/Spoke Identifier (Campus code) of Hospital **B**.
- Diagnosis and Procedure Codes from information provided by **B**: each procedure with contract procedure flag for admitted services (F only) (see *Responsibility for exchange of information* above).
- Separation Date: actual date patient separated from **B**.

B records:

- Admission Date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 4 *Contract Type (A)B*.
- Contract Role code B *Hospital B*.
- Contract/Spoke Identifier (Campus code) of Hospital **A**.
- Diagnosis and Procedure Codes.
- Separation Date.

5 Contract Type BA

The contract may be for non-admitted services.

B records:

- Admission Date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 5 *Contract Type BA*.
- Contract Role code B *Hospital B*.
- Contract Identifier (Campus code) of Hospital **A**.
- Diagnosis and Procedure Codes from information provided by **B**.
- Separation Date: actual date patient separated from **B**.
- Separation Mode code T: requires Transfer Destination code.
- Transfer Destination: Contracting Hospital **A**.

A records:

- Admission Date: actual date admitted to **B**.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 5 *Contract Type BA*.
- Contract Role code A *Hospital A*.
- Contract Identifier (Campus code) of Hospital **B**.
- Admission Source code T: requires Transfer Source code.
- Transfer Source: Contracted Hospital **B**.
- Contracted Leave Days: report difference between date patient admitted by **B** and date patient separated from **B** to go to **A**. If patient not admitted by **B**, contract leave is nil. If patient not admitted by **B**, contract leave is nil.
- Diagnosis and Procedure Codes: include any additional diagnoses identified by **B**, and procedures provided by **B** each with relevant contract procedure flag (F or N) (see *Responsibility for exchange of information* above).
- Separation Date: actual date patient separated from **A**.
- Length of stay is Separation Date minus Admission Date minus Total [normal] Leave days; thus contract leave days are effectively treated as patient days and included in Length of Stay.

6 Contract Type A(B)**A records:**

- Admission Date.
- Funding Arrangement code 1 *Contract*.
- Contract Type code 6 *Contract Type A(B)*.
- Contract Role code A *Hospital A*.
- Contract Identifier (Campus code) of Hospital **B**.
- Separation Date.

B is not required to record any information about this episode.

7 Contract Type (A)

A records:

- Admission Date: actual date Interim Care commenced.
- Funding Arrangement code 1 Contract.
- Contract Type code 7 Contract Type (A).
- Contract Role code A Hospital A.
- Contract/Spoke Identifier: 0050 or 0070 Interim Care Program.
- Diagnosis and Procedure Codes including information provided by residential aged care facility (see Responsibility for exchange of information above).
- Separation Date: actual date Interim Care finishes.

Elimination of duplicate procedures and patient days

Each contract type is clearly distinguished by the combination of reporting in the Contract Type and Contract Role fields. Apart from the Type B, A(B) and (A) contracts, all other contract types may involve duplication of reporting some or all of the procedures and patient days.

At a State level, to determine total activity figures for procedures and patient days, it is possible to determine aggregate figures and then subtract those procedures and patient days performed in cases where the Contract Type is 2, 3, 4, or 5 and Contract Role is B (Hospital **B**).

However, for VAED reporting, no discounting of activity figures is required.

Refer to:

- Section 2: *Contracted Care, Interim Care, Leave – Contract, Leave Without Permission and Patient Day.*
- Section 3: *Contract Leave Days Financial Year-To-Date, Contract Leave Days Month-To-Date, Contract Leave Days Total, Contract Role, Contract/Spoke Identifier, Contract Type, Funding Arrangement and Procedure Codes.*
- Section 4: Business Rules (tabular) *Contracting: Contract Fields, Contract Leave and Funding Arrangement* page 4-38, *Contracting: Funding Arrangement and Contract Fields* page 4-39, and *Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode* page 4-41.

Episode of Care

Guide for use

An overnight or multi-day stay patient may receive more than one type of care during a period of hospitalisation. If so, the period of hospitalisation is broken into Episodes of Care, one for each type of care (Care Type).

An Episode of Care refers to a phase of treatment and is designed to reflect the changing diagnosis and/or treatment of the patient. The Episode of Care ends when the Care Type changes or the patient physically leaves the hospital.

There are some exceptions to rules inherent in the above definition:

- (Compulsory for public hospitals) A newborn changing Qualification Status during an Episode of Care may also require a change in Care Type. If a newborn initially receiving Unqualified Newborn Care changes Qualification Status, their Care Type for the entire episode is reported as Acute Care.
- A patient cannot have two changes of Care Type on the one day (that is, start the day as one Care Type, become another Care Type, and then revert to the original Care Type or change to a third Care Type). PRS/2's editing prevents such a sequence: to accept it would result in a single day being double-counted as a patient day (once in the same day episode and once as the admission day of the following episode). Only the patient's Care Type 'as of midnight' should be reported to PRS/2.
- Similarly, a patient may not change Care Type on the date of formal admission or separation as this results in a single day being double-counted as a patient day.
- Public hospitals must use the Palliative Care Type only on formal admission, if the patient receives Palliative Care under the supervision of a palliative care specialist or physician. A statistical change to Palliative Care is permitted only when the patient changes between Nursing Home Type (Care Types 1, 5T or F) and Palliative Care.
- Public hospitals may use the Alcohol and Drug Care Type only on formal admission; it is not for use following another Episode of Care.
- Public hospital patients may not change Care Type between a Designated Rehabilitation Program: Level 1, 2 or 3; patients must stay at their original level.
- A patient transferred to another campus but intending to return to this campus should be placed on leave for the duration of stay at the other campus. If the patient attends the other campus as a day-only admission, the leave should be recorded on the patient's record but should not be reported to the VAED.

Refer to:

- Section 2: *Acute Care, Admitted Patient, Episode of Admitted Patient Care, Geriatric Evaluation and Management, Interim Care Program, Newborn, Nursing Home Type/Non-Acute, Palliative Care, Rehabilitation, and Separation.*
- Section 3: *Admission Source, Care Type, Qualification Status and Separation Mode.*

Geriatric Respite

Guide for use

Admissions to Geriatric Respite must be formal admissions. Geriatric Respite excludes:

- Nursing Home Type/Non-Acute patients and patients awaiting placement in residential care (refer to Interim Care).
- Residents of residential care facilities.

Geriatric Respite patients may be reported with a Care Type of 4 or 9, depending on the Health Service Agreement and/or Statement of Priorities of the hospital.

Geriatric Respite patients must:

- Be denoted by the use of one of the following Diagnosis Codes:
 - Z75.5 *Holiday relief care*, or
 - Z74.2 *Need for assistance at home and no other household member able to render care*
- Have an Account Class of MR.

Refer to:

- Section 3: *Account Class*.

Hub and Spoke

Guide for use

Reporting guidelines include:

- Same-day episodes are reported by the hub hospital only, using the Funding Arrangement data item.
- Where a multi-day episode in the spoke includes a procedure completed by the hub:
 - The hub reports a same day episode and;
 - The spoke reports a multi-day episode excluding the Procedure performed by the hub.
- Neither hub nor spoke hospital reports these episodes as contracted care.

Reporting guidelines depend on whether the episode is same day or multi-day.

Same-day episodes

Same-day episodes are reported by the hub hospital only, using the Funding Arrangement data item.

Hub Hospital records:

- Admission and separation dates.
- Funding Arrangement code 2 *Hub and Spoke*.
- Contract/Spoke Identifier code: report the Hospital Campus or Satellite Site Code that denotes the Spoke hospital/site.
- Diagnosis and procedure codes: all diagnosis and procedure codes undertaken at the Spoke hospital/site.

Spoke Hospital/Site records:

- Nil.

Multi-day Episodes

Where a multi-day episode in the spoke includes a procedure completed by the hub, the hub reports a same day episode and the spoke reports a multi-day episode excluding the procedure/s performed by the hub.

Hub Hospital records:

- Same Day Admission and Separation Dates (date of procedure/s performed by Hub).
- Funding Arrangement code 2 *Hub and Spoke*.
- Contract/Spoke Identifier code: report the Hospital Campus Code that denotes the Spoke hospital.
- Diagnosis and Procedure Codes: all relevant diagnosis codes, and procedures undertaken by the Hub at the Spoke hospital.

Spoke Hospital records:

- Admission and Separation Dates.
- Diagnosis Codes: diagnosis codes should be assigned for conditions where care is provided by the spoke hospital. This includes conditions that require care at the spoke hospital prior to and/or after the procedure performed by the hub hospital.
- Procedure Codes: assign codes only for procedures not undertaken by the hub hospital. Under no circumstances are procedure codes performed by the hub hospital to be assigned by the spoke hospital.

Neither hub nor spoke hospitals should report these episodes as contracted care.

Refer to:

- Section 2: *Hub and Spoke*.
- Section 3: *Contract/Spoke Identifier and Funding Arrangement*.

Interim Care Program and Contracting Arrangements

Guide for use

Contracting Episodes (see table)

Where an Interim Care period of care continues (that is, there is no change in Care Type) but the hospital contracts *part* of the time to another hospital or to a non-hospital:

- Report a *single* episode of care to PRS/2.
- Contract with other public or private hospital: Report the four character Campus Code that identifies the other party to the contracted service arrangement.
- Contract with service other than public or private hospital: Use Contract/Spoke ID codes 0050 and 0070 for episodes contracted to facilities other than public or private hospitals. These may include supported residential services, hostels etc. Contract/Spoke ID 0050 and 0070 can only be reported with Contract Type 7.

If the combination of care providers is more than one hospital:

- Report *Contract Type* as 2, 3, 4 or 5 as best fits the circumstances.
- Report *Contract Spoke ID* for the hospital providing the greatest number of days in the episode.

If the combination of care providers is one (or more) hospital(s) and one (or more) non-hospital(s):

- Report *Contract Type* as 2, 3, 4 or 5 as best fits the circumstances.
- Report *Contract Spoke ID* for the hospital (rather than 0050 or 0070 representing the non-hospital). Where there is more than one hospital select the hospital providing the greatest number of days in the episode.

	Contract with other hospital		Contract with non-hospital facility
	Contracting Hospital	Contracted Hospital	
Funding Arrangement	1 Contract		1 Contract
Contract Type	2, 3, 4, or 5		7 Contract Type (A)
Contract Role	A Hospital A	B Hospital B	A Hospital A
Contract Spoke ID	Campus Code which identifies the other hospital to the contract		0050 or 0070 <i>Interim Care Program</i>

Refer to:

- Section 2: *Episode of Admitted Patient Care and Interim Care Program.*
- Section 3: *Care Type.*
- Section 4: Business Rules (tabular) *Care Type: Interim Care Program (F and E)* page 4-36.
- Section 5: *Sub-Acute Record.*
- Section 9: Code Lists: *Care Type Care Type F and E: Interim Care Programs.*

Leave

Guide for use

Contract

Contract leave days are reported only by the contracting (purchasing) hospital, are treated as patient days and included in the length of stay at that hospital. There is no limit to the duration of contract leave. Patients commencing a period of contract leave are not separated.

With Permission

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

Examples where leave should be recorded are:

- Patient presents to hospital for induction of labour, sent home, to return when in established labour. Patient returns the next morning. Patient should only have one episode for this period. If the induction meets Criteria for Admission, the patient should be placed on leave whilst at home, as she is expected to return within seven days for continuing care.
- Rehabilitation patient leaves on the 24 December to return the 26 December, so that they can spend Christmas in the care of their family.

Example where leave should not be recorded:

- Patient presents to hospital believing they are in early labour, diagnosed as in false labour and sent home after 2 hours, to return when in labour. This presentation should not be reported on the VAED as it does not meet any Criterion for Admission, and therefore it follows that the patient cannot be placed on leave.

Patients going on leave with permission are not separated unless the patient fails to return within seven days. If so, the patient should be formally separated, effective from the date of leaving the hospital. If the patient later returns to the hospital, a new episode is started and the patient is formally admitted.

Unless the patient is on contract or normal leave, an overnight or multi-day stay patient in one hospital campus cannot concurrently be a patient in another hospital campus. Such a patient must be separated from one hospital campus and admitted to the other hospital campus on each occasion of transfer.

Where it is intended that a patient with a same day episode return to the hospital within seven days for a Type B (or Type C with appropriate certification) procedure (for example dialysis, chemotherapy, plasmapheresis, ECT), the patient should be separated and re-admitted.

Where it is intended that a patient return to the hospital at intervals of not more than seven days for a series of non-Type B procedures, the patient is:

- A multi-day patient on leave with permission between treatments; and
- Not a same day patient, even if the patient does not stay overnight in the hospital.

In such cases, documentation to justify for the admission must be provided (that is, why it is not non-admitted care).

A period of absence starting and ending on the same date is not counted as leave with permission but the patient must be recorded as absent in his/her medical record. The patient may be recorded as absent in the hospital's computer system; however, the system must not report a day's leave to PRS/2 nor deduct a patient day in other reporting.

Where a Hospital in the Home patient does not receive any admitted type services on a particular date, this day should be recorded as a leave with permission day.

Newborns are not permitted to go on leave with permission; they should be separated.

Without Permission

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

Newborns are not permitted to go on leave without permission; they should be separated.

Refer to:

- Section 2: *Length of Stay, Newborn, Overnight or Multi-Day Stay Patient, Patient Day, and Separation.*
- Section 3: *Leave With Permission Days Financial Year-To-Date, Leave With Permission Days Month-To-Date, and Leave With Permission Days Total.*

Length of Stay

Guide for use

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

- Retrospective: Separation Date minus Admission Date minus Total leave with and without permission days; and
- Progressive: sum of patient days (including contract leave days) accrued to date.

By whichever method, the result must be the same at the conclusion of an individual patient episode.

Both methods of calculating LOS have some fundamental principles:

- 1 The sum of patient days (including contract leave days) and leave with and without permission days must equal the number of days elapsed between Admission Date and Separation Date.
- 2 For any given date, either a patient day (including a contract leave day) or a leave day (with and without permission) may be counted, but not both.
- 3 Patient days are not accrued when the patient is out of the hospital on leave (with and without permission), regardless of whether a bed is 'being held' for the patient during his/her absence.
Contract leave days are treated as patient days and included in Length of Stay.
- 4 For patients admitted and separated on different dates: count one patient day for date of admission; count no patient day for date of separation.
- 5 For patients admitted and separated on the same date: count one patient day; no leave days; and LOS = 1 day.
- 6 A period of absence starting and ending on the same date is not counted as leave.

Some Specific Guidelines for Counting Patient Days, Contract Leave Days and Leave Days (With and Without Permission), and Hence Calculating LOS

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

Refer to:

- Section 2: *Leave - Contract, Leave With Permission, Leave Without Permission, Length of Stay, Overnight or Multi-Day Stay patient, and Same Day Patient.*
- Section 3: *Admission Date, Patient Days Financial Year-To-Date, Patient Days Month-To-Date, Patient Days Total, and Separation Date.*

Medi-hotel Reporting

Guide for use Generally a patient resident in a Medi-hotel is considered to be on leave. However, for reporting reasons related to the VAED file structure and business rules, the following guidelines apply for reporting accommodation provided in a Medi-hotel.

1. Accommodation in Medi-hotel can only be reported to the VAED where the patient receives admitted services on the day before and the day after the Medi-hotel stay.
2. For Medi-hotel, movement between ward accommodation and the Medi-hotel accommodation is reported in the Status Segments within the same episode, excluding notes listed in 4. The Accommodation Type shown for each patient day shall be:
 - 1 *Overnight accommodation: shared room* or 2 *Overnight accommodation: single room* where the patient remains in a traditional hospital setting at midnight;
 - 7 *Ward Based/Medi-Hotel combination* when a patient is in a traditional hospital setting during the day and in a Medi-hotel at midnight.

For example, where a patient is admitted to a shared hospital ward on the 1 July 2003, moves to the Medi-hotel at 1700 on the 4 July 2003, and returns to the traditional hospital setting at 0900 on the 5 July 2003 where they are discharged at 1600, the Accommodation Type for the first three patient days is 2 *Overnight accommodation: single room*; and the Accommodation Type for the last patient day is 7 *Ward Based/Medi-Hotel combination*.

3. The use of Medi-hotel must be recorded as leave in the following circumstances:
 - Where the patient receives two or more consecutive days of non-admitted services (not a substitute for traditional admitted care), with an intervening night in the Medi-hotel, and the patient receives admitted patient care both directly before and after this period.
 - Where the patient receives no care for two to seven consecutive days, with an intervening night(s) in the Medi-hotel, and the patient receives admitted patient care both directly before and after this period.
4. The use of Medi-hotel must not be recorded as part of an admitted episode in the following circumstances:
 - Where the patient is receiving only non-admitted services on the first day(s), or no services (for example, a night in Medi-hotel to facilitate an 07:00 Admission Time), the patient must be admitted on the day they first received admitted services.
 - Where the patient is receiving only non-admitted services on the last day(s), the patient must be separated at the time they left the admitted services area (to go to the Medi-hotel).

Hospitals, for their own purposes, may wish to record these times in their in-house systems: if so, the hospital's interface must identify and exclude these times from transmission to the VAED.

Refer to:

- Section 2: *Criteria for Admission, Hospital in the Home, Medi-Hotel and Patient Day.*
- Section 3: *Accommodation Type.*

Newborn Reporting

Guide for use

Newborn episodes are the only episodes where a change in Care Type does not result in a statistical discharge and re-admission (refer to Section 2: *Episode of Care*). It is also necessary to record Qualification Status. See the table below for the specific VAED data items containing 'newborn' information.

Field	Values	Applies	Allocated
Criterion for Admission	<i>Qualified or Unqualified</i>	At admission	At admission, never revised
Qualification Status	<i>Qualified or Unqualified</i>	To <i>days</i> during the episode	At each change in Qualification Status during the episode
Care Type	<i>Acute or Unqualified</i>	To highest level of care during the episode	At admission. However, if newborn at admission does not meet any criterion to be Qualified but later does meet a criterion to be Qualified, the Care Type is <i>changed</i> to Acute

Newborns may be:

- Admitted at or directly after birth: the birth episode.
- Admitted after the birth episode, while still 9 days old or less.

Regardless of whether it is the birth episode, Newborns:

- Cannot go on [normal] leave or contract leave.
- Meeting one of the criteria for 'Qualified Newborn' at Admission, are admitted as Qualified (Criterion for Admission).
- Newborns 'rooming in' with the mother cannot be considered to be admitted without the mother.
- If unqualified and in a private hospital, do not have to be reported. However, all instructions regarding unqualified patients and bed days need to be followed by private hospitals where they choose to report episodes relating to Unqualified Newborns.
- If the Unqualified Newborn remains in the hospital when they turn 10 days of age, and is not receiving clinical care, they must be separated. At this point in time it becomes a boarder and the episode being reported to VAED is ended.
- Unqualified Newborns must not be changed to Qualified in order to report Accommodation Type 4 *Hospital in the Home*.

Status Segments are used to record changes between Qualified and Unqualified status for newborns and the duration of these periods (Patient Days).

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

Event	Date	Hospital's data records:
Birth of a single liveborn. Baby needs Special Care Nursery	1 Sep	Admission details for newborn. Status Segment <i>Qualified</i>
Baby improves; transferred to ward	2 Sep	New Status Segment <i>Unqualified</i>
Baby worsens; transferred back to SCN	3 Sep	New Status Segment <i>Qualified</i>
Baby improves; transferred back to ward	4 Sep	New Status Segment <i>Unqualified</i>
Mother and baby both go home	6 Sep	Separation details for mother, baby

Table 1: Birth Episode:

The Newborn	Criterion for Admission	Qualification Status	Care Type	Acc Class	Acc Class on Sep'n
Qualified at admission, remained so for entire episode	N <i>Qualified Newborn</i>	Starts as N <i>Qualified</i> , remains so for entire episode	4 <i>Other Care (Acute) including Qualified newborn</i>	Expected to be same as mother	Expected to be same as mother
Unqualified at admission, remained so for entire episode	U <i>Unqualified Newborn</i>	Starts as U <i>Unqualified</i> , remains so for entire episode	U <i>Unqualified newborn</i>	Expected to be same as mother	Expected to be same as mother
Qualified at admission but later ceased to be qualified	N <i>Qualified Newborn</i>	Starts as N <i>Qualified</i> but has some days as U <i>Unqualified</i>	4 <i>Other Care (Acute) including Qualified newborn</i>	Expected to be same as mother	Expected to be same as mother
Unqualified at admission but later became qualified	U <i>Unqualified Newborn</i>	Starts as U <i>Unqualified</i> but has some days as N <i>Qualified</i>	U <i>Unqualified newborn</i> but later must be amended to 4 <i>Other Care (Acute) including Qualified newborn</i>	Expected to be same as mother	Expected to be same as mother

Table 2: Not Birth Episode

The Newborn	Criterion for Admission	Qualification Status	Care Type	Account Class	Acc Class on Sep'n
Qualified at admission, remained so for entire episode	N <i>Qualified Newborn</i>	Starts as N <i>Qualified</i> , remains so for entire episode	4 <i>Other Care (Acute) including Qualified newborn</i>	As appropriate (probably same as mother)	As appropriate at separation
Accompanying mother & Unqualified at admission, remained so for entire episode	U <i>Unqualified Newborn</i>	Starts as U <i>Unqualified</i> , remains so for entire episode	U <i>Unqualified newborn</i>	NT	NT
Qualified at admission but later ceased to be qualified	N <i>Qualified Newborn</i>	Starts as N <i>Qualified</i> but has some days as U <i>Unqualified</i>	4 <i>Other Care (Acute) including Qualified newborn</i>	As appropriate (probably same as mother)	As appropriate at separation
Accompanying mother & Unqualified at admission but later became qualified	U <i>Unqualified Newborn</i>	Starts as U <i>Unqualified</i> but has some days as N <i>Qualified</i>	U <i>Unqualified newborn</i> but later must be amended to 4 <i>Other Care (Acute) including Qualified newborn</i>	NT for original Unqualified days. As appropriate (probably same as mother) for Qualified days. Continue this Account Class for any subsequent Unqualified days.	As appropriate for Qualified days. Do not report as NT on separation.

Palliative Care Reporting

Guide for use

The Palliative Care Type and Palliative Care Patient Days are only reported to the VAED for patients admitted to approved programs. Palliative Care patients receiving 'acute' services for the alleviation of pain or symptomatic relief may be reported as Care Type 8 Palliative Care and Palliative Care Patient Days.

Care Type 8

For public hospitals, activity reported under Care Type 8 is delivered by approved palliative care programs. This activity counts towards palliative care targets.

An approved program is one funded specifically for the delivery of palliative care to patients in approved beds or units by suitably qualified staff.

In some circumstances it may be appropriate for Care Type 8 to be reported where the patient is not in a designated palliative care bed but the palliative care program was primarily responsible for the patient's care. This may occur if a designated palliative care bed is not available or it is inappropriate to move the patient to a designated palliative care bed.

Palliative Care Patient Days

Patients treated under an approved palliative care program should be reported under Palliative Care Patient Days whether they are coded as Care Type 8 or another Care Type.

The list of campuses authorised to report this data item is the same as those eligible to report Care Type of 8.

Funding for episodes where the Care Type is not 8 is based on the Care Type reported and does not count towards palliative care targets.

The Cancer and Palliative Care Unit, DHS, determines which campuses can report Care Type 8 and palliative care patient days.

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

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

Refer to:

- Section 2: *Episode of Admitted Patient Care*.
- Section 3: *Care Type and Palliative Care Patient Days*.
- Section 5: *Sub-Acute Record*.
- Section 9: Supplementary Code Lists: *Care Type 8 and Palliative Care Days: Palliative Care Units*:
<http://www.health.vic.gov.au/hdss/reffiles/index.htm>

Reporting history of code changes

Guide for use **Account Class, Accommodation Type and Qualification Status**

The Account Class, Accommodation Type and Qualification Status of a patient are reported 'as of midnight' to PRS/2. A history of changes is reported in the Status Segments of the Episode (E4) record. If more than one change occurs within the same day, do not report the first change, only report the patient's status as of midnight each day. This is because bed days are reported for each status segment, therefore if there is more than one status segment reported for activity within the same day, bed day calculations will be incorrect.

Examples:

A patient is admitted to a private ward for three days and is then moved to a shared ward for two days. Report three days Accommodation Type 2 in the first Status Segment, and two days for Accommodation Type 1 in the second Status Segment.

A patient is admitted as Account Class PE *Medical 1* but is changed to Account Class PC *Surgery* on the same day where the patient remains until separation. Report only one Status Segment with Account Class PC.

A patient is admitted to Emergency Department Accommodation at 9.00am, is moved to a Private Ward at 10.30am and moved again to a Shared Ward at 10.45pm. Report only Accommodation Type 1 *Overnight Accommodation: Shared room*.

Refer to:

- Section 2: *Length of Stay*.
- Section 4: *Length of Stay*.

How to Count Patient Days

It is not possible for a Status Segment to have zero Patient Days, therefore:

- If, on the one day, a patient's details change, then change again, the first change should not be reported to PRS/2.
- If, on the one day, a patient's details are changed then found to be incorrect, the incorrect change should not be reported to PRS/2.
- If, on the one day, a patient's details change then the patient is separated (formally or statistically), the change should not be reported to PRS/2; the separation should be reported.
- If, on the one day, a patient is admitted then their details change, the original details should not be reported to PRS/2.

Refer to:

- Section 2: *Length of Stay*.
- Section 4: *Length of Stay*.

When to create a Status Segment

The first Status Segment must be created, recording the details at admission (formal or statistical).

If later there is a change to Account Class, Accommodation Type or Qualification Status, a new Status Segment is created. A move to or from Accommodation Type 4 *In the Home (Hospital – HITH)* is reported as a new Status Segment, not a new Episode Record.

A Status Segment should only be created if it is needed; surplus Status Segments should be left blank, not zero-filled.

Care Type

Changes to Care Type must result in a new episode record being created, rather than a new Status Segment. The only exception to this rule is when newborns change between Qualified and Unqualified; this should be reported as a new status segment rather than a new episode.

Only one care type change per day can be reported. For example, if a patient is admitted as Care Type 4 and then changes to Care Type 5x the same day, do not report the Care Type 4 portion of the episode to the VAED.

The Separation Mode of the first episode must be S *Statistical Separation (change in Care Type within this hospital)* and the Admission Source of the next episode must be S *Statistical Admission (change in Care Type within this hospital)*, thereby linking the two episodes statistically. The Admission Time of the subsequent episode must be one minute after the Separation Time of the previous episode.

Statistical readmissions to or from Care Type 8 are not permitted, unless a patient changes between Nursing Home Type (Care Types 1, 5T or F) and Palliative Care.

Refer to:

Section 4: *Episode of Care*

Section 5: *Episode Record*

Transfer Reporting

Guide for use Reporting requirements are listed below:

Transfer between hospitals

- Unless the patient is on contract or normal leave, an overnight or multi-day stay patient in one hospital campus cannot concurrently be a patient in another hospital campus. Such a patient must be separated from one hospital campus and admitted to the other hospital campus on each occasion of transfer.
- A patient transferred to another campus but intending to return to this campus should be placed on leave for the duration of stay at the other campus. If the patient attends the other campus as a day-only admission, the leave should be recorded on the patient's record but should not be reported to the VAED.

Hospitals transferring admitted patients to a second hospital

- Separation Mode: T *Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre*
- Transfer Destination: Report appropriate hospital campus code.

Hospitals receiving patients from another hospital

- Admission Source: T *Transfer from acute hospital/extended care/rehabilitation/geriatric centre*
- Transfer Source: Report appropriate hospital campus code.

Refer to:

- Section 2: *Campus, Criteria for Admission, and Hospital.*
- Section 3: *Admission Source, Separation Mode, Transfer Destination, Transfer Source.*

Business Rules (tabular)

Account Class, Acc Type, Care Type and Medicare Suffix

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 M S	4, U	name, C-U
MP	4 C	4	name, C-U
MP	6 8 M S	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 M S	4, U	N-E
ME	4 7 C	4	N-E
ME	6 8 M S	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 M S	1, 5T	name, C-U, N-E
MN	1 2	F	name, C-U
M5	1 2 6 M S	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 M S	4, U	name, C-U
MA	4 C	4	name, C-U
MA	6 8 M S	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 M S	4, U	N-E
MF	4 C	4	N-E

Account Class	Accom Type	Care Type	Medicare Suffix
MF	6 8 M S	P, 2, 6, 7, K, 8, 9, 5K, 5G, 5S, 5A	N-E
MF	7	4	N-E
Private			
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 8B M S	4, U	name, C-U, N-E
PA	4 C	4	name, C-U, N-E
PA	6 8 M S	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 8B M S	4, U	name, C-U, N-E
PB	4 C	4	name, C-U, N-E
PB	6 8 M S	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 8B M S	4, U	name, C-U, N-E
PC	4 C	4	name, C-U, N-E
PC	6 8 M S	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 8B M S	4, U	name, C-U, N-E
PD	4 C	4	name, C-U, N-E
PD	6 8 M S	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 8B M S	4, U	name, C-U, N-E
PE	4 C	4	name, C-U, N-E
PE	6 8 M S	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 8B M S	4, U	name, C-U, N-E
PF	4 C	4	name, C-U, N-E
PF	6 8 M S	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 M S	4, U	name, C-U, N-E
PG	6 M S	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 M S	4, U	name, C-U, N-E
PH	6 M S	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 M S	P, 2, 6, 7, K	name, C-U, N-E
PJ	1 2 6 M S	P, 2, 6, 7, K	name, C-U, N-E
PK	1 2 6 M S	P, 2, 6, 7, K	name, C-U, N-E

Account Class	Accom Type	Care Type	Medicare Suffix
PL	1 2 3 4 6 M S	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PM	1 2 4 6 M S	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PN	1 2 4 6 M S	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
PO	1 2 3 4 6 8 BC M S	4	name, C-U, N-E
PO	6 8 M S	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 BC M S	4	name, C-U, N-E
PP	6 8 M S	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 BC M S	4	name, C-U, N-E
PQ	6 8 M S	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 BC M S	4	name, C-U, N-E
PR	6 8 M S	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 M S	1, 5T	name, C-U, N-E
PT	1 2 4 6 M S	1, 5T	name, C-U, N-E
PU	1 2 4 6 M S	1, 5T	name, C-U, N-E
PV	1 2 4 6 M S	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 M S	4, U	name, C-U
VX	4 C	4	name, C-U
VX	6 8 M S	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 M S	1, 5T	name, C-U
VN	1 2	F	name, C-U
V5	1 2 6 M S	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 M S	4, U	name, P-N
JP	6 8 M S	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 M S	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 M S	4, U	name, C-U, N-E, P-N
WC	4	4	name, C-U, N-E, P-N

Account Class	Accom Type	Care Type	Medicare Suffix
WC	6 8 M S	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
WC	C	4	name, C-U
WN	1 2 6 M S	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 M S	4, U	name, C-U, N-E, P-N
TA	4 C	4	name, C-U, N-E, P-N
TA	6 8 M S	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 M S	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 M S	4, U	name, C-U
AS	4 C	4	name, C-U
AS	6 8 M S	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 M S	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 M S	4, U	name, C-U, N-E
SS	4 C	4	name, C-U, N-E
SS	6 8 M S	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 M S	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 M S	4, U	name, C-U, N-E
CL	4 C	4	name, C-U, N-E
CL	6 8 M S	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 M S	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 M S	4, U	name, C-U, N-E
OO	4 C	4	name, C-U, N-E
OO	6 8 M S	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 M S	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 M S	4, U	N-E
XX	4 C	4	N-E

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

Account Class: Geriatric Respite

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
E4 Episode Record	
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
X4 Diagnosis Record	
Principal Diagnosis	Z75.5 <i>Holiday relief care, or</i> 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
Duration of NIV	Spaces

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

Edits 329 Geri Respite – Invalid Comb

Account Class: Newborn, Unqualified, Not Birth Episode

If Account Class is NT *Newborn (Unqualified, Not birth episode)* then the following fields must contain the codes shown below*. Only fields that cannot contain the full code set are listed.

Field	Valid codes
E4 Episode Record	
Accommodation Type	B
Admission Type	C, L, O, X
Care Type	U
Criterion for Admission	U

* 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 455 Inconsis Newborn Transferred/Unqual Data

Admission Source and Admission Type

If Admission Source is	then Admission Type must be
S Statistical Admission (change in Care Type within this hospital)	S
Y Birth Episode	Y
T Transfer from Acute hospital/Extended care/Rehabilitation/Geriatric centre	M, C, L, O, X
B Transfer from Transition Care bed based program	C, L, O, X
N Transfer from Aged Care Residential Facility	M, C, L, O, X
A Transfer from Mental Health Residential Facility	M, C, L, O, X
H Admission from Private Residence/Accommodation	M, C, L, O, X
If Admission Type is	then Admission Source must be
S Statistical Admission (change in Care Type within this hospital)	S
Y Birth Episode	Y
M Maternity	T, N, A, H
C Emergency Admission through Emergency Department at this hospital	T, B, N, A, H
L Admission – from the Waiting List	T, B, N, A, H
O Other Emergency Admission	T, B, N, A, H
X Other Admission	T, B, N, A, H

Edit 056 Incompatible Adm Type/Source

Admission Source and Age

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

If Age at admission is	then Admission Source must be
< 2 days	Y, T, H
< 10 days	T, H
> 9 days and <= 2 years	S, T, H
> 2 years	S, T, B, N, A H
If Admission Source is	then Age at admission must be
S Statistical Admission (change in Care Type within this hospital)	> 9 days
Y Birth Episode*	< 2 days
B Transfer from Transition Care bed based program	> 2 years
N Transfer from Aged Care Residential Facility	> 2 years
A Transfer from Mental Health Residential Facility	> 2 years

* Private hospitals may report Admission Source code Y for Age at admission > 2 days.

Edit 479 Incompatible Adm Source/Age

Admission Source and Care Type

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

Admission Source and Criterion For Admission

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

If Admission Source is	then Criterion For Admission must be
S Statistical Admission (change in Care Type within this hospital)	B, C, E, O
Y Birth Episode	N, U
B Transfer from Transition Care bed based program	B, C, E, O
N Transfer from Aged Care Residential Facility	B, C, E, O
A Transfer from Mental Health Residential Facility	B, C, E, O
If Criterion For Admission is	then Admission Source must be
B Day Only Bands	S, T, B, N, A, H
C Type C Professional Attention Procedures	S, T, B, N, A, H
N Qualified Newborn	Y, T, H
U Unqualified Newborn	Y, T, H
E Extended Medical Treatment	S, T, B, N, A, H
O Expected to require hospitalisation for minimum of one night	S, T, B, N, A, H
S Secondary Family Member	T, H

Edit 482 Incompatible Adm Source/Crit for Adm

Admission Source and Qualification Status

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

If Admission Source is	then Qualification Status must be
S Statistical Admission (change in Care Type within this hospital)	X
Y Birth Episode	N, U
B Transfer from Transition Care bed based program	X
N Transfer from Aged Care Residential Facility	X
A Transfer from Mental Health Residential Facility	X
If Qualification Status is	then Admission Source must be
N Qualified Newborn	Y, T, H
U Unqualified Newborn	Y, T, H
X Not Applicable	S, T, B, N, A, H

Edit 483 Incompatible Adm Source/Qual Stat

Admission Type and Age

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

If Age at admission is	then Admission Type must be
< 2 days	Y, C, O, X
< 10 days	C, L, O, X
> 9 days	S, C, L, O, X
11-54 yrs (inclusive)	S, M, C, L, O, X
If Admission Type is	then Age at admission must be
S Statistical Admission (change in Care Type within this hospital)	> 9 days
Y Birth Episode*	< 2 days
M Maternity	11-54 yrs (inclusive)
L Admission – from the Waiting List	>= 2 days

* Private hospitals may report Admission Type code Y for Age at admission > 2 days.

Edit 057 Incompat Adm Type/Age

Admission Type and Criterion For Admission

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

If Admission Type is	then Criterion For Admission must be
S Statistical Admission (change in Care Type within this hospital)	B, C, E, O
Y Birth Episode	N, U
M Maternity	B, C, E, O
If Criterion For Admission is	then Admission Type must be
B Day Only Bands	S, M, C, L, O, X
C Type C Professional Attention Procedures	S, M, C, L, O, X
N Qualified Newborn	Y, C, L, O, X
U Unqualified Newborn	Y, C, L, O, X
E Extended Medical Treatment	S, M, C, L, O, X
O Expected to require hospitalisation for minimum of one night	S, M, C, L, O, X
S Secondary Family Member	C, L, O, X

Edit 484 Incompatible Adm Type/Crit for Adm

Admission Type and Qualification Status

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

If Admission Type is	then Qualification Status must be
S Statistical Admission (change in Care Type within this hospital)	X
Y Birth Episode	N, U
M Maternity	X
If Qualification Status is	then Admission Type must be
N Qualified Newborn	Y, C, L, O, X
U Unqualified Newborn	Y, C, L, O, X
X Not Applicable	S, M, C, L, O, X

Edit 485 Incompatible Adm Type/Qual Stat

Age and Criterion For Admission

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

If Age at admission is	then Criterion For Admission must be
< 2 days	N, U
< 10 days	B, N, U
> 9 days	B, C, E, O, S
If Criterion For Admission is	then Age at admission must be
B Day Only	>= 2 days
C Type C Professional Attention Procedures	> 9 days
N Qualified Newborn	< 10 days
U Unqualified Newborn	< 10 days
E Extended Medical Treatment	> 9 days
O Overnight	> 9 days
S Secondary Family Member	> 9 days

Edit 486 Incompatible Age/Crit for Adm

Age and Qualification Status

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

If Age at admission is	then Qualification Status must be
< 10 days	N, U
> 9 days	X
If Qualification Status is	then Age at admission must be
N Qualified Newborn	< 10 days
U Unqualified Newborn	< 10 days
X Not Applicable	> 9 days

Edit 487 Incompatible Age/Qual Stat

Age, Care Type, Carer Availability and Separation Mode

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

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

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
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, C, E, O
Mental Health Legal Status	9
Funding Arrangement	1 or space
X4 Diagnosis Record	
Admission weight	Spaces
Duration of MV	Spaces
Duration of NIV	Spaces
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

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: Designated Paediatric Rehabilitation Program (P)

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, C, E, O
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
	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: Interim Care Program (F and E)

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
E4 Episode Record	
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, MF, 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, MF, 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
X4 Diagnosis Record	
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
Duration of NIV	Spaces
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 *	Spaces
Onset Date *	Spaces
Admission/Re-admission to Rehabilitation *	Spaces
RUG ADL on Admission *	Spaces
RUG ADL on Separation *	Spaces
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	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
	627	Care Type changed, Sub-Acute data deleted

Care Type and Separation Mode

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
O 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
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Contracting: Contract Fields, Contract Leave and Funding Arrangement

Edits not applied until Separation Date present. Valid combinations of Contract fields:

Contract Type	Contract Role	Contract/Spoke Identifier	Contract Leave	Funding Arrangement
Space	Space	Space	MTD, YTD: Space Total: Space	Space
1 Type B	B Hospital B	Valid code (not 0050 or 0070)	MTD, YTD: Space Total: Space	1 Contract
2 Type ABA	A Hospital A	Valid code	MTD, YTD: Value or space Total: Value or space*	1 Contract
	B Hospital B	Valid code	MTD, YTD: Space Total: Space	1 Contract
3 Type AB	A Hospital A	Valid code	MTD, YTD: Value or space Total: Value or space*	1 Contract
	B Hospital B	Valid code	MTD, YTD: Space Total: Space	1 Contract
4 Type (A)B	A Hospital A	Valid code	MTD, YTD: Space Total: Space	1 Contract
	B Hospital B	Valid code	MTD, YTD: Space Total: Space	1 Contract
5 Type BA	A Hospital A	Valid code	MTD, YTD: Value or space Total: Value or space*	1 Contract
	B Hospital B	Valid code	MTD, YTD: Space Total: Space	1 Contract
6 Type A(B)	A Hospital A	Valid code	MTD, YTD: Space Total: Space	1 Contract
7 Type (A)	A Hospital A	0050 or 0070	MTD, YTD: Space Total: Space	1 Contract

* Can be space: if contract leave is *same day*, no Leave Day is counted.

Edit 410 Illegal Comb Fund Arrange & Contract
456 Contract Leave, No Contract

Contracting: Funding Arrangement and Contract Fields

Valid combinations for public and private hospitals and day procedure centres.

Edits not applied until Separation Date present. If Funding Arrangement code is as shown in the first column, the various Contract fields must contain codes as shown in the Code column.

Funding Arrangement	Contract fields	Code
Space – None	Contract Type	Space
	Contract Role	Space
	Contract/Spoke Identifier	Space
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
1 Contract with Contract Type 1	Contract Type	1
	Contract Role	B
	Contract/Spoke Identifier	Valid External Purchaser Agency code: 0100-0900. For reporting the location of lithotripsy services provided by St Vincent's Hospital only, codes: 0910, 0920, 0930, 0940, 0950, 0960, 0970, 0980, 0990.
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
1 Contract with Contract Types 2, 3, 4, 5	Contract Type	2, 3, 4, 5
	Contract Role	A, B
	Contract/Spoke Identifier	Valid Campus code
	Contract Leave Days MTD	Value or space*
	Contract Leave Days YTD	Value or space*
	Contract Leave Days Total	Value or space*
1 Contract with Contract Type 4	Contract Type	2, 3, 4, 5
	Contract Role	A, B
	Contract/Spoke Identifier	Valid Campus code
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
1 Contract with Contract Type 6	Contract Type	6
	Contract Role	A
	Contract/Spoke Identifier	Valid Campus code
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
1 Contract with Contract Type 7	Contract Type	7
	Contract Role	A
	Contract/Spoke Identifier	Valid External Purchaser Agency code: 0050, 0070.
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
2 Hub/spoke	Contract Type	Space
	Contract Role	Space

Funding Arrangement	Contract fields	Code
	Contract/Spoke Identifier	Valid Campus code or Contract/Spoke Identifier
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
3 Healthstreams	Contract Type	Space
	Contract Role	Space
	Contract/Spoke Identifier	Space
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
4 Coordinated Care Trial	Contract Type	Space
	Contract Role	Space
	Contract/Spoke Identifier	Space
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
5 Rural Patients Initiative	Contract Type	Space
	Contract Role	Space
	Contract/Spoke Identifier	Space
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
6 Elective Surgery Access Service	Contract Type	Space
	Contract Role	Space
	Contract/Spoke Identifier	Space
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
7 Private Hospital elective surgery initiative	Contract Type	Space
	Contract Role	Space
	Contract/Spoke Identifier	Space
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space
8 National Bowel Cancer Screening Program	Contract Type	Space
	Contract Role	Space
	Contract/Spoke Identifier	Space
	Contract Leave Days MTD	Space
	Contract Leave Days YTD	Space
	Contract Leave Days Total	Space

* Can be space: if contract leave is *same day*, no Leave Day is counted.

Edit 410 Illegal Comb Fund Arrange and Contract
 626 Invalid combination for Funding Arrangement PHESI

Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode

Edit not applied until Separation Date present. If an episode has the combination of Contract fields in the *first three columns*, then a Transfer must be indicated in Admission Source and/or Separation Mode as indicated in the last two columns. Valid combinations:

Funding Arrangement	Contract Type	Contract Role	Admission Source	Separation Mode
1 Contract	2 Contract Type ABA	B Hospital B	T Transfer from acute hospital/extended care/rehabilitation/geriatric centre	T Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre
1 Contract	3 Contract Type AB	A Hospital A		T Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre
1 Contract	3 Contract Type AB	B Hospital B	T Transfer from acute hospital/extended care/rehabilitation/geriatric centre	
1 Contract	5 Contract Type BA	B Hospital B		T Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre
1 Contract	5 Contract Type BA	A Hospital A	T Transfer from acute hospital/extended care/rehabilitation/geriatric centre	

Edit

423 Invalid Comb Fund / Contract /Transfer

Criterion for Admission and Newborn Qualification Status (1st Status Segment)

This edit table, in addition to the edit table 'Criterion for Admission and Qualification Status' further specifies the Qualification Status code required for newborns in the 1st Status Segment of the admission.

If Criterion For Admission is	then Qualification Status (1st Status Segment) must be
B Day Only Bands	N, X
C Type C Professional Attention Procedures	X
N Qualified Newborn	N
U Unqualified Newborn	U
E Extended Medical Treatment	X
O Overnight	X
If Qualification Status (1st Status Segment) is	then Criterion For Admission
N Qualified Newborn	B, N
U Unqualified Newborn	U
X Not Applicable	B, C, E, O

Edit 490 Incompatible Crit for Adm/Qual Stat

Criterion for Admission and Qualification Status

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

If Criterion For Admission is	then Qualification Status must be
B Day Only Bands	N, X
C Type C Professional Attention Procedures	X
N Qualified Newborn	N, U
U Unqualified Newborn	U, N
E Extended Medical Treatment	X
O Overnight	X
S Secondary Family Member	X
If Qualification Status is	then Criterion For Admission
N Qualified Newborn	B, C, N, U
U Unqualified Newborn	U, N
X Not Applicable	B, C, O, S

Edit 490 Incompatible Crit for Adm/Qual Stat

Criterion for Admission: Secondary Family Member

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
E4 Episode Record	
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
X4 Diagnosis Record	
Duration of Stay in ICU	Spaces
Duration of MV	Spaces
Duration of Stay in CCU	Spaces
Duration of NIV	Spaces

Edit 328 Early Parenting Centre – Invalid Comb

Funding Arrangement: Elective Surgery Access Service

If Funding Arrangement is *6 Elective Surgery Access Service*, then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Field	Valid codes
E4 Episode Record	
Admission Type	L
Admission Source	T, B, N, A, H
Account Class	MP, PA, PB, PC, PD, PE, PF, VX, WC, TA, AS, CL, OO
Qualification Status	X
Carer Availability	Space
Care Type	4
Criterion for Admission	B, C, E, O
Mental Health Legal Status	9

Edit 491 Incompat Fields for ESAS

Funding Arrangement: Private Hospital Elective Surgery Initiative

If Funding Arrangement is 7 *Private Hospital Elective Surgery Initiative*, this must be a PRIVATE HOSPITAL (in the panel selected by tender process) and the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Field	Valid codes
E4 Episode Record	
Admission Type	C, L, O
Admission Source	T, B, N, A, H
Account Class	MP
Qualification Status	X
Carer Availability	Space
Care Type	4
Criterion for Admission	B, C, E, O
Mental Health Legal Status	9

Edit 626 Invalid combination for Funding Arrangement PHESI

Funding Arrangement: Rural Patients Initiative

If Funding Arrangement is 5 *Rural Patients Initiative*, then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Field	Valid codes
E4 Episode Record	
Admission Type	S, L, X, C, O
Admission Source	S, T, B, N, A, H
Account Class	MP, PE, PF, VX, TA, AS, CL, OO
Qualification Status	X
Carer Availability	Space
Care Type	4
Criterion for Admission	B, C, E, O
Mental Health Legal Status	9

Edit 492 Incompat Fields for RPI

Intention to Readmit and Separation Mode

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

If Intention to Readmit is	then Separation Mode must be
0 Not applicable	S, D, Z, T
1 Re-admission planned this hospital within 28 days, booking arranged	B, N, A, H
2 Re-admission planned this hospital within 28 days, no booking arranged	B, N, A, H
3 Re-admission planned other hospital within 28 days, booking arranged	B, N, A, H
4 Re-admission planned other hospital within 28 days, no booking arranged	B, N, A, H
9 No plan to re-admit within 28 days	B, N, A, H
If Separation Mode is	then Intention to Readmit must be
S Statistical Separation (change in Care Type within this hospital)	0
D Death	0
Z Left against medical advice	0
T Separation and Transfer to other Acute Hospital/Extended Care/Rehabilitation/Geriatric Centre	0
B Separation and Transfer to Transition Care bed based program	1, 2, 3, 4, 9
N Separation and Transfer to Aged Care Residential Facility	1, 2, 3, 4, 9
A Separation and Transfer to Mental Health Residential Facility	1, 2, 3, 4, 9
H Separation to Private Residence/Accommodation	1, 2, 3, 4, 9

Edit

192 Invalid Comb Int./Readmit/Sep Mode

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	< > (0002 or 1201)
2	No	< > 0002
9	Not Stated / Inadequately Described	0002
If Preferred Language is		Then Interpreter Required must be
< > (0002 or 1201) Refer VAED Manual Section 9 <i>Preferred Language</i>		1, 2
1201	English	2
0002	Not stated	9

Edits 592 Invalid Comb Int Req/Pref Lang

Locality/Postcode

The validity of the Locality and Postcode combination is checked against the Postcode/Locality reference file, available at: <http://www.health.vic.gov.au/hdss/reffiles/index.htm> Reject (Edit 058) records if there is not an exact match for both Locality and Postcode, including the following editing on the Locality and Postcode data items:

- If the Locality is blank and the Postcode is not 1000 or 9988.
- If the Locality is not blank and the Postcode is 1000 or 9988.
- If Postcode is 8888 and Locality is between 0000 and 1199.
- If Postcode is 8888 and Locality is not a valid country code from the Postcode/Locality reference file.

Accepted variations of locality spellings in the Postcode/Locality reference file

Australia Post Postcode/Locality Examples of accepted variations of locality spellings

Compass bearing descriptors:

3051 NORTH MELBOURNE	3051 MELBOURNE NORTH 3051 NTH MELBOURNE 3051 MELBOURNE NTH 3051 NTH.MELBOURNE 3051 N.MELBOURNE
3205 SOUTH MELBOURNE	3205 MELBOURNE SOUTH 3205 STH MELBOURNE 3205 MELBOURNE STH 3205 STH.MELBOURNE 3205 S.MELBOURNE
3002 EAST MELBOURNE	3002 MELBOURNE EAST 3002 E.MELBOURNE
3003 WEST MELBOURNE	3003 MELBOURNE WEST 3003 W.MELBOURNE

Other locality descriptors:

3107 TEMPLESTOWE LOWER	3107 LOWER TEMPLESTOWE
3123 HAWTHORN UPPER	3123 UPPER HAWTHORN
3212 LARA LAKE	3212 LAKE LARA
3149 MOUNT WAVERLEY	3149 MT WAVERLEY 3149 MT. WAVERLEY 3149 MT.WAVERLEY
3182 ST KILDA	3182 ST.KILDA 3182 ST. KILDA 3182 SAINT KILDA
3030 POINT COOK	3030 PT.COOK 3030 PT. COOK 3030 PT COOK
3193 RICKETTS POINT	3193 RICKETTS PT. 3193 RICKETTS PT

Examples of errors in postcodes and localities that will be rejected

Error Type	Example	Result	Remedy*
Inclusion of region in locality field	3350 ALFREDTON BALLARAT	Rejection	3350 ALFREDTON
Inclusion of state identifier in locality field	3820 WARRAGUL VIC	Rejection	3820 WARRAGUL
Inclusion of street address in locality field	3181 76 WILLIAMS RD PRAHRAN	Rejection	3181 PRAHRAN
Invalid postcode and/or locality	3057 BRUNSWICK	Rejection	3056 BRUNSWICK <i>or</i> 3057 EAST BRUNSWICK
Invalid use of 'dot'	3350 BALLARAT.	Rejection	3350 BALLARAT
Incorrect number of words	3024 WYNDHAMVALE 3006 SOUTH BANK	Rejection	3024 WYNDHAM VALE 3006 SOUTHBANK
More than one space between words	3021 ST ALBANS	Rejection	3021 ST ALBANS
Invalid abbreviation of locality descriptor	3055 W BRUNSWICK 3107 LWR TEMPLESTOWE	Rejection	3055 W.BRUNSWICK 3107 LOWER TEMPLESTOWE
Misspellings	3064 CRAIGEBURN 3064 CRAIGIBURN	Rejection	3064 CRAIGIEBURN

* Check latest postcode/locality reference file and/or Australia Post postcode/locality listings

Newborns: Criteria for Admission, Qualification Status, Care Type

Newborns in their birth episode should always have the following:

- Admission Type: Y *Birth Episode*
- Accommodation Type: C *Nursery accommodation: NICU/SCN only* or B *Other nursery accommodation or mother's bedside (rooming in)*

If Criteria for Admission codes N or U are present, the following are usual combinations. Some combinations outside of those listed below will trigger Warning edits, others will trigger Rejection edits:

Criterion for Admission	Qualification Status	Care Type
N Qualified Newborn	N Qualified	4 Other Care (Acute) including Qualified newborn
U Unqualified Newborn	U Unqualified	U Unqualified newborn
N Qualified Newborn	N Qualified* and U Unqualified	4 Other Care (Acute) including Qualified newborn
U Unqualified Newborn	U Unqualified* and N Qualified	4 Other Care (Acute) including Qualified newborn

* The Qualification Status value that must be reported in the 1st Status Segment.

Edits	235	Adm Crit is N But Care Not 4
	260	Invalid Care For Qual
	490	Incompat Crit For Adm/Qual Stat