HCP1 Data from insurers to the Department

DATA SPECIFICATIONS (HCP1)

HCP1 INPUT FILE FORMAT (2011–12)

The input file from each Insurer will be processed according to the following format:

Item		Quantity	Type & size	Format	Values/description
FILE HEADER		one per physical file of data	A(7) A(3) A(6) N(2)	YYYYMM	Valid value 'HCPDATA' Source identifier (INSURER (or other) IDENTIFIER) YEAR-MONTH (separation month reported) The number of Insurers whose data is reported in this file; valid values 1-99 eg. > 1 if one organisation is reporting multiple affiliated insurers
May be repeated within a file	**INSURER HEADER**	one per Insurer	A(1) A(3) A(6)	YYYYMM	Valid value 'B' INSURER IDENTIFIER YEAR-MONTH (separation month reported)
	EPISODE RECORDS	many per Insurer	A(1322)		1322 characters; record type of 'E' followed by 1321 character record as specified in this document.
	MEDICAL RECORDS	many per episode	A(92)		92 characters; record type of 'M' followed by 91 character record as specified in this document.
	PROSTHETIC RECORDS	0 to many per episode	A(54)		54 characters; record type of 'P' followed by 53 character record as specified in this document.
	AN-SNAP RECORDS	0 to many per episode	A(95)		95 characters; record type of 'S' followed by 94 character record as specified in this document.
	INSURER TRAILER	one per Insurer	A(1) A(3) N(6) N(6) N(6) N(6)		Valid Value 'T' INSURER IDENTIFIER Number of Episode records Number of Medical records Number of Prosthetic records ('000000' means no prosthetic records) Number of AN-SNAP records ('000000' means no AN-SNAP records)
FILE TRAILER		one per physical file of data	A(1)		Valid value 'Z'

EXPLANATORY NOTES (HCP1)

Scope of Data Collection

The Hospital Casemix Protocol specifies the financial, clinical and demographic data that hospitals must provide private health insurers and private health insurers must provide the Department, in respect of each episode of admitted hospital treatment for which a benefit has been paid.
For the purposes of this collection, an episode is the period between *admission* and *separation* that a person spends in one hospital, and includes leave periods not exceeding seven days. Admission and separation can be either formal or statistical (refer to definitions).

It is preferable that each episode refer to only one care type (being the descriptor of the overall nature of a service provided). That is, if a patient's care type changes during a hospital stay, it would be preferable for the patient to be statistically separated from one episode for the first care type and statistically admitted for another episode for the new care type, so that two episode records are submitted.

All reporting requirements governing HCP data include AN-SNAP data as:
- AN-SNAP is not a stand-alone dataset but rather a supplementary file to the HCP file.
- AN-SNAP specifications are incorporated into the DoHA Hospital to Insurer HCP format.
- The requirement to supply HCP to insurers (and by implication AN-SNAP also) does not depend on the existence of a contract between the hospital and insurer but rather whether an insurer benefit is paid to a hospital for admitted episodes of hospital treatment.

For further information about the HCP data requirements, please refer to the following legislation:

- *Private Health Insurance Act 2007*
- Private Health Insurance (Data Provision) Rules 2010

This document specifies the data to be provided from Insurers to the Department.

Reporting Requirements

The insurer will provide the Department with HCP data for separations by calendar month within 12 weeks of the month to which it relates. For example, data for separations during the month of July are to be submitted by no later than the first week in November.

Notes about the input file

- If the input file is not structured as per page 1, it will be rejected.
- For each Private Health Insurer, episode records, medical records, prosthetic records and rehabilitation (AN-SNAP) records are to be grouped separately. That is, all episode records are to be followed by all medical records which are followed by all prosthetic records which are followed by all rehabilitation (AN-SNAP) records. **Records should be sorted within each group in ascending LINK-IDENTIFIED ORDER.**
- If any characters, other than those specified above or in this document are detected, such as end of line or end of file characters, the record or file will be rejected.

- The Insurer header, episode records, medical records, prosthetic records, rehabilitation (AN-SNAP) records, and Insurer trailer grouping can be repeated within the same file header and file trailer, to enable data for a number of Insurers to be contained in the same file.

Notes about the specifications

The ***data item column*** indicates the short name for the data item and, where applicable, the reference number for the item in the National Health Data Dictionary as accessed via the Metadata Online Registry (METeOR) at: http://meteor.aihw.gov.au/content/index.phtml/itemId/237518

The ***obligation column*** indicates whether provision of each particular data item is:
- MAA – Mandatory for all public and private hospitals (including day facilities)
- MAO - Mandatory for all private hospitals (including day facilities) and optional for public hospitals
- MAS – Mandatory for same-day patients
- OPA – Optional for all
- CON – Conditional items that must be completed by all hospitals but only in the circumstances specified in the specifications.

The ***position column*** indicates the position within the fixed file format that each data item is to be reported.

The ***type and size column*** indicates the number and type of character/s the data item should contain where:
- A indicates the data item contains alphanumeric characters (alphabetic, numeric and other special characters). Data must be left justified.
- N indicates the data item contains numeric characters (numbers 0 to 9) only. Data items must be right justified and zero-prefixed to fully fill the item unless otherwise stated in the coding description. All values must be positive.

The ***format column*** indicates the format of the characters of the data item:

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

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

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

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

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

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

See the coding description column for any other special formatting requirements.

The ***repetition column*** indicates the number of times the data item is repeated within the data file.

The ***coding description column*** provides the definition for the data item, valid values and any additional information to clarify what data should be reported and how. If a METeOR reference is indicated in the data item column, refer to the National Health Data Dictionary for definition and collection methods.

The ***edit rules column*** outlines the edit checks the Department will run the data through using the Check-It software. These are split into critical errors where data will be rejected and warnings where data will be identified.

The ***error codes column*** indicates the error code attributed to each of the edit checks.

Definitions/acronyms

ACHI means the Australian Classification of Health Interventions.

ADA means the Australian Dental Association.

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

CCU means the coronary care unit of a hospital.

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

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

DRG means the Australian Refined Diagnosis Related Group.

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

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

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

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

HDU means the high dependency unit of a hospital.

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

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

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

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

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

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

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

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

ICU means the intensive care unit of a hospital.

insurer means a private health insurer.

MBS means the Medicare Benefits Schedule, comprising:

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

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

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

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

METeOR (Metadata Online Registry) for national data standards.

miscellaneous service code means any miscellaneous hospital-specific or insurer-specific non-MBS code. ADA items can be reported here.

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

NICU means the neonatal intensive care unit of a hospital.

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

PHIAC *means* Private Health Insurance Administration Council

PICU means the paediatric intensive care unit of a hospital.

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

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

SCN means the special care nursery of a hospital.

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

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

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

Guide for Use

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

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

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

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

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

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

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

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

Infant weight neonate - For live births, birth weight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birth weight, weights should not be recorded in those groupings. The actual weight

should be recorded to the degree of accuracy to which it is measured. In perinatal collections the birth weight is to be provided for live born and stillborn babies.

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

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

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

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

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

Qualified days for newborns - The number of qualified days is calculated with reference to the date of admission, date of separation and any other date(s) of change of qualification status: the date of admission is counted if the patient was qualified at the end of the day; the date of change to qualification status is counted if the patient was qualified at the end of the day; the date of separation is not counted, even if the patient was qualified on that day. The normal rules for calculations of patient days apply. To determine if newborn days are qualified days, see the METeOR definition for Newborn Qualification Status (Metadata glossary item 327254).

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

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

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

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

Data Quality

Error Codes

1st Character – represents the type of record i.e. E (episode), P (prosthetic), A (AN-SNAP), M (medical), R (edits checking across records)
2nd Character – W (represents a warning where an edit rule has been identified)– the record will be accepted and insurers notified
2nd Character – E (represents an error where an edit rule has failed) – the record will be rejected and insurers notified

Further information

For further information about the HCP requirements including AN-SNAP, please see the following websites:

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

- www.health.gov.au/casemix

List of Hospital provider numbers

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

Metadata and health dictionary specifications

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

For private health insurance industry information

- www.phiac.gov.au

Commonwealth Prosthesis list

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

DATA SPECIFICATIONS (HCP1)

HCP1 DATA ITEM AND RECORD EDITING (2011–12)

EPISODE RECORD

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
1	Insurer identifier	MAA	1-3	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if not a valid Insurer code.	EE001
2	Link Identifier	MAA	4-27	A(24)	Left justify	1	A unique identifier of an episode that links data items from this (episode) record to the associated medical, prosthetic or AN-SNAP records.	**Reject** record if blank	EE002
3	Provider (hospital) code	MAA	28-35	A(8)	NNNNNNNA (uppercase)	1	The Commonwealth-issued hospital provider number, as selected from the lists maintained by the Department of Health and Ageing. "OVERSEAS" = overseas provider	**Reject** record if not (a valid 8 character Commonwealth provider number or 'OVERSEAS').	EE003
4	Product code	MAA	36-43	A(8)		1	The product code for patient's insurance cover at admission.	**Reject** record if blank.	EE004
5	Hospital contract status	MAA	44	A(1)	Left justify	1	The payment arrangement the insurer has with the hospital. Y = a hospital with which an Insurer has a contract N = a hospital with which the Insurer does not have a contract. T = a hospital is paid under 2nd Tier benefit arrangement B = a hospital is paid under a "Bulk payment" arrangement	**Reject** record if not (Y or N or T or B).	EE005
6	Total days paid	MAA	45-48	N(4)	Right justify Zero prefix	1	The total number of days for which benefits were paid by the Insurer, including days for which benefits were paid as a Nursing Home Type Patient. Same-day cases equal 0001. Zero fill if no benefit paid for accommodation by fund.	**Reject** record if not numeric **Identify** if total days paid > (date separated – date admitted – leave days) **Identify** if same-day status is 1 and total days paid is not 0001	EE006 EW006.0 EW006.1

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
7	Accommodation charge	MAA	49-57	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for accommodation (include ex-gratia and patient portion accommodation charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	**Reject** record if not numeric	EE007
8	Accommodation benefit	MAA	58-66	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for accommodation (include ex-gratia accommodation benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	**Reject** record if not numeric	EE008
9	Theatre charge	MAA	67-75	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for a theatre/procedure room/ angiography suite (include ex-gratia and patient portion theatre charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE009 *EW009**
10	Theatre benefit	MAA	76-84	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for a theatre/procedure room/angiography suite (include ex-gratia theatre benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE010 *EW010**
11	Labour ward charge	MAA	85-93	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for labour ward (include ex-gratia and patient portion labour ward charges). Blank means this charge was not separately identified but charged under another item. Zero fill if no amount charged.	**Reject** record if not numeric **warning for public hospitals*	EE011 *EW011**
12	Labour ward benefit	MAA	94-102	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for labour ward (include ex-gratia labour ward benefits) Blank means this benefit was not separately identified but paid under another item. Zero fill if no amount paid.	**Reject** record if not numeric **warning for public hospitals*	EE012 *EW012**

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
13	Intensive Care Unit Charge	MAA	103-111	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	Intensive Care Unit charge must reflect the gross amount charged for ICU (include ex-gratia and patient portion ICU charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE013 *EW013**
14	Intensive Care Unit Benefit	MAA	112-120	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for ICU (include ex-gratia ICU benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE014 *EW014**
15	Prosthesis charge	MAA	121-129	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross maximum amount charged for prosthesis (include ex-gratia prosthesis charges, handling fee and patient portion). Blank means this charge was not separately identified but charged under another item. Zero fill if no amount charged.	**Reject** record if not numeric **warning for public hospitals*	EE015 *EW015**
16	Prosthesis benefit	MAA	130-138	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for prosthesis (include ex-gratia prosthesis benefit and handling fee). Blank means this benefit was not separately identified but paid under another item. Zero fill if no amount paid.	**Reject** record if not numeric **warning for public hospitals*	EE016 *EW016**
17	Pharmacy charge	MAA	139-147	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for pharmacy (include ex-gratia and patient portion pharmacy charges, exclude discharge medications). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE017 *EW017**
18	Pharmacy benefit	MAA	148-156	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for pharmacy (include ex-gratia pharmacy benefits, exclude discharge medications.) Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE018 *EW018**

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
19	Bundled charges	MAA	157-165	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross bundled charge raised (include ex-gratia and patient portion bundled charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE019 *EW019**
20	Bundled benefits	MAA	166-174	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross bundled benefit paid (include ex-gratia bundled benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE020 *EW020**
21	Other charges	MAA	175-183	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for any chargeable item which cannot be specifically categorised elsewhere (exclude ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE021 *EW021**
22	Other benefits	MAA	184-192	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for any chargeable item which cannot be specifically categorised elsewhere, (exclude ex-gratia benefits, television, phone calls, extra meals, FED, reversals or journal adjustments). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	**Reject** record if not numeric **warning for public hospitals*	EE022 *EW022**
23	Front end deductible	MAA	193-201	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The amount of Front End Deductible (excess) deducted from the benefit otherwise payable by the Insurer to the hospital. Zero fill if no FED applicable.	**Reject** record if not numeric	EE023
24	Ancillary cover status	MAA	202	A(1)		1	An indicator of whether a patient has ancillary cover at the time of admission. Y = patient has ancillary cover; N = patient does not have ancillary cover	**Reject** record if not ('Y' or 'N').	EE024

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
25	Ancillary charges	OPA	203-211	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total charge raised for in-hospital benefits claimed under an ancillary table. Zero fill if no amount charged.	If present, **identify** if not numeric	EW025
26	Ancillary benefits	OPA	212-220	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total benefit paid for in hospital benefits paid under an ancillary table. Zero fill if no amount paid.	If present, **identify** if not numeric	EW026
27	Total Medical charges	MAA	221-229	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total charge for medical items, as set out in the medical records associated with the episode. Zero fill if no amount charged.	**Reject** record if not numeric **warning for public hospitals*	EE027 *EW027**
28	Total Medical Benefits	MAA	230-238	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total benefit paid for medical items (by both Medicare and Insurer) as set out in the medical records associated with the episode. Zero fill if no amount paid.	**Reject** record if not numeric **warning for public hospitals*	E028 *EW028**
29	Date of birth METeOR: 287007	MAA	239-246	A(8)	DDMMYYYY	1	The date of birth of the patient.	**Reject** record if not in format DDMMYYYY	EE029
30	Postcode METeOR: 287224	MAA	247-250	N(4)	Right justify Zero prefix	1	The patient's residential post code. 9999 = unknown postcode 8888 = overseas	**Reject** record if not (a valid Australian postcode or 9999 or 8888).	EE030
31	Sex METeOR: 287316	MAA	251	N(1)		1	The biological sex of the patient. 1 = male 2 = female 3 = intersex or indeterminate 9 = not stated/inadequately described	**Reject** record if not (1, 2, 3 or 9).	EE031
32	Admission date METeOR: 269967	MAA	252-259	A(8)	DDMMYYYY	1	Date on which an admitted patient commences an episode of care by either formal or statistical processes.	**Reject** record if not in format DDMMYYYY	EE032
33	Separation date METeOR: 270025	MAA	260-267	A(8)	DDMMYYYY	1	Date on which an admitted patient completes an episode of care by either formal or statistical processes.	**Reject** record if not in format DDMMYYYY, blank or if not ≥ Admission date, or if MM is not same as month input in Insurer Header.	EE033

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
34	Hospital type	MAA	268	N(1)		1	The type of hospital where the episode occurred. 1 = public 2 = private 3 = private day facility 4 = public day facility 9 = other/unknown	**Reject** record if not (1, 2, 3, 4, or 9). **Identify** if Hospital type does not match provider hospital table	EE034 EW034
35	ICU days	MAA	269-271	N(3)	Right justify Zero prefix	1	The number of days the patient spent in ICU, NICU or PICU. Zero fill if not applicable. *refer to guide for use	**Reject** record if not numeric. **Reject** record if not zero for day facilities (private or public) **warning for public hospitals*	EE035.0 *EW035.0** EE035.1 *EW035.1**
36	DRG code METeOR: 270195	OPA	272-275	A(4)	Left justify	1	The DRG code which describes the episode of care. "GEN " = A generated episode not suitable for grouping according to the health Insurer practices. This should be the Health Insurer DRG wherever possible; otherwise the Hospital DRG.	If present, **identify** record if not (a valid DRG code for DRG version in item 37 or 'GEN ')	EW036
37	DRG version	CON	276-277	N(2)		1	The version of the DRG classification: 31 = version 3.1 32 = version 3.2 41 = version 4.1 42 = version 4.2 50 = version 5.0 51 = version 5.1 52 = version 5.2 60 = version 6.0 mn = version m.n Must be supplied if DRG code provided at item 36.	If present, **identify** record if not valid version. **Identify** if blank and DRG code provided.	EW037.0 EW037.1
38	Admission time METeOR: 269972	MAS	278-281	N(4)	hhmm (24 hour clock)	1	Time at which an admitted patient commences an episode of care by either formal or statistical processes. Mandatory for same-day patients.	**Reject** record if not in range 0000 – 2359 and same-day status is 1.	E038
39	Infant weight, neonate, stillborn METeOR: 269938	MAA	282-285	N(4)	Right justify Zero prefix	1	The first weight, in grams, of the live-born or still-born baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth. Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days. An entry of 0000 means the patient's age >= 365 days or weight was > 9000 grams. *refer to guide for use	**Reject** record if not numeric **Identify** if weight > 9000g **Identify** if weight > 0 and age > 365 days **warning for public hospitals*	EE039.0 *EW039.0* EW039.1 EW039.2

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
40	Hours of mechanical ventilation	MAA	286-289	N(4)	Right justify Zero prefix	1	The total number of hours (rounded) for which the patient received mechanical ventilation in ICU, NICU, PICU or combined ICU/CCU during the episode. Zero fill if not applicable.	**Reject** record if not numeric **warning for public hospitals*	EE040 *EW040**
41	Mode of separation METeOR: 270094	MAA	290-291	N(2)	Left justify and follow with space (may also submit in old format with zero prefix)	1	The status at separation of person (discharge/ transfer/death) and place to which person is released: 1 = discharge/transfer to an(other) acute hospital 2 = discharge/transfer to a residential aged care service, unless this is the usual place of residence 3 = discharge/transfer to an(other) psychiatric hospital 4 = discharge/transfer to other health care accommodation (includes mothercraft hospitals) 5 = statistical discharge— type change 6 = left against medical advice/discharge at own risk 7 = statistical discharge from leave 8 = died 9 = other (includes discharge to usual residence, own accommodation or welfare institution (includes prisons, hostels and group homes providing primarily welfare services))	**Reject** record if not (01, 02, 03, 04, 05, 06, 07, 08, 09, 1, 2, 3, 4, 5, 6, 7, 8 or 9).	EE041
42	Separation time METeOR: 270026	MAS	292-295	N(4)	hhmm (24 hour clock)	1	Time at which an admitted patient completes an episode of care by either formal or statistical processes. Conditional item – mandatory for same-day patients	**Reject** record if not in range 0000 – 2359 and same-day status is 1.	EE042
43	Source of referral	MAA	296	N(1)		1	The facility from which the patient was referred: 0 = Born in hospital 1 = Admitted patient transferred from another hospital 2 = Statistical admission – care type change 4 = from Accident/Emergency 5 = from Community Health service; 6 = from Outpatients department 7 = from Nursing home 8 = by outside medical practitioner 9 = Other	**Reject** record if not (0, 1, 2, 4, 5, 6, 7, 8 or 9).	EE043

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
44	Care Type METeOR: 270174	MAA	297-299	N(3)	Left justify two digit codes and follow with a blank space	1	The type of service for which the patient was initially admitted: 10 = Acute care 20 = Rehabilitation care 21 = Rehabilitation care delivered in a designated unit 22 = Rehabilitation care according to a designated program 23 = Rehabilitation care is the principle clinical intent 30 = Palliative care 31 = Palliative care delivered in a designated unit 32 = Palliative care according to a designated program 33 = Palliative care is the principle clinical intent 40 = Geriatric Evaluation and management 50 = Psychogeriatric care 60 = Maintenance care 70 = Newborn care 80 = Other admitted patient care 90 = Organ procurement – posthumous 100 = Hospital boarder	**Reject** record if not (10, 20, 21, 22, 23, 30, 31, 32, 33, 40, 50, 60, 70, 80, 90 or 100)	EE044
45	Total leave days METeOR: 270251	MAA	300-303	N(4)	Right justify Zero prefix	1	The sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay. Zero fill if not applicable.	**Reject** record if not numeric.	EE045
46	Non-Certified days of stay	MAO	304-307	N(4)	Right justify Zero prefix	1	The number of days spent in the hospital, without certification, that exceeded 35 days. Zero fill if not applicable. Mandatory for private hospitals and private day facilities.	If present, **reject** record if not numeric. **Reject** record if blank and hospital type is (private or private day facility).	EE046.0 EE046.1

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
47	Principal diagnosis code METeOR: 333838	MAA	308-312	A(5)	ANNNN Left justify Strip hyphen, dots & morphology codes	1	The diagnosis established after study to be chiefly responsible for occasioning the patient's episode. The principal diagnosis should be reported in the most current version of ICD-10-AM and selected according to the National Coding Standards. *refer to guide for use	If present, **reject** if not a valid ICD-10-AM principal diagnosis code **Reject** if blank and private hospital or contracted episode. **Identify** if blank and public hospital or non-contracted episode. **Identify** if Care Type = (20, 21, 22 or 23) and not Z50.? **Identify** if Care Type = 60 and not (Z74.2 or Z75.?)	EE047.0 EE047.1 EW047 EW047.1 EW047.2
48	Additional diagnosis codes METeOR: 333832	MAA	313-557	A(5)	ANNNN Left justify Strip hyphen, dots & morphology codes	49	A condition or complaint either co-existing with the principal diagnosis or arising during the episode of admitted care, as represented by an ICD-10-AM code. Blank means no additional diagnosis codes (or not 49 repetitions)	**Reject** if not (a valid ICD-10-AM code or blank). **Identify** if the same as 'Principal Diagnosis Code'	EE048 EW048
49	Procedure codes METeOR: 333828	MAA	558-907	A(7)	NNNNNNN Left justify Strip hyphen	50	The procedure code, as represented by the latest version of ACHI and selected according to the National Coding Standards. Blank means no ICD-10-AM procedure codes (or not 50 repetitions)	**Reject** if not (a valid ICD-10-AM code or blank)	EE049
50	Same-day status	MAA	908	N(1)		1	An indicator of whether the patient was admitted to the facility for an overnight stay. 0 = patient with a valid arrangement allowing for overnight stay for procedure normally performed on a same-day basis. 1 = same-day patient; 2 = overnight patient (other than type 0 above)	**Reject** record if not (0, 1 or 2).	EE050

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
51	Principal MBS item number	MAO	909-922	A(14)	Left justify	1	A valid Medical Benefits Schedule item according to the relevant MBS Schedule valid for the MBS date (Item 52). Blank means there was no applicable MBS or a public hospital. * refer to guide for use.	If present, **reject** record if not a valid MBS item from the relevant MBS Schedule valid for the service date (Item 52)	EE051
52	Principal Item Date	MAO	923-930	A(8)	DDMMYYYY	1	The date on which; i) the principal MBS item (item 51) was carried out, or ii) (if item 51 is blank), the first Miscellaneous Service Code (item 68) was carried out. Conditional item - Mandatory for private hospitals and private day facilities where principal MBS (item 51) is populated.	If present, **reject** record if not in format DDMMYYYY. **Reject** record if date is before admission date or after discharge date **Reject** record if blank and item 51 is populated and hospital type is private or private day facility.	EE052.0 EE052.1 EE052.2
53	Minutes of operating theatre time METeOR: 270350	MAO	931-934	N(4)	Right justify Zero prefix minutes	1	The time in minutes that the patient spent on their first visit to theatre/ procedure room/coronary angiography suite. Should be populated if surgical ADA code provided in Miscellaneous Service Code field (item 68). Must be filled with 0000 if no time spent in operating theatre. Blank means there was no applicable MBS Item or a public hospital. *refer to guide for use Conditional item - Mandatory for private hospitals and private day facilities where principal MBS (item 51) or Miscellaneous Service Code (item 68) is populated.	If present, **reject** record if not numeric. **Identify** record if blank and hospital type is private or private day facility and item 51 or item 68 is populated.	EE053 EW053
54	Secondary MBS item numbers	MAO	935-1060	A(14)	Left justify	9	Additional MBS item numbers are all MBS items performed in theatre/procedure room/ angiography suite, which are not the principal MBS. Blank means that there was no additional item or code (or not 9 repetitions).	If present, **reject** record if not (a valid MBS item number from the relevant MBS Schedule(s) current during the episode)	EE054

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
55	Number of Hospital-in-the-home (HITH) care days METeOR: 270305	MAO	1061-1064	N(4)	Right justify Zero prefix	1	The number of hospital-in-the-home care days occurring within an episode. Calculate with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and hospital-in-the-home accommodation. Zero fill if not applicable. * refer to definitions.	**Reject** record if not numeric. **Identify** if item not = (HITH Completed date – HITH Commencement Date)	EE055 EW055
56	Total psychiatric care days METeOR: 270300	MAA	1065-1067	N(3)	Right justify Zero prefix	1	The sum of the number of days or part days of stay that the person was an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit. Zero fill if not applicable.	**Reject** if not numeric.	EE056
57	Mental health legal status METeOR: 270351	MAO	1068	N(1)		1	An indicator of whether a person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the episode. Involuntary patients are persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care. 1 = Involuntary patient 2 = Voluntary patient 3 = Not permitted to be reported under the laws of a State or Territory 8 = Not applicable	If present, **reject** record if not (1, 2, 3, or 8). **Reject** record if blank and hospital type is (private or private day facility).	EE057.0 EE057.1
58	ICU hours	OPA	1069-1072	N(4)	Right justify Zero prefix	1	The number of hours spent by the patient in an ICU, NICU or PICU. Zero fill if not applicable. *refer to guide for use	If present, **identify** if not numeric.	EW058
59	Urgency of admission METeOR: 269986	MAA	1073	N(1)		1	An indicator of the admission status of the patient: 1 = Urgency status assigned – Emergency 2 = Urgency status assigned – Elective 3 = Urgency status not assigned 9 = Not known/not reported	**Reject** if not (1, 2, 3 or 9)	EE059

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
60	Inter-hospital contracted patient METeOR: 270409	MAO	1074	N(1)		1	An indicator of the status of a service provided in your hospital 1 = Inter-Hospital contracted patient from public sector; 2 = Inter-Hospital contracted patient from private sector 3 = Not contracted 9 = Not reported	If present, **reject** if not (1, 2, 3 or 9). **Reject** if blank and hospital type is (private or private day facility).	EE060.0 EE060.1
61	Palliative care Status	MAO	1075	N(1)		1	An indication of whether the episode involved palliative care: 1 = patient required palliative care during episode 2 = no palliative care required during episode Mandatory for private hospitals & private day facilities. This item is required because some States do not statistically discharge to palliative care. * refer to guide for use.	If present, **identify** if not (1 or 2). I**dentify** if blank and hospital type is (private or private day facility).	EW061.0 EW061.1
62	Re-admission within 28 days	MAA	1076	N(1)		1	An indicator of the re-admission of a patient to hospital within 28 days of previous discharge for treatment of a similar or related condition. 1 = Unplanned re-admission and patient previously treated in this hospital 2 = Unplanned re-admission and patient previously treated in another hospital 3 = Planned re-admission from this or another hospital 8 = Not applicable/not known Note: do not include transfers from another hospital as re-admissions	**Reject** if not (1,2,3 or 8)	EE062
63	Unplanned theatre visit during episode	MAA	1077	N(1)		1	An indicator of whether the patient required a theatre visit which was not anticipated or planned at the time of admission: 1 = Unplanned theatre visit 2 = No unplanned theatre visit	**Reject** if not (1 or 2)	EE063

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
64	Provider number of hospital from which transferred	MAA	1078-1085	A(8)	NNNNNNNA (uppercase)	1	The Commonwealth-issued hospital provider number for the hospital from which a patient has been transferred (Provider number required only when HCP item number 43 is reported as: 1- Admitted patient transferred from another hospital) Blank fill if no hospital transfer. Overseas hospitals to be coded as OVERSEAS	**Reject** if not (a valid 8 character Commonwealth provider number or blank)	EE064
65	Provider number of hospital to which transferred	MAA	1086-1093	A(8)	NNNNNNNA (uppercase)	1	The Commonwealth hospital provider number for the hospital to which a patient has been transferred. Blank fill if no hospital transfer (Provider number required only when HCP item number 41 is reported as: 1- Discharge/transfer to an(other) acute hospital, or 3 - Discharge/transfer to a(nother) psychiatric hospital or 4 - Discharge/transfer to another health care accommodation (includes mothercraft hospitals)) Overseas hospitals to be coded as OVERSEAS	**Reject** if not (a valid 8 character Commonwealth provider number or blank)	EE065
66	Discharge intention on admission	OPA	1094	N(1)		1	The intended mode of separation at time of admission: 1 = Discharge to an(other) acute hospital 2 = Discharge to a nursing home 3 = Discharge to a psychiatric hospital 4 = Discharge to palliative care unit/hospice 5 = Discharge to other health care accommodation 8 = To pass away 9 = Discharge to usual residence	If present, **identify** if not (1, 2, 3, 4, 5, 8 or 9)	EW066
67	Person Identifier	MAA	1095-1115	A(21)	Left justify	1	This is an Insurer-specific person identifier, unique within an establishment or agency, regardless of any change in membership.	**Reject** record if blank	EE067
68	Miscellaneous Service Codes	MAO	1116-1225	A(11)	Left justify	10	Any miscellaneous service codes (i.e. non MBS items or Australian Dental Association codes) used for billing. Up to 10 codes may be entered. Blank means that there were no miscellaneous service codes or not 10 repetitions.		

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
69	Hospital-in-the-home care Charges	MAA	1226-1234	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for hospital-in-the-home care service (include ex-gratia and HITH patient portion charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item.	**Reject** record if not numeric	EE069
70	Hospital-in-the-home care Benefits	MAA	1235-1243	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefits paid for hospital-in-the-home care service (include ex-gratia HITH benefits). Blank means this benefit was not separately identified but paid under another item. Zero fill if no amount paid.	**Reject** record if not numeric	EE070
71	Special Care Nursery Charges	MAA	1244-1252	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charges raised for SCN (include ex-gratia and patient portion SCN charges, exclude NICU charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use.	**Reject** record if not numeric **warning for public hospitals*	EE071 *EW071**
72	Special Care Nursery Benefits	MAA	1253-1261	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for SCN (include ex-gratia SCN benefits, exclude NICU benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use.	**Reject** record if not numeric **warning for public hospitals*	EE072 *EW072**
73	Coronary Care Unit Charges	MAA	1262-1270	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for CCU (include ex-gratia and patient portion CCU charges)**.** Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use.	**Reject** record if not numeric **warning for public hospitals*	EE073 *EW073**
74	Coronary Care Unit Benefits	MAA	1271-1279	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for CCU (include ex-gratia CCU benefits) Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use.	**Reject** record if not numeric **warning for public hospitals*	EE074 *EW074**
75	Special Care Nursery Hours	OPA	1280-1283	N(4)	Right justify Zero prefix	1	The number of hours the patient spent in a SCN. Zero fill if not applicable. *refer to guide for use.	If present, **identify** if not numeric.	EW075

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
76	Coronary Care Unit Hours	OPA	1284-1287	N(4)	Right justify Zero prefix	1	The number of hours the patient spent in a CCU. Zero fill if not applicable. *refer to guide for use.	If present, **identify** if not numeric.	EW076
77	Special Care Nursery Days	MAO	1288-1290	N(3)	Right justify Zero prefix	1	The number of days the patient spent in a SCN. Zero fill if not applicable. *refer to guide for use.	**Reject** record if not numeric. **Reject** if not zero for day facilities (private or public)	EE077.0 EE077.1
78	Coronary Care Unit Days	MAO	1291-1293	N(3)	Right justify Zero prefix	1	The number of days the patient spent in a CCU. Zero fill if not applicable. *refer to guide for use	**Reject** record if not numeric. **Reject** if not zero for day facilities (private or public)	EE078.0 EE078.1
79	Number of Qualified Days for Newborns METeOR: 270033	MAA	1294-1297	N(4)	Right justify Zero prefix	1	The number of qualified newborn days occurring within a newborn episode of care. Zero fill if not applicable. * Refer to guide for use.	**Reject** record if not numeric **Identify** record if >0000 and (Care Type not Newborn Care)	EE079 EW079
80	Hospital-in-the-home care Commencement Date	CON	1298-1305	A(8)	DDMMYYYY	1	Date on which an admitted patient commences an episode of hospital-in-the-home care services. Blank fill if not applicable. Conditional item, must be provided if HITH charges (item 69) > 0.	**Reject** record if HITH benefits or charges > 0 (items 69 and 70) and item is blank, or if not in format DDMMYYYY **Reject** record if commencement date > HITH completed date	EE080.0 EE080.1
81	Hospital-in-the-home care Completed Date	CON	1306-1313	A(8)	DDMMYYYY	1	Date on which an admitted patient completes an episode of hospital-in-the-home care services. Blank fill if not applicable. Conditional item, must be provided if HITH charges (item 69) > 0.	**Reject** record if HITH benefits or charges > 0 (items 69 and 70) and item is blank, or if not in format DDMMYYYY **Reject** record if HITH completed date < HITH commencement date	EE081.0 EE081.1
82	Number of hospital-in-the-home care visit days	CON	1314-1317	N(4)	Right justify Zero prefix	1	The total number of days during a HITH care episode that the patient was actually visited/received a service. Conditional item, must be provided if HITH charges (item 69) > 0. Zero fill if not applicable. * refer to definitions.	**Reject** if not numeric or if > HITH care days (item 55) [calculated as HITH completed date – HITH commencement date] + 1.	EE082

No	Data Item	Obligation	Position	Type & size	Format	Repeti-tion	Coding description	Edit Rules	Error code/s
83	Palliative Care Days	MAO	1318-1321	N(4)	Right justify Zero prefix	1	The number of days a patient received palliative care during an episode. Where the entire episode is Palliative, provide the total length of stay in days. Zero fill if not applicable. *refer to guide for use	If present, **reject** record if not numeric. **Reject** if blank and hospital type is private or private day facility **Identify** record if 0 and Palliative Care Status (item 61) =1	EE083.0 EE083.1 EW083

Total record length 1321

EPISODE RECORD CHECKS

	EDIT RULES	ERROR CODE/S
Extras	**Reject** record if Separation date (Item 32) does not equal Admission date (Item 33) where Same-day Status (Item 50) = 1 (reject if Separation date = Admission date and Same-Day Status not equal to 1)	EE201
	Identify record if Total benefits exceed Total charges	EW202
	Reject record if ICU charge but no ICU days recorded and no ICU hours recorded	EE203
	Identify record if prosthesis charge but no Theatre or Bundled charge (and hospital type is private or private day facility).	EW204
	Identify record if therapeutic Principal MBS present but no Principal Procedure	EW205
	Identify record if accommodation charge exceeds $2,000 x Length Of Stay (LOS)	EW206
	Identify record if ICU charge >$5,000 per day	EW207
	Reject record if no charges or no benefits reported (total charge=0 or total benefit =0)	EE208

Medical Record

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
1	Insurer identifier	MAA	1-3	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if not a valid Insurer code.	ME001
2	Link Identifier	MAA	4-27	A(24)	Left justify	1	A unique identifier of an episode that links data items from this medical record to the associated episode (and/or prosthetic or AN-SNAP records).	**Reject** record if blank.	ME002
3	MBS item	MAA	28-41	A(14)	Left justify	1	The MBS item billed by the medical provider. The MBS schedule is available from MBS Online at "http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1".	**Reject** record if not a valid MBS item according to the relevant MBS Schedule valid at the MBS date of service (Data Item number 7).	ME003
4	Item charge	MAA	42-50	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The amount the patient was billed for the MBS item identified in data item 3. Zero fill if no amount charged.	**Reject** record if not numeric or if negative. **Identify** record Item charge less than MBS Benefit. A five cent tolerance applied to accommodate rounding.	ME004.0 MW004.1
5	MBS benefit	MAA	51-59	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The amount paid to the patient as the Medicare entitlement. Zero fill if no amount paid.	**Reject** record if not numeric.	ME005.0
6	Insurer benefit	MAA	60-68	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The amount (excluding Medicare benefit) paid by the Insurer. Zero fill if no amount paid.	**Reject** record if not numeric. **Reject** record if > (Item charge – MBS benefit). A 5cent tolerance applied for rounding purposes.	ME006.0 ME006.1
7	MBS date of service	MAA	69-76	A(8)	DDMMYYYY	1	Date the MBS item number identified in Data Item 3 was performed.	**Reject** record if not in format DDMMYYYY	ME007

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
8	Medical Payment Type	MAA	77	N(1)		1	An indicator of the medical payment type. 1 = Agreement with an individual provider (No- gap agreement) 2 = Agreement with a hospital (No-gap agreement) 3 = Gap Cover Scheme (No-gap agreement) 4 = Gap Cover Scheme (Known-gap agreement) 5 = MBS schedule fee charged 6 = No gap cover scheme, charge over MBS schedule fee	**Reject** record if not (1, 2, 3, 4, 5 or 6).	ME008
9	Gap Cover Scheme Identifier	OPA	78-82	A(5)	Blank Fill.	1	Blank fill. Gap cover schemes are not applicable. This field has been retained as a placeholder to minimise system format changes for insurers.		
10	MBS Fee	MAA	83-91	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point	1	The MBS or derived fee for the item.	**Reject** record if not numeric	ME010.0

Total record length 91

PROSTHESIS RECORD									
No	**Data Item**	**Obligation**	**Position**	**Type & size**	**Format**	**Repetition**	**Coding description**	**Edit Rules**	**Error code/s**
1	Insurer Identifier	MAA	1-3	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if not a valid Insurer code.	PE001
2	Link Identifier	MAA	4-27	A(24)	Left justify	1	A unique identifier of an episode that links data items from this prosthetic record to the associated episode (and/or medical or AN-SNAP records).	**Reject** record if blank	PE002
3	Prosthetic Item	MAA	28-32	A(5)	Right justify Zero prefix	1	The billing codes are contained in the most relevant version (ie, the one covering the date(s) of the admitted patient record) of the prosthesis list. The relevant prosthesis list can be found at www.health.gov.au/internet/wcms/publishing.nsf/content/health-privatehealth-prostheseslist.htm If ex-gratia prosthetic item (see user guide), report as "EXGRA". Where applicable, the handling fee will be reported as "PHFEE"	**Reject** record if not (a valid Commonwealth prosthesis code or "PHFEE" or "EXGRA"). ** warnings for public hospitals*	PE003 *PW003**
4	Number of Items	MAA	33-35	N(3)	Right justify Zero prefix	1	Number of prosthetic items listed in data item 3. Zero prefix.	**Reject** record if not >0 ** warnings for public hospitals*	PE004 *PW004**
5	Total Prosthetic Item Charge	MAA	36-44	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total charge for the prosthesis item (include cents but omit decimal point). Handling fee(s) may be reported with an item code of PHFEE. Use leading zeros to fully fill the item. If provided, and identified, as 'ex gratia' in data item 3, then charge should be included.	**Reject** record if not numeric or if negative. **Identify** record if the total charge is greater than the prosthesis schedule minimum benefit multiplied by the number of items, but only for items with a blank maximum benefit (allow a 5 cent tolerance). Ignore where prosthetic item is "EXGRA" or "PHFEE", or not a valid prosthesis item.	PE005.0 *PW005.0** PW005.1

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
								Identify record if the total charge is greater than the prosthesis schedule maximum benefit multiplied by the number of items, but only for items with a value for maximum benefit (allow a 5 cent tolerance). Ignore where prosthetic item is “EXGRA” or “PHFEE”, or not a valid prosthesis item. ** warnings for public hospitals*	PW005.2
6	Total Prosthetic Item Benefit	MAA	45-53	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total benefit for the prosthesis item (include cents but omit decimal points). Use leading zeros to fully fill the item. Zero fill if no amount paid.	**Reject** record if not numeric or if negative. **Reject** record if greater than total charge (allow 5 cent tolerance). **Reject** record if the benefit is not equal to charge and the maximum benefit on the relevant edition of the prosthesis schedule is blank (allow a 5 cent tolerance). Ignore where prosthetic item is “EXGRA” or “PHFEE”, or not a valid prosthesis item. **Reject** record if the benefit is less than the prosthesis schedule minimum benefit multiplied by the number of items or greater than the prosthesis schedule maximum benefit multiplied by the number of items, but only for items with a value for	PE006.0 *PW006.0** PE006.1 *PW006.1** PE006.2 *PW006.2** PE006.3 *PW006.3**

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
								maximum benefit (allow a 5 cent tolerance). Ignore where prosthetic item is “EXGRA” or “PHFEE”, or not a valid prosthesis item. ** warnings for public hospitals*	

Total record length 53

AN-SNAP RECORD									
No	**Data Item**	**Obligation**	**Position**	**Type & size**	**Format**	**Repeti-tion**	**Coding description**	**Edit Rules**	**Error code/s**
1	Insurer Identifier	MAA	1-3	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if not a valid insurer code.	AE001
2	Link Identifier	MAA	4-27	A(24)	Left justify	1	Unique identifier of an episode that links data items from this (AN-SNAP) record to the associated episode (and/or medical and prosthetic records).	**Reject** record if blank	AE002
3	Episode Type	MAA	28	A(1)		1	An indicator of the type of admitted rehabilitation program undertaken during the episode that relates to the AN-SNAP records. O = Overnight Admitted Patient – Assign this value for patients who stay overnight during the admitted rehabilitation program. S = Same-day Admitted Patient – Assign this value for patients who undertake an admitted rehabilitation program consisting of multiple same day visits/services. It is recommended that one AN-SNAP record is reported that covers the entire program (not separate episodes for each visit/service). In this case, Admission date = date of 1st visit/service and Separation date = date of last visit/service in the Same-day admitted program. The AN-SNAP record should be linked to the episode with the same separation date.	**Reject** record if not ('O' or 'S').	AE003

4	Admission FIM Item Scores	MAA	29-46	N(1)		18	The FIM score on admission for each of the 18 FIM motor and cognition items **No Helper:** Score of 7 – Complete Independence Score of 6 – Modified Independence **Helper:** Score of 5 – Supervision or setup Score of 4 – Minimal assistance Score of 3 – Moderate assistance Score of 2 – Maximal assistance Score of 1 – Total assistance *refer to guide for use	**Reject** record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O. **Identify** record if episode type is S and not blank fill	AE004 AW004
5	Discharge FIM Item Scores	MAA	47-64	N(1)		18	The FIM score on discharge for each of the 18 FIM motor and cognition items. **No Helper:** Score of 7 – Complete Independence Score of 6 – Modified Independence **Helper:** Score of 5 – Supervision or setup Score of 4 – Minimal assistance Score of 3 – Moderate assistance Score of 2 – Maximal assistance Score of 1 – Total assistance *refer to guide for use	**Reject** record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O and not Episode Mode of Separation = 8 **Identify** record if episode type is S and not blank fill	AE005 AW005
6	AROC Impairment Codes	MAA	65-71	A(7)	NN.NNNN Left justify	1	Enter the Impairment Code (AUS version 1) that best describes the primary reason for admission to the rehabilitation episode. Code as specifically as possible and where possible avoid the use of impairment group 13 - 'Other Disabling Impairments'. Each entry should consist of: - two (2) digits that represent the impairment group (zero prefixed if 1 digit) - a decimal point - up to four (4) digits that represent more specific categories within impairment groups if applicable (blank fill any unused characters).	**Reject** record if not a valid code or if trailing zeros.	AE006
7	Assessment Only Indicator METeOR: 339509	MAA	72	N(1)		1	AN-SNAP has separate classes for Assessment Only episodes. Assessment only occurs when the person was seen on one occasion only for assessment and no rehabilitation treatment and no further intervention by this service team is planned	**Reject** record if not (1 or 2).	AE007

							to occur within the next 90 days. If a person is booked/seen for subsequent treatment within 90 days, they are not Assessment Only. If a person is booked for subsequent assessment (but not treatment), they are assessment only. Record: 1 = Yes 2 = No		
8	AN-SNAP Class	MAA	73-76	N(4)		1	The AN-SNAP class to which the episode is assigned. AN-SNAP Class is only applicable to overnight episodes and must be reported as 4 characters in the following format: - "2" prefix followed by AN-SNAP version 2 class code.	**Reject** if not a valid code and episode type = O **Identify** record if episode type = S and not blank fill.	AE008 AW008
9	SNAP Version	MAA	77-78	N(2)		1	The version of the AN-SNAP Classification used to report item 8. 02 = AN-SNAP Version 2	**Reject** if not (01 or 02) and episode type = O **Identify** if episode type = S and not blank fill **Identify** if (01) and episode type = O	AE009 AW009.1 AW009.2
10	Multi-disciplinary rehabilitation plan date METeOR: 341640	MAA	79-86	A(8)	DDMMYYYY	1	The date a multi-disciplinary rehabilitation plan is established for an episode of admitted patient care.	**Reject** record if not in format DDMMYYYY	AE010
11	Discharge plan date	MAA	87-94	A(8)	DDMMYYYY	1	The date a discharge plan is established for an episode of admitted patient care.	**Reject** record if not in format DDMMYYYY	AE011

Total record length 94

RECORD EDITING ACROSS ALL RECORDS

EDIT RULES	ERROR CODE/S
Reject all duplicate records. A duplicate is defined as two or more episode records with the same **Insurer Identifier** and **Link Identifier**. The associated medical records are rejected and each episode rejected is included in the error count towards rejecting the whole file. The medical records are not examined for duplicates.	RE001
If an episode record is rejected because of an invalid data item, **reject** all associated medical records. Each rejected episode record is counted towards rejecting the whole file.	RE002
If a medical record is rejected because of an invalid data item, **reject** the associated episode and other medical records. Each rejected episode record is counted towards rejecting the whole file.	RE003
Reject all medical records without an associated episode record.	RE004
If the Total Medical charges (Item 27) in the episode record are greater than 0, then they must equal the sum of the Item charges (Item 4) in all associated medical records. If they don't, **reject** the episode record and all associated medical records. Each rejected episode record is counted towards rejecting the whole file.	RE005
If the Total Medical Benefits (Item 28) in the episode record are greater than 0, then they must equal the sum of the MBS benefits (Item 5) and Insurer benefits (Item 6) in all associated medical records. If they don't, **reject** the episode record and all associated medical records. Each rejected episode record is counted towards rejecting the whole file.	RE006
Reject all Prosthetic records without an associated episode record.	RE007
Warning flag is given where medical records attached to individual episode records exceed 200. This is for departmental information only.	RW008
Reject all AN-SNAP records without an associated episode record.	RE009