Scope of Data Collection (PHDB)

The scope of the Private Hospital Data Bureau collection are episodes of hospital treatment for admitted patients in all private hospitals and day facilities.
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.

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

- *Private Health Insurance Act 2007*
- *Private Health Insurance (Health Insurance Business) Rules 2010*

Reporting Requirements

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

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 fill* , in relation to a data item, means that the data item is filled with blank spaces.
- *zero fill,* in relation to a data item, means 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* – supply in dollars and cents (omit decimal point) with leading zeros to fully fill item. All values must be ≥ 0 (i.e. negative charges not permitted). An entry of 000000000 means that no benefit/charge was recorded. Zeros are valid when this item cannot be separately identified but was reported under another charge item.

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.
CCU means the coronary care unit of a hospital.
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.
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 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.

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".

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.

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 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 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

- W (represents a warning where an edit rule has been identified) – the record will be accepted and private hospitals notified
- E (represents an error where an edit rule has failed) – the record will be rejected and private hospitals notified

Further information

For further information about the PHDB requirements, 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
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	Provider number (valid 8 character Commonwealth provider number (include leading zeros)	Reject the file if not a valid 8 character Commonwealth provider number	HE01
2	Fund/Group Identifier	M	9-11	A(3)		Blank fill		
3	Disk Reference number	M	12-19	A(8)		Number identifies the disk ID		
4	Date Prepared	M	20-27	A(8)	DDMMYYYY	The date the PHDB data was prepared by the hospital		
5	Number of records	M	28-31	N(4)		The number of episodes on the file	Reject the file if mismatch on Episode record count	HE05
6	Test Flag	M	32	A(1)		T=Test, P=Production		
7	Resubmitted Disk	M	33	A(1)		Indicates if the 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	HE08
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		
11	ICD Version	M	54-57	N(4)		ICD Version - 10.3=1003, 10.4=1004, 10.5=1005, 10.6=1006, 10.7 = 1007, 10.8 = 1008		

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)	Blank fill	1			
2	Payer identifier			M	16	18	A(3)		1	An indicator of the way in which the episode was funded: IH = Insured with agreement with hospital IN = Insured with no agreement with hospital SI = Self Insured WC = Workers Compensation TP = Third Party CP = Contracted to Public Sector DV = Department of Veteran's Affairs patient DE = Department of Defence patient SE = Seaman OT = Other	**Reject** record if not a valid code	E002
3	Episode Identifier			M	19	33	A(15)		1	Unique episode identifier of an episode of care.	**Reject** record if blank	E003
4	Family Name	286953		M	34	61	A(28)	Blank fill	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.		
5	Given Name	287035		M	62	81	A(20)	Blank fill	1	The person's identifying name within the family group or by which the person is socially identified, as represented by text.		
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	E006
7	Postcode – Australian	287224		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. 9999 = unknown postcode 8888 = overseas	**Reject** record if not (a valid Australian postcode or 9999 or 8888)	E007
8	Sex	287316		M	94	94	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)	E008
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	E009
10	Separation Date	270025		M	103	110	A(8)	DDMMYYYY	1	Date on which an admitted patient completes an episode of care.	**Reject** record if not in format DDMMYYYY, or if not ≥ admission date, or if MM is not same as month input in Fund Header	E010
11	Hospital Type			M	111	111	N(1)		1	The type of hospital where the episode occurred. 2 = Private 3 = Private Day Facility 9 = Other/unknown	**Reject** record if not (2, 3 or 9). **Identify** if hospital type does not match provider hospital table.	E011 W011
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.	E012.0 E012.1
13	ICU Hours			O	115	118	N(4)	Right justify Zero prefix	1	The number of hours spent by the patient in an ICU, NICU or PICU. * refer to guide for use.	If present, **identify** if not numeric	W013
14	Total Psychiatric Care Days	270300		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	E014
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.	W015

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)	Left justify	1	The version of the DRG classification: 31 = version 3.1 32 = version 3.2 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 15.	If present, **identify** record if not a valid version. **Identify** if blank and DRG code provided at item 15.	W016.0 W016.1
17	Admission Time	269972		M	130	133	N(4)	hhmm (24 hour clock)	1	Time at which an admitted patient commences an episode of care. Zero fill if not applicable. Mandatory - Same-day patients only.	**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) and same-day status is 1.	E017
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)	E018
19	Provider Number of Hospital from which transferred			M	135	142	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 PHDB item number 21 is reported as: 1- Admitted patient transferred from another hospital) Blank fill if no hospital transfer.	**Reject** if not (a valid 8 character Commonwealth provider number or blank)	E019
20	Care Type	270174		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 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 = 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)	E020
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 (1, 2, 4, 5, 6, 7, 8 or 9)	E021

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, **identify** if not (1, 2, 3, 4, 5, 8 or 9)	W022
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)	E023
24	Mental Health Legal Status	270351		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	**Reject** record if not (1, 2, 3 or 8)	E024
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 Zero fill if not applicable. *refer to guide for use	**Identify** record if not (1 or 2).	W025
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)	E026
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)	E027
28	Infant weight, neonate, stillborn	269938		M	153	156	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** if weight >9000g. **Identify** if weight > 0 and age >365 days	E028 W028.0 W028.1

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
29	Hours of Mechanical Ventilation			M	157	160	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	E029
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 (01, 02, 03, 04, 05, 06, 07, 08, 09 or 1, 2, 3, 4, 5, 6, 7, 8 or 9).	E030
31	Separation Time	270026		M	163	166	N(4)	hhmm (24 hour clock)	1	Time at which an admitted patient completes an episode of care. Mandatory - Same-day patients only.	**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) and same-day status is 1.	E031
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	E032
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 PHDB item number 30 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)). Blank fill if no hospital transfer.	**Reject** if not (a valid 8 character Commonwealth provider number or blank)	E033
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.	E034
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** if item not = (HITH Completed date – HITH Commencement Date)	E035 W035

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
36	Principal Diagnosis	391326		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 - 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 vaild ICD-10-AM principal diagnosis code **Identify** if Care Type = (20, 21, 22 or 23) and not Z50.? **Identify** if Care Type = 60 and not (Z74.2 or Z75.?). **Identify** if condition onset flag = 1 and not Z38.?	E036 W036.1 W036.2 W036.3
37	Additional Diagnosis	391322		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 - 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** if not (a valid ICD-10-AM code or blank) **Identify** if the same as 'Principal Diagnosis Code'	E037 W037
38	Procedure	391349		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)	E038

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 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)	E039
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 41)	E040
41	Principal MBS Date			M	852	859	A(8)	DDMMYYYY	1	The date on which; i) the principal MBS (item 40) was carried out or ii) (if item 40 is blank), the first Miscellaneous Service Code (item 53) was carried out. Mandatory where item 40 populated. *refer to guide for use	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	E041.0 E041.1 E041.2
42	Minutes of operating theatre time	270350		M	860	863	N(4)		1	Total time, in minutes, spent by a patient in operating theatres during current episode of hospitalisation. Must be filled with 0000 if no time spent in operating theatre. Should be populated if surgical ADA code provided in Miscellaneous Service Code field (item 53). Blank means there was no applicable MBS Item or ADA code. **Mandatory** where item 40 or item 53 is populated. *refer to guide for use	If present, **reject** record if not numeric. **Identify** if blank and item 40 or item 53 is populated	E042 W042
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 code. Blank means that there was no additional item or code (or not 9 repetitions). *refer to guide for use	**Reject** record if not (a valid MBS item number from the relevant MBS Schedule(s) current during the episode or blank)	E043
44	Accommodation Charge			M	990	998	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for accommodation (include ex-gratia and patient portion accommodation charges). Zero fill if no amount charged. *refer to guide for use	**Reject** record if not numeric	E044
45	Theatre Charge			M	999	1007	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for a theatre/procedure room/ angiography suite (include ex-gratia and patient portion theatre charges). Zero fill if no amount charged. *refer to guide for use	**Reject** record if not numeric	E045
46	Labour Ward Charge			M	1008	1016	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for labour ward (include ex-gratia and patient portion labour ward charges). Zero fill if no amount charged.	**Reject** record if not numeric	E046
47	Intensive Care Unit Charge			M	1017	1025	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross amount charged for ICU (include ex-gratia and patient portion ICU charges). Zero fill if no amount charged. *refer to guide for use	**Reject** record if not numeric	E047
48	Prosthesis Charge			M	1026	1034	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross maximum amount charged for prosthesis (include ex-gratia prosthesis charges, handling fee and patient portion), Zero fill if no amount charged.	**Reject** record if not numeric	E048

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 $$$$$$$cc (omit decimal point)	1	The gross charge raised for pharmacy (include ex-gratia and patient portion pharmacy charges, exclude discharge medications). Zero fill if no amount charged.	**Reject** record if not numeric	E049
50	Other Charges			M	1044	1052	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for any chargeable item which cannot be specifically categorised elsewhere (exclude ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments). Zero fill if no amount charged. * refer to guide for use	**Reject** record if not numeric	E050
51	Bundled Charges			M	1053	1061	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross bundled charge raised (include ex-gratia and patient portion bundled charges). Zero fill if no amount charged. *refer to guide for use	**Reject** record if not numeric	E051
52	Medical Record Number			M	1062	1081	A(20)	Left justify	1	The Medical Record Number (or unit record number) that uniquely identifies the patient, regardless of the number of admissions they have had to the facility.	**Reject** record if blank	E052
53	Miscellaneous Service Codes			M	1082	1191	A(11)	Left justify	10	Any miscellaneous service codes (i.e. non MBS items or Australian Dental Association codes) used for billing. Up to 10 codes may be entered. Blank means that there were no miscellaneous service codes or not 10 repetitions.		
54	Hospital-in-the-home care Charges			M	1192	1200	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charge raised for hospital-in-the-home care service (include ex-gratia and HITH patient portion charges). Zero fill if no amount charged.	**Reject** record if not numeric	E054
55	Special Care Nursery Charges			M	1201	1209	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point)	1	The gross charges raised for SCN (include ex-gratia and patient portion SCN charges, exclude NICU charges). Zero fill if no amount charged. *refer to guide for use	**Reject** record if not numeric	E055
56	Coronary Care Unit Charges			M	1210	1218	N(9)	Right justify Zero prefix $$$$$$$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	E056
57	Special Care Nursery hours			O	1219	1222	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, **identify** record if not numeric	W057
58	Coronary Care Unit hours			O	1223	1226	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, **identify** record if not numeric	W058
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	E059.0 E059.1
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	E060.0 E060.1
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** record if >0000 and (care type not newborn care)	E061 W061

No	Data Item	METeOR identifier	ECLIPSE identifier	Obligation	Position Start	Position End	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
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 charge (item 54) > 0 Blank fill if not applicable.	**Reject r**ecord if item 54 is populated and item is blank or not in format DDMMYYYY. **Reject** record if commencement date > HITH completed date.	E062.0 E062.1
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 charge (item 54) > 0. Blank fill if not applicable.	**Reject** record if item 54 is populated and item is blank or not in format DDMMYYYY. **Reject** record if completed date < HITH commencement date.	E063.0 E063.1
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. Zero fill if not applicable. *refer to guide for use	**Reject** record if not numeric. **Identify** record if 0 and palliative care status (item 25) = 1	E065 W065

Total record length = 1257

	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
	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
	Identify record if no charges reported (total charge=0)	EW208