Scope of Data Collection (HCP2)

The HCP2 data specifications specify the data health insurers must supply the Department in respect of hospital treatment they have paid benefits for, which do not qualify as an 'episode of admitted patient care' and are therefore out of scope of the HCP1. That is, services (that qualify as hospital treatment) provided to patients who are not admitted to hospital.

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 2011*

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

Reporting Unit

Where possible, reporting should be completed at the service event level.
It is recognised that service event details may not be always available where claims cover:

(a) a number of service events bundled together for a progress payment or
(b) a complete program of care

In these cases, the record should reflect all service event(s) that relate to the claim.

Quarterly Reporting

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

Reversals are permitted in this collection. Reversals should be reported based on date of cancellation. The reversal may therefore be reported in a different quarter to the claim the reversal relates to.

Notes

- If the input file is not structured as per page 1, it will be rejected.
- If any characters, other than those specified in this document are detected, such as end of line or end of file characters, the record or file will be rejected.

File Naming Standards

In order for your files to be correctly processed by the Data Submission Portal your submitted HCP2 files are required to follow the format listed below:

InsurerCode (underscore)**HCP2**(underscore)***MonthYear***

InsurerCode = 3 character code used to uniquely identify the Health Fund.
MonthYear = Final month in quarter reported (e.g. Quarter 1 data would have March (03) as month for filename).
Character values in the format MM(e.g. Q1 March="03", Q2 June ="06") for month and YYYY (e.g. 2011) for year.

example: **ABC_HCP2_032013.txt**

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

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

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

- MAA – Mandatory for all public and private hospitals (including day facilities)

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.

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

In this document:

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.

insurer means a private health insurer.

NHDD means the (most current version of the) 'National Health Data Dictionary', accessible via the Metadata Online Registry (METeOR).

service is the period reported in the record. It can relate to an individual service event or program, or a number of services events covered during the period of a claim.

service event means an interaction between one or more health care providers with one or more persons for assessment, care, consultation and/or treatment.

PHIAC means the Private Health Insurance Administration Council.

CHECK-IT2 is a software application developed by the Department to check and report the compliance of PHDB and HCP data files against the data specifications. It was produced to assist hospitals and health insurers submit correct and timely HCP and PHDB data.

Further information

For further information about the HCP requirements, please see the following websites:

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

http://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

http://www.phiac.gov.au

#	Item		Quantity	Type & size	Format	Values/description	Edit Rules	Error Code/s
1	**FILE HEADER**		one per physical file of data	A(8)	YYYYMM	Valid value 'HCPDATA2'		
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 (last month of the claims processing quarter 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 values 1-99 eg. > 1 if one organisation is reporting multiple affiliated insurers	If present, **reject** file if not = 1 or 01.	HE04
5	May be repeated within a file	**INSURER HEADER**	one per Insurer	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 (last month of the claims processing quarter reported)	**Reject** file if not same as YEAR-MONTH value in FILE HEADER section item 3 above.	HE07
8		**SERVICE RECORDS**	many per Insurer	A(112)		112 characters; record type of 'O' followed by 111 character record as specified in this document		
9		**INSURER TRAILER**	one per Insurer	A(1)		Valid Value 'T'	**Reject** file if not = 'T'	HE09
10				A(3)		INSURER IDENTIFIER	**Reject** file if not same as Source Identifier value in FILE HEADER section item 2 above.	HE10
11				N(6)		Number of service episode records	If present, **reject** file if not numeric	HE11
12	**FILE TRAILER**		one per physical file of data	A(1)		Valid value 'Z'	Reject file if not 'Z'	HE12

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 from a list of registered private health insurers.	**Reject** record if not same as Source Identifier value in FILE HEADER item 2.	SE001.1
2	Person Identifier			MAA	4	24	A(21)	Left justify	1	This is an insurer-specific person identifier, unique within an establishment or agency, regardless of any change in membership. This number should be consistently used for each event or episode that a person receives so that a patient's journey can be constructed regardless of place of care.	**Reject** record if blank	SE002
3	Provider (hospital) code			MAA	25	32	A(8)	NNNNNNNA	1	The hospital provider number. Provider number must be 8 characters in length (include leading zeros) and in upper case. "OVERSEAS" = overseas provider Format: 0NNNNNNA	**Reject** record if not (a valid 8 character Commonwealth provider number or 'OVERSEAS').	SE003
4	Hospital type			MAA	33	33	N(1)		1	The type of hospital. 1 = public 2 = private 3 = private day facility 4 = public day facility	**Reject** record if not (1, 2, 3 or 4). **Identify** if Hospital type does not match provider hospital table	SE004 SW004
5	Hospital contract status			MAA	34	34	A(1)		1	The payment arrangement the insurer has with the hospital Y = a hospital with which a 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').	SE005
6	Service charge			MAA	35	43	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for the service event(s) or program reported in this record provided within the service start and end date. Reversals are permitted and the negative sign must be the first character – eg "-00010000". Zero fill if no amount charged.	**Reject** record if not numeric	SE006
7	Service benefit			MAA	44	52	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross benefit paid for the service event(s) or program reported in this record provided within the service start and end date. Reversals are permitted and the negative sign must be the first character – eg "-00010000". Zero fill if no amount paid (treatment where no benefit is paid is out of scope for the collection, but will not be rejected if supplied).	**Reject** record if not numeric	SE007
8	Front end deductible			MAA	53	61	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The amount of Front End Deductible (excess) deducted from the benefit otherwise payable by the Insurer to the hospital. Reversals are permitted and the negative sign must be the first character – eg "-00010000". Zero fill if not applicable.	**Reject** record if not numeric	SE008
9	Date of birth	287007		MAA	62	69	A(8)	DDMMYYYY	1	The date of birth of the person.	**Reject** record if not in format DDMMYYYY	SE009
10	Sex	287316		MAA	70	70	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).	SE010
11	Postcode - Australian	287224		MAA	71	74	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).	SE011

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
12	Service start date			MAA	75	82	A(8)	DDMMYYYY	1	The date on which a service event or program of treatment commenced. This may relate to an individual service event date, the date of the first service event in a program of care, or the first service event included in the claim for this record.	**Reject** record if not in format DDMMYYYY	SE012
13	Service end date			MAA	83	90	A(8)	DDMMYYYY	1	The date on which a service event(s) or program of treatment was completed. This may relate to an individual service event date, the date of the last service event in a program of care, or the last service event included in the claim for this record.	**Reject** record if not in format DDMMYYYY, or if not ≥ event start date.	SE013
14	Service specialty			MAA	91	93	N(3)	Left justify	1	A description of the service event or program for which the service relates. 001 = Acupuncture / Acupressure 002 = Chiropractic 003 = Community, Home, District Nursing 004 = Dental 005 = Dietetics 006 = Domestic Assistance 007 = Maternity Services 008 = Occupational Therapy 009 = Optical 010 = Orthoptics (Eye Therapy) 011 = Osteopathic Services 012 = Physiotherapy 013 = Podiatry (Chiropody) 014 = Psych/Group Therapy 015 = Speech Therapy 016 = Other 022 = Rehabilitation - General 023 = Oncology Maintenance Services 024 = Wound Management 025 = Minor Procedures and Consultations 026 = Major Procedures 027 = Stomal Therapy 028 = Care of Implanted Catheter 029 = Accommodation Preventative Health/Health Management Program: 017 = Cardiac Rehabilitation Program 018 = Diabetes 019 = Weight Loss Program 020 = Quit Smoking Program 021 = Other Program	**Reject** record if not valid code	SE014
15	Service codes			MAA	94	108	A(15)	Left justify	1	An insurer-specific code that represents the type of treatment provided. To be refined with the assistance of insurers and hospitals. Insurers to submit their in-house codes for inclusion in CHECK-IT2.	**Identify** if code not in insurer-specific list	SW015
16	Number of service events			MAA	109	111	N(3)	Right justify Zero prefix	1	The number of service event(s) provided for the claim reported in this record. If this record relates to an individual service event, report 001. If this record relates to a group of service events or a program, report the total number of service events paid for. Reversals are permitted and the negative sign must be the first character – eg "-03". Report 000 where the number of service events actually provided is not known.	**Reject** record if not numeric	SE016

Total record length = 112 characters; record type of 'O' followed by 111 character record