Scope of Data Collection (HCP1)

The Hospital Casemix Protocol specifies the financial, clinical and demographic data that hospitals must provide private health insurers and private health insurers must provide the Department, in respect of each episode of admitted hospital treatment for which a benefit has been paid.

For the purposes of this collection, an episode is the period between *admission* and *separation* that a person spends in one hospital, and includes leave periods not exceeding seven days. Admission and separation can be either formal or statistical (refer to definitions).

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

All reporting requirements governing HCP data include AN-SNAP data as:

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

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

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

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

Reporting Requirements

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

File Naming Standards

In order for your files to be correctly processed by the Data Submission Portal your submitted HCP1 files are required to follow the format listed below:

InsurerCode (underscore)**HCP1**(underscore)***MonthYear***

InsurerCode = 3 character code used to uniquely identify the Health Fund.

MonthYear = Month reported. Character values in the format MM(e.g. JUL="07", AUG="08") for month and YYYY (e.g. 2011) for year.

example: **ABC_HCP1_042013.txt**

All files are to be saved as text files (.txt)

Notes about the input file

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

• Only a single Insurer header and its associated episode records, medical records, prosthetic records, rehabilitation (AN-SNAP) records, and Insurer trailer grouping can be recorded within a single file.

Notes about the specifications

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

The ***obligation column*** indicates whether provision of each particular data item is:

- MAA - Mandatory for all public and private hospitals (including day facilities)
- MAO - Mandatory for all private hospitals (including day facilities) and optional for public hospitals
- MAS - Mandatory for same-day patients
- OPA - Optional for all

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 reference is indicated in the data item column, refer to the National Health Data Dictionary for definition and collection methods.

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

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

Definitions/acronyms

ACHI means the Australian Classification of Health Interventions.

ADA means the Australian Dental Association.

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

CCU means the coronary care unit of a hospital.

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

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

DRG means the Australian Refined Diagnosis Related Group.

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

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

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

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

HDU means the high dependency unit of a hospital.

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

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

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

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

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

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

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

ICU means the intensive care unit of a hospital.

insurer means a private health insurer.

MBS means the Medicare Benefits Schedule, comprising:

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

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

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

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

METeOR (Metadata Online Registry) for national data standards.

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

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

NICU means the neonatal intensive care unit of a hospital.

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

PHIAC *means* Private Health Insurance Administration Council

PICU means the paediatric intensive care unit of a hospital.

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

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

SCN means the special care nursery of a hospital.

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

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

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

Guide for Use

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

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

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

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

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

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

Hospital-in-the-home (HITH) - Episodes which include HITH services should be reported in a manner consistent with claiming practice. For example,

(a) HITH services which are part of an admitted psychiatric program and are claimed as a single same day service must be reported as single same day episode. This includes psychiatric patients that remain in an admitted HITH program over extended periods of time.

(b) If hospital claims are submitted to insurers at the conclusion of the admitted psychiatric HITH program, then one episode must be reported spanning the length of the program.

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

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

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

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

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

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

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

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

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

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

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

Data Quality

Error Codes

1st Character – represents the type of record i.e. E (episode), P (prosthetic), A (AN-SNAP), M (medical), R (edits checking across records)

2nd Character – W (represents a warning where an edit rule has been identified)– the record will be accepted and insurers notified

2nd Character – E (represents an error where an edit rule has failed) – the record will be rejected and insurers notified

Further information

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

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

www.health.gov.au/casemix

List of Hospital provider numbers

To request a list of hospital provider numbers please email: declarations@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.phiac.gov.au

Commonwealth Prosthesis list

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

#	Item		Quantity	Type & size	Format	Values/description	Edit Rules	Error Code/s
1	**FILE HEADER**		one per physical file of data	A(7)	YYYYMM	Valid value 'HCPDATA'		
2				A(3)		Source identifier (INSURER (or other) IDENTIFIER)	**Reject** file if not same as specified in the physical file name.	HE02.0
							Reject file if not a valid insurer code.	HE02.1
3				A(6)		YEAR-MONTH (separation month reported)	**Reject** file if not in format YYYYMM.	HE03.0
							Reject file if does not match the month year specified in the physical file name.	HE03.1
4				N(2)		The number of Insurers' data in this file; valid value '1'	If present, **reject** file if not = 1 or 01.	HE04
5		**INSURER HEADER**	one per physical file of data	A(1)	YYYYMM	Valid value 'B'	**Reject** file if not = 'B'	HE05
6				A(3)		INSURER IDENTIFIER	**Reject** file if not same as Source identifier value in FILE HEADER section item 2 above.	HE06
7				A(6)		YEAR-MONTH (separation month reported)	**Reject** file if not same as YEAR-MONTH value in FILE HEADER section item 3 above.	HE07
8		**EPISODE RECORDS**	many per physical file of data	A(1371)		1371 characters; record type of 'E' followed by 1370 character record as specified in this document.		
9		**MEDICAL RECORDS**	many per episode	A(92)		92 characters; record type of 'M' followed by 91 character record as specified in this document.		
10		**PROSTHETIC RECORDS**	0 to many per episode	A(54)		54 characters; record type of 'P' followed by 53 character record as specified in this document.		
11		**AN-SNAP RECORDS**	0 to many per episode	A(95)		95 characters; record type of 'S' followed by 94 character record as specified in this document.		
12		**INSURER TRAILER**	one per physical file of data	A(1)		Valid Value 'T'	**Reject** file if not = 'T'	HE12
13				A(3)		INSURER IDENTIFIER	**Reject** file if not same as Source Identifier value in FILE HEADER section item 2 above.	HE13
14				N(6)		Number of Episode records	If present, **reject** file if not numeric	HE14
15				N(6)		Number of Medical records	If present, **reject** file if not numeric	HE15
16				N(6)		Number of Prosthetic records ('000000' means no prosthetic records)	If present, **reject** file if not numeric	HE16
17				N(6)		Number of AN-SNAP records ('000000' means no AN-SNAP records)	If present, **reject** file if not numeric	HE17
18	**FILE TRAILER**		one per physical file of data	A(1)		Valid value 'Z'	Reject file if not 'Z'	HE18

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 identifier			MAA	1	3	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if not same as Source Identifier value in FILE HEADER item 2.	EE001.1
2	Link Identifier			MAA	4	27	A(24)	Left justify	1	A unique identifier of an episode that links data items from this (episode) record to the associated medical, prosthetic or AN-SNAP records.	**Reject** record if blank	EE002
3	Provider (hospital) code			MAA	28	35	A(8)	NNNNNNNA (uppercase)	1	The Commonwealth-issued hospital provider number, as selected from the lists maintained by the Department of Health and Ageing. "OVERSEAS" = overseas provider	**Reject** record if not (a valid 8 character Commonwealth provider number or 'OVERSEAS').	EE003
4	Product code			MAA	36	43	A(8)		1	The product code for patient's insurance cover at admission.	**Reject** record if blank.	EE004
5	Hospital contract status			MAA	44	44	A(1)	Left justify	1	The payment arrangement the insurer has with the hospital. Y = a hospital with which an Insurer has a contract N = a hospital with which the Insurer does not have a contract. T = a hospital is paid under 2nd Tier benefit arrangement B = a hospital is paid under a "Bulk payment" arrangement	**Reject** record if not (Y or N or T or B).	EE005
6	Total days paid			MAA	45	48	N(4)	Right justify Zero prefix	1	The total number of days for which benefits were paid by the Insurer, including days for which benefits were paid as a Nursing Home Type Patient. Same-day cases equal 0001. Zero fill if no benefit paid for accommodation by fund.	**Reject** record if not numeric **Identify** if total days paid > (date separated – date admitted – leave days) **Identify** if same-day status is 1 and total days paid is not 0001	EE006 EW006.0 EW006.1
7	Accommodation charge			MAA	49	57	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for accommodation (include ex-gratia and patient portion accommodation charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	If present, **reject** record if not numeric	EE007
8	Accommodation benefit			MAA	58	66	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for accommodation (include ex-gratia accommodation benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	If present, **reject** record if not numeric	EE008
9	Theatre charge			MAA	67	75	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for a theatre/procedure room/ angiography suite (include ex-gratia and patient portion theatre charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	If present, **reject** record if not numeric	EE009
10	Theatre benefit			MAA	76	84	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for a theatre/procedure room/angiography suite (include ex-gratia theatre benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	If present, **reject** record if not numeric	EE010
11	Labour ward charge			MAA	85	93	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for labour ward (include ex-gratia and patient portion labour ward charges). Blank means this charge was not separately identified but charged under another item. Zero fill if no amount charged.	If present, **reject** record if not numeric	EE011
12	Labour ward benefit			MAA	94	102	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for labour ward (include ex-gratia labour ward benefits) Blank means this benefit was not separately identified but paid under another item. Zero fill if no amount paid.	If present, **reject** record if not numeric	EE012

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
13	Intensive Care Unit Charge			MAA	103	111	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	Intensive Care Unit charge must reflect the gross amount charged for ICU (include ex-gratia and patient portion ICU charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	If present, **reject** record if not numeric	EE013
14	Intensive Care Unit Benefit			MAA	112	120	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for ICU (include ex-gratia ICU benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	If present, **reject** record if not numeric	EE014
15	Prosthesis charge			MAA	121	129	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross maximum amount charged for prosthesis (include ex-gratia prosthesis charges, handling fee and patient portion). Blank means this charge was not separately identified but charged under another item. Zero fill if no amount charged.	If present, **reject** record if not numeric	EE015
16	Prosthesis benefit			MAA	130	138	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for prosthesis (include ex-gratia prosthesis benefit and handling fee). Blank means this benefit was not separately identified but paid under another item. Zero fill if no amount paid.	If present, **reject** record if not numeric	EE016
17	Pharmacy charge			MAA	139	147	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for pharmacy (include ex-gratia and patient portion pharmacy charges, exclude discharge medications). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	If present, **reject** record if not numeric	EE017
18	Pharmacy benefit			MAA	148	156	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for pharmacy (include ex-gratia pharmacy benefits, exclude discharge medications.) Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	If present, **reject** record if not numeric	EE018
19	Bundled charges			MAA	157	165	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross bundled charge raised (include ex-gratia and patient portion bundled charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	If present, **reject** record if not numeric	EE019
20	Bundled benefits			MAA	166	174	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross bundled benefit paid (include ex-gratia bundled benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	If present, **reject** record if not numeric	EE020
21	Other charges			MAA	175	183	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for any chargeable item which cannot be specifically categorised elsewhere (exclude ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use	If present, **reject** record if not numeric	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	Other benefits			MAA	184	192	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for any chargeable item which cannot be specifically categorised elsewhere, (exclude ex-gratia benefits, television, phone calls, extra meals, FED, reversals or journal adjustments). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use	If present, **reject** record if not numeric	EE022
23	Front end deductible			MAA	193	201	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The amount of Front End Deductible (excess) deducted from the benefit otherwise payable by the Insurer to the hospital. Zero fill if no FED applicable.	**Reject** record if not numeric	EE023
24	Ancillary cover status			MAA	202	202	A(1)		1	An indicator of whether a patient has ancillary cover at the time of admission. Y = patient has ancillary cover; N = patient does not have ancillary cover	**Reject** record if not ('Y' or 'N').	EE024
25	Ancillary charges			OPA	203	211	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total charge raised for in-hospital benefits claimed under an ancillary table. Zero fill if no amount charged.	If present, **reject** record if not numeric	EE025
26	Ancillary benefits			OPA	212	220	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total benefit paid for in hospital benefits paid under an ancillary table. Zero fill if no amount paid.	If present, **reject** record if not numeric	EE026
27	Total Medical charges			MAA	221	229	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total charge for medical items, as set out in the medical records associated with the episode. Zero fill if no amount charged.	**Reject** record if not numeric	EE027
28	Total Medical Benefits			MAA	230	238	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total benefit paid for medical items (by both Medicare and Insurer) as set out in the medical records associated with the episode. Zero fill if no amount paid.	**Reject** record if not numeric	E028
29	Date of birth	287007		MAA	239	246	A(8)	DDMMYYYY	1	The date of birth of the person.	**Reject** record if not in format DDMMYYYY	EE029
30	Postcode - Australian	287224		MAA	247	250	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. 9999 = unknown postcode 8888 = overseas	**Reject** record if not (a valid Australian postcode or 9999 or 8888).	EE030
31	Sex	287316		MAA	251	251	N(1)		1	The biological distinction between male and female, as represented by a code. 1 = male 2 = female 3 = intersex or indeterminate 9 = not stated/inadequately described	**Reject** record if not (1, 2, 3 or 9).	EE031
32	Admission date	269967		MAA	252	259	A(8)	DDMMYYYY	1	Date on which an admitted patient commences an episode of care.	**Reject** record if not in format DDMMYYYY	EE032
33	Separation date	270025		MAA	260	267	A(8)	DDMMYYYY	1	Date on which an admitted patient completes an episode of care.	**Reject** file if not in format DDMMYYYY, blank or if not ≥ Admission date, or if MM is not same as month input in Insurer Header.	EE033

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
34	Hospital type			MAA	268	268	N(1)		1	The type of hospital where the episode occurred. 1 = public 2 = private 3 = private day facility 4 = public day facility 9 = other/unknown	**Reject** record if not (1, 2, 3, 4, or 9). **Identify** record if Hospital type does not match provider hospital table	EE034 EW034
35	ICU days			MAA	269	271	N(3)	Right justify Zero prefix	1	The number of days the patient spent in ICU, NICU or PICU. Zero fill if not applicable. *refer to guide for use	**Reject** record if not numeric. **Reject** record if not zero for private day facilities **Identify** record if not zero for public day facilities (item 34 = 4)	EE035.0 EE035.1 EW035.1
36	Diagnosis related group	391295		OPA	272	275	A(4)	Left justify	1	The DRG code which describes the episode of care. "GEN " = A generated episode not suitable for grouping according to the health Insurer practices. This should be the Health Insurer DRG wherever possible; otherwise the Hospital DRG.	If present, **identify** record if not (a valid DRG code for DRG version in item 37 or 'GEN ')	EW036
37	DRG version			CON	276	277	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 na = version n.a Must be supplied if DRG code provided at item 36.	If present, **identify** record if not valid version. **Identify** record if blank and DRG code provided.	EW037.0 EW037.1
38	Admission time	269972		MAS	278	281	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.	**Reject** record if blank and same-day status (item 50) 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)	EE038 EE038.1
39	Infant weight, neonate, stillborn	269938		MAA	282	285	N(4)	Right justify Zero prefix	1	The first weight, in grams, 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. 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)*	EE039.0 EW039.1 EW039.2
40	Hours of mechanical ventilation			MAA	286	289	N(4)	Right justify Zero prefix	1	The total number of hours (rounded) for which the patient received mechanical ventilation in ICU, NICU, PICU or combined ICU/CCU during the episode. Zero fill if not applicable.	**Reject** record if not numeric	EE040

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
41	Mode of separation	270094		MAA	290	291	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 (01, 02, 03, 04, 05, 06, 07, 08, 09, 1, 2, 3, 4, 5, 6, 7, 8 or 9).	EE041
42	Separation time	270026		MAS	292	295	N(4)	hhmm (24 hour clock)	1	Time at which an admitted patient completes an episode of care. Blank fill if not applicable. Conditional item – mandatory for same-day patients	**Reject** record if blank and same-day status (item 50) 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)	EE042 EE042.1
43	Source of referral			MAA	296	296	N(1)		1	The facility from which the patient was referred: 0 = Born in hospital 1 = Admitted patient transferred from another hospital 2 = Statistical admission – care type change 4 = from Accident/Emergency 5 = from Community Health service; 6 = from Outpatients department 7 = from Nursing home 8 = by outside medical practitioner 9 = Other	**Reject** record if not (0, 1, 2, 4, 5, 6, 7, 8 or 9).	EE043
44	Care Type	270174		MAA	297	299	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 20 = Rehabilitation care 21 = Rehabilitation care delivered in a designated unit 22 = Rehabilitation care according to a designated program 23 = Rehabilitation care is the principle clinical intent 30 = Palliative care 31 = Palliative care delivered in a designated unit 32 = Palliative care according to a designated program 33 = Palliative care is the principle clinical intent 40 = Geriatric Evaluation and management 50 = Psychogeriatric care 60 = Maintenance care 70 = Newborn care 80 = Other admitted patient care 90 = Organ procurement – posthumous 100 = Hospital boarder	**Reject** record if not (10, 20, 21, 22, 23, 30, 31, 32, 33, 40, 50, 60, 70, 80, 90 or 100)	EE044
45	Total leave days	270251		MAA	300	303	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.	EE045
46	Non-Certified days of stay			MAO	304	307	N(4)	Right justify Zero prefix	1	The number of days spent in the hospital, without certification, that exceeded 35 days. Zero fill if not applicable. Mandatory for private hospitals and private day facilities.	If present, **reject** record if not numeric. **Reject** record if blank and hospital type is (private or private day facility).	EE046.0 EE046.1

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
47	Principal diagnosis	391326		MAA	308	313	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 - 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.	If present, **reject** record if not a valid ICD-10-AM principal diagnosis code **Reject** record if blank and private hospital (item 34 = 2 or 3) ~~or~~ and contracted episode (item 5= 'Y' or 'B'). **Identify** record if blank and public hospital (item 34 = 1 or 4) or non-contracted episode (item 5 = 'T' or 'N'). **Identify** record if Care Type = (20, 21, 22 or 23) and not 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 Z38N or Z38NN (where N = 0 to 9).	EE047.0 EE047.1 EW047 EW047.1 EW047.2 EW047.3
48	Additional diagnosis	391322		MAA	314	607	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 - 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 the same as 'Principal Diagnosis Code'	EE048 EW048
49	Procedure	391349		MAA	608	957	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** record if not (a valid ICD-10-AM code or blank)	EE049

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
50	Same-day status			MAA	958	958	N(1)		1	An indicator of whether the patient was admitted to the facility for an overnight stay. 0 = patient with a valid arrangement allowing for overnight stay for procedure normally performed on a same-day basis. 1 = same-day patient; 2 = overnight patient (other than type 0 above)	**Reject** record if not (0, 1 or 2).	EE050
51	Principal MBS item number			MAO	959	972	A(14)	Left justify	1	A valid Medical Benefits Schedule item according to the relevant MBS Schedule valid for the MBS date (Item 52). Blank means there was no applicable MBS or a public hospital. * refer to guide for use.	If present, **reject** record if not a valid MBS item from the relevant MBS Schedule valid for the service date (Item 52)	EE051
52	Principal Item Date			MAO	973	980	A(8)	DDMMYYYY	1	The date on which; i) the principal MBS item (item 51) was carried out, or ii) (if item 51 is blank), the first Miscellaneous Service Code (item 68) was carried out. Conditional item - Mandatory for private hospitals and private day facilities where principal MBS (item 51) is populated.	If present, **reject** record if not in format DDMMYYYY. **Reject** record if date is before admission date or after discharge date **Reject** record if blank and item 51 is populated and hospital type is private or private day facility.	EE052.0 EE052.1 EE052.2
53	Minutes of operating theatre time	270350		MAO	981	984	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 68). Must be filled with 0000 if no time spent in operating theatre. Blank means there was no applicable MBS Item or a public hospital. *refer to guide for use Conditional item - Mandatory for private hospitals and private day facilities where principal MBS (item 51) or Miscellaneous Service Code (item 68) is populated.	If present, **reject** record if not numeric. **Identify** record if blank and hospital type is private or private day facility and item 51 or item 68 is populated.	EE053 EW053
54	Secondary MBS item numbers			MAO	985	1110	A(14)	Left justify	9	Additional MBS item numbers are all MBS items performed in theatre/procedure room/ angiography suite, which are not the principal MBS. Blank means that there was no additional item or code (or not 9 repetitions).	If present, **reject** record if not (a valid MBS item number from the relevant MBS Schedule(s) current during the episode)	EE054
55	Number of days of hospital-in-the-home care	270305		MAO	1111	1114	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** if item not = (HITH Completed date – HITH Commencement Date)	EE055 EW055
56	Total psychiatric care days	270300		MAA	1115	1119	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** record if not numeric.	EE056

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
57	Mental health legal status	270351		MAO	1120	1120	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. Involuntary patients are persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care. 1 = Involuntary patient 2 = Voluntary patient 3 = Not permitted to be reported under the laws of a State or Territory 8 = Not applicable	If present, **reject** record if not (1, 2, 3, or 8). **Reject** record if blank and hospital type is (private or private day facility) (item 34 = 2 or 3).	EE057.0 EE057.1
58	ICU hours			OPA	1121	1124	N(4)	Right justify Zero prefix	1	The number of hours spent by the patient in an ICU, NICU or PICU. Zero fill if not applicable. *refer to guide for use	If present, **reject** record if not numeric.	EE058
59	Urgency of admission	269986		MAA	1125	1125	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)	EE059
60	Inter-hospital contracted patient	270409		MAO	1126	1126	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	If present, **reject** record if not (1, 2, 3 or 9). **Reject** record if blank and hospital type is (private or private day facility).	EE060.0 EE060.1
61	Palliative care Status			MAO	1127	1127	N(1)		1	An indication of whether the episode involved palliative care: 1 = patient required palliative care during episode 2 = no palliative care required during episode Mandatory for private hospitals & private day facilities. This item is required because some States do not statistically discharge to palliative care. * refer to guide for use.	If present, **identify** 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.	EW061.0 EW061.1 EE061.2
62	Re-admission within 28 days			MAA	1128	1128	N(1)		1	An indicator of the re-admission of a patient to hospital within 28 days of previous discharge for treatment of a similar or related condition. 1 = Unplanned re-admission and patient previously treated in this hospital 2 = Unplanned re-admission and patient previously treated in another hospital 3 = Planned re-admission from this or another hospital 8 = Not applicable/not known Note: do not include transfers from another hospital as re-admissions	**Reject** record if not (1,2,3 or 8)	EE062

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
63	Unplanned theatre visit during episode			MAA	1129	1129	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)	EE063
64	Provider number of hospital from which transferred			MAA	1130	1137	A(8)	NNNNNNNA (uppercase)	1	The Commonwealth-issued hospital provider number for the hospital from which a patient has been transferred (Provider number required only when HCP item number 43 is reported as: 1- Admitted patient transferred from another hospital) Blank fill if no hospital transfer. Overseas hospitals to be coded as OVERSEAS	**Reject** record if Source of referral (item 43) is 1 and item 64 is not (a valid 8 character Commonwealth provider number or OVERSEAS) **Reject** record if Source of referral (item 43) is not 1 and item 64 is not blank	EE064 EE064.1
65	Provider number of hospital to which transferred			MAA	1138	1145	A(8)	NNNNNNNA (uppercase)	1	The Commonwealth hospital provider number for the hospital to which a patient has been transferred. Blank fill if no hospital transfer (Provider number required only when HCP item number 41 is reported as: 1 = Discharge/transfer to an(other) acute hospital, or 3 = Discharge/transfer to a(nother) psychiatric hospital or 4 = Discharge/transfer to another health care accommodation (includes mothercraft hospitals)) Overseas hospitals to be coded as OVERSEAS	**Reject** record if Mode of separation (item 41) is 1, 3 or 4 and item 65 is not (a valid 8 character Commonwealth provider number or OVERSEAS) **Reject** record if Mode of separation (item 41) is 2, 5, 6, 7, 8 or 9 and item 65 is not blank.	EE065 EE065.1
66	Discharge intention on admission			OPA	1146	1146	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)	EE066
67	Person Identifier			MAA	1147	1167	A(21)	Left justify	1	This is an Insurer-specific person identifier, unique within an establishment or agency, regardless of any change in membership.	**Reject** record if blank	EE067
68	Miscellaneous Service Codes			MAO	1168	1277	A(11)	Left justify	10	Any miscellaneous service codes (i.e. non MBS items or Australian Dental Association codes) used for billing. Up to 10 codes may be entered. Blank means that there were no miscellaneous service codes or not 10 repetitions.		
69	Hospital-in-the-home care Charges			MAA	1278	1286	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for hospital-in-the-home care service (include ex-gratia and HITH patient portion charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item.	If present, **reject** record if not numeric	EE069
70	Hospital-in-the-home care Benefits			MAA	1287	1295	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefits paid for hospital-in-the-home care service (include ex-gratia HITH benefits). Blank means this benefit was not separately identified but paid under another item. Zero fill if no amount paid.	If present, **reject** record if not numeric	EE070
71	Special Care Nursery Charges			MAA	1296	1304	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charges raised for SCN (include ex-gratia and patient portion SCN charges, exclude NICU charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use.	If present, **reject** record if not numeric	EE071
72	Special Care Nursery Benefits			MAA	1305	1313	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for SCN (include ex-gratia SCN benefits, exclude NICU benefits). Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use.	If present, **reject** record if not numeric	EE072

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
73	Coronary Care Unit Charges			MAA	1314	1322	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for CCU (include ex-gratia and patient portion CCU charges). Zero fill if no amount charged. Blank means this charge was not separately identified but charged under another item. *refer to guide for use.	If present, **reject** record if not numeric	EE073
74	Coronary Care Unit Benefits			MAA	1323	1331	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for CCU (include ex-gratia CCU benefits) Zero fill if no amount paid. Blank means this benefit was not separately identified but paid under another item. *refer to guide for use.	If present, **reject** record if not numeric	EE074
75	Special Care Nursery Hours			OPA	1332	1335	N(4)	Right justify Zero prefix	1	The number of hours the patient spent in a SCN. Zero fill if not applicable. *refer to guide for use.	If present, **reject** record if not numeric.	EE075
76	Coronary Care Unit Hours			OPA	1336	1339	N(4)	Right justify Zero prefix	1	The number of hours the patient spent in a CCU. Zero fill if not applicable. *refer to guide for use.	If present, **reject** record if not numeric.	EE076
77	Special Care Nursery Days			MAO	1340	1342	N(3)	Right justify Zero prefix	1	The number of days the patient spent in a SCN. Zero fill if not applicable. *refer to guide for use.	**Reject** record if not numeric. **Reject** if not zero for day facilities (private or public)	EE077.0 EE077.1
78	Coronary Care Unit Days			MAO	1343	1345	N(3)	Right justify Zero prefix	1	The number of days the patient spent in a CCU. Zero fill if not applicable. *refer to guide for use	**Reject** record if not numeric. **Reject** if not zero for day facilities (private or public)	EE078.0 EE078.1
79	Number of Qualified Days for Newborns	270033		MAA	1346	1350	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** record if >0000 and (Care Type not Newborn Care)	EE079 EW079
80	Hospital-in-the-home care Commencement Date			CON	1351	1358	A(8)	DDMMYYYY	1	Date on which an admitted patient commences an episode of hospital-in-the-home care services. Blank fill if not applicable. Conditional item, must be provided if HITH charges (item 69) > 0.	**Reject** record if HITH benefits or charges > 0 (items 69 and 70) and item is blank, or if not in format DDMMYYYY **Reject** record if commencement date > HITH completed date	EE080.0 EE080.1
81	Hospital-in-the-home care Completed Date			CON	1359	1366	A(8)	DDMMYYYY	1	Date on which an admitted patient completes an episode of hospital-in-the-home care services. Blank fill if not applicable. Conditional item, must be provided if HITH charges (item 69) > 0.	**Reject** record if HITH benefits or charges > 0 (items 69 and 70) and item is blank, or if not in format DDMMYYYY **Reject** record if HITH completed date < HITH commencement date	EE081.0 EE081.1
82	Palliative Care Days			MAO	1367	1370	N(4)	Right justify Zero prefix	1	The number of days a patient received palliative care during an episode. Where the entire episode is Palliative, provide the total length of stay in days. Zero fill if not applicable. *refer to guide for use	**Reject** record if not numeric. **Reject** if blank and hospital type is private or private day facility **Identify** record if 0 and Palliative Care Status (item 61) =1	EE082.0 EE082.1 EW082

Total record length = 1371 characters; record type of 'E' followed by 1370 character record

	EDIT RULES	ERROR CODE/S
Extras	**Reject** record if Separation date (Item 32) does not equal Admission date (Item 33) where Same-day Status (Item 50) = 1 (reject if Separation date = Admission date and Same-Day Status not equal to 1)	EE201
	Identify record if Total benefits exceed Total charges	EW202
	Reject record if ICU charge but no ICU days recorded and no ICU hours recorded	EE203
	Identify record if prosthesis charge but no Theatre or Bundled charge (and hospital type is private or private day facility).	EW204
	Identify record if therapeutic Principal MBS present but no Principal Procedure	EW205
	Identify record if accommodation charge exceeds $2,000 x Length Of Stay (LOS)	EW206
	Identify record if ICU charge >$5,000 per day	EW207
	Reject record if no charges reported (total charge=0)	EE208
	Reject record if no benefits reported (total benefit =0)	EE209

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 identifier			MAA	1	3	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if not same as Source Identifier value in FILE HEADER item 2.	ME001.1
2	Link Identifier			MAA	4	27	A(24)	Left justify	1	A unique identifier of an episode that links data items from this medical record to the associated episode (and/or prosthetic or AN-SNAP records).	**Reject** record if blank.	ME002
3	MBS item			MAA	28	41	A(14)	Left justify	1	The MBS item billed by the medical provider. The MBS schedule is available from MBS Online at "http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1".	**Reject** record if not a valid MBS item according to the relevant MBS Schedule valid at the MBS date of service (Data Item number 7).	ME003
4	Item charge			MAA	42	50	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The amount the patient was billed for the MBS item identified in data item 3. Zero fill if no amount charged.	**Reject** record if not numeric or if negative. **Identify** record Item charge less than MBS Benefit. A five cent tolerance applied to accommodate rounding.	ME004.0 MW004.1
5	MBS benefit			MAA	51	59	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The amount paid to the patient as the Medicare entitlement. Zero fill if no amount paid.	**Reject** record if not numeric.	ME005.0
6	Insurer benefit			MAA	60	68	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The amount (excluding Medicare benefit) paid by the Insurer. Zero fill if no amount paid.	**Reject** record if not numeric. **Reject** record if > (Item charge – MBS benefit). A 5cent tolerance applied for rounding purposes.	ME006.0 ME006.1
7	MBS date of service			MAA	69	76	A(8)	DDMMYYYY	1	Date the MBS item number identified in Data Item 3 was performed.	**Reject** record if not in format DDMMYYYY	ME007
8	Medical Payment Type			MAA	77	77	N(1)		1	An indicator of the medical payment type. 1 = Agreement with an individual provider (No- gap agreement) 2 = Agreement with a hospital (No-gap agreement) 3 = Gap Cover Scheme (No-gap agreement) 4 = Gap Cover Scheme (Known-gap agreement) 5 = MBS schedule fee charged 6 = No gap cover scheme, charge over MBS schedule fee	**Reject** record if not (1, 2, 3, 4, 5 or 6).	ME008
9	Gap Cover Scheme Identifier			OPA	78	82	A(5)	Blank Fill.	1	Blank fill. Gap cover schemes are not applicable. This field has been retained as a placeholder to minimise system format changes for insurers.		
10	MBS Fee			MAA	83	91	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The MBS or derived fee for the item.	**Reject** record if not numeric	ME010.0

Total record length = 92 characters; record type of 'M' followed by 91 character record

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 Identifier			MAA	1	3	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if not same as Source Identifier value in FILE HEADER item 2.	PE001.1
2	Link Identifier			MAA	4	27	A(24)	Left justify	1	A unique identifier of an episode that links data items from this prosthetic record to the associated episode (and/or medical or AN-SNAP records).	**Reject** record if blank	PE002
3	Prosthetic Item			MAA	28	32	A(5)	Right justify Zero prefix	1	The billing codes are contained in the most relevant version (ie, the one covering the date(s) of the admitted patient record) of the prosthesis list. The relevant prosthesis list can be found at www.health.gov.au/internet/main/publishing.nsf/content/health-privatehealth-prostheseslist.htm If ex-gratia prosthetic item (see user guide), report as “EXGRA”.	**Identify** record if not (a valid Commonwealth prosthesis code or “EXGRA”).	PW003
4	Number of Items			MAA	33	35	N(3)	Right justify Zero prefix	1	Number of prosthetic items listed in data item 3. Zero prefix.	**Reject** record if not >0 ** warnings for public hospitals* **Reject** record if not numeric.	PE004 *PW004** PE004.1
5	Total Prosthetic Item Charge			MAA	36	44	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total charge for the prosthesis item (include cents but omit decimal point). Use leading zeros to fully fill the item. If provided, and identified, as ‘ex gratia’ in data item 3, then charge should be included.	**Reject** record if negative. **Reject** record if not numeric. **Identify** record if the total charge is greater than the prosthesis schedule minimum benefit multiplied by the number of items, but only for items with a blank maximum benefit (allow a 5 cent tolerance). Ignore where prosthetic item is “EXGRA” or not a valid prosthesis item. **Identify** record if the total charge is greater than the prosthesis schedule maximum benefit multiplied by the number of items, but only for items with a value for maximum benefit (allow a 5 cent tolerance). Ignore where prosthetic item is “EXGRA” or not a valid prosthesis item. ** warnings for public hospitals*	PE005.0 *PW005.0** PE005.1 PW005.1 PW005.2

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
6	Total Prosthetic Item Benefit			MAA	45	53	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The total benefit for the prosthesis item (include cents but omit decimal points). Use leading zeros to fully fill the item. Zero fill if no amount paid.	**Reject** record if negative. * warnings for public hospitals **Identify** record if greater than total charge (allow 5 cent tolerance). **Identify** record if the benefit is not equal to charge and the maximum benefit on the relevant edition of the prosthesis schedule is blank (allow a 5 cent tolerance). Ignore where prosthetic item is “EXGRA” or not a valid prosthesis item. **Identify** record if the benefit is less than the prosthesis schedule minimum benefit multiplied by the number of items or greater than the prosthesis schedule maximum benefit multiplied by the number of items, but only for items with a value for maximum benefit (allow a 5 cent tolerance). Ignore where prosthetic item is “EXGRA” or not a valid prosthesis item. **Reject** record if not numeric	PE006.0 *PW006.0** PW006.1 PW006.2 PW006.3 PE006.4

Total record length = 54 characters; record type of ‘P’ followed by 53 character record

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 Identifier			MAA	1	3	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	**Reject** record if not same as Source Identifier value in FILE HEADER item 2.	AE001.1
2	Link Identifier			MAA	4	27	A(24)	Left justify	1	Unique identifier of an episode that links data items from this (AN-SNAP) record to the associated episode (and/or medical and prosthetic records).	**Reject** record if blank	AE002
3	Episode Type			MAA	28	28	A(1)		1	An indicator of the type of admitted rehabilitation program undertaken during the episode that relates to the AN-SNAP records. O = Overnight Admitted Patient – Assign this value for patients who stay overnight during the admitted rehabilitation program. S = Same-day Admitted Patient – Assign this value for patients who undertake an admitted rehabilitation program consisting of multiple same day visits/services. It is recommended that one AN-SNAP record is reported that covers the entire program (not separate episodes for each visit/service). In this case, Admission date = date of 1st visit/service and Separation date = date of last visit/service in the Same-day admitted program. The AN-SNAP record should be linked to the episode with the same separation date.	**Reject** record if not ('O' or 'S').	AE003
4	Admission FIM Item Scores			MAA	29	46	N(1)		18	The FIM score on admission for each of the 18 FIM motor and cognition items No Helper: Score of 7 – Complete Independence Score of 6 – Modified Independence Helper: Score of 5 – Supervision or setup Score of 4 – Minimal assistance Score of 3 – Moderate assistance Score of 2 – Maximal assistance Score of 1 – Total assistance *refer to guide for use	**Reject** record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O. If present, **reject** if not numeric. **Identify** record if episode type is S and not blank fill	AE004 AE004.1 AW004
5	Discharge FIM Item Scores			MAA	47	64	N(1)		18	The FIM score on discharge for each of the 18 FIM motor and cognition items. No Helper: Score of 7 – Complete Independence Score of 6 – Modified Independence Helper: Score of 5 – Supervision or setup Score of 4 – Minimal assistance Score of 3 – Moderate assistance Score of 2 – Maximal assistance Score of 1 – Total assistance *refer to guide for use	**Reject** record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O and not Episode Mode of Separation = 8 If present, **reject** if not numeric. **Identify** record if episode type is S and not blank fill	AE005 AE005.1 AW005
6	AROC Impairment Codes			MAA	65	71	A(7)	NN.NNNN Left justify	1	Enter the Impairment Code (AUS version 2) that best describes the primary reason for admission to the rehabilitation episode. Code as specifically as possible and where possible avoid the use of impairment group 13 - 'Other Disabling Impairments'. Each entry should consist of: - two (2) digits that represent the impairment group (zero prefixed if 1 digit) - a decimal point - up to four (4) digits that represent more specific categories within impairment groups if applicable (blank fill any unused characters).	**Reject** record if not a valid code.	AE006

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
7	Assessment Only Indicator			MAA	72	72	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).	AE007
8	AN-SNAP Class			MAA	73	76	N(4)		1	The AN-SNAP class to which the episode is assigned. AN-SNAP Class is only applicable to overnight episodes and must be reported as 4 characters in the following format: - "2" prefix followed by AN-SNAP version 2 class code. - "3" prefix followed by AN-SNAP version 3 class code.	**Reject** if not a valid code and episode type = O If present, **reject** if not numeric. **Identify** record if episode type = S and not blank fill.	AE008 AE008.1 AW008
9	SNAP Version			MAA	77	78	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	**Reject** record if not (01, 02 or 03) and episode type = O If present, **reject** if not numeric. **Identify** record if episode type = S and not blank fill. **Identify** if (01) and episode type = O	AE009 AE009.1 AW009.1 AW009.2
10	Rehabilitation plan date			MAA	79	86	A(8)	DDMMYYYY	1	The date a multi-disciplinary rehabilitation plan is established for an episode of admitted patient care.	**Reject** record if not in format DDMMYYYY	AE010
11	Discharge plan date			MAA	87	94	A(8)	DDMMYYYY	1	The date a discharge plan is established for an episode of admitted patient care.	**Reject** record if not in format DDMMYYYY	AE011

Total record length = 95 characters; record type of 'S' followed by 94 character record

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