Section 3 – Data definitions

Victorian Admitted Episodes Dataset (VAED) manual

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Department of Health & Human Services

State Government Victoria

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Contents

Introduction

This section provides the specifications for each data item collected during an admitted episode of care, and later submitted to PRS/2.

Additional items that are included in PRS/2 transmissions, such as Trailer Record statistics and fillers, are specified in Section 5, along with the file structures of each Transaction Record.

Additional items are derived from items submitted in PRS/2. These are referenced in Section 2 for information only. Some of these derived items are listed in the Transmitted Transaction reports (such as the DRG); others are used in validations, including age and length of stay.

Information about each data item is presented in the following structured format:

Data Item Name

Specification

Definition	A statement that expresses the essential nature of a data item and its differentiation from all other data items.
Field size	The maximum number of characters accommodated by this field.
Layout	The layout of characters for the data element, expressed by a character string representation. Examples include: 'DDMMYYYY' for dates, 'N' for a 1-digit numeric value, spaces or blank, and 'A' for a 1-character alpha value, spaces or blank. 'X' for spaces, apostrophes, hyphens, alphas or numeric
Location	The Transaction Record in which this element is submitted to PRS/2. For example, the Episode Record.
Reported by	The requirement for this data element to be collected by public hospitals only or public *and* private hospitals (includes day procedure centres).
Reported for	The specific circumstances when this data item must be reported. For example: Carer Availability is reported when the Care Type for the episode is 1, P, 6, 8, 9, or MC and Separation Mode is H Separation to private residence/accommodation.
Reported when	The stage in the episode/data submission cycle when this data element is to be reported to PRS/2. For example: Subacute data elements are reported following the transmission of a Separation Date in the Episode Record.
Code set	The set of representations of permissible values for the data item, according to the form, layout, data type and field size.
Reporting guide	Additional comments or advice on reporting the data item.
Validations	A list of validations (validation numbers and long descriptors) that relate to this data element.

Related items	A list of related data items, Business Rule Tables, Concept Definitions and Supplementary Code Lists that affect the assignment of a code in this data item.

Administration

Purpose	The main reason/s for the collection of this data item.
Principal data users	Identifies the primary user/s of the data collected.
Collection start	The year the collection of this data item commenced.
Definition source	Identifies the authority that defined this data item.
Code set source	Identifies the authority that developed the code set for this data item.

Definitions

ACAS Status

Specification

Definition

The type of involvement of the Aged Care Assessment Service (ACAS) in patient separation.

Field size 1 **Layout** N or space

Location

Episode Record

Reported by

Public hospitals

Private hospitals – Optional. If the private hospital chooses not to report these data items, report spaces in the field.

Reported for

Episodes with:

- Care Type 1, 4, 6, 8, 9, or MC, **and**
- Where the patient's age is equal to or greater than 50, **and**
- Where the episode is not a same day episode.

For Care Types P, 0, 5x, 10 and U, report spaces in this field.

Reported when

A Separation Date is reported in the Episode Record.

Code set

Select the first appropriate category:

Code	Descriptor
1	ACAS Assessment completed during this episode
2	ACAS Assessment incomplete: referral to Sub-acute services
3	ACAS Assessment incomplete: other reason
4	ACAS Consultation only during this episode
5	No ACAS involvement during this episode

Reporting guide

This information should be noted in the patient's health record by staff members or by ACAS.

1 ACAS Assessment completed during this episode

Use code 1 if the patient has received a comprehensive assessment by a member of the ACAS of their physical, medical, psychological, social and restorative care needs with a recommendation for the patient's long term care setting and all the relevant paperwork completed (for example, 2624 certificate completed and signed if required).

2 ACAS Assessment incomplete: referral to Sub-acute services

Use code 2 if the patient was seen by the ACAS who referred the patient to sub-acute services (for example, GEM or rehabilitation) at this hospital or another campus/hospital.

Excludes when the assessment was not completed because the patient:

- Required further acute care to become medically stable (use 3)
- Began an assessment that was completed in a subsequent statistical episode (use 3)
- Died (use 3)
- Left against medical advice (use 3)

3 ACAS Assessment incomplete: other reason

Use code 3 if the patient was seen by the ACAS but a final care plan and long term care setting recommendation could not be made.

Includes when the assessment was not completed because the patient:

- Required further acute care to become medically stable.
- Began an assessment that was completed in a subsequent statistical episode.
- Died.
- Left against medical advice

Excludes when the assessment was not completed because the patient:

- Was referred to sub-acute services (eg GEM or rehabilitation)(use 2)

4 ACAS Consultation only during this episode

Use code 4 if the ACAS were consulted, or gave advice to the Hospital staff (discharge planner, social worker) about a patient's discharge and long term care setting and care plan options, but did not conduct a full assessment.

5 No ACAS involvement during this episode

Use code 5 if ACAS had no involvement with the patient.

Includes:

- Patient referred to ACAS for a home-based assessment (record this in Separation Referral).

Validations

460 Invalid ACAS Status
461 ACAS Status not Required
462 Incompat ACAS Status and Sep Referral
533 ACAS Status Code Required

Related items Section 3: Separation Referral

Administration

Purpose Assist in measuring demand, and for planning of future services.

Principal data users Department of Health & Human Services (DHHS)

Collection start	2003-04	**Version**	1 Effective 1 July 2003
Definition source	DHHS	**Code set source**	DHHS

Accommodation Type (a)

Accommodation Type on Separation (b)

Specification

Definition

(a) The accommodation type or types occupied by the patient during their admission, including changes to this item during the episode.

(b) The accommodation type last occupied by the patient on the day of separation.

Field size 1 **Layout** N or A

Location

(a) Status Segments of the Episode Record

(b) Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when

(a) The Episode Record is reported. Any changes in Accommodation Type are reported in new Status Segments.

(b) Once the Separation Date is reported in the Episode Record.

Code set

For data items (a) and (b), select the first appropriate category:

Code	Descriptor
R	Off-site
4	In the Home (Hospital - HITH)
7	Ward Based/Medi-Hotel combination
S	Short Stay Observation Unit
M	Medical Assessment and Planning Unit
6	Emergency Department
C	Nursery accommodation: NICU/SCN
B	Other nursery accommodation or mother's bedside (rooming in)
3	Same Day accommodation
2	Overnight accommodation: single room
1	Overnight accommodation: shared room

Reporting guide

Status Segments are used to record changes of Accommodation Type during the episode. If more than one change of Accommodation Type occurs within the same day, do not report the first change; only report the patient's status as of midnight each day.

R Off-site
Care delivered in an off-site facility which is not the patient's usual place of residence.
Excludes:

- Hospital in the Home (HITH) program (use code 4)
- Maintenance care provided in the hospital (use code 1 or 2)

4 In the Home (Hospital - HITH)
Provision of care to hospital admitted patients in their place of residence as a substitute for traditional hospital accommodation.

Includes*:*

- Under the Hospital in the Home (HITH) program
- Geriatric Evaluation and Management Program (home based)

Excludes*:*

- Accommodation in a Medi-Hotel (use code 7)

7 Ward Based/Medi-Hotel combination

For multi-day stay patients, where the patient receives treatment as an inpatient in a traditional hospital setting (ward) during the day and resides in the hospital's Medi-Hotel overnight.

Includes:

- Accommodation in same day facilities during the day
- Where the patient is cared for in the Medi-Hotel by someone not arranged for, provided by, or paid for by the hospital, such as a relative or other carer

Excludes:

- Accommodation In the Home (HITH) (use code 4).

S Short Stay Observation Unit

Accommodation within an approved Short Stay Observation Unit (SOU). The facility may be in, adjacent to, or remote from the Emergency Department.

SOU is a designated unit that is specifically staffed and equipped to provide observation care and treatment for emergency patients who have an expected length of stay between 4 and 24 hours.

Includes:

- General and specific Short Stay Observation Units, for example chest pain units.

Excludes:

- Short stay facilities designated specifically for elective surgical and radiological procedures
- Medical Assessment and Planning Unit admissions (use code M)

M Medical Assessment and Planning Unit

Accommodation within an approved Medical Assessment and Planning Unit (MAPU). MAPUs concentrate on admissions for general medical conditions in one geographical area to streamline the care planning processes. Planned length of stay in the Medical Assessment and Planning Unit may be up to 48 hours prior to transfer to another Accommodation Type (ward) or separation home.

Excludes:

- Short Stay Observation Unit (use code S)

6 Emergency Department

Patient accommodation provided in the emergency department or urgent care centre

C Nursery accommodation: NICU/SCN

Accommodation provided to any infant in a facility approved by the Commonwealth Minister for the purpose of provision of neonatal intensive or special care.

B Other nursery accommodation or mother's bedside (rooming in)
Accommodation provided to any infant in a postnatal ward, either in a nursery that is not an approved NICU or SCN or by its mother's bedside (that is 'rooming in').

For infants in paediatric wards, report code 1, 2 or 3 as appropriate.

3 Same Day accommodation
Same day bed or accommodation such as a renal dialysis chair, regardless of whether this bed/chair is in a single or shared room.

Excludes:
Where a same day patient is accommodated in a ward or bed not designated as a same day ward/bed either because the hospital has no such designated accommodation or because that accommodation is full.

2 Overnight accommodation: single room
Sole occupation of a room intended for the overnight accommodation of a single patient but only when the patient has requested single accommodation.

Includes:
- Where the patient has requested single accommodation and occupies a room intended for single occupancy but her newborn is rooming-in
- Where a same day patient is accommodated in a ward/bed not designated as a same day ward/bed either because the hospital has no such designated accommodation or because that accommodation is full
- Maintenance care delivered in this hospital

Excludes:
- Where the patient is the only person occupying a room intended for shared occupancy, such as the isolation of a patient for medical reasons, or where there is no available shared room (use code 1)
- Where the patient occupies a single room but has not requested single accommodation (use code 1)

1 Overnight accommodation: shared room

Occupation of a room intended for the overnight accommodation of more than one patient.

Includes:
- Where the patient is the only person occupying a room intended for shared occupancy
- Where the patient and her rooming-in newborn are the only people occupying a room intended for occupancy by more than one adult patient
- Where the patient has not requested single accommodation but occupies a single room because of a clinical decision
- Where a same day patient accommodated in a ward/bed not designated as a same day ward/bed either because the hospital has no such designated accommodation or because that accommodation is full
- Maintenance care delivered in this hospital

Validations

(a)	076	Not Sufficient Fields First Status
	077	Not Sufficient Fields Other Status
	084	Invalid Accom Type
	106	Invalid Sep Accom

	240	Newborn Accom But Over 4 Months
	432	MAPU or SOU >48 Hours
	434	NICU/SCN Accom But Unqual Newborn
	464	Accom Type 7, not Care Type 4
	520	Accom Type 7, not approved for Medi-hotel
	521	Accom Type M, no registered MAPU
	522	Accom Type S, no registered SOU
	602	Newborn Accom But Over 12 Months
	706	Accom Type 7: First Status or Accom on Sep
(b)	106	Invalid Sep Accom
	108	Field(s) Missing From Sep
	401	Accom Type On Sep – Emerg
	455	Inconsist Newborn Transferred/Unqual Data
	706	Accom Type 7: First Status or Accom on Sep

Related items

Section 2: Admitted Patient, Hospital in the Home, Intensive Care Unit, Medi-Hotel and Maintenance Care.

Section 4:

- Business Rules (non-tabular) Medi-Hotel Reporting and Reporting history of code changes.
- Business Rules (tabular) Account Class and Medicare Suffix and Criterion for Admission: Secondary Family Member.

Section 5: Status Segments.

Administration

Purpose	For analysis of patient movement during an episode.		
Principal data users	Multiple internal and external data users		
Collection start	1991-92	**Version**	
Definition source	DHHS	**Code set source**	DHHS

Account Class (a)

Account Class on Separation (b)

Specification

Definition

(a) The agency/individual chargeable for this episode, and associated sub-categories, for this episode of care, including changes to this item during the episode

(b) The agency/individual chargeable for this episode, and associated sub-categories, on the last (counted) patient day

Field size 2 **Layout** AA or AN

Location

(a) Status Segments of the Episode Record

(b) Episode Record

Reported by All Victorian hospitals (public and private)

Reported for All admitted episodes of care

Reported when

(a) The Episode Record is reported

(b) Once the Separation Date is reported in the Episode Record

Code set

Code	Descriptor
Posthumous Organ Procurement episode	
KK	Posthumous Organ Procurement episode
Unqualified Newborns (Not Birth Episode)	
NT	Newborn (Unqualified, Not birth episode)
Public (Acute Care) Patient	
MP	Public: Eligible
ME	Ineligible: hospital exempt
MF	Ineligible: Asylum Seeker
MN	Public NHT – without NH5
M5	Public NHT - with NH5
MA	Reciprocal Health Care Agreement
Private Patient	
PA	Advanced surgery 1 (1-14 days)
PB	Advanced surgery 2 (15+ days)
PC	Surgery (1-14 days)
PD	Surgery 2 (15+ days)
PE	Medical 1 (1-14 days)
PF	Medical 2 (15+ days)
PG	Obstetric 1 (1-14 days)
PH	Obstetric 2 (15+ days)
PI	Rehabilitation 1 (1-49 days)
PJ	Rehabilitation 2 (50-65 days)
PK	Rehabilitation 3 (66+ days)
PL	Psychiatric 1 (1-42 days)
PM	Psychiatric 2 (43-65 days)
PN	Psychiatric 3 (66+ days)

PO	Same Day (Band 1)
PP	Same Day (Band 2)
PQ	Same Day (Band 3)
PR	Same Day (Band 4)
PS	Private NHT - with general care-without NH5
PT	Private NHT - with general care-with NH5
PU	Private NHT - with extensive care-without NH5
PV	Private NHT - with extensive care-with NH5

Department of Veterans' Affairs Patient

VX	Department of Veterans' Affairs (DVA)
VN	Department of Veterans Affairs NHT-without NH5
V5	Department of Veterans' Affairs NHT-with NH5

Compensable Patient

WC	Victorian WorkCover Authority (VWA)
WN	Victorian WorkCover Authority (VWA) - Non-Acute
TA	Transport Accident Commission (TAC)
TN	Transport Accident Commission (TAC) - Non-Acute
AS	Armed Services
AN	Armed Services - Non-Acute
SS	Seamen
SN	Seamen - Non-Acute
CL	Common Law Recoveries
CN	Common Law Recoveries - Non-Acute
OO	Other compensable
ON	Other compensable - Non-Acute
JP	Prisoner
JN	Prisoner Non-Acute

Ineligible

XX	Ineligible non-Australian residents (not exempted from fees)
XN	Ineligible non-Australian residents (not exempted from fees) - Non-Acute

Reporting guide

Status Segments are used to record changes of Account Class during the episode.

If more than one change occurs within the same day, do not report the first change; only report the patient's status as of midnight each day.

Note: An episode cannot have both public and compensable Account Classes in different status segments.

Newborns are expected to have the same Account Class as their mother for the birth episode. In certain circumstances in public hospitals, the mother may be public and the baby private, or the mother private and the baby public.

For example:

- Where the mother does not have private insurance and elects for the baby to be treated as private and pay all expenses; and
- Where the mother has single private insurance and elects to be private, the baby can be a public patient.

Where the newborn is unqualified and it is not the birth episode, report Account Class NT.

KK Posthumous Organ Procurement

All Posthumous Organ Procurement episodes in public hospitals.

Use this code only for episodes in which human tissue is to be procured for the purpose of transplantation from a donor who has been declared brain dead prior to the commencement of this episode.

NT Newborn (Unqualified, Not birth episode)
A newborn (under 10 days old at admission), admitted subsequent to the birth episode (where the Account Class should be the same as the mother's) who does not meet the criteria for a qualified newborn. Usually these babies are transferred from another hospital.

Note: The newborn may have been reported as qualified or unqualified at a prior hospital

MP Public: Eligible
An eligible person, who, on admission to a recognised hospital or a private hospital for services provided under contract, or as soon as possible thereafter, elects to be treated as a public patient. The hospital provides comprehensive care including all necessary medical, nursing and diagnostic services and, if available, dental and paramedical services, by means of its own staff or by other agreed arrangements, without charge to the patient.

Includes:
- Persons holding a current Interim Medicare Card.

Excludes:
- Persons holding an expired Interim Medicare Card (report XX Ineligible)
- A person admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient's treatment

ME Ineligible: Hospital Exempt

An ineligible non-Australian resident:
- Specifically referred to Australia for hospital services not available in the patient's own country and for whom the Secretary of the Department has determined that no fee be charged; or
- Who has been declared a safe haven resident and whose treatment is provided or arranged by a designated hospital

MF Ineligible: Asylum Seeker

A Medicare ineligible asylum seeker.
- Admitted for immediately necessary medical treatment (but only as a public patient); and
- Has met the criteria for Medicare Ineligible Asylum Seeker

MN Public NHT – without Aged Care Client Record

A patient as defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation, the patient is classified as a NHT patient unless a medical practitioner certifies that the patient is in need of acute care.

For example:
- Professional attention for an acute phase of the patient's condition; or
- Active rehabilitation; or
- Continued management, for medical reasons, as an admitted patient.

Nursing Home Type patients can be of the following types:
Public

- Private with general care
- Private with extensive care
- DVA with general care
- DVA with extensive care

If a NHT patient is out of a hospital for seven days or less and is readmitted, the count of days continues (the days out of hospital are not added). If a NHT patient is out of hospital for more than seven consecutive days, the patient is formally separated. If the patient later returns to the hospital, the patient is formally admitted as an acute patient.

M5 Public NHT – with Aged Care Client Record

A NHT patient who has been assessed by an Aged Care Assessment Team and has an approved Aged Care Client Record.

MA Reciprocal Health Care Agreement

A visitor to Australia who is ordinarily resident in a country with which Australia has a Reciprocal Health Care Agreement (RHCA), admitted for necessary medical treatment (but only as a public patient), as is clinically necessary for the diagnosis, alleviation or care of the condition requiring attention, on terms no less favourable than would apply to a resident.

P Private Patient

A person who elects in writing to be treated (in a public or private hospital) as an admitted patient by a medical practitioner of their own choice and to be responsible for paying the charges referred to in clause B13 of the 2009 National Healthcare Agreement.

Includes:

- A patient on whose behalf election has been made by another person with patient's express or implied consent
- A patient admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient's treatment

V Department of Veterans' Affairs Patient

An eligible person whose charges for this episode of care are met by the Department of Veterans' Affairs (DVA). A gold card holder is automatically eligible as a veteran, but a white card holder's eligibility must be established at the time of admission or on the next business day if the patient is admitted over a weekend (contact Department of Veterans' Affairs, State office, telephone (03) 9284 6111 or fax (03) 9284 6440). If DVA does not accept responsibility, then normal patient election applies.

Public hospitals: If the first character of the patient's Account Class is V, a V5 DVA and TAC Record must be submitted every time the Episode Record is transmitted.

-- Compensable Patient

An eligible person who is an admitted patient and who is entitled under a law that is or was in force in Victoria, other than Veterans' Affairs legislation, to the payment of, or who has been paid compensation for, damages or other benefits (including a payment in settlement of a claim for compensation, damages, or

other benefits) in respect of the injury, illness or disease for which he/she is receiving hospital services.

This category includes workers compensation, transport accident, criminal injury and common law cases and members of the Defence Forces and seamen with personnel entitlements.

- N Compensable Non-Acute Patient

A person, who has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not a compensable patient, would be deemed to be a Nursing Home Type patient.

J Prisoner Patient

A person who is an admitted patient and is currently in the custody of Correctional Services in Victoria.

XX Ineligible Non-Australian Resident Patient

A person who is an admitted patient but who is not eligible for Medicare and therefore not exempted from fees.

Includes:
Persons holding expired Interim Medicare Cards (should be billed for services).

XN Ineligible Non-Australian Resident - Non-Acute Patient

A person, who has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not an ineligible patient, would be deemed to be a Nursing Home Type patient.

Public hospitals:

Report the patient's Account Class according to the Fees and Charges for Acute Health Services in Victoria - A Handbook for Public Hospitals document, available at:
http://www.health.vic.gov.au/feesman/index.htm

The patient elects to be treated as a Public or Private patient, or may be eligible for DVA or a compensable class, or may be ineligible. Refer to above document for the correct wording for the 'Form of Election for Admission to Public Hospital'

After admission and initial election, patient election status can only be changed in the event of unforseen circumstances. Examples of unforseen circumstances include, but are not limited to:

- Patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;
- Patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health professional; and
- Patients whose social circumstances change while in hospital (for example, loss of job).

Inadequate private health insurance cover is not a sufficient reason for changing a patient's election status.

Private Patients:

Within each broad Account Class, categorisation of patients is a medical decision and is performed by medical staff at the hospital or the referring medical practitioner; patients cannot elect to be charged as a particular Account Class as this will depend on what surgery, if any, is performed and complexity of the care.

Fees depend on whether the patient has been an admitted patient in any hospital within the seven days before this admission. Previous hospitalisation may alter the patient's length of stay classification

Private patients specify on the election form whether they wish to be accommodated in a single room.

The fee charged to a private patient will depend upon:

- Patient account classification and length of stay
- Type of accommodation

Private hospitals:

Record patient Account Class as 'best fit' Account Class according to the Fees and Charges for Acute Health Services in Victoria - A Handbook for Public Hospitals document.

Because of the many patient account options used in private hospitals, and the limited applicability of the comparatively small range of Account Classes offered in PRS/2, private hospitals and day procedure centres are not required to supply comprehensive Account Class data. Only the following broad categories apply:

Contracted patients*:* Use the appropriate Account Class from the range of valid codes. Where public patients are admitted under contract, use code MP.

A patient admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient's treatment is not considered to be a public patient. These patients should be reported using an appropriate private account class.

If a patient is admitted as fee-paying but is unable/unwilling to pay their account and the fee is written off, the original Account Class should be used (for example, PE, PC). Do not change the Account Class to a Medicare no-charge category.

For all private acute same day patients, use any code respectively, from the following list:

PO PP PQ PR

For all private acute overnight/multi-day patients, use a code starting P, with any valid combination of second character, from the following list:

PA PB PC PD PE PF PG PH PI
PJ PK PL PM PN

Nursing Home Type patients (Private and Department of Veterans' Affairs) must be classed to the existing range of codes:

PS PT PU PV VN V5

However, accurate specification of general or extensive care level or NH5 status is not required for private hospital NHT or Department of Veterans' Affairs NHT

patients.

Compensable or Ineligible patients should be identified as such, including detail of the relevant funder. These patients need only be classified to the following level of detail:

WC TA AS SS CL OO XX

There is no requirement to use the codes with second-character N.

Validations

(a)

076	Not Sufficient Fields First Status
077	Not Sufficient Fields Other Status
083	Invalid Account Class
094	Invalid Combination A/C Med Suff
111	Same Day A/C Stat Not The Only Status
113	Same Day Status: Total Pt Days Not 1
116	Sep A/C Class Not In A Status Seg
222	Unqual Newborn; Adm Date Not Birth
324	Incompat ICU Hrs, A/C Class
325	Incompat MV Hrs, Acct Class
372	Episode Deletion: Multiple Epis Trans
374	Episode DVA/TAC: No V5 Transaction
375	Episode DVA/TAC: V5 Trans Rejected
377	Episode DVA/TAC: Multiple E5 Trans
378	Episode DVA/TAC: Multiple V5 Trans
379	Epis Not DVA/TAC: V5 Trans Present
380	Epis Not DVA/TAC: V5 Trans: Multiple E5s
382	Epis Not DVA/TAC: Multiple V5 Trans
391	Recip HCA Account, Not O/Seas P/Code
392	Recip HCA Account, Not O/Seas Born
393	Recip HCA Account, Indig Stat A or TI
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
532	Account Class MA: not 4, 5E, 5K, 5G, 5S, 5A or U
571	Acct Recip, Pcode Oseas, Locality Not RHCA
572	Postcode Overseas, Account Not Recip, or Inelig
573	Postcode Overseas, Account Public
574	Postcode Overseas, Locality RHCA, Acct Not RHCA
626	Invalid Combination for Funding Arrangement PHESI
637	Illegal Combination of Account Classes
638	Private Hosp, Public Account Without Contract

(b)

105	Invalid Sep Account Class
108	Field(s) missing From Sep
116	Sep A/C Class Not In A Status Seg
455	Inconsist Newborn Transferred/Unqual Data

Related Items

Section 2:
Boarder, Medicare Eligibility Status - Eligible Person, Medicare Eligibility Status - Ineligible Person, and Newborn, Posthumous Organ Procurement.
Section 4:

- Business Rules (non-tabular) Newborn Reporting, and Reporting history of code changes.
- Business Rules (tabular) Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative, Posthumous

Organ Procurement.

Section 5: Status Segments

Administration

Purpose

(a) To:

- Distinguish between broad categories (public, private, DVA, compensable).
- Identify patients with DVA account classes (for accounting purposes).
- Identify certain compensable patients (so DRG Statements are raised).
- Verify other fields (such as Care Type, Accommodation Type) for consistency.

(b) To:

- Identify the Account Class of a patient at separation.
- For use in summary analyses.
- To place patients into broad account categories for reporting to the Commonwealth.
- To identify posthumous organ procurement episodes.

Principal data users

Department of Health and Human Services (DHHS)

Department of Veterans' Affairs (DVA)

Transport Accident Commission (TAC)

WorkCover (VWA)

Collection start

1979-80

Definition source

DHHS

Code set source

DHHS

Account Classes on Separation mapped to Separation patient type code (derived item)

Account Class on Separation (first character)	Separation patient type
M, N	H Public
P	P Private
V	V DVA
W, T, A, S, C, O, J	S Compensable
X	X Ineligible
K	K Posthumous organ procurement

Admission Date

Specification

Definition

Date on which an admitted patient commences an episode of care (formal or statistical)

Field size 8 **Layout** DDMMYYYY

Location

Episode Record

DVA and TAC Record

Reported by

All Victorian hospitals (public and private)

Private hospitals: Do not report a DVA and TAC Record.

Reported for

All admitted episodes of care

Reported when

The Episode Record or DVA and TAC Record is reported

Code set

Valid date

Reporting guide

Admission of Birth Episode

For the first episode of a Newborn, the Admission Date will be the Date of Birth, except in the unusual circumstance where the newborn is born before arrival at this hospital, and where the birth occurs just before midnight and the newborn arrives at this hospital after midnight.

Admission from Non-admitted Services

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall not be regarded as part of the admitted episode.

Statistical Admissions

Statistical admissions must have an Admission Date equalling the previous episode's Separation Date. Statistical separations and admissions cannot occur over midnight.

Validations

026	Zero Sep; Existing Not Discharged
027	Adm Record; Overlaps Existing
028	Prior Adm; No Sep Date
035	Invalid Date of Birth
038	Invalid Adm Date
039	Invalid Adm Date; > Header
057	Incompat Adm Type/Age
062	Duplicate Pt ID, Adm Date Time, Diff. Unique
063	Prior Not Discharged
064	Duplicate Pt ID, Date Time
069	Newborn From Overseas
080	Sex Indeterminate Age< 90 Days
102	Sep Date < Adm Date
112	Calc Los + Leave Not = Adm/Sep
115	Adm Time Not< Sep Time
122	Sameday Adm Source/Sep Mode Mismatch
127	Nil Value DRG
160	AR-DRG Grouper GST Code> Zero
178	Trans Adm Not Same As Episode
186	Neonate MDC But Age > = 28 days

187 Adm Weight Too Low
188 Adm Weight Too High
189 Age < 1 Year But Adm Weight Missing
190 Adm Wt Present But Not Aged < 1 Year
215 Sex Indeterminate But Age >9 Days
222 Unqual Newborn; Adm Date Not Birth
226 Adm Date Before Birth Date
227 Age Calculated As 120 Years & Over
240 Newborn Accom But Over 4 Months
245 Adm Wt >=9Kg But Age >=5 Mth
255 Rehab: Invalid Onset Date
261 Newborn Care Type But Age >9 days
262 Invalid Care Type For Newborn
289 Adm Sc T'fer & Onset =Adm Date
290 Stat Adm Sc, & Onset = Adm Date
322 ICU/CCU Stay > Total Stay
323 MV Duration > Total Stay
353 Code & Age Incompatible
390 Incompat Care Type, Carer Avail, Age and Sep Mode
397 Sep Referral Postnatal, Incompat Age/Sex
401 Accom Type On Sep - Emerg
438 NIV Duration > Total Stay
447 Unqual Newborn; Age at Sep > 10 Days
461 ACAS Status not Required
465 Adm Duration < 15 Mins
467 Adm Wt <1000g, LOS <28 Days, Sep Mode ≠ T or D
468 Care Type ≠ 1 or F, LOS >365 Days
479 Incompat Adm Source/Age
480 Incompat Adm Source/Age <15
481 Incompat Adm Source/Age <55
486 Incompat Age/Crit for Adm
487 Incompat Age/Qual Stat
493 Incompat Sep Mode/Age <15
494 Incompat Sep Mode/Age <55
504 Stat Episode: Next Episode > 1 Minute Apart
505 Stat Episode: Previous Episode > 1 Minute Apart
518 Medicare Code = 0, Age > 6 Months
519 Medicare Code = 0, Age > 12 Months
533 ACAS Status Code Required
549 Type B Crit for Adm, LOS >1
550 Type C Crit for Adm, LOS >1
551 Type C Crit for Adm, LOS >4 hrs
552 Type E Crit for Adm, LOS >1
553 Type E Crit for Adm, LOS <4 hrs
554 Date of Accident > Adm Date
596 Same Day ECT: Not in Care Type 4
598 Same Day Rehabilitation: Not in Scope
602 Newborn Accom But over 12 Months

Related items	Section 2: Age, Length of Stay, Overnight or Multi-day Stay Patient, and Same Day Patient. Section 3: Date of Birth. Section 4: Business Rules (non-tabular) Length of Stay Business Rules (tabular): Admission Source and Age; Admission Type and Age; Age and Criterion for Admission; Age, Care Type, Carer Availability and Separation Mode.

Administration

Purpose	To enable (for data validation purposes) 'patient days' (patient's length of stay) and normal leave days to be balanced with the difference between Admission Date and Separation Date. To enable calculation of age.
Principal data users	Multiple internal and external data users.
Collection start	1979-80
Definition source	NHDD

Admission Source

Specification

Definition

Describes where the patient was residing or living prior to the commencement of an episode of care.

Field size 1 **Layout** A

Location

Episode Record

Reported by

All Victorian hospitals (public and private).

Reported for

All admitted episodes of care.

Reported when

The Episode Record is reported.

Code set

Select the first appropriate category:

Code	Descriptor
K	Posthumous Organ Procurement
S	Statistical Admission (change in Care Type within the hospital)
Y	Birth episode
T	Transfer from acute hospital/extended care/rehabilitation/geriatric centre
B	Transfer from Transition Care bed based program
A	Transfer from mental health residential facility
N	Transfer from aged care residential facility
H	Admission from private residence/accommodation

Reporting guide

K Posthumous Organ Procurement

Assign this code for posthumous organ procurement episodes (Care Type 10)

S Statistical Admission (change in Care Type within this hospital)

Assign this code when a new episode of care has commenced within the same hospital stay on the same hospital campus.

Excludes:

- Patients who die in hospital and a new episode is created for organ procurement (use code K)
- Change from or to Unqualified newborn (Care Type U) as a Statistical Separation or a Statistical Admission. Changes between Qualified and Unqualified status of newborns are recorded in Status Segments using the Qualification Status field. Refer to Section 4: Newborn.
- Change between Rehabilitation Program/Units - Care Types (6, P).

Y Birth episode

Admission of newborn at or directly after birth.

- Excludes second or subsequent admissions in the newborn period:
- Newborns admitted after the birth episode, while still nine (9) days old or less (use code T or H).

T Transfer from acute hospital / extended care / rehabilitation / geriatric centre

Admission to this hospital, directly from another acute hospital, extended care, rehabilitation or geriatric centre, regardless of whether the patient was admitted or not at the transferring hospital. Requires a Transfer Source code.

Includes:

Public and private acute, extended care and mental health admitted patient units.

Excludes:

- Transition Care bed based program (use code B)
- Aged care residential facilities (use code N)
- Mental health residential facility (use code A).

B Transfer from Transition Care bed based program

Admission to hospital directly from a Transition Care bed based program. Does not require a Transfer Source code.

Excludes:

- Home-based Transition Care

A Transfer from mental health residential facility

Transfer from mental health residential facility (includes Psychogeriatric nursing homes and community care units) (Rehabilitation/Continuing Care/Other Care) funded by Mental Health Services. Does not require a Transfer Source code.

Includes:

- Mental health aged care residential facility.

Excludes:

- Mental health admitted patient units (use code T).

N Transfer from aged care residential facility

Admission to hospital directly from an aged care residential facility (includes nursing home and hostel). Does not require a Transfer Source code.

Excludes:

- Transition Care bed based program (use code B)
- Mental health aged care residential facility (use code A).

H Private Residence/Accommodation

Place of residence immediately prior to admission.

Includes:

- Home or home of relative or friend
- Supported residential facilities.
- Special accommodation houses
- Training centres for intellectually disabled persons
- Prison
- Forensic hospital (Thomas Embling)
- Juvenile detention centre
- Armed forces base camp/hospital

- Homeless (shelters, half way houses)

Excludes:

- Transition Care bed based program (use code B)
- Aged care residential facility (use code N)
- Mental health residential facility (use code A)

Validations

041 Invalid Adm Source
051 Transfer Source Blank
056 Incompatible Adm Type/Source
122 Sameday Adm Source/Sep Mode Mismatch
289 Adm Sc T'fer & Onset = Adm Date
290 Stat Adm Sc & Onset Date = Adm Date
328 Early Parenting Centre – Invalid Comb
423 Invalid Comb Fund/Contract/Transfer
479 Incompat Adm Source/Age
480 Incompat Adm Source/Age <15
481 Incompat Adm Source/Age <55
482 Incompat Adm Source/Crit for Adm
483 Incompat Adm Source/Qual Stat
488 Incompat Care Type/Adm Source Statistical
491 Incompat Fields for ESAS
492 Incompat Fields for RPI
499 Stat Admission: No Prev Episode
501 Stat Episode: Adm Source ≠ Sep Mode Prev Episode
503 Stat Episode: Care Type same as Prior Episode
505 Stat Episode: Previous Episode > 1 Minute Apart
507 Stat Episode: Rehab also in Prior Episode
509 Stat Episode: Sep Mode ≠ Adm Source Next Episode
510 Stat Sep Mode: No Subsequent Episode
626 Invalid Combination for Funding Arrangement PHESI
629 Incompatible Adm Source/Indigenous Status

Related items

Section 2: Admission, Admitted Patient, Episode of Admitted Patient Care, Geriatric Evaluation and Management Program, Hospital Stay, Newborns, Nursing Home Type/Non-Acute care, Palliative Care, Rehabilitation Care and Transfer.

Section 3: Transfer Source

Section 4: Business Rules (non-tabular) Transfer

Business Rules (tabular) Admission Source and Admission Type; Admission Source and Age; Admission Source and Care Type; Admission Source and Criterion For Admission; Admission Source and Qualification Status; Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode

Administration

Purpose To analyse patient movement.

Principal data users Multiple internal and external data users.

Collection start 1979-80

Definition source NHDD **Code set source** DHHS

Admission Time

Specification

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

Field size 4 **Layout** HHMM

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set A valid 24-hour time (not 0000 or 2400)

Reporting guide

For a **formal admission**, the Admission Time is the actual time at which patient was admitted (at the admission desk), the time of birth, or the time the patient leaves the clinical area of the Emergency Department (see below).

For a **statistical admission** (Care Type change), a dummy Admission Time is acceptable to enable the times to be automatically recorded. Care Type changes could be recorded as occurring at midday. The Admission Time must be one minute later than the Separation Time of the preceding episode (for example, if Separation Time of the earlier episode was made to be 1200, Admission Time of the new episode would be 1201).

Note: For episodes for posthumous organ procurement (Care Type 10), report Admission Time as after the certified time of death.

Newborns

- For newborns born in this hospital, the Admission Time is the time of birth.
- For newborns born before arrival or transferred to this hospital from another, the Admission Time is time of arrival at this hospital.

Admission from Non-admitted Services

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall not be regarded as part of the admitted episode. For example, when a patient is admitted from the Emergency Department or outpatient clinic, then the Admission Time is the time the patient physically leaves the clinical area of the Emergency Department or outpatient clinic for immediate transfer to a ward or operating theatre/procedure room at the same hospital.

Note

Admission Time must not be prior to the time the patient leaves the non-admitted service.

Validations	027	Adm Record; Overlaps Existing
	040	Invalid Adm Time
	062	Duplicate Pt ID, Adm Date Time, Diff Unique
	064	Duplicate Pt ID, Date Time
	115	Adm Time Not < Sep Time
	322	ICU/CCU Stay > Total Stay
	323	MV Duration > Total Stay
	438	NIV Duration >Total Stay
	465	Adm Duration < 15 Mins
	504	Stat Episode: Next Episode > 1 Minute Apart
	505	Stat Episode: Previous Episode > 1 Minute Apart
	551	Type C Crit for Adm, LOS >4 hrs
	553	Type E Crit for Adm, LOS <4 hrs

Related items Section 3: Admission Date

Administration

Purpose To enable the exact Length of Stay to be determined.

Principal data users Multiple internal and external data users.

Collection start 1990-91

Definition source NHDD

Admission Type

Specification

Definition The category of admission (patient characteristic) relating to this episode of care.

Field size 1 **Layout** A

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Select the first appropriate category:

Code	Descriptor
K	Posthumous Organ Procurement
S	Statistical admission (change in Care Type within this hospital)
Y	Birth episode
M	Maternity
C	Emergency admission through Emergency Department at this campus
O	Other emergency admission
P	Elective admission

Reporting guide

K Posthumous Organ Procurement

Assign this code for posthumous organ procurement episodes (Care Type 10)

S Statistical admission (change in Care Type within this campus)

Used for statistical admissions.
Excludes:

- Patients who die in hospital and a new episode is then created for posthumous organ procurement (use code K).

Y Birth episode

Admission of newborn at or directly after birth.
Excludes:

- Second or subsequent admissions in the newborn period. Newborns admitted after the birth episode, while still nine (9) days old or less (use code C, O or P).

M Maternity

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

C Emergency admission through Emergency Department at this campus

Admission of an emergency patient, arising from presentation at the Emergency Department or Urgent Care Centre at this campus.

Includes:

- Threatened miscarriage before 20 weeks.

Excludes:

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

Note: An emergency admission is for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours.

O Other emergency admission

Admission of an emergency patient, not arising from presentation at the Emergency Department or Urgent Care Centre at this campus.

Includes:

- GP-referred admission or self-referral for acute illness (such as unstable diabetes, CCF, pneumonia, asthma attack) directly for emergency admission.
- Threatened miscarriage before 20 weeks.
- Crisis Assessment and Treatment Team (CATT) referred admission
- Emergency transfer from another campus
- Admission from Outpatient Department where patient is an emergency patient.

Excludes:

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).
- Admission via the emergency department at this campus (use C).
- A person who is ‘dead on arrival’ who then proceeds to a posthumous organ procurement episode (report only the Posthumous Organ Procurement episode (use code K)

P Elective admission

Routine or elective admission for medical or surgical treatment.

Includes:

- Admission from a hospital waiting list.
- Planned admission for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.
- Planned transfer from another campus
- Admission from Outpatient Department where patient is an elective patient.
- Follow-up admission following a previous emergency admission or presentation.

Excludes:

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

Note: An elective admission is for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours

Validations

052	Invalid Adm Type
056	Incompatible Adm Type/Source
057	Incompat Adm Type/Age
059	Maternity - Not Female
328	Early Parenting Centre – Invalid Comb
455	Inconsist Newborn Transferred/Unqual Data
484	Incompat Adm Type/Crit for Adm
485	Incompat Adm Type/Qual Stat
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
626	Invalid Combination for Funding Arrangement PHESI
633	Delivery Episode, Adm Type not M

Related items

Section 2: Admission, Newborn.

Section 4:

Business Rules (non-tabular) Newborn Reporting.

Business Rules (tabular) Admission Source and Admission Type; Admission Type and Age; Admission Type and Criterion For Admission; Admission Type and Qualification Status; Care Type: Organ Procurement – posthumous (10).

Administration

Purpose

To:

Distinguish between emergency and non-emergency admissions.

Identify data for maternity and birth episodes.

Identify episodes for posthumous organ procurement.

Principal data users DHHS

Collection start 1979-80

Definition source DHHS

Code set source DHHS

Admission Weight

Specification

Definition The birth weight of the live baby or the weight of the neonate or infant (under one year of age) on the date admitted, if this is different from the date of birth

Field size 4 **Layout** NNNN or spaces.
Right justify, leading zeros.

Location Diagnosis Record

Reported by All Victorian hospitals (public and private)

Reported for All admitted patients under 1 year of age

Reported when A Separation Date is reported in the Episode Record

Code set Valid weight in grams, 100-9999.

If Admission Weight is not required, report spaces, not zeros.

Reporting guide Admission Weight is required for all infants under 1 year of age at admission (that is, admitted on a date earlier than the infant's first birthday).

Where admission is on the day of birth, the birth weight is the Admission Weight.

If Admission Weight is unknown or heavier than 9999, and the patient is aged greater than 27 days, use 9999. If the patient is less than 28 days, estimate the weight.

Validations

187	Adm Weight Too Low
188	Adm Weight Too High
189	Age < 1 Year But Adm Weight Missing
190	Adm Wt Present But Not Aged < 1 Year
245	Adm Wt >= 9kg But Age <= 5 Mth
411	Adm Wt < 1000g, No Matching Dx Code
412	Adm Wt is 1000-2499g, No Matching Dx Code
413	Adm Wt > 6000g, No Matching Dx Code
467	Adm Wt <1000g, LOS < 28 Days, Sep Mode ≠ T or D
534	Invalid Adm Weight

Related items Section 3: Admission Date and Date of Birth.

Administration

Purpose To monitor the weight of patients <1 year of age. Weight is an important indicator of pregnancy outcome; is a major risk factor for neonatal morbidity and mortality; and is required to analyse peri-natal services for high-risk infants.

To enable accurate grouping in DRG systems.

Principal data users DHHS

Collection start 1993-94

Definition source DHHS

Advanced Care Plan Alert

Specification

Definition An alert, flag or similar present in the medical record or patient management system that indicates an advance care plan and/or substitute decision maker has been recorded.

Field size 1 **Layout** N or space

Location Extra Episode Record

Reported by Public hospitals – optional **Note:** This item may become mandatory in 2016-17

Reported for All admitted episodes of care

Reported when A Separation Date is reported in the Episode Record

Code set

1 No advance care plan alert

2 Presence of an advance care plan alert

3 Presence of a substitute decision maker alert

4 Presence of both an advance care plan alert and a substitute decision maker alert

Reporting guide An advance care plan alert will be identified by an alert identifying any of the following:

- A completed Refusal of Treatment Certificate
- A formally documented advance care plan
- Other advance care planning documentation (documentation of a person's future wishes such as a written letter or advance care planning discussion record)

* A resuscitation plan, limitation of treatment order or goals of patient care form alone do not meet the requirements for this data item.

A substitute decision maker alert will be identified by an alert, flag or similar identifying any of the following:

- Enduring power of attorney (medical treatment)
- Enduring Power of Guardianship which includes consent to health care.
- Guardian appointed by VCAT with powers to consent to health care
- Nomination in writing of a person responsible
- Identification of the 'person responsible' as per the 'person responsible hierarchy'

Advance care planning: have the conversation: A strategy for Victorian health services 2014-2018 (the Strategy) www.health.vic.gov.au/acp

Validations 707 Invalid Advance Care Plan Alert

Administration

Purpose To provide data on advance care planning that will quantify activity and enable benchmarking across the service system.

Principal data users Department of Health & Human Services

Collection start 2015

Definition source DHHS **Value Domain Source** DHHS

Campus Code

Specification

Definition Indicates the hospital campus where the episode of care was provided. Patient activity must be reported under the campus code at which it occurred.

Field size 4 **Layout** NNNN

Location Episode Record

Reported by All Victorian hospitals (public and private)

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Campus code table available on the HDSS website at:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Reporting guide Report patient activity under the campus code at which it occurred.

Validations

330	Invalid Campus Code
420	Contract/Spoke = Campus Code
472	Pall Care, not approved for Palliative Care Program
473	Care Type 9, not approved for GEM
477	Funding Arrangement 5, not approved for Rural Patients Initiative
478	Funding Arrangement 6, not approved for ESAS
520	Accom Type 7, not approved for Medi-hotel
521	Accom Type M, no registered MAPU
522	Accom Type S, no registered SOU
523	CCU Hrs, no Approved CCU
526	ICU Hrs, not approved ICU or NICU
630	Contract/Spoke Identifier cannot be reported for this campus
628	Cannot report for this campus
631	Care Type P not approved for Paediatric Rehabilitation
651	Program Identifier, campus not approved for program

Related items Section 2: Campus, and Hospital.
Campus code table available on HDSS website at
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Administration

Purpose To identify the specific campus of a hospital providing this episode of care, for use in policy and planning development.

Principal data users DHHS

Collection start 1998-99

Definition source DHHS **Code set source** DHHS

Care Plan Documented Date

Specification

Definition
The date of documentation that either a multidisciplinary care plan or an interdisciplinary care plan was first agreed.

Field size 8 **Layout** DDMMYYYY

Location
Diagnosis Record

Reported by
Public hospitals. Private hospitals, report spaces

Reported for
Care Types 6, P, 8, 9 and MC with Separation Date 7 days or more after Admission Date.

For Care Types 6, P, 8, 9 and MC with Separation Date less than 7 days after Admission Date, report spaces.

For Care Types 1, 4, 5x, 0, U or 10, report spaces.

Reported when
A Separation Date is reported in the Episode Record

Code set
Valid date

Reporting guide
Care Plan Documented Date should be within the first 7 days of the sub-acute episode.

- Where a Care Plan was documented prior to the start of this Episode (for example where this episode is a statistical change from a previous Care Type) and another has not been completed within 7 days of the Admission Date of the current episode, report the Care Plan Documented Date as being the Date of Admission for this episode.
- Where a Care Plan is not documented during a stay that exceeds 7 days in duration, report spaces in this field.
- Where a Care Plan is documented in this stay, but this is not done in the first 7 days after the Admission Date, report the date on which the Care Plan was documented.
- Where a Care Plan is documented in the first 7 days of stay, but it is not a multidisciplinary or interdisciplinary Care Plan, report spaces in this field.

The first 7 days of stay is interpreted as the day of admission and the next 6 days; if the patient goes on leave in that period, the count of days for the purposes of Care Plan Documented Date does not stop.

Validations

668	Care Plan Doc Date reported but Care Type not sub-acute
669	Care Plan Doc Date reported > 7 days after Adm Date
670	Care Type Sub-acute, Separated, Care Plan Doc Date is null
671	Care Plan Doc Date < Adm Date or > Sep Date
672	Invalid Care Plan Documented Date

Related items
Section 2: Care Plans, Section 3: Care Type, Section 5: Diagnosis Record

Administration

Purpose
To enable reporting against the Timeliness of Care Key Performance Indicator required under the National Partnerships Agreement Subacute Care Performance Indicators.

Principal data users
Multiple internal and external data users.

Collection start
2012

Definition source DHHS **Value Domain Source** DHHS

Care Type

Specification

Definition

The nature of the clinical service provided to an admitted patient during an episode of care.

Field size 2 **Layout** AA or NN or NA
Left justified, trailing spaces.

Location

Episode Record

Reported by

All Victorian hospitals (public and private).

Reported for

All admitted episodes of care.

Reported when

The Episode Record is reported.

Code set

Select the first appropriate category:

Code	Descriptor
10	Posthumous Organ Procurement
1	NHT/Non-Acute
P	Designated Paediatric Rehabilitation Program/Unit
6	Designated Rehabilitation Program/Unit
8	Palliative Care Program
5x	Approved Mental Health Service or Psychogeriatric Program: 5T – Mental Health Nursing Home Type 5E – Mental Health Secure Extended Care Unit (SECU) 5K – Child and Adolescent Mental Health Service (CAMHS) 5G – Acute, Aged Persons Mental Health Service (APMH) 5S – Acute, Specialist Mental Health Service 5A – Acute, Adult Mental Health Service
9	Geriatric Evaluation and Management Program
MC	Maintenance Care
0	Alcohol and Drug Program
4	Other care (Acute) including Qualified newborn
U	Unqualified newborn

Reporting guide

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

10 Posthumous Organ Procurement

Reportable by public hospitals only

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

Episodes in which posthumous organ procurement is conducted are registered by the hospital, and reported to the VAED, although they are not admitted episodes. Diagnosis and procedure codes for activity to facilitate posthumous organ procurement, including mechanical ventilation and tissue procurement, are recorded in accordance with the relevant ICD-10-AM Australian Coding Standards.

Reporting guide

Includes:

- A patient who has died in hospital, been formally separated at the time of death, and for whom this new episode is being created to report posthumous organ procurement.
- A person who was 'dead on arrival' and for whom this new episode is being created to report posthumous organ procurement.

1 NHT/Non-Acute

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

NHT

After 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner provides certification documented in the medical record that the patient is in need of acute care.

Non-Acute

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

Such a patient may or may not have been assessed by an Aged Care Assessment Team and may or may not have an approved Aged Care Client Record (ACCR) (formerly '2624 certificate').

Excludes:

- Approved Mental Health Service or Psychogeriatric Program Mental Health Nursing Home Type (5T)

.

P Designated Paediatric Rehabilitation Program/Unit

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

Private hospitals: Do not use code P.

6 Designated Rehabilitation Program/Unit

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

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

8 Palliative Care Program

Applies to a patient who is admitted or transferred to a designated Palliative Care Program/Unit.

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

5x Approved Mental Health Service or Psychogeriatric Program

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

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

5T Mental Health Nursing Home Type

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

NHT

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

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

Excludes:

- NHT/Non-Acute (1)

5E Mental Health Secure Extended Care Unit (SECU)

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

Excludes:

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

5K Child and Adolescent Mental Health Service (CAMHS)

A patient who is admitted to an approved CAMHS unit.

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

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

Excludes:

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

5S Acute, Specialist Mental Health Service

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

Includes:

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

Excludes:

- Child and Adolescent Mental Health Service (5K)

5A Acute, Adult Mental Health Service

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

Excludes:

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

MC Maintenance Care

A patient who is admitted for Maintenance Care. Aims of maintenance care include:

- to prevent deterioration in the function and health status of a patient who is assessed as not requiring acute or subacute care
- to provide a person centred approach to care evidenced by an individualised assessment and case management plan
- to provide a time limited and low level therapy program developed by an allied health professional that promotes patient's independence and case management to determine long term care planning.

Use only if the health service provides Maintenance Care.

9 Geriatric Evaluation and Management Program

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

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

0 Alcohol and Drug Program

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

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

4 Other (Acute) Care including Qualified newborn

Other types of patient:

Includes:

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

Excludes:

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

U Unqualified newborn

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

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

Validations

107	Invalid Care Type
222	Unqual Newborn; Adm Date Not Birth
250	Deleted – Episode is Sub-Acute
253	Rehab: Invalid Impairment
255	Rehab: Invalid Onset Date
258	Sub- Acute: No Sub – Acute Record
260	Invalid Care For Qual
261	Newborn Care But Age > 9 Days
262	Invalid Care Type For Newborn
268	Inv Comb Legal, Care & PFS
285	Sub-Acute Record not required
289	Adm Sce T'fer & Onset = Adm Date
290	Stat Adm Sc & Onset = Adm Date
293	Impairment Present
294	Onset Date Present
297	Sep Rug ADL & Sep Mode Incompatible
390	Incompat Care Type, Carer Avail and Sep Mode
406	Rehab Care Type W/Out Rehab Diag
421	Not Separated; Carer Avail Present
437	NIV Duration for Unqual Newborn
447	Unqual Newborn; Age at Sep
448	ICU Stay but Care Type not Acute
455	Inconsist Newborn Transferred/Unqual Data
461	ACAS Status not Required
464	Accom Type 7, not Care Type 4
468	Not NHT, LOS >365 Days
471	Care Type 5x, not usual Sep Referral
472	Pall Care, not approved for Palliative Care Program
473	Care Type 9, not approved for GEM
488	Incompat Care Type/Adm Source Statistical
489	Incompat Care Type/Sep Mode Statistical

491 Incompat Fields for ESAS
492 Incompat Fields for RPI
498 Pall Care without Pall care Diag
502 Stat Episode: Care Type same as Next Episode
503 Stat Episode: Care Type same as Prior Episode
532 Account Class MA: not 4, 5E, 5K, 5G, 5S, 5A or U
533 ACAS Status Code Required
535 Care Type 5E, not approved for SECU
536 Care Type 5T, not approved for NHT
537 Care Type 5K, not approved for CAMHS
538 Care Type 5G, not approved for Aged Acute
539 Care Type 5S, not approved for Specialist Acute
540 Care Type 5A, not approved for Adult Acute
575 Care Type 5x, MHSWPI Blank
587 Care Type 6, not approved for Rehab
596 Same Day ECT: Not in Care Type 4
597 Mental Health Episode: Sep Mode = S
598 Same Day Rehabilitation: Not in Scope
599 Carer Availability Not Required
626 Invalid Combination for Funding Arrangement PHESI
631 Care Type P, not approved for Paediatric Rehabilitation
660 Care Type not equal to 5x, Procedure Code 93341-xx MHSWPI mismatch
667 Incompat Care Type/Crit for Adm

Related items

Section 2:
Acute Care, Admission, Admitted Patient, Episode of Admitted Patient Care, Geriatric Evaluation and Management Program, Newborns, Nursing Home Type/Non-Acute Care, Palliative Care, Posthumous Organ Procurement, Maintenance Care, Rehabilitation Care and Subacute Care.
Section 4:
Business Rules (non-tabular) Episode of Care, Newborn Reporting and Palliative Care Reporting.
Business Rules (tabular) Admission Source and Care Type, and Care Type: Designated Rehabilitation Program (6), and Designated Paediatric Rehabilitation (P), and Care Type and Separation Mode, and Age, Care Type, Carer Availability and Separation Mode, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative, and Funding Arrangement: Private Hospitals Elective Surgery Initiative, and Newborns: Criteria for Admission, Qualification Status, Care Type.

Administration

Purpose

To distinguish various types of care in order to:

Apply the appropriate funding formula to the episode.

Group episodes to facilitate analysis.

Principal data users DHHS

Collection start 1995-96

Definition source DHHS **Code set source** DHHS

Carer Availability

Specification

Definition

A record of whether a person, such as a family member, friend or neighbour has been identified as providing regular on-going care or assistance, not linked to a formal service.

Field size 1 **Layout** N or space

Location

Episode Record

Reported by

Public hospitals.

Private hospitals: Report a space in this field.

Reported for

Admitted episodes with a Care Type of 1, P, 6, 8, 9 or MC and Separation Mode is H Separation to private residence/accommodation

For all other Care Types and Separation Modes, report a space in this field.

Reported when

A Separation Date is reported in the Episode Record

Code set

Code	Descriptor
1	Carer not needed/not applicable
2	Lives alone, has a carer
3	Lives alone, has no carer
4	Lives with another, has no carer
5	Lives with another, has a resident carer
6	Lives with another, has a non-resident carer
7	Lives in a mutually dependent situation
8	Missing or not recorded

Reporting Guide

Availability infers carer willingness and ability to undertake the caring role and can apply when there are several carers. Where a potential carer is not prepared to undertake the role, or when their capacity to carry out necessary tasks is minimal, then the patient must be reported as not having an *informal* carer.

Where there are several carers, a decision should be taken as to which of these is the main or primary carer and report accordingly.

Excludes:

- Formal services such as meals on wheels, personal support or household support provided by local council

1 Carer not needed/not applicable

Person able to self-care and/or their therapeutic regime does not require the input of an informal carer.

Includes:

- Those circumstances where it may be inappropriate for a carer at home to undertake a complex medical procedure requiring a high level of nursing skill.
- Person who is discharged to supported accommodation or other care facility that will provide the formal care required.

Excludes:

Circumstances where a relative or friend is available but is unwilling or unable to undertake a carer role (report 3 or 4).

2 Lives alone, has a carer

Person lives alone and has an informal carer who is able and willing to attend to the person's recuperative needs on an ongoing basis.

3 Lives alone, has no carer

Person lives alone and does not have an informal carer willing and/or able to visit for the purpose of assisting with care on an arranged and regular basis.

4 Lives with another, has no carer

Person does not live alone but the co-resident/s is/are unable or unwilling to provide the care needed and there is no other external informal carer available.

5 Lives with another, has a resident carer

Household where the person lives with another who is willing and able to provide the care required for recuperation.

Excludes:

Person whose potential co-resident carer is mutually dependent (7).

6 Lives with another, has a non-resident carer

Person does not live alone but the co-resident/s is/are unable and/or unwilling to provide the care needed, but there is an external informal carer who is willing and able to provide this care.

7 Lives in a mutually dependent situation

Households where the service recipient and another person are mutually dependent. The critical aspect of such households is that if either member becomes unavailable for any reason, the other is either at high risk or unable to remain at home.

8 Missing or not recorded

Insufficient information to determine Carer Availability

Validations

390	Incompat Care Type, Carer Avail and Sep Mode
421	Not Separated; Carer Avail Present
591	Invalid Carer Availability
599	Carer Availability Not Required

Related items Section 3: Separation Mode.

Administration

Purpose To enable monitoring of the impact of Carer Availability on separation timing and use of ambulatory services, to support policy development and planning.

Principal data users Department of Health & Human Services

Collection start 1999-00

Definition source NHDD

Code set source NHDD (DHHS modified)

Clinical group

Specification

Definition	A free text field that hospitals can use to record a clinical or discharge unit or clinician to allow sub-hospital analysis of dr foster ® performance indicators.		
Field size	12	**Layout**	Characters or spaces
Location	Extra Episode Record		
Reported by	Public hospitals		
Reported for	All admitted episodes of care (optional)		
Reported when	A Separation Date is reported in the Episode Record		
Code set	Free text field		
Reporting guide	None		
Validations	Not applicable		

Administration

Purpose	To facilitate sub-hospital analysis of dr foster ® performance indicators		
Principal data users	Health Services		
Collection start	2015		
Definition source	DHHS	**Value Domain Source**	None

Contract Leave Days Financial Year-to-Date

Specification

Definition

The number of days during this episode of care that the patient was out of hospital on 'contract leave' in the financial year being reported (includes the month being reported).

Field size 2 **Layout** NN or spaces
Right justified and zero filled.

Location

Episode Record

Reported by

Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases and providers of contracted care).

All other sites, report spaces in this field.

Reported for

Episodes where:

- Funding Arrangement is 1 Contract and
- Contract Type is 2 Contract Type ABA, 3 Contract Type AB or 5 Contract Type BA and
- Contract Role A Hospital A.

Contract leave is not reported where a patient goes on contract leave and returns on the same day.

Reported when

This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

Code set

A valid number equal to or greater than month-to-date contract leave days.

The minimum valid number is 01. If there are no Contract Leave Days, report spaces, not zeros.

Reporting guide

Contacted Leave Days are included in Patient Days.

Contract Leave Days Financial Year-to-Date must be equal to or greater than Contracted Leave Days Month-to-Date and equal to or less than Contract Leave Days Total.

Validations

278	Contract Lve YTD Not Num/Blank
282	Contract Lve YTD < MTD
284	Contract Lve Total < YTD
456	Contract Leave, No Contract

Related items

Section 2: Contracted Care and Patient Day

Section 3: Contract Leave Days Month-to-Date,Contract Leave Days Total

Section 4: Business Rules (non-tabular) Contracted Care and Length of Stay,

Business Rules (tabular) Funding Arrangement and Contract Fields

Administration

Purpose

To identify days (in this financial year to date) a patient was on contract leave from this hospital (not on leave with or without permission).

Principal data users

Department of Health and Human Services

Collection start

1996-97

Definition source DHHS DHHS

Contract Leave Days Month-to-Date

Specification

Definition
The number of days during this episode of care that the patient was out of hospital on 'contract leave' in the month being reported (month-to-date).

Field size 2 **Layout** NN or spaces
Right justified and zero filled.

Location
Episode Record

Reported by
Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases and providers of contracted care).

All other sites, report spaces in this field.

Reported for
Episodes where:

- Funding Arrangement is 1 Contract and
- Contract Type is 2 Contract Type ABA, 3 Contract Type AB or 5 Contract Type BA and
- Contract Role A Hospital A.

Contract leave is not reported where a patient goes on contract leave and returns on the same day.

Reported when
This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

Code set
A valid number less than or equal to the number of month-to-date patient days.

The minimum valid number is 01. If there are no Contract Leave Days, report spaces, not zeros.

Reporting guide
Contacted Leave Days are included in Patient Days.

Contract Leave Days Month-to-Date must be equal to or less than Contracted Leave Days Financial Year-to-Date and Contract Leave Days Total.

Validations

277	Contract Lve MTD Not num/blank
282	Contract Lve YTD < MTD
283	Contract Lve Total < MTD
456	Contract Leave, No Contract

Related items
Section 2: Contracted Care, Patient Day

Section 3: Contract Leave Days Total

Section 4: Business Rules (non-tabular) Contracted Care, Length of Stay

Business Rules (tabular) Funding Arrangement and Contract Fields.

Administration

Purpose
To identify days (in this month to date) that a patient was on contract leave from this hospital (not on leave with or without permission).

Principal data users
Department of Health and Human Services

Collection start
1996-97

Definition source DHHS **Code set source** DHHS

Contract Leave Days Total

Specification

Definition

The total number of days during this episode of care that the patient was out of hospital on 'contract leave', including days from the previous financial year(s).

Field size 2 **Layout** NN or spaces

Right justified and zero filled.

Location

Episode Record

Reported by

Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases and providers of contracted care).

All other sites, report a space in this field.

Reported for

Episodes where:

- Funding Arrangement is 1 Contract and
- Contract Type is 2 Contract Type ABA, 3 Contract Type AB or 5 Contract Type BA and
- Contract Role A Hospital A.

Contract leave is not reported where a patient goes on contract leave and returns on the same day.

Reported when

This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

Code set

A valid number equal to or greater than financial year-to-date contract leave days.

The minimum valid number is 01. If there are no Contract Leave Days, report spaces, not zeros.

Reporting guide

Contacted Leave Days are included in Patient Days.

Contract Leave Days Total must be equal to or greater than Contracted Leave Days Month-to-Date and Contract Leave Days Year-to-Date.

Validations

279	Contract Lve Total Not num/Blank
283	Contract Lve Total < MTD
284	Contract Lve Total < YTD
456	Contract Leave, No Contract

Related items

Section 2: Contracted Care, Patient Day.

Section 3: Contract Leave Days Month-to-Date

Section 4: Business Rules (non-tabular) Contracted Care and Length of Stay

Business Rules (tabular) Funding Arrangement and Contract Fields.

Administration

Purpose

To identify the total days that a patient was on contract leave from this hospital (not on leave with or without permission).

Principal data users

Department of Health and Human Services

Collection start

1996-97

Definition source DHHS **Code set source** DHHS

Contract Role

Specification

Definition

Identifies whether the hospital is the purchaser of hospital care (contracting hospital) or the provider of an admitted or non-admitted service (contracted hospital).

Field size 1 **Layout** A or space.

Location

Episode Record

Reported by

Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases and providers of contracted care).

All other sites, report a space in this field.

Reported for

Episodes where Funding Arrangement is 1 Contract.

If Funding Arrangement is not 1, report a space in this field.

Reported when

This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

Code set

Code	Descriptor
A	Hospital A (purchasing hospital)
B	Hospital B (service provider hospital)

Reporting guide

A Hospital A (purchasing hospital)

This hospital is the contracting (purchasing) hospital.

B Hospital B (service provider hospital)

This hospital is the contracted (service provider) hospital.

Validations

408	Contract Role 'A' W/Out Proc Flag
409	Proc Flag W/Out Contract Role 'A'
410	Illegal Comb Fund Arrange & Contract
418	Invalid Contract Role
423	Invalid Comb Fund Arrange, Contract/Transfer
456	Contract Leave, No Contract

Related items

Section 2: Contracted Care, Leave Without Permission and Leave - Contract.

Section 4: Business Rules (non-tabular) Contracted Care

Business Rules (tabular) Contracting: Funding Arrangement, Contract Type, Contract Role with Admission Source and Separation Mode; Funding Arrangement and Contract fields

Administration

Purpose

- To identify the reporting hospital as purchaser or provider
- To make a public hospital casemix payment to the contracting hospital
- To avoid double counting the episode (epidemiological & planning purposes)

Principal data users Multiple internal and external data users.

Collection start 1999-00

Definition source NHDD **Code set source** NHDD

Contract/Spoke Identifier

Specification

Definition

This field identifies:

- The public or private hospital or day procedure centre involved in contracted care arrangements with this hospital (as purchaser or provider of contracted care).
- The Spoke hospital in a Hub and Spoke arrangement for this episode (the Spoke hospital does not report the episode unless it is a multi-day stay).
- The exact nature of the contract involving an external purchaser.

Field size 4 **Layout** NNNN or spaces.

Location Episode Record

Reported by

Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases and providers of contracted care).

All other sites, report a space in this field.

Reported for

This item is mandatory if Funding Arrangement is:

1 Contract or

2 Hub/Spoke

Otherwise, report a space in this field.

Reported when

This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

Code set

Where Funding Arrangement is 1 Contract, report the relevant Campus Code from the Campus code table available at http://www.health.vic.gov.au/hdss/reffiles/index.htm which identifies the other party to the contracted service arrangement, with the following exception:

When

- Funding Arrangement 1 Contract and
- Contract Type 1 Contract Type B,

Report the code from the list below that identifies the external purchaser/program relevant to the episode of care

Where the Funding Arrangement is 2 Hub/Spoke, report the relevant Contract/Spoke Identifier from the list below or relevant Campus Code.

Code	Descriptor
0010	Melbourne Health Same Day ECT – Northern
0011	Melbourne Health Same Day ECT - Sunshine
0012	Melbourne Health Same Day ECT - Broadmeadows
0030	Other Funding Source
0100	Australian Health Care Agreement (AHCA) - Elective Surgery
0200	Department of Health: HIV AIDS
0300	Department of Veterans' Affairs: Veterans' Cardiac Agreement
0311	Brunswick Dialysis Unit
0312	Coburg Dialysis Unit

0313	Broadmeadows Dialysis Unit
0314	Williamstown Dialysis Unit
0315	Sunshine Hospital Dialysis Unit
0316	Northern Hospital Dialysis Unit
0317	Craigieburn Health Service
0318	St George's Dialysis
0321	Caulfield General Medical Centre Dialysis Unit
0331	Austin Training Satellite Dialysis Unit
0332	Heidelberg Repatriation Hospital Dialysis Unit
0333	North East Kidney Service
0334	Epping Dialysis Unit
0351	Newcomb Dialysis Unit
0352	Rotary House Dialysis Unit
0353	South Geelong Renal Unit
0361	Maroondah Hospital Dialysis Unit
0362	Spring Street Dialysis Unit
0399	Big Red Kidney Bus
0400	Individual contracts with international patients
0500	Transport Accident Commission: Alfred Road Trauma Unit
0600	Department of Health: Rural & Remote Health Agency Program
0700	Department of Health: Bowen Centre - ARMC
0710	Department of Health: Interim Payment
0800	Victorian Maintenance Dialysis Program
0900	St Jude Pacemaker Replacement Program

Reporting guide

Validations

410	Illegal Comb Fund Arrange & Contract
419	Invalid Contract/Spoke Identifier
420	Contract/Spoke = Campus/Site
456	Contract Leave, No Contract

Related items

Section 2: Contracted Care, Leave – Contract, Leave and Hub and Spoke.

Section 4:

Business Rules (non-tabular) Contracted Care and Hub and Spoke

Business Rules (tabular) Funding Arrangement and Contract Fields.

Administration

Purpose To enable monitoring of health services provided under contract in Victoria.

Principal data users Department of Health and Human Services

Collection start 1999-00

Definition source DHHS

Code set source DHHS

Contract Type

Specification

Definition

Describes the contract arrangement between the contractor and the contracted hospital/facility. Contract Types are distinguished by the physical movement of the patient between the contracting (where applicable) and contracted hospitals.

Field size 1 **Layout** N or space.

Location

Episode Record

Reported by

Victorian public and private hospitals involved in contracted care arrangements (purchases and providers of contracted care).

All other sites, report a space in this field.

Reported for

Episodes where the Funding Arrangement is 1 Contract. For all other episodes, report a space in this field.

Reported when

This field can be reported during the patient's stay and must be present when the Separation Date is reported in the Episode Record.

Code set

Code	Descriptor
1	Contract Type B
2	Contract Type ABA
3	Contract Type AB
4	Contract Type (A)B
5	Contract Type BA
6	Contract Type A(B)

Reporting guide

The contracting (purchasing) hospital (or authority) is termed Hospital **A**.

The contracted (service provider) hospital is termed Hospital **B**.

Contract Types are described by the sequence of the **A** and **B** characters, representing the movement of the patient between the contracting and contracted entities. Brackets indicate the patient was not physically present in one of either the contracting or contracted hospital. For example, (A) means the patient was not physically present in the contracting hospital.

1 Contract Type B

A (health authority/other external purchaser) contracts **B** (hospital) for admitted service.

2 Contract Type ABA

Patient admitted by Hospital **A**.

Hospital A contracts Hospital **B** for admitted or non-admitted patient service.

Patient returns to Hospital **A** on completion of service by Hospital B.

3 Contract Type AB

Patient admitted by Hospital A.

Hospital A contracts Hospital B for admitted or non-admitted patient service.

Patient does not return to Hospital A on completion of service by Hospital B.

4 Contract Type (A)B

Patient is not present in the Contracting Hospital (A) at any time during the episode.

Hospital A contracts Hospital B for the whole admitted patient service.

An (A)B contract type cannot occur between two public hospitals unless approved by the Hospital & Health Service Performance Division of the Department of Health. Where two public hospitals enter into a contract, the contracting hospital must provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).

5 Contract Type BA

Hospital A contracts Hospital **B** for an admitted patient service following which the patient moves to Hospital **A** for the remainder of the care.

6 Contract Type A(B)

Hospital **A** contracts Hospital B for the whole admitted patient service.

Hospital B provides the service at Hospital A.

Patient is not present in the Contracted Hospital **(B)** at any time during the episode.

An **A(B)** contract type cannot occur between two public hospitals unless approved by the Hospital & Health Service Performance Division of the department. Where two public hospitals enter into a contract, the contracting hospital must admit and provide care or treatment for the patient as part of the overall service provided (Contract Types **ABA**, **AB** and **BA**).

Validations

410	Illegal Comb Fund Arrange & Contract
417	Invalid Contract Type
423	Invalid Comb Fund/Contract/Transfer
456	Contract Leave, No Contract

Related items

Section 2: Contracted Care, Leave – Contract and Leave Without Permission.

Section 4: Business Rules (non-tabular) Contracted Care

Business Rules (tabular) Contracting: Contract Fields, Contract Leave and Funding Arrangement, and Contracting: Funding Arrangement and Contract Fields, and Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode.

Administration

Purpose

To identify the type of contract arrangement (if any) that applies to this episode, to make a link (if appropriate) to the record reported by the other party to the contract arrangement.

Principal data users

Department of Health and Human Services

Collection start

1999-00

Definition source

NHDD

Code set source

NHDD

Country of Birth (SACC code set)

Specification

Definition The country in which the person was born as represented by a code.

Field size 4 **Layout** NNNN

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Refer to Country of Birth and Country of Residence SACC code set available on the HDSS website at http://www.health.vic.gov.au/hdss/reffiles/index.htm

Reporting guide Report the country in which the patient was born, not the country of residence.

Validations

036	Invalid Country of Birth
069	Newborn From Overseas
228	Unusual Birth Place
234	Aboriginal/Ts Islander But Not Aust Born
392	Recip HCA Account, Not O/Seas Born
571	Acct Recip, Pcode Oseas, Locality not RHCA
574	Postcode Overseas, Locality RHCA, Acct not RHCA

Related items

Administration

Purpose To facilitate epidemiological studies.

Principal data users Multiple internal and external data users.

Collection start 1979-80

Definition source NHDD **Code set source** ABS SACC Country of Birth, Second Edition, Revision 1 (2011 edition), DHHS

Criterion for Admission

Specification

Definition The criterion which has been met to justify the patient's admission, or in the case of posthumous organ procurement, to allow for the reporting of that episode.

Field size 1 **Layout** A

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Criteria for Admission Decision Chart

Code	Descriptor
K	Posthumous Organ Procurement
N	Qualified newborn
U	Unqualified newborn
O	Patient expected to require hospitalisation for minimum of one night
B	Day-only Automatically Admitted Procedures
E	Day-only Extended Medical Treatment
C	Day-only Not Automatically Qualified Procedures
S	Secondary family member

Reporting guide Only a brief guide to Criteria for Admission (CFA) is provided below. This document should be read in conjunction with the Victorian Hospital Admission Policy, Admission Policy Procedure Code Lists, Admission Policy Factsheets and Criteria for Admission decision chart available on the HDSS website at: http://www.health.vic.gov.au/hdss/vaed/index.htm

The appropriate criterion for admission is determined at the point of admission and does not change even if the patient's circumstances change. See Victorian Hospital Admission Policy Fact Sheet for more information.

K Posthumous Organ Procurement

A person who has been declared brain dead but from whom human tissue is being procured in this episode for the purpose of transplantation.

These episodes are required to be reported to the VAED although the activity is not regarded as care or treatment of an admitted patient.

Only public hospitals can report this category.

N Qualified newborn

The patient is nine days old or less at the time of admission and meets at least one of the following criteria:

- Admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the provision of special care in designated Neonatal Intensive Care Units (NICUs) and designated Special Care Nurseries (SCNs), or
- Is the second or subsequent live born of a multiple birth, or
- Remains in hospital after their mother is separated from hospital, or is admitted to hospital without their mother.

U Unqualified newborn

The patient is nine days old or less at the time of admission but does not meet any of the criteria for CFA N.

Unqualified newborns who are still in the hospital when they turn 10 days old and are not receiving clinical care become boarders, and because boarders are not reported to the VAED, they must be separated.

Public hospitals are expected to admit all unqualified newborns.

O Patient expected to require hospitalisation for minimum of one night

The patient is expected to require overnight or multi-day hospitalisation. CFA O should be used where there is an expectation that the patient will require ongoing admitted care.

B Day-only Automatically Admitted Procedures

In order to meet CFA B, it must be the intention that the patient will:

- Receive at least one procedure listed on the Automatically Admitted Procedure List; AND
- Receive treatment on a day-only basis.

The Automatically Admitted Procedure List is available at www.health.vic.gov.au/hdss/vaed/index.htm

E Extended Medical Treatment

CFA E should be used where:

A patient receives a minimum of four hours of continuous active management consisting of:

- Regular observations (which may include diagnostic or investigative procedures); OR
- Continuous monitoring; OR

A patient is transferred from the emergency department to a Short Stay Unit, or an equivalent, and has a clearly documented clinical management plan or pathway while in the unit.

C Day-only Not Automatically Qualified Procedures

The Not Automatically Qualified for Admission List identifies procedures that would normally be undertaken on a non-admitted basis and therefore not normally reported to the VAED.

In order to meet CFA C, a patient must:

- Receive a procedure on the Not Automatically Qualified for Admission List; AND
- Be intended to be treated on a day-only basis; AND
- have their specific special circumstances documented in the medical record by the treating doctor to provide evidence that the admission is justified.

Audits of medical records may be conducted for the purpose of ensuring that documentation is provided that justifies the treatment of such patients, and is specific to the individual patient, in an admitted patient setting.

The Not Automatically Qualified for Admission List is available at www.health.vic.gov.au/hdss/vaed/index.htm

S Secondary Family Member

A patient qualifies for CFA S if:

- they do not meet any other CFA but are accompanying a patient who is admitted

AND

- the location is an Early Parenting Centre.

Validations

072	Invalid Criterion for Adm
235	Adm Crit N But Care Not 4
308	Adm Crit O But Int'd Same Day
309	Adm Crit B & Int'd Overnight
310	Adm Crit C Int'd Overnight
311	Adm Crit N & Int'd Same Day
312	Adm Crit U Int'd Same Day
328	Early Parenting Centre -Invalid comb
455	Inconsist Newborn Transferred/Unqual Data
482	Incompat Adm Source/Crit for Adm
484	Incompat Adm Type/Crit for Adm
486	Incompat Age/Crit for Adm
490	Incompat Crit For Adm/Qual Stat
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
549	Type B Crit for Adm, LOS >1
550	Type C Crit for Adm, LOS >1
551	Type C Crit for Adm, LOS >4 hrs
552	Type E Crit for Adm, LOS >1
553	Type E Crit for Adm, LOS <4 hrs
667	Incompat Care Type/Crit for Adm

Related items

Section 2: Criteria for Admission, Newborn, and Overnight or Multi-day Stay.

Section 4: Business Rules (tabular) Admission Source and Criterion For Admission, and Admission Type and Criterion For Admission, and Age and Criterion For Admission, and Care Type and Criterion for Admission, and Criterion for Admission and Qualification Status, and Criterion for Admission: Secondary Family Member, and Newborns: Criterion for Admission and Qualification Status, Care Type and Care Type: Organ Procurement – Posthumous (10).

Administration

Purpose

To prompt the hospital to consider the eligibility of the patient for admission, to identify:

- Any patient admitted for procedures listed on Automatically Admitted Procedure List
- Any patient with special circumstances requiring admission (rather than treatment as an ambulatory patient).
- Any person treated in an Early Parenting Centre not meeting the requirements to be admitted (to omit such episodes from reporting to the Commonwealth).

Principal data users Department of Health and Human Services

Collection start 1993-94

Definition source Commonwealth (DHHS modified) **Code set source** DHHS

Date of Accident

Specification

Definition The date of the transport accident causing the person to require hospitalisation.

Field size 8 **Layout** DDMMYYYY

Location DVA and TAC Record

Reported by Public hospitals.

Reported for Episodes with an Account Class of TAC (T-).

Reported when The Episode Record is reported.

Code set

Episodes with an Account Class of DVA (V-): blank.

Episodes with an Account Class of TAC (T-): A valid date.

Reporting guide

For all episodes with an Account Class of TAC (T-), Date of Accident must not be blank or later than Admission Date.

For the majority of episodes with an Account Class of TAC (T-), Date of Accident should not be:

- Prior to the Date of Birth
- Report unknown Date of Accident as 01011901

Validations

444	Invalid Date of Accident
445	Dt of Accid Incompat W TAC Claim Nbr – Fatal
446	Dt of Accid Incompat W TAC Claim Nbr - Warning
554	Date of Accident > Admission Date
555	Date of Accident < Date of Birth

Related items Section 3: Account Class.

Administration

Purpose

To enable TAC payment of relevant episodes of care. Date of Accident is used in the matching process to link hospital admissions to TAC claims.

These data are held separately to other VAED data to ensure that personal information remains confidential.

Principal data users Transport Accident Commission

Collection start 2002—03

Definition source TAC

Date of Birth

Specification

Definition The date of birth of the person.

Field size 8 **Layout** DDMMYYYY

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set A valid date.

Reporting guide The Date of Birth must be on or before Date of Admission.

Year (YYYY) can only be 19xx or 20xx.

If the Date of Birth is unknown or has been estimated, the appropriate value should be reported in the Date of Birth Accuracy field.

Validations

035	Invalid Date of Birth
057	Incompat Adm Type/Age
069	Newborn From Overseas
080	Sex Indeterminate Age > 90
127	Nil Value DRG
160	AR-DRG Grouper GST Code> Zero
186	Neonate MDC But Age>= 28 Days
187	Adm Weight Too Low
188	Adm Wt Too High
189	Age < 1 Year But Adm Weight Missing
190	Adm Wt Present But Not Aged < 1 Year
215	Sex Indeterminate But Age >= 90 Days
222	Unqual Newborn; Adm Date Not Birth
226	Adm Date Before Date of Birth
227	Age Calculated As 120 Yrs & Over
240	Newborn Accom But Over 4 Months
245	Adm Wt >= 9kg But Age is <= 5 Mth
255	Rehab: Invalid Onset Date
261	Newborn Care Type But Age > 9 Days
262	Invalid Care Type For Newborn
353	Code & Age Incompatible
397	Sep Referral Postnatal, Incompatible Age/Sex
447	Unqual Newborn; Age at Sep > 10 Days
461	ACAS Status not Required
467	Adm Wt <1000g, LOS < 28 Days, Sep Mode ≠ T or D
479	Incompat Adm Source/Age
480	Incompat Adm Source/Age <15

481	Incompat Adm Source/Age <55
486	Incompat Age/Crit for Adm
487	Incompat Age/Qual Stat/Care Type
493	Incompat Sep Mode/Age <15
494	Incompat Sep Mode/Age <55
518	Medicare Code = 0, Age > 6 Months
519	Medicare Code = 0, Age > 12 Months
533	ACAS Status Code Required
555	Date of Accident < Date of Birth
579	MHSWPI Valid, no Matching DOB
602	Newborn Accom but Over 12 Months
640	DOB Accuracy and DOB mismatch

Related items

Section 2: Age.

Section 3: Admission Date, Date of Birth Accuracy.

Section 4: Business Rules (tabular) Admission Source and Age, and Admission Type and Age, and Age and Criterion For Admission, and Age, Qualification Status and Care Type.

Administration

Purpose

To:

- Enable calculation of 'age at admission' (difference between Date of Birth and Admission Date) that is used in the allocation of DRGs and for analysis of service utilisation, need for services and epidemiological studies.
- Verify other fields (such as diagnosis and procedure codes) for consistency with calculated age.

Principal data users

Multiple internal and external data users.

Collection start

1979-80

Definition source

NHDD

Date of Birth Accuracy

Specification

Definition A code representing the accuracy of the components of a date - day, month, year.

Field size 3 ***Layout*** AAA

Location Episode Record

Reported by All Victorian Health Services (public and private).

Reported for All admitted episodes of care.

Reported when The episode record is reported.

Value domain This data element's value domain consists of a combination of three codes, each of which denotes the accuracy of one date component:

Code	Descriptor
A	The referred date component is accurate
E	The referred date component is not known but is estimated
U	The referred date component is not known and not estimated.

This data element contains three positional components (DMY) that reflect the order of the date components in the format (DDMMYYYY) of the reported Date of Birth.

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

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

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

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

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

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

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

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

Examples:
Valid combinations include:

DOB Accuracy = 'AAA', DOB = '03/11/1956'
DOB Accuracy = 'EEE', DOB = '03/11/1956'

DOB Accuracy = 'UUE', DOB = '00/00/1945'

DOB Accuracy = 'UUE', DOB = '01/01/1945'

Invalid combinations include:

DOB Accuracy = 'AAA', DOB = '00/00/1956'

DOB Accuracy = 'AAA', DOB = '00/06/1956'

DOB Accuracy = 'EEE', DOB = '00/00/1956'

DOB Accuracy = 'UUE', DOB = '00/00/0000'
DOB Accuracy = 'UEE', DOB = '00/00/1956'

Validations

639 Invalid Date of Birth Accuracy code
640 DOB Accuracy and DOB mismatch

Related items

Section 2: Age
Section 3: Date of Birth

Administration

Purpose

Required to derive age for demographic analyses and for analysis by age at a point of time.

Principal data users

Multiple internal and external research users.

Collection Start

2008-09

Definition source

NHDD (department modified)

Value Domain source

NHDD 294429

Diagnosis Codes

Specification

Definition At least one (principal diagnosis) and up to 40 ICD-10-AM codes reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care.

Field size 8 (x 40) **Layout** AANNNNspacespace

Left justify, with trailing spaces.

Location Diagnosis Record (12)
Extra Diagnosis Record (28)

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

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

Code set DHHS ICD-10-AM Library File is available on application to the HDSS help desk.

Reporting guide Report diagnoses in accordance with *Australian Coding Standards* and the *Victorian Additions to Australian Coding Standards*. The Victorian Additions to Australian Coding Standards are available at:
http://www.health.vic.gov.au/hdss/healthclassifications/vic-additions-acs.htm

Omit punctuation as shown in ICD-10-AM books (that is, no dot or oblique in codes): for example, ICD-10-AM diagnosis code A00.0 Cholera due to Vibrio cholerae 01, biovar cholerae must be entered as A000.

When a code is shown in ICD-10-AM with a symbol (dagger or asterisk), omit the symbol when transmitting to PRS/2.

The first character of the field is the prefix: P, A, C or M (see below for more information).

In the first diagnosis code field:

- Character 1 must be P (except for neonate in birth episode where it may be C).
- Next five characters must contain an alpha/numeric code of three, four or five characters (with trailing spaces if required).
- Characters 7 and 8 must be spaces.

For the remaining thirty nine diagnosis code fields, *if* a code is present:

Character 1 must be P, A, C or M.

- Next six characters must contain an alpha/numeric code of three, four, five or six characters (with trailing spaces if required).
- Character 8 must be a space.

Morphology codes (where first character is M)
Submit without punctuation (oblique) and with M prefix: for example MM80703

Prefixes: Definitions for P, A, C, M
All diagnosis codes require a prefix. Prefixes indicate whether the condition was present on, or arose during admission, and also denote morphology codes. DH will map prefixes to the NHDD Condition Onset Flag in order to report to the Commonwealth.

Refer to the *Victorian Additions to the Australian Coding Standards*

Effect of prefix A
A secondary function of the A prefix is to suppress the code description appearing in data extracts provided to TAC and on DRG statements generated by PRS/2 for Work Cover Patients.

Validations

127	Nil Value DRG
160	AR-DRG Grouper GST Code > Zero
186	Neonate MDC But Age >= 28 Days
195	Blank X5
197	Embedded Blank Diag Oper
231	P - Diag Not Prefixed By P
334	Hosp Generated DRG Not = PRS/2 DRG
351	Illegal Code Format
352	Code Not Found On Code File
353	Code & Age Incompatible
354	Code & Sex Incompatible
355	Invalid Principal Diag - Rejection
355	Invalid Principal Diag - Warning
358	Rare diagnosis or procedure code
361	External Cause Code Missing
362	Morphology Code Missing
363	External Cause needs Place Code
364	External Cause/Activity Code Mismatch
403	Qual Newborn W/Out Justificat
406	Rehab Type W/Out Rehab Diag
411	Adm Wt < 1000g, No Matching Dx Code
412	Adm Wt 1000-2499g, No Matching Dx Code
413	Adm Wt > 6000g, No Matching Dx Code
426	Y5 Not Accompanied by X5
428	X5 Upd not Accompanied by Y5 Upd
442	NIV Duration for Healthy Newborn
447	Unqual Newborn; Age at Sep > 10 Days
450	Code Incompatible W Female Sex
451	Code Incompat W Male Sex
452	Place/Activity W/Out External Cause Code
498	Pall Care without Pall care Diag
525	Diagnosis Code Indicates Boarder Episode
559	Prefix = P, Unusual Code Combination
560	Prefix = P, Unusual Code Combination
561	Prefix = C, Unusual Code Combination
562	Prefix = C, Unusual Code Combination
563	Prefix = A, Unusual Code Combination
564	Prefix = A, Unusual Code Combination
590	Diag Prefix M, Morph Code mismatch

595 Neoplasm Code Missing
600 Invalid Code
601 Sequencing Error

Related items Section 2: DRG Classification and Principal Diagnosis.

Section 3:

Hospital Generated DRG.

Section 4: Business Rules (tabular) Account Class: Geriatric Respite.

Administration

Purpose To:

Facilitate epidemiological studies and other research.
Identify episodes containing specified codes for co-payments.
Facilitate grouping for casemix purposes.

Principal data users Multiple internal and external data users.

Collection start 1979-80

Definition source DHHS **Code set source** ICD-10-AM

Duration of Mechanical Ventilation in ICU

Specification

Definition

Total duration of Mechanical Ventilation (MV) in hours provided in an approved Intensive Care Unit (ICU) or Neonatal Intensive Care (NICU) during this episode of care.

Field size 4 **Layout** NNNN or spaces.

Right-justified and zero-filled.

Location

Diagnosis Record

Reported by

Public and private hospitals with an approved ICU or NICU, and hospitals contracting with a hospital with an approved ICU.

Otherwise, report spaces.

Reported for

Episodes where MV is provided in such an ICU or NICU. Otherwise, report spaces.

Reported when

A Separation Date is reported in the Episode Record.

Code set

A number in the range 0001 to 9999.

Reporting guide

If the patient has more than one period of MV in ICU during this episode, the total duration of all such periods is reported.

Duration is reported in hours, rounded up. Only MV hours provided in an ICU are counted:

- Where a patient is intubated and MV starts in an operating theatre, for the purposes of the Duration of MV field, *the counting of the duration of MV commences when the patient enters the ICU*.
- It is not necessary to stop the MV clock when a ventilated patient is transferred from the ICU to theatre and back; instead the intervening hours will count towards the total MV hours.
- Where a patient receives MV in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.

Refer to ACS 1006 Ventilatory support.

Duration of MV is validated against Duration of Stay in ICU.

A patient who receives MV in an ICU in Hospital B during a contracted service episode has the duration of that MV reported by Hospital B; Hospital A also reports the MV hours received in Hospital B in addition to any MV hours the patient received in an ICU at Hospital A.

Note: Duration of MV is not passed to the grouper; the grouper uses the duration from the ACHI ventilation procedure code.

Validations

317	Invalid MV Duration
318	MV Duration >ICU Stay
319	MV Duration But No ICU Stay
320	MV Duration But No Proc Code
323	MV Duration >Total Stay
325	Incompat MV Hrs, A/C Class
328	Early Parenting Centre – Invalid Comb
641	MV Hours with Incorrect Procedure Code

Related items

Section 2: Intensive Care Unit

Section 3: Duration of Stay in Intensive Care Unit.

Section 4:

Business Rules (tabular) Care Type: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P), and Criterion for Admission: Secondary Family Member.

Administration

Purpose To facilitate a co-payment on specified DRGs. MV hours represent a sound and clinically valid surrogate for illness severity.

Principal data users Department of Health and Human Services

Collection start 1996-97

Definition source DHHS

Code set source -

Duration of Non-invasive Ventilation (NIV) in ICU

Specification

Definition

Total number of hours of non-invasive ventilatory assistance given via any route other than intubation or tracheostomy, provided to patients in an approved Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN) or Intensive Care Unit (ICU).

By far the most common is Continuous Positive Airway Pressure (CPAP). Duration of the following, less common, methods of ventilatory assistance should also be reported in this field:

- Bi-level Positive Airway Pressure (BiPAP)
- Intermittent Positive Pressure Breathing (IPPB), and/or
- Intermittent Mandatory Ventilation (IMV)

Field size 4 **Layout** NNNN or spaces. Right justified and zero-filled

Location Diagnosis Record

Reported by

Optional for public and private hospitals providing NIV in an approved Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN) or Intensive Care Unit (ICU).

Otherwise, report spaces.

Reported for

Episodes of care for patients receiving NIV in a NICU and/or SCN and/or ICU. Otherwise, report spaces.

Reported when

A Separation Date is reported in the Episode Record.

Code set

A number in the range 0001 to 9999.

Reporting guide

Respiratory support by intubation and/or tracheostomy
If CPAP, BiPAP, IPPB or IMV is performed by intubation or tracheostomy in an ICU or NICU, this duration should be reported in Duration of Mechanical Ventilation in ICU, and not Duration of Non-invasive Ventilation.

Counting duration of NIV
All NIV hours given in NICU, SCN and/or ICU are counted.

Reference below to '24-hour period' means 'midnight to midnight'.

- Where the NIV starts in an operating theatre, for the purpose of the Duration of NIV field, the counting of the duration of NIV starts when the patient enters the NICU or SCN or ICU.
- It is not necessary to stop the NIV clock when a ventilated patient is transferred from the ICU to theatre and back; instead the intervening hours will count towards the total NIV hours.

Calculation is in four stages:
1. Counting non-intermittent NIV
2. Counting intermittent NIV
3. Counting Contracted NIV hours (if any)
4. Summing and rounding above calculations

1 Counting non-intermittent NIV
If the patient has more than one period of non-intermittent NIV during this episode, sum the duration of all such periods.

2 Counting intermittent NIV

If a patient is cycling on and off NIV (usually only for NICU/SCN patients):

- If NIV was given for *four or more hours* in the 24-hour period between midnight and midnight, count this as 24 hours.
- If NIV was given for *less than four hours* in the 24-hour period between midnight and midnight, count the actual number of hours.

3 Counting Contracted NIV hours

When a patient receives NIV provided in a NICU, SCN or ICU in Hospital B during a contracted service episode:

- Hospital B reports the duration of NIV calculated according to these rules;
- Hospital A also includes the NIV hours received in Hospital B in addition to any NIV hours the patient received at Hospital A, each calculated according to these rules.

4 Summing and rounding above calculations

Sum the resulting figures for non-intermittent and intermittent NIV (including any Contracted hours). Then round up to the nearest hour.

Refer to ACS 1006 Ventilatory support.

Validations

328 Early Parenting Centre – Invalid Comb
435 Invalid NIV Duration
437 NIV Duration for Unqual Newborn
438 NIV Duration > Total Stay
442 NIV Duration for Healthy Newborn
583 NIV Duration High
644 NIV Hours With Incorrect Procedure Code

Related items

Section 2: Intensive Care Unit
Section 3: Duration of Stay in Intensive Care Unit.
Section 4: Business Rules (tabular) Care Type: Designated Rehabilitation Programs (6), and Designated Paediatric Rehabilitation Program (P), and Criterion for Admission: Secondary Family Member.

Administration

Purpose

To evaluate the need for a co-payment on specified DRGs. Although the preliminary evaluation has not resulted in a co-payment, this item remains to facilitate further evaluation if deemed necessary.

Principal data users

Department of Health and Human Services

Collection start

2002-03

Definition source

Australian and New Zealand Neonatal Network (amended: in PRS/2, NIV via nasopharyngeal intubation is reported in Duration of MV in ICU field)

Duration of Stay in Cardiac/Coronary Care Unit

Specification

Definition Total duration of stay (hours) in an approved Cardiac/Coronary Care Unit (CCU), during this episode of care.

Field size 4 **Layout** NNNN or spaces.

Right justified and zero filled.

Location Diagnosis Record

Reported by Public and private hospitals with an approved CCU, and hospitals contracting with a hospital with an approved CCU.

Otherwise, report spaces.

Reported for Episodes where time is spent in such a CCU. Otherwise, report spaces.

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

Code set A number in the range 0001 to 9999.

Reporting guide If patient has more than one period in CCU during this episode, the total duration of all such periods is reported.

Duration is reported in hours, rounded up.

Where a hospital has a combined ICU/CCU, the duration of stay is reported in *either* the ICU field *or* the CCU field, not both. However, where a patient receives *mechanical ventilation* or *non-invasive ventilation* in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.

A patient admitted to a CCU in Hospital B during a contracted service episode has the duration of that CCU stay reported by Hospital B; Hospital A also reports the hours spent in CCU in Hospital B in addition to any hours spent in CCU at Hospital A.

Validations

322	ICU/CCU Stay > Total Stay
328	Early Parenting Centre – Invalid Comb
333	Invalid CCU Stay
523	CCU Hrs, no Approved CCU
582	CCU Duration High

Related items Section 2: Cardiac/Coronary Care Unit
Section 3:
Duration of Mechanical Ventilation in ICU,
Duration of Non-invasive Ventilation (NIV).

Administration

Purpose To facilitate a co-payment on specified DRGs.

Principal data users Department of Health and Human Services

Collection start 1998-99

Definition source DHHS

Duration of Stay in Intensive Care Unit

Specification

Definition Total duration of stay (hours) in an approved Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU), during this episode of care.

Field size 4 **Layout** NNNN or spaces.

Right-justified, zero-filled.

Location Diagnosis Record

Reported by Public and private hospitals with an approved ICU/NICU, and hospitals contracting with a hospital with an approved ICU.

Otherwise, report spaces.

Reported for Episodes where time is spent in such an ICU/NICU. Otherwise, report spaces.

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

Code set A valid number in the range 0001 to 9999.

Reporting guide If patient has more than one period in ICU/NICU during this episode, the total duration of all such periods is reported.

Duration is reported in hours, rounded up. Only the time in the ICU/NICU is counted, not time, for example, in an operating theatre.

Where a hospital has a combined ICU/CCU, the duration of stay is reported in *either* the ICU field *or* the CCU field, not both. However, where a patient receives mechanical ventilation or non-invasive ventilation in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.

A patient admitted to an ICU/NICU in Hospital B during a contracted service episode has the duration of that ICU/NICU stay reported by Hospital B; Hospital A also reports the hours spent in ICU/NICU in Hospital B in addition to any hours spent in ICU/NICU at Hospital A.

Validations

316	Invalid ICU Duration
318	MV Duration >ICU Stay
319	MV But No ICU Stay
322	ICU/ CCU Stay > Total Stay
324	Incompat ICU Hrs, A/C Class
328	Early Parenting Centre – Invalid Comb
448	ICU Stay but Care Type not Acute
526	ICU Hrs, no approved ICU or NICU

Related items Section 2: Intensive Care Unit

Section 3:

Duration of Mechanical Ventilation in ICU

Administration

Purpose To facilitate a co-payment on specified DRGs.

Principal data users Department of Health and Human Services

Collection start 1996-97

Definition source DHHS

DVA ID / TAC Claim Number (Where Account Class is V- *DVA*)

Specification

Definition The Department of Veterans' Affairs file number of the person.

Field size 9 **Layout** AAAANNNX or AAAANNNXA

Location DVA and TAC Record (Shared field DVA ID/TAC Claim Number)

Reported by Public hospitals

Reported for Episodes with an Account Class of DVA (V-).

Reported when The Episode Record is reported.

Code set Obtained from the DVA card, held by those eligible for DVA benefits.

Reporting guide

Layout:

Part 1	State identifier. Valid codes: Q, N, V, T, S or W. ACT is included in N (NSW) and NT with S (SA).
Part 2	War Group Code, (Alphanumeric characters) may be up to 3 characters
Part 3	Serial Number (numeric characters) may be 2 to 6 characters in length.
Part 4 (optional)	Spouse or Dependent Identifier, may be 1 character in length.

Valid format (see also above layout and following examples):

Only alphabetic and numeric characters and spaces are permitted

Alphabetic characters must be in uppercase

A maximum of six numeric characters is permitted

Trailing spaces (to the right) are permitted.

Spaces between characters are not permitted.

Note: VAED does not validate war codes but a list of codes is available at: http://www.health.vic.gov.au/hdss/reffiles/index.htm

Examples of permitted formats: N123456, VX123456, WXX123A, QXXX1B

If a DVA ID / TAC Claim Number that the hospital believes is correct cannot pass these validations, the hospital should refer the problem to their local DVA office.

Validations

180	DVA ID/TAC Claim Number Blank
181	DVA ID/TAC Claim Number Incorrect

Related items Section 3: Account Class.

Administration

Purpose To facilitate payment by DVA for DVA patients. This data is held separately to other VAED data to ensure that personal information remains confidential.

Principal data users Department of Veterans' Affairs

Collection start 1992-93

Definition source NHDD **Code set source** DVA

DVA ID / TAC Claim Number (Where Account Class is T- *TAC*)

Specification

Definition The Transport Accident Commission Claim Number of the person, relating to this hospital admission.

Field size 9 **Layout** YYXXXXX

Location DVA and TAC Record (Shared field DVA ID/TAC Claim Number)

Reported by Public hospitals.

Reported for Episodes with an Account Class of TAC (T-).

Reported when The Episode Record is reported.

Code set Obtained from the TAC, allocated to those eligible for TAC benefits.

C-U Claim number unavailable should be reported when the person's TAC claim number is not known by the hospital.

Reporting guide

Characters 1-2: Financial year of claim acceptance.

Characters 3-7: Numeric characters allocated by TAC.

Characters 8-9: Spaces

Examples of permitted formats: 9812345, 5412345

Hospitals wishing to obtain TAC Claim Numbers can contact TAC on: 1300 654 329 (Choose option 2: Service Provider to a TAC Customer).

Validations

180	DVA ID/TAC Claim Number Blank
181	DVA ID/TAC Claim Number Incorrect
445	Dt of Accid Incompat W TAC Claim Nbr – Fatal
446	Dt of Accid Imcompat W TAC Claim Nbr - Warning

Related items Section 3: Account Class and Date of Accident.

Administration

Purpose To facilitate payment by TAC for TAC patients.

This data is held separately to other VAED data to ensure that personal information remains confidential.

Principal data users Transport Accident Commission

Collection start 2002—03

Definition source TAC **Code set source** TAC

FIM Score on Admission (a)

FIM Score on Separation (b)

Specification

Definition FIM™ Score, as assessed on admission
FIM™ Score, as assessed on separation

Field size 18 **Layout** NNNNNNNNNNNNNNNNNN
Right justified with leading zeros.

Location Subacute Record

Reported by Public hospitals

Reported for Care Types 6 and 9
For Care Type P, report spaces.

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

Code set Report a score for each item i.e. 1 digit score (range 1-7) for 18 items:

FIM™ is comprised of 18 items, grouped into 2 subscales - motor and cognition

Item sequence	Motor subscale
1	Eating
2	Grooming
3	Bathing
4	Dressing Upper Body
5	Dressing Lower Body
6	Toileting
7	Bladder Management
8	Bowel Management
9	Transfers – Bed/Chair/Wheelchair
10	Transfers - Toilet
11	Transfers – Bath/Shower
12	Walk/Wheelchair
13	Stairs
	Cognitive subscale
14	Comprehension
15	Expression
16	Social Interaction
17	Problem Solving
18	Memory

Each item is scored on a 7 point ordinal scale

1 - Total assistance with helper

2 - Maximal assistance with helper

3 - Moderate assistance with helper

4 - Minimal assistance with helper

5 - Supervision or setup with helper

6 - Modified independence with no helper

7 - Complete independence with no helper

Reporting guide

Assessment of FIM™ Scores is required at admission and separation for all S5 Records (excluding Paediatric Rehabilitation Care Type P)

For statistical separations from episodes with Care Types 6 or 9 to episodes with Care Type 6 or 9 the Separation FIM™ of the prior episode may be repeated as the Admission FIM™ of the subsequent episode.

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

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

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

Validations

(a)	645	Invalid Admission FIM™
(b)	646	Invalid Separation FIM™
(a)	662	Adm FIM™ /Functional Assessment Date/Care Type mismatch
(b)	663	Sep FIM™ /Functional Assessment Date/Care Type mismatch
(b)	690	Sep FIM™ & Sep Mode Incompat
	691	Adm FIM™ > Sep FIM™

Related items

Section 3:

Functional Assessment Date on Admission

Functional Assessment Date on Separation

Section 4:

Care Type: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P)

Administration

Purpose

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

Principal data users

Department of Health and Human Services

Collection start

2009-10

Definition source

Department of Health

Code set source

FIM™

Functional Assessment Date on Admission (a)

Functional Assessment Date on Separation (b)

Specification

Definition Date of functional assessment for assignment of FIM™ Score on admission.

Date of functional assessment for assignment of FIM™ Score on separation

Field size 8 **Layout** DDMMYYYY

Location Subacute Record

Reported by Public hospitals.

Reported for Admitted episodes with Care Types 6, 9

For Care Types P report spaces.

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

Code set Valid Date

Reporting guide Reported when a FIM™ Score is reported, for Rehabilitation and GEM (Care Types 6 or 9).

(a) The Functional Assessment must be performed on or after the date of admission, but should be within 72 hours of admission.

(b) The Functional Assessment must be performed on or before the date of separation, but should be within 72 hours prior to separation.

Where a patient dies in hospital, the Functional Assessment Date on Separation may be reported as spaces.

For statistical separations from episodes with Care Types 6 or 9 to episodes with Care Types 6 or 9, Functional Assessment Date on Separation of the prior episode may be repeated as the Functional Assessment Date on Admission of the subsequent episode.

Validation of data is carried out on the S5 Sub-Acute record. If an E5 Episode record update is submitted with a Care Type change from 6 or 9 to Care Type 1, P, 8, 5x, 0, 4, U or 10 (which does not require Functional Assessment Date on Admission/Separation), the Subacute data will be deleted from the database and a warning edit to this effect will be triggered by the E5 Episode record.

Validations

(a)	618	Invalid Adm Functional Assessment Date
	622	Functional Assessment Date < 7 days before Adm Date
	624	Functional Assessment Date < Adm Date or > 7 days after Adm Date
	627	Care Type changed, Sub-Acute data deleted
(b)	619	Invalid Sep Functional Assessment Date
	625	Functional Assessment Date > 7 days after Sep Date
	626	Functional Assessment Date > Sep Date or < 3 days before Sep Date
	627	Care Type changed, Sub-Acute data deleted
	662	Adm FIM™/ Functional Assessment Date/Care Type mismatch
	663	Sep FIM™/ Functional Assessment Date/Care Type mismatch

Related items	Section 3: FIM™ Score on Admission FIM™ Score on Separation Section 4: Business Rules (tabular), Care Type: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P), and Care Type: Geriatric Evaluation and Management.

Administration

Purpose	To support annual reporting obligation under the Australian Health Care Agreement.
Principal data users	Department of Health and Human Services
Collection start	2006-07
Definition source	DHHS

Funding Arrangement

Specification

Definition

Identifies the specific funding arrangement, if any, which applies to this episode of care.

Field size 1 **Layout** N or space

Location

Episode Record

Reported by

- Any Victorian public and private hospital involved in contracted care arrangements with another hospital (purchasers and providers of contracted care).
- Any Victorian public and private hospital involved in hub and spoke arrangements with another hospital or satellite site.
- Any Victorian public or private hospital treating a patient identified as a Coordinated Care Trial patient.
- Any Victorian public hospital involved in the Rural Patients Initiative program.
- Any Victorian public hospital involved in the Elective Surgery Access Service program (ESAS).
- Any Victorian private hospital involved in the Public/Private Elective Surgery Initiative (PHESI).
- Any Victorian public or private hospital involved in the National Bowel Cancer Screening Program
- Any Victorian public hospital involved in the Healthlinks program

All other circumstances, report a space in this field.

Reported for

Episodes where an admitted service is provided under contract, hub and spoke, Coordinated Care Trial arrangements, Rural Patients Initiative, Elective Surgery Access Service (ESAS) or Private Hospital Elective Surgery Initiative or Healthlinks program

Otherwise, report a space in this field.

Reported when

The Episode Record is reported

Code set

Code	Descriptor
1	Contract
2	Hub and spoke
4	Coordinated Care Trial
5	Rural Patients Initiative
6	Elective Surgery Access Service
7	Private Hospital Elective Surgery Initiative
8	National Bowel Cancer Screening Program
9	Healthlinks program

Reporting guide

1 Contract

Patient receiving contracted hospital care under an agreement between a purchaser of hospital care (contractor) and a provider of an admitted or non-admitted service (contracted hospital).

2 Hub and Spoke

Patient receiving a specialist service at another hospital or satellite site (spoke)

under a hub and spoke arrangement. This hospital is the hub hospital. (Any service provided at a spoke hospital or satellite site is reported by the hub hospital only.)

4 Coordinated Care Trial

Patient identified as a Coordinated Care Trial patient.

5 Rural Patients Initiative

Admission under the Rural Patients Initiative. Use code 5 only if the public hospital has been allocated resources through the Rural Patients Initiative.

Private hospitals: Do not use code 5.

6 Elective Surgery Access Service (ESAS)

Admission under the Elective Surgery Access Service (ESAS). Use code 6 only if the public hospital has been allocated resources through the Elective Surgery Access Service.

Private hospitals: Do not use code 6.

7 Private Hospital Elective Surgery Initiative

Admission under the Public/Private Elective Surgery Initiative. Use code 7 only if approved by DH.

Public hospitals: Do not use code 7.

8 National Bowel Cancer Screening Program

Admission under the National Bowel Cancer Screening Program.

Use code 8 only if a designated provider.

9 Healthlinks Program

Admission under the Healthlinks program

Validations

108	Field(s) Missing From Sep
410	Illegal Comb Fund Arrang & Contract
416	Invalid Fund Arrangement
423	Invalid Comb Funding/Contract/Transfer
424	Not Separated: Fund Arr S/Be Spaces
456	Contract Leave, No Contract
477	Funding Arrangement 5, not approved for Rural Patients Initiative
478	Funding Arrangement 6, not approved for ESAS
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
626	Invalid combination for Funding Arrangement PHESI
635	NBCSP but Age < 50 Years
638	Private Hosp, Public Account Without Contract

Related items

Section 2: Contracted Care and Hub and Spoke.

Section 3: Contract Role and Contract Type.

Section 4: Business Rules (non-tabular) Contracted Care and Hub and Spoke.

Business Rules (tabular) Contracting: Contract Fields, Contract Leave and Funding Arrangement, and Contracting: Funding Arrangement and Contract Fields, and Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode, and Funding Arrangement: Elective Surgery Access Service, Funding Arrangement: Rural Patients Initiative and Funding Arrangement: Private Hospital Elective Surgery Initiative.

Administration

Purpose	To: Identify whether a specific funding arrangement applies to this episode. Facilitate health services planning and monitoring.		
Principal data users	Multiple internal and external data users.		
Collection start	1996-97		
Definition source	DHHS	**Code set source**	DHHS

Given Name(s)

Specification

Definition	The given name/s of the DVA or TAC patient.		
Field size	15	**Layout**	AXXXXXXXXXXXXXX
Location	DVA and TAC Record		
Reported by	Public hospitals.		
Reported for	Admitted episodes with an Account Class of V- *DVA* or T- *TAC*.		
Reported when	The Episode Record is reported.		
Code set	-		
Reporting guide	The given name/s of the patient. Permitted characters: A to Z (uppercase), space, apostrophe and hyphen The first character must be an alpha character.		
Validation	162 Invalid Given Name		
Related items	Section 3: Account Class and Surname		

Administration

Purpose	To facilitate payment by DVA and TAC for relevant episodes of care. This data is held separately to other VAED data to ensure that personal information remains confidential.		
Principal data users	Department of Veterans' Affairs and Transport Accident Commission.		
Collection start	1992-93		
Definition source	DHHS	**Code set source**	-

Hospital Generated DRG

Specification

Definition	The DRG generated by the in-house hospital grouper for this episode of care.		
Field size	4	**Layout**	ANNA or NNNA or spaces
Location	Diagnosis Record		
Reported by	Public and private hospitals - **optional.** Otherwise, report spaces in this field. Reporting in this field is recommended for hospital quality control, if the hospital has onsite grouping facilities.		
Reported for	Any/all admitted episodes of care. Otherwise, report spaces in this field.		
Reported when	The Separation Date is reported in the Episode Record		
Code set	AR-DRG or Vic DRG used by the hospital.		
Reporting guide	Report the AR-DRG or Vic DRG generated by the hospital for each episode. This field should be automatically reported for all episodes grouped by the hospital.		
Validation	334 Hosp Generated DRG Not = PRS2 DRG		
Related items	Section 2: DRG Classification.		

Administration

Purpose	To enable hospitals to detect differences between their grouping processes and those of the department		
Principal data users	Hospital Health Information Managers.		
Collection Start	1 July 1998	**Version**	
Definition source	Department of Health and Human Services	**Code set source**	Commonwealth Department of Health and Aged Care. Department of Health and Human Services, Victorian health policy and funding guidelines 2015-2016

Hospital Insurance Status

Specification

Definition The patient's hospital insurance status, regardless of whether they elect to be a public or private patient, or are a compensable or ineligible patient.

Field size 1 **Layout** N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Select the first appropriate category:

Code	Descriptor
2	Hospital Insurance
4	No Hospital Insurance
9	Hospital Insurance Status Unknown

Reporting guide Persons covered by insurance for benefits for ancillary services only are included in 4 *No Hospital Insurance*.

Do not assume that a mother's hospital insurance status will apply to her newborn baby. In particular, single insurance cover does not provide for a newborn baby of the policyholder.

Validation 044 Invalid Hospital Insurance Status Code

Related items

Administration

Purpose To monitor patterns of hospital insurance usage to inform health policy and planning.

Principal data users Department of Health and Human Services

Collection start 1990-91

Definition source DHHS **Code set source** DHHS

Impairment

Specification

Definition The impairment group according to the primary reason for the current episode of rehabilitation care.

Field size 6 **Layout** NNNNNN or spaces

Left justified, trailing spaces

Location Subacute Record

Reported by Public hospitals

Reported for Mandatory if Care type = 6 or P.
For Care Type 9, report spaces.

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

Code set

Code	Descriptor
	Stroke
	Haemorrhagic
0111	Left Body Involvement (Right Brain)
0112	Right Body Involvement (Left Brain)
0113	Bilateral Involvement
0114	No Paresis
0119	Other stroke
	Ischaemic
0121	Left Body Involvement (Right Brain)
0122	Right Body Involvement (Left Brain)
0123	Bilateral Involvement
0124	No Paresis
0129	Other stroke
	Brain Dysfunction
	Non-traumatic brain dysfunction
0211	Sub-arachnoid haemorrhage
0212	Anoxic brain damage
0213	Other non-traumatic brain dysfunction
	Traumatic brain dysfunction
0221	Open injury
0222	Closed injury
	Neurological Conditions
031	Multiple sclerosis
032	Parkinsonism
033	Polyneuropathy
034	Guillain-Barre Syndrome
035	Cerebral Palsy
038	Neuromuscular disorders (include motor neuron disease)
039	Other neurological disorders

Spinal Cord Dysfunction

Non-traumatic spinal cord dysfunction

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

Traumatic spinal cord dysfunction

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

Amputation of Limb

Not resulting from trauma

0511	Single Upper Amputation Above the Elbow
0512	Single Upper Amputation Below the Elbow
0513	Single Lower Amputation Above the Knee (includes through knee)
0514	Single Lower Amputation Below the Knee
0515	Double Lower Amputation Above the Knee (includes through knee)
0516	Double Lower Amputation Above/below the Knee
0517	Double Lower Amputation Below the Knee
0518	Partial Foot Amputation (includes single/double)
0519	Other Amputation

Resulting from trauma

0521	Single upper above elbow
0522	Single upper below elbow
0523	Single lower above knee (includes through knee)
0524	Single lower below knee
0525	Double lower above knee (includes through knee)
0526	Double lower above/below knee
0527	Double lower below knee
0528	Partial foot (single or double)
0529	Other amputation from trauma

Arthritis

061	Rheumatoid
062	Osteoarthritis
069	Other Arthritis

Pain Syndromes

071	Neck pain
072	Back pain
073	Extremity pain

074 Headache (includes migraine)
075 Multi-site pain
079 Other pain (includes abdominal/chest wall)

Orthopaedic Conditions

Fracture (includes dislocation)

08111 Fracture of hip, unilateral (includes #NOF)
08112 Fracture of hip, bilateral (includes #NOF)
0812 Fracture of shaft of femur (excludes femur involving knee joint)
0813 Fracture of pelvis
08141 Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
08142 Fracture of lower leg, ankle, foot
0815 Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
0816 Fracture of spine (excludes where the major disorder is pain)
0817 Fracture of multiple sites (multiple bones of same lower limb, both lower limbs, lower with upper limb, lower limb with rib or sternum
Excludes with brain injury or with spinal cord injury)
0819 Other orthopaedic fracture (includes jaw, face, rib, orbit or sites not elsewhere classified)

Post Orthopaedic Surgery (includes secondary to fracture or arthritis)

08211 Unilateral hip replacement
08212 Bilateral hip replacement
08221 Unilateral knee replacement
08222 Bilateral knee replacement
08231 Knee and hip replacement same side
08232 Knee and hip replacement different sides
0824 Shoulder replacement or repair
0825 Post spinal surgery (includes nerve root injury (laminectomy, spinal fusion, discectomy; excludes spinal cord injury or caudaequina)
0826 Other orthopaedic surgery

Soft tissue injury

083 Soft tissue injury

Cardiac

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

Pulmonary

101 Chronic Obstructive Pulmonary Disease
102 Lung Transplant
109 Other pulmonary

Burns

110 Burns

Congenital Deformities

121 Spina Bifida
129 Other congenital deformity

Other Disabling Impairments

131 Lymphoedema
133 Conversion disorder
139 Other disabling impairments that cannot be classified into a specific group (this group should be rarely used)

Major Multiple Trauma

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

Developmental Disabilities

151 Developmental disabilities (excludes cerebral palsy)

Re-Conditioning/Restorative

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

Reporting guide

Impairment codes should be assigned by the treating clinician. Code assignment must be supported by the appropriate ICD-10-AM codes reported in the X5/Y5 Diagnosis/Extra Diagnosis Records.

The Australian Rehabilitation Outcomes Centre (AROC) provides guidelines for coding Impairments:

http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow125260.pdf

Validations

253 Rehab Invalid Impairment
258 Sub-Acute: No Sub-Acute Record
293 Impairment Present

Related items

Section 2: Rehabilitation Care
Section 4: Care Type: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P), and Care Type: Geriatric Evaluation and Management

Administration

Purpose To classify rehabilitation episodes according to impairment group

Principal data users Department of Health and Human Services

Collection start 2009-10

Definition source DHHS

Code set source AROC impairment codes – v 4 dataset (July 2012)

Indigenous Status

Specification

Definition An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.

Field size 1 **Layout** N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set

Code	Descriptor
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
8	Question unable to be asked
9	Patient refused to answer

Reporting guide

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

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

- When the patient's medical condition prevents the question of Indigenous Status being asked; or
- In the case of an unaccompanied child who is too young to be asked their Indigenous Status.

Collect for every admitted episode

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

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

For further information refer to the *National best practice guidelines for collecting Indigenous status in health data sets* available on the AIHW website at: http://www.aihw.gov.au/guidelines-for-collecting-indigenous-status/

Validations

070	Invalid Indigenous Status
234	Aboriginal/Ts Island But Not Aust Born
393	Recip HCA Account, Indig Stat A Or TI

495	Incompat Sep Referral and Indigenous Status
513	Indigenous Status/Preferred Language Mismatch
629	Incompatible Adm Source/Indigenous Status

Related items Section 2: Country of Birth and Preferred Language.

Administration

Purpose To:

Enable planning and service delivery, and monitoring of indigenous health at state and national level

Facilitate application of specific funding arrangements.

Principal data users Department of Health and Human Services

Collection start 1987-88

Definition source NHDD

Code set source NHDD (DHHS modified)

Intended Duration of Stay

Specification

Definition The intention of the responsible clinician at the time of the patient's admission to hospital, to discharge the patient either on the day of admission or a subsequent date.

Field size 1 **Layout** N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set

Code	Descriptor
1	Intended same day
2	Intended overnight (or longer)

Reporting guide The intended duration of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital. This should not be altered after admission, regardless of the actual duration of the episode.

Validations

307	Invalid Intended Duration
308	Adm Crit O But Int'd Same Day
309	Adm Crit B & Int'd Overnight
310	Adm Crit C Int'd Overnight
311	Adm Crit N Int'd Same Day
312	Adm Crit U & Int'd Same Day

Administration

Purpose To provide clinical indicator data.

Principal data users Multiple internal and external data users

Collection start 1996-97

Definition source NHDD **Code set source** NHDD (DHHS modified)

Intention to Re-Admit

Specification

Definition The intention of the responsible clinician, at the time of the patient's separation from hospital, to re-admit the patient within 28 days.

Field size 1 **Layout** N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Separation Date is reported. Otherwise, report spaces.

Code set

Code	Descriptor
	Select the first appropriate category:
0	Not applicable
1	Re-admission planned to this hospital within 28 days *and* booking arranged
2	Re-admission planned to this hospital within 28 days *but no* booking yet arranged
3	Re-admission planned to another acute hospital within 28 days *and* booking arranged
4	Re-admission planned to another acute hospital within 28 days *but no* booking yet arranged
9	No plan to re-admit within 28 days

Reporting guide

For **statistical** separations, and for patients who have been transferred, died, or left against medical advice, code 0 (zero) indicates *not applicable*.

For **formal** separations, this information should be recorded by the patient's treating medical practitioner at the time of separation to indicate whether or not there is an *intention* on the part of the medical practitioner that the patient would be admitted within 28 days either to this hospital or to another acute hospital.

Intention to re-admit may be for treatment of a condition related to the one for which the patient was originally hospitalised *or for another reason*.

For Posthumous Organ Procurement episodes (Care Type 10), always assign code 0 Not applicable in this field.

0 Not applicable

Includes:

- Patient statistically separated (Separation Mode S).
- Died in hospital (Separation Mode D).
- Patient who left hospital at own risk against medical advice (Separation Mode Z).
- Patient transferred directly to another acute hospital, extended care, rehabilitation or geriatric centre (Separation Mode T), even though arrangements may have been made to re-admit the patient back to this

hospital.

- Posthumous Organ Procurement episodes (Separation Mode G)

Excludes:

- Patients who go to an aged care residential facility.
- Patients separated to a Transition Care bed based program

1, 2, 3 and 4 Re-admission planned

Includes:

- Patient whose re-admission is planned to this or another acute hospital within 28 days with or without a booking.
- Antenatal patient whose dates or medical condition indicate the birth could be within 28 days.

Excludes:

Separation Modes S, D, Z, T or G (use code 0 *Not applicable*).

9 No plan to re-admit within 28 days

Includes:

- Patient whose only plan is for an appointment for a *non-admitted* (outpatient) occasion of service.
- Patient whose medical practitioner has *no plan* to re-admit but expects the patient, of the patient's own accord, may re-present at this or another hospital within 28 days because of debility, habit or a chronic condition.

Excludes:

- Antenatal patient whose dates or medical condition indicate the birth could be within 28 days (classify to appropriate re-admission planned code).
- Separation Modes S, D, Z, T or G (use code 0 *Not applicable*).

Validations

191 Invalid Intention to Readmit
192 Invalid Comb Int. Readmit/Sep Mode
193 Not Separated – Intent Readmit

Related items

Section 3: Separation Mode.
Section 4: Business Rules (tabular) Intention to Readmit and Separation Mode

Administration

Purpose

To:

Calculate rate of unplanned readmissions.

Provide clinical indicator data.

Principal data users Multiple internal and external data users

Collection start 1996-97

Definition source DHHS

Code set source DHHS

Interpreter Required

Specification

Definition

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

Field size 1 **Layout** N or space

Location

Episode Record

Reported by

Public hospitals (voluntary for private hospitals).

Reported for

All admitted episodes of care.

Reported when

The Episode Record is reported.

Code set

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

Reporting guide

Preferred Language to be asked before Interpreter Required.

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

This data item must:

- Be checked for every admitted patient episode.
- Not be set up to input a default code on computer systems.
- Be collected on, or as soon as possible after, admission.

The standard question is:

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

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

1 Yes

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

2 No

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

Includes:
Where the Preferred Language is English.

9 Not Stated / Inadequately Described

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

Includes where Preferred Language is:

0002 *Not Stated* or

0000 *Inadequately described*.

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

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

Validations

517 Invalid Interpreter Required
592 Invalid Comb Int Req/Pref Lang

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

Administration

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

Principal data users Multiple internal and external data users

Collection start 2003-04

Definition source DHHS

Code set source DHHS

Leave with Permission Days Financial Year-to-Date

Specification

Definition The number of days during this episode of care that the patient was out of hospital 'on leave with permission' in the financial year being reported (includes the month being reported).

Field size 3 **Layout** NNN or spaces.
Right justified, zero filled.

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for Episodes where there was a period of leave with permission for the financial year-to-date.

Reported when The Episode Record is reported.

Code set A valid number complying with the business rules

Reporting guide Leave With Permission Days Financial Year-to-Date must be equal to or greater than Leave With Permission Days Month-to-Date and equal to or less than Leave With Permission Days Total.

Validations

047	Leave W Perm Days YTD Not Numeric or Blank
053	Leave W Perm YTD< MTD
055	Leave W Perm Tot<YTD
224	Newborn With Leave

Related items Section 2: Leave With Permission and Leave Without Permission.
Section 3: Leave with Permission Days Month-to-Date, and Leave with Permission Days Total.
Section 4: Business Rules (non-tabular) Leave

Administration

Purpose To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of leave days) against the difference between Admission Date and Separation Date.

Principal data users Automated PRS/2 processes

Collection start 1990-91

Definition source DHHS

Leave with Permission Days Month-to-Date

Specification

Definition The number of days during this episode of care that the patient was out of hospital 'on leave with permission' in the month being reported (month-to-date).

Field size 2 **Layout** NN or spaces.
Right justified, zero filled.

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for Episodes where there was a period of leave with permission for the month.

Reported when The Episode Record is reported.

Code set A valid number complying with the business rules.

Reporting guide Leave With Permission Days Month-to-Date must be equal to or less than Leave With Permission Days Financial Year-to-Date and Leave With Permission Days Total.

Validations

046	Leave W Perm Days MTD Not Numeric or Blank
053	Leave W Perm YTD< MTD
055	Leave W Perm Tot<YTD
224	Newborn With Leave

Related items Section 2: Leave With Permission and Leave Without Permission.

Section 3:

Leave with Permission Days Financial Year-to-Date, and Leave with Permission Days Total.

Section 4: Business Rules (non-tabular) Leave.

Administration

Purpose To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of leave days) against the difference between Admission Date and Separation Date.

Principal data users Automated PRS/2 processes.

Collection start 1990-91

Definition source DHHS

Leave with Permission Days Total

Specification

Definition The total number of days during this episode of care that the patient was out of hospital 'on leave with permission', including days from the previous financial year/s.

Field size 3 **Layout** NNN or spaces.
Right justified, zero filled.

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for Episodes where there was a period of leave with permission.

Reported when The Episode Record is reported.

Code set A valid number complying with the business rules.

Reporting guide Leave With Permission Days Total must be equal to or greater than Leave With Permission Days Month-to-Date and Leave With Permission Days Financial Year-to-Date.

Validations

049	Leave W Perm Days Tot Not Numeric or Blank
054	Leave W Perm Tot<MTD
055	Leave W Perm Tot< YTD
112	Calc Los + Leave Not = Adm/Sep
224	Newborn With Leave

Related items Section 2: Leave With Permission and Leave Without Permission.
Section 3:
Leave with Permission Days Financial Year-to-Date, and Leave with Permission Days Month-to-Date.
Section 4: Business Rules (non-tabular) Leave.

Administration

Purpose To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of normal leave days) against the difference between Admission Date and Separation Date.

Principal data users Automated PRS/2 processes.

Collection start DHHS

Definition source Department of Health

Leave without Permission Days Financial Year-to-Date

Specification

Definition The number of days during this episode of care that the patient was out of hospital 'on leave without permission' in the financial year being reported (includes the month being reported).

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

Right justified, zero filled.

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for Episodes where there was a period of leave without permission for the financial year-to-date.

Reported when The Episode Record is reported.

Code set A valid number complying with the business rules.

Reporting guide Leave Without Permission Days Financial Year-to-Date must be equal to or greater than Leave Without Permission Days Month-to-Date and equal to or less than Leave Without Permission Days Total.

Validations

224	Newborn With Leave
566	Leave W/O Perm Days YTD Not Numeric or Blank
568	Leave W/O Perm YTD< MTD
570	Leave W/O Perm Tot<YTD

Related items Section 2: Leave With Permission and Leave Without Permission.

Section 3: Leave Without Permission Days Month-to-Date and Leave Without Permission Days Total.

Section 4: Business Rules (non-tabular) Leave.

Administration

Purpose To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of leave days) against the difference between Admission Date and Separation Date.

Principal data users Automated PRS/2 processes.

Collection start 2003-04

Definition source DHHS

Leave without Permission Days Month-to-Date

Specification

Definition The number of days during this episode of care that the patient was out of hospital 'on leave without permission' in the month being reported (month-to-date).

Field size 2 **Layout** NN or spaces.
Right justified, zero filled.

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for Episodes where there was a period of leave without permission for the month.

Reported when The Episode Record is reported.

Code set A valid number complying with the business rules.

Reporting guide Leave Without Permission Days Month-to-Date must be equal to or less than Leave Without Permission Days Financial Year-to-Date and Leave Without Permission Days Total.

VAlidations

224	Newborn With Leave
565	Leave W/O Perm Days MTD Not Numeric or Blank
568	Leave W/O Perm YTD< MTD
569	Leave W/O Perm Tot < MTD

Related items
Section 2: Leave With Permission and Leave Without Permission.
Section 3: Leave Without Permission Days Financial Year-to-Date and Leave Without Permission Days Total.
Section 4: Business Rules (non-tabular) Leave.

Administration

Purpose To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of leave days) against the difference between Admission Date and Separation Date.

Principal data users Automated PRS/2 processes.

Collection start 2003-04

Definition source DHHS

Leave without Permission Days Total

Specification

Definition The total number of days during this episode of care that the patient was out of hospital 'on leave without permission', including days from the previous financial year/s.

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

Right justified, zero filled.

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for Episodes where there was a period of leave without permission.

Reported when The Episode Record is reported.

Code set A valid number complying with the business rules.

Reporting guide Leave Without Permission Days Total must be equal to or greater than Leave Without Permission Days Month-to-Date and Leave Without Permission Days Financial Year-to-Date.

Validations

112	Calc LOS + Leave Not = Adm/Sep
224	Newborn With Leave
567	Leave W/O Perm Days Tot Not Numeric or Blank
569	Leave W/O Perm Tot<MTD
570	Leave W/O Perm Tot< YTD

Related items Section 2: Leave With Permission and Leave Without Permission.

Section 3: Leave Without Permission Days Financial Year-to-Date and Leave Without Permission Days Month-to-Date.

Section 4: Business Rules (non-tabular) *Leave.*

Administration

Purpose To balance (for validation purposes) 'patient days' (patient's length of stay) (by the addition of leave days) against the difference between Admission Date and Separation Date.

Principal data users Automated PRS/2 processes.

Collection start 2003-04

Definition source DHHS

Locality

Specification

Definition Geographic location (suburb/town/locality for Australian residents, country for overseas residents) of usual residence of the person (not postal address).

Field size 22 **Layout** AAAAAAAAAAAAAAAAAAAAA
Left justified.

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Refer to the Postcode/Locality reference file available from:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Reporting guide Australia Post web-site listing of postcodes is available at: www.auspost.com.au

The DHHS file excludes non-residential postcodes listed in the Australia Post file. Common variations of locality spellings, as used in Melway references and the Australian Bureau of Statistics National Locality Index (Cat. No. 1252), are included in the DHHS file.

Locality must be blank if the Postcode is 1000 or 9988. Where the Postcode is 8888 (overseas), report the country the patient lives in, in Locality. The four digit country code must be one that corresponds with a code listed against 8888 (overseas) in the Postcode/Locality reference file.

Validations

058	Invalid Postcode/Locality
571	Acct Recip, Pcode Oseas, Locality Not RHCA
574	Postcode Overseas, Locality RHCA, Acct Not RHCA

Related items Section 3: Postcode

Administration

Purpose To enable calculation (with Postcode field) of the patient's appropriate Local Government Area (LGA) which enables:

- Analysis of service utilisation and need for services.
- Identification of patients living outside Victoria for purposes of cross-border funding.
- Identification of patients living outside Australia for the Reciprocal Health Care Agreement (RHCA).

Principal data users Automated PRS/2 processes. Multiple internal and external users.

Collection start 1990-91

Definition source DHHS **Code set source** ABS National Locality Index (Cat. No. 1252)(DHHS modified)

Marital Status

Specification

Definition Current marital status of the person.

Field size 1 **Layout** N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set

Code	Descriptor
1	Never married
2	Widowed
3	Divorced
4	Separated
5	Married
6	De facto
9	Not stated / inadequately described

Reporting guide Report the current marital status of the person.

Validation 034 Invalid Marital Status

Administration

Purpose To facilitate social and epidemiological studies.

Principal data users Multiple internal and external users.

Collection start 1979-80

Definition source NHDD **Code set source** CCDS

Medicare Number

Specification

Definition Personal identifier allocated by Medicare Australia to eligible persons under the Medicare scheme.

Field size 11 **Layout** NNNNNNNNNNN or spaces (all zeros are invalid).

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for Public hospitals: All patients except in the circumstances covered under Medicare Suffix.

Private hospitals: All contracted patients and for all other patients, where possible. The exceptions are covered under Medicare Suffix.

Reported when The Episode Record is reported.

Code set The patient's Medicare number and code, issued by Medicare Australia.

Reporting guide Valid:

- First character can only be a: 2, 3, 4, 5, or 6
- Numeric or all blanks
- Check digit (ninth character) is the remainder of the following equation: [(1st digit * 1) + (2nd digit * 3) + (3rd digit * 7) + (4th digit * 9) +(5th digit * 1) + (6th digit * 3) + (7th digit * 7) + (8th digit * 9)] / 10

Invalid:

- Special characters (for example, $, #)
- Alphabetic characters
- Zero-filled (if the Medicare number is not available or not applicable, the Medicare number must be left blank)

The Medicare number is printed in the centre on the Medicare card.

The Medicare code is also called the 'eleventh character' of the number.

It is the number printed to the left of the name of the patient.

Neonates

For neonates who have not yet been added to the family Medicare card, and therefore have no Medicare code, there are two reporting options:

- Mother's/family's Medicare number in the first ten characters and a zero (0) as the eleventh character
- Mother's/family's Medicare number in the first ten characters and the mother's code as the eleventh character.

Validations

030	Invalid Medicare number
518	Medicare Code = 0, Age > 6 Months
519	Medicare Code = 0, Age > 12 Months

Related items

Section 2: Asylum Seeker, and Medicare Eligibility Status – Eligible Person, and Medicare Eligibility Status – Ineligible Person.

Section 3: Medicare Suffix.

Administration

Purpose

To:

Assist in monitoring continuity of care across hospitals.

Ensure eligibility for publicly funded health care.

Principal data users

Department of Health and Human Services

Collection start

1979-80

Definition source

NHDD

Code set source

Medicare Australia

Medicare Suffix

Specification

Definition First three characters of patient's first given name (as it appears on the persons Medicare card).

Field size 3 **Layout** XXX or A-A

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set The first 3 characters of the patient's first given name.

Characters permitted:

- Upper case alphas
- Space as second and third characters
- Space as third character
- Hyphen or apostrophe as second character or hyphen or apostrophe as third character.

If Medicare number is unavailable or the patient is not eligible for a Medicare number, leave the Medicare number blank (not zero-filled) and enter the appropriate suffix:

Code	Descriptor
C-U	Card unavailable/Not applicable
N-E	Not eligible for Medicare
P-N	Prisoner

Reporting guide

RCHA

For patients with Account Class MA Reciprocal Health Care Agreement, report C-U

Unnamed neonate

For unnamed neonates where the family has a Medicare number, report a Medicare suffix of 'BAB'. The Medicare number issued to the mother/family must also be reported with

- A Medicare code ('eleventh character') of zero (0), OR
- The Medicare code of the mother.

Validations

031 Blank Medicare Suffix
032 Invalid Medicare Suffix
094 Comb A/C Accom Care Med Suff

Related items	Section 2: Asylum Seeker, and Medicare Eligibility Status – Eligible Person, and Medicare Eligibility Status – Ineligible Person. Section 3: Medicare number. Section 4: Business Rules (tabular) Account Class and Medicare Suffix

Administration

Purpose	To: Assist in monitoring continuity of care across hospitals. Ensure eligibility for publicly funded health care.	
Principal data users	Department of Health and Human Services	
Collection start	1979-80	
Definition source	DHHS	**Code set source**

Mental Health Legal Status

Specification

Definition

Whether a person is treated on an involuntary basis under the relevant State mental health legislation, at any time during an admitted episode of care.

Involuntary patients are persons who are detained in hospital under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

Field size 1 **Layout** N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

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

Code set

Code	Descriptor
1	Involuntary for all or part of this episode
2	Not involuntary at any time during this episode
9	Not applicable

Reporting guide

Private hospitals

Report code 9 Not applicable for all patients as private hospitals are not proclaimed to provide services for involuntary (compulsory) patients.

Public hospitals

Patients in Care Type 5x Approved Mental Health Service or Psychogeriatric Program in public hospitals whose care is funded by Mental Health Services:

- Report either code 1 Involuntary (compulsory) or code 2 Not involuntary (compulsory).
- Only hospitals with Approved Mental Health Services can report codes 1 or 2. Where a patient is treated under contract at such an Approved Mental Health Service (as Hospital B in a contracted service arrangement), only the contract service provider (Hospital B) should report codes 1 or 2; the contracting hospital (Hospital A) should report code 9 Not applicable for the contracted component of that episode.

Patients in Care Type 1 NHT/Non-Acute in public hospitals whose care is funded by Mental Health Services:

- Report code 9 Not applicable

Patients in all Care Types, other than Care Type 5x Approved Mental Health Service or Psychogeriatric Program, in public hospitals:

- Report code 9 Not applicable

Validations	108	Field(s) are Missing From Sep
	265	Mental Health Status - Not Separated
	266	Invalid Legal Status
	268	Inv Comb Legal, Status, Care & PFS
	334	Hospital Generated DRG Not = PRS/2 DRG
	491	Incompat Fields for ESAS
	492	Incompat Fields for RPI
	626	Invalid Combination for Funding Arrangement PHESI

Related items Section 4:

Business Rules (tabular) Care Type: Designated Rehabilitation Program (6), and Designated Paediatric Rehabilitation Program (P),and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative, and Funding Arrangement: Private Hospitals Elective Surgery Initiative.

Administration

Purpose To enable grouping into AR-DRGs.

Principal data users Automated PRS/2 processes.

Collection start 1996-97

Definition source NHDD

Meteor Identifier 534063

Code set source DHHS modified

Mental Health State Wide Patient Identifier

Specification

Definition The client identifier, unique to the client for approved Mental Health Service and Psychogeriatric Programs.

Field size 10 **Layout** NNNNNNNNNN or spaces

Right justified, zero filled.

Location Episode Record

Reported by All Victorian public hospitals with an approved Mental Health Service.

Private hospitals: Report spaces in this field.

Reported for All mental health admitted episodes of care (Care Type 5x) and Care Type 4 episodes in which an ECT has been performed.

Reported when The episode record is reported.

Code set ODS generated.

Reporting guide Report the primary Mental Health State-wide Patient Identifier for all mental health episodes of care (Care Types 5x) and episodes reported in which an ECT has been performed, and with an ACHI code in the range 93341-00 to 93341-99.

Validations

575	Care Type 5x, MHSWPI Blank
576	Invalid MHSWPI
577	MHSWPI not on ODS
578	MHSWPI Present, not Care Type 5x
579	MHSWPI Valid, no Matching DOB
580	MHSWPI Valid, no Matching Sex
581	MHSWPI Valid, Secondary on ODS
660	Care Type ≠ 5x, Procedure Code 93341-xx, MHSWPI mismatch

Related items

Administration

Purpose To enable management of clients and their associated data.

Principal data users Department of Health and Human Services

Collection start 2004-05

Definition source DHHS **Code set source** ODS generated

Mother's UR

Specification

Definition	The UR Number (Patient Identifier) of the mother of the baby.		
Field size	10	**Layout**	XXXXXXXXXX or spaces Right justified, zero filled.
Location	Episode Record		
Reported by	Victorian hospitals (public and private).		
Reported for	Public Hospitals: Newborn episodes where both mother and baby are admitted. Private hospitals: Newborn episodes where both mother and baby are admitted and the newborn episode is reported.		
Reported when	The Episode Record is reported.		
Code set	Valid Patient Identifier.		
Reporting guide	When the baby is born in hospital during this episode of care, report the Patient Identifier of the mother's episode of care. If the baby was not born during this episode of care, but both mother and baby are admitted to the hospital, report the Patient Identifier of the mother's episode of care.		
Validations	652 Invalid format Mother's UR 653 Mother's UR and Admission Source mismatch 654 Mother's UR does not exist		
Related items	Section 3: Patient Identifier		

Administration

Purpose	To enable analysis of the factors affecting the care of both the mother and baby.		
Principal data users	Internal and External data users.		
Collection start	2009-10		
Definition source	DHHS	**Code set source**	Hospitals

Onset Date

Specification

Definition Date of admission for the acute episode for care, relating to an injury or disease condition, for which the person has now been admitted for a subsequent rehabilitation episode of care.

Field size 8 **Layout** DDMMYYYY or spaces.

Location Subacute Record

Reported by Public hospitals.

Reported for Episodes with Care Type P or 6.

For Care Types 9, report spaces in this field.

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

Code set Valid date

Reporting guide Onset Date must be equal to or earlier than the Admission Date, and after the Date of Birth.

The Admission Date of the acute episode should be obtained from the acute hospital where the acute episode occurred.

If the patient is admitted to rehabilitation directly from the community, this field should match the date of admission in the Episode Record.

Validations

255	Rehab: Invalid Onset Date
258	Sub-Acute: No Sub-Acute Record
289	Adm Sc is T'fer & Onset = Adm Date
290	Stat Adm Sc & Onset = Adm Date
294	Onset Date Present

Related items Section 2: Rehabilitation Care.
Section 4: Business Rules (tabular)
Care Type: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P)

Administration

Purpose To enable measurement of the time elapsed since the initial acute episode, to support and further develop casemix classifications for sub-acute episodes.

Principal data users Department of Health and Human Services

Collection start 1995-96

Definition source DHHS

Patient Days Financial Year-to-Date

Specification

Definition	The number of patient days the person has accrued during the current financial year-to-date excluding leave with and without permission days (includes the month being reported). (Total of patient days recorded in each of the status segments.)		
Field size	3	**Layout**	NNN Right justified, zero filled.
Location	Status Segments of the Episode Record.		
Reported by	All Victorian hospitals (public and private).		
Reported for	All admitted episodes of care.		
Reported when	The Episode Record is reported.		
Code set	A number in the range 00 to 366		
Reporting guide	Patient Days includes Contracted Leave Days. Patient Days Financial Year-to-Date must be equal to or greater than Patient Days Month-to-Date and equal to or less than Patient Days Total.		

Validations

076	Not Sufficient Fields First Status
077	Not Sufficient Fields Other Status
087	Pt Days YTD Not Numeric Or Blank
091	Pt Days YTD <MTD
093	Pt Days Total< YTD

Related items

Section 2: Contracted Care and Patient Day.Contract Leave Days Month-to-Date, Contract Leave Days Total, Patient Days Month-to-Date , and Patient Days Total.
Section 4: Business Rules (non-tabular) Length of Stay.
Section 5: Status Segments.

Administration

Purpose	To enable hospitals to reconcile YTD days reported each month.
Principal data users	Automated PRS/2 processes
Collection start	1983-84
Definition source	DHHS

Patient Days Month-to-Date

Specification

Definition The number of patient days the person has accrued during the current month excluding leave with and without permission days, where current month refers to the month nominated by the Header start and end dates. (Total of patient days recorded in each of the status segments.)

Field size 2 **Layout** NN

Right justified, zero filled.

Location Status Segments of the Episode Record.

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set A number in the range 00 to 31

Reporting guide Patient Days includes Contracted Leave Days.

Patient Days Month-to-Date must be equal to or less than Patient Days Financial Year-to-Date and Patient Days total.

Validations

076	Not Sufficient Fields First Status
077	Not Sufficient Fields Other Status
086	Pt Days MTD Not Numeric Or Blank
091	Pt Days YTD<MTD
092	Pt Days Total<MTD

Related items Section2: Contract Care and Patient Day. Contract Leave Days Month-to-Date, Contract Leave Days Total, Patient Days Financial Year-to-Date, and Patient Days Total.

Section 4:

Business Rules (non-tabular) Length of Stay.
Section 5: Status Segments.

Administration

Purpose To enable hospitals to reconcile MTD days reported each month.

Principal data users Automated PRS/2 processes.

Collection start 1983-84

Definition source DHHS

Patient Days Total

Specification

Definition The total number of patient days the person has accrued during the whole episode of care to date excluding leave with and without permission days (includes the month being reported). (Total of patient days recorded in each of the status segments.)

Field size 4 **Layout** NNNN

Right justified, zero filled.

Location Status Segments of the Episode Record.

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set A number in the range 0001 to 9999

Reporting guide Patient Days includes Contracted Leave Days.

Patient Days Total must be equal to or greater than Patient Days Month-to-Date and Patient Days Financial Year-to- Date.

Validations

076	Not Sufficient Fields First Status
077	Not Sufficient Fields Other Status
089	Pt Days Tot < Not Numeric Or Blank
092	Pt Days Total < MTD
093	Pt Days Total <YTD
096	Total Days Can't Be Zero
112	Calc LOS + Leave Not = Adm /Sep
113	Same Day Status: Total Pt Days Not 1
243	Unqual Newborn But Total Days > 9
432	MAPU or SOU > 48 Hours

Related items Section 2: Contracted Care and Patient Day.Contract Leave Days Month-to-Date, Contract Leave Days Total, Patient Days Financial Year-to-Date, and Patient Days Month-to-Date.

Section 4: Business Rules (non-tabular) Length of Stay.
Section 5: Status Segments.

Administration

Purpose Major measure of resource use. Also identifies whether episode is:

- An inlier or outlier for the appropriate DRG.
- Same day or one day or multi day.

Principal data users Multiple internal and external users.

Collection start 1979-80

Definition source DHHS

Patient Identifier

Specification

Definition An identifier, unique to a patient within this hospital or campus (patient's record number/unit record number).

Field size 10 **Layout** XXXXXXXXXX
Right justified, zero filled.

Location
Episode Record
Sub-Acute Record
Palliative Record
DVA and TAC Record

Reported by Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record, Sub-Acute Record, Palliative Record or DVA and TAC Record are reported.

Code set Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

Reporting guide If multiple campuses transmit to PRS/2 in a single file, the Patient Identifier must be unique to the service. If the campuses transmit data separately to PRS/2, the Patient Identifier must be unique to each campus.

All newborns must have their own Patient Identifier. This cannot be the newborn's mother's Patient Identifier but could be the mother's Patient Identifier with a prefix or suffix.

Validations

026	Zero Sep; Existing Not Discharged
027	Adm Record; Overlaps Existing
028	Prior Adm; No Sep Date
029	Invalid Pt ID
062	Duplicate Pt ID, Adm Date Time, Diff Unique
063	Prior Not Discharged
064	Duplicate Pt ID, Date Time
248	Tran Pt ID Not Same As Episode Or Sub Ac
499	Stat Admission: No Prev Episode
510	Stat Sep Mode: No Subsequent Episode
531	Same UK, diff Pt ID
686	Tran Pt ID not same as Episode or Pall

Related items -

Administration

Purpose To enable relevant episodes to be updated and provide the potential for episodes to be linked across patient settings.

Principal data users Automated PRS/2 processes.

Collection start 1979-80

Definition source DHHS **Code set source** Hospitals

Phase of Care Change Date (a)

Final Phase of Care Start Date (b)

Specification

Definition

(a) The date of a change in the Phase of Care

(b) The date the final Phase of Care begins (where more than 10 changes of Phase of Care occur)

Field size 8 **Layout** DDMMYYYY

Location

Palliative Record

Reported by

Public hospitals.

Reported for

Care Type 8

Reported when

A Separation Date is reported in the Episode Record

Code set

A valid date

Reporting guide

After admission, when a change of Phase of Care occurs, a set of three data items must be reported:

- Phase of Care Change Date (a),
- Phase of Care on Phase Change, and
- RUG ADL on Phase Change.

Up to ten changes of Phase of Care can be reported: each time the Phase of Care changes, a new set of these three data items must be reported.

Phase changes are reported in sequence.

Note: Where more than ten changes of Phase of Care occur, all Phase changes after the tenth change are omitted and only details of the final Phase of Care are reported in the following fields:

- Final Phase of Care,
- Final Phase of Care Start Date (b) and
- RUG ADL on Start Final Phase of Care.

Validations

674	Phase of Care Change Date < Adm Date or > Sep Date
676	Phase of Care Change Dates not in sequence/repeated
679	Invalid Phase of Care Change Date
684	Not sufficient fields: Phase of Care change
698	Invalid Final Phase of Care
702	Not sufficient fields: Final Phase of Care
703	Final Phase of Care present but < 10 Change

Related items

Section 2: Phase of Care, Section 3: Care Type, Phase of Care, RUG ADL Score, Section 4: Palliative Care reporting, Section 5: Palliative Record

Administration

Purpose

To enable derivation of AN-SNAP classification.

Principal data users

Multiple internal and external data users

Collection start

2012

Definition source

Proposed Palliative Care NMDS (DHHS modified) PCOC v3 (draft)

Value Domain Source

Proposed Palliative Care NMDS (DHHS modified) PCOC v3 (draft)

Phase of Care on Admission (a)

Final Phase of Care (b)

Phase of Care on Phase Change (c)

Specification

Definition

(a) The Phase of Care at the start of the Palliative Care episode

(b) The last Phase of Care within the Palliative Care episode
(where more than 10 changes of Phase of Care occur)

(c) The new Phase of Care when a phase change occurs

Field size 1 **Layout** N

Location Palliative Record

Reported by Public hospitals

Reported for Care Type 8

Reported when A Separation Date is reported in the Episode Record

Code set

Code	Descriptor
1	Stable phase
2	Unstable phase
3	Deteriorating phase
4	Terminal phase

Reporting guide

Phase of Care on Admission (a) is reported as the Phase at the time of admission.

After admission, when a change of Phase of Care occurs, a set of three data items must be reported:

- Phase of Care Change Date;
- Phase of Care on Phase Change (c); and
- RUG ADL on Phase Change.

Up to ten changes of Phase of Care can be reported: each time the Phase of Care changes, a new set of these three data items must be reported.

Phase changes must be reported in sequence.

Note
Where more than ten changes of Phase of Care occur, all Phase changes after the tenth change are omitted and details of only the final Phase of Care are reported in the following fields:

- Final Phase of Care (b),
- Final Phase of Care Start Date, and
- RUG ADL on Start Final Phase of Care.

1 - Stable phase

All patients not classified as unstable, deteriorating or terminal.

The patient's/client's symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned.

The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

2 - Unstable phase

The patient/client experiences the development of a new unexpected problem or a rapid increase in the severity of existing problems, either of which requires an urgent change in management or emergency treatment.

The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.

3 - Deteriorating phase

The patient/client experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.

The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the patient. This requires a planned support program and counselling as necessary.

4 - Terminal phase

Death of patient/client with life-limiting illness is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

- Profoundly weak
- Essentially bed bound
- Drowsy for extended periods
- Disoriented for time and has a severely limited attention span
- Increasingly disinterested in food and drink
- Finding it difficult to swallow medication

This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues.

The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

Validations

677	Invalid Phase of Care on Admission
678	Phase of Care on Phase Change same as previous
684	Not sufficient fields: Phase of Care change
687	Palliative Care: No Palliative
698	Invalid Final Phase of Care
699	Invalid Phase of Care on Phase Change
700	Palliative Record: Phase of Care on Adm Blank
702	Not sufficient fields: Final Phase of Care
703	Final Phase of Care present but < 10 Changes

Related items

Section 2: Phase of Care

Section 3: Care Type, Phase of Care Change Date, RUG ADL Score

Section 4: Palliative Care reporting

Section 5: Palliative Record

Administration

Purpose To enable derivation of AN-SNAP classification.

Principal data users Multiple internal and external data users.

Collection start 2012

Definition source	Proposed Palliative Care NMDS (DHHS modified) PCOC v3 (modified)	**Value Domain** **Source**	Proposed Palliative Care NMDS (DHHS modified) PCOC v3 (modified)

Postcode

Specification

Definition Postcode or locality in which the person usually resides (not postal address).

Field size 4 **Layout** NNNN

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Refer to the Postcode/Locality reference file available from:

http://www.health.vic.gov.au/hdss/reffiles/index.htm

Other codes for use in this field:

Code	Descriptor
1000	No fixed abode
8888	Overseas (Report the four digit country code in the Locality field.)
9988	Unknown

Reporting guide The Australia Post listing of postcodes and localities is available from:
www.auspost.com.au
From the Australia Post list, non-residential postcodes are excluded and common variations of locality spellings, as used in Melway references and the Australian Bureau of Statistics National Locality Index (Cat. No. 1252), are included.

The hospital may collect the patient's postal address for its own purposes. However, for transmission to PRS/2, the Postcode must represent the patient's residential address. PRS/2 will reject non-residential Postcodes (such as mail delivery centres).

For newborns, use the postcode of mother's residential address.

Locality must be blank if the Postcode is 1000 or 9988. Where the Postcode is 8888 (overseas), report the country the patient lives in, in Locality. The four digit country code must be one that corresponds with a code listed against 8888 (overseas) in the Postcode/Locality reference file.

Validations

058	Invalid Postcode/Locality
391	Recip HCA Account, Not O/Seas P/Code
571	Acct Recip, Pcode Oseas, Locality Not RHCA
572	Postcode Overseas, Account Not Recip, or Inelig
573	Postcode Overseas, Account Public
574	Postcode Overseas, Locality RHCA, Acct Not RHCA

Related items Section 3: Locality

Administration

Purpose

- Used for calculation (with Locality field) of the patient's appropriate Local Government Area (LGA) to:
- Analyse service utilisation and need for services.
- Identify patients living outside Victoria for purposes of cross-border funding.
- Identify patients living outside Australia for the Reciprocal Health Care Agreement (RHCA).

Principal data users Multiple internal and external users.

Collection start 1979-80

Definition source DHHS

Code set source Australia Post (DHHS modified)

Preferred Language

Specification

Definition The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.

Field size 4 **Layout** NNNN or spaces

Location Episode Record

Reported by Public hospitals (voluntary for private hospitals).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Refer to Preferred Language ACSL Code set effective 1 July 2012 available on the HDSS website at http://www.health.vic.gov.au/hdss/reffiles/index.htm

Reporting guide This information must:

- Be checked for every admitted patient episode.
- Not be set up to a default code on computer systems.
- Be collected on, or as soon as possible after, admission.

The standard question is:
What is [your] [the person's] preferred language?

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

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

8000 Australian Indigenous languages, NEC

Includes:

All Australian Indigenous languages not shown separately on the code list.

0002 Not Stated

Includes:

- Patients who are not able to respond to this question at any time during their hospital stay.
- Child unaccompanied by an adult, who is too young to identify preferred language in relation to the ability to consent.
- This question on the form was not filled in, or filled in correctly and cannot be verified throughout the admission.

Validations	511	Invalid Preferred Language
	513	Indigenous Status/Preferred Language Mismatch
	514	Language is Unspecified
	592	Invalid Comb Int Req/Pref Lang

Related items Section 3: Country of Birth, Indigenous Status, and Interpreter Required.

Administration

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

Principal data users Department of Health and Human Services

Collection start 2003-04

Definition source NHDD

Code set source ABS Australian Standard Classification of Languages (ASCL), 2011 version

Procedure Start Date Time

Specification

Definition Date and Time at which a procedure commenced for an admitted patient.

Field size 12 **Layout** DDMMYYYYHHMM or spaces

Location Diagnosis Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care where a procedure occurring in an operating room or a cardiac catheter laboratory or involving a scope is recorded as the first coded procedure.

(Note: Time of procedure is optional and may be reported as spaces, e.g. '01082015 ').

Reported when The Diagnosis Record is reported.

Code set Valid date time.

Reporting guide Procedure Start Date time should be reported for an episode where the first coded procedure is one identified in the ICD-10-AM/ACHI Library file for the current year as requiring the procedure start date time:

[On Library file: column K, Coding practices, code 4]

The Library file is available from HDSS help desk

- The procedure is deemed to have commenced when:
- The first incision is made for a surgical procedure.
- The instrument is inserted for procedures in a cardiac catheter laboratory or those involving the use of a scope.

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

Validations

655	Invalid Procedure Start DateTime
656	Proc Start DateTime < Adm Date or > Sep Date
657	Proc Start DateTime and Valid Proc Mismatch

Related items Section 3 Procedure codes

Administration

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

Principal data users Department of Health and Human Services

Collection start 2009-10

Definition source DHHS

Procedure Codes

Specification

Definition	Up to 40 ACHI codes reflecting the interventions used for the diagnosis and/or treatment of ill health during this episode of care.		
Data type	Alphanumeric	**Form**	Code
Field size	8 (x 40)	**Layout**	NNNNNNN 8th character - A or space. Left justified, trailing spaces.
Location	Diagnosis Record (12) Extra Diagnosis Record (28)		
Reported by	All Victorian hospitals (public and private).		
Reported for	All admitted episodes of care.		
Reported when	A Separation Date is reported in the Episode Record.		
Code set	DHHS ICD-10-AM/ACHI/ACS Library File is available from HDSS help desk Where no procedures were performed, report spaces.		
Reporting guide	Character 1-7 must contain a numeric code of seven characters. Character 8 must be F, N or space. Report procedures undertaken during this episode of care in accordance with the Australian Coding Standards Eighth Edition and the Victorian Additions to Australian Coding Standards. The Victorian Additions to Australian Coding Standards are available at: http://www.health.vic.gov.au/hdss/healthclassifications/vic-additions-acs.htm Omit punctuation as shown in ACHI books (no dash in codes); for example, ACHI procedure code 40903-00 *Neuro-endoscopy* must be entered 4090300. Do not transmit Block numbers. **Procedures performed under contract at another agency** Procedures performed at another hospital under contract to this hospital are recorded by both hospitals (where the episode is admitted by both hospitals), but flagged in the contracting hospital only, by use of a flag in the eighth character allocated for each procedure code. 'F' indicating the procedure was performed at another hospital on an admitted basis. 'N' indicating the procedure was performed at another hospital on a non-admitted basis.		

Validations

127	Nil Value DRG
160	AR-DRG Grouper GST Code>Zero
195	Blank X5
197	Embedded Blank Diag Oper
320	MV Duration But No Procedure Code
334	Hosp Generated DRG Not = PRS/2 DRG
351	Illegal Code Format
352	Code Not found On Code File
353	Code & Age Incompatible
354	Code & Sex Incompatible
358	Area Code Restraint
408	Contract Role 'A' W/Out Proc Flag
409	Proc Flag W/out Contract Role 'A'
428	X5 Upd not Accompanied by Y5 Upd
450	Code Incompatible W Female Sex
451	Code Incompat W Male Sex
596	Same Day ECT: Not in Care Type 4
600	Invalid Code
641	MV Hours with Incorrect Procedure Code
644	NIV Hours with Incorrect Procedure Code

Related items

Section 2: Contracted Care, DRG Classification and Procedure.

Section 3:

Hospital Generated DRG.

Section 4: Business Rules (non-tabular) Contracted Care.

Administration

Purpose

To facilitate:

Epidemiological studies and other research.

Grouping for casemix purposes.

Principal data users

Multiple internal and external data users.

Collection start

1979-80

Definition source

DHHS

Code set source

ACHI

Program Identifier

Specification

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

Field size 2 Layout NN or space

Location Episode Record

Reported by Public and Private Hospitals

Reported for Episodes for patients admitted under a specified DHHS program.
Otherwise, report a space in this field.

Reported when An Episode Record is transmitted.

Code set

Code	Descriptor
05	Home Birthing Program
06	Competitive Elective Surgery Funding Initiative (CESFI)
07	Program Identifier A
08	Program Identifier B
09	Specialist ABI Rehabilitation Service

Reporting guide Report the corresponding code for the program when advised to do so by the Department of Health unit responsible for administration of the program.

05 Home Birthing Program

Patient identified as a Home Birthing Program patient as approved by DH. Use code 05 for both mother and baby episodes.

06 Competitive Elective Surgery Funding Initiative (CESFI)

Patient identified as a CESFI patient, as approved by DH. Use code 06 only with Care Type 4.

09 Specialist ABI Rehabilitation Service

Patient admitted to centre providing statewide specialist Acquired Brain Injury (ABI) rehabilitation for Victorians with severe/catastrophic ABI.

Validations

648	Invalid Program Identifier
649	Program Identifier Care Type Mismatch
651	Program Identifier, campus not approved for program

Administration

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

Principal data users Multiple internal and external data users.

Collection start 2009-10

Definition source DHHS **Code set source** DHHS

Qualification Status

Specification

Definition Qualification status indicates whether each patient day within a newborn episode of care is either qualified or unqualified.

Field size 1 **Layout** A

Location Status Segments of the Episode Record

Reported by All Victorian hospitals (public and private)

Reported for All admitted episodes of care

Reported when The Episode Record is reported.

Code set

Code	Descriptor
N	Qualified newborn
U	Unqualified newborn
X	Not applicable

Reporting guide

Status Segments are used to record changes between Qualified and Unqualified status for newborns and the duration of these periods (Patient Days).

The patient's Qualification Status 'as of midnight' should be reported to VAED. If the Qualification Status changes more than once during the day, report the last Qualification Status before midnight.

Note: In order to meet criteria to be a 'Qualified Newborn' during a period of accommodation in HITH, a newborn must be 'the second or subsequent live born of a multiple birth'.

For all other admitted patients, a single Qualification Status code (X) is recorded; indicating newborn qualification status is not relevant to this patient.

Qualification Status is not relevant in episodes for posthumous organ procurement (Care Type 10), including where the donor is under 10 days of age: report code X *Not applicable*.

N Qualified newborn

A newborn who, for the patient days being recorded in this Status Segment, meets at least one of the following criteria:

- Admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the provision of special care in designated Neonatal Intensive Care Units (NICUs) and designated Special Care Nurseries (SCNs), or
- Is the second or subsequent live born of a multiple birth, or
- Remains in hospital after their mother is separated from hospital, or is admitted to hospital without their mother.

U Unqualified newborn

A newborn who, for the patient days being recorded in this Status Segment, does not meet any of the criteria for 'Qualified Newborn'.

	X	**Not applicable**
	An admitted patient other than a newborn	

Validations

076	Not Sufficient Fields First Status
077	Not Sufficient Other Status
098	Invalid Qual Type
224	Newborn With Leave
241	Illegal Qual Stat Combination N &X
242	Illegal Qual Stat Combination U &X
243	Unqual Newborn But Total Days > 9
260	Invalid Care For Qual
403	Qual Newborn W/Out Justificat
434	NICU/SCN Accom But Unqual Newborn
483	Incompat Adm Source/Qual Stat
485	Incompat Adm Type/Qual Stat
487	Incompat Age/Qual Stat/Care Type
490	Incompat Crit For Adm/Qual Stat
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
626	Invalid Combination for Funding Arrangement PHESI
642	Unqualified Newborn but Separation Mode D

Related items

Section 2: Newborn, Qualification (Newborn)
Section 3: Care Type
Section 4:
Business Rules (non-tabular) Newborn Reporting
Business Rules (tabular) Admission Source and Qualification Status, and Admission Type and Qualification Status, and Age Qualification Status and Care Type, and Criterion for Admission and Qualification Status, and Newborns: Criteria for Admission, Qualification Status, Care Type
Section 5: Status Segments

Administration

Purpose

To enable removal of unqualified newborn days, and episodes where the newborn is unqualified for the entire length of stay, to satisfy reporting requirements under the AHCA.

Principal data users

Australian Institute of Health & Welfare

Collection start

1995-96

Definition source

NHDD

Code set source

DHHS

RUG ADL on Admission (a)

RUG ADL on Separation (b)

RUG ADL on Phase Change (c)

RUG ADL on start Final Phase of Care (d)

Specification

Definition

RUG ADL (Resource Utilisation Group Activities of Daily Living):
(a) As assessed on admission.
(b) As assessed on separation.
(c) As assessed at the start of a new Phase of Care (up to 10 changes)
(d) As assessed at the start of the Final Phase of Care (where more than 10 changes of Phase of Care occur)

Field size 2 **Layout** NN or spaces
Right justify, leading zeros.

Location Palliative Record

Reported by Public hospitals.

Reported for

Episodes with Care Type 8 Palliative Care and MC Maintenance Care

RUG ADL on Admission (a) – Care Types 8, MC
RUG ADL on Separation (b) – Care Types 8, MC
RUG ADL on Phase Change (c) – Care Type 8
RUG ADL on start Final Phase of Care (d) – Care Type 8

Reported when

A Separation Date is reported in the Episode Record.

Note
RUG ADL on start Final Phase of Care (d) – field is only used when more than 10 changes of Phase of Care occur.

Code set

(a), (c), (d) 04 to18 (RUG ADL score from assessment)

(b) 04 to 18 (RUG ADL score from assessment)
00 No assessment - person died

Reporting guide

Record what the person actually does, not what they are capable of doing; that is, record the lowest performance of the assessment period.

On the score sheet, do not leave any spaces blank. It is essential that each data collector knows what behaviours and/or tasks are contained within each item and have a 'working knowledge' of the scale.

RUG ADL must be reported each time a patient enters a new Phase of Care in their palliative care episode.

If the person dies in hospital, record a score of 00 for the RUG ADL on Separation.

RUG Item	Score	Definition
Bed Mobility		Ability to move in bed after the transfer into bed has been completed.
Independent supervision	1	Able to readjust position in bed, and perform own pressure area relief, through spontaneous movement around bed or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.
Limited assistance	3	Able to readjust position in bed, and perform own pressure area relief, with the assistance of one person.
Other than two persons	4	Requires the use of a hoist or other assistive device to readjust position in bed and provide pressure relief. Still requires the assistance of one person for task.
Two or more persons physical assist	5	Requires 2 or more assistants to readjust position in bed, and perform pressure area relief.
Toileting		Includes mobilising to the toilet, adjustment of clothing before and after toileting and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes. If level of assistance differs between voiding and bowel movement, record the lower performance.
Independent/ supervision	1	Able to mobilise to toilet, adjusts clothing, cleans self, adjusts clothing, and has no incontinence or soiling of clothing. All tasks are performed independently or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.
Limited assistance	3	Requires hands-on assistance of one person for one or more of the tasks.
Other than two persons physical assist	4	Requires the use of a catheter/uridome/urinal and/or colostomy/bedpan/commode chair and/or insertion of enema/ suppository. Requires assistance of one person for management of the device.
Two or more persons physical assist	5	Requires two or more assistants to perform any step of the task.
Transfer		Includes the transfer in and out of bed, bed to chair, in and out of shower/tub. Record the lowest performance of the day/night.
Independent/ supervision	1	Able to perform all transfers independently or with prompting of carer. No hands-on assistance required. May be independent with the use of a device.
Limited assistance	3	Requires hands-on assistance of one person to perform any transfer of the day/night.
Other than two persons physical assist	4	Requires use of a device for any of the transfers performed in the day/night. Requires only one person plus a device to perform the task.
Two or more persons physical assist	5	Requires 2 or more assistants to perform any transfer of the day/night.
Eating		Includes the tasks of cutting food, bringing food to mouth and chewing and swallowing food. Does not include preparation of the meal.

RUG Item	Score	Definition
Independent/ supervision	1	Able to cut, chew and swallow food, independently or with supervision, once meal has been presented in the customary fashion. No hands-on assistance required. If individual relies on parenteral or gastrostomy feeding that he/she administers him/herself then Score 1.
Limited assistance	2	Requires hands on assistance of one person to set up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet).
Extensive assistance/ total dependence/ tube fed	3	Person needs to be fed meal by assistant, or the individual does not eat or drink full meals by mouth but relies on parenteral/ gastrostomy feeding and does not administer feeds by him/herself.
TOTAL		(Score out of 18)

Validations

(a)	680	Palliative Record: Adm RUG ADL Blank or Invalid Range
(b)	297	Sep RUG ADL & Sep Mode Incompatible
	681	Palliative Record: Sep RUG ADL Blank or Invalid Range
(c)	682	Palliative Record: Invalid RUG ADL on Phase Change
(d)	682	Palliative Record: Invalid RUG ADL on Phase Change

Related items

Section 2: Palliative Care, Maintenance Care
Section 4: Business Rules (non-tabular) Palliative Care Reporting
Section 5: Palliative Record

Administration

Purpose

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

Principal data users

Department of Health and Human Services

Collection start

1996-97

Definition source

DHHS

Code set source

RUG ADL

Separation Date

Specification

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

Field size 8 **Layout** DDMMYYYY

Location Episode Record
DVA and TAC Record

Reported by All Victorian hospitals (public and private)

Reported for All admitted episodes of care

Reported when The episode of care is completed

Code set A valid date

Reporting guide The Separation Date must be on or after the Admission Date.

If no other separation details are submitted (patient not yet separated), zero-filled Separation Date is accepted.

The Separation Date may relate to a formal or statistical separation.

Statistical Separations

Statistical Separation must have a Separation Date equalling the next episode's Admission Date. Statistical separations and admissions cannot occur over midnight.

Validations

026	Zero Sep; Existing not Discharged
027	Adm Record; Overlaps Existing
028	Prior Adm; No Sep Date
063	Prior Not Discharged
065	Original Deleted Upd Sep < Cutoff
066	Sep Date Prior to Cutoff Date
101	Invalid Sep Date
102	Sep Date < Adm Date
108	Field(s) are missing From Sep
112	Calc Los +Leave Not = Adm/Sep
115	Adm Time Not < Sep Time
119	Sep Time - No Sep Date
122	Sameday Adm Source/ Sep Mode Mismatch
127	Nil Value DRG
160	AR-DRG Grouper GST Code > Code
179	Trans Sep Not Same As Episode
193	Not Separated – Intent Readmit
196	X5 Record Epis. Not Separated
258	Sub – Acute: No Sub Acute Record
259	Invalid Rehab/Subac – Episode Sep Date
265	Mental Health Status - Not Separated
322	ICU/CCU Stay > Total Stay
323	MV Duration > Total Stay
352	Code Not Found On Code File

388	Sep Referral - Episode Not Separated
421	Not Separated; Carer Avail Present
424	Not Separated: Fund Arr S/Be Spaces
438	NIV Duration >Total Stay
461	ACAS Status not Required
465	Adm Duration < 15 Mins
467	Adm Wt <1000g, LOS <28 Days, Sep Mode ≠ T or D
468	Care Type ≠ 1 or F, LOS >365 Days
504	Stat Episode: Next Episode > 1 Minute Apart
505	Stat Episode: Previous Episode > 1 Minute Apart
533	ACAS Status Code Required
593	Invalid Sep Date; > Header
596	Same Day ECT: Not in Care Type 4
598	Same Day Rehabilitation: Not in Scope

Related items Section 2: Length of Stay, Overnight or Multi-day Stay Patient, and Same Day Patient.
Section 4: Business Rules (non-tabular) Length of Stay.

Administration

Purpose To enable validation of patient days and to enable an episode of care to be placed into month and year of separation:
For counting purposes.
To check codes in the record against the valid codes for that year.

Principal data users Automated PRS/2 processes.

Collection start 1979-80

Definition source NHDD

Separation Mode

Specification

Definition Status at separation of the person, and place to which the person is released (where applicable)

Field size 1 **Layout** A

Location Episode Record

Reported by All Victorian hospitals (public and private)

Reported for All admitted episodes of care

Reported when A Separation Date is reported in the Episode Record

Code set **Select the first appropriate category:**

Code	Descriptor
G	Posthumous Organ Procurement
S	Statistical Separation (change in Care Type within this hospital)
D	Death
Z	Left against medical advice
T	Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre
B	Separation and transfer to Transition Care bed based program
A	Separation and transfer to mental health residential facility
N	Separation and transfer to aged care residential facility
H	Separation to private residence/accommodation

G Posthumous Organ Procurement

Assign this code for posthumous organ procurement episodes (Care Type 10) only.

Excludes:

A patient who has died in hospital (use code D).

Reporting guide

S Statistical Separation (change in Care Type within this hospital campus)

Assign this code when a new episode of care (change in Care Type) occurs within the same hospital stay.

Excludes:

- Change to Alcohol and Drug Program Care Type following another episode of care (for public hospitals).
- Change from or to Unqualified newborn (Care Type U) as a Statistical Separation or a Statistical Admission. Changes between Qualified and Unqualified status of newborns are recorded in Status Segments using the Qualification Status field. Refer to Section 2: *Newborns*.

D Death

Died in hospital

Z Left against medical advice

Patient absconds or leaves against medical advice, at own risk. This Separation Mode is significant in the allocation of some DRGs.

Includes:

Newborns taken from the hospital against medical advice.

T Separation and transfer to other acute hospital / extended care / rehabilitation / geriatric centre

Separation and transfer to another hospital, regardless of whether the patient is to be admitted at the receiving hospital. Requires a Transfer Destination code.

Includes:

- Unqualified newborn being transferred to another hospital.
- Public and private acute, extended care and mental health admitted patient units.

Excludes:

- Transition Care bed based program (use code B).
- Aged care residential facilities (use code N).
- Mental health residential units (use code A).

B Separation and transfer to Transition Care bed based program

Separation and transfer directly to a Transition Care bed based program. Does not require a Transfer Destination code.

Excludes:

Home-based Transition Care (use code H and Separation Referral Code T).

A Separation and transfer to mental health residential facility

Separation and transfer to mental health residential facility (includes psychogeriatric nursing home and community care unit) funded by Mental Health Services. Does not require a Transfer Destination code.

Includes:

- Patient returning to the mental health residential facility in which they live.
- Mental health aged care residential facility.

Excludes:

Mental health admitted patient units (use code T).

N Separation and transfer to aged care residential facility

Separation and transfer to an aged care residential facility (includes nursing home and hostel). Does not require a Transfer Destination code.

Includes:

Patient returning to the aged care residential facility in which they live.

Excludes:

- Transition Care bed based program (use code B).
- Mental health aged care residential facility (use code A).

H Separation to private residence/accommodation

Place of residence immediately following separation. Requires a Separation Referral code.

Includes:

- Home or home of relative or friend.
- Supported residential facilities.
- Special accommodation houses.
- Training centres for intellectually disabled persons.
- Prison.
- Forensic hospital (Thomas Embling)
- Juvenile detention centre.
- Armed forces base camp.
- Homeless (shelters, half way houses).
- A patient in Accommodation Type 4 in the Home (Hospital – HITH) in private accommodation or residential facility who, on separation, remains in the same private accommodation.
- Home-based Transition Care.

Excludes:

- Transition Care bed based program (use code B).
- Aged care residential facility (use code N).
- Mental health residential facility (use code A).

Validations

103 Invalid Sep Mode
108 Fields(s) Missing From Sep
109 Trans Dest Not Blank
110 Invalid Transfer Type
122 Sameday Adm Source/ Sep Mode Mismatch
127 Nil Value DRG
160 AR-DRG Grouper GST Code Zero
192 Invalid Comb Int. Readmit Sep Mode
297 Sep Rug ADL & Sep Mode Incompatible
328 Early Parenting Centre – Invalid Comb
334 Hosp Generated DRG Not = PRS/2 DRG
390 Incompat Care Type, Carer Avail, Age and Sep Mode
394 Sep Mode Home, No Sep Referral
395 Sep Mode Not Home, Sep Referral Present
397 Sep Referral Postnatal, Incompat Age/Sex
423 Invalid Comb Fund/ Contract /Transfer
467 Adm Wt <1000g, LOS < 28 Days, Sep Mode ≠ T or D
471 Care Type 5x, not usual Sep Referral
489 Incompat Care Type/Sep Mode Statistical
493 Incompat Sep Mode/Age <15
494 Incompat Sep Mode/Age <55
501 Stat Episode: Adm Source ≠ Sep Mode Prev Episode
502 Stat Episode: Care Type same as Next Episode
504 Stat Episode: Next Episode > 1 Minute Apart
506 Stat Episode: Rehab also in Next Episode
509 Stat Episode: Sep Mode ≠ Adm Source Next Episode
510 Stat Sep Mode: No Subsequent Episode
597 Mental Health Episode: Sep Mode = S

642 Unqualified Newborn but Separation Mode D
643 Maternity Episode but Separation Mode D
690 Sep FIM™ & Sep Mode Incompatible
696 Posthumous Organ Proc: Care Type/Sep Mode mismatch

Related items

Section 2: Admission, Admitted Patient, Episode of Admitted Patient Care, Geriatric Evaluation and Management Program, Hospital Stay, Nursing Home Type/Non-Acute care, Palliative Care, Rehabilitation Care and Transfer.

Section 3: Data Definitions, Transfer Source

Section 4: Business Rules (non-tabular) Episode of Care and Transfer Reporting

Section 4: Business Rules (tabular) Care Type and Separation Mode; Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode; Criterion for Admission: Secondary Family Member; Intention to Readmit and Separation Mode; Care Type: Posthumous Organ Procurement (10)

Administration

Purpose

To:
Distinguish between formal and statistical separations.
Study service patterns - Care Type changes, transfers.
Assist in the allocation of DRGs.

Principal data users Multiple internal and external data users.

Collection start 1979-80

Definition source NHDD **Code set source** DHHS

Mapping between Separation Mode and the Grouper Mode of Separation:

Separation Mode (VAED)		Mode of Separation (NHDD and Grouper)	
G	Posthumous Organ Procurement	9	Other (includes to usual residence)
D	Death	8	Died
Z	Left against medical advice	6	Left against medical advice
T	Separation and transfer to other acute hospital/ extended care/rehabilitation/geriatric centre	1	Discharge/transfer to an(other) acute hospital
B	Separation and transfer to Transition Care bed based program	4	Discharge/transfer to other health care accommodation
N	Separation and transfer to aged care residential facility	2	Discharge/transfer to a Residential Aged Care Service
A	Separation and transfer to mental health residential facility	4	Discharge/transfer to other health care accommodation
H	Separation to private residence/accommodation	9	Other (includes to usual residence)
S	Statistical separation (change in Care Type within this hospital)	5	Statistical discharge-type change

Separation Referral

Specification

Definition Clinical care and support services arranged by the hospital to meet the person's recuperative needs when discharged to private accommodation or home.

Field size 4 **Layout** AAAA or spaces
Left justified, trailing spaces.

Location Episode Record

Reported by Public hospitals.

Private hospitals – Optional. If the private hospital chooses not to report these data, report spaces in this field.

Reported for Episodes where the Separation Mode is H Separation to private residence/accommodation.

For all other Separation Modes, report spaces in this field.

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

Code set Select up to four options from list. Do not repeat codes. If more than four referrals have been made, select the first four listed:

Code	Descriptor
F	Domiciliary postnatal care, arranged before discharge
E	Domiciliary postnatal care, referral declined
H	Health Independence Program services, arranged before discharge
L	Alcohol and drug treatment service, arranged before discharge
B	Community palliative care support, arranged before discharge
U	Home nursing support, arranged before discharge
C	Mental health community services, arranged before discharge
S	Referral to private psychiatrist, arranged before discharge
D	Psychiatric disability support services, arranged before discharge
G	Referral to general practitioner, arranged before discharge
A	Referral to Aged Care Assessment Service (ACAS), arranged before discharge
K	Referral to Aboriginal and Torres Strait Islander (ATSI) service, arranged before discharge
T	Referral to Transition Care home based program, arranged before discharge
R	Other clinical care and/or support services, arranged before discharge
X	No referral or support services arranged before discharge

Reporting guide In arranging the referral of a patient to these services, the hospital would expect to receive confirmation from the referred provider of their preparedness to accept responsibility for delivering the required services to the patient upon discharge.

Unless a specific service has been arranged, or referral to domiciliary postnatal care specifically declined, use code X No referral or support services arranged before discharge.

F Domiciliary postnatal care, arranged before discharge

Mother discharged, with domiciliary postnatal care arranged before discharge to her own home or home of relative or friend or other private accommodation*. Domiciliary care includes that provided by the hospital and by home nursing services.

Code not for use for the baby's Separation Mode: unless a specific service (with another code) has been arranged for the baby, baby's code would be X No referral or support services arranged before discharge.

Excludes:

Referral to domiciliary postnatal care offered, but declined by patient (use code E)

E Domiciliary postnatal care, referral declined

Mother discharged. Mother offered referral to domiciliary postnatal care before discharge but declined referral. Domiciliary care includes that provided by the hospital, by home nursing services and by community services.

Code not for use for the baby's Separation Mode.

H Health Independence Program services, arranged before discharge

Referral to a health independence program (HIP), arranged before discharge

Includes:

Programs previously known as Post Acute Care, Hospital Admission Risk Program, Subacute Ambulatory Care Services and Residential In Reach

L Referral to alcohol and drug treatment service, arranged before discharge

Discharge, with referral to alcohol and drug treatment service, arranged before discharge to own home or home of relative or friend or other private accommodation*.

B Community palliative care support, arranged before discharge

Discharge, with community palliative care service support arranged before discharge to own home or home of relative or friend or other private accommodation*.

U Home nursing support, arranged before discharge

Discharge, with home nursing support arranged before discharge to own home or home of relative or friend or other private accommodation*. Home nursing support includes that provided by the hospital and by district nursing services.

C Mental health community services, arranged before discharge

Discharge, with mental health community services arranged before discharge to own home or home of relative or friend or other private accommodation*.

S Referral to private psychiatrist, arranged before discharge

Discharge, with referral to a private psychiatrist arranged before discharge to own home or home of relative or friend or other private accommodation*.

D Psychiatric disability support services, arranged before discharge

Discharge, with referral to psychiatric disability support services arranged before discharge to own home or home of relative or friend or other private accommodation*.

G Referral to general practitioner, arranged before discharge

Discharge, with referral to general practitioner arranged before discharge to own home or home of relative or friend or other private accommodation*.

A Referral to Aged Care Assessment Service (ACAS), arranged before discharge

Discharge, with referral to Aged Care Assessment Service (ACAS) arranged before discharge to own home or home of a relative or friend or other private accommodation.

K Referral to Aboriginal and Torres Strait Islander (ATSI) service, arranged before discharge

Discharge, with referral to an Aboriginal and Torres Strait Islander (ATSI) service arranged before discharge to own home or home of a relative or friend or other private accommodation*.

Includes:

- Services provided by the local Aboriginal co-operative
- Designated Koori HACC services
- Designated Koori Alcohol and Drug Services

T Referral to Transition Care home based program, arranged before discharge

Discharge, with referral to a Transition Care home based program arranged before discharge to own home or home of a relative or friend or other private accommodation*.

Excludes:

Bed-based Transition Care (use Separation Mode code B).

R Other clinical care and/or support services, arranged before discharge

Discharge, with other clinical care and support service arranged before discharge to own home or home of relative or friend or other private accommodation*.

Includes:

- Discharge to residential care facility if patient was admitted from a *less* supportive form of accommodation, such as a private home.
- Discharge of newborn to foster care.
- Any service not under the other values for this field (for example, outpatient appointment, specialist appointment, meals on wheels, home maintenance services, private community care and services, community health services, private allied health services, maternal and child health services).

X No referral or support services arranged before discharge

No referral or support services arranged before discharge to own home or home of relative or friend or other private accommodation*.

Notes:

*Private accommodation comprises:

Supported residential facilities, special accommodation houses, half-way houses, training centres for intellectually disabled persons, prisons, and armed forces hospitals.

Includes:

- A patient treated under the HITH program in private accommodation or residential facility who, on separation, remains in the same private accommodation.
- A newborn discharged with his/her mother.

Validations

388	Sep Referral - Episode Not Separated
389	Invalid Sep Referral
394	Sep Mode Home, No Sep Referral
395	Sep Mode not Home, Sep Referral Present
396	Sep Referral, No Refer Plus Other Ref
397	Sep Referral Postnatal, Incompatible Age/ Sex
398	Sep Referral, Duplicates
462	Incompat ACAS Status and Sep Referral
471	Care Type 5x, not usual Sep Referral
495	Incompat Sep Referral and Indigenous Status

Related items

Section 3: Separation Mode.

Section 4:

Business Rules (tabular) Care Type: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P).

Administration

Purpose To monitor discharge planning processes to inform policy and planning.

Principal data users Department of Health

Collection start 1999-00 (Formerly a sub-set of Separation Mode)

Definition source DHHS **Code set source** DHHS

Separation Time

Specification

Definition The time at which a patient completes an episode of care.

Field size 4 **Layout** HHMM

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

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

Code set A valid 24-hour time (not 0000 or 2400)

Reporting guide

For a **formal separation,** the Separation Time is the time at which patient presents at the discharge office/desk. For patients who leave against medical advice, Separation Time is the time of last patient contact. For patients who die in hospital, Separation Time is the time of death (that is, brain death).

For a **statistical separation,** (Care Type change), a dummy Separation Time is acceptable to enable the times to be automatically recorded. Care Type changes could be recorded as occurring at midday. The Separation Time must be one minute earlier than the Admission Time of the following episode (for example, if Separation Time of the earlier episode was made to be 1200, Admission Time of the new episode would be 1201).

Note: For episodes for posthumous organ procurement (Care Type 10), report Separation Time after all activity related to the organ procurement has ceased.

Validations

027	Adm Record; Overlap Existing
108	Fields(s) Missing From Sep
114	Invalid Sep Time
115	Adm Time Not < Sep Time
119	Sep Time - No Sep Date
322	ICU/CCU Stay > Total Stay
323	MV Duration > Total Stay
438	NIV Duration > Total Stay
465	Adm Duration < 15 Mins
504	Stat Episode: Next Episode > 1 Minute Apart
505	Stat Episode: Previous Episode > 1 Minute Apart
551	Type C Crit for Adm, LOS >4 hrs
553	Type E Crit for Adm, LOS <4 hrs

Related items Section 2: Time of Death.

Administration

Purpose To enable the exact Length of Stay to be determined.

Principal data users Multiple internal and external data users.

Collection start 1993-94

Definition source DHHS

Sex

Specification

Definition The sex of the person.

Field size 1 **Layout** N

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set

Code	Descriptor
1	Male
2	Female
3	Indeterminate
4	Intersex

Reporting guide

Sex should be inferred or accepted as reported by the respondent, as at the time of the admission. That is, it is usually unnecessary and may be inappropriate or even offensive to ask a person their sex. Sex may be inferred from other cues such as observation, relationship to respondent, or first name.

A person's sex may change during their lifetime as a result of procedures known alternatively as Sex change, Gender reassignment, Transsexual surgery, Transgender reassignment or Sexual reassignment. Throughout this process, which may be over a considerable period of time, sex could be recorded as either Male or Female.

In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate ICD-10-AM code(s) that clearly identify that the person is undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (for example, where the patient has prostate or ovarian cancer).

3 Indeterminate

Code 3 *Indeterminate* should be used for infants with ambiguous genitalia, where the biological sex, even following genetic testing, cannot be determined. This code should not generally be used on data collection forms completed by the respondent.

Code 3 can only be assigned for infants aged less than 90 days.

4 Intersex

The term 'intersex' 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 and who identifies as being neither male nor female; OR
- identifies as being neither male nor female

Excludes: transgender, transsexual and chromosomally indeterminate individuals who identify with a particular sex (male or female).

Validations

033	Invalid Sex
059	Maternity - Not Female
080	Sex Indeterminate, age < 90 days
127	Nil Value DRG
160	AR-DRG Grouper GST Code>Zero
215	Sex Indeterminate But Age>= 90 days
354	Code & Sex Incompatible
397	Sep Referral Postnatal, Incompat Age/Sex
450	Code Incompatible W Female Sex
451	Code Incompat W Male Sex
580	MHSWPI Valid, no Matching Sex
585	Sex Code Intersex

Related items Section 2: Age and DRG Classification.

Administration

Purpose To enable:

- Analyses of service utilisation, need for services and epidemiological studies.
- Verification of other fields (such as diagnosis and procedure codes) for consistency.
- To assist in the allocation of DRGs.

Principal data users Multiple internal and external data users.

Collection start 1979-80

Definition source ABS

Code set source NHDD (DHHS modified).

Source of Referral to Palliative Care

Specification

Definition The source of the person's referral to the DHHS Palliative Care Program.

Field size 2 **Layout** NN
Right justified, leading zero.

Location Palliative Record

Reported by Public hospitals.

Reported for Episodes with Care Type 8

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

Code set Select the first appropriate category:

Code	Descriptor
10	Public hospital – not further defined
11	Public hospital – palliative care unit/team
12	Public hospital – oncology unit/team
13	Public hospital – medical unit/team
14	Public hospital – surgical unit/team
15	Public hospital – emergency department
20	Private hospital – not further defined
21	Private hospital – palliative care unit/team
22	Private hospital – oncology unit/team
23	Private hospital – medical unit/team
24	Private hospital – surgical unit/team
25	Private hospital – emergency department
30	Outpatient clinic
40	General Practitioner
50	Specialist Practitioner
60	Community Palliative Care Service
61	Community Generalist Service
70	Residential Aged Care Facility
80	Self, carer(s), family, friends
90	Other
99	Unknown/inadequately described

Reporting guide Report the source of the person's referral to the Palliative Care Program

Validations
683 Invalid Source Of Refer to Pal Care
687 Pall Care: No Palliative Record

Related items Section 2: Palliative Care, Section 4: Palliative Care Reporting, Section 5: Palliative Record

Administration

Purpose To inform policy and planning decisions.

Principal data users Department of Health and Human Services

Collection start 1998-99

Definition source DHHS **Code set** DHHS

Surname

Specification

Definition	The surname of the DVA or TAC patient.		
Field size	25	**Layout**	AXXXXXXXXXXXXXXXXXXXXXXXXX
Location	DVA and TAC Record		
Reported by	Public hospitals		
Reported for	Admitted episodes with an Account Class of V- *DVA* or T- *TAC*		
Reported when	The Episode Record is reported		
Reporting guide	Surname of the person Permitted characters: A to Z (uppercase), space, apostrophe, and hyphen. The first character must be an alpha character		
Validation	161 Invalid Surname		
Related items	Section 3: Account Class and Given Name(s)		

Administration

Purpose	To facilitate payment by DVA and TAC for relevant episodes of care. This data is held separately to other VAED data to ensure that personal information remains confidential.		
Principal data users	Department of Veteran's Affairs and Transport Accident Commission.		
Collection start	1992-93		
Definition source	DHHS	Code set source	-

Transfer Destination

Specification

Definition Identification of the hospital campus to which a person is transferred, following separation from this hospital campus.

Field size 4 **Layout** NNNN or spaces

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for Admitted episodes where the Separation Mode is T Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centres.
Otherwise, report spaces.

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

Code set Refer to the Campus code table reference file available from:

http://www.health.vic.gov.au/hdss/reffiles/index.htm

Hospital identifier for interstate and overseas hospitals
Compile a code according to the following convention:

First character:
9 for all interstate and overseas hospitals

Second character: state/overseas identifier
0 Queensland
1 New South Wales
2 Tasmania
3 South Australia
4 Western Australia
5 ACT
6 Northern Territory
7 New Zealand
8 Other overseas

Third character: hospital type
0 Major specialist/teaching
1 Other public acute
2 Extended care
3 Private
5 Psychiatric (public only)
6 Rehabilitation (public only)
9 Other healthcare accommodation (eg early parenting centres)

Fourth character:
7 for all interstate and overseas hospitals

Thus, an extended care hospital in New South Wales would be coded 9127.
Unknown Transfer Destination code is 9999

Reporting guide **Forensic Hospitals and Armed Forces Hospitals**

These are not generally recognised as hospitals by the Australian Government Department of Health and Ageing, and therefore separation to such facilities is not an inter-hospital transfer (use Separation Mode H *Separation to private*

accommodation or home).

Validations

078 T- Srce T- Dest Code Matches Hosp
109 Transfer Dest Not Blank
110 Invalid Transfer Type

Related items

Section 2: Transfer
Section 4: Business Rules (non-tabular) Transfer Reporting
Refer to the Campus code table reference file available from:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Administration

Purpose Study of transfer patterns.

Principal data users Department of Health and Human Services

Collection start 1999-00

Definition source DHHS

Code set source DHHS

Transfer Source

Specification

Definition Identification of the hospital campus the person has been transferred from, following separation from that hospital.

Field size 4 **Layout** NNNN or spaces

Location Episode Record

Reported by All Victorian hospitals (public and private)

Reported for Admitted episodes where the Admission Source is T Transfer from acute hospital/extended care/rehabilitation/geriatric centres

Otherwise, report spaces

Reported when The Episode Record is reported

Code set Refer to the Campus code table reference file available from:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Hospital identifier for interstate and overseas hospitals
Compile a code according to the following convention:
First character:
9 for all interstate and overseas hospitals

Second character: state/overseas identifier
0 Queensland
1 New South Wales
2 Tasmania
3 South Australia
4 Western Australia
5 ACT
6 Northern Territory
7 New Zealand
8 Other overseas

Third character: hospital type
0 Major specialist/teaching
1 Other public acute
2 Extended care
3 Private
5 Psychiatric (public only)
6 Rehabilitation (public only)
9 Other healthcare accommodation (eg early parenting centres)

Fourth character:
7 for all interstate and overseas hospitals

Thus, an extended care hospital in New South Wales would be coded 9127.

Unknown Transfer Source code is 9999

Reporting guide **Forensic Hospitals and Armed Forces Hospitals**

These are not generally recognised as hospitals by the Australian Government

Department of Health and Ageing, and therefore admission from such facilities is not an inter-hospital transfer (use Admission Source Z Other formal admission source).

Validations

042 Invalid Transfer Source
051 Transfer Source Not Blank
078 T- Srce/ T- Dest Code Matches Hosp

Related items

Section 2: Transfer
Section 4: Business Rules (non-tabular) Transfer Reporting.

Refer to the Campus code table reference file available from:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Administration

Purpose Study of transfer patterns

Principal data users Department of Health and Human Services

Collection start 1979-80

Definition source DHHS **Code set source** DHHS

Unique Key

Specification

Definition A unique identifier specific to an individual admitted patient episode of care.

Field size 9 **Layout** XXXXXXXXX
Right justified, zero filled.

Location
Episode Record
Extra Episode Record
Diagnosis Record
Extra Diagnosis Record
Sub-Acute Record
Palliative Record
DVA and TAC Record

Reported by All Victorian hospitals (public and private)

Reported for All admitted episodes of care

Reported when Any of the above record types is reported

Code set Hospital-generated

Reporting guide

The Unique Key can be computer-generated or have specific relevance at the hospital.

A Unique Key should not be changed. If in exceptional circumstances there is a need to alter the number (eg data entry error) the original episode would have to be deleted and re-submitted with a new Unique Key.

Do not re-use a Unique Key; a Unique Key must not be re-assigned to another episode for the same patient or to another patient. When changing software supplier, care must be taken to ensure Unique Keys remain unique, i.e. new episodes should be allocated a number higher than the last number reported.

Validations

005	Deletion Record - No Match Found
026	Zero Sep; Existing Not Discharged
027	Adm Record; Overlaps Existing
028	Prior Adm; No Sep Date
060	Unique Key Blank
062	Duplicate Pt ID, Adm Date Time, Diff Unique
063	Prior Not Discharged
064	Duplicate Pt ID, Date Time
169	No Corresponding Episode
192	Diagnoses Delete: No Record On File
248	Tran Pt ID Not Same As Episode Or Subac
249	No Sub-Acute to Delete
259	Invalid Rehab/Subac- Episode Sep Date
371	Episode Deletion: DVA/TAC Trans Present
372	Episode Deletion: Multiple Epis Trans
374	Episode DVA/TAC V5 Transaction
375	Episode DVA/TAC: V5 Trans Rejected

377	Episode DVA/TAC: Multiple E5 Trans
378	Episode DVA/TAC: Multiple V5 Trans
379	Epis Not DVA/TAC: V5 Trans Present
380	Epis Not DVA/TAC: V5 Trans: Multiple E5s
382	Epis Not DVA/TAC: Multiple V5 Trans
383	V5 Trans: No Episode Trans
384	V5 Trans: Multiple Episode Trans
531	Same UK, diff Pt ID

Related items -

Administration

Purpose To enable data records (E5, J5, X5, Y5, S5, P5 and V5) to be amalgamated into a single record for each episode of care, for validation and reporting purposes.

Principal data users Automated PRS/2 processes

Collection start 1990-91

Definition source DHHS

Code set source Hospital-generated