Australian Government

Department of Health and Ageing

A Users Guide for the Collection of

Hospital Casemix Protocol (HCP)

And

Private Hospital Data Bureau (PHDB)

Version 1.2

By the Healthcare Services Information Branch

Department of Health and Ageing (DoHA)

Document History

Version – Release	Comments
1.0 – March 2008	Initial Version
1.1 -	Updates to ICU, SCN, CCU days and hours definitions
1.2 – May 2010	Updates to Hospital treatment, FIM definitions
	Updates to Assessment Only Indicator, AN-SNAP Collection, AN-SNAP Class, Functional Independence Measure, Hospital-in-the-home (HITH), Infant Weight, neonate, stillborn, Other charges/benefits, Principal Item Date, Principal MBS Item Number, Re-admission within 28 days Guide for Use
	Updates to AN-SNAP Class, Assessment Only Indicator, Gap Cover Scheme Identifier, Hospital-in-the-Home care visit days, Insurer Benefit, Intensive Care Unit (ICU) Charge, Item Charge, MBS item, MBS benefit, MBS Fee, Principal MBS Item Number, Secondary MBS Item Numbers, SNAP Version, Total Prosthetic Item Benefit, Total Prosthetic Item Charge edit rules
	Updates to AN-SNAP Class, Episode Type, Gap Cover Scheme Identifier, Principal MBS Item Date, Principal MBS Item Number, Provider Number of Hospital from which Transferred, Provider Number of Hospital to which Transferred, Prosthetic Item, Secondary MBS Item Numbers, Total Prosthetic Item Charge description
	Updates to Provider (hospital) Code, Provider Number of Hospital from which Transferred, Provider Number of Hospital to which Transferred format
	Updates to Mode of Separation maximum character length

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Notes about the Specifications

DDMMYYYY - indicates the data item contains date information where DD represents the day, MM represents the month and YYYY represents the century and year. For example, 5 July 2006 would be entered 05072006

hhmm - indicates the data item contains time information based on a 24-hour clock, where hh represents the hour and mm represents the minutes. For example 2.35pm would be entered 1435.

blank filled - in relation to a data item, means that the data item is filled with blank spaces.

zero filled - in relation to a data item, means that the data item is filled with zeros.

zero prefix - means that leading zeros are to be inserted if necessary to ensure that the number of characters in the entry matches the data item size specified for the item.

Charges & Benefits - supply in dollars and cents (omit decimal point) with leading zeros to fully fill item. All values must be ≥ 0 (i.e. negative amounts are not permitted). An entry of 000000000 means that no benefit/charge was recorded. Zeros are valid when this item cannot be separately identified but was reported under another charge/benefit item.

Definitions/acronyms

ACHI   means the Australian Classification of Health Interventions.

ADA   means the Australian Dental Association.

AN-SNAP   means the Australian National Sub-Acute and Non-Acute Patient Classification System.

CCU   means the coronary care unit of a hospital.

Contracted doctor means a doctor who has entered into an agreement with a private health insurer where the doctor agrees to accept payment by the insurer in relation to treatment provided to the insured person.

Contracted hospital means a hospital which has entered into an agreement with a private health insurer to accept payment in relation to an episode of hospital treatment for an insured person under a complying health product.

DRG   means the Australian Refined Diagnosis Related Group.

Episode   means the period of admitted patient care between a formal or statistical **admission** and a formal or statistical **separation**, characterised by only one care type.

FIM   means functional independence measure and is the outcome measure used for overnight-stay rehabilitation patients.

Formal admission, in relation to a person, means the administrative process used by a hospital to record the commencement of accommodation, care or treatment of the person.

Formal separation, in relation to a person, means the administrative process used by a hospital to record the cessation of accommodation, care or treatment of the person.

HDU means the high dependency unit of a hospital.

Hospital means a facility for which there is in force a Ministerial declaration that the facility is hospital under subsection 121-5(6) of the *Private Health Insurance Act 2007*.

Hospital treatment is treatment (including the provision of goods and services) provided to a person with the intention to manage a disease, injury or condition, either at a hospital or with direct involvement of the hospital, by either a person who is authorised by a hospital to provide the treatment or under the management or control of such a person (subsection 121-5, *Private Health Insurance Act 2007*).

Exclusions to hospital treatment (eg treatment provided in an emergency department of a hospital) are specified in the Private Health Insurance (Health Insurance Business) Rules 2010, Part 3, Rule 8.

Inclusions to hospital treatment (eg some Chronic Disease Management Programs not involving prevention) are specified in the Private Health Insurance (Health Insurance Business) Rules *2010, Part 3.*

Hospital-in-the-home means the provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary (METeOR glossary item ID: 327308).

Hospital-in-the-home care days means the total number of days between HiTH commencement date and HiTH completion date.

Hospital-in-the-home care visit days means the total number of days during a HiTH care episode that the patient was actually visited/received a service. This might be calculated by subtracting HiTH care completion date from HiTH care commencement date and then subtracting total leave days.

ICD-10-AM means 'The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification, published by the National Centre for Classification in Health (Australia).

ICU means the intensive care unit of a hospital.

Insurer means a private health insurer.

MBS means the Medicare Benefits Schedule, comprising:
(a) The Health Insurance (Diagnostic Imaging Services Table Regulations 2005; and

(b) The Health Insurance (General Medical Services Table) Regulations 2005; and

(c) The Health Insurance (Pathology Services Table) Regulations 2005 as in force from time to time, or any Regulations made in substitution for those Regulations.

METeOR (Metadata Online Registry) for national data standards.

Miscellaneous service code means any miscellaneous hospital-specific or insurer-specific non-MBS or non-ADA billing code.

NHDD means the (most current version of the) 'National Health Data Dictionary'.

NICU means the neonatal intensive care unit of a hospital.

Overnight-stay patient means a person who is admitted to and separates from a hospital on different dates.

PHIAC means Private Health Insurance Administration Council

PICU means the paediatric intensive care unit of a hospital.

Procedure means clinical intervention that is surgical in nature, carries a procedural risk, carries an anaesthetic risk, requires specialised training, and/or requires special facilities or equipment only available in an acute care setting

Same-day patient means a person who is admitted to and separates from a hospital on the same date.

SCN means the special care nursery of a hospital.

Special character means a character that has a visual representation but is not an alphanumeric character, ideogram or blank space.

Statistical admission, in relation to a person, means the administrative process used by a hospital to record the commencement of a new episode of care that provides the person with a new care type during a single hospital stay.

Statistical separation, in relation to a person, means the administrative process used by a hospital to record the cessation of an episode of care of the person during a single hospital stay.

Guide for Use

Accommodation charges/benefits - refer to private, shared or high dependency accommodation for any Accommodation Type (i.e. advanced surgical, surgical, medical, rehabilitation, obstetrics, and psychiatry). All hospital episodes must have a charge/benefit component relating to accommodation, unless it was bundled, or the hospital billed a procedure-only fee. Therefore, cases such as chemotherapy should either have a charge/benefit component in "bundled" or "accommodation" or "theatre". They should <u>not</u> be reported as "other".

AN-SNAP Collection – the AN-SNAP collection is a separate data collection to the episode record for rehabilitation, which provides specific information regarding the functional gains of patients undergoing rehabilitation, as well as the AN-SNAP class for overnight admitted patients. It is expected that one AN-SNAP record be reported for each overnight admitted rehabilitation program, and one AN-SNAP record be reported for an entire episode of care consisting of multiple same day visits. The AN-SNAP record should be linked to the episode with the same separation date.

AN-SNAP Class – The AN-SNAP class allocated to each overnight admitted patient is in part determined by their FIM admission score. Given the FIM is not collected for same-day patients it is impossible to allocate same-day patients an AN-SNAP class.

Bundled charges/benefits – refer to an aggregate of 2 or more charges billed by the hospital, such as case payments by DRG or MBS.

CCU charges, benefits, days and hours - exclude ICU, SCN, NICU, PICU and HDU in calculations.

Functional Independence Measure - The FIM score for each of the 18 FIM motor and cognition items (maximum score of seven and a minimum score of one). Total scores can range from 18 to 126. Admission data must be collected within 72 hours after the admission. Discharge scores must be collected within 72 hours of discharge. Guide for collecting the AROC inpatient data set should be followed for scoring the FIM should be followed. This applies to AN-SNAP admission and discharge FIM scores for overnight-stay patients. The FIM is not collected for same-day patients.

Hospital-in-the-home (HITH) – Episodes which include HITH services should be reported in a manner consistent with claiming practice. For example,
(a) HITH services which are part of an admitted psychiatric program and are claimed as a single same day service must be reported as single same day episode. This includes psychiatric patients that remain in an admitted HITH program over extended periods of time.
(b) If hospital claims are submitted to insurers at the conclusion of the admitted psychiatric HITH program, then one episode must be reported spanning the length of the program.

ICU charges, benefits, days and hours - include NICU and PICU; exclude SCN, CCU or HDU in calculations.

Infant weight neonate - For live births, birth weight should preferably be measured within the first hour of life before significant postnatal weight loss

has occurred. While statistical tabulations include 500 g groupings for birth weight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured. In perinatal collections the birth weight is to be provided for live born and stillborn babies.

Minutes in Theatre - calculate from the time the patient entered the operating theatre or procedure room until the time the patient left the operating theatre or procedure room. For example, coronary angiography/angioplasty, lithotripsy and ECT must have minutes of operating theatre time reported, even though they are performed in a procedure room rather than a theatre.

Other charges/benefits – refer to services which cannot be categorised as accommodation, theatre, labour, ICU, pharmacy, prosthesis, bundled, SCN, CCU or HITH. It excludes ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments.

Palliative care status and days - include care provided in: a palliative care unit; a designated palliative care program; or under the principal clinical management of a palliative care physician or in the opinion of the treating doctor, when the principal clinical intent of care is palliation.

Principal MBS item - select on the basis of: (a) the patient's first visit to a theatre or procedure room/coronary angiography suite; and (b) the MBS or ADA item with the highest benefit amount. The principal MBS item or ADA code relates to theatre or procedure room/angiography suite, and not to the medical item billed by the doctor. It may not necessarily correlate to the Principal Procedure Code. For example, renal dialysis, coronary angiography/ angioplasty, same-day chemotherapy, lithotripsy, ECT and sleep studies must have an MBS item number reported, even though they are procedure room rather than theatre. Where possible, any services that do not have a valid MBS item or ADA code should be reported in the Miscellaneous Service Code item (item 68).

Principal Item Date – The date on which the principal MBS item is carried out. If there is no principal MBS item, then the date that the first Miscellaneous Service Code item was carried out may optionally be entered.

Qualified days for newborns - The number of qualified days is calculated with reference to the date of admission, date of separation and any other date(s) of change of qualification status: the date of admission is counted if the patient was qualified at the end of the day; the date of change to qualification status is counted if the patient was qualified at the end of the day; the date of separation is not counted, even if the patient was qualified on that day. The normal rules for calculations of patient days apply.

SCN charges, benefits, days and hours - exclude NICU, ICU, CCU, PICU and HDU in calculations.

Secondary MBS item - The secondary MBS items or ADA codes relate to theatre, and not to the medical item billed by the doctor. It may not always correlate to the Procedure Codes (ICD-10-AM). Where possible, any services that do not have a valid MBS item or ADA code should be reported in the Miscellaneous Service Code item (item 68).

Theatre charges/benefits – refer to a theatre/procedure room/ angiography suite

Re-admission within 28 days – Planned re-admission refers to planned re-admission within 28 days from this or another hospital. Note: do not include transfers from another hospital as re-admissions.

Further information

For further information about the HCP requirements, please see the following websites:

General information about the data collection, health insurer codes, reports and software

- www.health.gov.au/casemix

List of Hospital provider numbers

- http://www.health.gov.au/internet/main/publishing.nsf/Content/hospitals2.htm

Metadata and health dictionary specifications

- http://meteor.aihw.gov.au/content/index.phtml/itemId/181162

For private health insurance industry information

- www.phiac.gov.au

For AN-SNAP related information

- chsd.uow.edu.au/aroc/

Commonwealth Prosthesis list

- http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-prostheseslist.htm

Accommodation Benefit

Identifying and definitional attributes

Record type: HCP 1 Episode data item 8

Data type: Numeric

Technical name: Accommodation Benefit

Format: N

Maximum character length: 9

Description: The gross benefit paid by the Insurer for accommodation including ex-gratia benefits.

Edit rules: Reject record if not numeric.

Collection and usage attributes

Guide for use: Zero fill if no amount paid.

Refer to private, shared or high dependency accommodation for any Accommodation Type (i.e. advanced surgical, surgical, medical, rehabilitation, obstetrics, and psychiatry). All hospital episodes must have a charge/benefit component relating to accommodation, unless it was bundled, or the hospital billed a procedure-only fee. Therefore, cases such as chemotherapy should either have a charge/benefit component in "bundled" or "accommodation" or "theatre". They should <u>not</u> be reported as "other".

Accommodation Charge

Identifying and definitional attributes

Record type: HCP 1 Episode data item 7, HCP Episode data item 44, PHDB
Episode data item 44

Data type: Numeric

Technical name: Accommodation charge

Format: N
Right justify
Zero prefix
$$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The gross amount charged by Hospital for accommodation
including ex-gratia and patient portion.

Edit rules: Reject record if not numeric.

Collection and usage attributes

Guide for use: Zero fill if no amount charged.

Refer to private, shared or high dependency accommodation for
any Accommodation Type (i.e. advanced surgical, surgical,
medical, rehabilitation, obstetrics, and psychiatry). All hospital
episodes must have a charge/benefit component relating to
accommodation, unless it was bundled, or the hospital billed a
procedure-only fee. Therefore, cases such as chemotherapy
should either have a charge/benefit component in "bundled" or
"accommodation" or "theatre". They should <u>not</u> be reported as
"other".

Additional Diagnosis

Identifying and definitional attributes

Record type	HCP 1 Episode data item 48, HCP Episode data item 37, PHDB Episode data item 37
Metadata item type:	Data Element
Technical name:	Episode of care—additional diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	356587
Registration status:	Health, Standard 05/02/2008
Definition:	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code.

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. Generally, external cause, place of occurrence and activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields.
	The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.
	Additional diagnoses give information on the conditions that are significant in terms of treatment required, investigations needed and resources used during the episode of care. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian Refined Diagnosis Related Groups (AR-DRGs).

Collection methods:	An additional diagnosis should be recorded and coded where appropriate upon separation of an episode of admitted patient care or the end of an episode of residential care. The additional diagnosis is derived from and must be substantiated by clinical documentation.
Comments:	Additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:

- Commencement, alteration or adjustment of therapeutic treatment
- Diagnostic procedures
- Increased clinical care and/or monitoring

In accordance with the Australian Coding Standards, certain conditions that do not meet the above criteria may also be recorded as additional diagnoses.

Additional diagnoses are significant for the allocation of Australian Refined Diagnosis Related Groups. The allocation of patient to major problem or complication and co-morbidity Diagnosis Related Groups is made on the basis of the presence of certain specified additional diagnoses. Additional diagnoses should be recorded when relevant to the patient's episode of care and not restricted by the number of fields on the morbidity form or computer screen.

External cause codes, although not diagnosis of condition codes, should be sequenced together with the additional diagnosis codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

Admission Date

Identifying and definitional attributes

Record type	HCP 1 Episode data item 32, HCP Episode data item 9, PHDB Episode data item 9
Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission date, DDMMYYYY
METeOR identifier:	269967
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care—admission date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Admission FIM Item Scores

Identifying and definitional attributes

Record type:	HCP 1 AN-SNAP data item 4
Data type:	Numeric
Format:	N
Maximum character length:	1
Description:	The FIM score on admission 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
Edit rules:	Reject record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O. Identify record if episode type is S and not blank fill

Collection and usage attributes

Guide for use:	FIM means functional independence measure

Admission Time

Identifying and definitional attributes

Record type   HCP 1 Episode data item 38, HCP Episode data item 17, PHDB
                                 Episode data item 17

Metadata item type: Data Element

Technical name: Episode of admitted patient care—admission time, hhmm

METeOR identifier: 269972

Registration status: Health, Standard 01/03/2005

Definition: Time at which an admitted patient commences an episode of
                                 care.

Data Element Concept: Episode of admitted patient care—admission time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

Reference documents: ISO 8601:2000 : Data elements and interchange formats -
                                 Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Comments: Required to identify the time of commencement of the episode or
                                 hospital stay, for calculation of waiting times and length of stay.

Ancillary Benefits

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 26
Data type:	Numeric
Technical name:	Total Benefits paid by Insurer under an ancillary table.
Format:	N
Maximum character length:	9
Description:	The total benefits paid by the Insurer for in-hospital goods and services claimed under an ancillary table.
Edit rules:	If present, identify if not numeric.

Collection and usage attributes

Guide for use:	Zero fills if no amount charged.

Ancillary Charges

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 25
Data type:	Numeric
Technical name:	Total charges claimed under an ancillary table.
Format:	N
Maximum character length:	9
Description:	The total charges raised for in-hospital benefits and claimed under an ancillary table.
Edit rules:	If present, identify if not numeric.

Collection and usage attributes

Guide for use:	Zero fills if no amount charged.

Ancillary Cover Status

Identifying and definitional attributes

Record type: HCP 1 Episode data item 24

Data type: Alpha

Technical name: Indicator of ancillary cover status at time of admission

Format: A

Maximum character length: 1

Description: An indicator of whether a patient has ancillary insurance cover at the time of admission.

Edit rules: Reject record if not 'Y' or 'N'

Collection and usage attributes

Guide for use: Y = patient *has* ancillary cover

                                N = patient *does not have* ancillary cover

AN-SNAP Class

Identifying and definitional attributes

Record type:	HCP 1 AN-SNAP data item 8
Data type:	Numeric
Format:	N Zero prefix
Maximum character length:	4
Description:	The AN-SNAP class to which the episode is assigned. AN-SNAP Class is only applicable to overnight episodes and must be reported as 4 characters in the following format: - "2" prefix followed by AN-SNAP version 2 class code.
Edit rules:	Reject if not a valid code and episode type = O Identify record if episode type = S and not blank fill

Collection and usage attributes

Guide for use:	AN-SNAP means the Australian National Sub-Acute and Non-Acute Patient Classification System

AROC Impairment Codes

Identifying and definitional attributes

Record type:	HCP 1 AN-SNAP data item 6
Data type:	Numeric
Format:	NN.NNNN
	Left justify
Maximum character length:	7
Description:	Enter the Impairment Code (AUS version 1) that best describes the primary reason for admission to the rehabilitation episode.
	Code as specifically as possible and where possible avoid the use of impairment group 13 - 'Other Disabling Impairments'.
	Each entry should consist of:
	- two (2) digits that represent the impairment group (zero prefixed if 1 digit)
	- a decimal point
	- up to four (4) digits that represent more specific categories within impairment groups if applicable (blank fill any unused characters
Edit rules:	Reject record if not a valid code or if trailing zeros.

Collection and usage attributes

Guide for use:

Assessment Only Indicator

Identifying and definitional attributes

Record type: HCP 1 AN-SNAP data item 7

Data type: Numeric

Format: N

Maximum character length: 1

Description: AN-SNAP has separate classes for Assessment Only episodes. Assessment only occurs when the person was seen on one occasion only for assessment and no rehabilitation treatment and no further intervention by this service team is planned to occur within the next 90 days. If a person is booked/seen for subsequent treatment within 90 days, they are not Assessment Only. If a person is booked for subsequent assessment (but not treatment), they are assessment only. Record:
1 = Yes
2 = No

Edit rules: Reject record if not (1 or 2).

Collection and usage attributes

Guide for use:

Bundled Benefits

Identifying and definitional attributes

Record type: HCP 1 Episode data item 20

Data type: Numeric

Technical name: Gross bundled benefits paid by Insurer

Format: N

Maximum character length: 9

Description: Gross bundled benefits paid by the Insurer including ex-gratia bundled benefits.

Edit rules: Reject record if not numeric

                               Warning for public hospitals

Collection and usage attributes

Guide for use: Zero fills if no amount charged.

                               Bundled charges/benefits – refer to an aggregate of 2 or more charges billed by the hospital, such as case payments by DRG or MBS.

Bundled Charges

Identifying and definitional attributes

Record type: HCP 1 Episode data item 19, HCP Episode data item 51 , PHDB
                                Episode data item 51

Data type: Numeric

Technical name: Gross bundled charges raised by Hospital

Format: N

Maximum character length: 9

Description: Gross bundled charges raised by Hospital including ex-gratia
                                and patient portion bundled charges.

Edit rules: Reject record if not numeric
                                Warning for public hospitals

Collection and usage attributes

Guide for use: Zero fills if no amount charged.

                                Bundled charges/benefits – refer to an aggregate of 2 or more
                                charges billed by the hospital, such as case payments by DRG or
                                MBS.

Care Type

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 44, HCP Episode data item 20, PHDB Episode data item 20
Metadata item type	Data element
Registration status	Health, Standard 01/03/2005
Definition	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.
METeOR identifier:	270174

Value Domain Attributes

Representational Attributes

Representation Class	Code
Data Type	Numeric
Maximum character length:	3
Format	Left justify two digit codes and follow with a blank space N[N].N
Description:	The type of service for which the patient was initially admitted:

10 = Acute 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 = Maintenance care

70 = Newborn care

80 = Other admitted patient care

90 = Organ procurement – posthumous

100 = Hospital boarder

Edit rules:	**Reject** record if not (10, 20, 21, 22, 23, 30, 31, 32, 33, 40, 50, 60, 70, 80, 90 or 100)

Collection and usage attributes

Guide for use: Persons with mental illness may receive any one of the care types (except

newborn and organ procurement). Classification depends on the principal clinical intent of the care received.

Admitted care can be one of the following:

CODE 1.0   Acute care (Admitted care)

Acute care is care in which the clinical intent or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

CODE 2.0   Rehabilitation care (Admitted care)

Rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. It includes care provided:

- in a designated rehabilitation unit (code 2.1), or
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation (code 2.2), or
- under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation (code 2.3).

Optional:

CODE 2.1   Rehabilitation care delivered in a designated unit (optional)

A designated rehabilitation care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care.

CODE 2.2   Rehabilitation care according to a designated program (optional)

In a designated rehabilitation care program, care is delivered by a specialised team of staff who provide rehabilitation care to patients in beds that may or may not be dedicated to rehabilitation care. The program may, or may not be funded through identified rehabilitation care funding. Code 2.1 should be used instead of code 2.2 if care is being delivered in a designated rehabilitation care program and a designated rehabilitation care unit.

CODE 2.3   Rehabilitation care is the principal clinical intent (optional)

Rehabilitation as principal clinical intent (code 2.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of the treating medical practitioner, the care provided is rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 2.1 or 2.2 should be used, respectively.

Code 3.0   Palliative care

Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided:

- in a palliative care unit (code 3.1); or
- in a designated palliative care program (code 3.2); or
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation (code 3.3).

Optional:

CODE 3.1   Palliative care delivered in a designated unit (optional)

A designated palliative care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for palliative care and/or primarily delivers palliative care.

CODE 3.2   Palliative care according to a designated program (optional)

In a designated palliative care program, care is delivered by a specialised team of staff who provide palliative care to patients in beds that may or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 3.1 should be used instead of code 3.2 if care is being delivered in a designated palliative care program and a designated palliative care unit.

CODE 3.3   Palliative care is the principal clinical intent (optional)

Palliative care as principal clinical intent occurs when the patient is primarily managed by a medical practitioner who is a specialist in palliative care or when, in the opinion of the treating medical practitioner, the care provided is palliative care even if the doctor is not a palliative care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 3.1 or 3.2 should be used, respectively. For example, code 3.3 would apply to a patient dying of cancer who was being treated in a geriatric ward without specialist input by palliative care staff.

CODE 4.0   Geriatric evaluation and management

Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

CODE 5.0   Psychogeriatric care

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatic care unit;
- in a designated psychogeriatic care program; or
- under the principal clinical management of a psychogeriatic physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatic care.

CODE 6.0   Maintenance care

Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting eg at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term.

CODE 7.0   Newborn care

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type

changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- patients aged less than 10 days and not admitted at birth (eg transferred from another hospital) are admitted with newborn care type
- patients aged greater than 9 days not previously admitted (eg transferred from another hospital) are either boarders or admitted with an acute care type
- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- a newborn is qualified when it meets at least one of the criteria detailed in Newborn qualification status.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.

CODE 8.0   Other admitted patient care

Other admitted patient care is care where the principal clinical intent does not meet the criteria for any of the above.

Other care can be one of the following:

CODE 9.0   Organ procurement - posthumous (Other care)

Organ procurement - posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

CODE 10.0   Hospital boarder (Other care)

Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days of less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Comments   Unqualified newborn days (and separations consisting entirely of unqualified newborn days are not to be counted under the Australian Health Care Agreements and they are ineligible for health insurance benefit purposes.

Coronary Care Unit Benefits

Identifying and definitional attributes

Record type: HCP 1 Episode data item 74

Data type: Numeric

Technical name: The gross benefits paid for Coronary Care Unit (CCU)

Format: N

Maximum character length: 9

Description: The gross benefits paid by the Insurer for CCU including ex-gratia CCU benefits

Edit rules: Reject record in not numeric

                                  Warning for Public Hospitals

Collection and usage attributes

Guide for use: Zero fill if no amount charged

                                  CCU means the coronary care unit of a hospital

Coronary Care Unit Charges

Identifying and definitional attributes

Record type: HCP 1 Episode data item 73, HCP Episode data item 56, PHDB
                                     Episode data item 56

Data type: Numeric

Format: N

Maximum character length: 9

Description: The gross charge raised by Hospital for CCU including ex-gratia
                                     and patient portion CCU charges

Edit rules: Reject record in not numeric
                                     Warning for Public Hospitals

Collection and usage attributes

Guide for use: Zero fill if no amount charged
                                     CCU means the coronary care unit of a hospital

Coronary Care Unit Days

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 78, HCP Episode data item 60, PHDB Episode data item 60
Data type:	Numeric
Format:	NN Right Justify Zero Prefix
Maximum character length:	3
Description:	The total number of days the patient spent in a CCU
Edit rules:	Reject record if not numeric Reject if not zero for day facilities private or public

Collection and usage attributes

Guide for use:	Zero fill if not applicable CCU means the coronary care unit of a hospital

Coronary Care Unit Hours

Identifying and definitional attributes

Record type: HCP 1 Episode data item 76, HCP Episode data item 58, PHDB
                                  Episode data item 58

Data type: Numeric

Format: NN
                                  Right Justify
                                  Zero Prefix

Maximum character length: 4

Description: The total number of hours the patient spent in a CCU

Edit rules: If present, identify if not numeric

Collection and usage attributes

Guide for use: Zero fill if not applicable
                                  CCU means the coronary care unit of a hospital

Date of Birth

Identifying and definitional attributes

Record type	HCP 1 Episode data item 29, HCP Episode data item 6, PHDB Episode data item 6
Metadata item type:	Data Element
Technical name:	Person—date of birth, DDMMYYYY
METeOR identifier:	287007
Registration status:	Health, Standard 04/05/2005
	Community services, Standard 25/08/2005
	Housing assistance, Standard 20/06/2005
Definition:	The date of birth of the person.
Data Element Concept:	Person—date of birth

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults, and to the nearest three months (or less) for children aged less than two years. Additionally, an estimated date flag or a date accuracy indicator should be reported in conjunction with all estimated dates of birth.
	For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under 2 years should be reported to the nearest 3 month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. Again, an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.
Collection methods:	Information on date of birth can be collected using the one question:
	What is your/(the person's) date of birth?

In self-reported data collections, it is recommended that the following response format is used:

Date of birth: _ _ / _ _ / _ _ _ _

This enables easy conversion to the preferred representational layout (DDMMYYYY).

For record identification and/or the derivation of other metadata items that require accurate date of birth information, estimated dates of birth should be identified by a date accuracy indicator to prevent inappropriate use of date of birth data . The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of an indicator of the accuracy of the date may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date—accuracy indicator, code AAA also be recorded at the time of record creation to flag the accuracy of the data.

Comments:	Privacy issues need to be taken into account in asking persons their date of birth.

Wherever possible and wherever appropriate, date of birth should be used rather than age because the actual date of birth allows a more precise calculation of age.

When date of birth is an estimated or default value, national health and community services collections typically use 0101 or 0107 or 3006 as the estimate or default for DDMM.

It is suggested that different rules for reporting data may apply when estimating the date of birth of children aged under 2 years because of the rapid growth and development of children within this age group which means that a child's development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is suggested.

Diagnosis Related Group

Identifying and definitional attributes

Record type	HCP 1 Episode data item 36, HCP Episode data item 15, PHDB Episode data item 15
Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA
METeOR identifier:	270195
Registration status:	Health, Standard 01/03/2005
Definition:	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.
Data Element Concept:	Episode of admitted patient care—diagnosis related group

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 5.1
Representation class:	Code
Data type:	String
Format:	ANNA
Maximum character length:	4

Data element attributes

Collection and usage attributes

Comments:	The Australian Refined Diagnosis Related Group is derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM. The data elements required are described in Related data elements.

Diagnostic Related Group (DRG) Version

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 37, HCP Episode data item 16, PHDB Episode data item 16
Data type:	Numeric
Technical name:	DRG Version
Format:	NN
Maximum character length:	2
Description:	The version of DRG classification used, as coded below
Edit rules:	If present, identify record if not valid version
	Identify if blank and DRG code provided

Collection and usage attributes

Guide for use:	31 = version 3.1
	32 = version 3.2
	41 = version 4.1
	42 = version 4.2
	50 = version 5.0
	51 = version 5.1
	52 = version 5.2
	60 = version 6.0
	Must be supplied if DRG code is provided at Item 36.

Discharge FIM Item Scores

Identifying and definitional attributes

Record type:	HCP 1 AN-SNAP data item 5
Data type:	Numeric
Format:	N
Maximum character length:	1
Description:	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
Edit rules:	Reject record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O.
	Identify record if episode type is S and not blank fill

Collection and usage attributes

Guide for use:	FIM means functional independence measure

Discharge Intention on Admission

Identifying and definitional attributes

Record type: HCP 1 Episode data item 66, HCP Episode data item 22, PHDB Episode data item 22

Data type: Numeric

Technical name: Indicator for discharge intention at time of admission

Format: N

Maximum character length: 1

Description: Indicator for intended mode of separation at the time of admission as coded below

Edit rules: If present, identify if not 1, 2, 3, 4, 5, 8 or 9

Collection and usage attributes

Guide for use: 1 = Discharge to an(other) acute hospital
2 = Discharge to a nursing home
3 = Discharge to a psychiatric hospital
4 = Discharge to palliative care unit/hospice
5 = Discharge to other healthcare accommodation
8 = Passed away (Died)
9 = Discharge to usual residence

Discharge plan date

Identifying and definitional attributes

Record type: HCP 1 AN-SNAP data item 11

Data type: Alpha

Format: DDMMYYYY

Maximum character length: 8

Description: The date a discharge plan is established for an
                                            episode of admitted patient care.

Edit rules: Reject record if not in format DDMMYYYY

Collection and usage attributes

Guide for use:

Episode Type

Identifying and definitional attributes

Record type: HCP 1 AN-SNAP data item 3

Data type: Alpha

Format: A

Maximum character length: 1

Description: An indicator of the type of admitted rehabilitation program undertaken during the episode that relates to the AN-SNAP records.

O = Overnight Admitted Patient – Assign this value for patients who stay overnight during the admitted rehabilitation program.

S = Same-day Admitted Patient – Assign this value for patients who undertake an admitted rehabilitation program consisting of multiple same day visits/services. It is recommended that one AN-SNAP record is reported that covers the entire program (not separate episodes for each visit/service). In this case, Admission date = date of 1st visit/service and Separation date = date of last visit/service in the Same-day admitted program. The AN-SNAP record should be linked to the episode with the same separation date.

Edit rules: Reject record if not ('O' or 'S').

Collection and usage attributes

Guide for use:

Family Name

Identifying and definitional attributes

Record type	HCP Episode data item 4, PHDB Episode Data Item 4
Metadata item type:	Data Element
Technical name:	
METeOR identifier:	286953
Registration status:	Health, Standard 04/05/2005
	Community services, Standard 25/08/2005
	Housing assistance, Standard 20/06/2005
Definition:	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.

Value domain attributes

Representational attributes

Classification scheme:	
Representation class:	Text
Data type:	Alpha
Format:	A
	Blank fill
Maximum character length:	24

Data element attributes

Collection and usage attributes

Guide for use:	The agency or establishment should record the person's full family name on their information systems.
	National Community Services Data Dictionary specific:
	In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. Or, where proof of identity is required, as the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity.
Collection Methods	This metadata item should be recorded for all persons who receive services from or are of interest to an organisation. For the purposes of positive identification, it may also be recorded for providers of those services who are individuals.
	Mixed case should be used.

Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type (see Comments).

A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the agency or establishment.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be the name on their Medicare card. The Person name type metadata item can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name? _____

Are you known by any other family names that you would like recorded? If so, what are they _____

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the agency or establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained. e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes persons with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Punctuation:

If special characters form part of the family name they should be included, e.g. hyphenated names should be entered with a hyphen.

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the last letter of 'Wilson' and the hyphen, nor a space between the hyphen and the first letter of 'Phillips'.

- apostrophe, e.g. O'Brien, D'Agostino

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, or a space between the apostrophe and 'Brien'.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between 'St' and the full stop. Do leave a space between the full stop and 'John'.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the health care client has recorded their family name as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

Registered unnamed newborn babies:

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother. Record unnamed babies under the newborn Name type.

Persons with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' field blank.

Registering an unidentified person:

The default for unknown family name should be unknown in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of unknown.

Registering health care clients from disaster sites:

Persons treated from disaster sites should be recorded under the alias Name Type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the family name needs to be shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit persons to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (Alias name) in addition to the person's Medicare card name.

Baby for adoption**:**

The word adoption should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name, and the record should not be linked to the birth record. This should be the current practice. Any old references to adoption in client registers (for names) should also be changed to unknown. Contact your State or Territory adoption information service for further information.

Prefixes:

Where a family name contains a prefix, such as one to indicate that the person is a widow, this must be entered as part of the 'Family name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic Names:

The Centrelink publication, Naming Systems for Ethnic Groups, provides the correct coding for ethnic names.

Misspelled family name:

If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

Comments	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between MacIntosh and McIntosh - can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal)

'Given name' and 'Family name'. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred names that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family name or surname separately. These should then be recorded as 'Given name' and 'Family name' as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the family name in combination with selected letters of the given name, date of birth and sex, may be used for record linkage for statistical purposes only.

Front-end Deductible (Excess)

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 23
Data type:	Numeric
Technical name:	Front-end deductible (Excess) rebate
Format:	N
	Right Justify
	Zero Prefix
	$$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The amount of front-end deductible (excess) deducted from the benefit, otherwise payable by the Insurer to the Hospital.
Edit rules:	Reject record if not numeric.

Collection and usage attributes

Guide for use:

Gap Cover Scheme Identifier

Identifying and definitional attributes

Record type:	HCP 1 Medical data item 9
Data type:	Alpha
Format:	Blank Fill
Maximum character length:	5
Description:	Blank fill. Gap cover schemes are not applicable. This field has been retained as a placeholder to minimise system format changes for insurers.

Edit rules:

Collection and usage attributes

Guide for use:

Given Name

Identifying and definitional attributes

Record type	HCP Episode data item 5, PHDB Episode data item 5
Metadata item type:	Data Element
METeOR identifier:	287035
Registration status:	Health, Standard 04/05/2005
	Community services, Standard 25/08/2005
	Housing assistance, Standard 20/06/2005
Definition:	The person's identifying name within the family group or by which the person is socially identified, as represented by text.

Value domain attributes

Representational attributes

Classification scheme:	
Representation class:	Text
Data type:	Alpha
Format:	A
	Blank Fill
Maximum character length:	20

Data element attributes

Collection and usage attributes

Guide for use: Person may have more than one Given name. All given names should be recorded.

The agency or establishment should record the person's full given name(s) on their information systems.

National Community Services Data Dictionary specific:

In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. In situations where proof of identity is required, the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity.

National Health Data Dictionary specific:

Each individual Given name should have a Given name sequence number associated with it.

Health care establishments may record given names (first and other given names) in one field or several fields. This metadata item definition applies regardless of

the format of data recording.

A full history of names is to be retained.

This metadata item should be recorded for all clients.

Given name(s) should be recorded in the format preferred by the person. The format should be the same as that indicated by the person (e.g. written on a form) or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one given name (e.g. formal name, birth name, nick name or shortened name, or tribal name) depending on the circumstances. A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Person name type metadata item (see Comments) can be used to distinguish between the different types of names that may be used by the person.

The following format may assist with data collection:

What is the given name you would like to be known by?

_____

Are you known by any other given names that you would like recorded?

If so, what are they

_____

Please indicate the 'type' of given name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by).

Whenever a person informs the agency or establishment of a change of given name (e.g. prefers to be know by their middle name), the former name should be recorded according to the appropriate name type. Do not delete or overwrite a previous given name e.g. 'Mary Georgina Smith' informs the hospital that she prefers to be known as 'Georgina'. Record 'Georgina' as her preferred given name and record 'Mary' as the Medicare card given name.

e.g. The establishment is informed that 'Baby of Louise Jones' has been named 'Mary Jones'. Retain 'Baby of Louise' as the newborn name and also record 'Mary' as the preferred 'Given name'.

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record

unknown in the 'Given name' field and use alias Name type. When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of unknown.

Use of first initial:

If the person's given name is not known, but the first letter (initial) of the given name is known, record the first letter in the preferred 'Given name' field. Do not record a full stop following the initial.

Persons with only one name:

Some people do not have a family name and a given name: they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' blank.

Record complete information:

All of the person's given names should be recorded.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as alias names as appropriate.

Example - The person's given name is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred 'Given name' and 'Jennifer' as her Medicare card name.

Example - The person's given name is 'Giovanni' but he prefers to be called 'John'.

Record 'John' as the preferred 'Given name' and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included, e.g. hyphenated names shall be entered with the hyphen.

- Hyphen, e.g. Anne-Maree, Mary-Jane

Do not leave a space before or after the hyphen, i.e. between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- spaces, e.g. Jean Claude Carcel Moreaux

If the person has recorded their given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way (i.e. Jean Claude is one given name and Marcel is another given name).

Names not for continued use:
For cultural reasons, a person such as an Aboriginal or Torres Strait Islander may

advise that they are no longer using the given name they previously used and are now using an alternative current name. Record their current name as their preferred given name and record their previously used name as an alias name (with a Name conditional use flag of 'not for continued use').
Composite name:
 If a person identifies their first name as being a composite word, both parts should be recorded under the first Given Name (rather than the first and second Given Name).
 e.g. 'Anne Marie Walker' notes her preferred Given Name to be 'Anne Marie', then 'Anne Marie' is recoded as (first) Given Name, and (second) Given Name is left blank.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'. For example, if the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the preferred 'Given name' field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred given name and retain the newborn name.

Registering unnamed multiple births:

An unnamed (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple births. For example, if the baby's mother's given name is 'Fiona' and a set of twins is to be registered, then record 'Twin 1 of Fiona' in the Given name field for the first born baby, and 'Twin 2 of Fiona' in the 'Given name' field of the second born baby. Arabic numbers (1, 2, 3 ...) are used, not Roman Numerals (I, II, III ......).

In the case of triplets or other multiple births the same logic applies. The following terms should be use for recording multiple births:

- Twin:

use Twin i.e. Twin 1 of Fiona

- Triplet:

use Trip i.e. Trip 1 of Fiona

- Quadruplet:

use Quad i.e. Quad 1 of Fiona

- Quintuplet:

use Quin i.e. Quin 1 of Fiona

1. Sextuplet:

use Sext i.e. Sext 1 of Fiona

- Septuplet:

use Sept i.e. Sept 1 of Fiona.

These names should be recorded under the newborn Person name type. When the babies are named, the actual names should be recorded as the preferred name. The newborn name is retained.

Aboriginal/Torres Strait Islander names not for continued use:

For cultural reasons, an Aboriginal or Torres Strait Islander may advise an agency or establishment that they are no longer using the given name that they had previously registered and are now using an alternative current name.

Record their current name as the preferred 'Given name' and record their previous used given name as an alias name.

Ethnic Names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the person's given name has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an Alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the client's name. Discretion should be used regarding the degree of recording that is maintained.

Comments	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between Thomas and Tom - can make Record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the given name in combination with selected letters of the family name, date of birth and sex may be used for record linkage for statistical

purposes only.

National Health Data Dictionary specific:

Health care provider identification DSS and Health care client identification DSS
For the purpose of positive identification or contact, agencies or establishments
that collect Given name should also collect Given name sequence number. Given
name sequence number is also a metadata item in Australian Standard AS4846-
2004 Health care provider identification and is proposed for inclusion in the
review of Australian Standard AS5017-2002 Health care client identification.
AS5017 and AS4846 use alternative alphabetic codes for Given name sequence
number. Refer to the current standards for more details.

Hospital Contract Status

Identifying and definitional attributes

Record type: HCP 1 Episode data item 5

Data type: Alpha

Technical name: Status of arrangement with Insurer

Format: A

                                 Left Justify

Maximum character length: 1

Description: The payment arrangement that the insurer has with the hospital

Edit rules: Reject record if not Y, N, T or B.

Collection and usage attributes

Guide for use: Y = a hospital with which an insurer has a contract

                                 N = a hospital with which the insurer does not have a contract

                                 T = a hospital is paid under 2nd Tier benefit arrangement

                                 B = a hospital is paid under a "Bulk payment" arrangement

                                 "Bulk Payment" arrangement.

                                 These are prospective payment arrangements. Payment rates are
                                 set up front, typically based on the Diagnosis Related Group
                                 (DRG) or bed days. Claims are made throughout the month, and
                                 may be supplied with zero charges. Payment from the insurer to
                                 the hospital is then made restrospectively based on the claims
                                 made against the prospective payment rates.

                                 These arrangements are common for psychiatric and
                                 rehabilitation facilities. As claims may be supplied with zero
                                 charges, it is important that these are correctly flagged as "Bulk
                                 Payment" arrangements.

Hospital-in-the-Home Care Benefits

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 70
Data type:	Numeric
Technical name:	The gross benefits paid for Hospital-In-The-Home (HITH) care services
Format:	N
	Right Justify
	Zero Prefix
	$$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The gross benefits paid by the Insurer for hospital-in-the-home care services including ex-gratia and HITH patient portion charges
Edit rules:	Reject record in not numeric

Collection and usage attributes

Guide for use:	Zero fill if no amount charged

Hospital-in-the-Home Care Charges

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 69, HCP Episode data item 54, PHDB Episode data item 54
Data type:	Numeric
Technical name:	The gross charge raised for Hospital-In-The-Home (HITH) care services
Format:	N
	Right Justify
	Zero Prefix
	$$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The gross charge raised for hospital-in-the-home care services including ex-gratia and HITH patient portion charges
Edit rules:	Reject record in not numeric

Collection and usage attributes

Guide for use:	Zero fill if no amount charged

Hospital-in-the-Home Care Commencement Date

Identifying and definitional attributes

Record type: HCP 1 Episode data item 80, HCP Episode data item 62, PHDB Episode data item 62

Data type: Numeric

Technical name: Hospital-in-the Home (HITH) Commencement Date

Format: DDMMYYYY

Maximum character length: 8

Description: Date on which an admitted patient commences an episode of hospital-in-the-home care services

Edit rules: Reject record if HITH benefits or charges >0 and item is blank or is not in format DDMMYYYY

                                      Reject record if commencement date >HITH completion date

Collection and usage attributes

Guide for use: Blank fill if not applicable

                                      This item must be provided if HITH charges >0

Hospital-in-the-Home Care Completion Date

Identifying and definitional attributes

Record type: HCP 1 Episode data item 81, HCP Episode data item 63, PHDB Episode data item 63

Data type: Numeric

Technical name: Hospital-in-the Home (HITH) Completion Date

Format: DDMMYYYY

Maximum character length: 8

Description: Date on which an admitted patient completes an episode of hospital-in-the-home care services

Edit rules: Reject record if HITH benefits or charges >0 and item is blank or is not in format DDMMYYYY

                                    Reject record if completion date >HITH commencement date

Collection and usage attributes

Guide for use: Blank fill if not applicable

                                    This item must be provided if HITH charges >0

Hospital-in-the-Home Care Number of Days

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 55, HCP Episode data item 35, PHDB data item 35
Data type:	Numeric
Metadata item type:	Data Element
METeOR identifier	270305
Technical name:	Episode of admitted patient care—number of days of hospital-in-the-home care, total {N[NN]}
Registration status:	Health, Standard 01/03/2005

Value domain attributes

Representational attributes

Representation class	Total
Data type:	Number
Format:	{N[NN]} Right justify Zero prefix
Maximum character length:	3
Unit of measure	Day
Description:	The number of hospital-in-the-home care days occurring within an episode. Calculate with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and hospital-in-the-home accommodation.
Edit rules:	Reject record if not numeric. Identify if item not = (HITH Completed date – HITH Commencement Date)

Collection and usage attributes

Guide for use:	Zero fill if not applicable This item must be provided if HITH charges > 0 The rules for calculating the number of hospital-in-the-home days are outlined below: • The number of hospital-in-the-home days is calculated with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and home accommodation; • The date of admission is counted if the patient was at home at the end of the day; • The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day; • The date of separation is not counted, even if the patient was at home at

the end of the day;

The normal rules for calculation of patient days apply, for example in relation to leave and same day patients.

Definition   Means the total number of days between HiTH commencement date and HiTH completion date

Hospital-in-the-Home care visit days

Identifying and definitional attributes

Record type	HCP 1 Episode data item 82, HCP Episode data item 64, PHDB Episode data item 64
Registration status:	Health, Standard 01/03/2005
Description	The total number of days during a HiTH care episode that the patient was actually visited/received a service. Conditional item, must be provided if HITH charges (item 69) > 0. Zero fill if not applicable.
Data Type	Numeric
Edit rules	Reject if > HITH care days (item 55) [calculated as HITH completed date – HITH commencement date] + 1
Format	N Right justify Zero Prefix
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Hospital-in-the-home care visit days means the total number of days during a HiTH care episode that the patient was actually visited/received a service. This might be calculated by subtracting HiTH care completion date from HiTH care commencement date and then subtracting total leave days.

Hospital Type

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 34, HCP Episode data item 11, PHDB Episode data item 11
Data type:	Numeric
Technical name:	Type of Hospital where episode occurred
Format:	N
Maximum character length:	1
Description:	The type of hospital where the episode occurred as determined by the designated codes below
Edit rules:	Reject record if not 1, 2, 3, 4 or 9.
	Identify if hospital type does not match provider hospital table

Collection and usage attributes

Guide for use:	1 = public
	2 = private
	3 = private day facility
	4 = public day facility
	9 = other/unknown

Hours of Mechanical Ventilation

Identifying and definitional attributes

Record type: HCP 1 Episode data item 40, HCP Episode data item 29, PHDB Episode data item 29

Data type: Numeric

Technical name: Total number of hours (rounded) of Mechanical Ventilation

Format: NN
Right Justify
Zero Prefix

Maximum character length: 4

Description: The total number of hours (rounded) for which the patient received mechanical ventilation in ICU, NICU, PICU or combined ICU/CCU during the episode of care.

Edit rules: Reject record if not numeric
Warning for public hospitals

Collection and usage attributes

Guide for use: Zero fill if not applicable.

Infant Weight, neonate, stillborn

Identifying and definitional attributes

Record type   Hcp 1 Episode data item 39, HCP Episode data item 28, PHDB
                           Episode data item 28

Metadata item type: Data Element

Technical name: Birth—birth weight, total grams NNNN

METeOR identifier: 269938

Registration status: Health, Standard 01/03/2005

Definition: The first weight, in grams, of the live-born or stillborn baby
                           obtained after birth, or the weight of the neonate or infant on the
                           date admitted if this is different from the date of birth.

Data Element Concept: Birth—birth weight

Value domain attributes

Representational attributes

Representation class: Total

Data type: Numeric

Format: NNNN
                           Right Justify
                           Zero Prefix

Maximum character length: 4

Unit of measure: Gram (g)

Data element attributes

Collection and usage attributes

Guide for use: For **live births**, **birthweight** should preferably be measured
                           within the first hour of life before significant postnatal weight
                           loss has occurred. While statistical tabulations include 500 g
                           groupings for birthweight, weights should not be recorded in
                           those groupings. The actual weight should be recorded to the
                           degree of accuracy to which it is measured.

                           In perinatal collections the birthweight is to be provided for
                           liveborn and stillborn babies.

                           Weight on the date the infant is admitted should be recorded if
                           the weight is less than or equal to 9000g and age is less than 365
                           days. An entry of 0000 means the patient's age >= 365 days or
                           weight was > 9000 grams.

Insurer Benefit

Identifying and definitional attributes

Record type: HCP 1 Medical data item 6

Data type: Numeric

Format: N
 Right justify
 Zero prefix
 $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The amount (excluding Medicare benefit) paid by the Insurer.

Edit rules: Reject record if not numeric.
Reject record if > (Item charge – MBS benefit). A 5 cent tolerance applied for rounding purposes

Collection and usage attributes

Guide for use: Zero fill if no amount paid.

Insurer Identifier

Identifying and definitional attributes

Record type: HCP 1 Episode data item 1, HCP 1 Medical data item 1,
                             HCP 1 Prosthesis data item 1, HCP 1 AN-SNAP data item 1, HCP
                             Episode data item 2

Data type: Alpha

Technical name: Insurer—identifier

Format: A
                             Left Justify

Maximum character length: 3

Description: Insurer identifier selected from the list of registered private
                             health insurers.

Edit rules: Reject record if not a valid Insurer Code.

Collection and usage attributes

Guide for use: (Insert)

Intensive Care Unit (ICU) Benefit

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 14
Data type:	Numeric
Technical name:	Gross benefit paid by Insurer for the Intensive Care Unit (ICU) care provided including ex-gratia benefits.
Format:	N
	Right Justify
	Zero Prefix
	$$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	Intensive Care Unit (ICU) gross benefit paid by Insurer
Edit rules:	Reject record if not numeric (warning for public hospitals).

Collection and usage attributes

Guide for use:	Zero fill if no amount charged.
	Include NICU and PICU; exclude SCN, CCU or HDU in calculations. PICU means the paediatric intensive care unit of a hospital.

Intensive Care Unit (ICU) Charge

Identifying and definitional attributes

Record type: HCP 1 Episode data item 13, HCP Episode data item 47, PHDB Episode data item 47

Data type: Numeric

Technical name: Intensive Care Unit (ICU) gross amount charge

Format: N

Right Justify

Zero Prefix

$$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: Gross amount charged by Hospital for the Intensive Care Unit (ICU) care provided including ex-gratia and patient portions.

Edit rules: Reject record if not numeric (warning for public hospitals).

Identify if present and ICU days and ICU Hours are zero

Collection and usage attributes

Guide for use: Zero fill if no amount charged.

Include NICU and PICU; exclude SCN, CCU or HDU in calculations. PICU means the paediatric intensive care unit of a hospital.

Intensive Care Unit (ICU) Days

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 35, HCP Episode data item 12, PHDB Episode data item 12
Data type:	Numeric
Technical name:	Number of days in ICU
Format:	N Right Justify Zero Prefix
Maximum character length:	3
Description:	The number of days the patient spent in ICU, NICU or PICU
Edit rules:	Reject record if not numeric
	Reject record if not zero for day facilities private or public (warning for public hospitals)

Collection and usage attributes

Guide for use:	Zero fills if not applicable
	ICU charges, benefits, days and hours - include NICU and PICU; exclude SCN, CCU or HDU in calculations.

ICU days and hours may be reported in two ways:
1. ICU days represent whole days spent in ICU, ICU hours represent part days.
2. Set ICU days to 0, and insert total hours into ICU hours.

Examples:

Scenario	Method 1		Method 2	
	ICU Days	ICU Hours	ICU Days	ICU Hours
6 hours	0	6	0	6
24 hours	1	0	0	24
28 hours	1	4	0	28
56 hours	2	8	0	56

Intensive Care Unit (ICU) Hours

Identifying and definitional attributes

Record type: HCP 1 Episode data item 58, HCP Episode data item 13, PHDB Episode data item 13

Data type: Numeric

Technical name: Number of hours in ICU

Format: NN
                              Right Justify
                              Zero Prefix

Maximum character length: 4

Description: The number of hours the patient spent in ICU, NICU or PICU

Edit rules: If present, identify if not numeric.

Collection and usage attributes

Guide for use: Zero fills if not applicable

                              ICU charges, benefits, days and hours - include NICU and PICU; exclude SCN, CCU or HDU in calculations

Inter-hospital Contracted Patient

Identifying and definitional attributes

Record type	HCP 1 Episode data item 60, HCP Episode data item 23, PHDB Episode data item 23
Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—inter-hospital contracted patient status, code N
METeOR identifier:	270409
Registration status:	Health, Standard 01/03/2005
Definition:	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.
Data Element Concept:	Episode of admitted patient care—inter-hospital contracted patient status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Numeric
Format:	N
Maximum character length:	1

Permissible values:	Value	Meaning
	1	Inter-hospital contracted patient from public sector hospital
	2	Inter-hospital contracted patient from private sector hospital
	3	Not contracted
Supplementary values:	9	Not reported

Data element attributes

Collection and usage attributes

Guide for use:	A specific arrangement should apply (either written or verbal) whereby one hospital contracts with another hospital for the provision of specific services. The arrangement may be between any combination of hospital; for example, public to public, public to private, private to private, or private to public.
	This data element item will be derived as follows.

If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 4 or 5 (that is, a hospital (Hospital A) purchases the activity, rather than a health authority or other external purchaser, and admits the patient for all or part of the episode of care, and/or records the contracted activity within the patient's record for the episode of care). Then record a value of 1, if Hospital A is a public hospital or record a value of 2, if Hospital A is a private hospital.

Otherwise if the Contract role is not B, and/or the Contract type is not 2, 3, 4 or 5 record a value of 3.

Collection methods: All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity.

Item Charge

Identifying and definitional attributes

Record type: HCP 1 Medical data item 4

Data type: Numeric

Format: N
                                   Right justify
                                   Zero prefix
                                  $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The amount the patient was billed for the MBS item.

Edit rules: Reject record if not numeric

                                  Identify record Item charge less than MBS Benefit. A five cent
                                  tolerance applied to accommodate rounding.

Collection and usage attributes

Guide for use: Zero fill if no amount charged

Labour Ward Benefit

Identifying and definitional attributes

Record type: HCP 1 Episode data item 12

Data type: Numeric

Technical name: Gross benefit paid for labour ward including ex-gratia benefits.

Format: N
                                Right Justify
                                Zero Prefix
                                $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The gross benefit paid by the Insurer to the Hospital for labour ward including ex-gratia benefits paid.

Edit rules: Reject record if not numeric
                                Warning for public hospitals

Collection and usage attributes

Guide for use: Zero fills if no amount charged.

Labour Ward Charge

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 11, HCP Episode data item 46, PHDB Episode data item 46
Data type:	Numeric
Technical name:	Gross amount charged for labour ward including ex-gratia and patient portion.
Format:	N
	Right Justify
	Zero Prefix
	$$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The gross amount charged by the Hospital for labour ward including ex-gratia and patient portion labour ward charges.
Edit rules:	Reject record if not numeric
	Warning for public hospitals

Collection and usage attributes

Guide for use:	Zero fill if no amount charged.

Link Identifier

Identifying and definitional attributes

Record type: HCP 1 Episode data item 2, HCP 1 Medical data item 2,
                              HCP 1 Prosthesis data item 2, HCP 1 AN-SNAP data item 2

Data type: Alpha

Technical name: Link—identifier

Format: A
                              Left Justify

Maximum character length: 24

Description: A unique identifier of an episode that links data items from this
                              (episode) record to the associated medical, prosthetic or AN-
                              SNAP records

Edit rules: Reject record if blank.

Collection and usage attributes

Guide for use: AN-SNAP means the Australian National Sub-Acute and
                              Non-Acute Patient Classification System

MBS item

Identifying and definitional attributes

Record type: HCP 1 Medical data item 3

Data type: Alpha

Format: A
                            Left justify

Maximum character length: 14

Description: The MBS item billed by the medical provider.

Edit rules: Reject record if not a valid MBS item according to the relevant MBS Schedule valid at the MBS date of service (data item 7).

Collection and usage attributes

Guide for use:

MBS means the Medicare Benefits Schedule, comprising:

> (a)   the Health Insurance (Diagnostic Imaging Services Table) Regulations 2005; and

> (b)   the Health Insurance (General Medical Services Table) Regulations 2005; and

> (c)   the Health Insurance (Pathology Services Table) Regulations 2005;

as in force from time to time, or any Regulations made in substitution for those Regulations.

MBS benefit

Identifying and definitional attributes

Record type: HCP 1 Medical data item 5

Data type: Numeric

Format: N
 Right justify
 Zero prefix
$$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The amount paid to the patient as the Medicare entitlement.

Edit rules: Reject record if not numeric.
Identify record if MBS item benefit greater than 75% of the
schedule fee for the MBS item (data item 3) from the relevant
MBS schedule valid at the date of service (data item 7 – MBS date
of service).
A 5 cent tolerance has been allowed for rounding purposes.

Collection and usage attributes

Guide for use: Zero fill if no amount paid.

MBS date of service

Identifying and definitional attributes

Record type:	HCP 1 Medical data item 7
Data type:	Alpha
Format:	DDMMYYYY
Maximum character length:	8
Description:	Date the MBS item/service was performed.
Edit rules:	Reject record if not in format DDMMYYYY

Collection and usage attributes

Guide for use:

MBS means the Medicare Benefits Schedule, comprising:

    (a)   the Health Insurance (Diagnostic Imaging Services Table) Regulations 2005; and

    (b)   the Health Insurance (General Medical Services Table) Regulations 2005; and

    (c)   the Health Insurance (Pathology Services Table) Regulations 2005;

As in force from time to time, or any Regulations made in substitution for those Regulations.

MBS Fee

Identifying and definitional attributes

Record type:	HCP 1 Medical data item 10
Data type:	Numeric
Format:	N Right justify Zero prefix $$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The MBS or derived fee for the item
Edit rules:	Reject record if not numeric
	Identify record if greater than MBS Scheduled Fee (from the latest MBS schedule) at the date of service (item 7 – MBS date) for the MBS item identified in data item 3.
	A 5 cent tolerance applied for rounding purposes.

Collection and usage attributes

Guide for use:

MBS means the Medicare Benefits Schedule, comprising:

(a) the Health Insurance (Diagnostic Imaging Services Table) Regulations 2005; and

(b) the Health Insurance (General Medical Services Table) Regulations 2005; and

(c) the Health Insurance (Pathology Services Table) Regulations 2005;

As in force from time to time, or any Regulations made in substitution for those Regulations.

Medical Payment Type

Identifying and definitional attributes

Record type:	HCP 1 Medical data item 8
Data type:	Numeric
Format:	N
Maximum character length:	1
Description:	An indicator of the medical payment type.
	1 = Agreement with an individual provider
	2 = Agreement with a hospital
	3 = Gap Cover Scheme (No-gap agreement)
	4 = Gap Cover Scheme (Known-gap agreement)
	5 = 100% MBS schedule fee charged
	6 = No Arrangement
Edit rules:	Reject record if not (1, 2, 3, 4, 5 or 6).

Collection and usage attributes

Guide for use:

Mental Health Legal Status

Identifying and definitional attributes

Record type	HCP 1 Episode data item 57, HCP Episode data item 24, PHDB Episode data item 24
Metadata item type:	Data Element
Technical name:	Episode of care—mental health legal status, code N
METeOR identifier:	270351
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period, as represented by a code.
Data Element Concept:	Episode of care—mental health legal status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Numeric
Format:	N
Maximum character length:	1

Permissible values:	Value	Meaning
	1	Involuntary patient
	2	Voluntary patient
Supplementary values:	3	Not permitted to be reported under legislative arrangements in the jurisdiction

Collection and usage attributes

Guide for use:	CODE 1 Involuntary patient

Involuntary patient should only be used by facilities which are approved for this purpose. While each state and territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients who are charged with or convicted of some form of criminal activity. Each state/territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and

code these as involuntary status.

CODE 2   Voluntary patient

Voluntary patient to be used for reporting to the NMDS-Community mental health care, where applicable.

CODE 3   Not permitted to be reported under legislative arrangements in the jurisdiction

Not permitted to be reported under legislative arrangements in the jurisdiction, is to be used for reporting to the National Minimum Data Set - Community mental health care, where applicable.

Data element attributes

Collection and usage attributes

Guide for use: The mental health legal status of admitted patients treated within approved hospitals may change many times throughout the episode of care.

Patients may be admitted to hospital on an involuntary basis and subsequently be changed to voluntary status; some patients are admitted as voluntary but are transferred to involuntary status during the hospital stay. Multiple changes between voluntary and involuntary status during an episode of care in hospital or treatment in the community may occur depending on the patient's clinical condition and his/her capacity to consent to treatment.

Similarly, the mental health legal status of residents treated within residential care services may change on multiple occasions throughout the episode of residential care or residential stay.

Collection methods: Admitted patients to be reported as involuntary if the patient is involuntary at any time during the episode of care.

Residents in **residential mental health services** to be reported as involuntary if the resident is involuntary at any time during the episode of residential care.

Patients of ambulatory mental health care services to be reported as involuntary if the patient is involuntary at the time of a service contact.

Minutes of Operating Theatre Time

Identifying and definitional attributes

Record type	HCP 1 Episode data item 53, HCP Episode data item 42, PHDB Episode data item 42
Metadata item type:	Data Element
Technical name:	Admitted patient hospital stay—operating theatre time, total minutes NNNN
METeOR identifier:	270350
Registration status:	Health, Standard 01/03/2005
Definition:	Total time, in minutes, spent by a patient in operating theatres during current episode of hospitalisation.
Data Element Concept:	Admitted patient hospital stay—operating theatre time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Numeric
Format:	NNNN
Maximum character length:	4
Unit of measure:	Minute (m)

Collection and usage attributes

Collection methods:	Right justified, zero filled.

Data element attributes

Collection and usage attributes

Comments:	This metadata item was recommended for inclusion in the *National Health Data Dictionary* by *Hindle (1988a, 1988b)* to assist with diagnosis related group costing studies in Australia.
	This metadata item has not been accepted for inclusion in the National Minimum Data Set (NMDS) - Admitted patient care.

Miscellaneous Service Codes

Identifying and definitional attributes

Record type: HCP 1 Episode data item 68, HCP Episode data item 53, PHDB
                            Episode data item 53

Data type: Alpha

Technical name: Any miscellaneous service codes used for billing

Format: A

Maximum character length: 11

Description: Any miscellaneous services codes used for billing that are not
                            MBS or ADA items or codes

Edit rules: N/A

Collection and usage attributes

Guide for use: Up to 10 codes may be entered

                            Blank means that there were no miscellaneous service codes or
                            not 10 repetitions

Mode of Separation

Identifying and definitional attributes

Record type	HCP 1 Episode data item 41, HCP Episode data item 30, PHDB Episode data item 30
Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation mode, code N
METeOR identifier:	270094
Registration status:	Health, Standard 01/03/2005
Definition:	Status at separation of person (discharge/transfer/death) and place to which person is released, as represented by a code.
Data Element Concept:	Episode of admitted patient care—separation mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Numeric
Format:	N
Maximum character length:	2

Permissible values:

Value	Meaning
1	Discharge/transfer to (an)other acute hospital
2	Discharge/transfer to a residential aged care service, unless this is the usual place of residence
3	Discharge/transfer to (an)other psychiatric hospital
4	Discharge/transfer to other health care accommodation (includes mothercraft hospitals)
5	Statistical discharge - type change
6	Left against medical advice/discharge at own risk
7	Statistical discharge from leave
8	Died
9	Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

Guide for use: CODE 4   Discharge/transfer to other health care accommodation (includes mothercraft hospitals). In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of Code 1. If the residential aged care service is the patient's place of usual residence then they should have a mode

of separation of Code 9.

Multi-disciplinary rehabilitation plan date

Identifying and definitional attributes

Record type: HCP 1 AN-SNAP data item 10

Data type: Numeric

Format: DDMMYYYY

Maximum character length: 8

Description: The date a multi-disciplinary rehabilitation plan is established for an episode of admitted patient care.

Edit rules: Reject record if not in format DDMMYYYY

Collection and usage attributes

Guide for use:

Non-Certified Days of Stay

Identifying and definitional attributes

Record type: HCP 1 Episode data item 46, HCP Episode data item 34, PHDB Episode data item 34

Data type: Numeric

Technical name: Non-Certified Days of Stay in Hospital

Format: NNNN
                              Right Justify
                              Zero Prefix

Maximum character length: 4

Description: The number of days spent in the hospital, without certification, that exceeded 35 days.

Edit rules: If present, reject record if not numeric

                              Reject record if blank and hospital type is private or private day facility

Collection and usage attributes

Guide for use: Zero fill if not applicable

                              Private Hospitals and Private Day Facilities must complete this field.

Number of Qualified Days for Newborns

Identifying and definitional attributes

Record type	HCP 1 Episode data item 79, HCP Episode data item 61, PHDB Episode data item 61
Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN]
METeOR identifier:	270033
Registration status:	Health, Standard 01/03/2005
Definition:	The number of qualified newborn days occurring within a newborn episode of care.
Data Element Concept:	Episode of admitted patient care (newborn)—number of qualified days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Numeric
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	Qualified days for newborns - The number of qualified days is calculated with reference to the date of admission, date of separation and any other date(s) of change of qualification status: the date of admission is counted if the patient was qualified at the end of the day; the date of change to qualification status is counted if the patient was qualified at the end of the day; the date of separation is not counted, even if the patient was qualified on that day. The normal rules for calculations of patient days apply.
	The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the Episode of admitted patient care—admission date, DDMMYYYY, Episode of admitted patient care—separation date, DDMMYYYY and any Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY:
	• the date of admission is counted if the patient was qualified

at the end of the day

- the date of change to qualification status is counted if the patient was qualified at the end of the day
- the date of separation is not counted, even if the patient was qualified on that day
- the normal rules for calculation of patient days apply, for example in relation to leave and same day patients

The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.

Identifying and definitional attributes

Record type:	Episode
Data type:	Numeric
Technical name:	Gross charge raised for pharmacy goods and services
Format:	$$$$$$?
Maximum character length:	
Description:	Gross charge raised by Hospital for pharmacy goods and services including ex-gratia and patient portion pharmacy charges and excluding discharge medications.
Edit rules:	Reject record if not numeric (warning for public hospitals).

Collection and usage attributes

Guide for use:	Zero fills if no amount charged.

Number of Prosthesis Items

Identifying and definitional attributes

Record type: HCP 1 Prosthesis data item 4

Data type: Numeric

Format: N
                              Right justify
                              Zero prefix

Maximum character length: 3

Description: Number used of prosthetic items used (specific to item 3)

Edit rules: **Reject** record if not >0
                              (warning for public hospitals)

Collection and usage attributes

Guide for use:

Other Benefits

Identifying and definitional attributes

Record type: HCP 1 Episode data item 22

Data type: Numeric

Technical name: Gross miscellaneous benefits paid by Insurer

Format: N
                              Right Justify
                              Zero Prefix
                              $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The gross benefit paid by Insurer for any chargeable item which cannot be specifically categorised elsewhere excluding ex-gratia benefits, television, phone calls, extra meals, FED, reversals or journal adjustments.

Edit rules: Reject record if not numeric
                              Warning for public hospitals

Collection and usage attributes

Guide for use: Zero fills if no amount charged.

                              Other charges/benefits – refer to services which cannot be categorised as accommodation, theatre, labour, ICU, pharmacy, prosthesis, bundled, SCN, CCU and HITH. It excludes ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments

Other Charges

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 21, HCP Episode data item 50, PHDB Episode data item 50
Data type:	Numeric
Technical name:	Gross miscellaneous charge raised by Hospital
Format:	N
	Right Justify
	Zero Prefix
	$$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The gross charge raised for any chargeable item which cannot be specifically categorised elsewhere excluding ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments.
Edit rules:	Reject record if not numeric
	Warning for public hospitals

Collection and usage attributes

Guide for use:	Zero fills if no amount charged.
	Other charges/benefits – refer to services which cannot be categorised as accommodation, theatre, labour, ICU, pharmacy, prosthesis, bundled, SCN, CCU and HITH. It excludes ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments

Palliative Care Days

Identifying and definitional attributes

Record type: HCP 1 Episode data item 83, HCP Episode data item 65, PHDB Episode data item 65

Data type: Numeric

Technical name: Number of Days patient received Palliative Care

Format: N
                                        Right Justify
                                        Zero Prefix

Maximum character length: 4

Description: The number of days a patient received palliative care during an episode.

Edit rules: If present, reject record if not numeric.
                                        Reject if blank and hospital type is private or private day facility.
                                        Identify record if 0 and Palliative Care Status = 1

Collection and usage attributes

Guide for use: Where the entire episode is Palliative, provide the total length of the stay in days.
                                        Zero fills if not applicable.

Palliative Care Status

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 61, HCP Episode data item 25, PHDB Episode data item 25
Data type:	Numeric
Technical name:	Indicator of Palliative Care Status
Format:	N
Maximum character length:	1
Description:	An indicator of whether the episode involved palliative care as coded below.
Edit rules:	If present, identify if not 1 or 2
	Identify if blank and hospital type is private or private day facility.

Collection and usage attributes

Guide for use:

1 = patient required palliative care during episode

2 = patient *did not* require palliative care during episode

Mandatory for private hospitals and private day facilities

This item is required because some States do not statistically discharge to palliative care

Palliative care status and days **-** include care provided in: a palliative care unit; a designated palliative care program; or under the principal clinical management of a palliative care physician or in the opinion of the treating doctor, when the principal clinical intent of care is palliation.

Payer Identifier

Identifying and definitional attributes

Record type: PHDB Episode data item 2

Data type: Alpha

Format: A

Maximum character length: 3

Description: An indicator of the way in which the episode was funded:
IH = Insured with agreement with hospital
IN = Insured with no agreement with hospital

SI = Self Insured
WC = Workers Compensation
TP = Third Party
CP = Contracted to Public Sector
DV = Department of Veteran's Affairs patient
DE = Department of Defence patient
SE = Seaman
OT = Other.

Edit rules: Reject record if not a valid code

Collection and usage attributes

Guide for use:

Person Identifier (Insurer)

Identifying and definitional attributes

Record type: HCP 1 Episode data item 67

Data type: Alpha

Technical name: Insurer-specific person identifier

Format: A

                                     Left Justify

Maximum character length: 21

Description: This is an insurer-specific person identifier unique within an establishment or agency, regardless of any change in membership

Edit rules: Reject record if blank

Collection and usage attributes

Guide for use: (Insert)

Pharmacy Benefit

Identifying and definitional attributes

Record type: HCP 1 Episode data item 18

Data type: Numeric

Technical name: Gross benefit paid by Insurer for pharmacy charges

Format: N
                              Right Justify
                              Zero Prefix
                              $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: Gross benefit paid by Insurer for pharmacy, including ex-gratia
                              pharmacy charges and excluding discharge medications.

Edit rules: Reject record if not numeric (warning for public hospitals).

Collection and usage attributes

Guide for use: Zero fills if no amount charged.

                              Other charges/benefits – refer to services which cannot be
                              categorised as accommodation, theatre, labour, ICU, pharmacy,
                              prosthesis or bundled. It excludes ex-gratia charges, television,
                              phone calls, extra meals, FED, reversals or journal adjustments

Pharmacy Charge

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 17, HCP Episode data item 49, PHDB Episode data item 49
Data type:	Numeric
Technical name:	Gross charge raised for pharmacy goods and services
Format:	N
	Right Justify
	Zero Prefix
	$$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	Gross charge raised by Hospital for pharmacy goods and services including ex-gratia and patient portion pharmacy charges and excluding discharge medications.
Edit rules:	Reject record if not numeric (warning for public hospitals).

Collection and usage attributes

Guide for use:	Zero fills if no amount charged.
	Other charges/benefits – refer to services which cannot be categorised as accommodation, theatre, labour, ICU, pharmacy, prosthesis or bundled. It excludes ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments

Postcode—Australian (person)

Identifying and definitional attributes

Record type	HCP 1 Episode data item 30, HCP Episode data item 7, PHDB Episode data item 7
Metadata item type:	Data Element
Technical name:	Person (address)—Australian postcode, code (Postcode datafile) {NNNN}
METeOR identifier:	287224
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.
Data Element Concept:	Person (address)—Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Numeric
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:	Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.
	When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI).

Data element attributes

Collection and usage attributes

Guide for use:	The postcode book is updated more than once annually as postcodes are a dynamic entity and are constantly changing.
Collection methods:	Leave Postcode - Australian blank for:

- Any overseas address
- Unknown address
- No fixed address.

May be collected as part of Address line or separately. Postal addresses may be different from where a person actually resides.

Principal Diagnosis

Identifying and definitional attributes

Record type	HCP 1 Episode data item 47, HCP Episode data item 36, PHDB Episode data item 36
Metadata item type:	Data Element
Technical name:	Episode of care—principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361034
Registration status:	Health, Standard 05/02/2008
Definition:	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.
Data Element Concept:	Episode of care—principal diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.
	As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM.
	For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian Refined Diagnosis Related Groups.
	Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the

injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes cannot be used as principal diagnosis.

Collection methods:	A principal diagnosis should be recorded and coded upon **separation**, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.
Comments:	The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Principal MBS Item Date

Identifying and definitional attributes

Record type: HCP 1 Episode data item 52, HCP Episode data item 41, PHDB Episode data item 41

Data type: Numeric

Technical name: Principal MBS Item Date

Format: DDMMYYYY

Maximum character length: 8

Description: The date on which the principal MBS Item was carried out or the fist Miscellaneous Service Code was carried out if the principal MBS Item is blank

Edit rules: If present, reject record if not in format DDMMYYYY

Reject record if date is before admission date or after discharge date

Reject record if blank and Principal MBS Item Number is populated and hospital type is private or private day facility

Collection and usage attributes

Guide for use: Blank entry means there was no principal MBS item or it is a public hospital.

Mandatory for private hospitals and private day facilities where principal MBS Item 51 is populated

HCP- Mandatory where item 40 is populated

Principal MBS Item Number

Identifying and definitional attributes

Record type: HCP 1 Episode data item 51, HCP Episode data item 40, PHDB
                                  Episode data item 40

Data type: Alpha

Technical name: Principal MBS Item Number

Format: A
                                  Left Justify

Maximum character length: 14

Description: This item seeks a valid Medical Benefits Schedule (MBS)

Edit rules: If present, reject record if not a valid MBS item from the relevant
                                  MBS Schedule valid for the service date

Collection and usage attributes

Guide for use: Blank entry means there was no applicable MBS code used or it
                                  is a public hospital.

                                  Principal MBS item **-** select on the basis of: (a) the patient's first
                                  visit to a theatre or procedure room/coronary angiography
                                  suite; and (b) the MBS item with the highest benefit amount. The
                                  principal MBS item relates to theatre or procedure
                                  room/angiography suite, and not to the medical item billed by
                                  the doctor. It may not necessarily correlate to the Principal
                                  Procedure Code. For example, renal dialysis, coronary
                                  angiography/ angioplasty, same-day chemotherapy, lithotripsy,
                                  ECT and sleep studies must have an MBS item number reported,
                                  even though they are procedure room rather than theatre. Where
                                  possible, any services that do not have a valid MBS item should
                                  be reported in the Miscellaneous Service Code item (item 68).

Procedure

Identifying and definitional attributes

Record type	HCP 1 Episode data item 49, HCP Episode data item 38, PHDB Episode data item 38
Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—procedure, code (ACHI 6th edn) NNNNN-NN
METeOR identifier:	361687
Registration status:	Health, Standard 05/02/2008
Definition:	A clinical intervention represented by a code that:

- is surgical in nature, and/or
- carries a procedural risk, and/or
- carries an anaesthetic risk, and/or
- requires specialised training, and/or
- requires special facilities or equipment only available in an acute care setting.

Data Element Concept:	Episode of admitted patient care—procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 6th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Collection methods:	Record and code all procedures undertaken during the episode of care in accordance with the ACHI (5th edition). Procedures are derived from and must be substantiated by clinical documentation.
Comments:	The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ACHI.

Product Code

Identifying and definitional attributes

Record type: HCP 1 Episode data item 4

Data type: Alpha

Technical name: Patients' insurance product code

Format: A

Maximum character length: 8

Description: The product code for the patient's insurance cover at admission

Edit rules: Reject record if blank

Collection and usage attributes

Guide for use: (Insert)

Prosthesis Benefit

Identifying and definitional attributes

Record type: HCP 1 Episode data item 16

Data type: Numeric

Technical name: Gross benefit paid by Insurer for Prosthesis

Format: N
                              Right Justify
                              Zero Prefix
                              $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: Gross maximum benefit paid by Insurer for prosthesis including
                              ex-gratia, handling fees and prosthesis benefits.

Edit rules: Reject record if not numeric
                              Warning for public hospitals

Collection and usage attributes

Guide for use: Zero fills if no amount charged.

Prosthesis Charge

Identifying and definitional attributes

Record type: HCP 1 Episode data item 15, HCP Episode charge 48, PHDB
                               Episode data item 48

Data type: Numeric

Technical name: Gross charge for Prosthesis

Format: N
                               Right Justify
                               Zero Prefix
                               $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: Gross maximum amount charged by Hospital for prosthesis
                               including ex-gratia, handling fees and patient charges.

Edit rules: Reject record if not numeric
                               Warning for public hospitals

Collection and usage attributes

Guide for use: Zero fills if no amount charged.

Prosthetic Item

Identifying and definitional attributes

Record type: HCP 1 Prosthesis data item 3

Data type: Alpha

Format: A
Right justify
Zero prefix

Maximum character length: 5

Description: The billing codes are contained in the most relevant version (ie, the one covering the date(s) of the admitted patient record) of the prosthesis list that is approved by the Minister and maintained by the Department. The relevant prosthesis list can be found at www.health.gov.au/internet/wcms/publishing.nsf/content/health-privatehealth-prostheseslist.htm
Where applicable, the handling fee will be reported as "PHFEE"
If ex-gratia prosthetic item, report as "EXGRA

Edit rules: **Reject** record if not (a valid Commonwealth prosthesis code or "PHFEE" or "EXGRA").
(warning for public hospitals

Collection and usage attributes

Guide for use:

Provider (hospital) Code

Identifying and definitional attributes

Record type: HCP 1 Episode data item 3

Data type: Alpha

Technical name: Hospital provider number

Format: NNNNNNNA (uppercase)

Maximum character length: 8

Description: The Department of Health Ageing (DoHA) issues hospital provider number that can be selected from the lists held and maintained by DoHA. OVERSEAS = overseas provider

Edit rules: Reject record if not a valid 8 character DoHA Hospital Provider Number or OVERSEAS

Collection and usage attributes

Guide for use: (Insert)

Provider Number of Hospital from which Transferred

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 64, HCP Episode data item 19, PHDB Episode data item 19
Data type:	Alpha
Technical name:	Transferred Hospital provider number
Format:	NNNNNNNA (uppercase)
Maximum character length:	8
Description:	The Department of Health Ageing (DoHA) hospital provider number for the hospital from which a patient has been transferred (Provider number required only when HCP item number 43 (Source of referral) is reported as:
	1- Admitted patient transferred from another hospital).
Edit rules:	Reject record if not a valid 8 character DoHA Hospital Provider Number or blank field

Collection and usage attributes

Guide for use:	Blank fill if no hospital transfer occurred
	The Department of Health Ageing (DoHA) issues hospital provider number that can be selected from the lists held and maintained by DoHA.

Provider Number of Hospital to which Transferred

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 65, HCP Episode data item 33, PHDB Episode data item 33
Data type:	Alpha
Technical name:	Transfer to another Hospital provider number
Format:	NNNNNNNA (uppercase)
Maximum character length:	8
Description:	The Department of Health Ageing (DoHA) hospital provider number for the hospital to which a patient has been transferred (Provider number required only when HCP item number 41 (Mode of separation) is reported as:
	1- Discharge/transfer to an(other) acute hospital, or
	3 - Discharge/transfer to a(nother) psychiatric hospital or
	4 - Discharge/transfer to another health care accommodation (includes mothercraft hospitals)).
Edit rules:	Reject record if not a valid 8 character DoHA Hospital Provider Number or blank field

Collection and usage attributes

Guide for use:	Blank fill if no hospital transfer occurred
	The Department of Health Ageing (DoHA) issues hospital provider number that can be selected from the lists held and maintained by DoHA.

Re-admission within 28 Days

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 62, HCP Episode data item 26, PHDB Episode data item 26
Data type:	Numeric
Technical name:	Indicator of re-admission within 28 days of discharge
Format:	N
Maximum character length:	1
Description:	An indicator of the re-admission of a patient to hospital within 28 days of previous discharge for treatment of a similar or related condition as coded below
Edit rules:	Reject if not 1, 2, 3 or 8

Collection and usage attributes

Guide for use:	1 = Unplanned re-admission and patient previously treated in *this* hospital
	2 = Unplanned re-admission and patient previously treated in *another* hospital
	3 = Planned re-admission from this or another hospital
	8 = Not applicable/not known
	Note: do not include transfers from another hospital as re-admissions

Same-day Status

Identifying and definitional attributes

Record type: HCP 1 Episode data item 50, HCP Episode data item 39, PHDB
                             Episode data item 39

Data type: Numeric

Technical name: Indicator of same-day status

Format: N

Maximum character length: 1

Description: An indicator of whether the patient was admitted to the facility
                             for an overnight stay according to the codes below.

Edit rules: Reject record if not 0, 1 or 2

Collection and usage attributes

Guide for use: 0 = patient with a valid arrangement allowing an overnight stay
                             for the procedure normally performed on a same-day basis

                             1 = same-day patient

                             2 = overnight patient other than type 0 above

Secondary MBS Item Numbers

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 54, HCP Episode data item 43, PHDB Episode data item 43
Data type:	Alpha
Technical name:	Secondary Medical Benefits Schedule Item Numbers
Format:	A
	Left Justify
Maximum character length:	14
Description:	Additional MBS Item Numbers are all MBS items performed in theatre/procedure room/angiography suite that are not the principal MBS.
Edit rules:	If present, reject record if not a valid MBS item number from the relevant MBS Schedule(s) current during the episode

Collection and usage attributes

Guide for use:	Blank means that there was no additional item or code or not 9 repetitions

Separation Date

Identifying and definitional attributes

Record type   HCP 1 Episode data item 33, HCP Episode data item 10, PHDB
                             Episode data item 10

Metadata item type: Data Element

Technical name: Episode of admitted patient care—separation date, DDMMYYYY

METeOR identifier: 270025

Registration status: Health, Standard 01/03/2005

Definition: Date on which an admitted patient completes an episode of care

Data Element Concept: Episode of admitted patient care—separation date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Comments: There may be variations amongst jurisdictions with respect to the
                             recording of separation date. This most often occurs for patients
                             who are statistically separated after a period of leave (and who
                             do not return for further hospital care). In this case, some
                             jurisdictions may record the separation date as the date of
                             statistical separation (and record intervening days as leave days)
                             while other jurisdictions may retrospectively separate patients on
                             the first day of leave. Despite the variations in recording of
                             separation date for this group of patients, the current practices
                             provide for the accurate recording of length of stay.

Separation Time

Identifying and definitional attributes

Record type	HCP 1 Episode data item 42, HCP Episode data item 31, PHDB Episode data item 31
Metadata item type:	Data Element
METeOR identifier:	270026
Registration status:	Health, Standard 01/03/2005
Definition:	Time at which an admitted patient completes an episode of care by either formal or statistical processes.
	Conditional item – mandatory for same-day patients
Data Element Concept:	Episode of admitted patient care—separation time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hmm (24 hour clock)
	Reject record if not in range 0000 – 2359 and same-day status is 1
Maximum character length:	4

Data element attributes

Collection and usage attributes

Comments:	Required to identify the time of completion of the episode or hospital stay, for calculation of length of stay.

Sex

Identifying and definitional attributes

Record type	HCP 1 Episode data item 31, HCP Episode data item 8, PHDB Episode data item 8
Metadata item type:	Data Element
Technical name:	Person—sex, code N
METeOR identifier:	287316
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The biological distinction between male and female, as represented by a code.
Data Element Concept:	Person—sex

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:	Value	Meaning
	1	Male
	2	Female
	3	Intersex or indeterminate
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	Diagnosis and procedure codes should be checked against the national ICD-10-AM sex edits, unless the person is undergoing, or has undergone a sex change or has a genetic condition resulting in a conflict between sex and ICD-10-AM code.
	CODE 3 Intersex or indeterminate
	Intersex or indeterminate, refers to a person, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason.
	Intersex or indeterminate, should be confirmed if reported for people aged 90 days or greater.
Comments:	The definition for Intersex in Guide for use is sourced from the ACT Legislation (Gay, Lesbian and Transgender) Amendment Act 2003.

SNAP Version

Identifying and definitional attributes

Record type: HCP 1 AN-SNAP data item 9

Data type: Numeric

Format: N

Maximum character length: 2

Description: The version of the AN-SNAP Classification used to
                                        report item 8.
                                        02 = AN-SNAP Version 2

Edit rules: Reject if not (01 or 02) and episode type = O
                                        Identify if episode type = S and not blank fill
                                        Identify if (01) and episode type = O

Collection and usage attributes

Guide for use:

Source of Referral

Identifying and definitional attributes

Record type: HCP 1 Episode data item 43, HCP Episode data item 21, PHDB Episode data item 21

Data type: Numeric

Technical name: Source of Referral

Format: N

Maximum character length: 1

Description: The facility from which the patient was referred as coded below

Edit rules: Reject record if not 0, 1, 2, 4, 5, 6, 7, 8 or 9).

Collection and usage attributes

Guide for use: 0 = born in Hospital

1 = Admitted patient transferred from another hospital

2 = Statistical admission – care type change

4 = from Accident/Emergency

5 = from Community Health Service

6 = from Outpatients Department

7 = from Nursing Home

8 = by outside Medical Practitioner

9 = Other

Special Care Nursery Benefits

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 72
Data type:	Numeric
Technical name:	The gross benefit paid for Special Care Nursery (SCN)
Format:	N
	Right Justify
	Zero Prefix
	$$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The gross benefit paid by the Insurer for SCN including ex-gratia SCN benefits and excluding NICU benefits paid
Edit rules:	Reject record in not numeric
	Warning for Public Hospitals

Collection and usage attributes

Guide for use:	Zero fill if no amount charged
	SCN charges, benefits, days and hour*s* - exclude NICU, ICU, CCU, PICU and HDU in calculations.

Special Care Nursery Charges

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 71, HCP Episode data item 55, PHDB Episode data item 55
Data type:	Numeric
Technical name:	The gross charge raised for Special Care Nursery (SCN)
Format:	N Right Justify Zero Prefix $$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The gross charge raised by Hospital for SCN including ex-gratia and patient portion SCN charges excluding NICU charges
Edit rules:	Reject record in not numeric Warning for Public Hospitals

Collection and usage attributes

Guide for use:	Zero fill if no amount charged SCN charges, benefits, days and hours - exclude NICU, ICU, CCU, PICU and HDU in calculations.

Special Care Nursery Days

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 77, HCP Episode data item 59, PHDB Episode data item 59
Data type:	Numeric
Technical name:	Number of days spent in a Special Care Nursery (SCN)
Format:	NN Right Justify Zero Prefix
Maximum character length:	3
Description:	The number of days the patient spent in a SCN
Edit rules:	Reject record if not numeric
	Reject if not zero for day facilities (private or public)

Collection and usage attributes

Guide for use:	Zero fill if not applicable
	SCN charges, benefits, days and hours - exclude NICU, ICU, CCU, PICU and HDU in calculations.

Special Care Nursery Hours

Identifying and definitional attributes

Record type: HCP 1 Episode data item 75, HCP Episode data item 57, PHDB
                                  Episode data item 57

Data type: Numeric

Technical name: Number of hours spent in a Special Care Nursery (SCN)

Format: NN
                                  Right Justify
                                  Zero Prefix

Maximum character length: 4

Description: The number of hours the patient spent in a SCN

Edit rules: If present, identify if not numeric

Collection and usage attributes

Guide for use: Zero fill if not applicable

                                  SCN charges, benefits, days and hours - exclude NICU, ICU,
                                  CCU, PICU and HDU in calculations.

Theatre Benefit

Identifying and definitional attributes

Record type: HCP 1 Episode data item 10

Data type: Numeric

Technical name: Gross Theatre Benefit paid by Health Fund

Format: N
                          Right Justify
                          Zero Prefix
                          $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The gross benefit paid for a theatre/procedure
                          room/angiography suite including ex-gratia theatre benefit.

Edit rules: Reject record if not numeric (warning for public hospitals)

Collection and usage attributes

Guide for use: Zero fills if no amount charged.

                          Refer to private, shared or high dependency
                          accommodation for any Accommodation Type (i.e.
                          advanced surgical, surgical, medical, rehabilitation,
                          obstetrics, and psychiatry). All hospital episodes must have
                          a charge/benefit component relating to accommodation,
                          unless it was bundled, or the hospital billed a procedure-
                          only fee. Therefore, cases such as chemotherapy should
                          either have a charge/benefit component in "bundled" or
                          "accommodation" or "theatre". They should not be
                          reported as "other

Theatre Charge

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 9, HCP Episode data item 45, PHDB Episode data item 45
Data type:	Number
Technical name:	Theatre Charge
Format:	N
	Right Justify
	Zero Prefix
	$$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The gross amount charged for a theatre/procedure room/angiography suite including ex-gratia and patient portion of theatre charges.
Edit rules:	Reject record if not numeric (warning for public hospitals)

Collection and usage attributes

Guide for use:	Zero fills if no amount charged.
	Refer to private, shared or high dependency accommodation for any Accommodation Type (i.e. advanced surgical, surgical, medical, rehabilitation, obstetrics, and psychiatry). All hospital episodes must have a charge/benefit component relating to accommodation, unless it was bundled, or the hospital billed a procedure-only fee. Therefore, cases such as chemotherapy should either have a charge/benefit component in "bundled" or "accommodation" or "theatre". They should <u>not</u> be reported as "other

Total Days Paid

Identifying and definitional attributes

Record type: HCP 1 Episode data item 6

Data type: Numeric

Technical name: Total number of days for which benefits were paid

Format: NNNN
Right Justify
Zero Prefix

Maximum character length: 4

Description: The total number of days for which the Insurer paid benefits including days paid as a Nursing Home Type Patient.

Edit rules: Reject record if not numeric.

Identify if total days paid is greater than the date separated minus the date admitted minus leave days.

Identify if same-day status is 1 and total days paid is not 0001

Collection and usage attributes

Guide for use: (Insert)

Total Leave Days

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 45, HCP Episode data item 32, PHDB Episode data item 32
Metadata item type:	Data Element
Registration status	Health, Standard 01/03/2005
METeOR identifier:	270251
Description:	The sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.
	Zero fill if not applicable.

Value Domain Attributes

Representational Attributes

Format:	N[NN]
	Right justify
	Zero prefix
Data type:	Numeric
Representation class	Total
Unit of measure	Day
Maximum character length:	3
Edit rules:	Reject record if not numeric

Collection and usage attributes

Guide for use: Day is measured from midnight to midnight.

The following rules apply in the calculation of leave days for both overnight and same-day patients:

- The day the patient goes on leave is counted as a leave day.
- The day the patient is on leave is counted as a leave day.
- The day the patient returns from leave is counted as a patient day.
- If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.
- If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.
- If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

Comments   It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF

Circular 354 (31 March 1994). This metadata item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Total Medical Benefits

Identifying and definitional attributes

Record type:	HCP 1 Episode data item 28
Data type:	Numeric
Technical name:	Total benefits paid for medical items.
Format:	N Right Justify Zero Prefix $$$$$$$cc (omit decimal point)
Maximum character length:	9
Description:	The total benefit paid for medical items by both Medicare and the Insurer as set out in the medical records associated with the episode.
Edit rules:	Reject record if not numeric (warning for public hospitals)

Collection and usage attributes

Guide for use:	Zero fills if no amount charged.

Total Medical Charges

Identifying and definitional attributes

Record type: HCP 1 Episode data item 27

Data type: Numeric

Technical name: Total medical items charges.

Format: N
                            Right Justify
                            Zero Prefix
                            $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The total charge for medical items as set out in the medical
                            records associated with the episode of care.

Edit rules: Reject record if not numeric (warning for public hospitals)

Collection and usage attributes

Guide for use: Zero fills if no amount charged.

Total Prosthetic Item Benefit

Identifying and definitional attributes

Record type: HCP 1 Prosthesis data item 6

Data type: Numeric

Format: n
                                        Right justify
                                        Zero prefix
                                        $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The total benefit for the prosthesis item (exclude any handling fee).

Edit rules: Reject record if not numeric or if negative
                                        Reject record if greater than total charge (allow 5 cent tolerance).
                                        Reject record if the benefit is not equal to charge and the maximum benefit on the relevant edition of the prosthesis schedule is blank (allow a 5 cent tolerance). Ignore where prosthetic item is "EXGRA" or "PHFEE", or not a valid prosthesis item.
                                        Reject record if the benefit is less than the prosthesis schedule minimum benefit multiplied by the number of items or greater than the prosthesis schedule maximum benefit multiplied by the number of items, but only for items with a value for maximum benefit (allow a 5 cent tolerance). Ignore where prosthetic item is "EXGRA" or "PHFEE", or not a valid prosthesis item.
                                        (warnings for public hospitals)

Collection and usage attributes

Guide for use: Zero fill if no amount paid.

Total Prosthetic Item Charge

Identifying and definitional attributes

Record type: HCP 1 Prosthesis data item 5

Data type: Numeric

Format: N
                            Right justify
                            Zero prefix
                            $$$$$$$cc (omit decimal point)

Maximum character length: 9

Description: The total charge for the prosthesis item (include cents but omit decimal point).
                            Handling fee(s) may be reported with an item code of PHFEE.

Edit rules: Reject record if not numeric or if negative
                            Identify record if the total charge is greater than the prosthesis schedule minimum benefit multiplied by the number of items, but only for items with a blank maximum benefit (allow a 5 cent tolerance). Ignore where prosthetic item is "EXGRA" or "PHFEE", or not a valid prosthesis item.
                            Identify record if the total charge is greater than the prosthesis schedule maximum benefit multiplied by the number of items, but only for items with a value for maximum benefit (allow a 5 cent tolerance). Ignore where prosthetic item is "EXGRA" or "PHFEE", or not a valid prosthesis item.
                            (warning for public hospitals)

Collection and usage attributes

Guide for use: Zero fill if no amount charged.

Total Psychiatric Care Days

Identifying and definitional attributes

Record type	HCP 1 Episode data item 56, HCP Episode data item 14, PHDB Episode data item 14
Metadata item type:	Data Element
Technical name:	Episode of care—number of psychiatric care days, total N[NNNN]
METeOR identifier:	270300
Registration status:	Health, Standard 01/03/2005
Definition:	The sum of the number of days or part days of stay that the person received care as an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.
Data Element Concept:	Episode of care—number of psychiatric care days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN] Right Justify Zero Prefix
Maximum character length:	5
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in community based residences.
	Public acute care hospitals:
	Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.
	Private acute care hospitals:
	Designated psychiatric units in private acute care hospitals

normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.

Psychiatric hospitals:

Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Commonwealth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Community-based residential services:

Designated psychiatric units refers to 24-hour staffed community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric nursing homes. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care:

Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type). Completion of care within a

designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type. Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall hospital stay.

Collection methods: Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by state or territory health authorities. Several mechanisms exist for this data field to be implemented:

- Ideally, the new data field should be collected locally by hospitals and added to the unit record data provided to the relevant state/territory health authority.

- Acute care hospitals in most states and territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes, to allow total psychiatric care days to be calculated for each episode of care.

- Acute care hospitals and 24-hour staffed community-based residential services should be identified separately at the level of the establishment.

Comments: This metadata item was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the community-based residential care sector. The metadata item is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Unplanned Theatre Visit during Episode

Identifying and definitional attributes

Record type: HCP 1 Episode data item 63, HCP Episode data item 27, PHDB Episode data item 27

Data type: Numeric

Technical name: Indicator for unplanned theatre visit during episode

Format: N

Maximum character length: 1

Description: An indicator of whether the patient required a theatre visit that was not anticipated or planned at the time of admission as coded below

Edit rules: Reject if not 1 or 2

Collection and usage attributes

Guide for use: 1 = Unplanned theatre visit

                                2 = No unplanned theatre visit

Urgency of Admission

Identifying and definitional attributes

Record type	HCP 1 Episode data item 59
Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission urgency status, code N
METeOR identifier:	269986
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the **admission** has an urgency status assigned and, if so, whether **admission** occurred on an emergency basis, as represented by a code.
Data Element Concept:	Episode of admitted patient care—admission urgency status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:	Value	Meaning
	1	Urgency status assigned - emergency
	2	Urgency status assigned - elective
	3	Urgency status not assigned
Supplementary values:	9	Not known/not reported

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Urgency status assigned - emergency

Emergency admission:

The following guidelines may be used by health professionals, hospitals and health insurers in determining whether an emergency admission has occurred. These guidelines should not be considered definitive.

An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.

Such a patient would be:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or

- suffering from suspected acute organ or system failure; or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- suffering from a drug overdoes, toxic substance or toxin effect; or
- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or
- suffering an acute condition which represents a significant threat to the patient's physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

If an admission meets the definition of emergency above, it is categorised as emergency, regardless of whether the admission occurred within 24 hours of such a categorisation being made, or after 24 hours or more.

CODE 2   Urgency status assigned - Elective

Elective admissions:

If an admission meets the definition of elective above, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.

Scheduled admissions:

A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.

Admissions from elective surgery waiting lists:

Patients on waiting lists for elective surgery are assigned a Clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an urgency of admission category, which may or may not be elective:

- Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see code 1 in metadata item Reason for removal from an elective surgery waiting list code N) will be assigned an Admission urgency status code N code of 2. In that case, their clinical urgency category could be regarded as further detail on how urgent their

- Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see code 2 in metadata item Reason for removal from an elective surgery waiting list code N), will be assigned an Admission urgency status code N code of 1.

CODE 3   Urgency status not assigned

Admissions for which an urgency status is usually not assigned:

An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions listed above and be admitted on an emergency basis.

CODE 9   Not known/not reported

This code is used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.