Specifications for revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2008

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Executive Summary

This document details the revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2008. These revisions are summarised below.

1. Addition of Date of Birth Accuracy Flag.
   Change required:
   i) To improve quality of data of the Date of Birth data item.
   ii) To bring the VAED in line with the NHDD and other DHS data collections.
   iii) To facilitate Commonwealth reporting.

2. Upgrade to ICD-10-AM/ACHI Sixth Edition.
   Change required:
   i) For Casemix funding.
   ii) To align with National standard.

3. Removal of Country of Birth Version Flag.
   Change required:
   i) This field was added as a temporary measure in 2007-08 to ensure the new Country of Birth Codeset was implemented. It is no longer required.

4. Interpreter Required: Remove Code 3 *Not Stated* and Add Code 9 *Not Stated/Inadequately Described*.
   Change required:
   i) To align the VAED with the Common Client Data Set

5. Marital Status: *Married* and *De facto* split into two codes, code 6 *Not stated/Inadequately described* becomes *De facto*, and code 9 *Not stated/Inadequately described* added.
   Changed required:
   i) To align the VAED with the Common Client Data Set

6. Indigenous Status: Code values changed (5, 6, 7, 2 become 1, 2, 3, 4 respectively). 8 and 9 unchanged.
   Changed required:
   i) To align the VAED with the Common Client Data Set

Introduction

The need for PRS/2 interface modifications

From 1 July 2008, 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 2007* 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 2008.
- End of financial year considerations.
- Amended file structures.

The *VAED Manual, 18th Edition, July 2008* will be distributed at a later date. Until then, the *VAED Manual, 17th Edition, July 2007* (and subsequent bulletins) together with this document will form the admitted patient data transmission specification for 2008–09.

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

The current *VAED Manual, 17th Edition, July 2007* 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 are highlighted in orange.
- Changes to existing items are highlighted in green.
- 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
AROC Australian Rehabilitation Outcomes Centre
DHS Department of Human Services
ERC Expenditure Review Committee
FIM Functional Independence Measure
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

Explanation of the decisions behind adoption or rejection of proposals

Proposal 1: Addition of Palliative Care Consultancy Flag (Rejected)

It was decided not to introduce this data item following feedback from those hospitals with a DHS-funded Palliative Care Consultancy Team. Some responders felt that this information would be more accurately and efficiently reported by the teams themselves. The Cancer and Palliative Care Unit will use an alternate method of data collection and review in twelve months.

Proposal 2: Addition of Date of Birth Accuracy Flag (Adopted)

Many hospitals are not reporting estimated dates as specified in the VAED manual and are using different 'default' dates specific to that hospital. This causes difficulties for the Department for several reasons:

i) The Commonwealth query records with unusual birth dates and those records are returned for time-consuming follow-up;

ii) Researchers find anomalies when comparing diagnoses and procedure codes, and other clinical information, with 'strange' dates, particularly dates that indicate the patient is very old;

iii) Being unaware that a date has been estimated makes matching data to other datasets such as Mental Health problematic.

It is not expected that the Date of Birth of every patient be verified for accuracy. We would expect that the default Accuracy Flag would be 'AAA' for all patients except those unable or unwilling to provide a Date of Birth. For those patients only, a flag would be added to their patient record to indicate the date has been estimated. Ideally, each segment of the Date of Birth would be reported separately, i.e. whether the day, month, and/or the year has been estimated. However, we will accept a value of 'EEE' for all estimated Dates of Birth. The types of patients that may have a date estimated would include patients arriving at the ED unconscious (and a date is unable to be provided during their stay in the hospital), a patient who refuses to provide their date of birth, a Mental Health patient who you suspect has not provided an accurate date of birth, etc.

Proposals 3 & 4: Impairment Codes and FIM Scores (Rejected)

The feedback we received for these proposals was mixed, with some sites supportive and some raising concerns. It has been decided not to include these data items for 2008-09, and in the next twelve months we will investigate other options in consultation with the Australasian Rehabilitation Outcomes Centre (AROC) and the Continuing Care & Clinical Service Development Unit.

Common Client Data Set Changes

The Department is working towards aligning the DHS data collections in order to reduce the burden on hospitals when reporting different values for the same data items. The Common Client Data Set defines data items and determines the code values for items that are collected by various data collections.

Some modifications have been necessary to Marital Status, Interpreter Required and Indigenous Status.

Date of Birth Accuracy Flag

Revision Summary	Introduction of Date of Birth Accuracy flag to: • Improve data quality for Date of Birth data item • Provide means of reporting that a DOB is an estimate, rather than services using a default date specified by the individual service and therefore meaningless in a statewide context.
Implementation Guide	Date of Birth Accuracy flag may be defaulted to 'AAA' for all patients except those for whom the Date of Birth has been estimated. Where the DOB has been estimated, ideally the accuracy of each segment of the date should be indicated. However, a default of 'EEE' will be acceptable. Therefore, a 'tick-box' system for this data item is considered sufficient. For HL7 users, this data item can be transmitted in the PID.32 message.

Date of Birth Accuracy *(New)*

Specification

Definition A code representing the accuracy of the components of a date - day, month, year.

Datatype Alpha ***Form*** Structured Code

Field size 3 ***Layout*** AAA

Location Episode Record

Reported by All Victorian Health Services (public and private).

Reported for All admitted episodes of care.

Reported when The episode record is reported.

Value domain This data element's value domain consists of a combination of three codes, each of which denotes the accuracy of one date component:

Code	**Descriptor**
A	The referred date component is accurate
E	The referred date component is not known but is estimated
U	The referred date component is not known and not estimated.

This data element contains three positional components (DMY) that reflect the order of the date components in the format (DDMMYYYY) of the reported *Date of Birth*.

Component	**Descriptor**
1st – D	Refers to the accuracy of the day component.
2nd – M	Refers to the accuracy of the month component
3rd - Y	Refers to the accuracy of the year component

Reporting guide Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

Where possible, report the accuracy of each date component. However, where software systems allow the collection of a binary value for Date of Birth Accuracy (that is the system has an 'Estimated Date of Birth' check box or similar) values such as 'AAA' and 'EEE' will be acceptable.

It is understood that the Date of Birth Accuracy Code will be reported as *'AAA'* unless the date has been flagged as an estimated date. It is not necessary to validate the Date of Birth provided by every patient unless there is a reasonable suspicion that the date provided is not correct. Where there is a question over the date provided, or where the patient is unable or unwilling to provide their date of birth, the date should be estimated and flagged as such.

If the date of birth is provided by a reliable source (for example the patient or close relative) and is known as accurate then the date accuracy indicator should be reported as *'AAA'*.

If the patient's approximate age is known, then the Date of Birth should be estimated using the approximate age to calculate an estimated year of birth. Sentinel dates should not be used. The Date of Birth Accuracy code would be reported as *'UUE'*, that is the day and month are 'unknown' and the year is 'estimated'.

A Year component value of *U – Unknown* is not acceptable.

Where the date part is accurate or estimated, the date part cannot be '00'.
Where the date part is unknown, the date part may be '00' or 'NN'.

Examples:

Valid combinations include:
DOB Accuracy = 'AAA', DOB = '03/11/1956'
DOB Accuracy = 'EEE', DOB = '03/11/1956'
DOB Accuracy = 'UUE', DOB = '00/00/1945'
DOB Accuracy = 'UUE', DOB = '01/01/1945'

Invalid combinations include:
DOB Accuracy = 'AAA', DOB = '00/00/1956'
DOB Accuracy = 'AAA', DOB = '00/06/1956'
DOB Accuracy = 'EEE', DOB = '00/00/1956'
DOB Accuracy = 'UUE', DOB = '00/00/0000'
DOB Accuracy = 'UEE', DOB = '00/00/1956'

Edits ### Invalid Date of Birth Accuracy code
DOB Accuracy and DOB mismatch

Related items Section 2: *Age*
Section 3: *Date of Birth*

Administration

Purpose Required to derive age for demographic analyses and for analysis by age at a point of time.

Principal data users Multiple internal and external research users.

Collection Start 2008-09

Definition source NHDD (DHS modified) **_Value Domain source_** NHDD 294429

Date of Birth *(Amended)*

Specification

Definition	The date of birth of the person.		
Datatype	Numeric	***Form***	Date
Field size	8	***Layout***	DDMMCCYY
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	A valid date.		
Reporting guide	The Date of Birth must be on or before Date of Admission. Century (CC) can only be 18, 19 or 20. ~~If unknown, estimate the year of birth and enter 0000 [zeros] in DDMM and the estimated year in CCYY. Date 00MMCCYY will not be accepted.~~ If the Date of Birth is unknown or has been estimated, the appropriate value should be reported in the Date of Birth Accuracy field.		

Remainder of table unchanged.

Invalid Date of Birth Accuracy code (*New*)

Effect REJECTION

Problem The E4 Episode Record's Date of Birth Accuracy code is null or invalid. Date of Birth Accuracy must be any combination of A, E and/or U representing the accuracy of each date part (D, M and Y). Any combination is acceptable, except for a Year component value of *U – Unknown*.

Remedy Check Date of Birth Accuracy for valid format and values.

DOB Accuracy and DOB mismatch (*New*)

Effect REJECTION

Problem The Date of Birth Accuracy does not match with the Date of Birth. Where the Accuracy flag is 'A' or 'E', the corresponding date part must be a valid value greater than '0'. Where the Accuracy flag is 'U", the corresponding date part may be '0' or a valid value (except for the Year component which cannot be 'U').

Remedy Check the Date of Birth Accuracy and Date of Birth. Refer to the definitions for each data item.

ICD-10-AM / ACHI Sixth Edition

Revision Summary	Introduction of ICD-10-AM / ACHI Sixth Edition. Reason for introduction: • Align with the National standard • Casemix funding
Implementation Guide	ICD-10-AM / ACHI Sixth Edition codes must be used for all separations on or after 1 July 2008. Note that the logic of edits relating to Diagnosis and Procedure codes remains unchanged. Functionality will change only as related to Library File amendments. A new Library File will be available at a later date. Advice will be issued via HDSS Bulletin.

Diagnosis Codes (*Amended*)

Specification

Definition At least one (principal diagnosis) and up to 40 ICD-10-AM (~~Fifth~~ Sixth Edition) codes reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care.

Datatype	Alphanumeric	***Form***	Code
Field size	8 (x 40)	***Layout***	AANNNNspacespace Left justify, with trailing spaces.

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

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

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

Code set DHS ICD-10-AM Library File ~~2007-08~~ 2008-09, available at:
~~http://www.health.vic.gov.au/hdss/reffiles/2007-08/vaed/libfil07.htm~~
http://www.health.vic.gov.au/hdss/reffiles/2008-09/vaed/libfil08.htm
(Note, file will be made available following release by NCCH)

Reporting guide

Report diagnoses in accordance with *Australian Coding Standards* and the *Victorian Additions to Australian Coding Standards*. The *Victorian Additions to Australian Coding Standards* are available at: http://www.health.vic.gov.au/hdss/icdcoding/index.htm

Omit punctuation as shown in ICD-10-AM books (that is, no dot or oblique in codes): for example, ICD-10-AM diagnosis code A00.0 *Cholera due to Vibrio cholerae 01, biovar cholerae* must be entered as A000.

When a code is shown in ICD-10-AM with a symbol (dagger or asterisk), *omit* the symbol when transmitting to PRS/2.

The first character of the field is the prefix: P, A, C or M.

In the first diagnosis code field:

- *Character 1* must be P.
- *Next five characters* must contain an alpha/numeric code of three, four or five characters (with trailing spaces if required).
- *Characters 7 and 8* must be spaces.

For the remaining thirty nine diagnosis code fields, *if* a code is present:

- *Character 1* must be P, A, C or M.
- *Next six characters* must contain an alpha/numeric code of three, four, five or six characters (with trailing spaces if required).
- *Character 8* must be a space.

Morphology codes (where first character is M)
Submit without punctuation (oblique) and with M prefix: for example MM80703

Prefixes: Definitions for P, A, C, M
Refer to the *Victorian Additions to the Australian Coding Standards*, available at: http://www.health.vic.gov.au/hdss/icdcoding/index.htm

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

Edits

127 Nil Value DRG
160 AR-DRG Grouper GST Code > Zero
186 Neonate MDC But Age >= 28 Days
195 Blank X4
197 Embedded Blank Diag Oper
231 P - Diag Not Prefixed By P
329 Geri Respite - Invalid comb
334 Hosp Generated DRG Not = PRS/2 DRG
351 Illegal Code Format
352 Code Not Found On Code File
353 Code & Age Incompatible
354 Code & Sex Incompatible
355 Invalid Principal Diag - Rejection
355 Invalid Principal Diag - Warning
358 Area Code Restraint
361 External Cause Code Missing
362 Morphology Code Missing
363 External Cause needs Place Code
364 External Cause/Activity Code Mismatch
403 Qual Newborn W/Out Justificat
406 Rehab Type W/Out Rehab PDx

411	Adm Wt < 1000g, No Matching Dx Code
412	Adm Wt 1000-2499g, No Matching Dx Code
413	Adm Wt > 6000g, No Matching Dx Code
426	Y4 Not Accompanied by X4
428	X4 Upd not Accompanied by Y4 Upd
442	NIV Duration for Healthy Newborn
447	Unqual Newborn; Age at Sep > 10 Days
450	Code Incompatible W Female Sex
451	Code Incompat W Male Sex
452	Place/Activity W/Out External Cause Code
453	Wrong PDx for Interim Care
454	Incompat Fields for Interim Care
498	Pall Care without Pall care Diag
525	Diagnosis Code Indicates Boarder Episode
559	Prefix = P, Unusual Code Combination
560	Prefix = P, Unusual Code Combination
561	Prefix = C, Unusual Code Combination
562	Prefix = C, Unusual Code Combination
563	Prefix = A, Unusual Code Combination
564	Prefix = A, Unusual Code Combination
590	Diag Prefix M, Not Morph Code
595	Neoplasm Code Missing
600	Invalid Code
601	Sequencing Error

Related items

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

Section 3: *Hospital Generated DRG* page 3-101.

Section 4:

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

Administration

Purpose

To:

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

Principal data users Multiple internal and external data users.

Collection start 1979-80

Definition source DHS

Code set source ICD-10-AM ~~Fifth~~ Sixth Edition

Procedure Codes (*Amended*)

Specification

Definition
Up to 40 ACHI ~~Fifth~~ Sixth Edition codes reflecting the interventions used for the diagnosis and/or treatment of ill health during this episode of care.

Datatype Alphanumeric ***Form*** Code

Field size 8 (x 40) ***Layout*** NNNNNNN 8th character - A or space.
Left justified, trailing spaces.

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

Reported by
All Victorian hospitals (public and private).

Reported for
All admitted episodes of care.

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

Code set
DHS ICD-10-AM Library File ~~2007-08~~ 2008-09, available at:
~~http://www.health.vic.gov.au/hdss/reffiles/2007-08/vaed/libfil07.htm~~
http://www.health.vic.gov.au/hdss/reffiles/2008-09/vaed/libfil08.htm
(Note, file will be made available following release by NCCH)

Where no procedures were performed, report spaces.

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

Character 8 must be F, N or space.

Report procedures undertaken during this episode of care in accordance with the *Australian Coding Standards ~~Fifth~~ Sixth Edition* and the *Victorian Additions to Australian Coding Standards*. The *Victorian Additions to Australian Coding Standards* are available at:
http://www.health.vic.gov.au/hdss/icdcoding/index.htm

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

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

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

Edits

127 Nil Value DRG
160 AR-DRG Grouper GST Code>Zero
195 Blank X4
197 Embedded Blank Diag Oper
320 MV Duration But No Procedure Code
334 Hosp Generated DRG Not = PRS/2 DRG
351 Illegal Code Format
352 Code Not found On Code File
353 Code & Age Incompatible
354 Code & Sex Incompatible
358 Area Code Restraint
408 Contract Role ‘A’ W/Out Proc Flag
409 Proc Flag W/out Contract Role ’A’
428 X4 Upd not Accompanied by Y4 Upd
440 NIV Duration without NIV Proc Code
450 Code Incompatible W Female Sex
451 Code Incompat W Male Sex
596 Same Day ECT: Not in Care Type 4
600 Invalid Code

Related items

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

Section 3: *Hospital Generated DRG* page 3-101.

Section 4:
- Business Rules (non-tabular) *Contracted Care.*

Administration

Purpose

To facilitate:
- Epidemiological studies and other research.
- Grouping for casemix purposes.

Principal data users

Multiple internal and external data users.

Collection start

1979-80

Definition source

DHS

Code set source

ACHI ~~Fifth~~ Sixth Edition

Removal of Country of Birth Version Flag

Revision Summary	Remove the Country of Birth Version Flag. • Data item was a temporary measure to ensure the new Country of Birth codeset had been implemented in 2007-08 and is not required for 2008-09.
Implementation Guide	Country of Birth Version Flag 'S' must be removed from the Episode record. The File Structure has been amended.

Country of Birth Version Flag (*Deleted*)

~~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 from 1 July 2007. 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: Country of Birth page 3-**Error! Bookmark not defined.**~~		

~~Administration~~

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

632 Country of Birth Version Flag Not “S” *(Deleted)*

~~***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.~~

Interpreter Required

Revision Summary	Remove Code 3 *Not Stated* and Add Code 9 *Not Stated/Inadequately Described*. This change: • Aligns the VAED with the DHS Common Client Data Set
Implementation Guide	Change code value. Refer to the *Interpreter Required/Preferred Language* business rules table under *Preferred Language* above.

Interpreter Required (*Amended*)

Specification

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

Datatype Numeric ***Form*** Code

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

Location Episode Record

Reported by Public hospitals (voluntary for private hospitals).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set

Code	*Descriptor*
1	Yes
2	No
~~3~~	~~Not Stated~~
9	Not Stated/Inadequately Described

Reporting guide Preferred Language to be asked before Interpreter Required.

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

This data item must:

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

The standard question is:

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

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

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

2 ***No***
Use code 2 if the patient indicates they do not need an interpreter.

Includes:
- Where the Preferred Language is English.

~~3~~ **9** ***Not Stated/Inadequately Described***
Use code ~~3~~ 9 if neither Yes nor No can be accurately ascertained.

Includes:
- Where the Preferred Language is 0002 *Not Stated*.
- Some instances where the Preferred Language is 9000 *Other Languages, nfd* or 0000 *Inadequately described*.

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

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

Related items Section 3: *Country of Birth* page 3-67, *Indigenous Status* page 3-103, and *Preferred Language* page 3-136.

Administration

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

Principal data users Multiple internal and external data users

Collection start 2003-04

Definition source DHS ***Code set source*** ~~DHS~~ CCDS

Interpreter Required and Preferred Language (*Amended*)

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
~~3~~ 9	Not Stated/Inadequately Described	0002
If Preferred Language is		**Then Interpreter Required must be**
<> (0002 or 1201)	Refer VAED Manual Section 9 *Preferred Language*	1, 2
1201	English	2
0002	Not Stated/Inadequately Described	~~3~~ 9

Edits 592 Invalid Comb Int Req/Pref Lang

Marital Status codeset

Revision Summary	*Married* and *De facto* split into two codes, code 6 *Not stated/Inadequately described* becomes *De facto*, and code 9 *Not stated/Inadequately described* added. This change: • Aligns the VAED with the DHS Common Client Data Set
Implementation Guide	The edits relating to this data item, 034 and 061, will not change in function. 034: The new code values will be made 'valid' 061: Triggers when the code is not 1 and the patient is under 16 so is not affected.

Marital Status (*Amended*)

Specification

Definition Current marital status of the person.

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

Code	***Descriptor***
1	Never married
2	Widowed
3	Divorced
4	Separated
5	~~Currently married (including defacto)~~ Married
6	~~Not stated/inadequately described~~ De facto
9	Not stated/inadequately described

Reporting guide Report the current marital status of the person.

Edits
034* Invalid Marital Status
061* Married - Age Not Within Range

Related items -

Administration

Purpose To facilitate social and epidemiological studies.

Principal data users Multiple internal and external users.

Collection start	1979-80		
Definition source	NHDD	***Code set source***	NHDD

Indigenous Status

Revision Summary	Code values change as follows: • 5 changes to 1 • 6 changes to 2 • 7 changes to 3 • 2 changes to 4 The wording of the code descriptions have changed slightly but the meaning is unchanged. Codes 8 and 9 remain unchanged. This change: • Aligns the VAED with the DHS Common Client Data Set
Implementation Guide	The edits relating to this data item, 034 and 061, will not change in function. 070: The new code values will be made 'valid' and the old 'invalid'. 629: Edit is unchanged Other related edits have changed as detailed below.

Indigenous Status *(Amended)*

Specification

Definition

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

Datatype Numeric ***Form*** Code

Field size 1 ***Layout*** N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set

Code	***Descriptor***
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin

Code	Descriptor
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
~~2~~	~~Not indigenous - *Not* Aboriginal or Torres Strait Islander origin~~
~~5~~	~~Indigenous - Aboriginal but not Torres Strait Islander origin~~
~~6~~	~~Indigenous - Torres Strait Islander but not Aboriginal origin~~
~~7~~	~~Indigenous - Aboriginal and Torres Strait Islander origin~~
8	Question unable to be asked
9	Patient refused to answer

Reporting guide

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

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

In Victoria, the community of Torres Strait Island people is small and the community of people of Aboriginal and Torres Strait Island people is smaller again, therefore code ~~6~~ 2 Indigenous-Torres Strait Islander but not Aboriginal origin and code ~~7~~ 3 Indigenous-Aboriginal and Torres Strait Islander origin would not be widely used.

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

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

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

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

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

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

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

Patient is baby or child

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

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

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

Edits

070* Invalid Indigenous Status

234* Aboriginal/Ts Island But Not Aust Born

393* Recip HCA Account, Indig Stat A Or TI

495* Incompat Sep Referral and Indigenous Status

513* Indigenous Status/Preferred Language Mismatch

629 Incompatible Adm Source/Indigenous Status

Related items

Section 2: *Country of Birth*, page 3-**Error! Bookmark not defined.**, and *Preferred Language* page 3-**Error! Bookmark not defined.**.

Administration

Purpose

To:

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

Principal data users

Koori Health Unit (Public Health, DHS).

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

Collection start

1987-88

Definition source NHDD

Code set source NHDD (DHS modified)

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

Effect

NOTIFIABLE

Problem

The E4 Episode Record's Indigenous Status indicates the patient is of Aboriginal or Torres Strait Islander origin ~~(5, 6 or 7)~~ (1, 2 or 3) but the Country of Birth is not one of the codes indicating Australia (1100 to 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 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.

393 Recip HCA Account, Indig Stat A Or TI *(Amended)*

Effect

Warning

Problem

The E4 Episode Record's Account Class is MA *Reciprocal Health Care Agreement* but the Indigenous Status is ~~5, 6 or 7~~ 1, 2 or 3 *Indigenous*. Treatment under a Reciprocal Health Care Agreement (RHCA) is only available to *visitors* to Australia who are ordinarily resident in a country with which Australia has a RHCA.

Remedy

Check Account Class and Indigenous Status, amend as appropriate, and re-transmit the E4

If the patient *was* ordinarily resident in a country with which Australia has an RHCA and the patient *was* an (Australian) Aboriginal or Torres Strait Islander, no further action is required.

495 Incompat Sep Referral and Indigenous Status *(Amended)*

Effect

Warning

Problem

The E4 Episode Record's Separation Referral is K Referral to Aboriginal or Torres Straight Islander (ATSI) service, arranged before discharge but the Indigenous Status is ~~2~~ 4 ~~Not indigenous – not~~ *Neither Aboriginal nor ~~or~~ Torres Straight Islander origin*.

Remedy

Check Indigenous Status and Separation Referral, amend as appropriate, and re-transmit the E4.

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

Effect

NOTIFIABLE

Problem

The E4 Episode Record's Indigenous Status is ~~5, 6 or 7~~ 1, 2 or 3 *Indigenous* but Preferred Language is not 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 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.

Revisions to Record Structures

Episode Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	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	Refer to Section 9
M	Medicare Number	11	26	NNNNNNNNNNN 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, 9
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
2	Patient Days Financial YTD	3	108, 121, 134, 147, 160, 173, 186	Must be present if other Status details are present

Note	Data Item	Field Size	Record Position	Layout/Code Set
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~~ 1, 2, 3, 4, 8, 9
M 6	Criterion for Admission	1	225	B, C, N, U, E, O, S
M	Intended Duration of Stay	1	226	1, 2
M	Hospital Insurance Fund	3	227	Refer to Section 3
M	Hospital Insurance Status	1	230	2, 4, 9
3	Mental Health Legal Status	1	231	1, 2, 9
7	Funding Arrangement	1	232	1, 2, 4, 5, 6, 7 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	4	246	NNNN Refer to Section 3
12	Interpreter Required	1	250	N Refer to Section 3
13	ACAS Status	1	251	N or space Refer to Section 3
15	Mental Health Statewide Patient Identifier	10	252	ODS generated or spaces Refer to Section 3
	Leave Without Permission Days MTD	2	262	NN or spaces
	Leave Without Permission Days Financial YTD	3	264	NNN or spaces
14	Leave Without Permission Days Total	3	267	NNN or spaces

Note	Data Item	Field Size	Record Position	Layout/Code Set
14 16	Palliative Care Patient Days	3	270	NNN or spaces
3	Intention to Readmit	1	273	0, 1, 2, 3, 4, 9
~~M~~	~~COB Version Flag~~	~~1~~	~~274~~	~~S or space~~
M	Date of Birth Accuracy Flag	3	274	AAA Refer to Section 3
		Total ~~274~~ 276		

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

M Mandatory

1 Transfer Source: Mandatory if Admission Source = T, else spaces. Transfer Destination: Mandatory if Separation Mode = T, else spaces.

2 Mandatory in first Status Segment. In any subsequent Status Segment, if any field is present, then all fields for that segment must be present.

3 Mandatory but transmit only when Separation Date is transmitted.

4 Mandatory for public hospital if Separation Mode = H but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.

5 Carer Availability: Mandatory for public hospitals when Care Type is 1, 2, 6, 7, K, 8, 9, F or E but transmit only when Separation Date is transmitted, else spaces. Private hospitals report a space.

6 Criterion for Admission: Code S only for use by Early Parenting Centres.

7 Mandatory for all hospitals involved in contracted care, hub and spoke arrangements, or the Healthstreams Program, else space.

8 Mandatory for all hospitals involved in contracted care arrangements, else space.

9 Mandatory for all hospitals involved in contracted care or Hub and Spoke (only Hub reports) arrangements, else spaces.

10 Mandatory for contracting hospitals, in specific instances. Refer to Section 3.

12 Mandatory for all public hospitals. Private hospitals report codes or spaces.

13 Mandatory for public hospitals when Care Type is 1, 2, 4, 6, 7, K, 8, 9, F or E, and patient age is greater than or equal to 50, and where the episode is not a sameday episode, but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.

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

15 Mandatory for all public hospitals with an approved Mental Health Service when Care Type is 5x. Private hospitals report spaces.

16 Mandatory for all public hospitals when Care Type is 8.

Reference Files

Coding Classification and Grouper Versions

For 2008-09, DHS will use AR-DRG Version 5.2 Grouper.

Information about AR-DRG Version 5.2 can be found on the website of the Commonwealth Department of Health and Ageing (http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-casemix-ardrg1.htm), and in the Australian Refined Diagnosis Related Groups Version 5.2 Definitions Manual.

ICD-10-AM Library File

Separations on or after 1 July 2008 will be verified against the ICD-10-AM Sixth Edition Library File.

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

The ICD-10-AM Sixth Edition Library File for 1 July 2008 will be released at a later date. Updates to this file during 2008-09 will again be published in the HDSS Bulletin, with the web version being amended accordingly at:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

End of Financial Year Considerations

Method for Reporting 'Remaining Ins' on 30 June 2008

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 2008, 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 2008:

- File transmissions with header dates prior to 1 July 2008 must contain records using the 2007–08 format/values.
- File transmissions with header dates of 1 July 2008 and beyond may contain records of patients separated prior to 1 July 2008; if present, those data records must use the 2007-08 format/values.
- File transmissions with header dates of 1 July 2008 and beyond may contain records of unseparated patients (those remaining in on 30 June 2008); if present, those data records must use 2008–09 format/values.
- File transmissions with header dates of 1 July 2008 and beyond must contain records of patients separated on and from 1 July 2008 using the 2008–09 format/values.

Test Transmissions of New 1 July 2008 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 suppled 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 to 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.