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**Victorian Activity Based Costing**

Victorian Cost Data Collection

Part B: Business rules and Specific costing guidance

Version 3.7

**OFFICIAL**



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Introduction

The purpose of the Victorian Cost Data Collection (VCDC) data specification, business rules and guidelines are to assist costing practitioners to attain all the relevant information for allocation of resources to patients.

This document assists health services in the reporting and costing of any submission year patient level cost data. This section focuses on **Part B: Business rules and Specific costing guidance:**

* **Business Rules –** guidance of the reporting and costing requirements to the Victorian Cost Data Collection.
* **Specific Costing Guidance –** guidance on specific criteria and conditions to be applied for the reporting of patient level cost data across various services.

This documentation also comprises of two other parts:

**Part A: VCDC process and Data Definition Specifications:**

* **References -** links to files and documentation relating to various sources of information and code sets to assist health services with their cost data submissions
* **Process flow** – outlines the processes that the files progress through the VCDC extract, transform and load process
* **Data Definition Specifications –** details of the requirements of the files to be submitted including the structure, values, and validation rules
* **Standard Principles** – includes scope of activity and expenditure,

**Part C: Review, Reconciliation, and communication:**

* **Review and Reconcile –** details of the data quality assurance checks and reconciliation reporting requirements
* **Communication –** notifications at each stage of the submission process.

This document has been developed by the Department of Health (the department) in consultation with relevant external stakeholders.

**Supporting NHCDC Compliance Through Robust VCDC Submissions**

We greatly appreciate the effort and time you commit to the VCDC Data Quality Statement and the VCDC Reconciliation report. Your contribution of high-quality data to the National Hospital Cost Data Collection (NHCDC) is essential for ensuring accurate, transparent, and equitable hospital funding across Australia. This data directly informs the calculation of the National Weighted Activity Unit (NWAU), which is the cornerstone of activity-based funding under the National Health Reform Agreement. When you submit reliable and comprehensive cost data, it strengthens the integrity of the national efficient price, enabling fair comparisons of hospital performance and supporting informed policy decisions. Ultimately, quality data ensures your health service is appropriately resourced for the care they deliver, driving improvements in efficiency and patient outcomes.   
(Source: [www.ihacpa.com.au](http://www.ihacpa.com.au/))

Key elements that are essential include:

**VCDC Reconciliation Report**

* Reconciliation of expenditure
* Patient demographic activity
* Patient utilisation by department feeder
* Cost centre movements within the costing general ledger
* Identification and treatment of virtual and dummy episodes

**VCDC Data Quality Statement (DQS)**

* Frequency and process for reviewing and updating the costing structure
* Use of costing information at the health service level
* Identification of campuses that have and have not reported
* Documentation of changes to source data
* Governance processes, including submission oversight, validation, and authorisation
* Treatment of work-in-progress patients
* Details of contractual arrangements
* Management of virtual and dummy episodes
* Quality assurance procedures
* Analysis of significant variations and root cause identification
* Improvements made to costing methodology

Business Rules

Business rules preserve the quality, consistency, and integrity of the data. Business rules are plain English statements which provide a constraint, condition, or restriction on an aspect of the data collection.

The Australian Hospital Patient Costing Standards v4.2 (AHPCS) require costing practitioners to liaise with stakeholders and understand how the standards can be applied and how the costing methodology can be adapted to their local environment.

Health services will need to ensure the reporting of costs is in alignment with the Data Definition Specifications documentation (DDS) outlined in this document.

# Patient resources

Terms used to refer to patient resources include patient services consumed, consumption data, utilisation, service codes, products, cost objects and resources.

Patient resources are a service department’s specific product or service describing what has been used by patients as part of their treatment from that service. For example:

* A drug - Colecalciferol 1000units dispensed by the Pharmacy department
* A chest x-ray-right performed by the Radiology department
* A CT scan performed by the CT Imaging department
* A CMBS code 69411 provided by the Pathology department
* Number of hours per day spent on Ward 2
* Number of minutes as a triage 3 category patient in the Emergency department
* Time spent providing the service for an intervention code 1234 Exercise therapy, shoulder joint by the Physiotherapy department
* Vascular prostheses code AC083 implanted while in surgery
* The number of minutes spent in the Operating Theatre by nursing staff and/or surgeons.

For each direct department or patient care area there will be a number of patient resources that are identified from the IT systems. This information can be extracted and used to allocate the expenses within the costing system.

Each feeder system and extract will contain the necessary fields to ensure appropriate alignment of the patient resources used to the patient activity encapsulating the level of complexity of each resource.

These patient resources will then be allocated the departments expenses using an appropriate allocation method that reflects the most accurate cost for providing that resource.

# Episode matching of resources

To ensure appropriate alignment of resources to the correct patients, a set of standard matching rules are applied. It is expected that costing practitioners consult with each service department, to ensure the rules are appropriately and accurately applied. Below are some common rules for matching episodes with resources.

### General matching

* Match and link to a valid episode number directly
* Match and link to an Inpatient episode number where the date of service falls between the admission and discharge dates
* Search 2 days backward from the date of service to match and link to an Emergency episode number
* Search +30 days from date of service to match and link to Non-Admitted episode number
* Create an Occasion of Service where the UR number is matched
* Where none of the above occurs, the record remains unlinked or linked to a default patient.

### Matching of ancillary services

Ancillary services such as diagnostic imaging, pathology and pharmacy should be linked to the episode of care where the service was ordered or delivered. The location where the service was **ordered should take precedence** over where the service was delivered.

If dates are used to link services, then the rules should follow the following preference:

1. identify an emergency episode with the date/time of the service, then
2. identify an admitted episode encompassing the date/time of the service, then
3. identify a non-admitted consultation matching the date of the service, then
4. identify a non-admitted consultation up to 30 days prior to the service date, then
5. identify a non-admitted consultation up to 30 days after the service date.

Where the funding source of these ancillary services is known, they should be linked to an episode of the same funding type. For example, public funded ancillary services should only be linked to a public non-admitted consultation.

### Matching other services

Matching of other services to the relevant episode should consider the type of service. For example:

* chemotherapy drugs dispensed prior to admission should be linked to a relevant admitted episode and not to an unrelated non-admitted presentation.
* radiotherapy treatments provided while admitted will be linked to admitted episodes. All other radiotherapy treatments are to be linked to non-admitted radiotherapy episodes.
* allied health practitioners do not generally order diagnostic investigations or prescribe medication and therefore these episodes should in most instances be excluded from the linking of these types of services.
* visiting nursing services should not generally attract diagnostic or pharmacy services.

For further information refer to AHPCS V4 Part 1 - Standards 5.2 Intermediate Products, AHPCS V4.2 Part 1 - Standards 2.2 Matching Cost Objects and Expenses, AHPCS V4.2 Part 1 - Standards 5.1 Final Products, AHPCS V4.2 Part 2 - Business rules 4.2C Feeder data and matching.

# Allocation methods

The allocation of expenses to the services that patients have consumed should reflect the relative intensity of the resource usage. The methodology is based on a relative value unit (RVU) where the weighting of one resource against another within a department is applied to achieve the most accurate result.

There are two methods used to allocate expenses, these are either the RVU or the service weight. These are outlined in the AHPCS V4.2, Part 2 Business rules, 5.2A3.5 defined as:

1. *An RVU is a weighted unit that reflects the comparative costs of production of one product or service against another. This is done across the full range of products or services produced within the same department. Relative value units are based on local data such as a work value unit for effort in conducting one pathology test against another or say the actual charge of a drug. In some instances, they may be externally referenced data at the unit level such as the actual reimbursement of a single test.*
2. *A service weight is a series of weightings by specified categories (for example, DRG) and by cost bucket which are a relative measure of resource use within a category. In the case of service weights, a weighting is applied at the classification level, and it assumes that on average the relative consumption of resources for episodes within that classification is similar.*

The use of service weights should be used as a last resort. Service weights are less likely to be reflective of clinical practice as they are derived at an aggregated classification level and not at the individual service level.

The most accurate allocation method is the one that has been developed in consultation with key stakeholders. Collaboration ensures that the correct expenses are apportioned to the resource.

## Direct departments allocation methods

The allocation methods to apportion the departments expenses that provided the direct patient care to the resources, will depend on the type of patient care area, the services provided, and products used.

Some common allocation methods used in order of preference (as outlined in the AHPCS Part 2: Business Rules 4.2B3.3 Final allocation statistics) are:

* Actual cost/actual time with patient – the purchase cost or production cost of the resource or the actual time spent with the patient.
* Planned/rostered time with patients - the time that it is planned or rostered for a professional to spend on each patient’s treatment.
* Actual utilisation with internally derived RVUs that measure relative costs of resources - the actual number of units consumed (from the feeder system), with an RVU developed from internal data (preferably with local clinical involvement) applied to reflect the relative cost of each resource consumed in providing treatment.
* Actual utilisation with externally derived RVUs that measure relative costs of intermediate products/services - the actual number of units consumed (from the feeder system), with an RVU developed from external data applied to reflect the relative cost of each resource consumed in providing treatment.
* Internally derived service weights - The modelled number of units consumed combined with the modelled relative costs developed from internal (within the hospital) data (preferably with local clinical involvement) applied to reflect the relative cost of each resource consumed in providing treatment.
* Externally derived service weights - The modelled number of units consumed combined with the modelled relative costs developed from external (outside of the hospital) data applied to reflect the relative cost of each resource consumed in providing treatment (e.g., the use of the national service weights).

## Overhead (indirect) allocation statistics

The costing process should recognise that overhead costs are distributed to all cost centres that interact with the overhead cost centre. Overhead allocations are applied to the direct care areas and the other overhead areas that also consume these services. The aim is to pass the costs of all overhead cost centres to the patient.

Health services should use the most appropriate statistic that best apportions the expenses within the overhead area to the departments who consume that service. In accordance with the AHPCS, Part 2 Business rules, 4.2A.3.13, other factors the costing practitioner should consider when choosing allocation statistics are:

* Cause and effect – the overhead should be allocated considering a cause and effect with products or services they produce.
* Quality of the allocation statistics available – the allocation statistics available should be accurate, reliable, consistent, and complete. They should be available and updated regularly to reflect any changes in operations.
* Economic feasibility – some of the allocation statistics are time-consuming and expensive to obtain or manage. Costing practitioners should consider whether the benefits of precise or more reliable cost information justify the additional expense incurred in obtaining accurate and detailed information.

# Resource categories (previously cost buckets)

Resource categories are designed to provide a summarised level of the types of expenses used in the treatment of patients, into a range of generic groups. The categories are aggregated from the Victorian standard Chart of Accounts cost centres and account code lists. Resource categories help with comparison for analysis, reporting and benchmarking objectives.

Detailed analysis can be derived from the individual cost centre and account codes.

Health services are required to submit the relevant cost centre code and account type map as outlined in the reference file found in the Reference section of Part A.

Included in the reference file is the cost bucket matrix which provides the cross- combination mapping to the cost groups (buckets) as well as the details of how they are derived. The department will be responsible for the mapping and rollup of VCDC data to local cost groups and the National Hospital Cost Data Collection (NHCDC) reporting requirements.

The department maintains the previous cost group mapping so that a time series comparison can be used in the development of funding models.

For further details and descriptions of how these cost buckets are derived please refer to the document Resource Categories Derivation at [Victorian Cost Data Collection.](https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc)< https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc>.

# Depreciation

**(Note Victoria is yet to transition to full compliance to the AHPCS)**

Reporting of depreciation costs to the VCDC is required for any submission year activity as part of the costing process. Health services will identify the depreciation expenses via the account code mapping table where the VCDC account type is ‘Deprec\*’[[1]](#footnote-2). Refer to the DDS at [Victorian Cost Data Collection.](https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc) < https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc>Although there are national standards relating to the allocation of depreciation, (Refer AHPCS V4.2 Part 2 – Business rules 3.1B Depreciation), Victoria does not include non-cash expenditures such as depreciation as it does not impact upon operational costs and comparisons should not be driven by an asset’s estimated life.

Victorian health services are currently unable to consistently apply the national methodology.

# Medical indemnity

Medical Indemnity (MI) expenses located in the health services general ledger must be allocated and reported to the VCDC. To assist health services with appropriate allocation, the department provides a matrix where the Victorian Managed Insurance Authority (VMIA) calculate the percentage proportion of each specialty group for the ‘exposure premium’ and apply the same percentages to the ‘final premium’. Health Services will use these ‘weights’ to allocate their MI premium costs to the appropriate clinical speciality areas (inpatients and emergency only).

Each year the Medical Indemnity Insurance Premium file derived by the VMIA is distributed to health services by the department.

The VMIA model is based on DRG specialties, with the emergency allocation based on VAED admission type of ‘E’. Health services should note that the cost allocations may not align with their clinical specialty cost groups. In these instances, local knowledge should be used to allocate costs to the most appropriate clinical cost area.

Health services are expected to record their MI allocation method for quality assurance feedback to the department.

## Allocation examples

* Emergency costs to be allocated to emergency department (ED) activity where possible. These costs have been identified as a separate data element in the matrix derived from the VAED admission type = ‘E’ emergency.
* Anaesthetics costs to be allocated to patients that have theatre utilisation. For example, use anaesthetics minutes as the allocation base.
* ICU costs to be allocated to patients that spent time in ICU. For example, use minutes in ICU (as per ward extract) rather than doctor minutes.
* Medical specialty costs to be allocated to the specific medical specialty activity for inpatients only. Health services can continue to assign costs to inpatients using existing health service indirect allocation.

Health services are encouraged to continually improve the method of allocation, and it is anticipated that a consistent approach is developed for future cost submissions.

For further details on how the VMIA determines the allocation methodology please contact the VCDC team via email at VCDCassist@health.vic.gov.au for documentation.

# Blood product costs

The National Blood Authority costs are not included in the general ledger of health services. The department provides health services with blood expenditure data as supplied by the National Blood Authority (NBA).

There is specific reporting and allocation rules relating to this expenditure and include:

* National Blood Authority costs provided to health services should be reported exclusively to the cost centre code Y0398 - National Blood Authority Blood and Blood Products.
* Any other costs relating to blood and blood products incurred by health services should be reported through the cost centre code Y0400 - Blood Products.

Further guidance on use and allocation of these costs is found at **Attachment 1 – National blood authority** advice.

# HealthShare Victoria expenses

**(previously known as Health Purchasing Victoria)**

HealthShare Victoria (HSV) was established on 1 January 2021 as an independent public sector and commercially oriented provider of supply chain, procurement, and corporate services to partner with Victoria’s public health services and suppliers in delivering best-value health-related goods and services.

HSVs expenses are currently held by the department and are not included in health services’ HSA expenses. The department provides the health services’ proportion of these expenses to be included in the costing ledger and reported to the VCDC.

The method for determining these proportions is outlined in **Attachment 3 – HPV VCDC guidance** and have been developed in conjunction with DH’s Finance department. Health services should use the cost centre range of M3201 – M3000 within their costing general ledger to allocate the expenses across all patients as an overhead cost and subsequently report it to the VCDC.

# Drug costs

Drug costs need to be identifiable as PBS, S100 or other drugs (Non-PBS). If PBS and S100 drug costs are unable to be distinguished from one another, the minimum requirement is for these drugs to be reported separately from Non-PBS drug costs.

If drug costs cannot be reported using the relevant account codes such as PharmPBS, PharmS100 or PharmNPBS, then costs should be reported under the relevant pharmacy cost areas (Refer to [Victorian Cost Data Collection.](https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc)**).**

Any pharmacy account codes such as PharmNPBS, PharmPBS and PharmS100 regardless of the cost area will be mapped to the CCSAA Pharmacy cost category (i.e., Cost bucket) outlined in Table 1 below.

Table 1: Pharmacy account types

| **Drug type** | **dhAccountType** | **dhCostArea** |
| --- | --- | --- |
| Pharmaceutical Benefits Schedule (PBS) | PharmPBS | N0896, N0897\* |
| High-cost drugs funded under Section 100 (S100) | PharmS100 | N0898, N0897\* |
| Non-PBS | PharmNPBS | N0002-0499, N0897\*, N0899-N1000 |

\*Cytoxic Drugs - these may be PBS, S100 or NPBS drugs and therefore if reported with this dhCostArea need to be identified by the appropriate dhAccountType.

# Medical costs

Medical costs are often difficult to allocate accurately as limited patient level activity data exists and the costs within the General Ledger (GL) can be difficult to apportion accurately to services provided.

Where possible, health services should separate the surgical medical costs (e.g. operating room expenses) from non-surgical medical expenses (e.g. consultation) for reporting. This allows for the accurate identification of full operating room costs. Health services need to apportion surgical expenses to a separate cost area and report the area code as in the reference file for mapping chart of accounts. The department will map to the operating room cost output under the AHPCS.

# Patient transport

Patient transport is defined through the AHPCS V4.2 A.3.17, Part 1 as:

Patient transport costs are goods and services used in the provision of patient transportation, and costs associated with transporting a patient’s carer or escort. This may be non-emergency transportation and can encompass, road transportation, commercial flights, ride sharing such as Uber and the costs associated with a taxi. Patient transport includes the cost of staff involved in transportation where these costs are included in the hospital’s general ledger.

Patient Transport does not include emergency or non-emergency curb side patient requested ambulance services or other transportation, where there is no cost incurred by the hospital.

There are two types of patient transport to be costed and submitted as part of the National Hospital Cost Data Collection (NHCDC). They include patient transport (PatTran) as outlined above and patient transport other (PatTran-other). The ‘Other’ refers to costs that are included within a hospital’s general ledger but are outside the scope of the Addendum under A12a. and these costs are partially or fully funded through other schemes by Commonwealth or jurisdictional transport schemes. Examples of these Other patient transport costs include Patient Transport Assistance Schemes and arrangements with the Royal Flying Doctor Service.

In summary Patient transport is to be used for costs that are funded through the National Health Reform Agreement (NHRA).

Patient transport – other is to be used for costs that are funded through Nationally Funded Centres (NFC).

## Victoria’s application

Patient transport expenses are identified using the Chart of Accounts account code list which can be found at [Victorian Cost Data Collection.](https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc)< https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc>.

To ensure Victoria adheres to the national reporting requirements:

* Those health services who have Nationally Funded Centres are to provide us with their cost centres/areas codes where the expenses (main) for those services are contained. The department will then map the patient transport costs within those codes to PatTran-Other.
* Health services are to ensure that all patient transport relating to the NFCs are reported within those cost centres and the patient transport expenses are reported to the VCDC as PtTransport.

All other transport related expenses are to be reported as part of the normal allocation process.

Specific costing guidance

# Purpose

This section focuses on specific services, or programs where detailed guidance is required.

Victorian health services are required to adhere to the Australian Hospital Patient Costing Standards (AHPCS) Version 4.2 in conjunction with the Victorian Cost Data Collection (VCDC) documentation to be applied for the VCDC submissions from 2024-25.

# Salaries and Wages Recoveries

The department has developed a guidance paper which outlines a consistent costing approach for the treatment of salary and wages recoveries recorded in the finance GL requiring an offset for costing purposes.

The paper considers various allocation methods, however the preferred option is to apportion to professional group(s) using the S&W account codes for basic pay. This can be done using absolute dollars or percentages.

Please refer to **Attachment 3** for the full details and guidance.

# Non-admitted Costing Guidelines

Non-admitted care encompasses services provided to patients who do not undergo a formal admission process and do not occupy a hospital bed. Non-admitted services are required to be identified, costed, and reported to the VCDC with the relevant stream, program, or service codes. This is a requirement for those listed but not limited to stream codes as outlined in Part A and the DDS. A list of programs/services found in the reference file at [Victorian Cost Data Collection.](https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc) < *https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc>.*

Non-admitted service event(s) are defined as ‘an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient’s medical record’. These are expected to be costed and reported through to the VCDC. Some areas may require further information to ascertain an appropriate allocation method for costing and reporting through to the VCDC. These areas include:

## Non-admitted did not attend contacts

Nationally there is a recommendation that costing practitioners and their stakeholders are “...to consider how they will treat activities which fall outside the definition of service events or require further consideration. For example, ‘did not attend’ records may require a minimum allocation of expense to recognise costs associated with bookings, medical record retrieval and other associated costs … and … should refer to their jurisdictions for further advice.” (AHPCS V4.2 Part 3 – Costing Guidelines CG 8.3.13)

While do-not-attends are not recognised by the current national and local funding models, costing these may influence future funding models which better reflect each patient’s resource usage.

Victoria has considered how the activities related to ‘did not attend’ are to be treated and the allocation of expenses. **The consensus is for ‘do-not-attends’ to be treated as an indirect/overhead expense which is associated with running Hospital Non-Admitted activity.**

For further details on the Victorian perspective of costing these activities please refer to **Attachment 4**.

## Home based non-admitted services

Generally, for a non-admitted service event to be counted, each of the criteria in the definition of a service event should be met, (refer to the service event definition in the VINAH manual). However, there are some services that are exceptions to this rule and include (may not be limited to):

* Home delivered ventilation
* Self-administered home dialysis; and
* Home delivered self-administered HEN and TPN.

These services generally have no interaction between a patient and a healthcare provider. The cost of consumables, equipment, maintenance, and overheads should be considered. Refer to the counting rules on Non-admitted care funding stream at [Non-admitted (health.vic.gov.au)](https://www.health.vic.gov.au/funding-performance-accountability/non-admitted).

<https://www.health.vic.gov.au/funding-performance-accountability/non-admitted>

These services are to be costed and reported through the VCDC under program NV (Non-Admitted-VINAH) with the corresponding code specified for reporting in the stream field, (refer VCDC data definition specification (DDS).

### There is further guidance provided on the non-admitted care funding stream available on the department’s website. < https://www.health.vic.gov.au/funding-performance-accountability/non-admitted > Home Enteral Nutrition (HEN)

Activity for patients enrolled in the HEN program will be collected at the episode level where an episode is to be opened for the duration until the patient ceases home-self administration One non- admitted service event should be counted per calendar month for episodes that have been active during the month.

### Total Parental Nutrition (TPN)

Activity for patients enrolled in the TPN program will be collected at the episode level where an episode is to be opened for the duration until the patient ceases home-self administration. One non- admitted service event should be counted per calendar month for episodes that have been active during the month.

### Home ventilation services

#### Complex Care (previously known as Family Choice Program (FCP)

The state-wide Complex Care Program provides home based support to families of children with high levels of complex ongoing medical care needs where children aged between 0 -17 years.

Self-administered ventilation by patient or the carer is included within Complex Care

Activity for patients enrolled in the Complex Care program will be collected at the episode level where an episode is to be opened for the duration, until the patient ceases home-self administration. One non- admitted service event should be counted per calendar month for episodes that have been active during the month.

The Program Streams to be assigned are as follows:

* Complex Care On Ventilation, dependant ‘52’
* Complex care: On Ventilation, not dependant ‘53’
* Complex Care: Non-Ventilation, ‘54’.

It is recommended that costing practitioners consult with their organisations’ stakeholders of Complex Care (FCP) to ensure all expenses and activities are captured and apportioned adequately.

#### Victorian Respiratory Support Services (VRSS)

The state-wide Victorian Respiratory Support Service (VRSS) is a specialist program which provides a range of services to adults with a chronic respiratory failure. The services include:

* Outpatient assessment
* Inpatient specialist clinical services
* Support to ventilator dependent people living in the community.

(Refer to website: [Austin Health: Victorian Respiratory Support Service](https://www.austin.org.au/victorian-respiratory-support-service) for further information).

It is recommended that costing practitioners consult with their organisations’ stakeholders of VRSS to ensure that this cohort of patients are correctly identified and costed under Program Streams:

* Pre-2017-18, Program Stream = ‘VRSS’ or ‘81’ Victorian Respiratory Support Service.
* From 2017-18, Program Streams are to be identified as:
  + ‘82’: Home Ventilation: continuous
  + ‘83’: Home Ventilation: overnight

## Medical salaries for private (MBS) & public non-admitted specialist clinics

The department needs to be able to distinguish public and private patient resource usage as well as new and review contacts, in order to inform local cost weight development for funding models.

Costing medical salaries is also a requirement of the current version of the AHPCS found on the IHPA website. Specifically, Part 2: Business rules, Stage 1: Identify relevant expenses, 1.1 General, 1.1A Medical expenses for private and public patients).

(Refer to website: [Australian Hospital Patient Costing Standards Version 4.2 | Resources | IHACPA](https://www.ihacpa.gov.au/resources/australian-hospital-patient-costing-standards-version-42)).

The department has developed guidance which aims to improve overall cost data quality and ensure cost data is fit for purpose when costing medical salaries for private (MBS) and public non- admitted specialist clinics.

The document at **Attachment 5** provides all the details.

# Admitted Costing Guidelines

## Prostheses

.

The department in collaboration with key stakeholders have developed guidance for a consistent method for costing of prostheses. These include:

* advice for allocating costs
* definitions that Victorian health services can use
* guide for identifying the components of prosthesis used for patients and
* guidance for quality assurance checking processes.

The document at **Attachment 6** provides all the details.

The department has analysed and developed boundary cost points for each identified DRG expected to have a prostheses cost. These boundaries can be found in the DDS.

## Victorian Perinatal Autopsy Service (VPAS)

The Victorian Perinatal Autopsy Service (VPAS) provides a co-ordinated state-wide service ensuring consistent standards of practice and expertise for the clinical investigation of perinatal deaths across Victoria.

The three organisations providing these services are The Royal Women’s Hospital (the Women’s), Monash Health and Mercy Hospital for Women, and their associated pathology departments at the Austin, Monash and the Royal Children’s Hospital.

To ensure the patients who use this service are costed and reported consistently across the health services, the department is has developed a paper, at **Attachment 7**, which aims to improve the understanding of the various scenarios.

## Sub-Acute Costing Guidelines

## Palliative Phase of Care

The costs for palliative care phase of care data are to be reported through the VCDC to enable a more accurate link of cost to the phase of care.

This cohort of patients are costed like any admitted patient cohort where the relevant service codes will be linked to patients’ encounters based on the service date time stamps within the patients’ start date time and end date time.

Further details regarding the phase of care file rules for reporting costs at the phase of care please refer to: **Attachment 8: Reporting Palliative Care (phase of care) to VCDC**.

## Reporting Palliative Care

The reporting of the cost data is to be provided using the xml and data reporting requirements as for the main VCDC file however the service date is a required field. This supplementary file will follow the phase of care file details as outlined in **Part A**.

# Mental Health Costing Guidelines

Mental Health provide services in admitted, community or residential settings. Both clinical and non-clinical services operate within geographically defined catchment areas.

For more information relating to the Victorian Mental Health Service go to the department’s website.

*[https://www.health.vic.gov.au/mental-health/about-victorias-mental-health-services].*

As a condition of funding, organisations are required to adhere to the service standards and guidelines applicable to the funded activity. This includes requirements set out in program management circulars and the Chief Psychiatrist’s Guidelines (issued by the department).

The costing of these services needs all the resources consumed throughout the treatment to be identified.

The Mental Health guidelines at **Attachment 9** outlines the scope, definitions, and guidance for costing to be applied by all health services who provide a mental health service.

The guidelines are currently in draft and are reviewed and updated in accordance with recommendations from the subcommittee members and stakeholders from the wider mental health services. The updating of the guideline informs the updating of this documentation.

## Reporting Mental Health for phase of care

The development of an Activity Based Funding (ABF) model for funding Mental Health services is underway. The department requires the cost data for all Mental Health services to be reported at a service date. This allows the linking of all related costs to a phase of care.

The process of providing the cost data is the same as for the palliative care phase of care reporting requirements for programs MH (admitted mental health) and M (community mental health).

# Reporting for COVID-19

The impact of COVID-19 continues to impact health services and the recording and reporting of its activities and costs.

The department has issued Data capture guidelines for COVID-19 to provide guidance to hospitals about how they should account for COVID-19 related transactions.

Costing practitioners in conjunction with their finance department are to confirm that the recording and reporting of these expenses are reflected in the GL in accordance with the latest guidelines to ensure the correct costs are allocated to patients.

For a copy of the department’ guidelines, please email to [VCDCassist@health.vic.gov.au.](mailto:VCDCassist@health.vic.gov.au)

|  |
| --- |
| Attachment 1 National Blood Authority - Blood Expenditure Data |
| Victorian Cost Data Collection costing guidance |
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Introduction

The Blood, Pharmaceutical, Organ and Tissue Donation Programs Unit of the department receives health services’ blood expenditure data supplied by NBA. The NBA sources the data from BloodNet which records all the products being supplied to health services and where health services are also required to enter their data such as their orders, transfers and discards.

The Victorian health services’ finance general ledger currently does not include the National Blood Authority (NBA) expenditures. Hence, the provision of the annual proportion of these expenses to health services for inclusion in the cost ledger and to be reported to the Victorian Cost Data Collection (VCDC) at patient level.

Purpose

To ensure that expenses incurred on behalf of an organisation by a third party, that directly contribute to delivery of that organisation’s products, are included in the cost ledger to reflect the full cost of product delivery[[2]](#footnote-3).

Overview

A hospital may receive corporate and/or shared services that are provided by another hospital, health service or government department or parent company. A number of these services may form an integral part of the hospital’s day to day functions and may be an important input to patient care.

Should these services not be provided, the hospital may be obligated to replace these services internally or reduce its scope of services and net outputs. For these reasons, expenses that relate to such services need to be identified and included in the full cost of the hospital’s products.[[3]](#footnote-4)

The National Blood Authority blood products are one of these third-party expenses where the department has provided costing practitioners with the relevant details required to include in their costing process. This paper provides guidance on how to allocate these expenses in health services’ costing systems.

What is in the file?

There are three sheets within the file provided yearly NBA allocation of expenses:

1. The blood product expenditure supplied (at the end of the fiscal year) by NBA is at the health service (including campus where this information is available) and blood product levels. Information provided in the file includes the quantity and expenditure of blood, blood transfers in and out and discarded blood products.

Health Services transfer products to other health services (for several reasons like the product may be due to expire or the other health service has requested supply as they are finding it difficult to obtain etc). These are the (TRANSFERRED IN) and (TRANSFERRED OUT) columns.

The “*Total Expenditure of Blood or Blood Products Issued, Transferred In and Transferred Out*” is the nett cost of blood & blood product received by the hospital and it includes the discarded products. This is the figure that is to be reconciled to health service’s internal blood product records (which may be conducted by the blood scientist or the pathology and/or pharmacy departments) and allocated to patients.

1. Blood type reference[[4]](#footnote-5) – lists the bloods, their categories and the ACHI codes related to them and the product setting as at 2019-20.
2. ACHI codes[[5]](#footnote-6)3 – lists the ACHI codes and the related blood products as at 2019-20.

Important note on Blood product expenditure

Since 2017-18 please note:

EHL - extended half-life are recombinant clotting factors, that under the contractual arrangements the NBA has in place with Bioverativ the prices for ELOCTATE, ADYNOVATE and ALPROLIX are confidential and must not be used or disseminated for any purpose other than the National Blood Arrangements.

This data does not split the expenditure by product type (e.g. admitted or non-admitted). Health services should seek further assistance on the allocation methodology of EHL to patients.

Blood product reporting and allocation process

This paper provides some guidance on the reporting of this expenditure through the Victorian Cost Data Collection (VCDC) process and how to best allocate this expenditure to the patient cohort.

Reporting

Health services are to report NBA blood expenditure costs (expenditure only and excluding overheads), to the VCDC across all relevant product types as cost centre Y0398 – National Blood Authority Blood and Blood Products.

Any other costs relating to blood and blood products incurred by health services should be reported to cost centre Y0400 Blood Products.

The correct assignment of cost centres will enable the department to consistently analyse the impact of blood costs across the sector.

Allocation

1. The preferred approach is to have a direct Blood feeder extract[[6]](#footnote-7) containing the actual patients’ issues of the blood products and the actual date of transfusions. There are number of health services that have implemented this methodology and th
2. is section is written in conjunction with some of these health services[[7]](#footnote-8).

The following methodology has been identified:

* 1. This would require the costing practitioners (or costing consultants) to contact the appropriate personnel who has access to the BloodNet database at their health services initially and on a regular basis[[8]](#footnote-9). This may be the blood scientist in pathology or the transfusion nurse and the pharmacy department[[9]](#footnote-10).
  2. Health services with pathology department obtain a direct patient feeder which denotes the blood products and other details (refer to Appendix A). This provides a better driver by which expenditures are to be allocated to patients.
  3. Currently, majority of health services obtain their direct patient feeder extract for Blood Products from the Pathology (and Pharmacy) departments.
  4. Reconciliation[[10]](#footnote-11) by health services is to be conducted on the data extract obtained internally with the NBA data provided.

1. From 2020-21, in the absence of the direct patient Blood feeder extract, the blood product information has to be reviewed by health services’ Health Information Management advisor and from this, a set of best fit selection of Australian Classification of Health Interventions (ACHI) procedure codes are to be mapped to each blood product type.
   1. These can assist costing practitioners (or costing consultants) identify the cohort of patients to allocate the expenses to.
   2. It has been an on-going advice when using this second allocation, that costing practitioners (or costing consultants) seek inputs from their respective Health Information Managers to inform the process within their respective organisations.

The ACHI codes

* Whilst the ACHI codes may provide a guide to the inpatient allocation, for the non-admitted allocation, costing practitioners (or costing consultants) are to give some consideration to the appropriate clinic or setting and establish the relevant cost driver for this process with their internal stakeholders.
* This advice is to help inform discussion of how the expenditure at the blood product level should be split, by product and by setting.
* As part of the second allocation process, it is recommended that costing practitioners (or costing consultants) seek assistance from their health service’s Transfusion Medicine Director and/or Pharmacy Director to help inform this split prior to allocating the blood product.

Methodology used for reporting

It is recommended that health services document their allocation process across expenditure lines and document their method of blood product allocation on the Data Quality Statement (DQS) after their final VCDC submission.

If there is currently no direct patient Blood feeder and using the ACHI allocation process, please include the date planned to migrate to the allocation of blood expenditures by actual blood products at patient level on the DQS.

Appendix A

#### Suggestions for a base Blood Feeder Data Extract from Pathology or Pharmacy:

Hospital Code

Lab Number

Patient Medical Number/ Patient Unique Identifiers

Patient Name

Patient DOB

Gender

Product Code

Product Description

Product Type Name

Quantity/Volume

Unit Price

Bar Code

Blood Group

Date of Issue

Date/Time of Transfusion

Date of Return

Issue Location

Unit/Doctor

Appendix B – Methodologies on Blood Products Feeder extracts by actual patients’ utilisations

**Methodology 1[[11]](#footnote-12):**

Obtain regular (e.g. monthly or quarterly) blood data extract from Pathology (e.g. AusLab) and Pharmacy (e.g. Merlin) and from any other source that might contain blood data at the patient level.

Summarise the internal blood data extract (from 1 above) received (monthly or quarterly) for the year by blood products units as per the Screen 1 below.

Upon receiving annual NBA data from the department (columns A to P on Screen 2 below), map[[12]](#footnote-13) the internal blood product feeder extract’s product codes with NBA blood product codes to obtain the unit costs (if this is unavailable) on the internal feeder blood extracts.

Further summarise the internal blood data extract (in 1 above) for the year by multiplying blood products units and calculate dollars (column V on Screen 2 below)

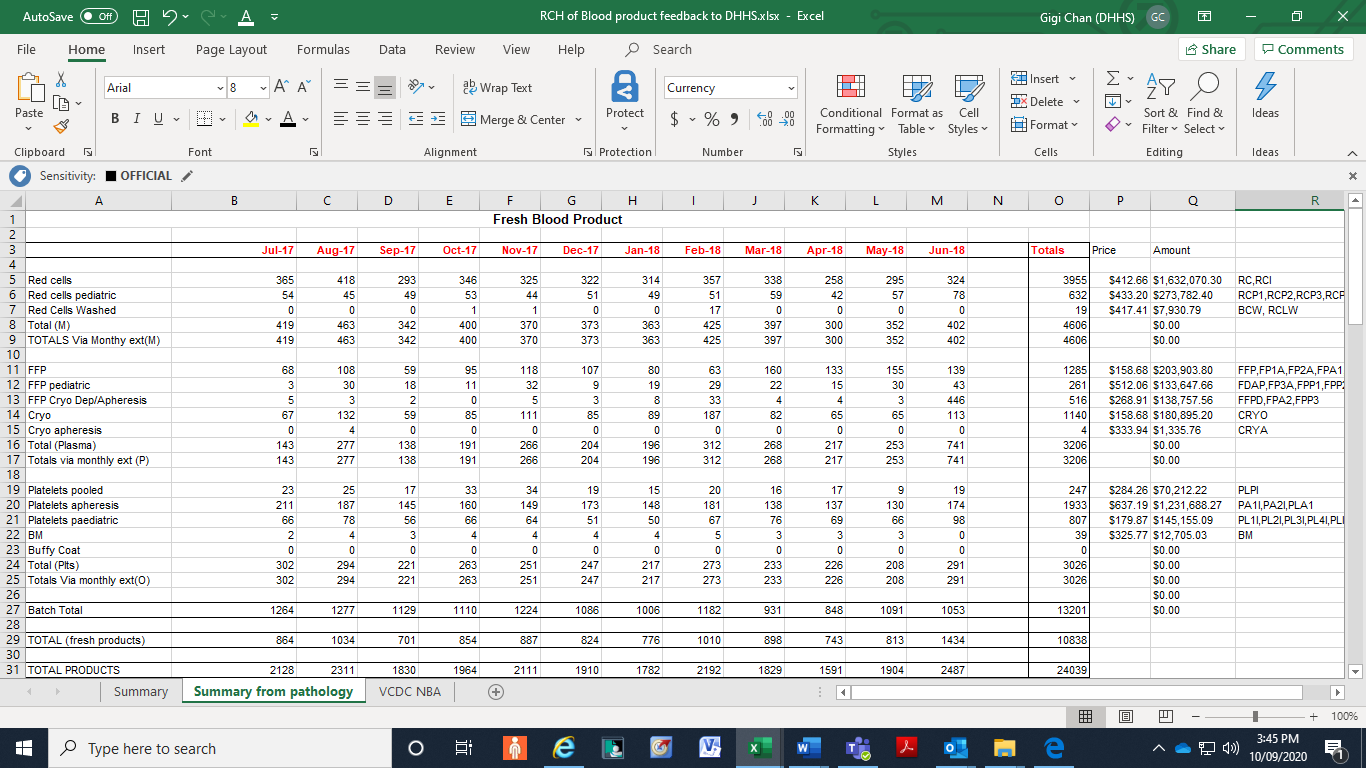
Compare the total units and dollars from 2 and 4 above (as per columns X and Y on Screen 2).

Follow up with blood manager to confirm mapping and find out any outstanding or anomalies (such as missing blood products (e.g. Berinert) and significant difference in units and or dollars (e.g. red blood cell in the example below).

Update/insert latest unit price in mapping table to be used in blood feeder extract.

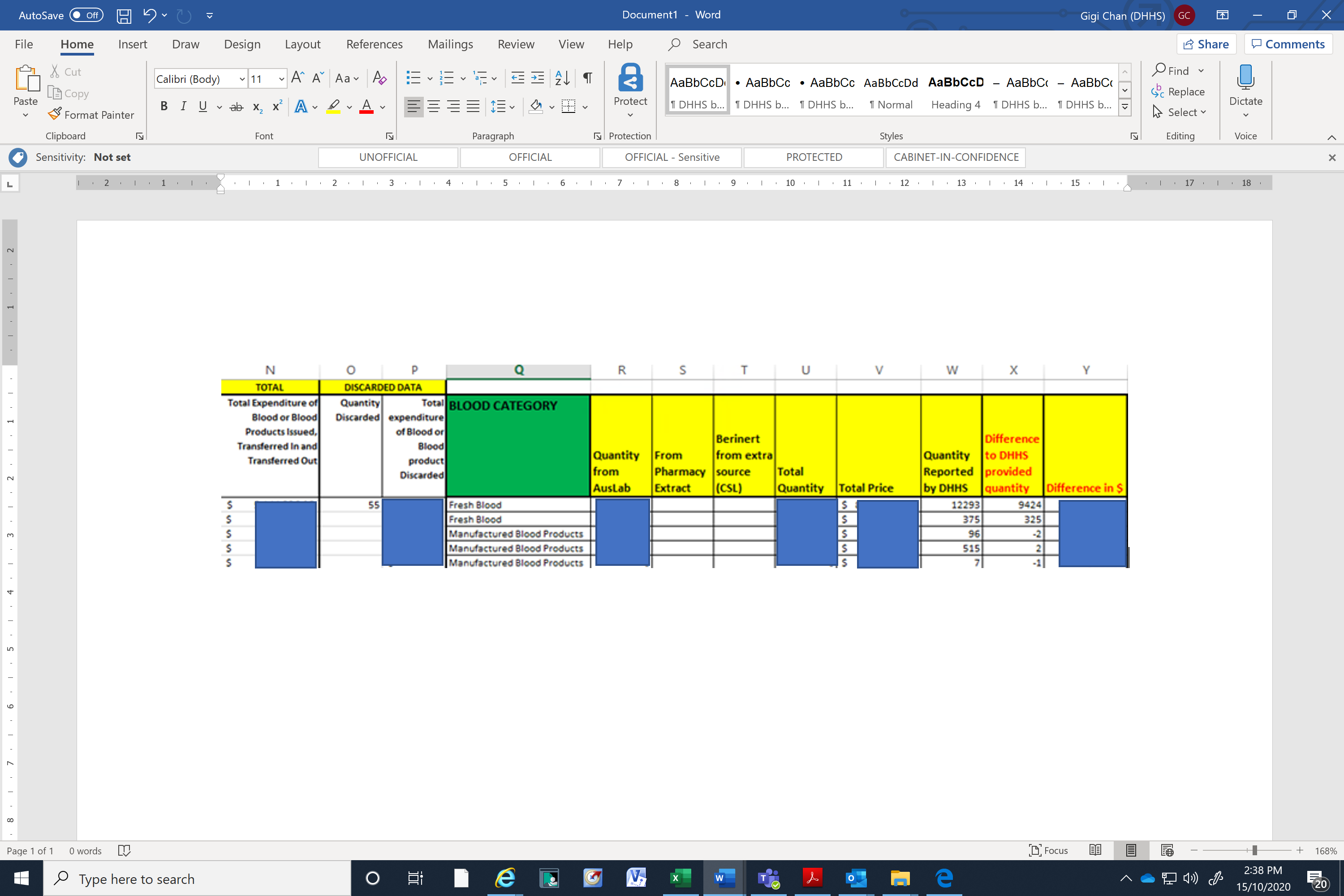
Allocate the blood cost using unit price as RVU.

**Screen 1: Summary of Blood Product Feeder extract by Units**



**Screen 2:**

Below is a screen dump of blood worksheet on reconciliation:  Columns A to P are sourced from the data provided by NBA. Columns Q to Y are the reconciliation columns.



**Methodology 2[[13]](#footnote-14):**

Methodology 2 is employed at health services where there is difficulty in the mapping of the internal blood product codes on the Blood product feeder to the NBA blood product codes, and where internal records of the blood product units and unit costs (kept internally by the blood scientist) are available.

This methodology allocates the Total expenditure (column N on the NBA data provided) in Y0398, but the internal charges stored on the pathology system are used as the RVUs on the Blood product feeder by actual patient utilisations. Investigation has shown what is recorded on the Blood product feeder extract from pathology reconciles to the NBA Total expenditure with only an insignificant discrepancy of 0.07%[[14]](#footnote-15).

The following steps may be followed:

Obtain regular (e.g. monthly or quarterly) blood data extract from Pathology (e.g. AusLab) and Pharmacy (e.g. Merlin) and from any other source that might contain blood data at the patient level including the charges/unit costs. Summarise the data.[[15]](#footnote-16)

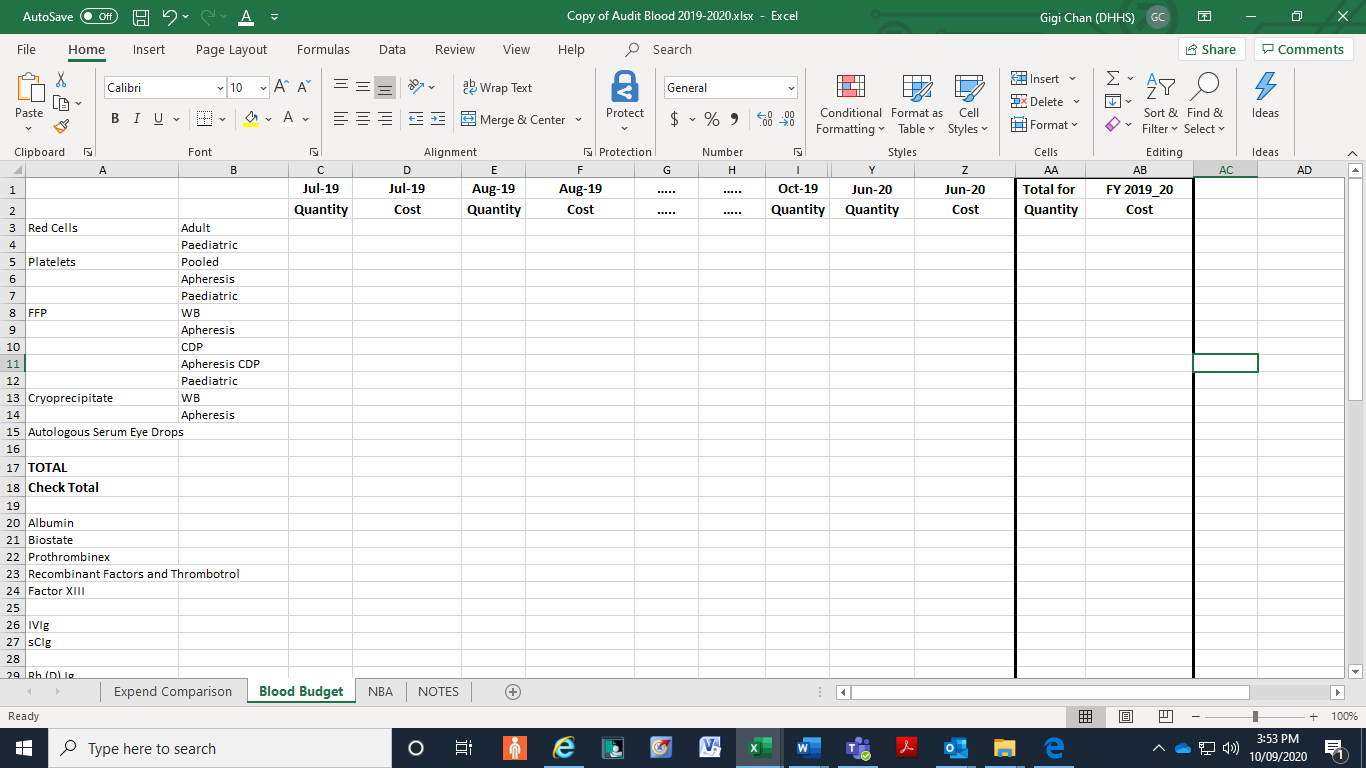
Obtain the summarised internal blood recorded received (from the blood scientist) for the year by blood products units as per the Screen 3 below.

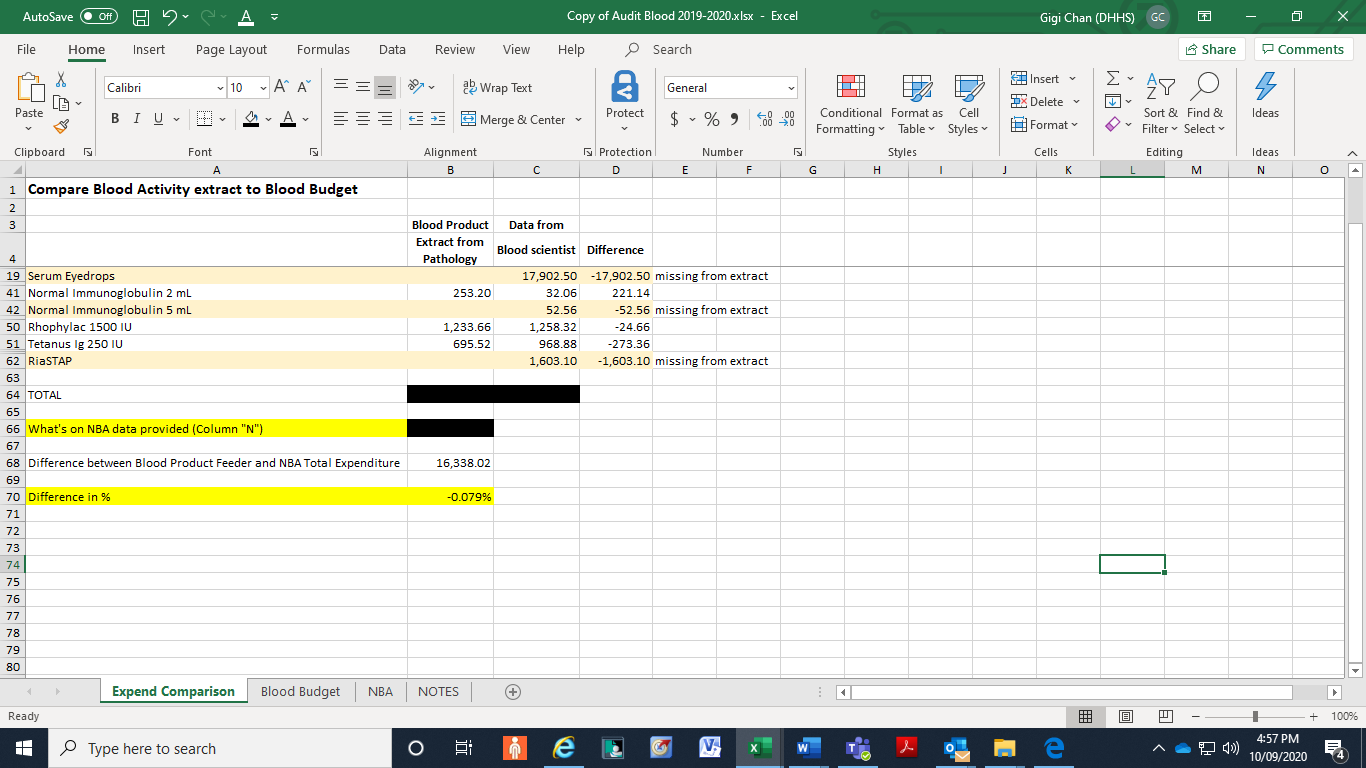
Compare and reconcile the results in each of the above two steps’ total as per Screen 4 below to the Total Expenditure on the NBA data provided.

Differences in step 3 (between the summarised records kept internally and the NBA Total expenditure provided) may be due to the unit costs as referenced on the internal blood products or due to internal procedures and processes.

Refinements in step 4 above will in due course close any discrepancies between what is kept on the internal at the summarised level and what is on the Pathology system.

**Screen 3: Summary of internal records**



**Screen 4: Compare the Totals on Blood Product data extract to the total on the NBA data provided**

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| Attachment 2 Health Share Victoria  (previously known as Health Purchasing Victoria) |
| Expenses to be included for the Victorian Cost Data Collection |
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Background Introduction

Established in 2001 to improve the collective purchasing power of Victorian public health services and hospitals, Health Share Victoria (HSV) achieves ‘best value’ outcomes in the procurement of health-related goods, services, and equipment through more than 40 contract categories.

We work in partnership with public hospitals and health services to understand their requirements, facilitate large scale tenders and manage common-use contracts on behalf of the state. HPV also takes a lead in identifying and evaluating opportunities for collective procurement and projects that enhance public health procurement capability.

HPV is responsible to the Minister for Health and works closely with the Department of Health. HPV is an independent statutory authority under Section 129 of the Health Services Act 1988.

HPV’s key role is to work collaboratively with the health sector in Victoria to find the best value outcomes in collective procurement. Beyond procurement, HPV works towards driving end-to-end supply chain reform across the health sector.

During 2020-21,Victorian government established a single state-wide supply chain for personal protective equipment (PPE) and medical consumables, within an integrated information system to provide visibility in managing medical consumable stocks and medicines across the health sector. As a result, Health Purchasing Victoria (HPV) ceased trading under this name on 31 December 2020 and Health Share Victoria (HSV) commenced operations on 1 January 2021.

Victorian Cost Data Collection

The HSV expense is currently held by the department and is not included in health services’ HSA expenses. The department provides the health services’ proportion of these expenses to be included in the costing ledger and reported to the VCDC.

The methodology for determining these proportions is outlined below and have been developed in conjunction with DH Finance department. Health services should use the cost centre range of M3201 – M3300 within their costing general ledger to allocate the expenses across all patients as an overhead cost and subsequently report it within their VCDC submission.

Compliance

As part of the National Health Reform Agreement (NHRA), Victoria uses the VCDC as the base data for submission to the Independent Hospital Pricing Authority’s (IHPA) National Hospital Cost Data Collection (NHCDC).

The NHCDC collects patient level cost data across the Commonwealth for the purposes of calculating national cost weights and determining the National Efficient Price (NEP) and National Efficient Cost (NEC).

To ensure there is consistent, reliable, and quality costed data, health services are to comply with the national Australian Hospital Patient Costing Standards (AHPCS) Version 4.2 as well as adhere to the VCDC activity-based costing documentation (previously VCDC documentation) and any other documentation or guidance provided by the department.

The national requirement which the HSV expenses comply with can be found on the IHPA website as Standard 1.2 Third-party expenses. <[Australian Hospital Patient Costing Standards Version 4.2 | Resources | IHACPA](https://www.ihacpa.gov.au/resources/australian-hospital-patient-costing-standards-version-42) .

Methodology

DH Finance department provides the VCDC Team with the consumable expenditure for health services including nurse agencies for the fiscal year.

The expense codes are taken from the F1 reports and includes:

12501-12550 for the Nurse Agency

20001 – 32150 for health services- a subset of consumables.

A proportion of the individual health service’s consumable expenditure is calculated.

This proportion is then applied to HSV’s total expenses reported in the annual report for that fiscal year.

The HSV amount calculated for each health service is to be included in the costing general ledger to be allocated across all patients as an overhead cost and subsequently reported to the VCDC.

The cost centre range of M3201 – M3300 is to be used in the costing general ledger for the health service’s proportion of the HSV expenses.

The department will provide this report once the financial data has been finalised for that year.

HSV health services’ proportion

Once the above methodology is applied and the proportions are finalised, the file will be provided to costing practitioners for their HSV dollar amount to be included in their costing general ledger.

This inclusion in the costing general ledger should follow the methodology outlined above for steps 4 and 5. If health services cannot adhere to that methodology, they should provide the reason as part of the data quality statement.

The file will be sent to health services’ costing practitioners and/or their costing consultants via the VCDC Secure Data Exchange (SDE) portal.

Impact of the COVID pandemic

Since 2019-20 the impact of the COVID pandemic has resulted in an update to the Chart Of Accounts and guidance to hospitals about how they should account for COVID-19 related transactions. These updates also ensure the COVID-19 cost centre structure and business rules allow us to meet all the requirements of the Commonwealth and allow us to support the National Partnership on COVID-19 Response (NPCR) agreement reconciliation.

Therefore, the allocation methodology as outlined in step 4 above should exclude the following COVID-19 related cost centre range(s):

A0566-A0570 HITH Expansion - COVID-19

A0697-A0699 Admitted – COVID-19

A0727-A0729 Intensive Care - COVID-19

B0297-B0299 Emergency – COVID-19

C1097-C1099 Non-admitted – COVID-19

D0199 Other Acute Health Funded Services - COVID-19

F0699 Subacute - COVID-19

H0399 Mental Health - COVID-19

J7195 Aged Care Support to Private Aged Care facilities – COVID-19

J7199 Aged Care – COVID-19

L0399 Primary Health – COVID-19

M1519-M1539 LPHU – vaccinations- COVID-19

M1541-M1545 LPHU - Clinical Reserves Unit - COVID-19

M1549 Local Public Health Unit

M1587 VIDRL - COVID-19

M3091-M3095 Ambulance Surge Initiative - COVID-19

M3099 Ambulance services - COVID-19

N0199 Pharmacy - COVID-19

R2111-R2115 Workforce Initiatives - COVID-19

R2116-R2120 Community Initiatives - COVID-19

R2485 Regional Response Testing - COVID-19

R2491 NPA Excluded Expenditure - COVID-19

R2495 Foregone Third Party Revenue - COVID-19

R2498-R2499 Management & Support – COVID-19

W0299 Balance Sheet COVID-19

X2189 Capital – vaccinations- COVID-19

X2194-X2195 Capital - Minor - COVID-19

X2198-X2199 Capital - Major - COVID-19

X3099 Capital (State Supply) - COVID-19

Further details

For further details or queries please contact [VCDCassist@health.vic.gov.au](mailto:VCDCassist@health.vic.gov.au).

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| Attachment 3 Salary and Wages (S&W) recoveries costing guidance |
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Purpose

To develop a consistent costing approach for the treatment of salary and wages recoveries recorded in the finance General Ledger (GL) requiring an offset for costing purposes with respect to:

Recoveries as expenses resulting in negative costs.

Recoveries as revenue of services provided to third party (external organisation) not contributing to the organisation’s output.

Guidance

Victorian hospitals are required to adhere to the Australian Hospital Patient Costing Standards

(AHPCS) Version 4.2 in conjunction with the Victorian Cost Data Collection (VCDC) documentation to be applied for the VCDC submissions from 2017-18.

The AHPCS requires costing practitioners ‘to ensure that where negative expenses have occurred within the period that they have been correctly offset and assigned to the corresponding final cost centre.’

The VCDC documentation outlines the mapping requirements of the Chart of Accounts to be reported to the Victorian cost collection. Following a review of this mapping for the 2015-16 submission year an issue identified that the recovery account codes mapped to the “Other’ cost bucket resulted in a negative cost.

These S&W recoveries refer two types as reported in the GL as.

Expenses (negative) as outlined in table 1.

Revenue as account code 57029 - Income - Salary Recoveries External Organisations.

Victoria has considered various allocation methodologies and although the options outlined below will ultimately produce a similar result, for consistency the preferred option is to apportion to professional group(s) using the S&W account codes for basic pay (either in absolute dollars or percentages).

Background

The requirement for granular details in understanding the patients’ cost profiles meant changes to the cost buckets were introduced for the 2015-16 Victorian Cost Data Collection (VCDC) submissions.

Following the 2015-16 cost data’s validation and analysis, an issue was identified with S&W recoveries mapped to the ‘Other’ cost bucket resulted in a negative cost.

Further investigation showed that where the financial accounting practice is to record S&W recoveries and transfers to a generic account (for all professional groups), this will trigger these S&W amounts to be rolled up into the ‘Other’ cost bucket with negative amounts accumulated from these accounts.

Another situation identified which contributes to having negative costs is with respect to S&W recoveries provided to an external organisation which does not contribute to the health service’s output.

The above two indirect impacts of having negative costs in a cost bucket contravenes both the business rules at national and local levels. A discussion paper was prepared for discussion with members of VTWG (formerly VCCUG) and this Guidance, non-costing vendor specific is the outcome from these discussions.

Defining the problem

The current VCDC Chart of Accounts’ alignment with the department’s Chart of Accounts is well observed by the Victorian health services participating in the annual VCDC submissions.

The main S&W account codes relating to basic pay, sick pay, overtime, penalties, allowances, work cover and departures are segregated into different professional groups below:

Nursing,

Ancillary Support -Allied Health,

Hotel and Allied Services,

Administration & Clerical,

Medical Support,

Hospital Medical Officers and Sessional Clinicians.

The following account codes do not report to the above professional groups and are consequently mapped to the ‘Other’ cost bucket;  Salary and Wages Recoveries - Internal/Recharges.

Parental Leave recoveries.

Accrual - Late Timesheets.

Agency.

Contract staff.

Following the introduction of changes to the Chart of Account mappings, three situations were identified where the ‘Other’ cost bucket may result in negative costs. These can be found at **Attachment 1**.

Based on the account codes outlined in **table 1**.

1. The service cost groups (cost centre) mapped to Allied Health, Medical or Nursing cost buckets and having the account codes outlined in **table 2**.
2. The service cost groups (cost centres) and having account codes mapping of SWHotel, SWHotelOc, SWMedSup, SWMedSupOc, SWOther, SWOtherOc outlined in **table 3**.

Recoveries as expenses

The expense account codes identified as recoveries (but not limited to) can be found at **Attachment 1, table 1**.

The department identified three options that will assist to develop a consistent approach for the treatment of these recovery account codes within the context of this paper. After extensive consultation with the costing sector, health services endorsed preferred methodology were either options 1 or 2.

The preferences are to be undertaken within the costing general ledger and your preferred option is to be reported in the notes to the reconciliation templates.

Allocation methodology

1. Apportioning to professional groups S&W account codes – Basic Pay

Costing practitioners in conjunction with advice from stakeholders (such as Program managers, Finance, Business managers, Directors, Executives) are to determine an appropriate allocation (either in absolute dollars or percentages) to apportion the S&W recoveries to the relevant basic pay account code for the professional group.

**Impact using option 1**

The outcome will result in the reduction of the S&W expenses within the professional group which will be reported through to the relevant cost bucket.

That is; where account code 11001 Salary and Wages Recoveries - Internal/Recharges has been identified as relating to 60% Nursing and 40% Allied Health within the same cost centre then by apportioning the 60% to Nursing S&W basic pay account code that will be reported in the Nursing cost bucket.

2. Deriving professional groups for the recovery account codes

Costing practitioners in conjunction with advice from stakeholders (such as Program managers, Finance, Business managers, Directors, Executives) are to determine an appropriate allocation (either in absolute dollars or percentages) to apportion the S&W recoveries to a derived professional group for that recovery account code.

**Impact using option 2**

The outcome will result in the reduction of the S&W expenses within the professional group which will be reported through to the relevant cost bucket.

That is, where account code 11001 Salary and Wages Recoveries - Internal/Recharges has been identified as relating to 60% Nursing and 40% Allied Health within the same cost centre then.

* deriving account code 11001\_10 Nursing Salary and Wages Recoveries -

Internal/Recharges and apportioning 60% will then be reported in the Nursing cost bucket and

* deriving account code 11001\_40 Hotel and Allied Services Salary and Wages Recoveries - Internal/Recharges and apportioning 40% will be reported in the Allied health cost bucket.

A sample of these derived account codes is outlined on **Attachment 2**.

Recoveries as revenue

The revenue account code identified as recoveries (but not limited to) is 57029 - Income - Salary Recoveries External Organisations - Non AFR Entities. Some health services record the reimbursement for services related externally to hospitals into this code however there may be other revenue codes that may also be included.

Such recoveries of services provided by the hospital when reimbursed by the external organisations are to be offset against their related expenditures in accordance with AHPCS v4.2 Part 2 – Business rules 1.3A.3.

Allocation methodology

Costing practitioners are to consult with stakeholders such as Program managers, Finance, Business managers, Directors, Executives, to determine the amount of service rendered to the third party or external organisation by professional groups either in absolute dollars[[16]](#footnote-17) (e.g., $10,000 to Medical) or in proportions2 of professional groups (e.g., 100% Medical or 50% Medical and 50% Nursing).

Following consultation with the sector, the department has identified two options that will assist to develop a consistent approach for the treatment of these recovery account codes within the context of this paper.

The preferences are to be undertaken within the costing general ledger and your preferred option is to be reported in the notes to the reconciliation templates

Where a revenue account code has been identified as a reimbursement then the following options can be applied.

A. Maintaining the revenue

Once the amount of expenses related to the revenue has been agreed then.

1. Set up a specific direct cost centre to contain these codes.
2. Transition both the revenue and expense amount(s) as reported to that specific cost centre. The expense amounts can be in absolute dollars or a proportion.
3. The expenses are to be allocated to a virtual (dummy) patient.

**Impact using option A**

The outcome will result in the reduction of the S&W expenses from the original cost centre maintaining the revenue information within the costing system.

B. Offsetting the expense

Once the amount of revenue related to the expenses in a particular cost centre has been agreed then.

1. Transition the revenue amount(s) as an expense (negative) to the associated cost centre. These amounts can be in absolute dollars or a proportion.
2. This offset is to be apportioned using one of the options as outlined in the recoveries as expenses section.

**Impact of using option B**

The outcome will result in the reduction of the S&W expenses within the professional group which will be reported through to the relevant cost bucket.

Future development

The most reliable option to develop a consistent approach for the treatment of S&W recoveries would be to update the department’s Chart of Accounts to accommodate the S&W recoveries account codes by the different professional groups.

Future discussions within the department regarding these updates have commenced. However, this process and change in practice across all health services will need to progress through the appropriate approval processes and procedures and will take time to implement.

Attachment 1

**Table 1:** The account codes mapped to the ‘Other’ cost bucket are:

| **Account Code** | **Account Description** | **Type** | **VCDC Account Type - Submitted** |
| --- | --- | --- | --- |
| 10901 | Accrual - Late Timesheets | E | SWOther |
| 10921 -  10949 | Salaries and Wages - Accruals Other | E | SWOther |
| 10980 -  10999 | Workcover Recoveries | E | SWOtherOc |
| 11001 | Salary and Wages Recoveries - Internal/Recharges[[17]](#footnote-18) | E | SWOther |
| 11002 | Parental Leave Recoveries1 | E | SWOther |
| 11003 | Parental Leave | E | SWOther |
| 11004 | Payroll Tax | E | SWOther |
| 11011 -  11160 | Other Salaries and Wages | E | SWOther |
| 12551 -  12599 | Agency Other | E | SWOther |
| 13001 -  13049 | External contract staff | E | SWOther |
| 13050 | External contract staff - Intragovernment | E | SWOther |
| 36551 | Professional-Entry Student Placements - Capital and Equipment (Not Capitalised) | E | SWOther |
| 36553 | Professional-Entry Student Placements - Library and IT | E | SWOther |
| 36555 | Professional-Entry Student Placements - Miscellaneous Service Costs | E | SWOther |
| 36557 | Professional-Entry Student Placements - Staff/Supervisor Teaching | E | SWOther |
| 36560 -  36585 | Staff Training and Development - Other | E | SWOther |
| 36586 -  36599 | Staff Training and Development - Intragovernment | E | SWOther |
| 36600 | Staff Training and Development - CME | E | SWOther |
| 36602 | Staff Training and Development - CME - Accommodation | E | SWOther |
| 36604 | Staff Training and Development - CME - Communication | E | SWOther |
| 36606 | Staff Training and Development - CME - Conference | E | SWOther |
| 36608 | Staff Training and Development - CME - Equipment (not capitalised) | E | SWOther |
| 36610 | Staff Training and Development - CME - Membership | E | SWOther |
| 36612 | Staff Training and Development - CME - Travel Costs | E | SWOther |
| 36614 -  36624 | Staff Training and Development - CME - Other | E | SWOther |
| 36626 | Junior Doctor Training Allowances | E | SWOther |
| 36650 | Staff Training & Development - Other VicGov (Non-Hospitals) | E | SWOther |

T**able 2:** The service cost groups (cost centre) mapped to Allied Health, MedNonSrg, MedSurg or Nursing cost buckets and having the following account codes:

| **Account Code** | **Account Description** | **Type** | **VCDC Account Type - Submitted** |
| --- | --- | --- | --- |
| 10030 | Basic Pay - Medical Support - System Generated | E | SWMedSup |
| 10040 | Basic Pay - Hotel and Allied Services - System Generated | E | SWHotel |
| 10130 | Sick Pay - Medical Support - System Generated | E | SWMedSup |
| 10140 | Sick Pay - Hotel and Allied Services - System Generated | E | SWHotel |
| 10230 -  10231 | Overtime/Recall - Unrostered - Medical Support - System Generated | E | SWMedSup |
| 10240 -  10241 | Overtime/Recall - Unrostered - Hotel and Allied Services - System Generated | E | SWHotel |
| 10330 | Overtime - Rostered - Medical Support - System Generated | E | SWMedSup |
| 10340 | Overtime - Rostered - Hotel and Allied Services - System Generated | E | SWHotel |
| 10430 | Penalties - Medical Support - System Generated | E | SWMedSup |
| 10440 | Penalties - Hotel and Allied Services - System Generated | E | SWHotel |
| 10530 | Public Holiday Penalties - Medical Support - System Generated | E | SWMedSup |
| 10540 | Public Holiday Penalties - Hotel and Allied Services - System Generated | E | SWHotel |
| 10630 | Allowances - Medical Support - System Generated | E | SWMedSup |
| 10640 | Allowances - Hotel and Allied Services - System Generated | E | SWHotel |
| 10730 | Workcover - Medical Support - System Generated | E | SWMedSupOc |
| 10740 | Workcover - Hotel and Allied Services - System Generated | E | SWHotelOc |
| 10830 | Departure Expenditure - Medical Support - System Generated | E | SWMedSupOc |
| 10840 | Departure Expenditure - Hotel and Allied Services - System Generated | E | SWHotelOc |

**Table 3:** The service cost groups (cost centres) with mapping to the ‘Other’ and having account codes mapping of SWHotel, SWHotelOc, SWMedSup, SWMedSupOc, SWOther, SWOtherOc:

|  |  |  |  |
| --- | --- | --- | --- |
| **Cost Centre code** | **Cost Centre level 1** | **D or I** | **Service**  **Cost**  **Group** |
| A4502 - 4510 | Clinic Research | D | Other |
| A4752 - 4760 | Community Medicine (inc. F.M.P.) | D | Other |
| H0402 - 0450 | Carer support (Carer Crisis) | D | Other |
| H0452 - 0500 | Clinical community care - adult | D | Other |
| H0502 - 0550 | Clinical community care - Child | D | Other |
| H0552 - 0600 | Clinical Community Care - Aged Persons/Psychogeriatric (PGAT) | D | Other |
| H0652 - 0670 | Crisis Assessment and Support | D | Other |
| H0702 - 0710 | Disability Support Services (PDSS) | D | Other |
| H0711 - 0750 | Community Care Units | D | Other |
| H0752 - 0760 | Intensive Youth Support | D | Other |
| H0802 - 0830 | Mobile Assessment and Support | D | Other |
| H0852 - 0900 | Research, Education, and Training and Development - General | D | Other |
| H0877 - 0900 | Research, Education, and Training and Development - Research | D | Other |
| H8702 - 8750 | Community Care Units | D | Other |
| J5002- 5310 | Home and Community Care (HACC) | D | Other |

| **Cost Centre code** | **Cost Centre level 1** | **D or I** | **Service**  **Cost**  **Group** |
| --- | --- | --- | --- |
| J7002 - 7030 | Aged Care Assessment Services | D | Other |
| J7052 - 7100 | Community Aged Care | D | Other |
| J7102 - 7150 | Other Community Care | D | Other |
| L0002 - 0100 | Health Promotion | D | Other |
| L0102 - 0200 | Community Health - Other | D | Other |
| L0202 - 0300 | Primary health Other | D | Other |
| L0302 - 0400 | Services to individuals | D | Other |
| L0402 - 0420 | Service System Development and Resourcing | D | Other |
| M0002 - 0050 | Residential - Adult | D | Other |
| M0052 - 0100 | Home Based - Adult | D | Other |
| M0102 - 0150 | Outreach - Adult | D | Other |
| M0152 - 0200 | Counselling - Adult | D | Other |
| M0202 - 0250 | Other - Adult | D | Other |
| M0252 - 0300 | Residential - Youth | D | Other |
| M0302 - 0350 | Home Based - Youth | D | Other |
| M0402 - 0450 | Outreach - Youth | D | Other |
| M0352 - 0370 | Counselling - Youth | D | Other |
| M0452 - 0470 | Other - Youth | D | Other |
| M0502 - 0550 | Community | D | Other |
| M0552 - 0560 | Mobile support | D | Other |
| M0602 - 0650 | Peer Support | D | Other |
| M0652 - 0700 | Outpatient Withdrawal | D | Other |
| M0702 - 0750 | Residential Withdrawal | D | Other |
| M0752 - 0760 | Home-based Withdrawal | D | Other |
| M0802 - 0850 | Needle and Syringe Program | D | Other |
| M0852 - 0860 | Capacity Building | D | Other |
| M0901 | Koori Services | D | Other |
| M0902 | Pharmacotherapy | D | Other |
| M0903 | Other (Support and Accommodation) | D | Other |
| M0904 | Other (Withdrawal) | D | Other |
| M1002 - 1020 | Individual Packages (Formerly Acquired Brain Injury) | D | Other |
| M1022 - 1030 | Residential Programs | D | Other |
| M1052 - 1060 | Planning Facilitation and Case Management (Formerly Case Management) | D | Other |
| M1152 - 1200 | Community Programs | D | Other |
| M1202 - 1210 | Community Planning Facilitation and Case Management (Formerly Case Management) | D | Other |
| M1252 - 1260 | Home First | D | Other |
| M1352 - 1400 | Aids and Equipment | D | Other |
| M1401 | Therapy and Behaviour Intervention | D | Other |
| M1502 - 1520 | Epidemiology and Public Health | D | Other |
| M1552 - 1600 | Other | D | Other |
| M5002 - 5100 | Department Funded Research | D | Other |
| Y2002 - 3000 | Commercial Ventures - inc retail | D | Other |

|  |  |  |  |
| --- | --- | --- | --- |
| **Cost Centre code** | **Cost Centre level 1** | **D or I** | **Service**  **Cost**  **Group** |
| Y3002 - 4000 | Departmental (internal) Funds | D | Other |
| Y4002 - 5000 | Fund Raising Activities | D | Other |
| Y6002 - 7500 | Specific Projects | D | Other |
| Y7502 - 9000 | Other | D | Other |
| Z0202 - 1000 | Research | D | Other |
| Z9102 - 9200 | Research | D | Other |

Attachment 2

**Table 1: Sample Costing GL accounts to distinguish professional groups**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Finance**  **GL**  **Account** | **Description** | **“New”**  **Costing GL**  **Account** | **Description** | **Mapping** |
| 11001 | Salary and  Wages  Recoveries -  Internal/  Recharges | 11001\_10 | Nursing Salary and Wages Recoveries - Internal/Recharges | SWNurs |
| 11001\_20 | Administration & Clerical Salary and Wages Recoveries - Internal/Recharges | SWAdmin |
| 11001\_30 | Medical Support Salary and Wages Recoveries - Internal/Recharges | SWMedSup |
| 11001\_40 | Hotel and Allied Services Salary and Wages Recoveries - Internal/Recharges | SWHotel |
| 11001\_50 | Medical Officers Salary and Wages Recoveries - Internal/Recharges | SWMed |
| 11001\_60 | Hospital Medical Officers Salary and Wages Recoveries - Internal/Recharges | SWHMO |
| 11001\_70 | Sessional Clinicians Salary and Wages Recoveries - Internal/Recharges | SWSess |
| 11001\_80 | Ancillary Support -Allied Health Salary and Wages Recoveries - Internal/Recharges | SWAH |
| 10921 | Salaries and  Wages - Accruals  Other | 10921\_10 | Nursing Salaries and Wages - Accruals Other | SWNurs |
| 10921\_20 | Administration & Clerical Salaries and Wages - Accruals Other | SWAdmin |
| 10921\_30 | Medical Support Salaries and Wages - Accruals Other | SWMedSup |
| 10921\_40 | Hotel and Allied Services Salaries and Wages - Accruals Other | SWHotel |
| 10921\_50 | Medical Officers’ Salaries and Wages - Accruals Other | SWMed |
| 10921\_60 | Hospital Medical Officers’ Salaries and Wages - Accruals Other | SWHMO |
| 10921\_70 | Sessional Clinicians Salaries and Wages - Accruals Other | SWSess |
| 10921\_80 | Ancillary Support -Allied Salaries and Wages - Accruals Other | SWAH |

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Purpose

This Guidance provides a consistent costing approach to be adopted to improve overall cost data quality and ensuring cost data is fit for purpose with regards ‘do-not-attends.’

Guidance

Victorian hospitals are required to adhere to the Australian Hospital Patient Costing Standards (AHPCS). Version 4 of these standards was released in February 2018.

The AHPCS require costing practitioners “...to consider how they will treat activities which, say, fall outside the definition of service events or require further consideration. For example, ‘did not attend’ records may require a minimum allocation of expense to recognise costs associated with bookings, medical record retrieval and other associated costs.” and ‘… should refer to their jurisdictions for further advice.” (CG 8.3.13)

The Department of Health funding models are evolving and moving towards reflecting an understanding of the patient journey where these can be linked to a non-admitted patient episode or service event. While do-not-attends are not recognised by the current national and local funding models, costing these may influence future funding models which better reflect each patient’s resource usage.

Victoria has considered how the activities related to ‘did not attend’ are to be treated and the allocation of expenses. The consensus is for ‘do-not-attends’ to be treated as an indirect/overhead expense which is associated with running Hospital Non-Admitted activity. Specifically:

Cost allocation

The Patient contacts reported in VINAH with the Contact Client Present Status field assigned under code 32: Patient/Client/Carer(s)/Relative(s) not present: Scheduled appointment not attended, and a Contact Delivery mode field assigned under code 9: Not applicable, will not require a corresponding cost record.

The cost of these ‘do-not-attends’ will be further embedded in the costs for those patients who attended a scheduled appointment.

Quality assurance

Costed contacts with total costs less than $20 will continue to be flagged as part of the quality assurance checks applied to the VCDC where these have not been reported as a do-not-attend.

The department will only exclude those records with total costs less than $20 if advised by costing practitioners that these are to be excluded for funding purposes.

Future development

This guidance will be reviewed as necessary in line with changes to national and local funding policy and/or changes to the applicable Australian Hospital Costing Standards.

Background

Members of VTWG (formerly VCCUG) non-admitted subcommittee expressed concerns regarding the costing of non-admitted episodes where the patient did-not-attend (DNA) which was first requested in the 2015-16 VCDC Data Request Specification and Business Rules published October 2016 (section 11.11.2 on page 46).

The consensus view from members was that including DNA events in cost data collections would create the following problems for costing practitioners:

* The allocation of DNA’s cost will most likely be arbitrary and hence meaningless.
* It can be expected that almost all these extra reported DNA patients will have an average cost less than $5.
* Correct details are not always available for these types of non-encounters which may create further problems in compliance with cost data collections (VCDC) requirements.
* Software and data collection sophistication is not yet at a point where ancillary services (if any) will not link to the DNA episodes. This will likely increase the problem of incorrect linking of services to these DNA episodes.
* Allocating costs for the resources used to ‘cancel’ an appointment for a patient that did not even attend creates problems regarding how hospital would be reimbursed (as these costs will then be missing from all other encounters).

Members concluded that including DNAs was of no value, not supported by most of the hospital non admitted clinical managers and effort was better spent on costing the actual non admitted treated attendances.

Defining the problem

How are do-not-attends identified?

The Department of Health maintains data around the provision of a range of non-admitted services in Victoria to provide equitable funding to public hospitals and support health services in their planning, policy formulation and epidemiological research. The VINAH Minimum Data Set consists of various linked data which reflect various aspects of service delivery within a health care setting. The VINAH model consists of an episode of care around which referral and contact information is collected.

Do-not-attends are recorded in VINAH under the *Contact Client Present Status* field and assigned code 32:

*Patient/Client/Carer(s)/Relative(s ) not present: Scheduled appointment not attended*. This is defined as including **“...contacts where the health service was expecting the patient/client to attend the contact on the scheduled time. This therefore excludes instances where the patient/carer provided notice that they would not be attending the scheduled contact.”**

As part of the VCDC submission process, the department provides costing practitioners with a VINAH extract of all contact information with a linking key. This extract includes recorded do-not-attends. VCDC cost records related to a do-not-attend can then be identified where there is a match to a corresponding VINAH contact record.

Funding implication

Funding per service event is different from the service event cost. Funding represents the amount of resources available whereas cost represents the amount of resources used.

There are no funding implications by including costed do-not attends contacts in the VCDC for the current local and national funding models.

Funding is determined by multiplying the amount of activity being purchased by the cost weight and then by price which is capped by the funding available. The Victorian funding model uses reported activity data from AIMS and VINAH and cost data from the VCDC to derive cost weights. Simply, cost weights are a state-wide average derived by dividing total costs by total activity (service events).

Costing practitioners should note that all contacts with reported total costs of less than $20 which have not been excluded for funding purposes will reduce cost weights for the relevant Tier 2 classes.

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Purpose

This Guidance provides a consistent costing approach to be adopted to improve overall cost data quality and ensuring cost data is fit for purpose when costing medical salaries for private (MBS) and public non admitted specialist clinics.

Background

The 2015-16 Victorian Cost Data Collection analysis identified potential issues with how medical salaries between public and private patients and between new and review service events were being apportioned. The department needs to be able to distinguish the resource usage of public and private patients and new and review contacts to inform local cost weight development and national and local funding models.

Costing medical salaries is also a requirement of the current version of the Australian Hospital Patient Costing

Standards found on the Independent Hospital Pricing Authority (IHPA) website. Specifically [Part 2: Business rules, Stage 1: Identify relevant expenses, 1.1 General, 1.1A Medical expenses for private and public patients.](https://www.ihpa.gov.au/sites/g/files/net636/f/publications/australian_hospital_patient_costing_standards_-_version_4.0_-_part_2_-_business_rules.pdf) Refer to **Attachment 1**).

*(Refer to website;* [*https://www.ihpa.gov.au/sites/g/files/net636/f/publications/australian\_hospital\_patient\_costing\_standards\_*https://www.ihpa.gov.au/sites/g/files/net636/f/publications/australian\_hospital\_patient\_costing\_standards\_-\_version\_4.0\_-\_part\_2\_-\_business\_rules.pdf*\_version\_4.0\_-\_part\_2\_-\_business\_rules.pdf)*](https://www.ihpa.gov.au/sites/g/files/net636/f/publications/australian_hospital_patient_costing_standards_-_version_4.0_-_part_2_-_business_rules.pdf)*.*

Defining the problem

The Department of Health maintains data around the provision of a range of non-admitted services in Victoria to provide equitable funding to public hospitals and support health services in their planning, policy formulation and epidemiological research. The VINAH Minimum Data Set consists of various linked data structures which reflect various aspects of service delivery within a health care setting. The VINAH model consists of an episode of care around which referral and contact information is collected.

Contact account class issues

1. For some Tier 2 classes the average cost of a Private (MBS) service event was more than the average cost of a public service event. Health services advised that it applies a mix of remuneration models depending on the speciality and arrangements with individual medical practitioners. Exactly how medical salary costs are applied, depend on how these arrangements are then reflected in the General Ledger (GL) and payroll.
2. This can be further complicated where a new patient may be seen as a private (MBS) patient and then seen as a public patient for subsequent review service events.

Contact purpose issues

(3) For some Tier 2 classes the average cost of new service events was less than the average cost of review service events. Health services indicated that this issue is a result of the granularity reflecting the complexity of types of patients such as new patients or reviewed patient. Most health services do not take this into consideration.

Specialist clinics remuneration models

In broad terms, there are two main remuneration models for MBS private practice arrangements in Victorian public hospitals:

* 100 per cent donation model
* 100 per cent retention model

Health services might apply a mix of these remuneration models depending on the speciality and arrangements with individual medical practitioners. Exactly how medical salary costs are applied will depend on how these arrangements are then reflected in the GL and payroll.

Health services may:

* Incur full salary cost in payroll and GL (salaries applied to public and MBS contact patients). If the MBS is not offset, then it would be expected that costs will be the same regardless of whether the patient is public, private, DVA or compensable.
* Offset MBS revenue against Specialist salaries. If the GL & Payroll reduce the contracted salary by the MBS component, then the expectation is that the residual will only be allocated to public patients.

Costing Guidance

To understand the resource usage of a health services’ activities and assist in measuring their attributes all expenditure is to be allocated to the appropriate patients. That is all expenses in the finance GL system that has been used in delivering the care to patients regardless of any funding source should be allocated[[18]](#footnote-19).

The finance GL systems have been designed to meet the financial obligations of health services. This structure differs to the requirements for costing patient activities therefore a costing GL within the costing systems will be derived. The health services will need to ensure that all expenses related to the relevant services are contained within the correct direct or overhead areas to be allocated to patients.

As endorsed at the 30 August 2017 Non-admitted Sub Committee the consensus is that for:

100 per cent donation specialist clinics models

* The full cost (Operational & SPF) reflected in each health service’s GL & Payroll is included.
* The health service’s non-admitted medical salary costs are not offset by MBS revenue.
* Medical salaries reflected in Payroll and the GL is distributed between public and private (MBS) activity.
* Medical salary costs are allocated on basis of contact duration. Where this is not available consultation with specific stakeholders to ascertain the agreed allocation methodology to be applied.

100 per cent retention specialist clinic models:

* The full cost (Operational & SPF) reflected in each health service’s GL & Payroll is included.
* Medical salaries reflected in Payroll and the GL is applied to public activity only.
* Medical costs are allocated based on contact duration. Where this is not available consultation with specific stakeholders to ascertain the agreed allocation methodology to be applied.

General rules:

* The above guidance assumes that the arrangements relating to the remuneration models are reflected as expenses. Where this is not the case and these have been processed as revenue, the treatment of these needs to be reviewed by relevant stakeholders, who understand the details involved, to decipher if they relate to hospital activities.
* To ascertain whether all expenses have been identified and assigned to the correct activities within the costing GL, the relevant stakeholders who understand these details will need to be consulted.
* Any income billed directly by the specialist which are not managed in either an operating or SPF account should not be imputed as a cost.
* Income generated by a hospital as a facility fee should not be offset against expenses.
* These rules refer only to the salaries of the specialists, however any other expenses that should be reflected in the costing general ledger that should be reflected and apportioned between public and private patients should also be reviewed to decipher if they relate to hospital activities.

Funding service events

Funding per service event is different from the service event cost. Funding represents the amount of resources available whereas cost represents the amount of resources used.

Funding is determined by multiplying the amount of activity being purchased by the cost weight and then by price which is capped by the funding available. The Victorian funding model uses reported activity data from AIMS and VINAH and cost data from the VCDC to derive cost weights. Simply, cost weights are a state-wide average derived by dividing total costs by total activity (service events).

For further information relating to the funding for non-admitted service events please refer to the departments [Policy and funding guidelines](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services)for Weighted Ambulatory Service Event (WASE). The link is <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>.

**Attachment 1**

**Australian Hospital Patient Costing Standards**

**Part 2: Business rules**

**Stage 1: Identify relevant expenses**

**1.1 General**

**1.1A Medical expenses for private and public patients**

**1.1A.1 Scope**

1.1A.1.1 This Business rule relates to the treatment of medical and other expenses found in Special Purpose Accounts (SPA), which are created to manage Rights of Private Practice (RoPP) arrangements.

**1.1A.2 Objective**

1.1A.2.1 The objective of this Business rule is to ensure that all expenses, regardless of their funding source, that contribute to hospital activities are identified and included in the patient costing process.

**1.1A.3 Business rule**

|  |  |
| --- | --- |
| 1.1A.3.1 | The Standards state that the hospital’s cost of production will include all hospital expenses, found on the hospital’s general ledger, and other inclusions, such as third-party costs, that contributed to the hospital’s full cost of production. |
| 1.1A.3.2 | This means that where funds have been paid from any SPA, including trust accounts, the associated hospital activities expenses need to be included in the cost of production as they relate to hospital activities. |
| 1.1A.3.3 | In broad terms, the source of the fund is not important; however, how these funds are used is important to the cost of production. Expenses in SPA need to be reviewed by relevant stakeholders, who understand the details involved, to understand if they relate to hospital activities. |
| 1.1A.3.4 | At a patient level, where a patient consumes medical resources, a cost is associated with this consumption and these costs should be allocated to the patient irrespective of funding source. |
| 1.1A.3.5 | Expenses that require close consideration are those in SPAs created to manage monies generated from RoPP. |
| 1.1A.3.6 | These SPAs would generally accumulate income generated from RoPP and paid to specialists as an expense to the trust account. Other payments may also be made for goods and services that relate to hospital activities depending on restrictions of the agreements. |
| 1.1A.3.7 | Expenses to specialists are effectively salary expenses and relevant stakeholders, who understand the details involved, will need to review the nature of these transactions from SPA to ensure these expenses are considered as salaries where appropriate. |
| 1.1A.3.8 | In this example:   * The payment to specialists is recognised as a salary expense and are considered third party costs as the expenses reflects services provided to a hospital’s patient. * Funds that are used on other activities are also in scope as these are hospital activities. |
| 1.1A.3.9 | Income under the 100% retention model and billed directly by the specialist and which are not managed in a SPA by the hospital should not be imputed as a cost. |
| 1.1A.3.10 Income generated by the hospital as a facility fee should also not be offset against expense. | |

1.1A.3.11 Relevant stakeholders will need to review and understand the purpose of expenses in SPA accounts and the various RoPP agreements as to align the appropriate expenses to final cost centres for product costing purposes.

1.1A.3.12 Relevant stakeholders should maintain documentation of the salary arrangements and the allocation methods applied as part of the product costing process and review at each costing iteration.

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1. Purpose

To develop a consistent approach in the identification and cost allocation of prostheses, for patient level cost data to be reported via the Victorian Cost Data Collection (VCDC).

2. Overview

VTWG (formerly VCCUG) members:

* endorsed the definition of prostheses as outlined by the Australian Department of Health and this can be found in **Appendix A**.
* Alfred Health, Royal Children’s Hospital, St. Vincent’s Hospital Melbourne, Melbourne Health and Peter McCallum Cancer Institute provided feedback on the updated list of prostheses related procedure codes (revised in January,2018) and their respective DRGs.

Due to the small number of feedback, the department further investigated the revised list of ICD-10-AM ACHI (Australian Classification of Health Interventions) codes for prostheses across all thirty-nine health services over a three-year period. The resulting analysis by the department also incorporated the final feedback provided by the five health services.

The department finalised the investigations of these ACHI codes. This final list at Appendix B of ICD-10AM 10th Edition ACHI codes for prostheses consists of:

* 729 ‘Definite’ codes instead of 658.
* 72 ‘Possible’ codes instead of 115.
* 21 ‘Definite’ codes that are specific to RCH (of which 11 are also ‘Definite’ to other health services).

This list has been reviewed and agreed by the Victorian Agency for Health Information (VAHI). The

‘Definite’ and ‘Possible’ list of ACHI codes on was also reviewed by VTWG (formerly VCDC) members and endorsed prior to July,2018 (former) VCCUG meeting. (For a copy of the full list please email VCDCassist)

This list also assisted in the identification of which AR-DRGs would be expecting to have a prostheses cost allocated based on the latest final VCDC database. The department’s derivation (via statistical analysis) of the upper and lower boundaries average cost range for these prostheses related AR-DRGs will enable health services to gauge what the expected costs may be, as well as what the quality assurance checks on the cost of prostheses.

These boundaries were further cross-checked against the average prosthesis costs over the last two VCDC submissions by health services. (For a copy of the full list please email VCDCassist)

Please note that the upper and lower boundaries provide a guideline for quality assurance and not for use as the relative value units (RVUs) for prostheses. Health services are to always refer to their hospital systems and consult with the relevant stakeholders to identify and allocate prostheses expenses accurately. This in turn will continue to improve the department’s derivation of the boundaries for health services as they submit quality prostheses costs from year to year.

3. Background

St. Vincent’s Hospital raised concerns regarding the variation of prosthesis costs across health services which in turn impact on the cost weights.

During discussions at the 2015 cost forums, it was apparent that there were different methodologies applied for allocating prostheses costs. This discussion highlighted the need to:

* define what a prosthesis is that Victorian health services can use.
* develop a guide for identifying the components of prostheses utilised for patients.
* develop a consistent methodology for allocating costs; and
* update and review the quality assurance checks to accurately reflect the cost inconsistencies.

This issue was later raised at a VTWG (formerly VCCUG) meeting in late 2017 where the department in conjunction with St Vincent’s drafted a discussion paper. Further to the original draft, Syris and a few other health services contributed to the refinement of this paper.

The list of procedure codes which relates to whether a prosthesis should exist or not, was developed several years ago.

In January,2018, an updated list of ACHI (10th edition ICD-10-AM) was provided by the department’s Information Management and Standards team as the ACHI codes for Prostheses.

This current list was derived by including the terms prosthesis, prosthetic, stent, shunt, seton, tube, insertion, implant, bypass, replacement, revision, arthroplasty, banding, hernia, adjustment,’ catheter/catheterization, balloon, internal fixation, arthrodesis, screw.

These were then grouped to indicate if a prosthesis is included or otherwise which resulted in 962 codes being categorised as following:

Inclusion terms:

* Definite (658 codes)
* Adjustment/Revision (77 codes)
* Code also fixation (12 codes)
* Possible (115 codes)
* Removal (100 codes).

From the above ACHI codes, the respective DRGs were then determined accordingly

4. Costing Guidance

Victorian hospitals are required to adhere to the Australian Hospital Patient Costing Standards (AHPCS) Version 4.2released and the VCDC Documentation, Data Request Specification and Business Rules.

Nationally, Part 1: Standards, Attachment A NHCDC Line Items, provides a general definition and links to the nationally developed prostheses list for private health insurers. As this is the only detailed reference proposed by the AHPCS, Victoria has developed a definition and costing methodology which better aligns the allocation of prostheses for our health services.

Ideally, where hospitals have feeder systems that measure prostheses or consumable consumption at the patient level should be used to apportion the prostheses expenses recorded on the general ledger (GL).

In the absence of these systems, alternative methodologies are to be adopted based on consultations between costing practitioners and internal stakeholders.

Audits and quality checks on prostheses costs are recommended within health services irrespective of the allocation methodologies utilised.

The department has identified some of these allocation methodologies and outlined them below.

Prostheses activity at patient level

Prostheses identifiable systems

The AHPCS Part 3: Costing Guidelines, CG 3 Operating room and special procedure suites, states that where hospitals have feeder systems that measure prostheses or consumable consumption at the patient level, these feeder systems will ideally include the following fields:

* the patient’s unique identifier.
* the patient’s unique episode identifier.
* the prosthesis or consumable code and description; • the prosthesis or consumable price; and
* the date of service.

The department agrees with this specific business rule and further recommends the list of fields could be expanded to include.

* Procedure Date (and Time),
* Surgeon,
* Specialty,
* Lot Number,
* Supplier,
* Quantity (which can be used as the volume driver),
* Actual Price/Charge (which can be used for Prostheses’ RVUs),
* Cost Centre/Account.

### ‘Pseudo’ electronic ‘in-house’ system

Health services’ may be able to interface systems like Theatres, Cath Labs, Day Surgery/Endoscopy suites and Interventional Radiology with the requisition/inventory systems and ‘create’ an ‘in-house’ prostheses feeder extract with the mandatory fields as listed above.

Alternative activities

Alternatively, where no electronic prostheses system is available, prostheses feeder extracts for costing may be created using the ACHI procedure codes outlined on Appendix B or the AR-DRG codes on Appendix C provided. These alternatives follow a similar path as a service weight and not recommended as an on-going solution. These include.

**Prosthetic ICD10 procedure codes**

The final list of patients’ ACHI procedure codes may form the basis in generating a prostheses feeder in the absence of an electronic prostheses system in the interim and where health services are working towards an electronic implementation.

**Prosthetic AR-DRG codes**

The respective DRGs (mapped to the patients’ ACHI procedure codes on the final list) may form the basis in generating a prostheses feeder in the absence of an electronic prostheses system in the interim and where health services are working towards an electronic implementation.

Prostheses Expenditures

Health services may have different approaches to the procurement of prostheses, and it is recommended that costing practitioners consult with their theatre procurement team (for example in theatre, endoscopy suite, catheterization laboratory, finance, and supply etc.) to understand their processes.

It is recommended that the costing practitioners also consult their stakeholders (e.g., finance, surgical specialty/program teams) to determine all related prostheses costs are captured and that the recording of prostheses costs on the finance GL is in accordance with the department’s account codes list.

Expenses in the Finance GL

Any expenditure for internal fixture devises and associated supplies and equipment are to be expensed against a prosthesis account code in the finance general ledger and reflected in the costing GL.

The VCDC Chart of Accounts (COA) on[Victorian Cost Data Collection (VCDC) (health.vic.gov.au)](https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc) is based on the department’s hospitals’ finance COA and specified cost centre, A8050, for prosthetic expenditures with the prostheses account codes as shown in the table below.

| **Account Code** | **Account code description** |
| --- | --- |
| 25001 | Surgical Implants - Other |
| 25002 | Surgical Implants – Intra government |
| 25003 | Prosthesis-Standardisation - Other |
| 25004 | Prosthesis-Standardisation – Intra government |
| 25006 | Prosthesis-Vascular - Other |
| 25007 | Prosthesis-Vascular – Intra government |
| 25011 - 25013 | Prosthesis-Joint Replacement - Other |
| 25014 - 25015 | Prosthesis-Joint Replacement – Intra government |
| 25016 | Prosthesis-Orthopaedic Trauma- Other |
| 25017 | Prosthesis-Orthopaedic Trauma – Intra government |
| 25021 | Prosthesis-Urogenital - Other |
| 25022 | Prosthesis-Urogenital – Intra government |
| 25026 | Prosthesis-Endoscopic - Other |
| 25027 | Prosthesis-Endoscopic – Intra government |
| 25031 | Prosthesis-Ophthalmic - Other |
| 25032 | Prosthesis-Ophthalmic – Intra government |
| 25036 | Automatic Implantable Defibrillator - Other |
| 25037 | Automatic Implantable Defibrillator – Intra government |
| 25041 | Prosthesis - Kidneys & Connectors - Other |
| 25042 | Prosthesis - Kidneys & Connectors – Intra government |
| 25046 | Prosthesis - Pacemakers and Electrodes – Other |
| 25047 | Prosthesis - Pacemakers and Electrodes – Intra government |
| 25051 | Prosthesis- Other Orthopaedic - Other |
| 25052 | Prosthesis- Other Orthopaedic – Intra government |
| 25056 | Prosthesis-Cardiothoracic - Other |
| 25057 | Prosthesis-Cardiothoracic – Intra government |
| 25061 | Prosthesis-Grafts - Other |
| 25062 | Prosthesis-Grafts – Intra government |
| 25066 | Prosthesis-Neurosurgical - Other |
| 25067 | Prosthesis-Neurosurgical – Intra government |
| 25068 | Prosthesis-Spinal - Other |
| 25069 | Prosthesis-Spinal – Intra government |
| 25071 | Angioplasty Stents - Other |
| 25072 | Angioplasty Stents – Intra government |
| 25076 | Prosthesis-Joint Reconstruction - Other |
| 25077 | Prosthesis-Joint Reconstruction – Intra government |
| 25078 | Prosthesis - Loan Kit and Consignment Fees |
| 25079 | Prosthesis - Plastic and Reconstructive - Other |
| 25080 | Prosthesis - Plastic and Reconstructive – Intra government |
| 25081 | Prosthesis- Knees - Other |
| 25082 | Prosthesis- Knees – Intra government |
| 25083 | Prosthesis- Hips - Other |
| 25084 | Prosthesis- Hips – Intra government |
| 25085 | Prosthesis- Shoulder - Other |
| 25086 | Prosthesis- Shoulder – Intra government |
| 25101 - 25150 | Other Prosthesis/ Surgical Implants - Other |
| 25151 - 25199 | Other Prosthesis/ Surgical Implants – Intra government |

Allocation Methodology

**Direct Costs**

The relative value unit (RVU) that could be used for allocating the prostheses expenses depends on how the prostheses feeder extract is generated for the activity at the patient level.

1. Where a prosthetic management system is available, the actual prostheses:
2. • costs (or charges) and
   * quantity (or volume).

1. Where an ‘in-house’ prostheses system is developed by health services, the actual prostheses: • costs (or charges) and
   * quantity (or volume).

1. Where no prostheses system exists and no actual costs (nor charges) and/or no actual quantity (nor volume) are available, cost practitioners are to consult their stakeholders to determine and agree on data that will best represent the RVUs of the prostheses based on either.
   * ACHI procedure codes
   * AR-DRG codes
   * Externally available data like Medicare Benefits Schedule (MBS) rebates based on the first 5-digits of the ICD10 procedure codes: <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home>may be used

but actual quantity or volume involved at the patient level will not be available. Alternatively, [http://www.health.gov.au/internet/main/publishing.nsf/content/health-privatehealthhttp://www.health.gov.au/internet/main/publishing.nsf/content/health-privatehealth-prostheseslist.htmprostheseslist.htm](http://www.health.gov.au/internet/main/publishing.nsf/content/health-privatehealth-prostheseslist.htm) may provide helpful reference to the Prostheses List’s benefits by Sponsor, Category, and Billing Code.

* + These alternatives follow a similar path as a service weight and not recommended as an on-going solution.

**Indirect Costs**

It is expected that expenses not directly traceable to prostheses but are related in the procurement of prostheses will require an allocation indirectly. For instance, the administrative costs of staff involved with ordering and stock take of prostheses.

Service codes for Prostheses

Some suggested data elements to factor in the service codes/intermediate products (generated from prostheses feeder extract) that may assist with assigning the prostheses costs within the costing GL to the patients using the RVUs are:

* Surgical Specialty (e.g., Orthopaedics, Cardiology, Cardiothoracic, Urology, Plastics etc.).
* Prosthetic Type (e.g., Stent, Hip, Knee, Shoulder, Grafts, Spine, Defibrillator, pacemaker etc.).
* Prostheses Product code (or ICD10 procedure or MBS codes if no prostheses system is available).

Multi-campuses may also find it useful to have the campus codes incorporated in the service codes.

Checking for Prostheses

The final list of ICD-10-AM ACHI procedure codes and AR-DRG codes (including the provision of low and high-cost boundaries of prostheses) have been defined to be used as audit tools before and after the costing process to ensure that patients with prostheses are appropriately identified, counted, and costed at health services.

When health services submit the annual VCDC, the department will further perform the quality assurance checks based on the cost ranges determined by the department’s statistical analysis.

Appendix A – Definition of Prostheses

Prosthesis is defined as an “artificial substitute or replacement body part attached or applied to the body to replace a missing part”[[19]](#footnote-20).

The *Private Health Insurance Act 2007* states that benefits from hospital treatment cover will be paid in respect of a kind of prosthesis listed in the Prosthesis Rules[[20]](#footnote-21) . Hence, the Commonwealth’s prosthesis list (as of August 2017) includes “more than 10,000 surgically implanted prosthesis, human tissue items and other medical devices” 1. The types of prosthesis 1 on this list are (and not limited to):

* hip, knee, and other joint replacement devices
* cardiac implantable electronic devices such as pacemakers and defibrillators
* cardiac stents
* vascular stents and grafts
* heart valves, and
* human tissue items such as whole bones and bone fragments, corneas, and heart valves.

The following are excluded1 from the prosthesis list:

* devices such as external limb prosthetics,
* external breast prosthesis,
* wigs2 and other such devices and
* implants used solely for cosmetic purposes.

The final report2 submitted by the industry working group on private health insurance prosthesis reform further provided the criteria for determining a prosthesis:

1. It is current on the Australian Register of Therapeutic Goods
2. It is provided to a patient as part of an episode of hospital treatment or hospital-substitute treatment
3. A Medicare benefit must be payable for the professional service associated with the provision of the product (or the provision of the product is associated with podiatric treatment by an accredited podiatrist) 4) It should:
   1. be implanted surgically in the patient and be purposely designed to
      1. replace an anatomical body part; or
      2. combat a pathological process; or
      3. modulate a physiological process; or
   2. be essential to and specifically designed as an integral single-use aid for implanting a product, described in 4(a) (i), (ii) or (iii) above, which is only suitable for use with the patient in whom that product is implanted or
   3. be critical to the continuing function of the surgically implanted product to achieve (i), (ii) or (iii) above and which is only suitable for use by the patient in whom that product is implanted; and

5) It has been compared to alternative products on the Prosthesis List or alternative treatments and

i) assessed as being, at least, of similar clinical effectiveness; and ii) the cost of the product is relative to its clinical effectiveness.

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| Attachment 7 Victorian Perinatal Autopsy Service (VPAS) costing guidance |
| Guidance for the Victorian Cost Data Collection |
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Purpose

To ensure that all resources utilised by the VPAS service are allocated to the appropriate type of patient(s) and the costs reported through the VCDC can be identified to enable further analysis and reporting. This paper seeks to provide a better understanding of the various scenarios relating to the VPAS service, where the activity can be identified and how the costs are allocated and reported as outlined below.

What is VPAS?

The Victorian Perinatal Autopsy Service (VPAS) is a statewide service that provides perinatal autopsies and investigations and related support, care and resources.

The service is fully funded and available for Victorian families who have experienced pregnancy loss from 20+ weeks’ gestation and have been either public or private patients. Families are not charged for autopsies for registered perinatal deaths (this includes stillborn babies delivered from 20 weeks’ gestation, or for infants who die before 28 days of life).

The Royal Women’s Hospital provides:

auspicing and governance of VPAS

centralised coordination of autopsy referrals and transportation of deceased babies from external health services

provision of consistent, family information regarding the process of arranging a perinatal autopsy and how to access bereavement support and advice

training and education for clinical staff involved in supporting families for pathways to still born baby autopsies.

For comprehensive information on how to access VPAS visit the [VPAS website](https://www.thewomens.org.au/health-professionals/victorian-perinatal-autopsy-service) <https://www.thewomens.org.au/health-professionals/VPAS>.

Autopsies are provided by three of the Maternity Capability Level 6 health services and their respective pathology service providers, including:

The Royal Women’s Hospital and their pathology provider, The Royal Children’s Hospital

Monash Health

Mercy Hospital for Women and their pathology provider, Austin Pathology.

These services are then reimbursed at an agreed rate.

All public health services:

are expected to use VPAS

are allocated a VPAS autopsy site which health services can find out more about at the [Referrals to VPAS webpage](https://www.thewomens.org.au/health-professionals/victorian-perinatal-autopsy-service/referrals-to-vpas/) <https://www.thewomens.org.au/health-professionals/victorian-perinatal-autopsy-service/referrals-to-vpas>

should offer and explain the importance of a perinatal autopsy, and pathological examination of the placenta by a senior clinician in all cases of perinatal death.

Perinatal autopsy findings directly inform and support the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) to provide expert advice on maternal and perinatal outcomes. Autopsy investigations help improve maternity and newborn care and education, by improving the quality of data on perinatal cause of death, and undertaking appropriate audits, investigations and classification.

Private health services are also encouraged to use the service.

Background[[21]](#footnote-22)

Data collections[[22]](#footnote-23)

Victorian Admitted Episodes Dataset - VAED

The Victorian Admitted Episodes Dataset (VAED) comprises demographic, clinical and administrative details for admitted episode of care occurring in Victorian hospitals, rehabilitation centres, extended care facilities and day procedure centres.

VAED data is used to provide equitable funding to public hospitals under the casemix system, support health service planning, policy formulation and epidemiological research, and meet national data reporting requirements.

The VAED manual specifies data items, reporting guidelines, file format and validations for reporting to the VAED.

Victorian Perinatal Data Collection - VPDC

The Victorian Perinatal Data Collection (VPDC) was established in 1982, by an amendment to the Health Act,under the functions of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM). The CCOPMM is the advisory body to the Minister for Health on maternal, perinatal and paediatric mortality and morbidity.

The VPDC was established as a population-based surveillance system to collect and analyse information on the health of mothers and babies to contribute to improvements in their health.

Data collected includes information on obstetric conditions, procedures and outcomes, neonatal morbidity and birth defects relating to births in Victoria. The scope of the collection includes live births and stillbirths. The following definitions of these terms apply for the purposes of VPDC reporting:

Livebirths: the complete expulsion or extraction from the mother, of a baby, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

Stillbirth (occurring before or during labour): a fetal death prior to the complete expulsion or extraction from its mother of a product of conception of at least 20 completed weeks of gestation or at least 400 grams if gestation is unknown. The death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

The majority of VPDC data items, of which there are more than 160, comply with the Perinatal National Minimum Data Set (NMDS), which specifies reporting standards for the perinatal data collections conducted by all states and territories. Data are sent to the Australian Institute of Health and Welfare (AIHW) to produce the annual report on Australia's mothers and babies.

The VPDC is conducted under the auspices of the CCOPMM, which also reviews all perinatal, infant, child (less than 18 years old) and maternal deaths, and severe maternal morbidity. Information provided to the CCOPMM is privileged from access by any third party, including the courts.

However, CCOPMM may, if it determines that it is in the public interest to do so, provide information to entities specified in s. 41 of the Public Health and Wellbeing Act.

Victorian Cost Data Collection – VCDC

The Victorian Cost Data Collection (VCDC) is a dataset reflecting the cost and mix of resources used to deliver patient care.

Victorian public hospitals are required to report costs for all operational funded activity and are expected to maintain patient costing systems that monitor service provision to patients and allow for the accurate determination of patient level costs.

The VCDC is used to:

* inform the setting of Victorian and national cost weights.
* inform national funding reform developments.
* analyse the cost of health care.
* benchmarking; and
* best practice quality improvement initiatives.
* Meet the cost data requirements of the National Health Reform Agreement (NHRA), via the National Hospital Cost Data Collection (NHCDC).

All Victorian metropolitan and major rural health services are required to submit annual patient level cost data to the VCDC.

The VCDC documentation specifies data items, reporting guidelines, file format and validations for reporting to the VCDC.

**Scenarios**

To understand the various arrangements for perinatal autopsy services and how the activity and costs are reported to the department, the following scenarios are provided.

**Key:**

**Hospital A** = VPAS tertiary maternity hospital with own VPAS pathology service (Monash Health)

**Hospital B** = VPAS tertiary maternity hospitals (Mercy Hospital for Women, Royal Women’s Hospital)

**Hospital C** = VPAS pathology services (Austin Health, Royal Children's Hospital, Monash Health)

**Hospital D** = Any non VPAS Victorian hospital

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| **Autopsy** |
| **Placental Pathology** |
| **Coronial Cases** |

| **Scenario** | **Scenario description** | **Description** | **Activity** | **Patient level costing (VCDC)** | **VCDC reporting** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| 1 - Stillborn | Born at a VPAS maternity hospital with own VPAS pathology service (A) | Mother is admitted to Hospital A and registered on their system. | Reported to the VAED as an acute patient | All services/resources performed on mother are allocated and costed to the mother. | Program AC |
| Baby is stillborn therefore not registered to Hospital A. | No details reported to VAED | All services/resources performed on baby (not including autopsy) are linked and allocated to the mother record. | Program AC |
| Autopsy performed by VPAS pathology service at Hospital A. | No details reported to VAED | All services/resources performed during autopsy are allocated and costed to the baby record (as identified by pathology) | Program U and stream code VPAS |
| Placental Pathology performed by VPAS Pathology at Hospital A | Reported to the VAED as an acute patient | All services/resources performed on the placenta are allocated and costed to the mother. | Program AC |
| Born at a VPAS maternity hospital (B) transferred to a VPAS pathology service (C) | Mother is admitted to Hospital B and registered on their system. | Reported to the VAED as an acute patient | All services/resources performed on mother are allocated and costed to the mother. | Program AC |
| Baby is stillborn therefore not registered to Hospital B. | No details reported to VAED | Any services/resources performed on baby at Hospital B are linked and allocated to the mother record. | Program AC |
| Stillborn transferred to VPAS pathology service Hospital C where autopsy performed | No details reported to VAED | Autopsy services performed on baby at Hospital C are allocated to the baby record. | Program U and stream code VPAS |
| Placental Pathology performed by VPAS Pathology at Hospital C | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| Born at a non VPAS Victorian Hospital (D) transferred to a VPAS pathology service (C) | Mother is admitted to Hospital D and registered on their system. | Reported to the VAED as an acute patient | All services/resources performed on mother are allocated and costed to the mother. | Program AC |
| Baby is stillborn therefore not registered to Hospital D. | No details reported to VAED | Any services/resources performed on baby at Hospital D are linked and allocated to the mother record. | Program AC |
| Stillborn transferred to VPAS pathology service Hospital C where autopsy performed. | No details reported to VAED | All autopsy services/resources performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| Placental Pathology performed by VPAS Pathology at Hospital C | No details reported to VAED | All autopsy services/resources performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| 2 - Neonatal death | Born at a VPAS maternity hospital with own VPAS pathology service (A) | Mother is admitted to Hospital A and registered on their system. | Reported to the VAED as an acute patient | All services/resources performed on mother are allocated and costed to the mother. | Program AC |
| Baby born alive, admitted to Hospital A and registered on their system. | Reported to the VAED as either a qualified or unqualified newborn | All services/resources performed on baby (not including autopsy) are linked and allocated to the baby record. | Program AC |
| Baby subsequently passes, autopsy performed at Hospital A. | Reported to the VAED as either a qualified or unqualified newborn | All services/resources performed on baby for an autopsy are linked and allocated to the baby record. | Program U and stream code VPAS |
| Placental Pathology performed by VPAS Pathology at Hospital A | Reported to the VAED as an acute patient | All services/resources performed on mother are allocated and costed to the mother. | Program AC |
| Born at a VPAS maternity hospital (B) transferred to a VPAS pathology service (C) | Mother is admitted to Hospital B and registered on their system. | Reported to the VAED as an acute patient | All services/resources performed on mother are allocated and costed to the mother. | Program AC |
| Baby born alive, admitted to Hospital B and registered on their system. | Reported to the VAED as either a qualified or unqualified newborn | All services/resources performed on baby at Hospital B are linked and allocated to the baby record. | Program AC |
| Baby subsequently passes, transferred to a VPAS pathology service Hospital C where autopsy performed. | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| Placental Pathology performed by VPAS Pathology at Hospital C | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| Born at a non VPAS Victorian hospital (D) transferred to a VPAS pathology service (C) | Mother is admitted to Hospital D and registered on their system. | Reported to the VAED as an acute patient | All services/resources performed on mother are allocated and costed to the mother. | Program AC |
| Baby born alive, admitted to Hospital D and registered on their system. | Reported to the VAED as either a qualified or unqualified newborn | All services/resources performed on baby are linked and allocated to the baby record. | Program AC |
| Baby subsequently passes, transferred to a VPAS pathology service Hospital C where autopsy performed. | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| Placental Pathology performed by VPAS Pathology at Hospital C | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| 3 - Newborn | Born at a non VPAS Victorian hospital (D), complications, transferred to a VPAS maternity hospital with own VPAS pathology service, passes (A) | Mother is admitted to Hospital D and registered on their system. | Reported to the VAED as an acute patient | All services/resources performed on mother are allocated and costed to the mother. | Program AC |
| Baby born alive, admitted to Hospital D and registered on their system. | Reported to the VAED as either a qualified or unqualified newborn | All services/resources performed on baby are linked and allocated to the baby record. | Program AC |
| Baby transferred to Hospital A (complications) admitted and registered on their system. | Reported to the VAED as a qualified newborn | All services/resources performed on baby (not including autopsy) are linked and allocated to the baby record. | Program AC |
| Baby subsequently passes. Autopsy performed at Hospital A |  | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| Placental Pathology performed by VPAS Pathology at Hospital C | Reported to the VAED as a qualified newborn | All services/resources performed on baby (including autopsy) are linked and allocated to the baby record. | Program AC |
| Born at a non VPAS Victorian hospital (D), complications, transferred to a VPAS maternity hospital (B), passes, transferred to a VPAS pathology service (C) | Mother is admitted to Hospital D and registered on their system. | Reported to the VAED as an acute patient | All services/resources performed on mother are allocated and costed to the mother. | Program AC |
| Baby born alive, admitted to Hospital D and registered on their system. | Reported to the VAED as either a qualified or unqualified newborn | All services/resources performed on baby are linked and allocated to the baby record. | Program AC |
| Baby transferred to Hospital B (complications) admitted and registered on their system. | Reported to the VAED as a qualified newborn | All services/resources performed on baby at Hospital B are linked and allocated to the baby record. | Program AC |
| Baby subsequently passes, transferred to a VPAS pathology service Hospital C where autopsy performed. | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| Placental Pathology performed by VPAS Pathology at Hospital C | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| 4 - Coronial Cases | | **Baby referred to Coroner for investigation** | | | |
| Coroners permits VPAS Pathology services Hospital C to perform autopsy under auspice of VIFM. | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| Placental Pathology performed by VPAS Pathology at Hospital C | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| 5 - Placental Pathology only, no post-mortem | | Placental Pathology performed by VPAS Pathology at Hospital C | No details reported to VAED | Autopsy services performed on baby at Hospital C are linked and allocated to the baby record. | Program U and stream code VPAS |
| 6 - Genetics testing | | Genetic testing performed by Victorian Clinical Genetics Service (VCGS) | VCGS is an Australian not-for-profit subsidiary of Murdoch Children’s Research Institute (MCRI). Therefore, no details reported or costed. | | |
| Genetic testing performed by VPAS Pathology |  |  |  |

General costing guidance

To understand the resource usage of a health services’ activities and assist in measuring their attributes all expenditure is to be allocated to the appropriate patients. That is all expenses in the finance GL system that has been used in delivering the care to patients regardless of any funding source should be allocated4.

➢ The finance GL systems have been designed to meet the financial obligations of health services. This structure differs to the requirements for costing patient activities therefore a costing GL within the costing systems will be derived. The health services will need to ensure that all expenses related to the relevant services are contained within the correct direct or overhead areas to be allocated to patients.

➢ To ascertain whether all expenses have been identified and assigned to the correct activities within the costing GL, the relevant stakeholders who understand these details will need to be consulted.

➢ Any other expenses that should be reflected in the costing general ledger that should be apportioned as a VPAS cost should also be reviewed to decipher if they relate to those hospital activities. This may include external services that may have been paid for by the health service such as genetic testing.

➢ Costing practitioners should review whether any overhead/indirect services should also be apportioned to the VPAS patients and update that allocation where appropriate. This will ensure that the complete patient level cost has been recognised.

**Further information**

For further information, contact [VCDCassist@health.vic.gov.au](mailto:VCDCassist@health.vic.gov.au)

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| Attachment 8 Reporting Palliative care (phase of care) |
| Victorian Cost Data Collection |
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Definition of Palliative care

Palliative care is defined as care in which the primary clinical purpose or treatment goal is optimising quality of life for a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:

managed or informed by a clinician with specialised expertise in palliative care

evidenced by an individualised multidisciplinary assessment and management plan that is documented in the patient’s medical record; it covers the physical, psychological, emotional, social, and spiritual needs of the patient and their negotiated goals.

The National Standards for Providing Quality Palliative Care define the patient, their carer and family as the unit of care. The needs of carers and families should be addressed in the patient’s management plan.

Admitted subacute funding model

AN-SNAP based funding model

Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5.0 (V5) only applies to episodes of admitted patient hospital care (same-day and overnight). It does not classify non-admitted care (because Independent Hospital Pricing Authority does not use AN-SNAP to price non-admitted subacute care). AN-SNAP V5 continues to classify admitted subacute and non-acute care into five care types: • rehabilitation care • palliative care • geriatric evaluation and management (GEM) • psychogeriatric care, and • non-acute care (sometimes referred to as maintenance care).

Palliative care model

The model provides bed day weights for palliative classes. The cost weights for palliative care differ only for the phase of care component of the classification. For each palliative care episode, the patient may be classified into multiple classes as their phase of care changes. Palliative care is the only care type which allows sub-episodic class changes. For all other care types, the patient stays in the same class for their entire episode of care.

Episode-based funding approach

The department is continuing the move towards funding episodes of care and not days of care through the introduction of a new funding approach from 2016-17. The move to episode-based funding is to provide further incentive for the system to find further efficiencies.

The experience of the department is that the episodic funding approach used for admitted acute activity has realised significant efficiency gains. The structure of (dis)incentives within episodic funding illustrates how the funding policy continually (dis)encourages (longer) shorter lengths of stay.

All health services providing inpatient palliative care services are required to report data elements linked to the phase of care, including specific elements for the final phase. Costs at the phase level are required for palliative care.

Victorian Cost Data Collection

The costs for palliative care phase of care data will need to be reported through the VCDC to enable a more accurate link of cost data to the phase of care. This requirement is based on a two-tiered approach; one to determine the cost drivers to accurately cost a palliative phase of care the other is to report the costs at the phase of care level. This paper outlines a solution for the later.

Reporting phase of care to VCDC

A proposed approach to enable the reporting of the current submission FY’s palliative care phase of care will involve health services to consult with their costing vendors to implement a process of extracting the cost data at the identifiable phase of care.

1. To assist with this, the department will provide a palliative care phase of care file for each health service containing the fields in table 1 below.

**Table 1: Palliative care – phase of care fields**

| **Field** | **Field description** | **Phase of care value example 1** | **Phase of care value example 2** | **Discharge phase of care value example** |
| --- | --- | --- | --- | --- |
| CAMPUS | Campus Code | 1234 | 1234 | 1234 |
| URNO | Medical Record Number | 987654 | 987654 | 987654 |
| KEY | DHUnique Key | 2113807 | 2113807 | 2113808 |
| CARE | Care Type | 8 | 8 | 8 |
| seq\_nbr | Phase of Care Sequence No | 1 | 1 | 1 |
| ansnap\_class | ANSNAP Group | AN-SNAP (Pall Care) | AN-SNAP (Pall Care) | AN-SNAP (Pall Care) |
| ansnap\_cd | ANSNAP Class Code | 4BT1 | 4BT1 | 4BT1 |
| ansnap\_desc | ANSNAP Class Description | Terminal phase | Terminal phase | Terminal phase |
| phaseofcare\_cd | Phase of Care Code | 4 | 4 | 4 |
| phaseofcare\_desc | Phase of Care Description | Terminal | Terminal | Terminal |
| phasecare\_start\_dt | Phase of Care start Date | 1/07/2020 | 1/07/2020 | 1/07/2020 |
| phasecare\_end\_dt | Phase of care end date | 3/07/2020 | 3/07/2020 | 3/07/2020 |
| admdate | Episode Admission Date | 1/07/2020 | 1/07/2020 | 1/07/2020 |
| sepdate | Episode Separation Date | 3/07/2020 | 3/07/2020 | 3/07/2020 |
| LengthOfPhase | Phase of care length of stay | 2 | 2 | 2 |
| RUGADL | RUD ADL Code | 18 | 18 | 18 |
| PALL\_Bed\_dt | Phase of Care date | 1/07/2020 | 2/07/2020 | 3/07/2020 |

1. The PALL\_Bed\_dt field depicts the data at a daily level for each phase including the admission and discharge phase of care dates.
2. This field will allow the linking of the costs already at a date of service level within costing systems to be matched to the relevant phase of care code (phaseofcare\_cd).
3. The reporting of this data will be sent through the Secure Data Exchange (SDE) in the same way as the normal submission however will be a separate file full year file.
4. The naming convention for this file will be in the format of VCDC\_CCCC\_YYYMMDD\_nn\_PAL.xml
   * + 1. Example: VCDC\_1140\_201191031\_01\_PAL.xml
5. The text delimited file for reporting the usual cost data to the VCDC can be used to report the palliative care phase of care data. The phase of date required to be submitted to ensure linking to the activity datasets will be populated using the sDate field.
6. The file will be validated as per the main VCDC submission files considering the multiple URNo and keys.
7. The cost data will be linked to the relevant activity datasets using the following fields.
   * + 1. Campus
       2. URNo
       3. Key
       4. sDate
8. The quality assurance reports will be determined shortly.

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The main VCDC submission file will include the episodic palliative care details as in previous years and all

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| **Guidelines for the costing of Mental Health Services**  Version 1.0 for the Victorian Cost Data Collection |
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Guideline

A. Purpose

The purpose of this guideline is to identify the most appropriate method for costing mental health activity. Mental health activity includes all services provided to clients who have a mental illness.

B. Scope

All services provided to admitted mental health patients and episodes of residential care. Also, all mental health services provided as non‐admitted contacts to registered clients, unregistered clients, and triage services for all age groups. These include non‐patient contacts such as GP support services or contacts with community organisations involved in the delivery of mental health services. They can be classified as:

1. Acute admitted (reports under Program A)
   1. VAED Care Types:
      1. 4 – Acute, where DRG in U range, e.g., U40Z – Sameday ECTi
      2. 5T – Mental Health Nursing Home Type
      3. 5E – Mental Health Secure Extended Care Unit (SECU)
      4. iv. 5K – Child and Adolescent Mental Health Service (CAMHS)
      5. 5G – Acute, Aged Persons Mental Health Service (APMH)
      6. 5S – Acute, Specialist Mental Health Service
      7. 5A – Acute, Adult Mental Health Service
   2. Forensicare‐ not currently reported through the VCDC but in‐scope to be included for future costing datasets and should be included in the costing process if the data is available.
2. Residential (reports under Program M),
   1. Community Care Units (CCU)
   2. Aged residential (excluding 5x‐Mental Health)

Including VAED care types 1 – Nursing Home Type

* 1. Prevention and Recovery Care (PARC)

1. Non admitted, including unregistered contacts – all in CMI (reports under Program
   1. M)
   2. Client Service contacts
      1. Type A – Registered contacts.
      2. Type B – Unregistered contacts.
      3. Type E – Case contacts.
   3. Community contacts

Type C – Community contacts, including professional contacts with other HCPs, GPs, and housing support services.

Other contacts, including

* + - 1. Type D – Non reportable contacts.
      2. Consultation liaison iii. Triage

**C. DEFINITIONS**

*ADMISSION*

An event within an open episode where a patient is admitted in an inpatient setting. Registered clients  Cases  Episodes  Admitted Episodes

*CAMPUS*

A campus is the central organising component of the CMI/ODS information system, operationally referred to as an area mental health service (AMHS). Refer to the “Recording a Case in the CMI/ODS” (2015) program management circular for more information.

*CASE*

A case is a clinically determined period of care that involves individual service planning and clinical review, generally within a framework of multidisciplinary care. Refer to [Recording a case in the CMI/ODS](https://www.health.vic.gov.au/research-and-reporting/recording-a-case-in-the-cmiods) .

*CATT (*Crisis and Assessment Treatment Team)

CATT provide mental health assessments and short‐term intensive community treatment for people in an acute stage of their illness. Involvement with the CATT team may mean that a person is becoming more acutely unwell, requiring additional support prior to or after an inpatient admission. CATT clinicians record reportable contacts in CMI.

*CCT (Continuing Care Team)*

Community service provided to clients who require a period of community case management. These “episodes” of care vary significantly in duration of care, ranging from a few days to many years. Continuing care teams record reportable contacts in CMI.

*CMI/ODS (Client Management Interface/Operational Data Store)*

The CMI/ODS is Victoria’s state-wide public mental health database. CMI is the primary means of communication between designated mental health services (DMHS) across the state and the Department of Health and stores only mental health information. It contains confidential information regarding patient presentations, episodes of care, diagnoses, demographics, service contacts, carer, and GP details as well as information pertaining to the Mental Health and Wellbeing Act 2022(and previous Mental Health Act 2014). All patients registered on the CMI/ODS will be allocated a state-wide UR number, which is commonly known as their ‘mental health number’. This remain remains constant across DMHS (unlike hospital or local UR numbers).

* The “RAPID” database is the collective name of what are essentially two separate, but connected, data warehouses – the CMI and the ODS.

* The CMI (Client Management Index) refers to locally stored data – e.g., the data services can enter and manipulate.

The ODS (Operational Data Store) is the name given to the collection of CMIs that contribute to a more global view of the consumer’s mental health history. When hospital staff are connected to the ODS, they can see the consumer’s legal status history, as well as any contacts, diagnoses, admissions, etc., which have occurred both at the local hospital and any other public mental health service within Victoria. The ODS includes selected data items from the CMI that are used for Department of Health reporting and support the statutory functions of the Chief Psychiatrist and the Mental Health Review Board Tribunal. See also [Reporting obligations for clinical mental health and wellbeing services | health.vic.gov.au](https://www.health.vic.gov.au/chief-psychiatrist/reporting-obligations-for-clinical-mental-health-and-wellbeing-services).

*COMMUNITY CARE UNIT*

CCUs provide medium to long-term residential clinical care and rehabilitation services for people with significant mental illness and associated psychosocial disability. Located in residential areas, CCUs provide a ‘home like’ environment where people can learn or re-learn everyday skills necessary for successful community living.

CCUs provide:

* Access to 24-hour multidisciplinary clinical support and treatment, including regular psychiatric review.
* Residential rehabilitation programs which aim to increase psychosocial independence and develop daily living skills.
* Individualised assessment care planning and review of suitability for less restrictive treatment and care.
* Monitoring, engagement, and support of people receiving compulsory treatment under the *Mental Health and Wellbeing Act 2022*.
* Psychoeducation and support to carers and promotion of continued links between consumer and their careers.
* Promotion of community links and partnerships to support consumers to integrate into the broader community.
* Stays in CCU will be recorded as a residential placement in CMI.

*CONTACTS*

A service contact occurs between a patient/client and an ambulatory care health unit (including outpatient and community health units). They are a unit of community mental health service provision and measured by the duration recorded at a set date and time. For more information, please see the Program Management Circulars (PMC) [Bulletins and Program Management Circulars (PMC) for public mental health services | health.vic.gov.au](https://www.health.vic.gov.au/research-and-reporting/bulletins-and-program-management-circulars-pmc).

*CONSULTATION LIAISON*

Consultation–liaison psychiatry is a psychiatric subspecialty focusing on the practice of psychiatry in collaboration with a range of other health professionals, usually in a hospital setting [RANZCP]v.

*CONTACT TYPES*

*Type A: Registered Contact*

Registered client service contact occurs after contacts are recorded against clients who are formally registered at the mental health services’ CMI campus and allocated a mental health state-wide unit record (UR) number [DH CMI/ODS Service Contact Data Definitions (2023)].

*Type B: Unregistered Contact*

Unregistered client service contact occurs when services are provided to people who are not registered with the mental health services’ CMI campus. A client can be a registered client at one services’ CMI campus and (concurrently) an unregistered client at another services’ CMI campus if the person has failed to satisfy the criteria for registration [DH CMI/ODS Service Contact Data Definitions (2023)].

*Type C: Community Contact*

Community contacts are provided by mental health services to community organisations or external service providers. The focus of the service is the external service provider, group, or organisation rather than the individual client or client group [DH CMI/ODS Service Contact Data Definitions (2023)].

*Type D: Non-Reportable Contact*

Non-reportable contact: This data is not sent to the Operational Data Store (ODS) and is reserved for local purposes only as it does not meet the criteria for recording a contact and does not count towards service contact hours. Services may determine what activity they need to record that does not meet the definition of a contact but would like to use the information internally. Includes:

* allocation meetings
* answering machine messages, either incoming or outgoing
* appointment scheduling
* administrative tasks
* case conferences
* clinically related administrative work (such as reading or researching patient notes for any purpose)
* clinical supervision – a formal professional relationship between two or more people in the designated roles of supervisor and supervisee. This relationship facilitates reflective practice, explores ethical issues and develops skills. The goals of supervision are to support the professional in their work and career, ensure effective and ethical practice and safety for clients ([About | ACSA (clinicalsupervision.org.au)](https://www.clinicalsupervision.org.au/about)
* coronial services liaison (statutory and non-statutory tasks)
* correspondence, either incoming or outgoing (hard copy and electronic)
* electronic contact (answering machine, email, SMS, text messaging, voicemail and similar forms of communication) with any person or organisation not consistent with the criteria for a service contact.
* email to (or from) any person or organisation not consistent with the criteria for a service contact
* escort time
* evidentiary depositions and compliance with subpoenas
* intake meetings
* intra-agency liaison
* intra-agency meetings
* intra-agency training
* post mortem clinical tasks
* post mortem liaison with police or members of the judiciary
* professional conferences, seminars or similar (internal and external)
* record keeping
* report writing or reviewing
* research on any topic for any purpose
* SMS to (or from) any person or organisation on any subject not consistent with the criteria for a service contact
* team meetings
* text messaging to (or from) any person or organisation on any subject not consistent with the criteria for a service contact
* travel time
* voicemail communication to (or from) any person or organisation on any subject not consistent with the criteria for a service contact

*Type E: Case Contact*

Case contact (is automatically derived by CMI/ODS): Case contacts are a subset of registered contacts (“A”). When a registered client is ‘within a case’ or period of case management the CMI/ODS will record a registered contact (as above) as a case contact. This circumstance is identified by the CMI/ODS at the time of data entry and does not require additional input by clinical or data entry staff.

*Contact Service Recipient*

The client, group or organisation that is receiving a mental health service.

*Contact Service Location*

The location where the contact has taken place.

*ECT (Electroconvulsive treatment)*

A medical procedure performed under general anaesthesia and muscle relaxation in which modified seizures are induced for therapeutic purposes by the selective passage of an electrical current through the brain. ECT is most prescribed for treating severe depression but is also used for other serious mental illnesses including mania, schizophrenia, and catatonia. For further information refer to the [Compliance implications for clinical mental health and wellbeing services | health.vic.gov.au](https://www.health.vic.gov.au/chief-psychiatrist/compliance-implications-for-clinical-mental-health-and-wellbeing-services)

*EPISODE*

An event within an open case. This includes community, inpatient or residential periods of care. Each episode reflects a period in which the consumer was receiving treatment from a particular team within the DMHS. Therefore, cases may be comprised of multiple episodes.

*HCP (Health Care Provider)*

The clinician providing the service to a community contact or an individual. This is identified in the contacts table in CMI.

*MENTAL HEALTH*

A person is described as having a mental illness when their thoughts, feelings and behaviour cause them, or others distress and are not in keeping with their cultural background. These include schizophrenia, depression and anxiety disorders (VicHealth 2008).

*MENTAL HEALTH and WELLBEING ACT 2022*

Refer to Department [Mental Health and Wellbeing Act 2022 | health.vic.gov.au](https://www.health.vic.gov.au/mental-health-and-wellbeing-act) <https://www.health.vic.gov.au/mental-health-and-wellbeing-act>.

All periods of compulsory treatment within designated mental health services in Victoria are recorded in the “Compulsory Orders” table in CMI.

*MENTAL HEALTH LEGAL STATUS*

The “legal status” of a patient is typically used in reference to whether they are receiving compulsory treatment or whether they are receiving treatment voluntarily (i.e., they have no legal status). This typically describes Assessment Orders, Temporary Treatment Orders and Treatment Orders.

*AO (Assessment Order)*

An Assessment Order is “the first step in initiating compulsory mental health treatment” made by a registered medical practitioner or a mental health practitioner ([Assessment orders | health.vic.gov.au](https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/assessment-orders)).

*TTO (Temporary Treatment Order)*

Temporary Treatment Order is completed by a Consultant Psychiatrist within a designated mental health service, confirming that in their opinion, the consumer meets the criteria under the Mental Health and Wellbeing Act 2022 to receive compulsory treatment. A TTO enables the treating team to provide compulsory treatment for up to 28 days in either/both inpatient and community settings. A Temporary Treatment Order may be revoked at any time prior to expiry if the Consultant Psychiatrist deems that the person no longer meets the criteria for compulsory treatment (i.e., the person will return to a voluntary legal status).

*TO (Treatment Order)*

A Treatment Order “authorizes the provision of compulsory mental health treatment” ([Treatment orders | health.vic.gov.au](https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/treatment-orders#how-a-treatment-order-is-made)) and is determined by the MHT (Mental Health Tribunal). It will determine the setting for the TO so that it will be either an Inpatient Treatment Order (ITO; i.e., treatment must occur within the psychiatric inpatient unit of a designated mental health service) or a Community Treatment Order (CTO; i.e., compulsory treatment is to be provided in the community). The Consultant Psychiatrist can vary the setting in which the treatment is provided (between inpatient and community) as often as required to facilitate the least restrictive treatment. The Consultant Psychiatrist may also revoke the Treatment Order once the patient no longer meets the criteria under the *Mental Health and Wellbeing Act 2022* for compulsory treatment.

*MHT (Mental Health Tribunal)*

The Mental Health Tribunal (the Tribunal) is an independent statutory tribunal established under the Mental Health and Wellbeing Act 2022. The Tribunal is an essential safeguard under the Act to protect the rights and dignity of people with mental illness. The primary function of the Tribunal is to determine whether the criteria for compulsory mental health treatment as set out in the Mental Health and Wellbeing Act 2022 apply to a person. The Tribunal makes a Treatment Order for a person if all the criteria in the legislation apply to that person. (MHT, 2025).

*MSTS (Mobile Support and Treatment Service)*

The Mobile Support and Treatment Service provide intensive ongoing support and treatment for people in their home environment.

*PARC (Prevention and Recovery Care)*

PARC is a short‐term residential program for generally under 28 days. PARC offers extra support to help people avoid becoming unwell and stay out of hospital. For people leaving hospital, PARC can be used as part of discharge to the community for people who don’t need to be in hospital but who are not quite ready to go home. PARC is sometimes referred to as step up/step down care.

*PMHT (Primary Mental Health Team)*

The Primary Mental Health team provide consultation, education and support for general practitioners and other primary care providers who are providing treatment to people with problems such as depress, anxiety and early psychosis.

*SUBCENTRE*

A subcentre is ‘the organisational setting or location from which programs are delivered. The subcentre provides the setting for inpatient, community residential and community activity for child and adolescent, adult, older persons or generalist client populations’ (DHS Subcentre Maintenance in CMI/ODS PMC, 2015).

*RESTRICTIVE INTERVENTIONS*

These involve “bodily restraint (bodily and mechanical restraint) and seclusion. A restrictive intervention may only be used where necessary to prevent serious and imminent harm to the person or another person. Bodily restraint may also be used where necessary to administer treatment or medical treatment. Chemical restraint may also be used in defined circumstances when a person is being transported under the Act.([Restrictive interventions | health.vic.gov.au](https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/restrictive-interventions#bodily-restraint)):

*BODILY RESTRAINT*

* *Physical restraint-* physical restraint – the use by a person of their body to prevent or restrict another person's movement. Physical restraint does not include the giving of physical support or assistance to a person in the least restrictive way that is reasonably necessary to enable the person to be supported or assisted to carry out daily activities; or to redirect the person because they are disoriented; or
* mechanical restraint – the use of a device to prevent or restrict a person’s movement.

CHEMICAL RESTRAINT

Chemical restraint means the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement

*SECLUSION*

A period of time during which a client is secluded from other patients to prevent harm to themselves or others. A client can only be secluded in a hospital inpatient setting.

*VCDC*

Victorian Cost Data Collection

**D. PROCESS**

1. Mapping the General Ledger

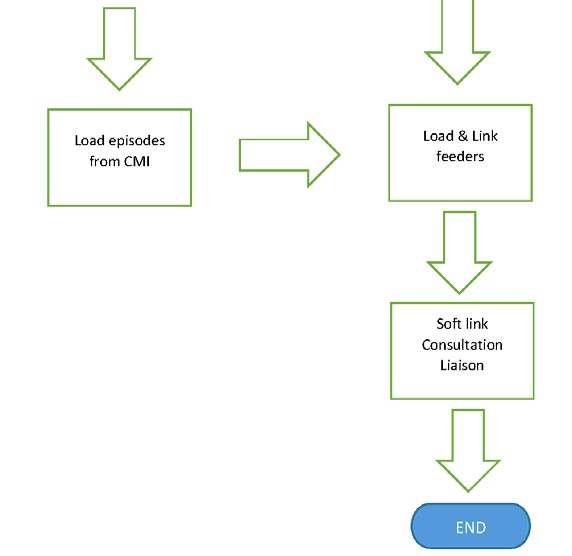
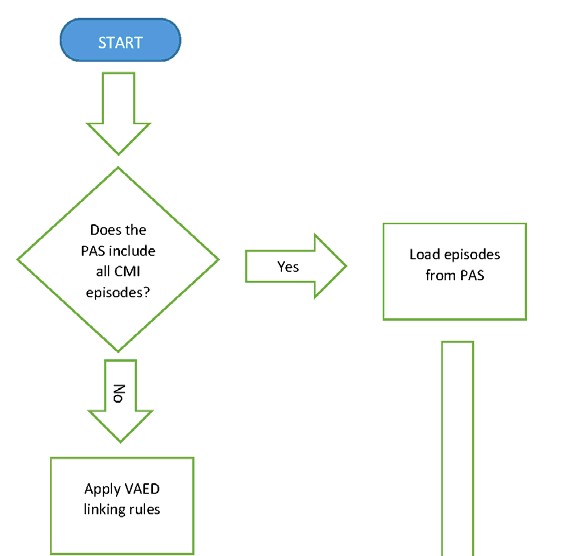
* + 1. There is usually a direct one to one mapping between each subcentre and a specific cost centre which holds related administrative and ward expenses.
    2. Medical expenses for clinicians providing services to mental health patients are usually recorded in separate cost centres and must be mapped to the appropriate activity. Sometimes there are separate cost centres for junior and senior medical staff. Allocations must be mapped in whole or in part to the appropriate subcentre activity based on advice from management and financial staff.
    3. Cost centres with no activity are mapped to an aggregate episode.
    4. Classifying cost centres as direct or indirect and allocating their expenses to the appropriate area or account type should be done in accordance with the rules and standards for the non-mental health component of the general ledger.

1. Activity and Feeder Data Sources

Client contact data is recorded in several systems for mental health patients:

* + 1. In Victoria, activity data is recorded in CMI for all client contacts, registered or unregistered, and for all admitted episodes.
    2. The hospital Patient Admission System will contain episode details for all admitted episodes and might contain non admitted data where it is used as a scheduling system.
    3. Other scheduling systems might contain booked appointment and client contact data where the PAS is not used for this purpose.
    4. Where mental health services are run out of a single hospital health service or network but cover a wide catchment area, some patient services might be provided by other hospitals, even where the mental health data is recorded in the administering hospital’s CMI.
    5. Feeder systems, such as those for pharmacy and imaging, should contain individual services/products provided to mental health patients and should be linked in accordance with the linking rules applied to other types of patients.

1. Linking activity



* 1. Unregistered Clients

The Victorian DH issues specific guidelines for when not to register a clientxii. These contacts cannot be linked to subsequent registered contacts for the same patient as no State-wide or hospital specific UR Number is attributed to them for the unregistered contact.

* 1. Network services linking (covering NWMH service and others)
     + - Network service provider of the mental health service will report the CMI MH CL contact cost and follow the same CL linking rules to include **all** VAED episodes from all sites related to the network.
       - Currently, no provision has been made to link the CMI MH CL contacts from the network service provider to VEMD episodes as CL contacts are considered community contact activity.

* 1. ED MH services (Psych triage team)
     + - Identified by a specific Emergency/Triage subcentre in CMI
       - Soft linking done to VEMD encounters.

1. Allocating Costs Using Relative Value Units

Mental health episode costs are largely driven by salaries and wages costs for mental health clinicians, including medical, nursing and allied health staff. Some imaging and pharmacy costs will also be incurred. The type and number of staff involved in each patient contact as well as the duration of the contact should be considered in allocating costs for different types of patient treatment. The following relative value units (RVUs) have been determined for allocating salaries and wages costs to patient episodes. Local service models differ across health services and can change over time‐ so it is vital that costing teams work closely with their mental health business units to ensure that the RVU used reflects their service model and that the most appropriate RVU is used each year.

*Duration of Contact*

The duration of each contact is the main driver for costs.

*Group Contacts*

Group contact RVUs may be set as follows: If ServiceRecipient = 2 Then RVU = (NumberOfHCP x Duration) / NumberReceivingService

*Multiple HCP Contacts*

For multiple clinicians per contact: If NumberofHCP > 1 Then RVU = NumberofHCP x Duration

*Leave*

Leave and Return is recorded in the Admission Events table in CMI. The total time costed is the total admission time minus Leave

*Seclusion*

Seclusion of a patient requires ongoing monitoring by staff. An appropriate RVU is therefore seclusion duration x 2.

*Mechanical Restraint*

Like seclusion, mechanical restraint can be considered as 2 x duration.

*Mental Health Legal Status*

For admitted episodes, If LegalStatusCode = ITO Then nurse RVU = x1.5.

For contacts, If LegalStatusCode = CTO Then weight as Duration x 2

*Admission Source*

Patients take time to settle when they are first admitted and require more staff attention as a result. For admitted episodes, where a patient AdmSourceCode = “A” Or AdmSourceCode = “AA” then the RVU = 2x nursing weight for first five beddays or until the end of the admission.

*Travel Time*

Where a patient is seen in a non‐hospital setting, subcentre staff travel time becomes a cost. CMI only records the contact time with the patient, not the travel time of the clinicians visiting them. Weight by DistanceTravelledByHCP field x 2 as calculated by postcodes where ServiceMedium code = 1 with a maximum of 120, Add to doctor minutes, otherwise to nurse minutes if there is no doctor RVU. For CMI, Travel Time is a field in the Contacts table which is calculated using the contact postcode and the subcentre postcode.

*Linked feeder data*

Existing feeders for pharmacy, pathology, imaging, etc. will be linked to CMI admissions and will drive the total episode cost accordingly.

**E. RECOMMENDATIONS**

**Accounting for Missing Contacts**

Periodically, work bans can affect the quantity of data recording in CMI. During Enterprise Bargaining Agreement negotiations, work bans can be imposed which reduce data entry for CMI without affecting patient care. This affects mainly mental health contacts. It has been estimated that 25% of contacts might be missing for a health service during this period. It can also affect particular Subcentres more than others. Community contacts are affected most, and some clients might not be registered because of the work bans.

To ensure consistency in costing across these periods and ensure that the costing of patient contacts in periods unaffected by work bans is high quality, the preferred option is to create aggregate episodes with appropriate volumes for the missing contacts and use them to allocate costs. This should be done in line with planned activity patterns. This can be achieved by following these steps:

1. Identify the period affected by the work bans. These can last for several months and may cross financial years.
2. Identify Subcentres affected. Not all Subcentres will be affected equally. The period affected and the level of compliance might vary.
3. Determine activity and resource consumption. Use the average number, type and duration of previous years’ contacts, by subcentre to determine the expected activity levels for the period being costed.
4. Factor in growth funding and known activity targets to make sure the estimated activity levels are reasonable and in line with planned hospital throughput.
5. Create aggregate episodes with the appropriate volumes and load these with existing mental health feeder extracts.xiii
6. Review and assess the results.

Where aggregating volumes is not feasible, an alternative is to exclude the affected periods altogether. This requires splitting the costing GL and the activity data.

**Costing Electro‐Convulsive Therapy (ECT)**

There are several sources of data for ECT treatment common in Victorian public hospitals. Generally, data should be sought from the following sources and in the priority listed. Ideally, all sources should be reconciled. However, some might not be complete, depending on hospital practice:

1. CMI – The task table in CMI stores ECT events. It is a requirement that all DMHS record ECT courses and treatment in the CMI/ODS database. However, in practice, this has not always been the case.
2. Treatment details – recorded by the mental health service.
3. ICD codes – ECT is required to be coded for each episode with different codes for the number of procedures carried out.
4. Theatre system – where a dedicated ECT suite is used or where main theatres deliver ECT the details should be recorded in the theatre system.
5. Transfer file – for some hospitals, ECT is not recorded in a separate theatre system but can be identified by specific ward codes.

**Consultation Liaison**

Consultation Liaison (CL) services exist in different forms across Victorian public hospitals. Specialist psychiatrists provide support to other medical practitioners providing care to patients in both admitted and non‐admitted settings. CL can include in‐reach services to acute admitted patients. They are recorded as contacts in the CMI and can be identified by the program. Dedicated CL subcentres can also exist.

Expenses for CL services funded under the Victorian Mental Health branch/program should be recorded in cost centre H0602 and the activity recorded as contacts in the CMI. For VCDC reporting, these CL costs should be reported as Program M under the Mental Health Program. However, informal CL services can be provided by psychiatric specialists paid under different cost centres with no CL contact recorded in the CMI. This occurs when medical staff provide advice and support similar to CL, but their role is not that of specialised CL services.

For costing CL services funded under the Mental Health branch/program, the following principles should be followed:

1. Identify CL contacts by program.
2. Identify any dedicated CL subcentres.
3. Investigate with the mental health staff where the expenses for these services are recorded in the GL.
4. Allocate expenses to the CL services identified during the previous steps.
5. CL services should be reported at contact level. However, for internal analysis, the costed contact can be rolled up to the appropriate episode (soft‐linked) receiving the CL service.
6. Where informal CL contacts are recorded in the CMI, but the program or subcentre does not identify them as CL services, these should be costed and reported in line with the other activity in their program or subcentre. They should not be reported as CL services funded under the Mental Health branch/program.

**F. NOTES TO THE GUIDELINE**

Mental health programs are often provided in the community which is similar to sub‐acute care and clients who have a mental health condition are offered a range of services that include acute and long-term bed-based care. For these reasons costing mental health activity will be different from inpatient and outpatient hospital-based activity.

Admitted episodes may include acute, PARC or CCU patients.

Non admitted contacts may include ED, CCT, MST, CATT or PMHT contacts.

Work‐In‐Progress is a special problem for costing mental health because patients may be admitted for a period of several years. Full episode costs for those patients will only be available after several years of costing. Costs allocated on fractional beddays or duration within a subcentre should only be allocated to those beddays within the costing year. Auditing those costs should also exclude the period of the WIP for which no beddays costs have been attributed so as not to skew the average costs. This should be considered when auditing costs results against an expected average bedday cost.

**G. FURTHER READING**

Buckingham, B., Burgess, P., Solomon, S., Pirkis, J., Eagar, K., *Mental Health Classification and Service Costs Project: Developing a Casemix Classification for mental Health Services*, 1998: http://www.amhocn.org/publications/developing‐casemix‐classification‐mental‐healthservices‐summary

Health Consult, *Mental Health Costing Study*, 2016: https://www.ihpa.gov.au/publications.

Independent Hospital Pricing Authority, *Development of the Australian mental Health Care*

*Classification: Project Plan*, 2014: https://www.ihpa.gov.au/publications.

The University of Queensland, *STAGE A Final Report: Defining mental health services for classification purposes*, 2013: https://www.ihpa.gov.au/publications.

**APPENDICES**

A. Matching CMI/ODS and VAED Data

The base data set are all inpatient separations occurring during the costing year, from the CMI/ODS system. The intention is to match all VAED separation data with a mental health care type (Care Type = 5x) using the following data items:

This method is summarized in the following tables:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  | **Matching Field** |  |  |
| **Iteration** | **State-wide UR** | **Local UR** | **ADT** | **SDT** | **Campus** |
| 01 |  |  |  |  |  |
| 02 |  |  |  |  |  |
| 03 |  |  |  |  |  |
| 04 |  |  |  |  |  |
| 05 |  |  |  ‐1d, +1d |  |  |
| 06 |  |  | ‐1d, +1d |  |  |
| 07 |  |  |  |  |  |
| 08 |  |  |  |  |  |
| 09 |  |  |  see (1) |  see (2) |  |
| 10 |  |  |  see (1) |  see (2) |  |
| 11 |  |  |  see (1) |  |  |
| 12 |  |  |  see (1) |  |  |
| 13 |  |  |  see (3) |  see (4) |  |
| 14 |  |  | No    match |  |  |

|  |  |
| --- | --- |
| *Notes:*  ADT | Admission Date |
| SDT | Separation Date |
| (1) | IP ADT between CMI ADT and SDT |
| (2) | IP SDT between CMI ADT and SDT |
| (3) | CMI ADT between IP ADT and SDT |
| (4) | CMI SDT between IP ADT and SDT |

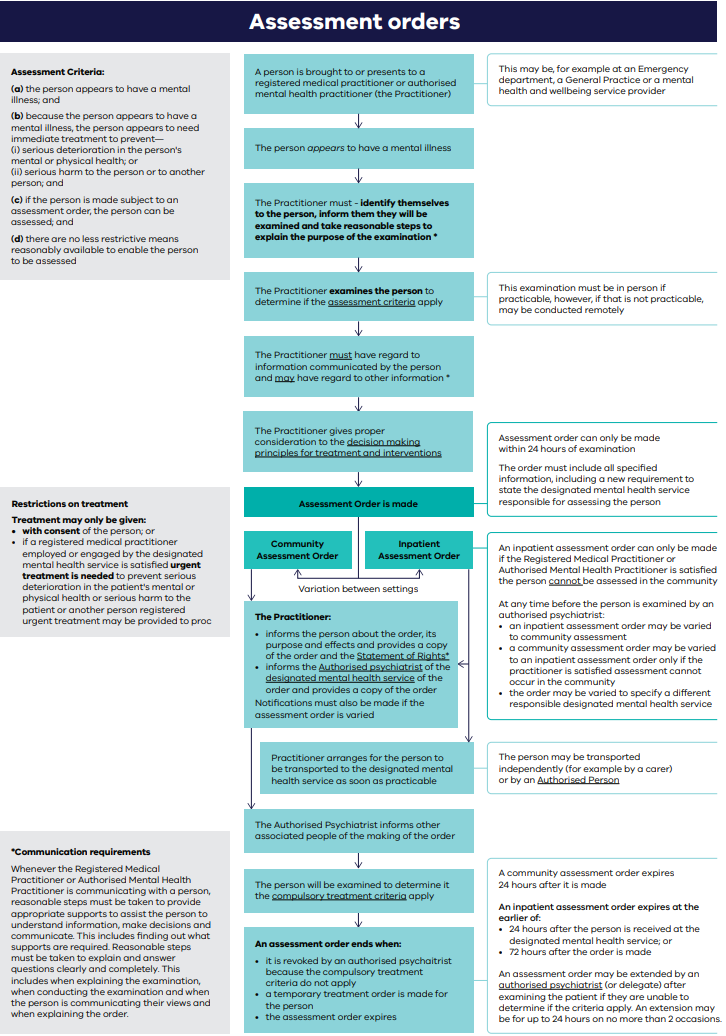
**B. INTERNAL REPORTING**

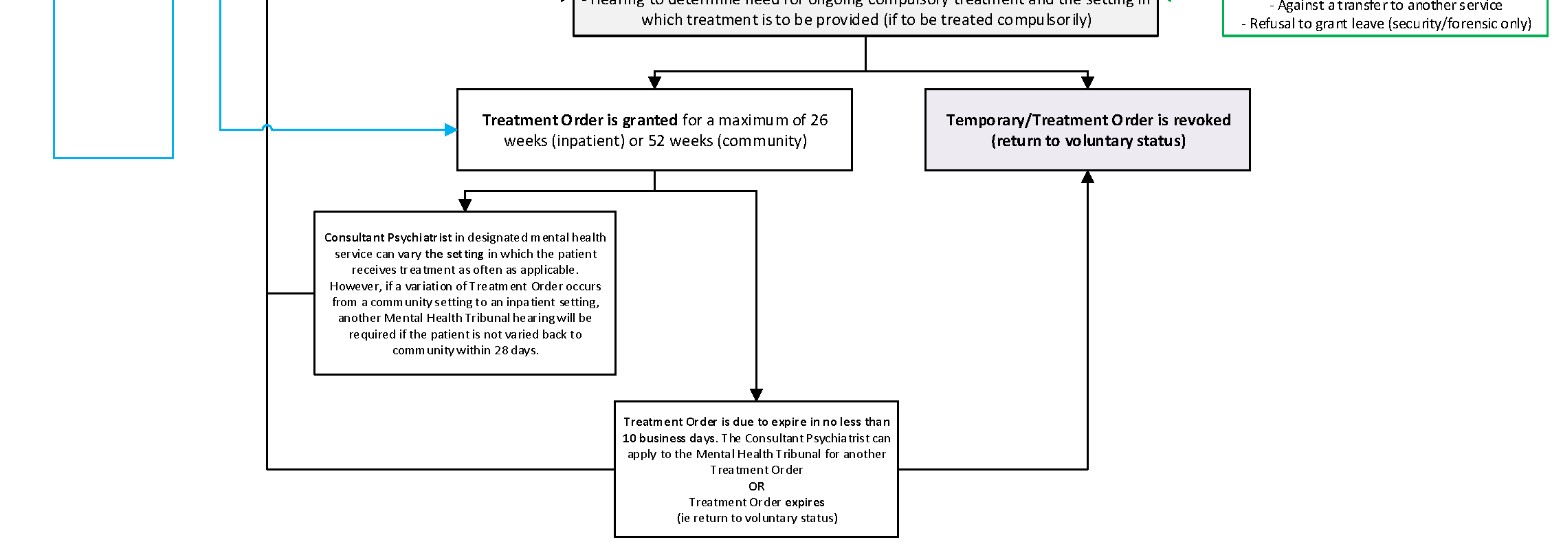
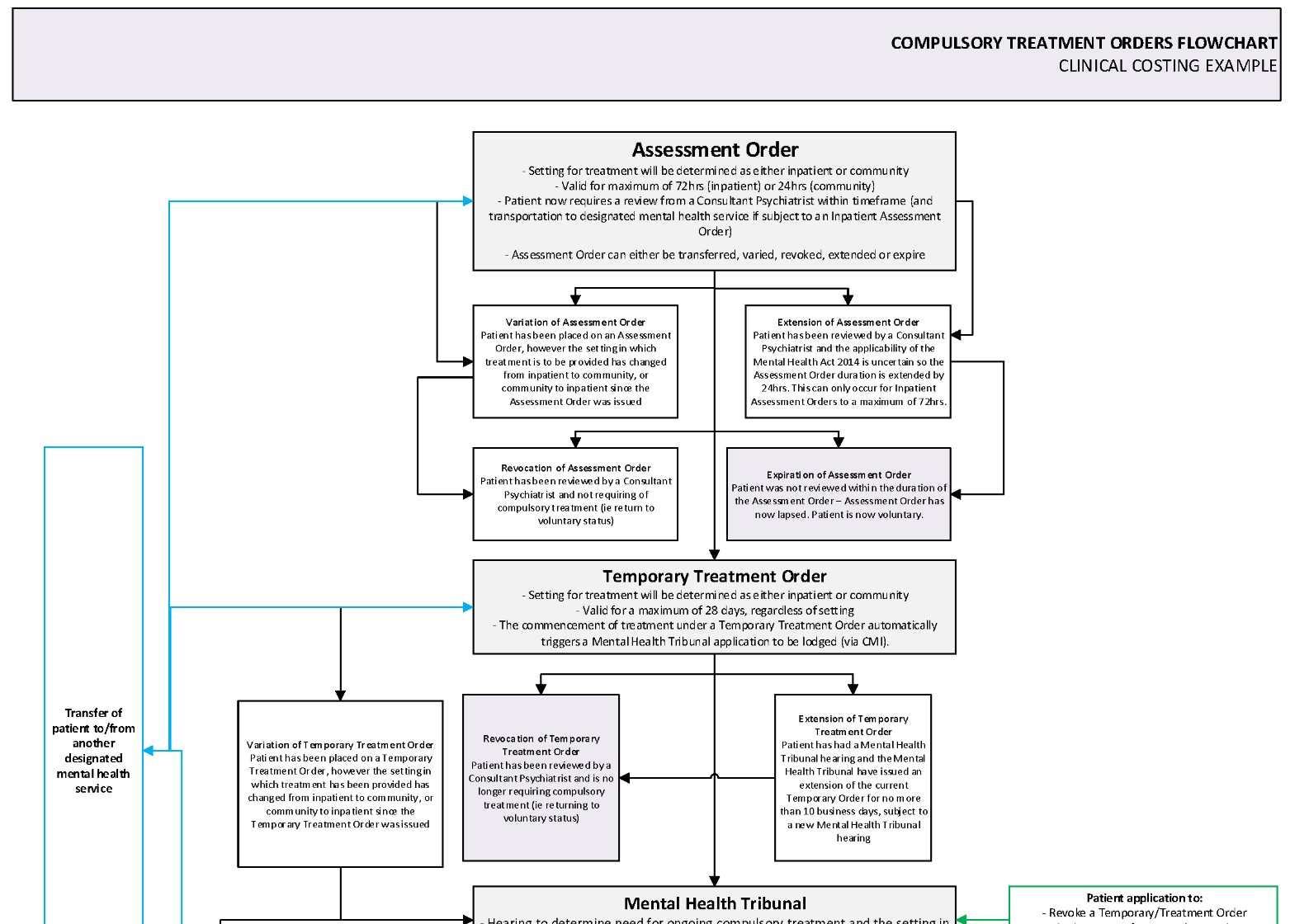
* Hospitals should routinely populate internal reports on mental health cost data as part of their normal validation process.
* Internal reports should cover: o Cost per bedday for admitted episodes o Cost per contact o Cost trends related to Subcentres o Cost trends related to Programs.

**C. DATA SOURCES AND STATUTORY COLLECTIONS**

* CMI/ODS
* An SQL script has been developed by the former VCCUG which can be used to extract data for costing from the Victorian Rapid/CMI database. This can be run against a hospital’s local replication of the system. The scripts are available for download from the VCCUG‐MH Google Drive folder. Any hospital using the script should be aware that the scripts are intended as a guide only and hospitals must do their own testing and development to ensure they run as expected on their local Rapid/CMI environment.

**D. Mental Health and Wellbeing Act 2022 Process flow**

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**References**

For the DH guidelines on reporting ECT refer to:

[Electroconvulsive treatment | health.vic.gov.au](https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/electroconvulsive-treatment) <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/electroconvulsive-treatment>

[Research and reporting (health.vic.gov.au)](https://www.health.vic.gov.au/mental-health/research-and-reporting) <https://www.health.vic.gov.au/mental-health/research-and-reporting>

[Program maintenance in CMI/ODS (health.vic.gov.au)](https://www.health.vic.gov.au/research-and-reporting/program-maintenance-in-cmiods)https://www.health.vic.gov.au/research-and-reporting/program-maintenance-in-cmiods

[Recording contacts in the CMI/ODS (health.vic.gov.au)](https://www.health.vic.gov.au/research-and-reporting/recording-contacts-in-the-cmiods) https://www.health.vic.gov.au/research-and-reporting/recording-contacts-in-the-cmiods

https://www.ranzcp.org/Membership/Faculties‐sections/Consultation‐Liaison.

Contact Type definitions are taken from the DH Contact Data Definition (CMI) (2023).

[Assessment orders | health.vic.gov.au](https://dhhsvicgovau.sharepoint.com/sites/DataanalysisandreportinginclVCDC/Shared%20Documents/VCDC%20collection/2024-2025%20VCDC/9.0%20Working%20Files/VCDC%20Documentation/Assessment%20orders%20|%20health.vic.gov.au) https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/assessment-orders

[Assessment orders | health.vic.gov.au](https://dhhsvicgovau.sharepoint.com/sites/DataanalysisandreportinginclVCDC/Shared%20Documents/VCDC%20collection/2024-2025%20VCDC/9.0%20Working%20Files/VCDC%20Documentation/Assessment%20orders%20|%20health.vic.gov.au) https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/assessment-orders#compulsory-assessment-criteria

[Restrictive interventions | health.vic.gov.au](https://dhhsvicgovau.sharepoint.com/sites/DataanalysisandreportinginclVCDC/Shared%20Documents/VCDC%20collection/2024-2025%20VCDC/9.0%20Working%20Files/VCDC%20Documentation/Restrictive%20interventions%20|%20health.vic.gov.au) https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/restrictive-interventions

[Registration of mental health clients](https://dhhsvicgovau.sharepoint.com/sites/DataanalysisandreportinginclVCDC/Shared%20Documents/VCDC%20collection/2024-2025%20VCDC/9.0%20Working%20Files/VCDC%20Documentation/Registration%20of%20mental%20health%20clients) https://www.health.vic.gov.au/research-and-reporting/registration-of-mental-health-clients

It is planned to develop a set of standard subcentre codes for use with aggregated episodes in Mental Health costing. These will be published in the Victorian Cost Data Collection Data Request Specification and Business Rules.

[Registration of mental health clients](https://www.health.vic.gov.au/research-and-reporting/registration-of-mental-health-clients) https://www.health.vic.gov.au/research-and-reporting/registration-of-mental-health-clients

1. AHPCS v4.2breaks down Deprec as DeprecB (building) and DeprecE (equipment) [↑](#footnote-ref-2)
2. Australian Hospital Patient Costing Standards (V4.2) – Part 1: Standards, Standard 1.2 Third party expenses [↑](#footnote-ref-3)
3. Australian Hospital Patient Costing Standards (V4.2) - Part 2: Business rules, Business Rule 1.2 Third party expenses [↑](#footnote-ref-4)
4. Please Note:

   Both the Blood type reference and ACHI codes are no longer updated from 2019-20 onwards as these are a guide only.

   With ACHI codes, health services using this methodology in previous years also seek advice from their respective Health Information Manager for confirmation.

   With Blood type reference, part of the allocation process in previous years requires costing staff to seek assistance from their health service’s Transfusion Medicine Director and/or Pharmacy Director to help inform the ‘split’ to their admitted and non-admitted patients prior to allocating the blood product in accordance with the activities at their health services. [↑](#footnote-ref-5)
5. [↑](#footnote-ref-6)
6. Some suggested fields on the Blood extract are outlined on Appendix A. [↑](#footnote-ref-7)
7. The department acknowledges the inputs from Monash Health, The Royal Children’s Hospital, The Austin and Melbourne Health for the updated sections in this guidance. [↑](#footnote-ref-8)
8. It is recommended that the internal extract is received on a more regularly basis during the year to carry of the preparation of costing patients. [↑](#footnote-ref-9)
9. Pharmacy will be able to provide an Immunoglobulin extract which will always match with NBA sheet as indicated by The Royal Children’s Hospital. [↑](#footnote-ref-10)
10. Refer to Appendix B for Reconciliation suggestions. [↑](#footnote-ref-11)
11. Adapted from Melbourne Health and with compliments from Austin Health regarding the Business rules in point nine. [↑](#footnote-ref-12)
12. It is helpful to create a mapping table of internal blood products to the NBA blood products that will update the unit costs and including any new blood products from year to year. [↑](#footnote-ref-13)
13. Adapted from Monash Health [↑](#footnote-ref-14)
14. Based on the 2019-20 NBA data provided [↑](#footnote-ref-15)
15. This would be similar to Screen 1 in Methodology 1 but using the Total column. [↑](#footnote-ref-16)
16. Either apportioning to Basic Pay account (Allocation Methodology 1) or to the Derived Pay types of accounts within the professional groups are acceptable (Allocation Methodology 2). 2 As above. [↑](#footnote-ref-17)
17. These accounts have been identified as the major cause for having negative costs in the ‘Other’ cost bucket.

    [↑](#footnote-ref-18)
18. This rule is stipulated in both the VCDC documentation and the AHPCS.

    Costing medial salaries for private (MBS) & public non-admitted specialist clinics two [↑](#footnote-ref-19)
19. http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-pros-consumers [↑](#footnote-ref-20)
20. Available on < http://www.health.gov.au/internet/main/publishing.nsf/Content/iwg-phi-pros-ref> [↑](#footnote-ref-21)
21. Department of Health , 2024-25 Policy and funding guidelines,Section 4.1 Victorian Perinatal Autopsy Service [↑](#footnote-ref-22)
22. Department Health website; www.health.vic.gov.au

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    [↑](#footnote-ref-23)