

Specifications for revisions to
PRS/2 and the Victorian Admitted
Episodes Dataset (VAED) for
1 July 2009

December 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. Change to deadlines for submission of Diagnosis records, and final consolidation date.
Change required: To allow for earlier access to WIES activity information for reporting and statistical purposes
2. Addition of *Impairment* codes for sub-acute episodes.
Change required:
 - i) To align the VAED with other collections, such as Australasian Rehabilitation Outcomes Centre (AROC).
 - ii) To provide a greater level of detail than the current Clinical Sub-Program codeset allows.
 - iii) To better reflect the information gathered by some services.
3. Addition of Admission and Separation FIM™ Scores.
Change required:
 - i) To align the VAED with other collections, such as Australasian Rehabilitation Outcomes Centre (AROC).
 - ii) The measure has greater clinical relevance for rehabilitation programs.
 - iii) To better reflect the information gathered by some services.
4. Allow statistical admission/separation to/from Palliative Care (Care Type 8) and remove the need to collect *Palliative Care Patient Days*.
Change required:
 - i) Improve data quality in palliative care reporting.
 - ii) Enable funding to be allocated to the type of care provided.
5. Inclusion of *Mental Health Statewide Patient Identifier* (MHSWPI) on Care Type 4 episodes in which an ECT is performed.
Change required: To improve the linkage of data between the datasets with a view to reducing duplicated data entry in the future.
6. Addition of *Program Identifier* to identify episodes admitted under specified programs
Changed required: To enable patients admitted under a specified program to be identified in the data, without affecting other data elements or funding streams.
7. Addition of *Procedure Start Datetime*.
Change required: To assess the length of time a patient waits for surgery.
8. Change of definition for *Admission Type* values to clarify meanings.
Change required:
 - i) To remove ambiguity.
 - ii) To improve data quality and consistency of use across services.
9. Add the Mother's UR number to the baby's record when the baby is born in the hospital.
Change required: To enable reliable data linkage between the mother and baby record for data analysis.
10. Introduction of *Country of Birth* (SACC) codeset 2nd Edition 2008.
Change required: To align with the NHDD.

Introduction

The need for PRS/2 interface modifications

From 1 July 2009, 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 2008* have been considered 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 is information in this document that has 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.
- End of financial year considerations.
- Amended file structures.

The *VAED Manual, 18th Edition, July 2009* will be distributed at a later date. Until then, the *VAED Manual, 17th Edition, July 2008* (and subsequent bulletins) together with this document will form the admitted patient data transmission specification for 2009–10.

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 2008* 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

There are a few features that require explanation:

- New values are marked as (New)
- **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	Australasian 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
KHSU	Koori Human Services 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: Change to deadlines for submission of Diagnosis records, and final consolidation date (*Modified*)

After consideration of the feedback from services, there has been some modification to this proposal. The deadlines will be as follows:

- Diagnosis records to be submitted one month and ten days after the month of separation (current deadline stipulates that the diagnosis record must be submitted one month and seventeen days after the month of separation). The new deadline will be on the 10th of the month, not the 17th.
- Final consolidation on 10 September (current final consolidation date is 17 September)
- Episode records to be submitted one month and ten days after the month in which the patient was admitted.

Proposal 2: Addition of Australian Impairment Codeset (*Adopted*)

This proposal received support from all respondents and the Funding Policy Unit. There was support for both Option 1 and Option 2, so it has been decided to implement Option 1 allowing hospitals to report either Clinical Sub-Program or Impairment codes.

Proposal 3: Addition of Admission and Separation Functional Independence Measure (FIM™ Scores) (*Adopted*)

This proposal received support from all respondents, including some not currently using the measure in their services. Barthel will continue to be collected, and FIM™ will be optional. Some respondents expressed concern that the *Reported For* in the data definition includes Care Type 9 GEM, however it should be noted that FIM™ is optional and only needs to be reported where it is currently collected.

Proposal 4: Allow statistical admission/separation to/from Palliative Care (Care Type 8) and remove the need to collect *Palliative Care Patient Days*. (*Adopted*)

This proposal received unanimous support from health service respondents and is supported within DHS. Therefore the proposal will be implemented without modification.

Proposal 5: Inclusion of *Mental Health Statewide Patient Identifier* (MHSWPI) on same-day ECT Care Type 4 episodes. (*Adopted, with modification*)

The Mental Health & Drugs Division would like to extend the collection of MHSWPI for all Care Type 4 episodes in which an ECT has been performed, which will include multi-day episodes as well as sameday episodes.

The services providing feedback felt that there will be duplication of data entry, however, the MHSWPI is the only reliable linking element between the CMI/ODS and the VAED so is therefore required on both systems.

Proposal 6: Addition of *Employment Status* and *Usual Accommodation Type* for Mental Health episodes. (*Rejected*)

The intention of this proposal was to prepare for the eventual removal of admitted episodes from the CMI/ODS. As this change is not scheduled to occur in the 2009-10 year, this proposal will be postponed for a later date.

Proposal 7: Addition of Program Identifier to identify episodes admitted under specified programs. (*Adopted*)

This proposal was not opposed and will be implemented.

Proposal 8: Addition of data elements relating to ICU/NICU accommodation. **(Rejected)**

Feedback to this proposal was generally negative, with the main reasons for opposition being the lack of integration between systems, the burden of reporting extra data elements that are not currently collected, and the lack of documentation in patient records. As a result, this proposal will not be implemented, but will be revisited as part of the HealthCollect data reform project.

Proposal 9: Addition of Start and End Datetime of a Procedure. **(Adopted, with modification)**

Feedback to this proposal was generally negative, with the main reasons for opposition being the lack of integration between systems, the burden of reporting extra data elements that are not currently collected, the lack of documentation in patient records, and the difficulty in defining a 'procedure'. However, the Access & Metropolitan Performance branch require this data so the proposal will be implemented with modification, collecting only the *Procedure Start Datetime*.

Proposal 10: Change of definition for Admission Type values. **(Adopted)**

Feedback to this proposal was generally positive and it will be implemented.

Proposal 11: Addition of data elements related to birth episodes. **(AGPAR1, AGPAR2 and First Birth Indicator: Rejected; Mother's UR: Adopted)**

Feedback to this proposal was generally negative, with the main reasons for opposition being the duplication of data which is already collected in the Perinatal collection, the burden of reporting extra data elements, and the burden of error checking and correction. As a result of the feedback, and because of the project currently underway to alter the method of data collection for the Perinatal collection (which will enable better linkage of data with the VAED), implementation of the AGPAR1/AGPAR2 and First Birth Indicator will not proceed. However, the Mother's UR on the baby's record will allow for reliable data linkage between mother and baby, improving data quality for analysis. Therefore, the implementation of the Mother's UR on the baby record will proceed.

Proposal 12: Addition of Ready for Separation Datetime data element, relating to patients awaiting referral to other services **(Rejected)**

Feedback to this proposal was generally negative, with the main reasons for opposition being the increased burden of reporting, problems with the definitions for the data element, the lack of documentation in patient records, and the significant change in practice that would be required. As a result, this proposal will not be implemented. However, the increasing importance of this information for clinical development may require the proposal to be revisited as part of HealthCollect data reform, or at some time in the future.

Proposal 13: Introduction of Country of Birth (SACC) codeset 2nd Edition 2008. **(Adopted)**

There was no opposition to this proposal.

Specifications

1 Data Submission Deadlines

Revision Summary	Data submission deadlines for 2009-10 will be as follows: <ul style="list-style-type: none">• Diagnosis records to be submitted one month and ten days after the month of separation (current deadline stipulates that the diagnosis record must be submitted one month and seventeen days after the month of separation). The new deadline will be on the 10th of the month, not the 17th.• Final consolidation on 10 September (current final consolidation date is 17 September)• Episode records to be submitted ten days after the month in which the patient was admitted. For example, the episode for a patient admitted on 3 August must be submitted by 10 September.
Implementation Guide	Data must be received by 5pm (or 12pm if submitting on media) on the 10 th of the month in order to be processed by the due date. Details of submission deadlines and applicable penalties will be published in the <i>Victoria – Public Hospitals & Mental Health Services Policy and Funding Guidelines 2009-10</i> .

2 Addition of Australian Impairment Codeset

Revision Summary	Introduction of Version 1 Australian Impairment codeset for Sub-Acute episodes as an optional field.
Implementation Guide	<p>Impairment to be collected for rehabilitation episodes (Care Types P, 2, 6, 7 and K). For all other episodes, report spaces.</p> <p>Either Clinical Sub-Program or Impairment codes can be reported:</p> <ul style="list-style-type: none"> Hospitals using the Impairment codeset - report only Impairment codes and DHS will programmatically map to Clinical Sub-Program. Hospitals using Clinical Sub-Program - continue to report Clinical Sub-Program only. <p>A mapping table will be provided to allow mapping from Impairment to Clinical Sub-Program, for services who may wish to introduce this codeset.</p>

Data Definition:

Impairment (*New*)

Specification

Definition	The diagnosis, based on the body system manifesting the reason for rehabilitation.		
Datatype	Numeric	Form	Code
Field size	6	Layout	NNNNNN or spaces Left justify, leading zero.
Location	Sub-Acute Record		
Reported by	Public hospitals.		
Reported for	Care Types P, 2, 6, 7 and K. For Care Types 8, 9, F and E, report spaces.		
Reported when	A Separation Date is reported in the Episode Record.		
Code set	Code	Descriptor	
	Stroke		
	011	Left Body Involvement (Right Brain)	
	012	Right Body Involvement (Left Brain)	
	013	Bilateral Involvement	
	014	No Paresis	
	019	Other stroke	
	Brain Dysfunction		
	Non-traumatic brain dysfunction:		
	0211	Sub-arachnoid haemorrhage	
	0212	Anoxic brain damage	
	0213	Other non-traumatic brain dysfunction	

Traumatic brain dysfunction:

- 0221 Open injury
- 0222 Closed injury

Neurological Conditions

- 031 Multiple sclerosis
- 032 Parkinsonism
- 033 Polyneuropathy
- 034 Guillain-Barre Syndrome
- 035 Cerebral Palsy
- 038 Neuromuscular disorders (include motor neuron disease)
- 039 Other neurological disorders

Spinal Cord Dysfunction

Non-traumatic spinal cord dysfunction:

- 04111 Paraplegia, incomplete
- 04112 Paraplegia complete
- 041211 Quadriplegia incomplete C1-4
- 041212 Quadriplegia incomplete C5-8
- 041221 Quadriplegia complete C1-4
- 041222 Quadriplegia complete C5-8
- 0413 Other non-traumatic SCI

Traumatic spinal cord dysfunction:

- 04211 Paraplegia, incomplete
- 04212 Paraplegia complete
- 042211 Quadriplegia incomplete C1-4
- 042212 Quadriplegia incomplete C5-8
- 042221 Quadriplegia complete C1-4
- 042222 Quadriplegia complete C5-8
- 0423 Other traumatic spinal cord dysfunction

Amputation of Limb

- 051 Single Upper Amputation Above the Elbow
- 052 Single Upper Amputation Below the Elbow
- 053 Single Lower Amputation Above the Knee (includes through knee)
- 054 Single Lower Amputation Below the Knee
- 055 Double Lower Amputation Above the Knee (includes through knee)
- 056 Double Lower Amputation Above/below the Knee
- 057 Double Lower Amputation Below the Knee
- 058 Partial Foot Amputation (includes single/double)
- 059 Other Amputation

Arthritis

- 061 Rheumatoid
- 062 Osteoarthritis
- 069 Other Arthritis

Pain Syndromes

- 071 Neck pain
- 072 Back pain
- 073 Extremity pain
- 074 Headache (includes migraine)
- 075 Multi-site pain
- 079 Other pain (includes abdominal/chest wall)

Orthopaedic Conditions

Fracture: (includes dislocation, excludes neurological involvement)

- 08111 Fracture of hip, unilateral (includes #NOF)

- 08112 Fracture of hip, bilateral (includes #NOF)
- 0812 Fracture of shaft of femur (excludes femur involving knee joint)
- 0813 Fracture of pelvis
- 08141 Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
- 08142 Fracture of lower leg, ankle, foot
- 0815 Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
- 0816 Fracture of spine (excludes where the major disorder is pain)
- 0817 Fracture of multiple sites (multiple bones of same lower limb, both lower limbs, lower with upper limb, lower limb with rib or sternum Excludes with brain injury or with spinal cord injury)
- 0819 Other orthopaedic fracture (includes jaw, face, rib, orbit or sites not elsewhere classified)

Post Orthopaedic Surgery: (includes secondary to fracture or arthritis)

- 08211 Unilateral hip replacement
- 08212 Bilateral hip replacement
- 08221 Unilateral knee replacement
- 08222 Bilateral hip replacement
- 08213 Knee and hip replacement same side
- 08232 Knee and hip replacement different sides
- 0824 Shoulder replacement or repair
- 0825 Post spinal surgery (includes nerve root injury (laminectomy, spinal fusion, discectomy; excludes spinal cord injury or caudaequina)
- 0826 Other orthopaedic surgery

Cardiac

- 091 Following recent onset of new cardiac impairment (AMI, heart transplant, cardiac surgery)
- 092 Chronic cardiac insufficiency
- 093 Heart and heart/lung transplant

Pulmonary

- 101 Chronic Obstructive Pulmonary Disease
- 102 Lung Transplant
- 109 Other pulmonary

Burns

- 110 Burns

Congenital Deformities

- 121 Spina Bifida
- 129 Other Congenital

Other Disabling Impairments

- 131 Lymphoedema
- 132 Other disabling impairments

Major Multiple Trauma

- 141 Brain and spinal cord injury
- 142 Brain and multiple fracture/amputation
- 143 Spinal cord and multiple fracture/amputation
- 149 Other multiple trauma

Developmental Disabilities

- 151 Developmental Disabilities

Re-Conditioning/Restorative

- 161 Re-conditioning following surgery
- 162 Re-conditioning following medical illness
- 163 Cancer rehab

Reporting guide

Impairment codes should be assigned by the treating clinician. Code assignment must be supported by the appropriate ICD-10-AM codes reported in the X4/Y4 Diagnosis/Extra Diagnosis Records.

The Australian Rehabilitation Outcomes Centre (AROC) provides guidelines for coding Impairments:
http://chsd.uow.edu.au/aroc/documents/aroc_aicv1_coding_guidelines.pdf

Edits

- 253* Rehab Invalid Clin Sub-Prog or Impairment
- 258* Sub-Acute: No Sub-Acute Record
- 293* Clin Sub-Prog or Impairment Present
- 405* Inapplic Clin Prog or Impairment For Care Type 2
- 454* Incompat Fields for Interim Care

Related items

Section 2: *Rehabilitation Care*.

Section 4: *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K)*, and *Care Type: Designated Paediatric Rehabilitation Program (P)*

Administration

Purpose

To support and further develop casemix classifications for sub-acute episodes of care.

Principal data users

Ambulatory and Continuing Care (Metropolitan Health and Aged Care Services, DHS).

Collection start

2009-10

Definition source

DHS

Code set source

DHS

3 Addition of Admission and Separation Functional Independence Measure (FIM™ Scores)

Revision Summary	Introduction of Admission and Separation FIM™ scores for rehabilitation episodes as an optional field.
Implementation Guide	<p>Barthel Index Scores will still be mandatory but FIM™ scores can also be reported. Services that currently use the FIM™ instrument will report both FIM™ and Barthel, but those who only use the Barthel measure are not required to report FIM™. Note that Barthel Index Scores will continue to be used for funding purposes.</p> <p>Both scores are required for a transitional period to model the mapping of FIM™ to Barthel to ensure the correct result for CRAFT funding. Once the mapping is confirmed, Barthel will no longer be required for those reporting FIM™.</p> <p>FIM™ scores should be reported for rehabilitation episodes (Care Types 2, 6, 7 and K) but may also be reported for GEM episodes (Care Type 9) if services use the measure for those patients.</p>

Data Definitions:

FIM Score on Admission (a) (New)

FIM Score on Separation (b) (New)

Specification

Definition	FIM™ Score, as assessed on admission. FIM™ Score, as assessed on separation.		
Datatype	Numeric	Form	Score
Field size	18	Layout	NNNNNNNNNNNNNNNNNNNN or spaces. Right justified with leading zeros.
Location	Sub-Acute Record		
Reported by	Public hospitals using the FIM™ Instrument.		
Reported for	Care Types F, E, 2, 6, 7, 9 and K. For Care Type 8, report spaces.		
Reported when	A Separation Date is reported in the Episode Record.		
Code set	Report a score for each item (i.e. 1 digit score for 18 items):		

FIM™ Scores

Score Sequence	Motor Subscale	FIM™ Scores
1	Eating	No Helper
2	Grooming	7 = Complete Independence
3	Bathing	6 = Modified Independence
4	Dressing Upper Body	Helper
5	Dressing Lower Body	5 = Supervision or setup
6	Toileting	4 = Minimal assistance
7	Bladder Management	3 = Moderate assistance
8	Bowel Management	2 = Maximal assistance
9	Transfers – Bed/Chair/Wheelchair	1 = Total assistance
10	Transfers - Toilet	
11	Transfers – Bath/Shower	
12	Walk/Wheelchair	
13	Stairs	
	Cognitive Subscale	
14	Comprehension	
15	Expression	
16	Social Interaction	
17	Problem Solving	
18	Memory	

Reporting guide

Assessment of FIM™ Scores is required at admission and separation for all S4 Records (excluding Palliative Care), where the instrument has been used for the assessment of the patient.

Statistical separations:

- From episodes with Care Types F, E, 2, 6, 7, K or 9 to episodes with Care Types F, E, 2, 6, 7, K or 9:
Separation FIM™ of the prior episode may be repeated as the Admission FIM™ of the subsequent episode.
- From episodes with Care Types F or E to episodes with Care Types F or E:
Admission FIM™ of prior episode may be repeated as both the Separation FIM™ of the prior episode and the Admission FIM™ of the subsequent episode.

The FIM™ on Admission should be assessed within 72 hours of episode start.

The FIM™ on Separation should be assessed within 72 hours prior to episode end.

The FIM™ on Separation for patients who die in hospital is 18 (i.e. a score of 1 for each item).

Edits

(a) XXX Invalid Admission FIM™

(b) XXX Invalid Separation FIM™

Related items

Section 3:

- *Functional Assessment Date on Admission*
- *Functional Assessment Date on Separation*
- *Barthel Index Score on Admission*
- *Barthel Index Score on Separation*

Section 4:

- *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), Care Type: Designated Paediatric Rehabilitation Program (P), and Care Type: Interim Care Program (F and E)*

Administration

Purpose

To support and further develop casemix classifications for sub-acute episodes of care.

Principal data users

Ambulatory and Continuing Care (Metropolitan Health and Aged Care Services, DHS).

Collection start

2009-10

Definition source

DHS

**Code set
source**

FIM™

4 Change to allow statistical changes to/from Palliative Care

Revision Summary	Allow patients to be statistically separated to and from Care Type 8 <i>Palliative Care Program</i> to other Care Types.
Implementation Guide	<p>A new episode should be created when a patient moves to or from a designated palliative care program from another care type. The patient must be under the principle care of a palliative care program in order to be reported as Care Type 8 <i>Palliative Care</i>.</p> <p>Statistical changes to and from Palliative Care must follow the established business rules for reporting other statistical changes. Refer to Section 4 of the VAED Manual, <i>Reporting History of Code Changes</i> for further details.</p>

Data Definitions (includes some changes for Specification 5: MHSWPI for ECT episodes):

Care Type (*Amended*)

Specification

Definition	The nature of the clinical service provided to an admitted patient during an episode of care.		
Datatype	Alphanumeric	Form	Code
Field size	2	Layout	AA or NN or NA Left justified, trailing spaces.
Location	Episode Record		
Reported by	All Victorian hospitals (public and private).		
Reported for	All admitted episodes of care.		
Reported when	The Episode Record is reported.		
Code set	Select the first appropriate category:		

Code	Descriptor
F	Interim Care Program – Nursing Home Type
E	Interim Care Program
1	NHT/Non-Acute
P	Designated Paediatric Rehabilitation Program/Unit
2	Designated Rehabilitation Program/Unit: Level 1
6	Designated Rehabilitation Program/Unit: Level 2
7	Designated Rehabilitation Program/Unit: Level 3
K	Non-Designated Rehabilitation Program/Unit
8	Palliative Care Program

5x	Approved Mental Health Service or Psychogeriatric Program: 5T – Mental Health Nursing Home Type 5E – Mental Health Secure Extended Care Unit (SECU) 5K – Child and Adolescent Mental Health Service (CAMHS) 5G – Acute, Aged Persons Mental Health Service (APMH) 5S – Acute, Specialist Mental Health Service 5A – Acute, Adult Mental Health Service
9	Geriatric Evaluation and Management Program
0	Alcohol and Drug Program
4	Other care (Acute) including Qualified newborn
U	Unqualified newborn

Reporting guide

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

F Interim Care Program –Nursing Home Type

Use this Care Type only for a patient admitted to a unit designated to provide Interim Care and who has been classified as NHT.

NHT

Defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner certifies that the patient is in need of acute care.

Such a patient will have been assessed by an Aged Care Assessment Service and will hold a 2624 certificate (formerly NH5 Form).

Private hospitals: Do not use code F.

Excludes:

- NHT/Non-Acute (1)
- Approved Mental Health Service or Psychogeriatric Program Mental Health Nursing Home Type (5T).

E Interim Care Program

Use this Care Type only for a patient admitted to a unit designated to provide Interim Care and who has not been classified as NHT.

Such a patient will have been assessed by an Aged Care Assessment Service and will hold a 2624 certificate (formerly NH5 Form) before 35 days of continuous hospitalisation.

Private hospitals: Do not use code E.

1 NHT/Non-Acute

This Care Type occurs after an admitted patient has been designated NHT or Non-Acute:

NHT

Defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner provides certification documented in the medical record that the patient is in need of acute care.

Non-Acute

The patient has been in one or more hospitals (public and private) for a continuous period of more than 35 days (with a maximum break of seven consecutive days). If this patient had not been a compensable/ineligible patient, they would be deemed to be a Nursing Home Type patient.

Such a patient may or may not have been assessed by an Aged Care Assessment Team and may or may not have an approved 2624 certificate (formerly NH5 Form).

Excludes:

- Interim Care Program – Nursing Home Type (F)
- Approved Mental Health Service or Psychogeriatric Program Mental Health Nursing Home Type (5T).

P Designated Paediatric Rehabilitation Program/Unit

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

Private hospitals: Do not use code P.

2 Designated Rehabilitation Program/Unit: Level 1

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

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

Private hospitals: Do not use code 2.

6 Designated Rehabilitation Program/Unit: Level 2

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

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

7 Designated Rehabilitation Program/Unit: Level 3

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

Private hospitals: Do not use code 7.

K Non-Designated Rehabilitation Program/Unit

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

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

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

Private hospitals: Do not use code K.

8 Palliative Care Program

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

Public hospitals: Code 8 must only be used on formal admission, if the patient receives palliative care under the supervision of a palliative care specialist or physician. A statistical change is permitted when a patient changes between Nursing Home Type (Care Types 1, 5T or F) and Palliative Care.

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

5x Approved Mental Health Service or Psychogeriatric Program

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

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

5T Mental Health Nursing Home Type

This Care Type occurs after an admitted patient has been designated NHT or Non-Acute:

NHT

Defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner certifies that the patient is in need of acute care.

Such a patient may or may not have been assessed by an Aged Psychiatric Assessment and Treatment Team (APATT) or an Aged Care Assessment Service (ACAS) and may or may not have an approved 2624 certificate (formerly NH5 Form).

Excludes:

- Interim Care Program – Nursing Home Type (F)
- NHT/Non-Acute (1).

5E Mental Health Secure Extended Care Unit (SECU)

This Care Type occurs when a patient is admitted to an approved unit designed to accommodate persons who require active clinical care in the secure/safe environment of a locked ward, often with the intention of longer term (extended) care.

Excludes:

- Mental Health Nursing Home Type (5T)
- Community Care Units (CCU) including Vahland CCU
- Aged Person's Mental Health Nursing Homes (APMHNH)
- Psychogeriatric Nursing Homes (PGNH)

5K Child and Adolescent Mental Health Service (CAMHS)

A patient who is admitted to an approved CAMHS unit.

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

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

Excludes:

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

5S Acute, Specialist Mental Health Service

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

Includes:

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

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

5A Acute, Adult Mental Health Service

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

Excludes:

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

9 Geriatric Evaluation and Management Program

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

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

0 Alcohol and Drug Program

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

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

4 Other (Acute) Care including Qualified newborn

Other types of patient:

Includes:

- Same day and acute (except mental health).
- Sameday ECT episodes.
- Acute episodes in which an ECT has been performed but the care is not principally mental health.
- Geriatric respite care.
- Newborn who has been a Qualified newborn for some or all of the duration of this episode.

Excludes:

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

U Unqualified newborn

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

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

Additional Notes:

Newborns

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

Refer to Sections 2 and 4: *Newborn*.

All other episodes

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

For example:

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

There are some circumstances when a patient cannot change between Care Types, for example, a patient cannot move between Care Type 4 and Care Type 8, they must remain under the original Care Type levels of rehabilitation. Further information on changes of Care Type is provided in Sections 2 and 4: *Episode of Care*.

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

Edits

094	Combination A/C Accom Care Med Suff
107	Invalid Care Type
122	Sameday Adm Source/Sep Mode Mismatch
222	Unqual Newborn; Adm Date Not Birth
235	Adm Criterion is N But Care Not 4
250	Deleted – Episode is Sub-Acute
251	Invalid Adm Barthel
252	Invalid Sep Barthel
253	Rehab: Invalid Clin Sub-Prog
254	Rehab: Invalid Adm/Re-Adm to Rehab
255	Rehab: Invalid Onset Date
258	Sub- Acute: No Sub – Acute Record
260	Invalid Care For Qual
261	Newborn Care But Age > 9 Days
262	Invalid Care Type For Newborn
268	Inv Comb Legal, Care & PFS
285	Sub-Acute Record not required
288	Sep Barthel & Sep Mode Incompatible
289	Adm Sce T'fer & Onset = Adm Date
290	Stat Adm Sc & Onset = Adm Date

291 Adm Barthel > Sep Barthel
 292 Sep Barthel Present
 293 Clin Sub-Prog Present
 294 Onset Date Present
 295 Adm/Readmit To Rehab Present
 297 Sep Rug ADL & Sep Mode Incompatible
 298 Adm Barthel Present
 303 Pall Care But Invalid Adm Rug ADL
 304 Pall Care But Invalid Sep Rug ADL
 305 Adm Rug ADL Present
 306 Sep Rug ADL Present
 329 Geri Respite – Invalid Comb
 340 Invalid Source Refer to Pal Care
 341 Source Refer to Pal Care Present
 390 Incompat Care Type, Carer Avail, Age and Sep Mode
 405 Inapplic Clin Prog For Care Type 2
 406 Rehab Care Type W/Out Rehab PDX
 407 Rehab Level 2 or 3 W Low Adm Barthel
 421 Not Separated; Carer Avail Present
 437 NIV Duration for Unqual Newborn
 447 Unqual Newborn; Age at Sep
 448 ICU Stay but Care Type not Acute
 453 Wrong PDx for Interim Care
 454 Incompat Fields for Interim Care
 455 Inconsist Newborn Transferred/Unqual Data
 461 ACAS Status not Required
 463 Accom Type 4, Care Type invalid
 464 Accom Type 7, not Care Type 4
 468 Care Type ≠ 1 or F of 5T, LOS >365 Days
 471 Care Type 5x, not usual Sep Referral
 472 Pall Care, not approved for Palliative Care Program (*Amended*)
 473 Care Type 9, not approved for GEM
 474 Care Type E, LOS > 35 Days
 475 Care Type F or E, not approved for Interim Care
 488 Incompat Care Type/Adm Source Statistical (*Amended*)
 489 Incompat Care Type/Sep Mode Statistical (*Amended*)
 491 Incompat Fields for ESAS
 492 Incompat Fields for RPI
 498 Pall Care without Pall care Diag
 502 Stat Episode: Care Type same as Next Episode
 503 Stat Episode: Care Type same as Prior Episode
 506 Stat Episode: Rehab also in Next Episode
 507 Stat Episode: Rehab also in Prior Episode
 528 ~~Stat Episode Pall: Not NHT in Prior Episode (*Deleted*)~~
 529 ~~Stat Episode Pall: Not NHT in Next Episode (*Deleted*)~~
 532 Account Class MA: not 4, 5E, 5K, 5G, 5S, 5A or U
 533 ACAS Status Code Required
 535 Care Type 5E, not approved for SECU
 536 Care Type 5T, not approved for NHT
 537 Care Type 5K, not approved for CAMHS
 538 Care Type 5G, not approved for Aged Acute
 539 Care Type 5S, not approved for Specialist Acute
 540 Care Type 5A, not approved for Adult Acute
 541 Care Type K, not approved for Non-Desig Rehab
 542 MH Acute Adult Care Type But Age < 14 Years
 543 MH Acute Adult Care Type But Age > 65 Years
 544 MH APMHS Care Type But Age < 55 Years
 545 MH CAMHS Care Type But Age < 5 Years
 546 MH CAMHS Care Type But Age > 19 Years
 547 MH SECU Care Type But Age < 14 Years

548 MH Specialist Acute Care Type But Age < 14 Years
 575 Care Type 5x, MHSWPI Blank
~~578* MHSWPI Present, not Care Type 5x (Amended)~~
 586 Care Type 2, not approved for Rehab Lvl 1
 587 Care Type 6, not approved for Rehab Lvl 2
 588 Care Type 7, not approved for Rehab Lvl 3
 596 Same Day ECT: Not in Care Type 4
 597 Mental Health Episode: Sep Mode = S
 598 Same Day Rehabilitation: Not in Scope
 599 Carer Availability Not Required
~~607 Care Type Pall Care: Pall Care Pt Days not = Pt Days Total (Deleted)~~
~~608 Invalid Palliative Care Pt Days (Deleted)~~
 620 Adm Barthel/Functional Assessment Date/Care Type mismatch
 621 Sep Barthel/Functional Assessment Date/Care Type mismatch
 626 Invalid Combination for Funding Arrangement PHESI
 631 Care Type P, not approved for Paediatric Rehabilitation
~~634 Palliative Care Patient Days = Total LOS, Care Type <=> 8 (Deleted)~~
~~XXX Care Type 4, Procedure code 93341-xx, MHSWPI Blank (New)~~

Related items

Section 2: *Acute Care, Admission, Admitted Patient, Episode of Admitted Patient Care, Geriatric Evaluation and Management Program, Interim Care Program, Newborns, Nursing Home Type/Non-Acute Care, Palliative Care, Rehabilitation Care and Sub-Acute Care.*

Section 4:

- Business Rules (non-tabular) *Episode of Care, Newborn Reporting and Palliative Care Reporting.*
- Business Rules (tabular) *Account Class, Acc Type, Care Type and Medicare Suffix, and Admission Source and Care Type, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type P: Designated Paediatric Rehabilitation, and Care Type: Interim Care Program (F and E), and Care Type and Separation Mode, and Age, Care Type, Carer Availability and Separation Mode, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative, and Funding Arrangement: Private Hospitals Elective Surgery Initiative, and Newborns: Criteria for Admission, Qualification Status, Care Type, and Reporting History of Code Changes.*

Section 5: *Status Segments.*

Section 9:

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

Administration

Purpose

To distinguish various types of care in order to:

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

Principal data users

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

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

Collection start

1995-96

Definition source

DHS

Code set source

DHS

Palliative Care Patient Days (*Deleted*)

Specification

Definition The total number of patient days for which the patient received palliative care under an approved palliative care program during the whole episode of care, excluding leave days.

Datatype Numeric **Form** Quantitative value

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

Location Episode Record

Reported by Public Hospitals

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

[For Care Types 0, 1, 5x, F and U, report spaces in this field.]

Otherwise, report spaces.

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

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

Reporting guide Palliative Care Patient Days is reported for patients treated under approved programs, as defined by the Cancer and Palliative Care unit. An approved program is one funded specifically for the delivery of palliative care to patients by suitably qualified staff. The list of public hospitals authorised to report this data item is the same as those eligible to report a Care Type of 8.

A day should be reported as a Palliative Care Patient Day when the Palliative care program was primarily responsible for the patients care.

Palliative Care Patient Days must be equal to or less than Patient Days Total. Where the Care Type is not 8, the Palliative Care Patient Days should not equal the total length of stay.

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

Edits

- 472 — Pall Care, not approved for Palliative Care Program
- 498 — Pall Care without Pall Care Diag
- 609 — Pall Care Pt Days > Patient Days Total
- 612 — Palliative Care mismatch
- 613 — Pall Care Diag no Pall Care (at approved campus)
- 634 — Palliative Care Patient Days = Total LOS, Care Type <> 8

Related items

Section 2: ~~Episode of Admitted Patient Care, Leave With Permission, Palliative Care and Patient Day.~~

Section 3: ~~Care Type, page 3-18, Diagnosis Code, page 3-**Error! Bookmark not defined.**, and Patient Days Total, page 3-**Error! Bookmark not defined.**~~

Section 4:

- ~~Business Rules (non-tabular) Palliative Care Reporting~~
- ~~Business Rules (tabular) Care Type and Palliative Care Patient Days~~

Section 9:

- ~~Care Type 8 and Palliative Care Patient Days: Palliative Care Program.~~

Administration

Purpose

~~To measure the demand for palliative care services for:~~

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

Principal data users

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

Collection start

~~2005-06~~

Definition source

DHS

Code set source

DHS

5 Inclusion of Mental Health Statewide Patient Identifier (MHSWPI) on ECT Care Type 4 episodes

Revision Summary	Mental Health Statewide Patient Identifier (MHSWPI) to be reported for all Care Type 4 episodes in which an ECT has been performed.
Implementation Guide	<p>Episodes reported with an ACHI code 93341-* will require a MHSWPI to be reported.</p> <p>Due to the complexity of editing the contents of episode records against diagnosis records, some edits may be relaxed. For example, edit 578 <i>MHSWPI Present, not Care Type 5x</i> will be amended to allow MHSWPI to be accepted for any Care Type 4 record, and output editing undertaken as a data quality exercise on a regular basis to identify any records with unusual or incorrect data combinations. Edit XXX <i>Care Type 4, Procedure Code 93341-xx MHSWPI mismatch</i> will reject records with invalid combinations of data.</p>

Data Definitions (see also Specification 4: *Palliative Care* for changes to the *Care Type* data element:

Mental Health Statewide Patient Identifier (Amended)

Specification

Definition	The client identifier, unique to the client for approved Mental Health Service and Psychogeriatric Programs.		
Datatype	Alphanumeric	Form	Code
Field size	10	Layout	NNNNNNNNNN or spaces Right justified, zero filled.
Location	Episode Record		
Reported by	All Victorian public hospitals with an approved Mental Health Service. Private hospitals: Report spaces in this field.		
Reported for	All mental health admitted episodes of care (Care Type 5x) and Care Type 4 episodes in which an ECT has been performed.		
Reported when	The episode record is reported.		
Code set	ODS generated.		
Reporting guide	Report the primary Mental Health Statewide Patient Identifier for all mental health episodes of care (Care Types 5x) and episodes reported with Care Type 4 in which an ECT has been performed, and with an ACHI code in the range 93341-00 to 93341-99.		
Edits	575	Care Type 5x, MHSWPI Blank	
	576	Invalid MHSWPI	
	577	MHSWPI not on ODS	

578 MHSWPI Present, not Care Type 5x (Amended)
 579 MHSWPI Valid, no Matching DOB
 580 MHSWPI Valid, no Matching Sex
 581 MHSWPI Valid, Secondary on ODS
 XXX Care Type 4, Procedure Code 93341-xx MHSWPI mismatch (New)

Related items

Section 9:

- Supplementary Code Lists: Care Type *Care Type 5A: Mental Health Service and Psychogeriatric Program – Acute, Adult Mental Health Service*, and *Care Type 5E: Mental Health Service and Psychogeriatric Program – Mental Health Secure Extended Care Unit (SECU)*, and *Care Type 5G: Mental Health Service and Psychogeriatric Program – Acute, Aged Persons Mental Health Service (APMH)*, and *Care Type 5K: Mental Health Service and Psychogeriatric Program – Child and Adolescent Mental Health Service (CAMHS)*, and *Care Type 5S: Mental Health Service and Psychogeriatric Program – Acute, Specialist Mental Health Service*, and *Care Type 5T: Mental Health Service and Psychogeriatric Program – Mental Health Nursing Home Type*.

Administration

Purpose To enable management of clients and their associated data.

Principal data users Mental Health Branch, DHS

Collection start 2004-05

Definition source DHS **Code set source** ODS generated

6 Addition of Program Identifier to identify episodes admitted under specified programs

Data Definitions:

Revision Summary	Addition of a new data element, <i>Program Identifier</i> , to enable patients admitted under various programs to be identified in the data.
Implementation Guide	The addition of this new data element will enable patients admitted under a specified program to be identified in the data, without affecting other data elements or funding streams. Codes for various programs may be added and de-activated as required.

Program Identifier (*New*)

Specification

Definition Identifies the specified program, if any, which applies to this episode of care.

Datatype Alphanumeric **Form** Code

Field size 2 **Layout** NN or space

Location Episode Record

Reported by Public and Private Hospitals.

Reported for Episodes for patients admitted under a specified DHS program.

Otherwise, report a space in this field.

Reported when An Episode Record is transmitted.

Code set

Code	Descriptor
01	Winter Demand Strategy
02	23 Hour Surgery Unit

Reporting guide Report the corresponding code for the program when advised to do so by the Department of Human Services' unit responsible for administration of the program, or by HDSS.

Edits XXX Invalid Program Identifier

Related items

Administration

Purpose To:

- Identify whether a specified program applies to this episode.
- Facilitate health services planning and monitoring.

Principal data users Multiple internal and external data users.

Collection start 2009-10

Definition source DHS **Code set source** DHS

7 Addition of Procedure Start Datetime

Revision Summary	Addition of a new data element: <i>Procedure Start Datetime</i> . The introduction of these data elements would enable the Department to collect patient level information relating to surgery and procedures, which will inform service and resource planning.
Implementation Guide	Where a patient experiences more than one visit to theatre during the episode of care, only information on the first visit will be collected. Although limiting to one visit will not provide optimal information, the current structural limitations of PRS/2 file structures precludes collecting multiple visit information.

Procedure Start Datetime (*New*)

Specification

Definition	Date and Time at which a procedure commenced for an admitted patient.		
Datatype	Numeric	Form	Datetime
Field size	12	Layout	DDMMYYYYHHMM or spaces
Location	Diagnosis Record		
Reported by	All Victorian hospitals (public and private).		
Reported for	All admitted episodes of care where a procedure occurring in an operating room or a cardiac catheter laboratory or involving a scope is recorded as the first coded procedure. (Note: Time of procedure is optional and may be reported as spaces, e.g. '01052009 ').		
Reported when	The Diagnosis Record is reported.		
Code set	Valid datetime.		
Reporting guide	Procedure Start Datetime should be reported for an episode where the first coded procedure: (i) Occurred in an operating room (procedures with an 'OR Flag' of 'O' in the ICD-10-AM Library File for the current year. The Library file is available from: http://www.health.vic.gov.au/hdss/icdcoding/libfilesindex.htm); or (ii) Occurs in a cardiac catheter laboratory (list of ICD-10-AM procedure codes to be provided as a reference file); or (iii) Involves the use of a scope (list of ICD-10-AM procedure codes to be provided as a reference file). The procedure is deemed to have commenced when:		

- For (i) above: the first incision is made for a surgical procedure.
- For (ii) and (iii) above - the instrument is inserted.

If the time of commencement is not available report DDMMYYYY and four spaces. If this data element is inapplicable to the episode, report all spaces in this field.

Edits

XXX	Invalid Procedure Start DateTime
XXX	Proc Start DateTime < Adm Date or > Sep Date
XXX	Proc Start DateTime and Valid Proc Mismatch

Related items Section 3 *Procedure codes*

Administration

Purpose To enable analysis of wait times for surgical and significant procedures.

Principal data users Access & Metropolitan Performance, DHS

Collection start 2009-10

Definition source DHS

8 Change of definition for Admission Type values

Revision Summary	Clarify the definitions of Admission Types L (<i>Admission – From the Waiting List</i>) and X (<i>Other Admission</i>), and C (<i>Emergency admission through Emergency Department at this hospital</i>) and O (<i>Other emergency admission</i>) to enable consistent reporting across services.
Implementation Guide	<p>Admission Type C – Hospitals reporting to VEMD only</p> <p>Admission Type O – All other emergency admissions</p> <p>Admission Type L – Episodes for patients admitted from the ESIS waiting list</p> <p>Admission Type X – All other planned admissions (including bookings)</p> <p>Assignment of Admission Type must be according to the hierarchy of codes, that is, the first applicable code in the list should be chosen.</p>

Admission Type (*Amended*)

Specification

Definition	The category of admission (patient characteristic) relating to this episode of care.		
Datatype	Alpha	Form	Code
Field size	1	Layout	A
Location	Episode Record		
Reported by	All Victorian hospitals (public and private).		
Reported for	All admitted episodes of care.		
Reported when	The Episode Record is reported.		
Code set	Select the first appropriate category:		
	Code	Descriptor	
	S	Statistical admission (change in Care Type within this hospital)	
	Y	Birth episode	
	M	Maternity	
	C	Emergency admission through Emergency Department at this hospital (VEMD Only)	
	L	Admission – from the Waiting List (ESIS Episodes Only)	
	O	Other emergency admission	
	X	Other admission	
Reporting guide	<p>S Statistical admission (change in Care Type within this hospital) Used for statistical admissions.</p> <p>Y Birth episode Admission of newborn at or directly after birth.</p>		

Excludes second or subsequent admissions in the newborn period:

- Newborns admitted after the birth episode, while still nine (9) days old or less (use code C, L, O or X).

M Maternity

Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy.

C Emergency admission through Emergency Department at this hospital (VEMD only)

Admission of an emergency patient, arising from presentation at the Emergency Department of this hospital.

Use of this code is **not** limited to those facilities that report to the Victorian Emergency Minimum Dataset (VEMD).

Includes:

- Threatened miscarriage before 20 weeks.

Excludes:

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).

L Admission – from the Waiting List (ESIS Episodes only)

Admission of a patient currently on the waiting list for elective medical or surgical treatment as an admitted patient. Waiting list patients include only those elective admissions for whom names, addresses and other necessary details are held by the hospital on a specific list prepared from a written request for admission from the patient's doctor.

Use of this code is **not** limited to those episodes that required to be reported to the Elective Surgery Information System (ESIS).

Includes:

Non-elective admissions managed through the use of a 'waiting list', for example rehabilitation episodes.

Excludes:

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).

O Other emergency admission

Admission of an emergency patient, not arising from presentation at the Emergency Department at this hospital, or arising from presentation at the Emergency Department of a hospital which does not report data to the Victorian Emergency Minimum Dataset (VEMD).

Includes:

- GP-referred admission or self-referral for acute illness (such as unstable diabetes, CCF, pneumonia, asthma attack) directly for emergency admission.
- Threatened miscarriage before 20 weeks.
- Emergency admission to a hospital without a formal Emergency Department.
- Emergency admission to a hospital which does not report data to the Victorian Emergency Minimum Dataset (VEMD).
- Admission from Outpatient Department where patient is an emergency patient.

Excludes:

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).
- Admission via the emergency department where the hospital reports to the VEMD (use C).

X Other admission

Routine or elective admission regardless of expected length of stay, where the patient is not recorded on the waiting list or the patient is recorded on a waiting list of a hospital which does not report to the Elective Surgery Information System (ESIS).

Includes:

- Admission from the waiting list of a hospital which does not report to the Elective Surgery Information System (ESIS).
- Planned admission for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.
- Admission from Outpatient Department where patient is an elective patient.
- Follow-up admission following a previous emergency admission or presentation where the patient has not been added to an elective surgery waiting list.

Edits

052	Invalid Adm Type
056	Incompatible Adm Type/Source
057	Incompat Adm Type/Age
059	Maternity - Not Female
328	Early Parenting Centre – Invalid Comb
329	Geriatric Respite - Invalid Comb
336	Invalid Comb For Crit Care Transfer
454	Incompat Fields for Interim Care
455	Inconsist Newborn Transferred/Unqual Data
466	Adm Type L & Newborn Qual Status
484	Incompat Adm Type/Crit for Adm
485	Incompat Adm Type/Qual Stat
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
626	Invalid Combination for Funding Arrangement PHESI
633	Delivery Episode, Adm Type not M

Related items Section 2: *Admission, Geriatric Respite, Newborn, and Urgency of Admission.*

Section 4:

- Business Rules (non-tabular) *Newborn Reporting.*
- Business Rules (tabular) *Account Class: Geriatric Respite, and Admission Source and Admission Type, and Admission Type and Age, and Admission Type and Criterion For Admission, and Admission Type and Qualification Status, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type P: Designated Paediatric Rehabilitation Program, and Care Type: Interim Care Program (F and E), and Criterion for Admission, Age, Admission Type, Admission Source, Qualification Status, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative and Funding Arrangement: Private Hospital Elective Surgery Initiative.*

Administration

Purpose	To:		
		<ul style="list-style-type: none">• Distinguish between emergency and non-emergency admissions.• Monitor admissions from the Waiting List.• Identify data for maternity and birth episodes.	
Principal data users	Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).		
Collection start	1979-80		
Definition source	DHS	Code set source	DHS

9 – Addition of Mother’s UR number on baby’s episode

Revision Summary	Addition of the Mother’s UR Number (Patient Identifier), to be reported on the baby’s episode record.
Implementation Guide	The Mother’s UR number (Patient Identifier) to be reported on the baby’s episode record when both the mother and baby are admitted.

Data Definitions:

Mother’s UR (*New*)

Specification

Definition	The UR Number (Patient Identifier) of the mother of the baby.		
Datatype	Alphanumeric	Form	Code
Field size	10	Layout	XXXXXXXXXX or spaces Right justified, zero filled.
Location	Episode Record		
Reported by	Victorian hospitals (public and private).		
Reported for	Public Hospitals: Newborn episodes where both mother and baby are admitted. Private hospitals: Newborn episodes where both mother and baby are admitted, and the newborn episode is reported.		
Reported when	The Episode Record is reported.		
Code set	Valid Patient Identifier.		
Reporting guide	When the baby is born in hospital during this episode of care, report the Patient Identifier of the mother’s episode of care. If the baby was not born during this episode of care, but both mother and baby are admitted to the hospital, report the Patient Identifier of the mother’s episode of care.		
Edits	XXX Invalid format Mother’s UR (<i>New</i>) XXX Mother’s UR does not exist (<i>New</i>) XXX Mother’s UR and Admission Source mismatch (<i>New</i>)		
Related items	Section 3: <i>Patient Identifier</i>		

Administration

Purpose	To enable analysis of the factors affecting the care of both the mother and baby.
Principal data users	Internal and External data users.

Collection start 2009-10

Definition source DHS

Code set source Hospitals

10 Introduction of Country of Birth (SACC) codeset 2nd Edition 2008

Revision Summary	Revision of the <i>Country of Birth and Country of Residence</i> codeset to be consistent with the Standard Australian Classification of Countries (SACC) Second Edition 2008.
Implementation Guide	The SACC codeset is used for the <i>Country of Birth</i> data element, as well as for reporting country of residence for overseas patients in the <i>Locality</i> data element.

Data Definitions:

Country of Birth

Specification

Definition	The country in which the person was born.		
Datatype	Numeric	Form	Code
Field size	4	Layout	NNNN
Location	Episode Record		
Reported by	All Victorian hospitals (public and private).		
Reported for	All admitted episodes of care.		
Reported when	The Episode Record is reported.		
Code set	Refer to Section 9: <i>Supplementary Code Lists</i> .		
Reporting guide	Report the country in which the patient was born, not the country of residence.		
Edits	036* Invalid Country of Birth 069* Newborn From Overseas 228 Unusual Birth Place 234 Aboriginal/Ts Islander But Not Aust Born 392 Recip HCA Account, Not O/Seas Born 571* Acct Recip, Pcode Oseas, Locality not RHCA 574* Postcode Overseas, Locality RHCA, Acct not RHCA		
Related items	Section 9: <ul style="list-style-type: none">• Supplementary Code Lists <i>Country of Birth</i>		

Administration

Purpose	To facilitate epidemiological studies.
Principal data users	Multiple internal and external data users.

Collection start 1979-80

Definition source NHDD SACC Country of Birth, Second Edition – DHS modified

Code set source DHS

Changed in name

Code	SACC Second Edition for 1 July 2009	Formerly
2100	United Kingdom, Channel Islands and Isle of Man	United Kingdom
2402	Faroe Islands	Faeroe Islands
5105	Vietnam	Viet Nam
6101	China (Excludes SARS and Taiwan)	China (Excludes SARS and Taiwan Province)
7206	Kyrgyzstan	Kyrgyz Republic

Added to the classification

Code	SACC Second Edition for 1 July 2009	Formerly in or part of
1513	Pitcairn Islands	1599 Polynesia (excludes Hawaii), nec
2107	Guernsey	2101 Channel Islands
2108	Jersey	2101 Channel Islands
2408	Aland Islands	2403 Finland
3216	Kosovo	3215 Serbia
4108	Spanish North Africa	4199 North Africa, nec
8431	St Barthelemy	8413 Guadeloupe
8432	St Martin (French part)	8413 Guadeloupe

Removed from the classification

Code	Name	SACC Second Edition for 1 July 2009
2101	Channel Islands	Separately identified as 2107 Guernsey and 2108 Jersey
4199	North Africa, nec	All parts now in 4108 Spanish North Africa

Business Rules (Non-Tabular):

Palliative Care Reporting (*Amended*)

Guide for use

The Palliative Care Type and Palliative Care Patient Days are only reported to the VAED for patients admitted to, or transferred to, a designated Palliative Care program 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. This activity counts towards palliative care targets.

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 (*Amended*)

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*

Business Rules (Tabular):

Care Type and Palliative Care Patient Days (Deleted)

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) (Amended)

If Care Type is 2 Designated Rehabilitation Program/Unit: Level 1, 6 Designated Rehabilitation Program/Unit: Level 2, 7 Designated Rehabilitation Program/Unit: Level 3 or K Non-Designated Rehabilitation Program/Unit then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

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

Field	Valid codes
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
FIM™ Score on Admission	Range 111111111111111111 to 7777777777777777, or spaces
FIM™ Score on Separation	Range 111111111111111111 to 7777777777777777, or spaces
Functional Assessment Date on Admission	DDMMCCYY
Functional Assessment Date on Separation	DDMMCCYY or spaces

Field	Valid codes
Clinical Sub-program	
If Care Type 2	02x, 04x, 05x (If Impairment is reported, may be spaces)
If Care Type 6, 7, K	Any code from list see section 3 (If Impairment is reported, may be spaces)
Impairment	
If Care Type 2	02x, 04x, 05x (If Clinical Sub-Program is reported, may be spaces)
If Care Type 6, 7, K	Any code from list see section 3 (If Clinical Sub-Program is reported, may be spaces)
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) (Amended)

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
FIM™ Score on Admission	Range 111111111111111111 to 7777777777777777, or spaces
FIM™ Score on Separation	Range 111111111111111111 to 7777777777777777, or spaces
Functional Assessment Date on Admission	Spaces
Functional Assessment Date on Separation	Spaces
Clinical Sub-program	Any code from list see section 3 (If Impairment is reported, may be spaces)
Impairment	Any code from list see section 3 (If Clinical Sub-Program is reported, may be spaces)
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) (Amended)

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
FIM™ Score on Admission	Range 111111111111111111 to 7777777777777777, or spaces
FIM™ Score on Separation	Range 111111111111111111 to 7777777777777777, or spaces
Functional Assessment Date on Admission	DDMMCCYY
Functional Assessment Date on Separation	DDMMCCYY or spaces
Clinical Sub-Program *	Spaces
Impairment	Spaces
Onset Date *	Spaces

Field	Valid codes
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

Edits:

Amended Edits:

248 Tran Pt ID Not Same As Episode Or Subac (Amended)

Effect	Warning
Problem	The Public Hospital S4 Sub-Acute Record's Unique Key/Patient Identifier does not match that in an E4 Episode Record or an S4 already on file.
Remedy	Check Patient Identifier and Unique Key in both the S4 and E4, amend as appropriate, and re-transmit the E4 and/or S4. If there is an S4 already on file with an incorrect Unique Key, delete it by re-transmitting the S4 with the Clinical Sub-Program or Impairment filled with 9s. If there is no earlier S4 on file, no action is necessary.

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

Effect	REJECTION
Problem	The E4 Episode Record's Care Type is P, 2, 6, 7 or K Rehabilitation but the S4 Sub-Acute Record's Clinical Sub-Program or Impairment code is invalid.
Remedy	Check Care Type (E4), and Clinical Sub-Program (S4), Impairment (S4) , amend as appropriate and re-transmit the E4 and/or S4. Refer to: Section 4: Business Rules (tabular) <i>Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), Care Type P: Designated Paediatric Rehabilitation Program/Unit.</i>

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

Effect	Warning
Problem	<p>The Public Hospital E4 Episode Record's Care Type is P, 2, 6, 7 or K Rehabilitation, 8 Palliative Care, 9 Geriatric Evaluation and Management Program or F or E Interim Care, and a Separation Date is present, however there has been no S4 Sub-Acute Record accepted for this patient.</p> <p>Triggers for this edit are: If Care Type = P, 2, 6, 7 or K, Clinical Sub-Program AND Impairment is not present. If Care Type = 9, E or F, Barthel Index on Admission is not present. If Care Type = 8, RUG ADL on Admission is not present.</p>
Remedy	<p>Check Care Type, Separation Date (E4) and all S4 data items (Admission/Readmission to Rehabilitation, Barthel Index Score on Admission and Separation, Clinical Sub-Program, Impairment, Onset Date, RUG ADL on Admission and Separation and Source of Referral to Palliative Care), amend as appropriate, and re-transmit the E4 and/or S4.</p> <p>If Care Type is correct, investigate why no S4 is recorded: if it has been submitted but rejected, amend and re-transmit; if the information is not yet available, ensure the S4 is submitted as soon as possible. If the patient is not yet separated, delete the Separation Date.</p>

293 Clin Sub-Program **or Impairment** Present (Amended)

Effect	REJECTION
Problem	The E4 Episode Record's Care Type is 8 Palliative Care, 9 Geriatric Evaluation and Management Program, or F or E Interim Care but the S4 Sub-Acute Record has a Clinical Sub-Program or Impairment code .
Remedy	Check Care Type (E4) I and Clinical Sub-Program (S4), and Impairment (S4) , amend as appropriate and re-transmit the E4 and/or S4.

405 Inapplic Clin Prog or Impairment For Care Type 2 (Amended)

Effect REJECTION

Problem The E4 Episode Record's Care Type is 2 *Rehabilitation–Level 1* but the S4 Sub-Acute Record's Clinical Sub-Program **or Impairment code** does not justify Level 1 Rehabilitation (and then only for the rehabilitation episode following acute treatment). The categories justifying Level 1 are represented by Clinical Sub-Programs **Impairment**:

- 02x Head injury
- 04x Spinal cord or
- 05x Amputation of limb.

Remedy Check Care Type (E4) **and** Clinical Sub-Program (S4), **and Impairment (S4)**, amend as appropriate and re-transmit the E4 and/or S4. If this is not the rehabilitation episode following acute treatment for head injury, spinal cord injury or amputation of limb, amend the Care Type to 6, 7 or K. If this is a rehabilitation episode following acute treatment for the relevant conditions, amend the Clinical Sub-Program **or Impairment code**.

Refer to:
Section 4: Business Rules (tabular) *Care Type: Designated and Non-Designated Rehabilitation Program (2, 6, 7 or K)*.

472 Pall Care, not approved for Palliative Care Program (Amended)

Effect REJECTION

Problem **The E4 Episode Record's Care Type is 8 Palliative Care This is a Palliative Care episode (represented by Care Type 8 and/or the presence of Palliative Care Patient Days in the E4 Episode Record)** yet this Hospital Campus is not approved to provide Palliative Care.

Remedy Check Care Type **and Palliative Care Patient Days**, amend as appropriate and re-transmit the E4. If you believe that this Hospital Campus is approved to report palliative care episodes under approved palliative care programs, contact the HDSS Help Desk.

Refer to Supplementary Code Lists Care Type 8 **and Palliative Care Days: Palliative Care Program:**
<http://www.health.vic.gov.au/hdss/reffiles/index.htm>

488 Incompat Care Type/Adm Source Statistical (*Amended*)

Effect REJECTION

Problem The E4 Episode Record has an invalid Care Type with Admission Source S
Statistical Admission (change in care type within this hospital).

Remedy Check Admission Source and Care Type, amend as appropriate and re-transmit
the E4.

In a public hospital, Care Type 0 *Alcohol & Drug Program* can only be used on
formal admission, not for statistical admission (private hospitals can have Care
Type 0 with a statistical Admission Source).

Care Type 8 Palliative Care Program must only be used on formal admission,
unless the episode is changing from Nursing Home Type (Care Type F, 1, 5T) to
Palliative Care (Care Type 8). A statistical admission is permitted only in this
instance.

Statistical changes between qualified and unqualified status of newborns are not
permitted. These changes are recorded in the Qualification Status field of the
Status Segments. Refer to Section 2: *Newborns*. Therefore statistical separation
from Care Type U with a subsequent statistical admission to a Care Type 4 is not
permissible.

Refer to:

Section 4: Business Rules (tabular) *Admission Source and Care Type*.

489 Incompat Care Type/Sep Mode Statistical (Amended)

Effect	REJECTION
Problem	The E4 Episode Record has an invalid Care Type with Separation Mode S <i>Statistical Separation (change in care type within this hospital)</i> .
Remedy	Check Care Type and Separation Mode, amend as appropriate and re-transmit the E4.

~~Patients admitted with a Care Type of 8 Palliative Care Program must remain so until they are formally separated, unless the episode is changing from Palliative Care (Care Type 8) to Nursing Home Type (Care Type F, 1, 5T). A statistical separation is permitted only in this instance.~~

Statistical changes between qualified and unqualified status of newborns is not permitted. These changes are recorded in the Qualification Status field of the Status Segments. Refer to Section 2: *Newborns*. Therefore statistical separation from Care Type U with a subsequent statistical admission to a Care Type 4 is not permissible.

Refer to:
Section 4: Business Rules (tabular) *Care Type and Separation Mode*.

578 MHSWPI Present, Not Care Type 5x or 4 (Amended)

Effect	REJECTION
Problem	The E4 Episode Record contains a Mental Health Statewide Patient Identifier, but the Care Type is not 5x <i>Approved Mental Health Service or Psychogeriatric Program</i> or Care Type 4 (in the case of ECT episodes).
	Note: MHSWPI should only be reported on Care Type 4 episodes when an ECT has been performed. However, this edit will not check the X4 Diagnosis Record for the presence of the ACHI code for an ECT. That function will be incorporated into Edit XXX <i>Care Type 4, Procedure Code 93341-xx MHSWPI mismatch</i>.
Remedy	Check Care Type and Mental Health Statewide Patient Identifier, amend as appropriate and re-transmit the E4.

613 Pall Care diag, no Pall Care (at approved campus) (*Amended*)

Effect	Warning
Problem	This hospital campus is approved to provide Palliative Care. The E4 Episode Record is neither not Care Type 8 Palliative Care nor has Palliative Care Patient Days reported , yet the X4/Y4 Diagnosis Record for this episode has a Diagnosis Code indicating that palliative care was provided during the episode (Z51.5 Palliative Care).
Remedy	Check Care Type, Palliative Care Patient Days and the Diagnosis Code, amend as appropriate and retransmit as required.

Edits with changed functionality but no change to wording:

R454 *Incompatible Fields for Interim Care*: Impairment added to the edit, as per edit table *Care Type: Interim Care Program (F and E)*

R036 *Invalid Country of Birth*: New SACC codelist to be used.

R069 *Newborn from Overseas*: New SACC codelist to be used.

R571 *Acct Recip, Pcode Overseas, Locality not RHCA*: New SACC codelist to be used.

R574 *Postcode Overseas, Locality RHCA, Acct not RHCA*: New SACC codelist to be used.

New Edits:

XXX Invalid Admission FIM™ (New)

Effect	REJECTION (S4)
Problem	The S4 Sub-Acute Record's FIM™ Score on Admission is in an invalid format (i.e. not NNNNNNNNNNNNNNNNNNN or spaces).
Remedy	Check FIM™ Score on Admission (S4), amend as appropriate and re-transmit the S4.

XXX Invalid Separation FIM™ (New)

Effect	REJECTION (S4)
Problem	The S4 Sub-Acute Record's FIM™ Score on Separation is in an invalid format (i.e. not NNNNNNNNNNNNNNNNNNN or spaces).
Remedy	Check FIM™ Score on Separation (S4), amend as appropriate and re-transmit the S4.

XXX Care Type 4, Procedure Code 93341-xx MHSWPI mismatch (New)

Effect	REJECTION (X4 NEW/UPD, AND E4 UPD)
Problem	The E4 Episode Record has Care Type 4 but either: <ul style="list-style-type: none">• The E4 Episode Record has no Mental Health Statewide Patient Identifier (MHSWPI), but the X4 Diagnosis Record has ACHI code 93341-xx, OR• The E4 Episode Record has a Mental Health Statewide Patient Identifier (MHSWPI), but the X4 Diagnosis Record does not contain ACHI code 93341-xx.
Remedy	Check the E4 Episode Record Care Type and MHSWPI and the X4 Diagnosis Record. For episodes in which an ECT has been performed, the X4 Diagnosis Record should contain ACHI code 93341-xx, and the E4 Episode Record should have a Mental Health Statewide Patient Identifier (MHSWPI).

XXX Invalid Program Identifier (*New*)

Effect REJECTION (E4)

Problem The E4 Episode Record has a Program Identifier which is:

- Invalid, OR
- Has an end-date before the episode Admission Date (that is, was not valid at the time the patient was admitted), OR
- Has start-date after the episode Admission Date (that is, was not valid at the time the patient was admitted).

Remedy Check the E4 Episode Record Program Identifier and Admission Date.

XXX Invalid format Mother's UR (*New*)

Effect REJECTION (E4)

Problem The E4 Episode Record has a Mother's UR number which is not in a valid format.

Remedy Check the E4 Episode Mother's UR Number.

XXX Mother's UR and Admission Source mismatch (*New*)

Effect REJECTION (E4)

Problem The E4 Episode Record has either:

- A Mother's UR number but the patient was not 9 days old or less on admission, OR
- The Admission Source is Y indicating the baby was born in hospital, but a Mother's UR has not been reported

Remedy Check the E4 Episode Record Mother's UR Number, Date of Birth, Admission Date and Admission Source.

XXX Mother's UR does not exist (*New*)

Effect NOTIFIABLE (E4)

Problem The E4 Episode Record has a Mother's UR which has not been reported for this campus.

Remedy Check the E4 Episode Record Mother's UR Number, and Admission Source.

XXX Invalid Procedure Start DateTime (*New*)

Effect REJECTION (X4)

Problem The E4 Episode Record has an invalid *Procedure Start DateTime*.

Remedy Check the E4 Episode Record *Procedure Start DateTime*.

XXX Proc Start DateTime < Adm Date or > Sep Date (*New*)

Effect REJECTION (X4)

Problem The X4 Diagnosis Record has a *Procedure Start DateTime* that is either less than the Admission Date or greater than the Separation Date.

Remedy Check the X4 Diagnosis Record *Procedure Start DateTime*, E4 Episode Record Admission Date and Separation Date.

XXX Proc Start DateTime and Valid Proc Mismatch (New)

Effect	REJECTION (X4)
Problem	The X4 Diagnosis Record has either reported a <i>Procedure Start DateTime</i> but no valid Procedure code, or has reported a valid Procedure code and no <i>Procedure Start DateTime</i> .
Remedy	Check the X4 Diagnosis Record Procedure Start DateTime and the Procedure Code. The Procedure Code should be one that is listed in the Procedure Code Reference file.

Deleted Edits:

- 609 Pall Care Pt Days > Patient Days Total
- 612 Palliative Care mismatch
- 634 Palliative Care Patient Days = Total LOS, Care Type <> 8

Revisions to Record Structures

Episode Record

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	NNNNNNNNNNNN or spaces
M	Medicare Suffix	3	37	AAA or A-A
M	Sex	1	40	1, 2, 3, 4
M	Marital Status	1	41	1, 2, 3, 4, 5, 6, 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
2	Patient Days Total	4	111, 124, 137, 150, 163, 176, 189	Must be present if other Status details are present

Note	Data Item	Field Size	Record Position	Layout/Code Set
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	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, 8 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
14-16	Palliative Care Patient Days	3	270	NNN or spaces
3	Intention to Readmit	1	273 270	0, 1, 2, 3, 4, 9
M	Date of Birth Accuracy Flag	3	274 271	AAA Refer to Section 3

Note	Data Item	Field Size	Record Position	Layout/Code Set
7, 14	Program Identifier	2	274	NN or spaces
16, 14	Mother's UR	10	276	NNNNNNNNNN or spaces
		Total		
		276		
		285		

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

M Mandatory

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

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

3 Mandatory but transmit only when Separation Date is transmitted.

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

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

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

7 Mandatory for all hospitals involved in contracted care, hub and spoke arrangements, or ~~the Healthstreams Program~~ specified funding arrangements, programs or initiatives, 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 or ~~Care Type 4 and an ECT has been performed~~. Private hospitals report spaces.

~~16 Mandatory for all public hospitals when Care Type is 9.~~

16 Mandatory for newborn episodes where the baby is born in the hospital.

Sub-Acute Record

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	S4
M	Unique Key	9	3	Hospital generated Right justified, zero filled
M	Patient Identifier	10	12	Hospital generated Right justified, zero filled
1, 2, 4	Barthel Index Score on Admission	3	22	Range 000 to 100 or spaces
1, 2, 4	Barthel Index Score on Separation	3	25	Range 000 to 100 or spaces
1, 6	Clinical Sub-program	3	28	From code list or spaces
1, 6	Onset Date	8	31	DDMMCCYY or spaces
1, 6	Admission/Re-admission to Rehabilitation	1	39	0, 1 or space
5	User Flag	1	40	Optional field, free text
3 5	RUG ADL on Admission	2	41	Range 00 to 18 or spaces
3 5	RUG ADL on Separation	2	43	Range 00 to 18 or spaces
3 5	Source of Referral to Palliative Care	2	45	Range 01 to 09 or spaces
1, 2, 4	Functional Assessment Date on Admission	8	47	DDMMCCYY or spaces
1, 2, 4	Functional Assessment Date on Separation	8	55	DDMMCCYY or spaces
7	Impairment	6	63	From code list or spaces
8	FIM™ Score on Admission	18	69	NNNNNNNNNNNNNNNNNN or spaces
8	FIM™ Score on Separation	18	87	NNNNNNNNNNNNNNNNNN or spaces
		Total 62 104		

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

M Mandatory

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

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

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

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

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

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

7 Optional if Care Type = 2, 6, 7, K, P

8 Optional if Care Type = 2, 6, 7, K, P, E, F, 9

Reported by Public hospitals.

[Private hospitals: Do not report S4s.]

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

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

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

Reporting guide **General**

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

Field	Rehab Care Type 2, 6, 7 or K	Palliative Care Type 8	GEM Care Type 9	Interim Care Type F, E	Paed Rehab Care Type P
Transaction Type	S4	S4	S4	S4	S4
Unique Key	*	*	*	*	*
Patient Identifier	*	*	*	*	*
Barthel Index Score on Adm	*	Spaces	*	*	Spaces
Barthel Index Score on Sep	*	Spaces	*	*	Spaces
Functional Assessment Date on Admission	*	Spaces	*	*	Spaces
Functional Assessment Date on Separation	*	Spaces	*	*	Spaces
Clinical Sub-Program	*	Spaces	Spaces	Spaces	*
Onset Date	*	Spaces	Spaces	Spaces	*
Admission / Re-admission	*	Spaces	Spaces	Spaces	*
RUG ADL on Admission	Spaces	*	Spaces	Spaces	Spaces
RUG ADL on Separation	Spaces	*	Spaces	Spaces	Spaces
Source of Referral to Palliative Care	Spaces	*	Spaces	Spaces	Spaces
Impairment	*	Spaces	Spaces	Spaces	*
FIM™ Score on Admission	*	Spaces	*	*	Spaces
FIM™ Score on Separation	*	Spaces	*	*	Spaces

Correction

To correct a Sub-Acute Record, re-transmit the entire Sub-Acute Record, including the corrections. This will overwrite the existing record held by PRS/2.

Re-transmitting the Sub-Acute Record causes the Episode Record to be re-edited.

Deletion

To delete a Sub-Acute Record, re-transmit Sub-Acute Record containing all 9s in the Clinical Sub-Program **or Impairment**.

If an Episode Record is deleted, the Sub-Acute Record will automatically be

deleted. Re-transmitting the Episode Record alone will not re-generate the Sub-Acute Record; the Sub-Acute Record must also be re-transmitted.

A record can be deleted and re-transmitted in the same transmission so long as the hospital sequences the deletion first.

If an episode that was previously reported with a Sub-Acute Care Type is amended to report a non-Sub-Acute Care Type, the Sub-Acute data will be deleted from the database and a Warning edit will be printed on the Control Report.

Data Items

Transaction Type

The value identifying the Sub-Acute Record is 'S4'.

User Flag

This field has been added at the suggestion of a software supplier. Hospitals can use the field for data management purposes, perhaps to flag certain types of records, such as corrections.

The content of this field will be printed in PRS/2 Control Reports, when and where the Sub-Acute Record is printed.

Diagnosis Record

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	X4
M	Unique Key	9	3	Hospital generated Right justified, zero filled
1	Diagnosis Code x 12 - each code	8 (8 x 12)	12	ICD-10-AM/ACHI/ACS 6th edition Each left justified, trailing spaces
2	Procedure Code x 12 - each code	8 (8 x 12)	108	ICD-10-AM/ACHI/ACS 6th edition Each left justified, trailing spaces
3	Admission Weight	4	204	In grams, or spaces
8	User Flag	1	208	Optional field, free text
4 8	Duration of Stay in Intensive Care Unit	4	209	0001 to 9999 or spaces
5 8	Duration of Mechanical Ventilation in ICU	4	213	0001 to 9999 or spaces
6 8	Hospital Generated DRG	4	217	ANNA or NNNA or spaces
7 8	Duration of Stay in Cardiac/Coronary Care Unit	4	221	0001 to 9999 or spaces
8	Duration of Non-Invasive Ventilation	4	225	00001 to 9999 or spaces
9	Procedure Start Datetime	12	229	DDMMCCYYHHMM
		Total		
		228		
		240		

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

M Mandatory

- 1 *First* diagnosis code is mandatory.
- 2 Eighth character is F or N for procedures occurring in the contracted hospital when reported by the *contracting* hospital, else space.
- 3 Mandatory if patient aged <1 year at admission, else spaces.
- 4 Mandatory for patients cared for in an ICU listed in Section 9, and by hospitals providing contracted services to those listed hospitals, else spaces.
- 5 Mandatory for patients who received mechanical ventilation in an ICU listed in Section 9, and by hospitals providing contracted services to those listed hospitals, else spaces.
- 6 Optional but recommended for all hospitals with grouping software; else spaces.
- 7 Mandatory for patients cared for in a CCU listed in Section 9, and by hospitals providing contracted services to those listed hospitals, else spaces.
- 8 Where a field at the end of a record has a value of space(s), the record can be ended at the last field where a value is not space(s).
- 9 Mandatory when a the patient has had a visit to theatre during the episode (refer to *Reporting guide*, Section 3)

Reference Files

Coding Classification and Grouper Versions and ICD-10-AM/ACHI Library File

There will be no change to the ICD-10-AM/ACHI version for 2009-10. Sixth Edition will continue to be used.

Advice regarding Grouper Versions will be released at a later stage.

End of Financial Year Considerations

Method for Reporting 'Remaining Ins' on 30 June 2009

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 2009, 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 2009:

- File transmissions with header dates prior to 1 July 2009 must contain records using the 2008–09 format/values.
- File transmissions with header dates of 1 July 2009 and beyond may contain records of patients separated prior to 1 July 2008; if present, those data records must use the 2008-09 format/values.
- File transmissions with header dates of 1 July 2009 and beyond may contain records of unseparated patients (those remaining in on 30 June 2009); if present, those data records must use 2009–10 format/values.
- File transmissions with header dates of 1 July 2009 and beyond must contain records of patients separated on and from 1 July 2009 using the 2009–10 format/values.

Test Transmissions of New 1 July 2009 Software

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

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

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

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

Turnaround time will depend on workload at the facilities manager.

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

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

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