



# PHI Act Data Specifications – 2026-27

## Changes effective for data with separations from July 2026 onwards

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<b>Version:</b>	3.0
<b>Date Updated:</b>	27 January 2026

# 1. Implementation

For PHDB (hospital to department), HCP (hospital to insurer), HCP1 (insurer to department), HCP2 (insurer to department) and GT-Dental (insurer to department) these proposed changes to data specifications are designed to apply to hospital separation data with separation month from July 2026 onwards, i.e. data relating to the 2026-27 financial year and following years.

Changes in this summary document are correspondingly indicated **IN RED** in the associated data specification workbooks for each collection.

## Summary of new reporting requirements by data collection

Collection	Source	New requirements with potential impact to coding
PHDB	Private hospitals and day facilities	<ul style="list-style-type: none"><li>• ICU Hours</li><li>• ICU Days</li></ul>
HCP	Public and private hospitals, including day facilities	<ul style="list-style-type: none"><li>• Primary Impairment type code (AROC 2012)</li><li>• ICU Hours</li><li>• ICU Days</li></ul>
HCP1	Private health insurers	<ul style="list-style-type: none"><li>• Product Code</li><li>• Primary Impairment type code (AROC 2012)</li><li>• ICU Hours</li><li>• ICU Days</li></ul>

## 2. Product Code

<b>Data item:</b>	Product Code										
<b>Dataset:</b>	HCP1										
<b>Changes:</b>	<p>The old field 'Product code' will be superseded and blank filled, and a new 'Product code' will be used instead. The product code will be validated against a list of Private Health Information Statement (PHIS) codes with open and closed dates to ensure only available and current products are accepted without warning. If a product code is blank or not valid for the month of separation, a warning error will flag for the data value (error code EW004). Every PHIS product is structured as follows:</p> <table border="0"> <tr> <td>HBA/</td> <td>H14/</td> <td>V</td> <td>ABCD</td> <td>2D</td> </tr> <tr> <td>Fund code</td> <td>3 or 4 characters, product group code</td> <td>1 character, state or territory*</td> <td>3 or 4 unique characters, unique within a fund</td> <td>Type of cover**</td> </tr> </table> <p>*A=All states; D=Northern Territory (Darwin); N=New South Wales (includes ACT); Q=Queensland; S=South Australia; T=Tasmania; V=Victoria; W=Western Australia **0D=0 adults, 2 or more dependents; 10=1 person; 1D=1 adult with dependants, including non-student(s); 1Y=1 adult with dependents, including non-student(s); 1C=1 adult with dependants, including Conditional non-student(s); 1P=1 adult with dependants, including person(s) with a disability; 20=2 adults, no dependants; 2D=2 adults with dependants, including student(s); 2Y=2 adults with dependants, including non-student(s); 2C=2 adults with dependants, including Conditional non-student(s); 2P=2 adults with dependants, including person(s) with a disability.</p> <p>The fund code is not required in this data item. However, the product group code is required as there are occasions where funds merge, and there are duplicates of the final part (i.e., VABCD2D) of the product code within a fund that refer to different products. A combined product will have one PHIS code; however, in circumstances where a person may be covered under two products, the PHIS code in relation to the hospital cover should be reported.</p>	HBA/	H14/	V	ABCD	2D	Fund code	3 or 4 characters, product group code	1 character, state or territory*	3 or 4 unique characters, unique within a fund	Type of cover**
HBA/	H14/	V	ABCD	2D							
Fund code	3 or 4 characters, product group code	1 character, state or territory*	3 or 4 unique characters, unique within a fund	Type of cover**							
<b>Reason:</b>	<p>The Product Code data item is currently collecting codes specific to each insurer's internal systems. The introduction of this new field and edit rule enables a mapping to nationally recognised product code identifiers in the PHIS. By standardising product codes, the department will be able to conduct analysis in relation to requirements for complying health insurance products (as per 60-1 of the <i>Private Health Insurance Act 2007</i> (the Act)) and analysis into the uptake of private health insurance (as per 3-1 of the Act) by products and their utilisation by treatments, outcomes and cost of care.</p>										

### HCP1 – Episode – revised field

No	Data Item	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
4	Product code (superseded)	MAA OPA	A(8)	Blank fill	1	This field has been retained as a placeholder to minimise system changes. See replacement item: 'Product code' (Item No 91)  <del>The product code for patient's insurance cover at admission.</del>	<del>Reject record if blank.</del>	<del>EE004</del>

### HCP1 – Episode – new field

No	Data Item	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
89	Product Code	MAA	A(11)	Left justify, follow codes with a blank space Strip forward slash	1	Each entry should consist of: - at most four (4) alphanumeric characters that represent the product group code - at most seven (7) alphanumeric characters that include the state (one (1) character), unique characters within a fund (three or four (3 or 4) characters) and type of cover (two (2) characters) This is the filename as specified on the patient's Private Health Information Statement for their product cover at admission, without the fund code. The list of product codes is available from the Private Health Insurance Ombudsman at <a href="https://data.gov.au/data/dataset/private-health-insurance">https://data.gov.au/data/dataset/private-health-insurance</a>	Identify record if not a valid product code or blank.	EW004

Total record length = ~~1397~~1408 characters; record type of 'E' followed by ~~1396~~ 1407 character record

### 3. Primary Impairment type code (AROC 2012)

<b>Data item:</b>	Primary Impairment type code (AROC 2012)
<b>Datasets:</b>	HCP and HCP1
<b>Changes:</b>	Updated AN_SNAP METeOR identifier
<b>Reason:</b>	To align to current reporting standards

#### HCP – AN-SNAP – revised field (same changes required for HCP1)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
14	Primary Impairment type code (AROC <del>2012</del> 2022)	<del>681412</del> <del>781319</del>	M	A(7)	NN.NNNN Left justify	1	The impairment which is the primary reason for the admission to an episode of care, as represented by a code. (AROC impairment codes – <del>AN-SNAP Version 4-dataset (July 2012 AROC 2022))</del> <del>Code as specifically as possible and where possible avoid the use of impairment group 13 - 'Other Disabling Impairments'.</del> Use the AROC impairment coding guidelines to code as specifically as possible – AROC Impairment Coding Guidelines 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).	<b>Reject</b> record if not a valid code	AE014

#### HCP – Further information – revised field (same changes required for HCP1)

##### AROC Impairment Coding Guidelines

<https://documents.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow125260.pdf>

## 4. ICU Hours

<b>Data item:</b>	ICU Hours
<b>Datasets:</b>	HCP, HCP1 and PHDB
<b>Changes:</b>	Removed neonatal intensive care units (NICUs) from the coding description, updated METeOR identifier and rounding methodology.
<b>Reason:</b>	The hours spent in NICUs are not to be reported in this data item. The removal of NICU from 'ICU Hours' aligns to current reporting practices observed in HCP1 and PHDB data and is consistent with changes to the Admitted Patient Care National Minimum Data Set from 1 July 2026.

### HCP – Episode – revised field (same changes required for HCP1 and PHDB)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
13	ICU Hours	<a href="#">471553</a>	O	N(4)	Right justify Zero prefix	1	<p>The number of completed cumulative hours (rounded <b>to the nearest hour down</b>) spent in ICU, <del>NICU</del> or PICU. If a patient has more than one period in ICU, <del>NICU</del> or PICU during this episode, the total duration of all such periods is reported.</p> <p>If the duration of length of stay in an intensive care unit is equal to or greater than 9999 hours, report 9999 hours.</p> <p>Zero fill if not applicable * refer to METeOR guide for use.</p>	If present, <b>reject</b> record if not numeric	EE013

### HCP – Explanatory notes – revised field (same changes required for HCP1 and PHDB)

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

## 5. ICU Days

<b>Data item:</b>	ICU Days
<b>Datasets:</b>	HCP, HCP1 and PHDB
<b>Changes:</b>	Removed neonatal intensive care units (NICUs).
<b>Reason:</b>	The hours spent in NICUs are not to be reported in this data item. The removal of NICU from 'ICU Hours' aligns to current reporting practices observed in HCP1 and PHDB data.

### HCP – Episode – revised field (same changes required for HCP1 and PHDB)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
12	ICU Days		M	N(3)	Right justify Zero prefix	1	The number of days the patient spent in ICU, <del>NICU</del> or PICU. Zero fill if not applicable. * refer to METeOR guide for use.	<b>Reject</b> record if not numeric.  <b>Reject</b> record if not zero for day facilities (public or private) <i>*warning for public hospitals</i>	EE012.0 <i>EW012.0*</i> EE012.1 <i>EW012.1*</i>

## 6. Reporting requirements

### HCP Reporting Requirements

<b>Data item:</b>	Explanatory notes – Reporting Requirements
<b>Datasets:</b>	HCP
<b>Changes:</b>	Extend reporting requirements by 5 weeks
<b>Reason:</b>	To accommodate for the one-month delay to the 2026-27 data specification finalisation

The hospital will provide a monthly data submission to the Insurer within ~~6 weeks~~ **11 weeks** after the end of a hospital separation month. For example, a file containing data for separations during the month of July is to be provided to insurers by ~~mid-September~~ **mid-October**.

## HCP1 Reporting Requirements

<b>Data item:</b>	Explanatory notes – Reporting Requirements
<b>Datasets:</b>	HCP1
<b>Changes:</b>	Removing extension provisions and extend typical 20 week reporting requirements by 5 weeks
<b>Reason:</b>	To accommodate for the one-month delay to the 2026-27 data specification finalisation and remove information specific to the supplementary data specifications.

The insurer will provide the Department with HCP data for separations by calendar month within ~~26.5 weeks~~ 25 weeks of the month to which it relates, ~~unless an extension is provided in writing from the department to the insurer before the end of that period.~~ For example, data for separations during the month of July 2025 are to be submitted by no later than ~~22 January~~ 31 January 2026. ~~Insurers may submit and validate 2025-26 HCP1 files including ‘Practitioner Provider Number’ from 1 November 2025 in the Data Submission Portal.~~

## HCP2 Quarterly Reporting

<b>Data item:</b>	Explanatory notes – Quarterly Reporting
<b>Datasets:</b>	HCP2
<b>Changes:</b>	Extend reporting requirements by 5 weeks
<b>Reason:</b>	To accommodate for the one-month delay to the 2026-27 data specification finalisation

The insurer will provide the information specified in the Hospital Casemix Protocol 2 (HCP2) to the Department within ~~4 weeks~~ 9 weeks after the end of each claims processing quarter for each service event where a benefit has been paid. For example, data for the quarter July to September is to be provided by ~~31 October~~ 2 December.

## PHDB Reporting Requirements

<b>Data item:</b>	Explanatory notes – Reporting Requirements
<b>Datasets:</b>	PHDB
<b>Changes:</b>	Extend reporting requirements by 5 weeks
<b>Reason:</b>	To accommodate for the one month delay to the 2026-27 data specification finalisation

The private hospital will provide a monthly data submission to the Department within ~~6 weeks~~ 11 weeks after the end of a hospital separation month for each episode. For example, a data file for all separations that occurred during the month of July must be submitted to the Department by ~~mid-September~~ mid-October.

## GT-Dental Monthly Reporting

<b>Data item:</b>	Explanatory notes – Monthly Reporting
<b>Datasets:</b>	GT-Dental
<b>Changes:</b>	Extend reporting requirements by 5 weeks
<b>Reason:</b>	To accommodate for the one-month delay to the 2026-27 data specification finalisation

The insurer will provide the information specified in the GT-Dental Protocol to the Department within ~~4 weeks~~ 9 weeks after the end of each claims processing month for each service event where a benefit has been paid. For example, data for the month of July is to be provided by ~~31 August~~ 2 October.

## 7. Other changes

- HCP1 - MDHT Table – ‘Medical device or human tissue product item’ updated link to prescribed list in the coding description to [www.health.gov.au/resources/publications/prescribed-list-of-medical-devices-and-human-tissue-products](http://www.health.gov.au/resources/publications/prescribed-list-of-medical-devices-and-human-tissue-products)
- HCP - ANSNAP Table – ‘Sex’ METeOR identifier updated to 741686, which was previously missed.
- HCP, HCP1 and PHDB – Explanatory notes - <https://www.health.gov.au/resources/publications/prostheses-list> updated to <https://www.health.gov.au/resources/publications/prescribed-list>.
- PHDB – Episode Table – Add METeOR identifiers for ‘Family name’ (613331) and ‘Given Name’ (613340).
- HCP1 – Explanatory notes – Notes about the input file updated wording ‘prosthetic records’ to ‘MDHT record’.
- HCP1 – Edit Rules – Episode – EW204 Rule description updated wording ‘prosthesis’ to ‘Medical Device and Human Tissue Products’.

### Unplanned return to operating theatre

<b>Data item:</b>	Unplanned return to operating theatre
<b>Datasets:</b>	HCP, HCP1 and PHDB
<b>Changes:</b>	Added METeOR identifier
<b>Reason:</b>	Added to link to Admitted Patient Care National Minimum Data set.

### HCP – Episode – revised field (same changes required for HCP1 and PHDB)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
27	Unplanned Theatre Visit During Episode	<a href="#">783891</a>	M	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	<b>Reject</b> record if not (1 or 2)	EE027

## Principal diagnosis and Additional diagnosis

<b>Data item:</b>	Principal diagnosis and Additional diagnosis
<b>Datasets:</b>	HCP, HCP1 and PHDB
<b>Changes:</b>	Move Condition onset flag to new METeOR identifier
<b>Reason:</b>	To be consistent with Admitted Patient Care National Minimum Data set.

Please refer to the data specification workbooks for the full coding descriptions. The descriptions in the page 12 have been reduced to include key points only for clarity.

### HCP – Episode – revised field (same changes required for HCP1 and PHDB)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
36	Principal Diagnosis	<del>686100</del> <del>796636</del> and <del>793125</del>	M	A(6)	NANNNN Left justify Strip hyphen, dots & morphology codes	1	Each entry should consist of: - one (1) digit that represents the Condition Onset Flag code - five (5) alphanumeric characters that represent the principal diagnosis code Condition Onset Flag (see METeOR <del>686100</del> <b>796636</b> ) - A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code. 1 = condition with onset during the episode of admitted patient care 2 = condition not noted as arising during the episode of admitted patient care 9 = not reported...	<i>Please refer to the data specification workbooks for the full coding descriptions</i>	

### HCP – Episode – revised field (same changes required for HCP1 and PHDB)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
37	Additional Diagnosis	<del>686100</del> <del>796636</del> and <a href="#">793130</a>	M	A(6)	NANNNN Left justify Strip hyphen, dots & morphology codes	49	Each entry should consist of: - one (1) digit that represents the Condition Onset Flag code - five (5) alphanumeric characters that represent the additional diagnosis code Condition Onset Flag (see METeOR <del>686100</del> <del>796636</del> ) - A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code. 1 = condition with onset during the episode of admitted patient care 2 = condition not noted as arising during the episode of admitted patient care 9 = not reported...	<i>Please refer to the data specification workbooks for the full coding descriptions</i>	

### Mode of Separation

<b>Data item:</b>	Mode of Separation
<b>Datasets:</b>	HCP, HCP1 and PHDB
<b>Changes:</b>	Removed format
<b>Reason:</b>	The format is no longer relevant with the coding descriptions in use.

### HCP – Episode – revised field (same changes required for HCP1 and PHDB)

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
30	Mode of Separation	<a href="#">722644</a>	M	N(2)	<del>Left justify</del> <del>and follow</del> <del>with space</del> <del>(may also</del> <del>submit in</del>	1	Status at separation of person (discharge/transfer/death) and place to which person is released, as represented by a code. 10 Discharge/transfer to (an)other acute hospital 21 Discharge/transfer to a residential aged care	Reject record if not (10, 21, 22, 30, 40, 50,	EE030

No	Data Item	METeOR identifier	Obligation	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
					<del>old format with zero prefix</del>		<p>service, which is not the usual place of residence</p> <p>22 Discharge/transfer to a residential aged care service, which is the usual place of residence</p> <p>30 Discharge/transfer to (an)other psychiatric hospital</p> <p>40 Discharge/transfer to other health care accommodation (includes mothercraft hospitals)</p> <p>50 Statistical discharge - type change</p> <p>60 Left against medical advice/discharge at own risk</p> <p>70 Statistical discharge from leave</p> <p>80 Died</p> <p>90 Other (includes discharge to usual residence (not including residential aged care), own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))</p>	60, 70, 80 or 90)	