PHI Data Specifications 2021/22

Changes effective for data with separation month from July 2021 onwards

Contents

Version: 3.0
Date Updated: **Monday, August 22, 2022**
Content Owner: Department of Health

1. Implementation

For PHDB (hospital to department), HCP (hospital to insurer), and HCP1 (insurer to department), these proposed changes to data specifications are designed to apply to hospital separation data with separation month from July 2021 onwards, i.e. data relating to the 2021-22 financial year and following years.

For GT-Dental (insurer to department) and HCP2 (insurer to department) there are no changes.

Changes in this summary document are correspondingly indicated IN RED in the associated data specification spreadsheets for each collection (PHDB, HCP or HCP1)

2. Accommodation charge

Data Item: Accommodation charge

Datasets: HCP (episode)

Change: Simplify HCP edit rule to prevent unnecessary critical errors.

Reason: Edit rule is currently giving critical errors for valid records (eg valid episodes with 'Theatre charge' only, or with 'Other charge' only).

HCP – Episode

No	Data Item	Type & size	Format	Coding description	Edit Rules	Error code/s
44	Accommodation Charge	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	The gross amount charged for accommodation (include ex-gratia and patient portion accommodation charges). Zero fill if no amount charged. * refer to guide for use.	~~**Reject** record if not numeric or if item blank and bundled charges, ICU charge, CCU charge, SCN charge and HITH charge are ALL zero or blank.~~ **Reject** record if not numeric	EE044

3. Birth weight of infant, neonate, stillborn

Data Item: Birth weight of infant, neonate, stillborn

Datasets: PHDB (episode), HCP (episode), HCP1 (episode)

Change: Change coding description to remove unnecessary text. Remove related text in explanatory notes which is out of date.

Reason: Minor change to improve clarity

PHDB – Episode (same changes for HCP and HCP1)

No	Data Item	METeOR identifier	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
28	Birth weight of infant, neonate, stillborn	668986	N(4)	Right justify Zero prefix		The first weight of the live born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth, measured in grams. For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 gram groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured. ~~In perinatal collections the birthweight is to be provided for live born and stillborn babies.~~ Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days. An entry of 0000 means the patient's age >= 365 days or weight was > 9000 grams. ~~*refer to guide for use~~	**Reject** record if not numeric. **Identify** record if weight >9000g LOS <= 365. **Identify** record if weight > 0 and LOS >365 days where, LOS = Admision Date (item 9) - Date of Birth (item 6)	E028 W028.0 W028.1

PHDB Explanatory Notes text deleted (same change for HCP and HCP1)

~~***Infant weight neonate*** – For live births (http://meteor.aihw.gov.au/content/pop/index.phtml/itemId/265594), birth weight (http://meteor.aihw.gov.au/content/pop/index.phtml/itemId/265625) 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.~~

4. Palliative care status

Data Item: Palliative Care Status

Datasets: These changes affects the following data specifications: PHDB (episode), HCP (episode), HCP1 (episode),

Change: 1. Change to existing edit rule in PHDB and HCP to make allowed values (1 or 2) only – consistent with HCP1

2. New edit rule to improve data quality

Reason: If 'Care type' is palliative care then 'Palliative Care Status' cannot be 2 ('No Palliative care…')

PHDB – Episode – new edit rule

No	Data Item	Type & size	Coding description	Edit Rules	Error code/s
25	Palliative Care Status	N(1)	An indicator of whether the episode involved palliative care. 1 = Patient required palliative care during episode 2 = No palliative care required during episode This item is required because some States do not statistically discharge to palliative care Zero fill if not applicable. * refer to guide for use.	~~**Reject** record if not (0, 1 or 2).~~ Reject record if not (1 or 2). Reject record if 2 AND 'care type' (Item 20) = 3	E025 E025.1

HCP – Episode – new edit rule

No	Data Item	Type & size	Coding description	Edit Rules	Error code/s
25	Palliative Care Status	N(1)	An indicator of whether the episode involved palliative care. 1 = Patient required palliative care during episode 2 = No palliative care required during episode This item is required because some States do not statistically discharge to palliative care. * refer to guide for use.	~~**Reject** record if not (0, 1 or 2).~~ Reject record if not (1 or 2). Reject record if 2 AND 'care type' (Item 20) = 3	EE025 EE025.1

HCP1– Episode – new edit rule

No	Data Item	Type & size	Coding description	Edit Rules	Error code/s
61	Palliative care Status	N(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** record if not (1 or 2). **Identify** record if blank and hospital type is (private or private day facility). If present, **reject** record if not numeric. If Palliative Care Status =2 then Reject record IF [('care type code' (Item 83) = 3) OR ('Care type code' (Item 83) is not present and 'Care type' (Item 44) is (30, 31, 32 or 33))]	EW061.0 EW061.1 EE061.2 EE061.3

5. Secondary MBS item numbers

Data Item: Secondary MBS Item numbers

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

Change: Relax the edit rule

Reason: Secondary MBS Item numbers don't have to be valid for the entire period of the episode (from admission to separation date).

PHDB – Episode

No	Data Item	Type & size	Coding description	Edit Rules	Error code/s
43	Secondary MBS Item numbers	A(14)	Additional MBS item numbers are all MBS items performed in theatre/procedure room/angiography suite, which are not the principal MBS code. Blank means that there was no additional item or code (or not 9 repetitions). * refer to guide for use.	~~**Reject** record if not (a valid MBS item number from the relevant MBS Schedule(s) current during the episode or blank)~~ If present, **reject** record if not a valid MBS item number from the relevant MBS Schedule(s) current for at least one day during the episode.	E043

HCP – Episode

No	Data Item	Type & size	Coding description	Edit Rules	Error code/s
43	Secondary MBS Item numbers	A(14)	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 MBS item (or not 9 repetitions). * refer to guide for use.	~~**Reject** record if not (a valid MBS item number from the relevant MBS Schedule(s) current during the episode or blank)~~ If present, **reject** record if not a valid MBS item number from the relevant MBS Schedule(s) current for at least one day during the episode.	EE043

HCP1 – Episode

No	Data Item	Type & size	Coding description	Edit Rules	Error code/s
54	Secondary MBS item numbers	A(14)	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)~~ If present, **reject** record if not a valid MBS item number from the relevant MBS Schedule(s) current for at least one day during the episode.	EE054

6. Patient transfers

Data Item: Provider Number of Hospital from which transferred, and Provider Number of Hospital to which transferred

Datasets: HCP (episode)

Change: Minor changes to edit rules and descriptions to allow overseas hospitals to be coded as OVERSEAS (as in HCP1)

Reason: Make HCP specification consistent with HCP1 specification

HCP – Episode

No	Data Item	Coding description	Edit Rules	Error code/s
19	Provider Number of Hospital from which transferred	The Commonwealth-issued hospital provider number for the hospital from which a patient has been transferred (Provider number required only when HCP item number 21 is reported as: 1- Admitted patient transferred from another hospital) Blank fill if no hospital transfer. Overseas hospitals to be coded as OVERSEAS If a patient was transferred from Accident/Emergency at a different hospital from the one in which this separation occurred, then enter the Commonwealth-issued Provider number of that hospital	~~**Reject** record if not a valid 8 character Commonwealth provider number and Source of Referral (item 21) is 1.~~ **Reject** record if Source of referral (item 21) is 1 and item 19 is not (a valid 8 character Commonwealth provider number or OVERSEAS) **Reject** record if not blank and Source of Referral (item 21) is not 1 or 4	EE019 EE019.1
33	Provider Number of Hospital to which transferred	The Commonwealth-issued hospital provider number for the hospital to which a patient has been transferred (Provider number required only when HCP item number 30 is reported as: 1 = Discharge/transfer to an(other) acute hospital, or 3 = Discharge/transfer to a(nother) psychiatric hospital Blank fill if no hospital transfer. Overseas hospitals to be coded as OVERSEAS	~~**Reject** record if not a valid 8 character Commonwealth provider number and Mode of Separation (item 30) is 1, 3.~~ Reject record if Mode of separation (item 30) is 1 or 3 and item 33 is not (a valid 8 character Commonwealth provider number or OVERSEAS) **Reject** record if not blank and Mode of Separation (item 30) is 2, 5, 6, 7, 8 or 9.	EE033 EE033.1

7. METeOR references

The following changes to update METeOR references are for HCP, HCP1 and PHDB except where otherwise indicated. These changes do not involve any change to data values or formats for data submission and so are considered minor changes. Where possible PHIA data specifications should use the latest METeOR references.

Family name: update METeOR reference from 286953 to 613331 in HCP only

Given name: update METeOR reference from 287035 to 613340 in HCP only

Admission date: update METeOR reference from 269967 to 695137

ICU Hours: update METeOR reference to 471553

Total psychiatric care days: update METeOR reference from 552375 to 722678

Diagnosis Related Group: update METeOR reference from 391295 to 729933

Urgency of admission update METeOR reference from 269986 to 686084

Mental Health Legal Status: update METeOR reference from 534063 to 722675

Hours of mechanical ventilation: update METeOR reference from 479010 to 708842

Number of days of hospital-in-the-home care: update METeOR reference from 270305 to 686115

Principal diagnosis: update METeOR reference from 680976 to 699609

Additional diagnosis: update METeOR reference from 680973 to 699606

Procedure: update METeOR reference from 641379 to 699716

Number of Qualified Days for Newborns: update METeOR reference from 270033 to 722649

8. Other changes- (also see spreadsheets for details)

- Inter-hospital contracted patient in PHDB and HCP, and Inter-hospital contracted patient code in HCP1 : Horizontal lines which separated values in the description have been removed to avoid confusion about meaning. Here is the revised version:

  Contracted (destination) hospital
  1 = Inter-hospital contracted patient from public sector hospital;
  2 = Inter-hospital contracted patient from private sector hospital;
  Contracting (originating) hospital
  3 = Inter-hospital contracted patient to public sector hospital;
  4 = Inter-hospital contracted patient to private sector hospital;

  5 = Not inter-hospital contracted;
  9 = Not stated.

- New file-naming conventions for HCP and ANSNAP files (for both hospitals and Insurance funds) are shown in Explanatory notes of HCP data specifications

- Edit rule W036.3 for Principal diagnosis (item 36) in PHDB: to bring this edit rule into line with corresponding edit rules in HCP and HCP1 it was changed to: **Identify** record if condition onset flag = 1 and not ~~Z50N~~ Z38N (where N = 0 to 9)

- Minor change to warning edit rules for Principal Diagnosis in HCP (item 36) and HCP1 (item 47) to make consistent with same warning edit rule in PHDB (item 36). Corrected version is: **Identify** record if condition onset flag = 1 and not Z38N (where N = 0 to 9) – see spreadsheets

- Edit rule EE040 in HCP - reference to Item 42 changed to item 41

- Edit rule EW028.1 in HCP – reference to Item 32 changed to item 9, reference to Item 29 changed to item 6

- AE001.1 in HCP (ANSNAP): The department would like users to be able to submit data for multiple funds in the same file. Consequently this rule will be ignored in the department's EDW

- AW003.2 in HCP (ANSNAP). The rule refers to the Medical Record Number (MRN) which is not included in the ANSNAP file. This rule will be ignored in the department's EDW

Explanation: MRN is in HCP Episode file but ANSNAP is a separate file – so the EDW system won't know about the MRN in the episode file – so can't perform the validation

No	Data Item	Coding description	Edit Rules	Error code/s
1	Insurer Membership Identifier	Insurer membership identifier.	~~**Reject** record if not same as Source Identifier value in FILE HEADER item 2.~~	~~AE001.1~~
3	AN-SNAP Identifier	A unique identifier for this AN-SNAP record that links it to the associated episode (and/or medical and prosthetic records). It is a combination of the Medical Record Number (in the Episode record) and hyphen and a record number (sequential counter)	**Reject** record if blank **Identify** record if no hyphen in the Identifier ~~**Identify** record if the characters prior to the hyphen do not match a Medical Record Number in the Episode Records~~	AE003 AW003.1 ~~AW003.2~~

- Add text "Must be filled with 0000 if no time spent in operating theatre in HCP " to description for 'Minutes in theatre or procedure room' (Item 42) in HCP in order to align description with the same field in PHDB and HCP1.

- References to ICD-10 in description for 'Procedure' item (in PHDB, HCP and HCP1) corrected to ACHI

- Updated HCP1 Explanatory Notes with 20 week data submission timeframe:
  The insurer will provide the Department with HCP data for separations by calendar month within 20 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 middle of December .