

Specification for Revisions to the Victorian Emergency Minimum Dataset for 1 July 2008

January 2008

Published by the Victorian Government Department of Human Services
Melbourne, Victoria

© Copyright State of Victoria 2008

This publication is copyright, no part may be reproduced by any process
except in accordance with the provisions of the *Copyright Act 1968*.

This document may also be downloaded from the Department of Human
Services web site at:

www.dhs.vic.gov.au or
www.health.vic.gov.au

Authorised by the State Government of Victoria, 50 Lonsdale Street,
Melbourne.

Table of Contents

Executive Summary	1
Introduction	2
The need for VEMD modifications	2
Distribution and contents of this document	2
Outcomes of the <i>Proposals for Revisions to the VEMD process</i>	3
Orientation to this document	4
VEMD Manual Content Summary	4
Abbreviations	5
Symbols	5
Section Three: <i>Data Definitions</i>	6
Date of Birth	6
Date of Birth Accuracy Code	8
Departure Status	11
Diagnosis – Additional Diagnoses 1 and 2	18
Diagnosis – Primary Diagnosis	18
Indigenous Status	23
Interpreter Required	26
Referred By	28
Section Four: <i>Business Rules</i>	30
Interpreter Required and Preferred Language	30
Section Five: <i>Compilation and Submission</i>	31
Guidelines for patients remaining in the emergency department on 30 June 2008	31
File Structure	32
Section Seven: <i>Editing</i>	36
List of new and amended edits	36
Amended edits	36
New edits	44
Section Eight: <i>Supplementary Code Lists</i>	45

Executive Summary

Each year the Department of Human Services (DHS) reviews the data elements and format of the Victorian Emergency Minimum Dataset (VEMD). This review seeks to ensure that the emergency department presentations data collection supports the Department's state and national reporting obligations, assists DHS planning and policy development, and incorporates appropriate feedback from data providers on improvements.

The revisions to the Victorian Emergency Minimum Dataset (VEMD) for 1 July 2008 include:

- Amended code sets for data items *Referred By*, *Departure Status*, *Indigenous Status* and *Interpreter Required*.
- Introduction of a new data item *Date of Birth Accuracy Code* to record the accuracy of the patient's reported date of birth, and
- Inclusion of new terms and codes the Diagnosis term set and update the VEMD library file to be consistent with ICD-10-AM Sixth edition.

VEMD reporting hospitals are now required to arrange for their software to be modified in accordance with these revised specifications.

Introduction

The need for VEMD modifications

From 1 July 2008, changes to the Victorian Emergency Minimum Dataset are necessary to assist Victorian health program monitoring, planning and policy development.

Additionally, DHS has been undertaking development of the Common Client Data Set (CCDS) which aims to create greater alignment of data provided by funded organisations that describes persons in receipt of DHS funded services. Where possible, the VEMD has been modified to align with the CCDS.

Comments from hospitals and software suppliers regarding the content of the document *Proposals for Revisions to the Victorian Emergency Minimum Dataset, November 2007* have been taken into account, and where possible these suggestions have been accommodated.

Please note that items presented in the *Proposals for Revisions to the Victorian Emergency Minimum Dataset* may be altered from their initial presentation in that document.

Distribution and contents of this document

This document has been distributed to all Victorian hospitals, software suppliers known to have Victorian clients, and to a range of industry bodies and DHS staff. It provides the following information:

- Amended, deleted and new concept definitions, data items and business rules.
- Reference files to be updated for 1 July 2008.
- Amended, and deleted Supplementary Code Lists.
- Amended file structures.

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

The *VEMD Manual, 13th Edition, July 2008* will be distributed at a later date.

The release of ICD-10-AM in early 2008 may inform some further edit revisions. These edits are highlighted in this document as requiring possible change, however the exact change (if any) will not be known until the release of the new ICD-10-AM. Notification of any related edit changes will be provided subsequent to the release of ICD-10-AM Sixth edition.

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.

Outcomes of the *Proposals for Revisions to the VEMD* process

In November 2007, the *Proposals for Revisions to the Victorian Emergency Minimum Dataset for 1 July 2008* were released. The release of this document generated good feedback and discussion in Health Services and at the Department of Human Services.

Proposal 1: Add a new code to the code set for existing data item *Referred By*

The proposal has been accepted. Based on feedback received, the code for 'Other Nurse' has also been changed.

Proposal 2: Add a new code to the code set for existing data item *Departure Status*

The proposal has been accepted. Based on feedback received, the code for 'Other Mental Health Bed – this campus' has also been changed.

Proposal 3: Add a new data item to record the accuracy of the Date of Birth

This proposal has been accepted. Feedback from hospitals indicated that the documentation provided regarding this item did not accurately reflect DHS' intentions for implementing this data item. The data item specification has now been rewritten to better reflect the intention of this data item.

Proposal 4: VEMD Library File Review.

This proposal has been accepted. Requests for additional terms/diagnoses for inclusion will now be accepted until mid-January 2008.

Proposal 5: VEMD Library File Update

This proposal has been accepted. A new ICD-10-AM Sixth edition library file will be released in 2008.

Proposal 6: Increase data submission frequency

This proposal has been rejected for 2008-09. Feedback from VEMD reporting hospitals indicated that a significant increase in emergency department clerical and other resources would be required to provide data with shortened time lines. Given the large numbers of admissions through emergency departments, and further follow up required for these patients, simply physically locating the patient's medical record so soon after their emergency department presentation was highlighted as a major difficulty.

Mesh Blocks for Geocoding addresses

Hospitals were asked to provide feedback regarding replacement of SLA with mesh blocks for geocoding addresses. Thank you to everyone who commented on this issue. Your feedback is being summarised for future DHS use, and for the Commonwealth for information.

Thank you to everyone who participated in this process. Your feedback and discussion is invaluable, and provides DHS with greater insight into hospital processes, resulting in better outcomes for everybody.

Orientation to this document

As this document details revisions to an existing dataset, there are a few features that require explanation:

- New values and definitions relating to existing items are highlighted in orange
- Changes to existing items are highlighted in green
- Redundant values and definitions relating to existing items ~~are struck through~~.
- Page numbers representing cross-referencing to another section of the VEMD Manual are represented by a hash (#).
- Edits with changes are marked with an asterisk (*) when listed as part of a Data Item or after an Edit Table.
- New edits are denoted by ###.
- The complete edit description for changed and new edits is listed in 'Section 7'.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Victorian Emergency Minimum Dataset Manual*.
 - *Specification*: details the reporting requirements for the item.
 - *Administration*: provides additional information including the purpose for the collection of the data item and the source of the code set and definitions.

This document is structured in the same order as the VEMD Manual. Revisions to a Section of the Manual are detailed under the appropriate Section heading. Where a Section has been omitted from this document, there are no revisions to that Section of the VEMD Manual.

VEMD Manual Content Summary

Section 1: Introduction

Outlines the background and uses of the VEMD, the VEMD data cycle, together with contact details, useful references and publications, and a list of abbreviations used in this manual.

Section 2: Concept and Derived item definitions

Provides definitions of concepts and derived items that contribute to the VEMD.

Section 3: Data Definitions

Presents the specifications of data items relating to individual emergency department presentations. The data items are arranged in alphabetical order.

Third-party software users whose software compiles data for submission to the VEMD should bear in mind that this manual describes the data as they should be transmitted to PRS/2.

The hospital's system need not exactly replicate the VEMD in all respects; however, the interface must be capable of formatting the data as specified for meaning and format for transmission to VEMD.

Section 4: Business Rules

Details the business rules that apply for reporting VEMD data.

Section 5: Compilation and Transmission

Provides the specifications for compiling a VEMD submission including file structure and format, file naming conventions, period of extract, and file security, data quality, schedule requirements, and related policies and test transmission and VEMD Editor

Section 6: Control Reports

Provides a summary of control report structure.

Section 7: Editing

Provides a summary of edit messages and specific details of each edit and its remedy.

Section 8: Supplementary Code Lists

Details a range of lengthy code sets for specific VEMD data items (most code sets are short and are included in Section 3 (actual lists are now available in electronic format only on the HDSS webpage).

Abbreviations

AIHW	Australian Institute of Health and Welfare
CCDS	Common Client Dataset
CCU	Coronary Care Unit
CMI	Client Management Interface
DHS	Department of Human Services
DMAC	Data Management Advisory Committee
ED	Emergency Department
EMU	Emergency Medical Unit
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
MAPU	Medical Assessment and Planning Unit
MHSOU	Mental Health Short Stay Observation Unit
NHDD	National Health Data Dictionary
ODS	Operational Data Store
PAPU	Psychiatric Assessment and Planning Unit
SLA	Statistical Local Area
SOU	Short Stay Observation Unit
VEMD	Victorian Emergency Minimum Dataset
VINAH	Victorian Integrated Non-Admitted Health Minimum Dataset

Symbols

<> Not equal to

Section Three: *Data Definitions*

Date of Birth

Revision Summary	Amend the reporting instructions for unknown Date of Birth to be consistent with advice in the new data item <i>Date of Birth Accuracy Code</i> . Amend edit 372 to disallow reporting of patients whose age is greater than 113 years. This is consistent with age edits applied by the AIHW.
-------------------------	---

Date of Birth (*Amended*)

Specification

Definition Patient's date of birth.

Datatype Date **Form** Date

Field size Eight **Layout** DDMMCCYY

Reported for Every Emergency Department presentation.

Reporting guide

Unknown Date of Birth:

~~If a patient's Date of Birth is unknown estimate the year of birth and report 0000 (zeros) in DDMM and estimated year in CCYY.~~

If the patient's date of birth is unknown, this should be estimated. If the patient's approximate age is known, then the Date of Birth should be estimated using the approximate age to calculate an estimated year of birth. Sentinel dates should not be used.

Edits

E086	Medicare Code and Date of Birth Combination Invalid
E089	Medicare Code and Date Of Birth Combination Invalid
E092	Sex Indeterminate with Age Greater Than or Equal To 90 Days
E093	Sex Indeterminate and Age Less Than 90 Days
E095	Date of Birth Invalid
E103	Invalid Combination of Date Of Birth, Arrival Date and Country Of Birth
E263	Diagnosis Code and Age Incompatible
E265	Diagnosis Code and Age — Check
E297	Injury Cause Code and Age Incompatible
E302	Human Intent Code and Age Incompatible

E355 Type of Usual Accommodation and Age Combination Invalid
*E372 Age Invalid

Related items

Section 2: *Age*

Section 3: *Date of Birth Accuracy Code*

Administration

Purpose

Used in the calculation of derived item *Age at admission*: Arrival Date/Time and Date of Birth.

Principal data users

Monash University Accident Research Centre; Hospital Demand Management, DHS.

Collection start

1 July 1995

Version

1 (Effective 01.07.95)

Definition source

NHDD

Code set source

DHS

Date of Birth Accuracy Code

Revision Summary	Introduction of a new data item <i>Date of Birth Accuracy Code</i> to: <ul style="list-style-type: none">• Improve data quality for the <i>Date of Birth</i> data item• Provide means of reporting that a <i>Date of Birth</i> is an estimate. This provides an alternative to health services using a default date specified by the individual service which is meaningless in a statewide context.
Implementation Information	<p>Date of Birth Accuracy Flag may be defaulted to 'AAA' for all patients except those for whom the Date of Birth has been estimated.</p> <p>Where the Date of Birth has been estimated, ideally the accuracy of each segment of the date should be indicated. However, a default of 'EEE' will be acceptable.</p> <p>Therefore, a 'tick-box' system for this data item is considered sufficient.</p> <p>For systems using HL7, this data item would be included in the PID.32 segment.</p> <p>Where data is updated from other systems (for example, the PAS propagates data to the ED system) hospitals and vendors will need to develop and implement methods to ensure data is of known quality. Ideally, both systems will contain estimated date information.</p>

Date of Birth Accuracy Code (*New*)

Specification

Definition	A code representing the accuracy of the components of a date - day, month, year.		
Datatype	Alpha	Form	Structured Code
Field size	3	Layout	AAA
Reported for	Every emergency department presentation.		
Value domain	Value domain consists of a combination of three codes, each of which denotes the accuracy of one date component:		
	Code	Descriptor	
	A	The referred date component is accurate	
	E	The referred date component is not known but is estimated	
	U	The referred date component is not known and not estimated.	
	This data element contains three positional components (DMY) that reflect the order of the date components in the format (DDMMYYYY) of the reported <i>Date of Birth</i> .		

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

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

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

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

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

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

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

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

Examples:

Valid combinations include:

DOB Accuracy = 'AAA', DOB = '03/11/1956'
 DOB Accuracy = 'EEE', DOB = '03/11/1956'
 DOB Accuracy = 'UUE', DOB = '00/00/1945'
 DOB Accuracy = 'UUE', DOB = '01/01/1945'

Invalid combinations include:

DOB Accuracy = 'AAA', DOB = '00/00/1956'
 DOB Accuracy = 'AAA', DOB = '00/06/1956'
 DOB Accuracy = 'EEE', DOB = '00/00/1956'
 DOB Accuracy = 'UUE', DOB = '00/00/0000'
 DOB Accuracy = 'UEE', DOB = '00/00/1956'

Edits ### Invalid Date of Birth Accuracy code

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

Administration

<i>Purpose</i>	Required to derive age for demographic analyses and for analysis by age at a point of time.		
<i>Principal data users</i>	Multiple internal and external research users.		
<i>Collection Start</i>	2008-09		
<i>Definition source</i>	NHDD (DHS modified)	Value Domain source	NHDD 294429

Departure Status

Revision summary	Add a new code (25) for 'Mental Health Observation/Assessment Unit' Add a new code(26) for 'Other Mental Health Bed – this Campus' Delete existing code (16) for 'Mental Health Bed – this Campus'
-------------------------	--

Departure Status (*Amended*)

Specification

Definition Patient destination or status on departure from the Emergency Department.

Datatype Alpha/numeric **Form** Code

Field size Two **Layout** N or NN

Reported for Every Emergency Department presentation.

Code set Select the first appropriate category

Code **Descriptor**

Departure Before Treatment Completed:

11	Left at own risk, without treatment
10	Left after clinical advice regarding treatment options
5	Left at own risk, after treatment started
7	Died within ED
8	Dead on arrival

Ward Setting at this Hospital Campus:

16	Mental Health Bed – this Campus
15	Intensive Care Unit – this campus
22	Coronary Care Unit – this campus
25	Mental Health Observation/Assessment Unit
3	Short Stay Observation Unit
13	Emergency Medical Unit
14	Medical Assessment and Planning Unit

26 Other Mental Health Bed - this Campus

18 Ward not elsewhere described

Transfers to another Hospital Campus:

17 Mental Health bed at another Hospital Campus

20 Another Hospital Campus - Intensive Care Unit

21 Another Hospital Campus - Coronary Care Unit

19 Another Hospital Campus

Returning to usual residence:

23 Mental health residential facility

24 Residential care facility

12 Correctional/Custodial Facility

1 Home

Reporting guide

Report the **immediate** destination or departure status of the patient upon departure from the ED. This may not necessarily be to the patient's usual place of residence.

Departure before treatment completed

11 Left at own risk, without treatment

Patient departs the Emergency Department before being seen by a definitive service provider:

- Without notifying staff,
- Despite being advised by clinical staff not to leave, or
- Without receiving advice about alternatives to treatment in the Emergency Department.

Common descriptions include: Did Not Wait, DNW, Failed To Answer, FTA.

10 Left after clinical advice regarding treatment options

At or subsequent to triage, the patient has received advice about Emergency Department and alternative treatment options. On consideration of this advice, the patient chooses to leave without being seen by a definitive service provider.

5 Left at own risk, after treatment started

Patient departs the Emergency Department after being seen by a definitive service provider despite being advised by clinical staff not to leave. The appropriate hospital forms must be completed and signed by the patient.

7 Died Within ED

Patient died after commencement of ED presentation. Includes where there is an intention to resuscitate but the patient is later pronounced dead.

8 Dead on Arrival

Patient is pronounced dead by a medical practitioner before (or without) being brought into the ED or where the patient is brought into the ED but there is no intention to resuscitate.

Ward Setting at this Hospital Campus

15 Intensive Care Unit – this campus

Patient is transferred to a registered ICU bed at this campus.

Excludes Coronary Care Unit (use 22).

Refer to: Section 2 *Intensive Care Unit*

22 Coronary Care Unit – this campus

Patient is transferred to a registered CCU bed at this campus.

Excludes Intensive Care Unit (use 15).

Refer to: Section 2 *Coronary Care Unit*

25 Mental Health Observation/Assessment Unit

Includes registered:

- Psychiatric Assessment and Planning Unit (PAPU)
- Mental Health Short Stay Observation Unit

Excludes:

- Other Mental Health Bed at this campus (use 26)
- Short Stay Observation Unit (use 3)
- Emergency Medical Unit (use 13)
- Medical Assessment and Planning Unit (use 14)

3 Short Stay Observation Unit (SOU)

Excludes:

- Emergency Medical Unit (use 13);
- Medical Assessment and Planning Unit (use 14);
- Mental Health Observation/Assessment Unit (use 25)

Refer to: Section 2 *Short Stay Observation Unit*

13 Emergency Medical Unit (EMU)

Excludes:

- Short Stay Observation Unit (use 3);
- Medical Assessment and Planning Unit (use 14);
- Mental Health Observation/Assessment Unit (use 25)

Refer to: Section 2 *Emergency Medical Unit*

14 Medical Assessment and Planning Unit (MAPU)

Excludes:

- Short Stay Observation Unit (use 3);
- Emergency Medical Unit (use 13);
- Mental Health Observation/Assessment Unit

Refer to: Section 2 *Medical Assessment and Planning Unit*

26 Other Mental Health bed – this campus

The bed or ward must be part of an approved mental health program.

Refer to: Section 2 *Mental Health Bed*

18 Ward

Includes patients who:

- Go to the ward after attending the ED at the same hospital.
- Go to HITH.
- Attend the ED from an inpatient ward at the same hospital and then return to the ward

Excludes patients who:

- Attend the ED from an inpatient ward at the same hospital and then return to a Mental Health bed (use 26).
- Depart to a Short Stay Observation Unit (use 3).
- Depart to an Emergency Medical Unit (use 13).
- Depart to a Medical Assessment and Planning Unit (use 14).
- Depart to an Intensive Care Unit (use 15).

Transfers to another Hospital Campus

17 Mental Health bed at another hospital campus

Patient has been transferred to a registered mental health bed at another hospital campus. A *Transfer Destination* must also be reported.

Refer to: Section 2 *Mental Health Bed*

20 Another Hospital Campus - Intensive Care Unit

Patient has been transferred to a registered ICU bed at another hospital campus. A *Transfer Destination* must also be reported.

Refer to: Section 2 *Intensive Care Unit*

21 Another Hospital Campus - Coronary Care Unit.

Patient has been transferred to a registered CCU bed at another hospital campus. A *Transfer Destination* must also be reported.

Refer to: Section 2 *Coronary Care Unit.*

19 Another hospital campus

Patient has been transferred to another hospital campus.

Excludes patients transferred to the following registered bed types at another campus:

- Mental Health bed (use 17)
- ICU bed (use 20)
- CCU bed (use 21)

A *Transfer Destination* must also be reported.

Returning to usual residence

23 Mental health residential facility

Includes psychogeriatric nursing home.

Excludes transfer to hospital Mental health bed:

- At this campus (use 26)
- At another hospital campus (use 17).

24 Residential care facility

Includes:

- Nursing home
- Hostel
- Residential care respite bed
- Nursing home beds located within an acute or sub-acute hospital campus.

Excludes psychogeriatric nursing home (use 23)

12 Correctional / Custodial Facility

The Commonwealth Department of Health and Aged Care does not recognise these facilities as hospitals and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

Does not require a *Transfer Destination* code.

1 Home

Includes:

- House,
- Unit,
- Boarding/rooming house,
- Hotel,
- Caravan,
- Youth hostel accommodation,
- Homeless person's shelters
- Shelter/refuges
- Armed forces hospitals and
- No fixed abode.
- Patients going to a Rehabilitation In The Home program

Armed Forces Hospitals

The Commonwealth Department of Health and Aged Care does not recognise these facilities as hospitals and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

If a patient is transferred from the ED to an Armed Forces hospital, Departure Status equals '1 - Home'.

Transit Lounges

Transit lounges/holding areas are not generally considered to be inpatient wards. Thus, emergency patients located in these areas, prior to being admitted to a ward, should be considered to be in the care of the emergency department.

Edits

E142	Dead on Arrival Combination Invalid
E182	First Seen By Treating Clinician Date/Time and Departure Status Combination Invalid
*E230	Departure Status Invalid
E232	Transfer Departure Status Code Combination Invalid
E233	Unregistered Short Stay Observation Unit
E242	Referred to on Departure and Departure Status Combination Invalid
E260	Primary Diagnosis Blank
E339	Inpatient Bed Request Date/Time and Departure Status Combination Invalid
E342	Primary Diagnosis Recorded When Departure Status Is '10', '11' OR '8'.
*E356	Type of Usual Accommodation and Departure Status Combination Invalid
E366	Departure Status and Triage Category Combination Invalid
E367	Unregistered Emergency Medical Unit
E376	Unregistered Medical Assessment and Planning Unit
E377	Unregistered Intensive Care Unit
E378	Unregistered Coronary Care Unit

Unregistered Mental Health Observation/Assessment Unit

Related items

Section 3: *Escort Source, Transfer Destination, Referred to on Departure, Reason for Transfer, Departure Transport Mode.*

Administration

Purpose

To:

- Identify and monitor the status and location of patients on departure from the ED.
- Define patients for performance measures calculation.

Principal data users Monash University Accident Research Centre; Statewide Emergency Program, DHS.

Collection start	1 July 1995	Version	1	(Effective 01.07.95)
			2	(Effective 01.07.00)
			3	(Effective 01.07.01)
			4	(Effective 01.07.02)
			5	(Effective 01.07.03)
			6	(Effective 01.07.06)
			7	(Effective 01.07.08)

Definition source NHDD

Code set source DHS

Diagnosis – Additional Diagnoses 1 and 2

Diagnosis – Primary Diagnosis

Revision summary Update the VEMD Library file to include additional codes and terms.

Revision

Update the VEMD Library file to include additional codes and terms for use in data items *Diagnosis—Primary Diagnosis* and *Diagnosis—Additional Diagnoses 1 and 2*.

The updated Library File will be published on the HDSS website (www.health.vic.gov.au/hdss) by 1 May 2008.

Submissions for inclusion of new diagnoses/terms in the updated Library File are welcome until mid-January 2008. These will then be ratified by the VEMD Technical Reference Group prior to inclusion in the updated Library File. Forward submissions to the HDSS help desk.

Revision summary Update the VEMD Library file to include ICD-10-AM Sixth edition codes.

Revision

Update the VEMD Library file to replace ICD-10-AM Fifth edition codes with ICD-10-AM Sixth Edition codes. This will ensure that the VEMD Diagnoses are consistent with other national datasets.

The updated Library File will be published on the HDSS website (www.health.vic.gov.au/hdss) by 1 May 2008.

Diagnosis-Additional Diagnoses 1 and 2 (Amended)

Specification

Definition

Additional diagnoses are those that:

- Existed at the time of presentation
- Arose while patient was in the Emergency Department
- Are expected to affect treatment plan or length of stay in the Emergency Department.

Datatype

Alpha/numeric

Form

Code

Field size

Five

Layout

ANN, ANNN or ANNNN

Reported for Mandatory if Primary Diagnosis is 'Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment'.

Optional for all other Emergency Department presentations.

Reporting guide Additional diagnoses give information on factors which result in increased length of stay, more intensive treatment or the use of greater resources. Additional diagnosis can include diseases, conditions, injuries, poisoning, signs, symptoms, abnormal findings, complaints, or other factors influencing the patient's health status.

In cases requiring mandatory assignment due to Primary Diagnosis of 'Z099', the Additional Diagnosis 1 provides information regarding the specific condition under review during the Emergency Department presentation.

The Additional Diagnosis 1 code identifies the condition under review, and it must not be 'Z099'.

Additional Diagnoses should correlate with and must be substantiated by clinical documentation.

Diagnosis code format:

Diagnosis codes must be submitted in ICD-10-AM format. Ensure any punctuation (decimal points or obliques) is removed from ICD-10-AM codes before submission, as codes with punctuation will not be accepted.

Only codes detailed in the VEMD ICD-10-AM [Sixth edition Library File](#) [Diagnosis Code list in Section 8 – Supplementary Code Lists](#) will be accepted. For diagnoses not detailed in this list please contact the HDSS Help Desk for assistance.

Edits

- *E261 Diagnosis Code Invalid
- *E262 Diagnosis Code and Sex Incompatible
- *E263 Diagnosis Code and Age Incompatible
- *E264 Diagnosis Code and Sex — Check
- *E265 Diagnosis Code and Age — Check
- *E341 Primary Diagnosis Equals 'Z099' but Additional Diagnosis Blank

Related items Primary Diagnosis.

Administration

Purpose To facilitate epidemiological studies and other research.

Principal data users Monash University Accident Research Centre; Statewide Emergency Program, DHS.

<i>Collection start</i>	1 July 1995	Version	1 (Effective 01.07.95)
			2 (Effective 01.07.98)
			3 (Effective 01.07.99)
			4 (Effective 01.07.01)
			5 (Effective 01.07.02)
<i>Definition source</i>	DHS	Code set source	DHS

Diagnosis - Primary Diagnosis (*Amended*)

Specification

Definition	The diagnosis primarily responsible for presentation to the Emergency Department.		
Datatype	Alpha/numeric	Form	Code
Field size	Five	Layout	ANNNN

Reported for Primary Diagnosis is mandatory, except where Departure Status is '10 – Left after clinical advice regarding treatment options' or '11 – Left at own risk, without treatment'.

If the Departure Status is '8 – Dead on Arrival'; the Primary Diagnosis must be 'R961 – Dead on Arrival' or 'R95 Sudden Infant Death Syndrome (SIDS)'.

Reporting guide If the Primary Diagnosis code is an injury, poisoning or other consequence of an external cause (VEMD diagnosis codes beginning with S or T), ensure that the corresponding Nature of Main Injury and Body Region combination is correct (Section 8 – Supplementary Code Lists).

Further specify the injury by utilising the Injury Surveillance items.

If the Primary Diagnosis code is 'Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment', an Additional Diagnosis 1 code is mandatory.

The Additional Diagnosis 1 code must identify the condition under review, and therefore must not be 'Z099'.

Primary Diagnosis must be substantiated by clinical documentation.

Diagnosis code format:

Diagnosis codes must be submitted in ICD-10-AM format. Ensure that any punctuation (decimal points or obliques) is removed from ICD-10-AM codes before submission, as codes with punctuation will not be accepted.

Only codes detailed in the VEMD ICD-10-AM **Sixth edition Library File** **Diagnosis Code list in Section 8 – Supplementary Code Lists** will be accepted. For diagnoses not detailed in this list please contact the HDSS Help Desk for assistance.

How to use the NoMI /B.Region Matrix:

1. Select the NoMI code appropriate
2. Scroll across row to body region the appropriate
3. Select the ICD-10-AM code in the intersecting cell of the matrix

Indigenous Status

Revision Summary	<p>Code values change as follows:</p> <ul style="list-style-type: none"> • 5 changes to 1 • 6 changes to 2 • 7 changes to 3 • 2 changes to 4 <p>The wording of the code descriptions have changed slightly but the meaning is unchanged.</p> <p>Codes 8 and 9 remain unchanged.</p> <p>This change aligns the ESIS with the DHS Common Client Data Set</p>
-------------------------	--

Indigenous Status (*Amended*)

Specification

Definition	An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.		
Label	Indigenous_Status		
Field size	N/A	Valid values	Code from Indigenous Status codeset
Reported in	Patient extract		
Reported for	All patient level records		
Reported when	The waiting list episode is first registered and whenever the field is updated. This field should be updated on each occasion that any other demographics are updated.		

Code set	Code	Descriptor
	1	Aboriginal but not Torres Strait Islander origin
	2	Torres Strait Islander but not Aboriginal origin
	3	Both Aboriginal and Torres Strait Islander origin
	4	Neither Aboriginal nor Torres Strait Islander origin
	2	Not indigenous—Not Aboriginal or Torres Strait Islander origin
	5	Indigenous—Aboriginal but not Torres Strait Islander origin
	6	Indigenous—Torres Strait Islander but not Aboriginal origin

7 ~~Indigenous—Aboriginal and Torres Strait Islander origin~~

8 Question unable to be asked

9 Patient refused to answer

Reporting guide

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

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

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

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

- When the patient's medical condition prevents the question of Indigenous Status being asked; or
- In the case of an unaccompanied child who is too young to be asked their Indigenous Status.
- Where registration for a waiting list episode occurs without the patient being present and cannot be determined from the information supplied. In this case it is expected that Indigenous Status will be updated prior to or at admission.

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

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

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

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

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

Patient is baby or child

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

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

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

Episodes registered before 1 July 2005

For episodes registered prior to 1 July 2005, if the patient's indigenous status is already stored in the reporting organisation's PMI, then report the existing value (assuming it is valid). For those patients where no value has been recorded, report code 8 *Question unable to be asked*. Indigenous Status should then be updated on the next occasion the patient's other demographic details are updated.

Edits *S425 Indigenous Status Invalid

Administration

Purpose To:

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

Principal data users Koori Health Unit (Public Health, DHS).
Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).

Collection start	July 2005	Version	1 (Effective 1 July 2005)
			2 (Effective 1 July 2008)

Definition source	NHDD	Codeset source	NHDD (DHS modified)
--------------------------	------	-----------------------	---------------------

Interpreter Required

Revision Summary	In order to align the VEMD with the DHS Common Client Data Set: <ul style="list-style-type: none">• Remove Code 3 <i>Not Stated</i>• Add Code 9 <i>Not Stated/Inadequately Described</i>.
Implementation Guide	Refer to the <i>Interpreter Required/Preferred Language</i> business rules table in Section Four: <i>Business Rules</i> .

Interpreter Required (*Amended*)

Specification

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

Datatype Numeric **Form** Code

Field size 1 **Layout** N or space

Reported for Every Emergency Department presentation.

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

Reporting guide Preferred Language to be asked before Interpreter Required.

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

This data item must:

- Be checked for every emergency department presentation.
- Not be set up to input a default code on computer systems.
- Be collected on, or as soon as possible after arrival.

The standard question is:

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

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

1 Yes

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

2 **No**

Use code 2 if the patient indicates they do not need an interpreter.

Includes:

- Where the Preferred Language is English.

3 9 **Not Stated / Inadequately Described**

Use code 3-9 if neither Yes nor No can be accurately ascertained.

Includes:

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

Patient is unable to consent (for example baby, child or elderly):

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

Edits	E358*	Invalid Interpreter Required
	E359*	Invalid Comb Int Req/Pref Lang

Related items Section 3: *Country of Birth, Indigenous Status and Preferred Language*.

Administration

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

Principal data users Multiple internal and external data users

Collection start 2003-04

Definition source DHS

Code set source DHS CCDS

Referred By

Revision summary	Add a new code (14) for 'Nurse on Call' Add a new code for (15) 'Other Nurse' Delete existing code (13) for 'Nurse'
-------------------------	---

Referred By

Specification

Definition Source from which patient was referred to this Emergency Department.

Datatype Alpha/numeric **Form** Code

Field size Two **Layout** N or NN

Reported for Every Emergency Department presentation.

Code set **Select the first appropriate category**

Code **Descriptor**

0 Staff from this campus

1 Self, family, friends

2 Local medical officer, includes local GP/Doctor

4 Private specialist

6 Staff from another campus

8 Correctional Officer / Police

9 Crisis Assessment Team

10 Community Services Staff

13 ~~Nurse (Excluding those in categories 0 to 10)~~

14 Nurse on Call

15 Other Nurse

19 Other

Reporting guide **6 Staff from another campus**
Includes: Admitted and non-admitted transfers.
Also record Transfer Source.

8 Correction Officer / Police
Includes prison hospitals as the Commonwealth Department of Health and Aged Care does not recognise these as hospitals. Therefore admission from, or separation to, such facilities are not an inter-hospital transfer.

14 Nurse on Call

Patient indicated that they had been advised by NURSE-ON-CALL to present to the Emergency Department of the nearest Hospital.

Excludes: District Nurse, Nurse Practitioner and Nurses employed within Aged Care Residential Care Facility (both high and low level care), Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.

15 Other Nurse

Includes: District Nurse, Nurse Practitioner and Nurses employed within Aged Care Residential Care Facility (both high and low level care), Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.

Excludes: Personal Care Attendants (PCA), Nurse on Call, and nurses within this hospital or other acute care facility.

19 Other

Includes armed forces hospitals as these are not recognised by the Commonwealth Department of Health and Aged Care and therefore admission from, or separation to, such facilities are not an inter-hospital transfer.

Edits

*E130 Referred By Invalid

*E136 Referred By and Transfer Source Combination Invalid

Related items

Section 3: *Arrival Transport Mode, Transfer Source*

Administration

Purpose

Analysis of referral patterns.

Collection start

1 July 1995

Version

1	(Effective 01.07.95)
2	(Effective 01.07.97)
3	(Effective 01.07.01)
4	(Effective 01.07.02)
5	(Effective 01.07.03)
6	(Effective 01.07.08)

Definition source

DHS

Code set source

DHS

Section Four: *Business Rules*

Interpreter Required and Preferred Language

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

If Interpreter Required is		then Preferred Language must be
1	Yes	<> (0002 or 1201)
2	No	<> 0002
3 9	Not Stated	0002
If Preferred Language is		Then Interpreter Required must be
<> (0002 or 1201) Refer VAED Manual Section 9 <i>Preferred Language</i>		1, 2
1201	English	2
0002	Not stated	3 9

Edits

*E359

Invalid Comb Int Req/Pref Lang

Section Five: *Compilation and Submission*

Guidelines for patients remaining in the emergency department on 30 June 2008

The required format of the VEMD for any given financial year applies to presentations with a **Departure Date on or after 1 July** in that financial year. This includes patients who remain in the Emergency Department after midnight on the 30 June of the previous financial year.

Data for patients who present to the emergency department on 30 June 2008 and depart the emergency department on or after 1 July 2008 must be reported according to the amended reporting requirements outlined in this document.

Data for patients who present and depart the emergency department before 30 June 2008 are reported in the 2007-08 format.

Data for patients who present to the emergency department on or after 1 July 2008 are reported in the 2008-09 format.

File Structure

The file structure details the sequence, length, type and layout of data items to be transmitted to the VEMD.

File Structure Notes:

- All alpha characters must be in UPPERCASE (optional for Description of Injury Event)
- Do not zero fill items unless specified
- Padding fields with space characters (either to the left or right) is unnecessary
- Conditional mandatory items: See Conditional Mandatory Items Key below for the conditions under which they become mandatory.
- The column headed Excel Position indicates the column in which each data item must be located in the file, see also Section 5 – Compilation and Submission (File Format).

Conditional Mandatory Items Key

Key	Descriptor
1	Mandatory item
2	Mandatory if Medicare Suffix does not equal C-U, N-E or P-N
3	Mandatory if Referred By = 6
4	Mandatory if Arrival Transport Mode = 1, 2, 3, 10
5	Mandatory if patient is transferred to another hospital campus (Departure Status is 17, 19, 20 or 21)
6	Mandatory where Departure Status code is not `10 – Left after clinical advice, regarding treatment options` or `11 – Left at own risk, without treatment`. Blank for Departure Status codes 10 and 11
7	See Section 4 – Business Rules, Injury Surveillance
8	Mandatory if the Nurse is the definitive service provider (except where Departure Status = `10 – Left after clinical advice, regarding treatment options` or `11 – Left at own risk, without treatment`).
9	Mandatory if the Doctor is the definitive service provider (except where Departure Status = `10 – Left after clinical advice, regarding treatment options` or `11 – Left at own risk, without treatment`).
10	Mandatory if the Mental Health Practitioner is the definitive service provider Blank where Departure Status = `10 – Left after clinical advice, regarding treatment options` or `11 – Left at own risk, without treatment`.
11	Mandatory if Primary Diagnosis code = `Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment`.
12	Mandatory if an inpatient bed request was made, regardless of whether the patient is actually moved to an inpatient bed.
13	Optional if Primary Diagnosis item is completed
14	Mandatory if Compensable Status = 2
15	Optional if patient is transferred to another hospital campus (Departure Status is 17, 19, 20 or 21)

Key	Field Name	Max Chars	Alpha / Numeric	Format / Values	Excel Position
1	Campus Code	4	A/N	XXXX	A
1	Unique Key	9	A/N	XXXXXXXXXX	B
Patient Biographic					
1	Patient Identifier	10	A/N	XXXXXXXXXX	C
2	Medicare Number	11	N	NNNNNNNNNNNN or blank	D
1	Medicare Suffix	3	A/N	XXX	E
14	DVA Number	9	A/N	See detailed specification: VEMD Manual, 3-54?	F
1	Sex	1	A/N	1, 2, 3, 4	G
1	Date of Birth	8	N	DDMMCCYY	H
1	Date of Birth Accuracy Code	3	A/N	XXX	I
1	Country of Birth	4	A/N	XXXX	J
1	Indigenous Status	1	A/N	2, 5, 6, 7, 8, 9	K
1	Interpreter Required	1	A/N	1, 2, 3	L
1	Preferred Language	2	A/N	XX	M
1	Locality	22	A/N	XXXXXXXXXXXXXXXXXXXXXXXXXX	N
1	Postcode	4	N	NNNN	O
1	Type of usual Accommodation	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 18, 19	P
Patient Management Data					
1	Arrival Transport Mode	2	A/N	1, 2, 3, 6, 8, 9, 10, 11, 99	Q
1	Referred By	2	A/N	0, 1, 2, 4, 6, 8, 9, 10, 13, 19	R
3	Transfer Source	4	A/N	XXXX	S
1	Type of Visit	2	A/N	1, 2, 8, 9, 10	T
1	Compensable Status	1	A/N	1, 2, 3, 4, 5, 6, 7	U
4	Ambulance Case Number	4	A/N	See detailed specification: VEMD Manual, Section 3.	V
1	Arrival Date	8	N	DDMMCCYY	W
1	Arrival Time	4	N	HHMM	X

Key	Field Name	Max Chars	Alpha / Numeric	Format / Values	Excel Position
1	Triage Date	8	N	DDMMCCYY	× Y
1	Triage Time	4	N	HHMM	× Z
1	Triage Category	1	A/N	1, 2, 3, 4, 5, 6	Z AA
8	First Seen by Treating Nurse Date	8	N	DDMMCCYY or Blank	AA AB
8	First Seen by Treating Nurse Time	4	N	HHMM or Blank	AB AC
9	First Seen by Treating Doctor Date	8	N	DDMMCCYY or Blank	AG AD
9	First Seen by Treating Doctor Time	4	N	HHMM or Blank	AD AE
10	First Seen by Mental Health Practitioner Date	8	N	DDMMCCYY or Blank	AE AF
10	First Seen by Mental Health Practitioner Time	4	N	HHMM or Blank	AF AG
13	Procedure	89	A/N	XX (x30)	AG AH
12	Inpatient Bed Request Date	8	N	DDMMCCYY or Blank	AH AI
12	Inpatient Bed Request Time	4	N	HHMM or Blank	AI AJ
1	Departure Date	8	N	DDMMCCYY	AJ AK
1	Departure Time	4	N	HHMM	AK AL
1	Departure Status	2	A/N	1, 3, 5, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24	AL AM
5	Transfer Destination	4	A/N	XXXX	AM AN
1	Referred to on Departure	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 16, 17, 18, 19	AN AO
5	Reason for Transfer	1	A/N	1, 2, 3, 4, 5, 6, 7, 9	AO AP
15	Escort Service	1	A/N	1, 2, 3, 4, 5, 9 or blank	AP-AQ
5	Departure Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 10, 11, 19	AQ AR
6	Primary Diagnosis	5	A/N	ICD-10-AM VEMD Code	AR AS
11	Additional Diagnosis 1	5	A/N	ICD-10-AM VEMD Code	AS AT
<input type="checkbox"/>	Additional Diagnosis 2	5	A/N	ICD-10-AM VEMD Code	AT AU

Key	Field Name	Max Chars	Alpha / Numeric	Format / Values	Excel Position
<u>Injury Surveillance Data</u>					
7	Nature of Main Injury	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26	AU AV
7	Body Region	2	A/N	F1, F2, F3, F4, F5, F6, F7 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22	AV -AW
7	Description of Injury Event	250	A/N		AW AX
7	Injury Cause	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30	AX -AY
7	Human Intent	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	AY AZ
7	Place Where Injury Occurred	1	A/N	H, I, S, A, R, T, C, Q, F, M, P, O, U	AZ BA
7	Activity When Injured	1	A/N	S, L, W, E, C, N, V, O, U	BA BB

Section Seven: *Editing*

List of new and amended edits

E105	Indigenous Status Invalid (<i>Amended</i>)	36
E107	Aboriginal or Torres Strait Islander Origin But Not Australian Born (<i>Amended</i>)	37
E130	Referred By Invalid (<i>Amended</i>)	37
E136	Referred By and Transfer Source Combination Invalid (<i>Amended</i>)	38
E142	Dead on Arrival Combination Invalid (<i>Amended</i>)	38
E230	Departure Status Invalid (<i>Amended</i>)	39
E261	Diagnosis Code Invalid (<i>Amended</i>)	39
E262	Diagnosis Code and Sex Incompatible (<i>Amended</i>)	40
E263	Diagnosis Code and Age Incompatible (<i>Amended</i>)	40
E264	Diagnosis Code and Sex — Check (<i>Amended</i>)	41
E265	Diagnosis Code and Age — Check (<i>Amended</i>)	41
E341	Primary Diagnosis Equals 'Z099' but Additional Diagnosis Blank (<i>Amended</i>)	41
E356	Type of Usual Accommodation & Departure Status Combination Invalid (<i>Amended</i>)	42
E358	Interpreter Required Invalid (<i>Amended</i>)	42
E359	Invalid Comb Interpreter Required /Preferred Language (<i>Amended</i>)	43
E360	Indigenous Status / Preferred Language Mismatch (<i>Amended</i>)	43
E372	Age Invalid (<i>Amended</i>)	44
E###	Unregistered MH Obs/Assess Unit (<i>New</i>)	44
E###	Invalid Date of Birth Accuracy code (<i>New</i>)	44

Amended edits

E105 Indigenous Status Invalid (*Amended*)

Effect	Rejection
Problem	An Indigenous Status value has not been reported or the value specified does not exist in the Indigenous Status codeset. <i>Modify for amended codeset.</i>
Remedy	Allocate an appropriate Indigenous Status code and re-submit the transaction. See: <ul style="list-style-type: none">• Section 3: Indigenous Status

E107 Aboriginal or Torres Strait Islander Origin But Not Australian Born (*Amended*)

Effect Notifiable

Problem The Indigenous Status specified in this record indicates that the patient is of Aboriginal or Torres Strait Islander origin, but the Country of Birth is not a code specific to Australia (1100, 1101, 1102, 1199).

It is unusual for Aboriginal or Torres Strait Islanders to have been born outside Australia.

Modify for amended codeset.

Remedy Check the Indigenous Status and the Country of Birth data items; if necessary, correct as appropriate and re-submit the transaction.

If correct, notify the VEMD Helpdesk of the accuracy of the record, providing detailed explanation. If the information is validated DHS will accept the record into the VEMD.

See Section 3: Country of Birth, Indigenous Status

E130 Referred By Invalid (*Amended*)

Effect REJECTION

Problem A Referred By value has not been reported or the value specified does not exist in the Referred By codeset.

Modify for amended codeset.

Remedy Allocate an appropriate Referred By code and re-submit the transaction.

E136 Referred By and Transfer Source Combination Invalid (*Amended*)

Effect REJECTION

Problem The combination of the Referred By and Transfer Source (which indicates transfer from another hospital) data items is invalid. For example:

- If the patient was transferred from another hospital or campus and Referred By is correctly reported as 6, the Transfer Source must be completed.
- If the patient was not transferred from another hospital or campus and the Referred By code was correctly reported as 1, 2, 4, 8, 9, 10, ~~13~~ 14, 15 or 19 (not 6), the Transfer Source item should remain blank.

Remedy If the patient was transferred from another hospital or campus, correct the Transfer Source and re-submit the transaction.

If the patient was not transferred from another hospital or campus, correct the Referred By data item from 6 to appropriate code and re-submit the transaction.

E142 Dead on Arrival Combination Invalid (*Amended*)

Effect REJECTION

Problem At least one of the following fields indicates that the patient was dead on arrival, but at least one of the remaining fields indicates that the patient was NOT dead on arrival.

Affected Data Fields

- Arrival Transport Mode
- Departure Status
- Diagnosis - Primary
- Referred to on Departure
- Triage Category
- Type of Visit

Note:

If a patient is not pronounced dead until after they have entered the ED, they should be recorded as Died in ED'.

Modification for amended codeset may be necessary. The release of ICD-10-AM 6th edition in early 2008 will inform this requirement.

Remedy

Ensure that all the fields listed above are accurate, correct any errors and re-submit the record.

E230 Departure Status Invalid (*Amended*)

Effect

REJECTION

Problem

A Departure Status value has not been reported or the value specified does not exist in the Departure Status codeset.

Modify for amended codeset.

Remedy

Allocate an appropriate Departure Status and re-submit the transaction.

E261 Diagnosis Code Invalid (*Amended*)

Effect

REJECTION

Problem

The Diagnosis code reported does not exist in the VEMD ICD-10-AM Diagnosis reference table; **OR**

The Diagnosis code format is not valid, e.g. it has a decimal point (.), forward slash or includes a space; **OR**

There is a blank Primary Diagnosis code, but Additional Diagnosis 1 and/or 2 is complete; **OR**

Primary Diagnosis is complete, Additional Diagnosis 1 is blank, but Additional Diagnosis 2 is complete

Modify for amended codeset.

Remedy

Check the Diagnosis Codes (Primary and Additional) and formatting and re-submit the transaction.

Contact software supplier to ensure that blank diagnoses are not transmitted to the VEMD.

E262 Diagnosis Code and Sex Incompatible (Amended)

Effect NOTIFIABLE

Problem Diagnosis code(s) reported is not compatible with the patient's sex.

Modify for amended codeset

Remedy Check code(s) (note edits in the VEMD Library file) and if necessary, correct code(s) and re-submit the transaction.

Check the sex and if necessary, correct and re-submit the transaction. If correct, notify the VEMD Helpdesk to confirm the accuracy of the record, providing a detailed explanation. If the information is validated DHS will accept the record into the VEMD.

E263 Diagnosis Code and Age Incompatible (Amended)

Effect NOTIFIABLE

Problem Diagnosis code(s) reported is not compatible with the patient's age (as calculated by subtracting Arrival Date from Date of Birth).

Remedy Check code(s) (note edits in the VEMD Library file); if necessary, correct code(s) and re-submit the transaction.

Check Date of Birth; if necessary, correct and re-submit the transaction. If correct, notify the VEMD Helpdesk to confirm the accuracy of the record, providing a detailed explanation. If the information is validated DHS will accept the record into the VEMD.

Modify for amended codeset

E264 Diagnosis Code and Sex — Check (Amended)

<i>Effect</i>	WARNING
<i>Problem</i>	Diagnosis code(s) reported is unusual for the patient's sex.
<i>Remedy</i>	<p>Check code(s) (note edits in the VEMD Library file); if necessary, correct code(s) and re-submit the transaction.</p> <p>Check the sex; if necessary, correct and re-submit the transaction.</p> <p>If you consider a sex edit unjustified, notify the HDSS Help-desk.</p> <p><i>Modify for amended codeset</i></p>

E265 Diagnosis Code and Age — Check (Amended)

<i>Effect</i>	WARNING
<i>Problem</i>	Diagnosis code(s) reported is unusual for the patient's age (as calculated by subtracting Arrival Date from Date of Birth).
<i>Remedy</i>	<p>Check code(s) (note VEMD Library file edits) and Date of Birth, if needed correct as necessary, and re-submit the transaction.</p> <p>If you consider an age edit unjustified, notify the HDSS Help-desk.</p> <p><i>Modify for amended codeset</i></p>

E341 Primary Diagnosis Equals 'Z099' but Additional Diagnosis Blank (Amended)

<i>Effect</i>	REJECTION
<i>Problem</i>	The Primary Diagnosis code in this record is 'Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment' but the Additional Diagnosis Code is blank.

An Additional Diagnosis code is a mandatory data item for all emergency attendances with a Primary Diagnosis of 'Z099'.

Modification for amended codeset may be necessary. The release of ICD-10-AM 6th edition in early 2008 will inform this requirement.

Remedy Allocate the appropriate Additional Diagnosis code to identify the condition under review during this emergency attendance.

E356 Type of Usual Accommodation & Departure Status Combination Invalid (*Amended*)

Effect WARNING

Problem The records Type of Usual Accommodation is 11 *Correction/Custodial Facility* but the Departure Status is not 3, 5, 7, 11, 12, 13, 14, 15, ~~16~~, 17, 18, 19, 20, 21, 22, **25 or 26**

Remedy It is unlikely that a patient with an identified Type of Usual Accommodation of 11 would have a discharge status other than one indicating the patient remains in hospital or custodial care.

Correct as appropriate and re-transmit.

E358 Interpreter Required Invalid (*Amended*)

Effect REJECTION

Problem An Interpreter Required value has not been reported or the value specified does not exist in the Interpreter Required codeset.

Modify for amended codeset.

Remedy Allocate an appropriate Interpreter Required code and re-submit the transaction.

E359 Invalid Comb Interpreter Required /Preferred Language (*Amended*)

Effect	REJECTION
Problem	The record has an invalid combination of Interpreter Required and Preferred Language. <i>Modify for amended codeset.</i>
Remedy	Check Interpreter Required and Preferred Language, amend as appropriate and re-submit the transaction.

E360 Indigenous Status / Preferred Language Mismatch (*Amended*)

Effect	Notifiable
Problem	Indigenous Status (5, 6 or 7 1, 2 or 3) indicates a person of Aboriginal or Torres Strait Islander origin but Preferred Language is not in the codeset of languages commonly associated with this indigenous status.
Remedy	<p>Check the Indigenous Status and Preferred Language values, correct any errors and re-submit the record.</p> <p>If correct, notify the VEMD Helpdesk of the accuracy of the record, providing a detailed explanation. If the information is validated DHS will accept the record into the VEMD.</p> <p>See:</p> <ul style="list-style-type: none">• Section 3: Indigenous Status, Preferred Language• Section 8: Preferred Language Reference Table• Reference table tlkpINDIGEN_PREF_LANG in VEMD Editor

E372 Age Invalid (*Amended*)

Effect REJECTION

Problem The age of this patient is more than 120 113 years.
Age is calculated as: Arrival Date – Date of Birth.

Remedy Verify that the Date of Birth and Arrival Date are correct. Amend the appropriate date and re-submit the transaction.

New edits

E### Unregistered MH Obs/Assess Unit (*New*)

Effect REJECTION

Problem The Departure Status is reported as 25 *Mental Health Observation/Assessment Unit*, but the reported Campus does not have a registered Mental Health Observation Assessment Unit, Psychiatric Assessment and Planning Unit or other similar registered unit.

Remedy Check the Departure Status, correct as appropriate and re-submit the transaction.

E### Invalid Date of Birth Accuracy code (*New*)

Effect REJECTION

Problem This record's Date of Birth Accuracy code is null or invalid.

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

Section Eight: *Supplementary Code Lists*

Revision

Update the VEMD Library file to include additional codes and terms for use in data items *Diagnosis—Primary Diagnosis* and *Diagnosis—Additional Diagnoses 1 and 2*.

Update the VEMD Library file to replace ICD-10-AM Fifth edition codes with ICD-10-AM Sixth Edition codes. This will ensure that the VEMD Diagnoses are consistent with other national datasets.

Note: Although VEMD uses diagnosis codes based on ICD-10-AM, they are not ICD-10-AM codes per se. Many codes will differ in form, description, and application, in order to make them more appropriate for the emergency department collection environment. Only VEMD diagnosis codes listed in the VEMD Library file will be valid.

The updated Library File will be published on the HDSS website (www.health.vic.gov.au/hdss) by 1 May 2008.

Submissions for inclusion of new diagnoses/terms in the updated Library File are welcome until mid-January 2008. These will then be ratified by the VEMD Technical Reference Group prior to inclusion in the updated Library File. Forward submissions to the HDSS help desk.