Scope of Data Collection (HCP)

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 2018*

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

Reporting Requirements

The hospital will provide a monthly data submission to the Insurer within 6 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.

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:

- M – Mandatory
- O – Optional

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. Negative amounts are permitted for reversals. An entry of 000000000 means that no benefit/charge was recorded.

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 data item exists, refer to the National Health Data Dictionary for definition and collection methods.

The ***edit rules column*** outlines the edit checks to be used to validate the data. 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.

AR-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.
ICD-10-AM means 'The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification

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 2018* ; and
(b) the *Health Insurance (General Medical Services Table) Regulations 2018* ; and
(c) the *Health Insurance (Pathology Services Table) Regulations 2018* ;

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 billing code.
NHDD means the (most current version of the) 'National Health Data Dictionary'.
NICU means the neonatal intensive care unit of a hospital.
overnight -stay patient means a person who is admitted to and separates from a hospital on different dates.
PHIAC *means* Private Health Insurance Administration Council
PICU means the paediatric intensive care unit of a hospital.
procedure means clinical intervention that is surgical in nature, carries a procedural risk, carries an anaesthetic risk, requires specialised training, and/or requires special facilities or equipment only available in an acute care setting

same-day patient means a person who is admitted to and separates from a hospital on the same date.
SCN means the special care nursery of a hospital.
special character means a character that has a visual representation but is not an alphanumeric character, ideogram or blank space.
statistical admission , in relation to a person, means the administrative process used by a hospital to record the commencement of a new episode of care that provides the person with a new care type during a single hospital stay.

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

Guide for Use

Accommodation charges/benefits - refer to private, shared or high dependency accommodation for any Accommodation Type (i.e. advanced surgical, surgical, medical, rehabilitation, obstetrics, and psychiatry). All hospital episodes must have a charge/benefit component relating to accommodation, unless it was bundled, or the hospital billed a procedure-only fee. Therefore, cases such as chemotherapy should either have a charge/benefit component in "bundled" or "accommodation" or “theatre”. They should 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/paid by the insurer, 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 is used to measure functional improvement and is comprised of 18 items (13 motor items and 5 cognition items) with a maximum score of seven and a minimum score of one. Total scores can range from 18 to 126. Admission scores must be collected within 72 hours after the admission. Discharge scores must be collected within 72 hours of discharge, unless the patient died during the episode. Guide for collecting the AROC inpatient data set should be followed for scoring the FIM. 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 (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.

Minutes in Theatre - 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 **-** calculations to include care provided in: a palliative care unit; a designated palliative care program; or under the principal clinical management of a palliative care

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 53).

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 53).

Theatre charges/benefits - refer to a theatre/procedure room/angiography suite. This applies to theatre charges, benefits and minutes in theatre.

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) and A (AN-SNAP)

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, please see the following websites:

General information about the data collection

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-about-HCP

Annual reports

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports

List of Hospital provider numbers

To request a list of hospital provider numbers please email: hcp@health.gov.au

Metadata and health dictionary specifications

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

For private health insurance industry information

www.apra.gov.au

Commonwealth Prosthesis list

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

Item No	Data Item	Obligation	Position	Type & Size	Format	Comments	Edit Rules	Error Code/s
1	Provider Number	M	1-8	A(8)	NNNNNNNA	The Commonwealth-issued hospital provider number (must be 8 characters, include leading zero)	**Reject** the file if not a valid 8 character Commonwealth provider number	HE01
2	Insurer/Group Identifier	M	9-11	A(3)		The insurer identifier selected from the list of registered private health insurers or the code for the group of insurers (e.g. AHS for Australian Health Service Alliance).		
3	Disk Reference number	M	12-19	A(8)		Number identifies the file/disk ID		
4	Date Prepared	M	20-27	A(8)	DDMMYYYY	The date data was prepared by hospital	**Reject** the file if not in format DDMMYYYY	HE04
5	Number of records	M	28-31	N(4)		The number of episodes on file/disk	**Reject** the file if mismatch on Episode record count **Reject** the file if not numeric	HE05 HE05.1
6	Test Flag	M	32	A(1)		T=Test, P=Production		
7	Resubmitted Disk	M	33	A(1)		Indicates if the file/disk is being resubmitted Y/N		
8	Period From	M	34-41	A(8)	DDMMYYYY	Period starting (separation month)	**Reject** the file if not in format DDMMYYYY **Reject** the file if not within date period applicable for month year specified in physical file name	HE08 HE08.1
9	Period to	M	42-49	A(8)	DDMMYYYY	Period ending (separation month)	**Reject** the file if not in format DDMMYYYY	HE09
10	HCP Version	M	50-53	N(4)		~~HCP version 0900~~ HCP version 1000		
11	ICD Version	M	54-57	N(4)		~~ICD version 10.10 = 1010~~ ICD version 10.11 = 1011	**Reject** if not a valid ICD version	HE11

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
1	Insurer Membership Identifier			M	1	15	A(15)	Left justify Blank fill	1	Insurer membership identifier.	**Reject** record if blank	EE001
2	Insurer Identifier			M	16	18	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if not a valid insurer code	EE002
3	Episode Identifier			M	19	33	A(15)	Left justify	1	Unique episode identifier for this episode of care.	**Reject** record if blank **Reject** record if not unique within monthly file	EE003 EE003.1
4	Family Name	286953		M	34	61	A(28)	Left justify	1	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.	**Reject** record if blank	EE004
5	Given Name	287035		M	62	81	A(20)	Left justify	1	The person's identifying name within the family group or by which the person is socially identified, as represented by text.	**Identify** record if blank	EW005
6	Date of Birth	287007		M	82	89	A(8)	DDMMYYYY	1	The date of birth of the person.	**Reject** record if not in format DDMMYYYY	EE006
7	Postcode - Australian	611398		M	90	93	N(4)		1	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person. Codes 9999 = unknown postcode and 8888 = overseas will be used instead of METeOR codes 0097, 0098, 0099.	**Reject** record if not (a valid Australian postcode or 9999 or 8888)	EE007
8	Sex	635126		M	94	94	N(1)		1	The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code. 1 = Male 2 = Female 3 = Other 9 = Not stated / inadequately described	**Reject** record if not (1, 2, 3 or 9)	EE008
9	Admission Date	269967		M	95	102	A(8)	DDMMYYYY	1	Date on which an admitted patient commences an episode of care.	**Reject** record if not in format DDMMYYYY	EE009
10	Separation Date	270025		M	103	110	A(8)	DDMMYYYY	1	Date on which an admitted patient completes an episode of care.	**Reject** file if not in format DDMMYYYY, or if not ≥ admission date, or if MM is not same as month input in Insurer Header	EE010
11	Hospital Type			M	111	111	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	EE011 EW011
12	ICU Days			M	112	114	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 (public or private) **warning for public hospitals*	EE012.0 *EW012.0** EE012.1 *EW012.1**
13	ICU Hours			O	115	118	N(4)	Right justify Zero prefix	1	The number of completed cumulative hours (rounded down) spent in ICU, NICU or PICU. If a patient has more than one period in ICU, NICU or PICU during this episode, the total duration of all such periods is reported. Zero fill if not applicable * refer to guide for use.	If present, **reject** record if not numeric	EE013
14	Total Psychiatric Care Days	552375		M	119	123	N(5)	Right justify Zero prefix	1	The sum of the number of days or part days of stay that the person received care as an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit. Zero fill if not applicable.	**Reject** if not numeric	EE014
15	Diagnosis Related Group	391295		O	124	127	A(4)	Left justify	1	A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital, as represented by a code.	If present, **identify** record if not a valid DRG code for DRG version supplied at item 16.	EW015

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
16	DRG Version			O	128	129	A(2)		1	The version of the DRG classification: 41 = version 4.1 42 = version 4.2 50 = version 5.0 51 = version 5.1 52 = version 5.2 60 = version 6.0 6x = version 6.x 70 = version 7.0 80 = version 8.0 90 = version 9.0 na = version n.a A0 = version 10.0 Must be supplied if DRG code provided at item 15.	If present, **identify** record if not a valid version. **Identify** if blank and DRG code provided at item 15.	EW016.0 EW016.1
17	Admission Time	682942		M	130	133	N(4)	hhmm (24 hour clock)	1	Time at which an admitted patient commences an episode of care. Blank fill if not applicable. Mandatory for same-day patients only.	**Reject** record if blank and same-day status is 1. If present, **Reject** record if not a valid time value in format HHMM (HH is in the range 00-23 and MM is in the range 00-59)	EE017 EE017.1
18	Urgency of Admission	269986		M	134	134	N(1)		1	Whether the admission has an urgency status assigned and, if so, whether admission occurred on an emergency basis, as represented by a code. 1 = Urgency status assigned - Emergency 2 = Urgency status assigned - Elective 3 = Urgency status not assigned 9 = Not known/not reported	**Reject** record if not (1, 2, 3 or 9)	EE018
19	Provider Number of Hospital from which transferred			M	135	142	A(8)	NNNNNNNA (upper case)	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 21 is reported as: 1- Admitted patient transferred from another hospital) Blank fill if no hospital transfer.	**Reject** record if not a valid 8 character Commonwealth provider number and Source of Referral (item 21) is 1. **Reject** record if not blank and Source of Referral (item 21) is not 1.	EE019 EE019.1
20	Care Type	METeOR 270174 but with additional code 11 = Mental Health Care (From METeOR 584408)		M	143	145	N(3)	Left justify two digit codes and follow with a blank space)	1	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care), as represented by a code. 10 = Acute Care 11 = Mental Health 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 principal 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 principal clinical intent 40 = Geriatric evaluation and management 50 = Psychogeriatric Care 60 = Nursing Home Type 70 = Newborn Care 80 = Other admitted patient care 90 = Organ procurement - posthumous 100 = Hospital boarder	**Reject** record if not (10, 11, 20, 21, 22, 23, 30, 31, 32, 33, 40, 50, 60, 70, 80, 90 or 100)	EE020
21	Source of Referral			M	146	146	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)	EE021

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
22	Discharge Intention on Admission			O	147	147	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, **reject** record if not (1, 2, 3, 4, 5, 8 or 9)	EE022
23	Inter-hospital contracted patient	270409		M	148	148	N(1)		1	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code. 1 = Inter-Hospital contracted patient from public sector 2 = Inter-Hospital contracted patient from private sector 3 = Not contracted 9 = Not reported	**Reject** record if not (1, 2, 3 or 9)	EE023
24	Mental Health Legal Status	534063		M	149	149	N(1)		1	Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period, as represented by a code. ~~1 = Involuntary patient~~ ~~2 = Voluntary patient~~ ~~3 = Not permitted to be reported under the laws of a State or Territory~~ ~~8 = Not applicable~~ 1 = Involuntary patient 2 = Voluntary patient 9 = Not reported/unknown	**Reject** record if not (1, 2, ~~3~~ or ~~8~~ 9)	EE024
25	Palliative Care Status			M	150	150	N(1)		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).	EE025
26	Re-admission within 28 Days			M	151	151	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 at this hospital 2 = Unplanned re-admission and patient previously treated at 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** record if not (1, 2, 3 or 8)	EE026
27	Unplanned Theatre Visit During Episode			M	152	152	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** record if not (1 or 2)	EE027

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
28	Birth weight of infant, neonate, stillborn	668986		M	153	156	N(4)	Right justify Zero prefix	1	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 and LOS <= 365 **Identify** record if weight > 0 and LOS > 365 days *where, LOS = Admission date (item 32) - Date of Birth (item 29)*	EE028 EW028.0 EW028.1
29	Hours of Mechanical Ventilation	479010		M	157	160	N(4)	Right justify Zero prefix	1	The total number of hours an admitted patient has spent on continuous ventilator support. Continuous ventilatory support refers to the application of ventilation via an invasive artificial airway. For the purposes of this data element, invasive artificial airway is that provided via an endotracheal tube or a tracheostomy tube. Zero fill if not applicable.	**Reject** record if not numeric **warning for public hospitals*	EE029 *EW029**
30	Mode of Separation	270094		M	161	162	N(2)	Left justify and follow with space (may also submit in old format with zero prefix)	1	Status at separation of person (discharge/transfer/death) and place to which person is released, as represented by a code. 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 (1, 2, 3, 4, 5, 6, 7, 8, 9, 01, 02, 03, 04, 05, 06, 07, 08 or 09).	EE030
31	Separation Time	682919		M	163	166	N(4)	hhmm (24 hour clock)	1	Time at which an admitted patient completes an episode of care. Blank fill if not applicable. Mandatory for same-day patients only.	**Reject** record if blank and same-day status is 1. **Reject** record if not a valid time value in format HHMM (HH is in the range 00-23 and MM is in the range 00-59) **Identify** record if hospital type (item 11) is 3 (Private Day Facility) and patient stay exceeds 23 hours	EE031 EE031.1 EW031
32	Total Leave Days	270251		M	167	170	N(4)	Right justify Zero prefix	1	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	EE032
33	Provider Number of Hospital to which transferred			M	171	178	A(8)	NNNNNNNA (uppercase)	1	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.	**Reject** record if not a valid 8 character Commonwealth provider number and Mode of Separation (item 30) is 1, 3. **Reject** record if not blank and Mode of Separation (item 30) is 2, 5, 6, 7, 8 or 9.	EE033 EE033.1
34	Non-Certified Days of Stay			M	179	182	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.	**Reject** record if not numeric. **warning for public hospitals*	EE034 *EW034**

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
35	Number of days of hospital-in-the-home care	270305		M	183	186	N(4)	Right justify Zero prefix	1	The number of hospital-in-the-home days occurring within an episode of care for an admitted patient. 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** record if not = HITH completed date - HITH commencement date).	EE035 EW035
36	Principal Diagnosis	680976		M	187	192	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 686100) - 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 Note: All patients should report a condition onset flag code of 2 for the principal diagnosis, with the exception of newborns. Newborns in their admitted birth episode within the hospital may report a condition onset flag code of 1 or 2 for the principal diagnosis. Newborn episodes can be identified by ICD-10-AM Code Z38.x in the principal or additional diagnosis code field. Principal Diagnosis - The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code. The principal diagnosis should be reported in the most current version of ICD-10-AM and selected according to the National Coding Standards.	**Reject** record if not a valid ICD-10-AM principal diagnosis code **Identify** record if Same-day Status (item 39) = 2 (overnight patient) and Z50N or Z50NN (where N = 0 to 9) **Identify** record if Care Type = 60 and not Z742 or Z75N or Z75NN. (where N = 0 to 9) **Identify** record if condition onset flag = 1 and not Z38.?	EE036 EW036.1 EW036.2 EW036.3
37	Additional Diagnosis	680973		M	193	486	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 686100) - 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 Additional diagnosis - A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code. Blank means no additional diagnosis codes (or not 49 repetitions).	**Reject** record if not (a valid ICD-10-AM code or blank). **Identify** record if same as 'Principal Diagnosis Code'	EE037 EW037
38	Procedure	641379		M	487	836	A(7)	NNNNNNN Left justify Strip hyphen	50	A clinical intervention represented by a code that: is surgical in nature, and/or carries a procedural risk, and/or carries an anaesthetic risk, and/or requires specialised training, and/or requires special facilities or equipment only available in an acute care setting. Blank means no ICD-10-AM procedure codes (or not 50 repetitions)	**Reject** if not (a valid ICD-10-AM code or blank).	EE038

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
39	Same-day Status			M	837	837	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).	EE039
40	Principal MBS Item Number			M	838	851	A(14)	Left justify	1	A valid Medical Benefits Schedule item according to the relevant MBS Schedule valid for the MBS date (Item 41). Blank means there was no applicable MBS item.	If present, **reject** record if not a valid MBS item from the relevant MBS Schedule valid for the service date (Item 42)	EE040
41	Principal MBS Item Date			M	852	859	A(8)	DDMMYYYY	1	The date on which; the principal MBS item (item 40) was carried out, or (if item 40 is blank), the first Miscellaneous Service Code (item 53) was carried out. Must be supplied if principal MBS item number provided (item 40).	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 40 is populated	EE041.0 EE041.1 EE041.2
42	Minutes of operating theatre time	270350		M	860	863	N(4)	Right justify Zero prefix minutes	1	Total time, in minutes, spent by a patient in operating theatres during current episode of hospitalisation. Should be populated if surgical ADA code provided in Miscellaneous Service Code field (item 53). Blank means there was no applicable MBS Item / ADA code or a public hospital. Must be supplied by private hospitals and private day facilities where MBS item number (item 40) or Miscellaneous Service Code (item 53) provided. * refer to guide for use.	If present, **reject** record if not numeric. **Identify** if blank and item 40 or item 53 is populated.	EE042 EW042
43	Secondary MBS Item numbers			M	864	989	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 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)	EE043
44	Accommodation Charge			M	990	998	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for accommodation (include ex-gratia and patient portion accommodation charges). Zero fill if no amount charged. * refer to guide for use.	**Reject** record if not numeric or if item blank and bundled charges, ICU charge, CCU charge, SCN charge and HITH charge are ALL zero or blank.	EE044
45	Theatre Charge			M	999	1007	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total amount charged for theatre/procedure room/angiography suite (include ex-gratia and patient portion theatre charges). Zero fill if no amount charged. * refer to guide for use.	**Reject** record if not numeric	EE045
46	Labour Ward Charge			M	1008	1016	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for labour ward (include ex-gratia and patient portion labour ward charges). Zero fill if no amount charged.	**Reject** record if not numeric	EE046
47	Intensive Care Unit Charge			M	1017	1025	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for ICU (include ex-gratia and patient portion ICU charges). Zero fill if no amount charged. * refer to guide for use.	**Reject** record if not numeric	EE047
48	Prosthesis Charge			M	1026	1034	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross maximum amount charged for prosthesis (include ex-gratia prosthesis charges and patient portion), Zero fill if no amount charged.	**Reject** record if not numeric	EE048

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
49	Pharmacy Charge			M	1035	1043	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for pharmacy (include ex-gratia and patient portion pharmacy charges, exclude discharge medications). Zero fill if no amount charged.	**Reject** record if not numeric	EE049
50	Other Charges			M	1044	1052	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for any chargeable item which cannot be specifically categorised elsewhere (exclude ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments). Zero fill if no amount charged. * refer to guide for use.	**Reject** record if not numeric	EE050
51	Bundled Charges			M	1053	1061	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross bundled charge raised (include ex-gratia and patient portion bundled charges). Zero fill if no amount charged. * refer to guide for use.	**Reject** record if not numeric	EE051
52	Medical Record Number			M	1062	1081	A(20)	Left justify Blank fill	1	The Medical Record Number (or unit record number) that uniquely identifies the patient, regardless of the number of admissions they have had to the facility.	**Reject** record if blank	EE052
53	Miscellaneous Service Codes			M	1082	1191	A(11)	Left justify	10	Any miscellaneous service codes (i.e. non MBS items or Australian Dental Association codes from the Australian Schedule of Dental Services and Glossary Twelfth edition 2017) used for billing. Up to 10 codes may be entered. Blank means that there were no miscellaneous service codes or not 10 repetitions.		
54	Hospital-in-the-home care Charges			M	1192	1200	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for hospital-in-the-home care service (include ex-gratia and HITH patient portion charges). Zero fill if no amount charged.	**Reject** record if not numeric **warning for public hospitals*	EE054 *EW054**
55	Special Care Nursery Charges			M	1201	1209	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for SCN (include ex-gratia and patient portion SCN charges, exclude NICU charges). Zero fill if no amount charged. * refer to guide for use.	**Reject** record if not numeric	EE055
56	Coronary Care Unit Charges			M	1210	1218	N(9)	Right justify Zero prefix $$$$$$$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. * refer to guide for use.	**Reject** record if not numeric	EE056
57	Special Care Nursery hours			O	1219	1222	N(4)	Right justify Zero prefix	1	The number of completed cumulative hours (rounded down) spent in SCN. If a patient has more than one period in SCN during this episode, the total duration of all such periods is reported. Zero fill if not applicable * refer to guide for use.	If present, **reject** record if not numeric.	EE057
58	Coronary Care Unit hours			O	1223	1226	N(4)	Right justify Zero prefix	1	The number of completed cumulative hours (rounded down) spent in CCU. If a patient has more than one period in CCU during this episode, the total duration of all such periods is reported. Zero fill if not applicable * refer to guide for use.	If present, r**eject** record if not numeric.	EE058
59	Special Care Nursery days			M	1227	1229	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** record if not zero for day facilities (public or private)	EE059.0 EE059.1
60	Coronary Care Unit days			M	1230	1232	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** record if not zero for day facilities (public or private)	EE060.0 EE060.1

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
61	Number of Qualified Days for Newborns	270033		M	1233	1237	N(5)	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**~~ **Reject** record if >0000 and (care type not newborn care).	EE061.0 E~~W~~E061.1
62	Hospital-in-the-home care Commencement Date			M	1238	1245	A(8)	DDMMYYYY	1	Date on which an admitted patient commences an episode of hospital-in-the-home care services. Conditional item if HITH charges (item 54) > 0. Blank fill if not applicable.	**Reject** record if Hospital-In-The-Home Charges (item 54) is populated and item is blank or not in format DDMMYYYY. **Reject** record if commencement date > HITH completed date.	EE062.0 EE062.1
63	Hospital-in-the-home care Completed Date			M	1246	1253	A(8)	DDMMYYYY	1	Date on which an admitted patient completes an episode of hospital-in-the-home care services. Conditional item if HITH charges (item 54) > 0. Blank fill if not applicable.	**Reject** record if Hospital-In-The-Home Charges (item 54) is populated and item is blank or not in format DDMMYYYY. **Reject** record if completed date < HITH commencement date.	EE063.0 EE063.1
64	Palliative Care Days			M	1254	1257	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. Conditional item if Palliative Care Status (item 25) = 1. Zero fill if no Palliative Care Days. * refer to guide for use.	**Reject** record if not numeric. **Identify** record if 0 and palliative care status (item 25) = 1	EE064 EW064

Total record length = 1257

Item No	Data Item	Obligation	Position	Type & Size	Format	Comments	Edit Rules	Error Code/s
1	Provider Number	M	1-8	A(8)	NNNNNNNA	The Commonwealth-issued hospital provider number (must be 8 characters, include leading zero)	**Reject** the file if not a valid 8 character Commonwealth provider number	HE01
2	Insurer/Group Identifier	M	9-11	A(3)		The insurer identifier selected from the list of registered private health insurers or the code for the group of insurers (e.g. AHS for Australian Health Service Alliance).		
3	Disk Reference number	M	12-19	A(8)		Number identifies the file/disk ID		
4	Date Prepared	M	20-27	A(8)	DDMMYYYY	The date data was prepared by hospital	**Reject** the file if not in format DDMMYYYY	HE04
5	Number of records	M	28-31	N(4)		The number of episodes on file/disk	**Reject** the file if mismatch on Episode record count **Reject** the file if not numeric	HE05 HE05.1
6	Test Flag	M	32	A(1)		T=Test, P=Production		
7	Resubmitted Disk	M	33	A(1)		Indicates if the file/disk is being resubmitted Y/N		
8	Period From	M	34-41	A(8)	DDMMYYYY	Period starting (separation month)	**Reject** the file if not in format DDMMYYYY **Reject** the file if not within date period applicable for month year specified in physical file name	HE08 HE08.1
9	Period to	M	42-49	A(8)	DDMMYYYY	Period ending (separation month)	**Reject** the file if not in format DDMMYYYY	HE09
10	AN-SNAP HCP Version	M	50-53	N(4)		AN-SNAP HCP version 0500,0700,0800,0900		
11	Blank fill	M	54-57	N(4)		Blank fill		
12	File Type	M	58	A(1)		S = Snap		

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
1	Insurer Membership Identifier			M	1	15	A(15)	Left justify	1	Insurer membership identifier.	**Reject** record if not same as Source Identifier value in FILE HEADER item 2.	AE001.1
2	Insurer Identifier			M	16	18	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if blank	AE002
3	AN-SNAP Identifier			MAA	19	33	A(15)	Left justify	1	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
4	Family Name	286953		O	34	61	A(28)	Left justify	1	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.	**Identify** record if blank	AE004
5	Given Name	287035		O	62	81	A(20)	Left justify	1	The person's identifying name within the family group or by which the person is socially identified, as represented by text.	**Identify** record if blank	AW005
6	Date of Birth	287007		M	82	89	A(8)	DDMMYYYY	1	The date of birth of the person.	**Reject** record if not in format DDMMYYYY	AE006
7	Postcode - Australian	611398		M	90	93	N(4)	Right justify Zero prefix	1	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person. Codes 9999 = unknown postcode and 8888 = overseas will be used instead of METeOR codes 0097, 0098, 0099.	**Reject** record if not (a valid Australian postcode or 8888 or 9999).	AE007
8	Sex	635126		M	94	94	N(1)		1	The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code. 1 = Male 2 = Female 3 = Other 9 = Not stated / inadequately described	**Reject** record if not (1, 2, 3 or 9)	AE008
9	Admission Date	269967		M	95	102	A(8)	DDMMYYYY	1	Date on which an admitted patient commences an episode of care.	**Reject** record if not in format DDMMYYYY	AE009
10	Separation Date	270025		M	103	110	A(8)	DDMMYYYY	1	Date on which an admitted patient completes an episode of care.	**Reject** file if not in format DDMMYYYY, or if not ≥ admission date, or if MM is not same as month input in Fund Header	AE010
11	Episode Type			M	111	111	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')	AE011

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
12	Admission FIM Item Scores			M	112	129	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	**Reject** record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O. If present, **reject** if not numeric. **Identify** record if episode type is S and not blank fill	AE012 AE012.1 AW012
13	Discharge FIM Item Scores			M	130	147	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	**Reject** record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O and not Episode Mode of Separation = 8 If present, **reject** if not numeric. **Identify** record if episode type is S and not blank fill	AE013 AE013.1 AW013
14	Primary Impairment type code (AROC 2012)	681412		M	148	154	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 – AN-SNAP Version 4 dataset (July 2012)) 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	AE014
15	Assessment Only Indicator			M	155	155	N(1)		1	Whether only assessment, and no treatment, was provided during an episode of admitted patient care, as represented by a code. Assessment only occurs when the person was seen on one occasion only for assessment and no rehabilitation treatment and no further intervention by this service team is planned to occur within the next 90 days. If a person is booked/seen for subsequent treatment within 90 days, they are not Assessment Only. If a person is booked for subsequent assessment (but not treatment), they are assessment only. Record: 1 = Yes 2 = No	**Reject** record if not (1 or 2)	AE015
16	AN-SNAP Class	449125		M	156	159	A(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. AN-SNAP class is a patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital, as represented by a code.	**Reject** if not a valid code and episode type = O **Identify** record if AN-SNAP Version = 02 or 03 and episode type = S and not blank fill. **Identify** record if AN-SNAP Version = 04 and episode type = S and not '4J01'.	AE016 AW016 AW016.1

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
17	AN-SNAP Version	448983		M	160	161	N(2)		1	The version of the AN-SNAP Classification used to report item 16. 02 = AN-SNAP Version 2 03 = AN-SNAP Version 3 04 = AN-SNAP Version 4	**Reject** record if not (01, 02, 03 or 04) and episode type = O If present, **reject** if not numeric. **Identify** record if episode type = S and not 04 or blank fill. **Identify** if (01) and episode type = O	AE017 AE017.1 AW017.1 AW017.2
18	Rehabilitation plan date	341640		M	162	169	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	AE018
19	Discharge plan date			M	170	177	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	AE019

Total record length = 177

	EDIT RULES	ERROR CODE/S
Extras	**Reject** record if Separation date (Item 10) does not equal Admission date (Item 9) where Same-day Status (Item 40) = 1 (reject if Separation date = Admission date and Same-Day Status not equal to 1)	EE201
	Identify if the records with 'Hospital Type' = 2 have more than 5% with 'Unplanned Theatre Visit' = 1	EW202
	Reject record if ICU charge but no ICU days recorded.	EE203
	Identify record if prosthesis charge but no Theatre or Bundled charge or Hospital-in-the-home care 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 >$8,000 per day	EW207
	Identify record if no charges reported (total charge=0)	EW208
	Identify if all records with 'Hospital Type' = 2 have 'Unplanned Theatre Visit' = 2 and there are greater than 100 episodes for the month.	EW209
	Identify if the records with Hospital Type' = 2 have more than 5% with 'Unplanned Theatre Visit' = 1	EW210
	Identify if all records with 'Hospital Type' = 2 have 'Readmission within 28 days' = 8 and there are greater than 100 episodes for the month.	EW211