PHI Data Specifications 2020/21

Changes effective for data with separation month from July 2020 onwards

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1. Implementation

For PHDB (hospital to department), HCP (hospital to insurer), and HCP1 (insurer to department), these proposed changes to data specifications are designed to apply to hospital separation data with separation month from July 2020 onwards, i.e. data relating to the 2020-21 financial year and following years.

For GT-Dental any changes will be based on the date of file submission, because GT-Dental files contain a range of service dates.

2. Care type code

Data Item: Care type code

Datasets: This change affects the following data specifications: HCP (episode), HCP1 (episode), PHDB (episode)

Change: Move to new METeOR (711010) values for care type.

In PHDB and HCP (hospital to insurer), old field ‘care type’ to be revised with new coding description and edit rules.

In HCP1 (insurer to department) both old ‘care type’ and new ‘care type code’ fields will be accepted during the 2 year period of transition to ECLIPSE web services (to June 30, 2022).

Reason: To align with METeOR (711010) and ECLIPSE web services.

See following pages

PHDB – Episode – revised field

No	Data Item	METeOR identifier	Type & size	Format	Coding description	Edit Rules	Error code/s
20	Care Type	~~METeOR 270174 but with additional code 11 = Mental Health Care (From METeOR 584408)~~ 711010	N(3)	~~Left justify two digit codes and follow with a blank space)~~ Left justify and follow with blank space(s)	~~The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care), as represented by a code.~~ ~~10 = Acute Care, 11 = Mental Health Care, 20 = Rehabilitation Care~~ ~~21 = Rehabilitation Care delivered in a designated unit~~ ~~22 = Rehabilitation Care according to a designated program~~ ~~23 = Rehabilitation Care is the principal clinical intent~~ ~~30 = Palliative Care~~ ~~31 = Palliative Care delivered in a designated unit~~ ~~32 = Palliative Care according to a designated program~~ ~~33 = Palliative Care is the principal clinical intent~~ ~~40 = Geriatric evaluation and management~~ ~~50 = Psychogeriatric Care, 60 = Nursing Home Type~~ ~~70 = Newborn Care, 80 = Other admitted patient care~~ ~~90 = Organ procurement - posthumous, 100 = Hospital boarder~~ The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. Admitted care 1 Acute care 2 Rehabilitation care 3 Palliative care 4 Geriatric evaluation and management 5 Psychogeriatric care 6 Maintenance care 7 Newborn care 11 Mental health care 88 Other admitted patient care Care other than admitted care 9 Organ procurement—posthumous 10 Hospital boarder	**Reject** ~~record if not (10, 11, 20, 21, 22, 23, 30, 31, 32, 33, 40, 50, 60, 70, 80, 90 or 100)~~ **Reject** record if not (1, 2, 3, 4, 5, 6, 7, 9, 10, 11 or 88) (Reject record if not in correct format: must be left justified and followed by blank(s))	E020

HCP – Episode - revised field

No	Data Item	METeOR identifier	Type & size	Format	Coding description	Edit Rules	Error code/s
20	Care Type	~~METeOR 270174 but with additional code 11 = Mental Health Care (From METeOR 584408)~~ 711010	N(3)	~~Left justify two digit codes and follow with a blank space)~~ Left justify and follow with blank space(s)	~~The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care), as represented by a code.~~ ~~10 = Acute Care, 11 = Mental Health Care, 20 = Rehabilitation Care~~ ~~21 = Rehabilitation Care delivered in a designated unit~~ ~~22 = Rehabilitation Care according to a designated program~~ ~~23 = Rehabilitation Care is the principal clinical intent~~ ~~30 = Palliative Care~~ ~~31 = Palliative Care delivered in a designated unit~~ ~~32 = Palliative Care according to a designated program~~ ~~33 = Palliative Care is the principal clinical intent~~ ~~40 = Geriatric evaluation and management~~ ~~50 = Psychogeriatric Care, 60 = Nursing Home Type~~ ~~70 = Newborn Care, 80 = Other admitted patient care~~ ~~90 = Organ procurement - posthumous, 100 = Hospital boarder~~ The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. Admitted care 1 Acute care 2 Rehabilitation care 3 Palliative care 4 Geriatric evaluation and management 5 Psychogeriatric care 6 Maintenance care 7 Newborn care 11 Mental health care 88 Other admitted patient care Care other than admitted care 9 Organ procurement—posthumous 10 Hospital boarder	~~**Reject** record if not (10, 11, 20, 21, 22, 23, 30, 31, 32, 33, 40, 50, 60, 70, 80, 90 or 100)~~ **Reject** record if not (1, 2, 3, 4, 5, 6, 7, 9, 10, 11 or 88) (Reject record if not in correct format: must be left justified and followed by blank(s))	EE020

HCP1 - episode - old field

In HCP1 both old and new versions will be accepted during the 2 year period of transition to ECLIPSE web services (to June 30, 2022)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
44	Care Type (superseded)	METeOR 270174 but with additional code 11 = Mental Health Care (From METeOR 584408)	MAA	N(3)	Left justify two digit codes and follow with a blank space	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care), as represented by a code. 10 = Acute care 11 = Mental Health Care 20 = Rehabilitation care 21 = Rehabilitation care delivered in a designated unit 22 = Rehabilitation care according to a designated program 23 = Rehabilitation care is the principle clinical intent 30 = Palliative care 31 = Palliative care delivered in a designated unit 32 = Palliative care according to a designated program 33 = Palliative care is the principle clinical intent 40 = Geriatric Evaluation and management 50 = Psychogeriatric care 60 = Nursing Home Type 70 = Newborn care 80 = Other admitted patient care 90 = Organ procurement – posthumous 100 = Hospital boarder This field has been superseded by the new item: 'Care type code' (Item No 83) but will still be accepted during the period of transition to ECLIPSE webservices.	**If not blank**, **Reject** record if not (10, 11, 20, 21, 22, 23, 30, 31, 32, 33, 40, 50, 60, 70, 80, 90 or 100)	EE044

HCP1 – episode – new field

In HCP1 both old and new fields will be accepted during the 2 year period of transition to ECLIPSE web services (to June 30, 2022)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
83	Care type code	711010	MAA	N(2)	Left justify. For one digit codes, follow with a blank space	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. Admitted care 1 Acute care 2 Rehabilitation care 3 Palliative care 4 Geriatric evaluation and management 5 Psychogeriatric care 6 Maintenance care 7 Newborn care 11 Mental health care 88 Other admitted patient care Care other than admitted care 9 Organ procurement—posthumous 10 Hospital boarder This field supersedes previous 'care type' field (Item 44)	**Reject** record if 'Care type' (Item 44) is blank and 'Care type code' (Item 83) is not (1, 2, 3, 4, 5, 6, 7, 9, 10, 11 or 88) (**Reject** record if not in correct format: single digits must be left justified and followed by a blank)	EE083

3. AR DRG version and Diagnosis Related Group

Data Items **‘**DRG version’, **‘**AR DRG version’ and ‘Diagnosis Related group’

Datasets: This change affects the following data specifications: HCP (episode), HCP1 (episode), PHDB (episode)

Changes: Move from previous 2 digit field ‘DRG version’ to new 3 digit field for ‘AR_DRG version’

- In PHDB and HCP (hospital to insurer) old field ‘DRG version’ will be blank filled and new field ‘AR DRG version’ will be used instead.
- In HCP1 (insurer to department) both old field ‘DRG version’ and new field ‘AR DRG version’ will be accepted during the 2 year period of transition to ECLIPSE web services (to June 30, 2022)

Correspondingly change edit rules for ‘Diagnosis related Group’ in PHDB, HCP and HCP1.

Reason: Move from previous 2 digit field ‘DRG version’ to new 3 digit field for ‘AR DRG version’ to align with ECLIPSE web services.

See following pages:

PHDB – episode – old field (to be blank filled)

No	Data Item	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
16	DRG Version (superseded)	O	A(2)	~~Left justify~~ Blank fill	~~The version of the DRG classification:~~ ~~41 = version 4.1 42 = version 4.2~~ ~~50 = version 5.0 51 = version 5.1~~ ~~52 = version 5.2 60 = version 6.0~~ ~~6x = version 6.x 70 = version 7.0~~ ~~80 = version 8.0 90 = version 9.0~~ ~~na = version n.a A0 = version 10.0~~ ~~Must be supplied if DRG code provided at item 15.~~ This field has been retained as a placeholder to minimise system changes. See replacement item: 'AR DRG version' (Item No 65)	~~If present, **identify** record if not a valid version.~~ ~~**Identify** record if blank and DRG code provided at item 15.~~	~~W016.0~~ ~~W016.1~~

PHDB – episode – new field

No	Data Item	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
65	AR DRG version	O	A(3)	Left justify. For two digit codes, follow with a blank space	The version of the AR-DRG classification: 41 = version 4.1 42 = version 4.2 50 = version 5.0 51 = version 5.1 52 = version 5.2 60 = version 6.0 6x = version 6.x 70 = version 7.0 80 = version 8.0 90 = version 9.0 na = version n.a 100 = version 10.0 Must be supplied if DRG code is provided at item 15 This field supersedes previous DRG version field (Item 16)	If present, **identify** record if not (41, 42, 50, 51, 52, 60, 6x, 70, 80, 90, na, 100) **Identify** record if blank and DRG code is provided (Item 15)	EW065.0 EW065.1

PHDB – episode – revised edit rule for 'Diagnosis Related Group'

No	Data Item	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
15	Diagnosis Related Group	O	A(4)	Left justify	A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital, as represented by a code.	If present, **identify** record if not a valid DRG code for AR DRG version supplied at item 65.	W015

HCP – episode – old field (to be blank filled)

No	Data Item	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
16	DRG Version (superseded)	O	A(2)	Blank fill	~~The version of the DRG classification:~~ ~~41 = version 4.1 42 = version 4.2~~ ~~50 = version 5.0 51 = version 5.1~~ ~~52 = version 5.2 60 = version 6.0~~ ~~6x = version 6.x 70 = version 7.0~~ ~~80 = version 8.0 90 = version 9.0~~ ~~na = version n.a A0 = version 10.0~~ ~~Must be supplied if DRG code provided at item 15.~~ This field has been retained as a placeholder to minimise system changes. See replacement item: 'AR DRG version' (Item No 65)	~~If present, **identify** record if not a valid version.~~ ~~**Identify** if blank and DRG code provided at item 15.~~	~~EW016.0~~ ~~EW016.1~~

HCP – episode – new field

No	Data Item	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
65	AR DRG version	CON	A(3)	Left justify. For two digit codes, follow with a blank space	The version of the AR-DRG classification: 41 = version 4.1 42 = version 4.2 50 = version 5.0 51 = version 5.1 52 = version 5.2 60 = version 6.0 6x = version 6.x 70 = version 7.0 80 = version 8.0 90 = version 9.0 na = version n.a 100 = version 10.0 Must be supplied if DRG code is provided at item 15 This field supersedes previous 'DRG version' field (Item 16)	If present, **identify** record if not (41, 42, 50, 51, 52, 60, 6x, 70, 80, 90, na, 100) **Identify** record if blank and DRG code is provided (Item 15)	EW065.0 EW065.1

HCP – episode – revised edit rule for Diagnosis related group

No	Data Item	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
15	Diagnosis Related Group	O	A(4)	Left justify	A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital, as represented by a code.	If present, **identify** record if not a valid DRG code for AR DRG version supplied at item 65.	EW015

HCP1 – episode – old field

In HCP1 both old and new fields will be accepted during the 2 year period of transition to ECLIPSE web services (to June 30, 2022)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
37	DRG version (superseded)	-	CON	A(2)		The version of the DRG classification: 41 = version 4.1 42 = version 4.2 50 = version 5.0 51 = version 5.1 52 = version 5.2 60 = version 6.0 6x = version 6.x 70 = version 7.0 80 = version 8.0 90 = version 9.0 na = version n.a A0 = version 10.0 ~~Must be supplied if DRG code provided at item 36.~~ This field has been superseded by the new item: 'AR_DRG Version' (Item 84) but will still be accepted during the period of transition to ECLIPSE webservices.	If present, **identify** record if not valid version. ~~**Identify** record if blank and DRG code provided.~~	EW037.0 ~~EW037.1~~

HCP1 – episode – new field

In HCP1 both old and new fields will be accepted during the 2 year period of transition to ECLIPSE web services (to June 30, 2022)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
84	AR DRG version		CON	A(3)	Left justify. For two digit codes, follow with a blank space	The version of the AR-DRG classification: 41 = version 4.1 42 = version 4.2 50 = version 5.0 51 = version 5.1 52 = version 5.2 60 = version 6.0 6x = version 6.x 70 = version 7.0 80 = version 8.0 90 = version 9.0 na = version n.a 100 = version 10.0 Must be supplied if DRG code is provided at item 36 and superseded item 'DRG version' (Item37) is blank This field supersedes previous DRG version field (Item 37)	If present, **identify** record if not (41, 42, 50, 51, 52, 60, 6x, 70, 80, 90, na, 100) **Identify** record if both DRG version (Item 37) and AR DRG version (Item 84) are blank and DRG code is provided (Item 36) and is not 'GEN'	EW084.0 EW084.1

HCP1 – episode – revised edit rule for 'diagnosis related group'

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
36	Diagnosis related group	391295	OPA	A(4)	Left justify	The DRG code which describes the episode of care. "GEN " = A generated episode not suitable for grouping according to the health Insurer practices. This should be the Health Insurer DRG wherever possible; otherwise the Hospital DRG.	If present, **identify** record if not (a valid DRG code for DRG version in Item 37 or for AR-DRG version in Item 84 or 'GEN ')	EW036

4. Inter-hospital contracted patient code

Data Item: Inter-hospital contracted patient code

Datasets: This change affects the following data specifications: HCP (episode), HCP1 (episode), PHDB (episode).

Change: Move from previous field ‘inter-hospital contracted patient’ to new field ‘inter-hospital contracted patient code’

In PHDB and HCP (hospital to insurer), old field to be revised with new coding description and edit rules.

In HCP1 (insurer to department) both old and new fields will be accepted during the 2 year period of transition to ECLIPSE web services (to June 30, 2022)

Reason: to align with METeoR (647105) and ECLIPSE web services.

See following pages

PHDB – episode – revised field

No	Data Item	METeOR identifier	Type & size	Format	Coding description	Edit Rules	Error code/s
23	Inter-hospital contracted patient	~~270409~~ 647105	N(1)		~~An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code.~~ ~~1 = Inter-Hospital contracted patient from public sector~~ ~~2 = Inter-Hospital contracted patient from private sector~~ ~~3 = Not contracted~~ ~~9 = Not reported~~ An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code. Contracted (destination) hospital 1 = Inter-hospital contracted patient from public sector hospital; 2 = Inter-hospital contracted patient from private sector hospital; Contracting (originating) hospital 3 = Inter-hospital contracted patient to public sector hospital; 4 = Inter-hospital contracted patient to private sector hospital; 5 = Not inter-hospital contracted; Supplementary values 9 = Not stated.	~~**Reject** record if not (1, 2, 3 or 9)~~ **Reject** record if not (1,2,3,4,5 or 9)	 E023

HCP – episode – revised field

No	Data Item	METeOR identifier	Type & size	Format	Coding description	Edit Rules	Error code/s
23	Inter-hospital contracted patient	~~270409~~ 647105	N(1)		~~An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code.~~ ~~1 = Inter-Hospital contracted patient from public sector~~ ~~2 = Inter-Hospital contracted patient from private sector~~ ~~3 = Not contracted~~ ~~9 = Not reported~~ An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code. Contracted (destination) hospital 1 = Inter-hospital contracted patient from public sector hospital; 2 = Inter-hospital contracted patient from private sector hospital; Contracting (originating) hospital 3 = Inter-hospital contracted patient to public sector hospital; 4 = Inter-hospital contracted patient to private sector hospital; 5 = Not inter-hospital contracted; Supplementary values 9 = Not stated.	~~**Reject** record if not (1, 2, 3 or 9)~~ **Reject** record if not (1,2,3,4,5 or 9)	 EE023

HCP1 – episode- old field - In HCP1 both old and new fields will be accepted during the 2 year period of transition to ECLIPSE web services

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Coding description	Edit Rules	Error code/s
60	Inter-hospital contracted patient (superseded)	270409	MAO	N(1)		An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code. 1 = Inter-Hospital contracted patient from public sector; 2 = Inter-Hospital contracted patient from private sector 3 = Not contracted 9 = Not reported This field has been superseded by the the new item: 'Inter hospital contracted patient code' (Item 87) but will still be accepted during the period of transition to ECLIPSE webservices.	If present, reject record if not (1, 2, 3 or 9). ~~**Reject** record if blank and hospital type is (private or private day facility).~~	EE060.0 ~~EE060.1~~

HCP1 – episode – new field - In HCP1 both old and new fields will be accepted during the 2 year period of transition to ECLIPSE web services

No	Data Item	METeOR identifier	Obligation	Type & size	Coding description	Edit Rules	Error code/s
87	Inter hospital contracted patient code	647105	MAO	N(1)	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code. Contracted (destination) hospital 1 = Inter-hospital contracted patient from public sector hospital; 2 = Inter-hospital contracted patient from private sector hospital; Contracting (originating) hospital 3 = Inter-hospital contracted patient to public sector hospital; 4 = Inter-hospital contracted patient to private sector hospital; 5 = Not inter-hospital contracted; Supplementary values 9 = Not stated. This field supersedes previous field:' Inter-hospital contracted patient' (Item 60)	If present, **reject** record if not (1,2,3,4,5 or 9) **Reject** record if both 'Inter hospital contracted patient' (Item 60) and 'Inter hospital contracted patient code' (Item 87) are blank and hospital type is (private or private day facility).	EE087.0 EE087.1

5. Total record length

Data Items: Total record length

Datasets: Changes to total record length affects the following data specifications:

- PHDB (episode)
- HCP (episode), HCP (AN-SNAP) ,
- HCP1 (episode), HCP1 (AN-SNAP)

Changes:

PHDB (episode)	Total record length changed from 1257 to 1260
HCP (episode)	Total record length changed from 1257 to 1260
HCP (AN-SNAP)	Total record length changed from 177 to 162
HCP1 (episode)	~~1371 characters; record type of 'E' followed by 1370 character record~~ 1377 characters; record type of 'E' followed by 1376 character record
HCP1 (AN-SNAP)	~~95 characters; record type of 'S' followed by 94 character record~~ 80 characters; record type of 'S' followed by 79 character record

Note: these changes to total record length are recorded at the bottom of the relevant worksheets. HCP1 (episode) and HCP1(AN-SNAP) changes are also noted in the INPUT FILE FORMAT worksheet of the HCP1 spreadsheet.

6. AN-SNAP delete fields

Datasets: This change affects the following data specifications: HCP (ANSNAP), HCP1 (ANSNAP)

Change: The following fields are to be DELETED (along with their associated edit rules)

Field	HCP (ANSNAP) item no. and edit rule	HCP1 (ANSNAP) item no. and edit rule
~~‘Assessment only Indicator ’,~~	~~15 (AE015)~~	~~7 (AE007)~~
~~‘Rehabilitation plan date’~~	~~18 (AE018)~~	~~10 (AE010)~~
~~‘Discharge plan date’~~	~~19 (AE019)~~	~~11 (AE011)~~

Because ‘Assessment only Indicator’ is deleted, the position of ‘AN-SNAP class’ and ‘AN_SNAP version’ will be altered

Reason: advice from The Australasian Rehabilitation Outcomes Centre (AROC) is that these fields are no longer required

HCP (AN-SNAP) field position changes

No	Data Item	METeOR identifier	Obligation	Position Start	Position End	Type & size
16	AN-SNAP Class	449125	M	~~156~~ 155	~~159~~ 158	A(4)
17	AN-SNAP Version	448983	M	~~160~~ 159	~~161~~ 160	N(2)

HCP1 (AN-SNAP) field position changes

No	Data Item	METeOR identifier	Obligation	Position Start	Position End	Type & size
8	AN-SNAP Class	449125	MAA	~~73~~ 72	~~76~~ 75	A(4)

9	AN-SNAP Version	448983	MAA	~~77~~ 76	~~78~~ 77	N(2)

7. AN-SNAP change edit rule plus new fields

Datasets: This change affects the following data specifications: HCP (ANSNAP), HCP1 (ANSNAP)

Change: Change edit rule for Discharge FIM Item Scores

Add two new AN-SNAP fields: Mode of 'Episode Start – Inpatient' and 'Mode of Episode End– Inpatient'.

Reason: advice from The Australasian Rehabilitation Outcomes Centre (AROC) and to be consistent with ECLIPSE web services

HCP (AN-SNAP)

No	Data Item	Coding description	Edit Rules	Error code/s
13	Discharge FIM Item Scores	The FIM score on discharge for each of the 18 FIM motor and cognition items. No Helper: Score of 7 – Complete Independence Score of 6 – Modified Independence Helper: Score of 5 – Supervision or setup Score of 4 – Minimal assistance Score of 3 – Moderate assistance Score of 2 – Maximal assistance Score of 1 – Total assistance	~~Reject record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O and not Episode Mode of Separation = 8~~ Reject record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O and 'Mode of Episode End – Inpatient' (Item 19) is (1,2, or 7) If present, **reject** if not numeric. **Identify** record if episode type is S and not blank fill	AE013 AE013.1 AW013

HCP1 (AN-SNAP)

No	Data Item	Coding description	Edit Rules	Error code/s
5	Discharge FIM Item Scores	The FIM score on discharge for each of the 18 FIM motor and cognition items. No Helper: Score of 7 – Complete Independence Score of 6 – Modified Independence Helper: Score of 5 – Supervision or setup Score of 4 – Minimal assistance Score of 3 – Moderate assistance Score of 2 – Maximal assistance Score of 1 – Total assistance *refer to guide for use	~~**Reject** record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O and not Episode Mode of Separation = 8~~ **Reject** record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O and 'Mode of Episode End – Inpatient' (Item 13) is (1,2, or 7) If present, **reject** if not numeric. **Identify** record if episode type is S and not blank fill	AE005 AE005.1 AW005

New HCP (AN-SNAP) fields:

No	Data Item	Obligation	Type & size	Coding description	Edit Rules	Error code/s
18	Mode of Episode Start – Inpatient	CON	N(1)	Where the patient came from when the inpatient rehabilitation episode started 1 Admitted from usual accommodation 2 Admitted from other than usual accommodation 3 Transferred from another hospital 4 Transferred from acute care in another ward 5 Transferred from acute specality unit 6 Change from acute care to sub/non-acute care same ward 7 Change of sub/non-acute care type 8 Other 9 Recommenced rehabilitation following suspension Conditional item: must be provided if overnight patient (Episode Type=O) and other AN-SNAP items provided. This item not relevant for same-day patients.	**Reject** record if not (1, 2, 3, 4, 5, 6 , 7, 8 or 9) and episode type is O.	AE018
19	Mode of Episode End – Inpatient	CON	N(1)	Where the patient went to at the end of their inpatient rehabilitation episode. There are two broad categories - Back into the community - Remain in the hospital system Permissible values: 1 Discharged to final accommodation 2 Discharged to interim accommodation 3 Death 4 Discharged/Transfered to another hospital 5 Care type change and transferred to a different ward 6 Care type change and remained on same ward 7 Change of care type within sub-acute/non-acute care 8 Discharged at own risk 9 Other and unspecified Conditional item: must be provided if overnight patient (Episode Type=O) and other AN-SNAP items provided. This item not relevant for same-day patients.	**Reject** record if not (1, 2, 3, 4, 5, 6 , 7, 8 or 9) and episode type is O.	AE019

New HCP1 (AN-SNAP) fields:

No	Data Item	Obligation	Type & size	Coding description	Edit Rules	Error code/s
12	Mode of Episode Start – Inpatient	CON	N(1)	Where the patient came from when the inpatient rehabilitation episode started 1 Admitted from usual accommodation 2 Admitted from other than usual accommodation 3 Transferred from another hospital 4 Transferred from acute care in another ward 5 Transferred from acute specialty unit 6 Change from acute care to sub/non-acute care same ward 7 Change of sub/non-acute care type 8 Other 9 Recommenced rehabilitation following suspension Conditional item: must be provided if overnight patient (Episode Type=O) and other AN-SNAP items provided. This item not relevant for same-day patients.	Reject record if not (1, 2, 3, 4, 5, 6 , 7, 8 or 9) and episode type is O.	AE012
13	Mode of Episode End – Inpatient	CON	N(1)	Where the patient went to at the end of their inpatient rehabilitation episode. There are two broad categories - Back into the community - Remain in the hospital system Permissible values: 1 Discharged to final accommodation 2 Discharged to interim accommodation 3 Death 4 Discharged/Transfered to another hospital 5 Care type change and transferred to a different ward 6 Care type change and remained on same ward 7 Change of care type within sub-acute/non-acute care 8 Discharged at own risk 9 Other and unspecified Conditional item: must be provided if overnight patient (Episode Type=O) and other AN-SNAP items provided. This item not relevant for same-day patients.	Reject record if not (1, 2, 3, 4, 5, 6 , 7, 8 or 9) and episode type is O.	AE013

8. Provider number of hospital from which transferred

Data item: Provider Number of hospital from which transferred

Datasets: This change affects the following data specifications: PHDB (episode), HCP (Episode) and HCP1 (Episode)

Change: Change edit rule/description so that 'Provider Number of hospital from which transferred' can be recorded when 'source of referral' is either

1- Admitted patient transferred from another hospital) OR

4 - From Accident/Emergency

Reason: To allow collection of referrals from Accident/Emergency in a transferring hospital

PHDB - Episode

No	Data Item	Type & size	Coding description	Edit Rules	Error code/s
19	Provider Number of Hospital from which transferred	A(8)	The Commonwealth-issued hospital provider number for the hospital from which a patient has been transferred (Provider number required only when PHDB item number 21 is reported as: 1- Admitted patient transferred from another hospital) Blank fill if no hospital transfer. If a patient was transferred from Accident/Emergency at a different hospital from the one in which this separation occurred, then enter the Commonwealth-issued Provider number of that hospital	**Reject** record if Source of Referral (item 21) is 1 and not (a valid 8 character Commonwealth provider number or OVERSEAS). ~~**Reject** record if Source of Referral (item 21) is not 1 and item 19 is not blank.~~ Reject record if not blank and Source of Referral (item 21) is not 1 or 4	E019 E019.1

HCP - Episode

No	Data Item	Type & size	Coding description	Edit Rules	Error code/s
19	Provider Number of Hospital from which transferred	A(8)	The Commonwealth-issued hospital provider number for the hospital from which a patient has been transferred (Provider number required only when HCP item number 21 is reported as: 1- Admitted patient transferred from another hospital) Blank fill if no hospital transfer. If a patient was transferred from Accident/Emergency at a different hospital from the one in which this separation occurred, then enter the Commonwealth-issued Provider number of that hospital	**Reject** record if not a valid 8 character Commonwealth provider number and Source of Referral (item 21) is 1. **Reject** record if not blank and Source of Referral (item 21) ~~is not 1~~ is not 1 or 4	EE019 EE019.1

HCP1 - Episode

No	Data Item	Type & size	Coding description	Edit Rules	Error code/s
64	Provider number of hospital from which transferred	A(8)	The Commonwealth-issued hospital provider number for the hospital from which a patient has been transferred (Provider number required only when HCP item number 43 is reported as: 1- Admitted patient transferred from another hospital) Blank fill if no hospital transfer. Overseas hospitals to be coded as OVERSEAS If a patient was transferred from Accident/Emergency at a different hospital from the one in which this separation occurred, then enter the Commonwealth-issued Provider number of that hospital	**Reject** record if Source of referral (item 43) is 1 and item 64 is not (a valid 8 character Commonwealth provider number or OVERSEAS) **Reject** record if not blank and Source of referral (Item 43) ~~is not 1~~ is not (1 or 4)	EE064 EE064.1

9. Other changes

- In HCP1, change existing critical error RE001 into a 'fatal' error (so file is rejected) when an insurer submits a monthly file in which the Link Identifier is duplicated.
- In PHDB, HCP and HCP1, remove meteor reference and make changes to the description and change the label for field 'Minutes of operating theatre time 'to 'Minutes in Theatre or Procedure Room' to be consistent with ECLIPSE and also with explanatory notes in HCP. (*HCP Explanatory Notes: Minutes in Theatre - from the time the patient entered the operating theatre or procedure room until the time the patient left the operating theatre or procedure room).* Remove meteor reference
- In HCP, HCP1 and PHDB, add extra text for description for 'Birth weight of infant, neonate, stillborn'
- Delete HCP1 edit rule ME201 because it is the same as ME006.1
- Delete HCP1 edit rule EE023.3 because rule EE0232.2 is sufficient.
- Simplify HCP1 Prosthesis edit rules to remove references to maximum benefit (which no longer exists).
- Re-label PHDB errors EE061.0 and EE061.1 as E061.0 and E061.1, to follow the standard labelling pattern in PHDB data specifications
- In GT-Dental, create a new edit rule to give a warning when the number of dental items reported for a particular record is greater than 20.
- Insurers are expected to report dental services using the full list of valid ADA codes in the Australian Schedule of Dental Services and Glossary 2017
- In HCP header record, change the value of 'HCP version' to 1100 as follows, because substantial changes have been made to HCP file

Item No	Data Item	Obligation	Type & Size	Comments
10	HCP Version	M	N(4)	~~HCP version 1000~~ HCP version 1100

- In HCP AN-SNAP header record, change the value of 'AN-SNAP HCP version' to 1000 as follows, because substantial changes have been made to the AN-SNAP record. AN-SNAP changes don't happen as often as HCP so we will keep it separate from the HCP version number.

Item No	Data Item	Obligation	Position	Type & Size	Comments
10	AN-SNAP HCP Version	M	50-53	N(4)	AN-SNAP HCP version ~~0500,0700,0800,0900~~ 1000

- Missing Item numbers: Items numbers in the data specifications are not important – they are only there so that we can refer to particular items. However, the corresponding edit rules are numbered according to the item numbers, and if the department change item numbers it would then have to change edit rule numbering for those fields in the data specifications. If the department updates item numbers because one field has been removed from a specification then that would cause extra work to update the numbering of corresponding edit rules for items further down the list.

That work would flow into extra IT system changes for Software providers, the department's data warehouse and for Check-It. Consequently, the department decided not to update some item numbers to avoid unnecessary work. So, in some data specifications, for example ANSNAP item 15 in HCP, one or more item numbers are missing from the specification.

10. Additional edit rule changes added 24 February

PHDB – episode – revised edit rule W036.2 for 'Principal Diagnosis'

No	Data Item	Coding description	Edit Rules	Error code/s
36	Principal Diagnosis	Each entry should consist of: - one (1) digit that represents the Condition Onset Flag code - five (5) alphanumeric characters that represent the principal diagnosis code Condition Onset Flag (see METeOR 686100) - A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code. 1 = condition with onset during the episode of admitted patient care 2 = condition not noted as arising during the episode of admitted patient care 9 = not reported Note: All patients should report a condition onset flag code of 2 for the principal diagnosis, with the exception of newborns. Newborns in their admitted birth episode within the hospital may report a condition onset flag code of 1 or 2 for the principal diagnosis. Newborn episodes can be identified by ICD-10-AM Code Z38.x in the principal or additional diagnosis code field. Principal Diagnosis - The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code. The principal diagnosis should be reported in the most current version of ICD-10-AM and selected according to the National Coding Standards.	**Reject** record if not a valid ICD-10-AM principal diagnosis code **Identify** record if Same-day Status (item 39) = 2 (overnight patient) and Z50N or Z50NN (where N = 0 to 9) **Identify** record if ~~Care Type = 60~~ Care Type = 6 and not Z742 or Z75N or Z75NN. (where N = 0 to 9) **Identify** record if condition onset flag = 1 and not Z50N (where N = 0 to 9)	E036 W036.1 W036.2 W036.3

PHDB – episode – revised edit rule E061.1 for 'Number of Qualified Days for Newborns'

No	Data Item	Coding description	Edit Rules	Error code/s
61	Number of Qualified Days for Newborns	The number of qualified newborn days occurring within a newborn episode of care. Zero fill if not applicable. * refer to guide for use.	**Reject** record if not numeric. **Reject** record if >0000 and (care type not 7 ~~newborn care~~).	~~EE061.0~~ E061.0 ~~EE061.1~~ E061.1

HCP – episode – revised edit rule W036.2 for 'Principal Diagnosis'

No	Data Item	Coding description	Edit Rules	Error code/s
36	Principal Diagnosis	Each entry should consist of: - one (1) digit that represents the Condition Onset Flag code - five (5) alphanumeric characters that represent the principal diagnosis code Condition Onset Flag (see METeOR 686100) - A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code. 1 = condition with onset during the episode of admitted patient care 2 = condition not noted as arising during the episode of admitted patient care 9 = not reported Note: All patients should report a condition onset flag code of 2 for the principal diagnosis, with the exception of newborns. Newborns in their admitted birth episode within the hospital may report a condition onset flag code of 1 or 2 for the principal diagnosis. Newborn episodes can be identified by ICD-10-AM Code Z38.x in the principal or additional diagnosis code field. Principal Diagnosis - The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code. The principal diagnosis should be reported in the most current version of ICD-10-AM and selected according to the National Coding Standards.	**Reject** record if not a valid ICD-10-AM principal diagnosis code **Identify** record if Same-day Status (item 39) = 2 (overnight patient) and Z50N or Z50NN (where N = 0 to 9) **Identify** record if ~~Care Type = 60~~ Care Type = 6 and not Z742 or Z75N or Z75NN. (where N = 0 to 9) **Identify** record if condition onset flag = 1 and not Z38.?	EE036 EW036.1 EW036.2 EW036.3

HCP – episode – revised edit rule E061.1 for 'Number of Qualified Days for Newborns'

No	Data Item	Coding description	Edit Rules	Error code/s
61	Number of Qualified Days for Newborns	The number of qualified newborn days occurring within a newborn episode of care. Zero fill if not applicable. * refer to guide for use.	**Reject** record if not numeric. **Reject** record if >0000 and (care type not 7 ~~newborn care~~).	EE061.0 EE061.1

HCP1 – episode – revised edit rule EW047.2 for 'Principal diagnosis' and revised edit rule EE079.1 for 'Number of Qualified Days for Newborns'

No	Data Item	Coding description	Edit Rules	Error code/s
47	Principal diagnosis	Each entry should consist of: - one (1) digit that represents the Condition Onset Flag code - five (5) alphanumeric characters that represent the principal diagnosis code Condition Onset Flag (see METeOR 686100) - A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code. 1 = condition with onset during the episode of admitted patient care 2 = condition not noted as arising during the episode of admitted patient care 9 = not reported Note: All patients should report a condition onset flag code of 2 for the principal diagnosis, with the exception of newborns. Newborns in their admitted birth episode within the hospital may report a condition onset flag code of 1 or 2 for the principal diagnosis. Newborn episodes can be identified by ICD-10-AM Code Z38.x in the principal or additional diagnosis code field. Principal Diagnosis - The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code. The principal diagnosis should be reported in the most current version of ICD-10-AM and selected according to the National Coding Standards.	If present, **reject** record if not a valid ICD-10-AM principal diagnosis code **Reject** record if blank and private hospital (item 34 = 2 or 3) and contracted episode (item 5= 'Y' or 'B'). **Identify** record if blank and public hospital (item 34 = 1 or 4) or non-contracted episode (item 5 = 'T' or 'N'). **Identify** record if Same-day Status (Item 50) = 2 (overnight patient) and Z50N or Z50NN (where N = 0 to 9). **Identify** record if ~~Care Type = 60~~ ('Care Type' = 60 OR 'Care Type Code' = 6) and not Z742 or Z75N or Z75NN (where N = 0 to 9). **Identify** record if condition onset flag = 1 and not Z38N or Z38NN (where N = 0 to 9).	EE047.0 EE047.1 EW047 EW047.1 EW047.2 EW047.3
79	Number of Qualified Days for Newborns	The number of qualified newborn days occurring within a newborn episode of care. Zero fill if not applicable. *refer to guide for use	**Reject** record if not numeric. **Reject** record if >0000 and ~~(care type not newborn care)~~ ('care type' is a non-blank value other than 70 OR 'care type code' is a non-blank value other than 7).	EE079.0 EE079.1