Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2014-2015

Version 1.2

Statistical Collections and Integration
Department of Health

Great state. Great opportunity.

Queensland Government

Queensland Hospital Admitted Patient Data Collection

(QHAPDC) Manual 2014 2015 collection year

Published by the State of Queensland (Queensland Health), June 2014

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For more information contact:
Health Statistics Unit, Department of Health, GPO Box 48, Brisbane QLD 4001, email Qhipsmail@health.qld.gov.au, phone 07 3234 0200.

An electronic version of this document is available at http://www.health.qld.gov.au/hsu

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1. INTRODUCTION

1.1 Overview

This manual provides an overview of the Queensland Hospital Admitted Patient Data Collection (QHAPDC). It is a reference for all hospitals (public and private), Hospital and Health Services and Department of Health personnel who are involved in the collection, extraction and use of admitted patient data.

This manual is not intended to be, or replace, any other hospital based information system manuals including Hospital Based Corporate Information System (HBCIS) user manual.

1.2 Purpose of the collection

The Queensland Hospital Admitted Patient Data Collection (QHAPDC) contains state-wide data capturing information about patients separated (an inclusive term meaning discharged, died, transferred or statistically separated) from any hospital permitted to admit patients, including public psychiatric hospitals.

QHAPDC data are also used to substantiate the number of patient days (occupied bed days) for public and private patients in declared public hospitals and licensed private hospitals, and day surgery units.

1.3 Reporting requirements

The QHAPDC allows Queensland to meet local, state and national reporting obligations.

For private hospitals reporting of to the QHAPDC is a requirement under *Private Health Facilities Act (1999).*

Accurate, timely, and complete QHAPDC data are critical to ensure Department of Health fulfils its obligations under the National Healthcare Agreement [1]and the National Health Reform Agreement[2] and the National Health Information Agreement.

Data reported to QHAPDC conform largely to the requirements of the National Health Data Dictionary[3] and the Queensland Health Data Dictionary[4]., available through the Queensland Health Information knowledgebase (QHIK)[5]

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[1] National Healthcare Agreement (2013). Available from < http://meteor.aihw.gov.au/content/index.phtml/itemId/496807 >[16 April 2014]
[2] National Healthcare Information Agreement. Available from < meteor.aihw.gov.au/content/index.phtml/itemId/18213>[16 April 2014]
[3] National Health Data Dictionary (2012) Version 16 (AIHW). Available from <http://www.aihw.gov.au/publication-detail/?id=10737422826>[16 April 2014]
[4] Queensland Health Data Dictionary(2013). Available from <http://www.health.qld.gov.au/hsu/qhdd/QHDD-OurPerf.pdf.[16 April 2014]

1.4 Stakeholders

The Healthcare Purchasing, Funding and Performance Management Branch, System, Policy and Performance Division are responsible for informing the Health Statistics Unit (HSU) of the collection requirements for national reporting relating to activity based funding arrangements.

1.5 Activity based funding and Casemix

Casemix is a health term describing a system which groups patients by predetermined factors into clinically meaningful and resource homogenous groups to describe the output of a hospital. The more generic term Activity Based Funding (ABF) is being used in Australian health care reforms and utilises casemix and health classifications as a basis for understanding, setting and negotiating prices for hospital services. The Australian Refined Diagnosis Related Groups (AR-DRGs) patient classification system is designed to classify acute admitted patient episodes from admission through to separation via grouping of *International Statistical Classification of Disease and Related Health Problems, 10th Edition, Australian Modificatio*n (ICD-10AM) diagnosis codes and *Australian Classification of Health Interventions* (ACHI) procedure codes. The timely and accurate coding of patient encounters from documented clinical activity is a critical factor in appropriate assignment of the DRG and the allocation of hospital funds to the type of activity performed.

Sub-acute and Non-acute admitted patients are classified using the Australian National Sub and Non Acute Patient (AN-SNAP) system that utilises assessment scores on a range of recognised functionality measures pertinent to a particular care type, grouped into a SNAP class. Where SNAP assessments are not utilised the care type assigned (other than Acute-01) takes precedence over the DRG assignment for funding allocation.

In ABF, other patient classifications are utilised for non-admitted activity - e.g. Outpatients via Clinic Type and Emergency via Urgency Related Groups (URG). ABF informs Department of Health's budget allocation to the Hospital and Health Service (HHS)) to fund health service delivery. The ABF Model provides a platform for a more transparent and devolved funding and budgeting system. A casemix funding model was introduced from 2007-08 with a further major refinement for ABF from 2011. The funding model is subject to yearly review via a strong governance framework.

The purpose of the ABF model is to enable budgeted activity to be funded on an equitable basis. Weighted activity units (WAUs) are applied to patient classification

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[5] Queensland Health Information Knowledgebase (QHIK). Available from < http://oascrasprod.co.health.qld.gov.au:7900/pls/qhik_prd/qhik_main_menu.entire_page> [16 April 2014]

systems to allocate available funds across hospitals. Whilst there are variable and fixed cost components within the model, the variable cost components relate to the counted activity on the following classifications:

- Acute Admitted Patients (DRG)
- Intensive Care (Designated Ward)
- Mental Health Admitted Patients (DRG)
- Sub and Non-acute Patients (Care type and SNAP Class)
- Outpatients (Clinic Types)
- Emergency Departments (UDG moving URGs with diagnosis element)

Therefore, it is imperative that data is at an optimal level of accuracy and provides complete information about each and every patient episode and service. Additionally high quality information needs to be provided in a timely manner to inform progress to budget and activity targets. Reducing delays and improving data quality will result in a more accurate view of hospital activity which will better inform funding policy.

The ABF website http://abf.health.qld.gov.au/ contains information on mandatory policy relating to data collection and classification along with other general information on casemix and ABF.

2. ABOUT THE COLLECTION

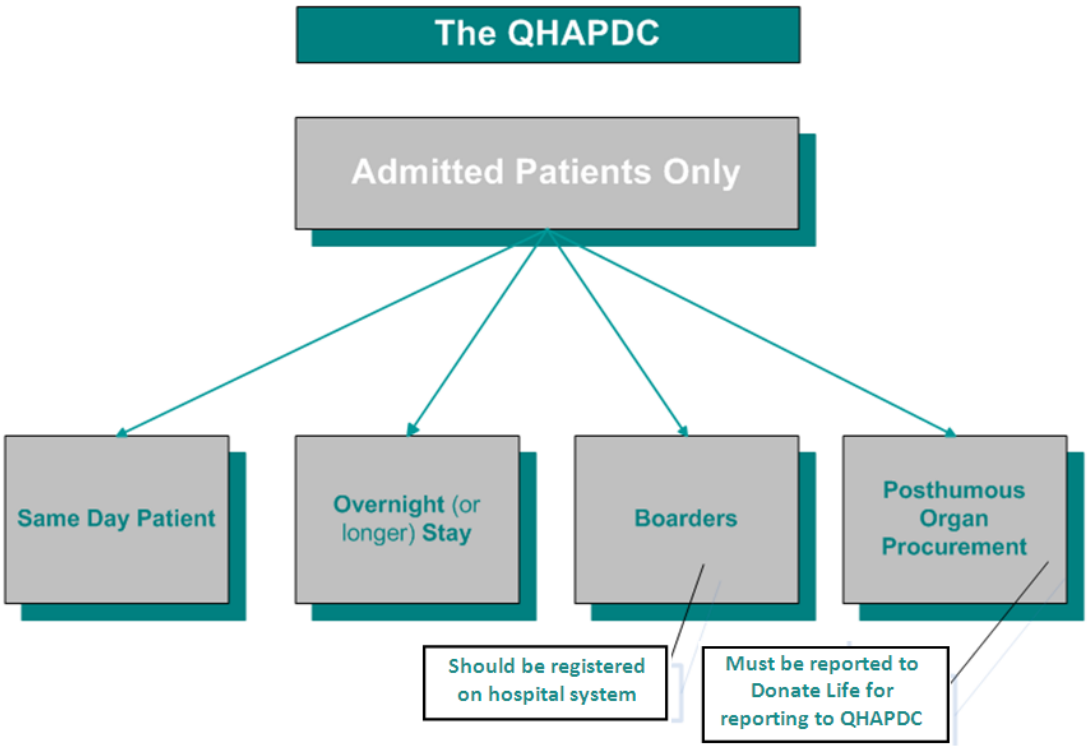
2.1 Coverage

The QHAPDC covers all admitted patient separations from declared public hospitals and licensed private hospitals and day surgery units. A separation can be a formal separation (including discharge, transfer or death) or a statistical separation (episode type changes). Departing the hospital on "leave" is not a separation unless the duration of the "leave" was greater than seven days (see 3.7.2 calculation of leave days). Data from each independent declared public/licensed facility must be reported separately.

Specialist public psychiatric hospitals have been required to submit data to QHAPDC since 1 July 1996. Hospitals with psychiatric units and specialist private psychiatric hospitals have submitted data in the past, but are required to also submit mental health data items.

Hospitals that are permitted to admit patients must contribute data to QHAPDC for each admission. These hospitals are the declared public hospitals, licensed private hospitals and day surgery units and public psychiatric hospitals listed in Appendix A of this manual. It is understood that whilst all the listed hospitals can admit patients, not all will do so. Some may admit exclusively on a same day basis, or admit irregularly.

Figure 1 Coverage

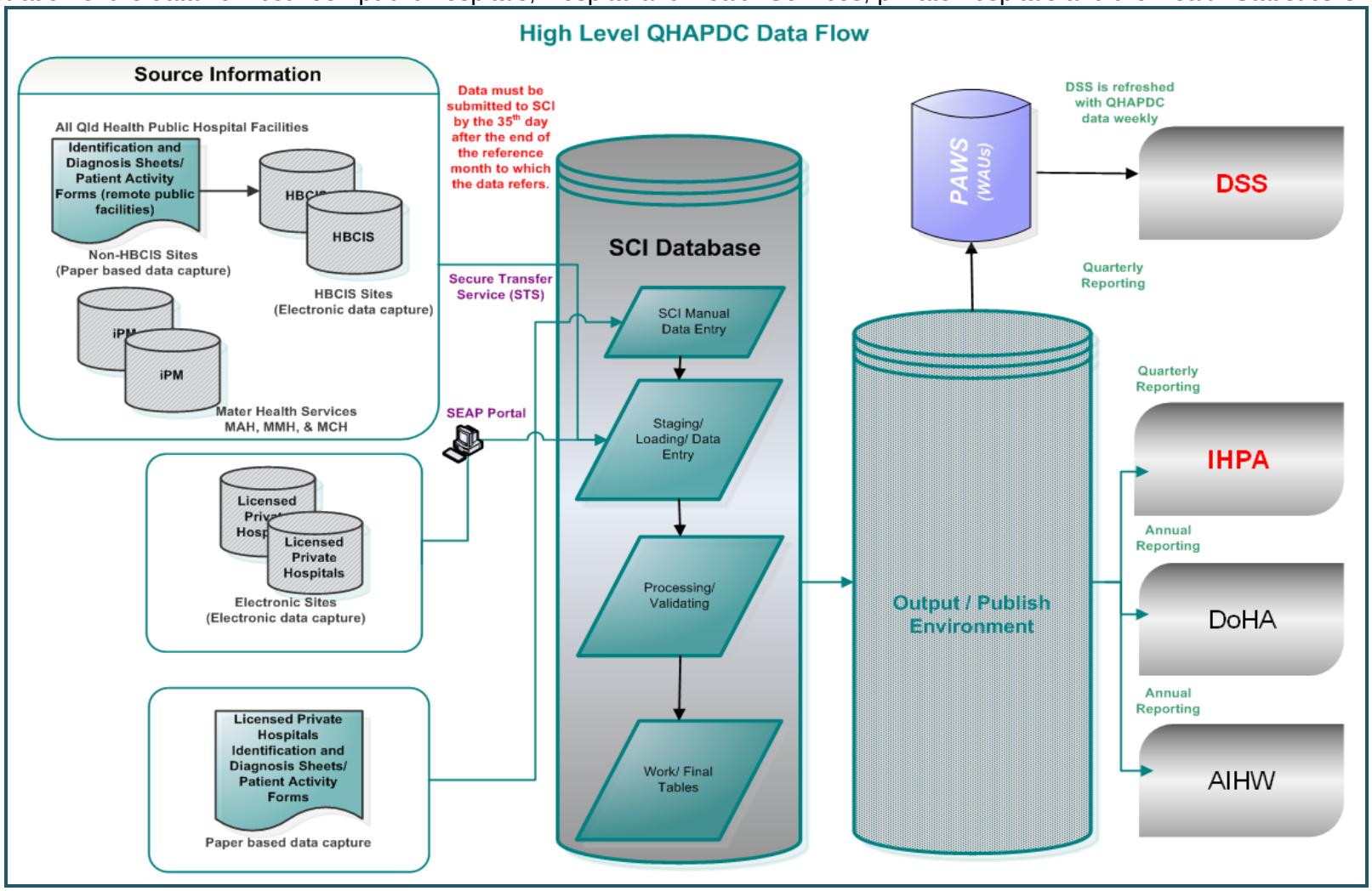


*All boarders and organ procurement donors should be registered on hospital systems and this information provided to the Health Statistics Unit.

2.2 Data Flow

Figure 2 Data Flow

An illustration of the data flow between public hospitals, Hospital and Health Services, private hospitals and the Health Statistics Unit.



2.3 Confidentiality and privacy

Confidentiality applies to information that could reasonably lead to the identification of an individual. Apart from the obvious characteristics (such as name and address), there are other data items which, if seen together, may be sufficient to allow an individual to be identified.

All persons involved in the collection, management and use of patient-related information must ensure that the uses of those data do not "compromise" the privacy of the individual to whom it relates.

All patients admitted to a public hospital must be asked for their consent to the release of their personal, admission and health details for funding purposes. The Patient Election Form is the instrument used to obtain patient consent in this instance. This consent is agency specific and related to the Department of Defence, Motor Accident Insurance Commission, Work Cover Queensland, other workers' compensation insurers and Department of Veterans' Affairs. Any consent given by a patient to release their details to any or all of these agencies does not include the release of any part of the medical record. The information that is released can only be used for the purposes for which it was given. A patient's consent to release their information, may not result in their information being released. Only those records with potential funding implications will be released.

2.4 Benefits of QHAPDC

QHAPDC is the means by which admitted patient activity can be reported, monitored, evaluated, planned for and researched, thereby allowing improved and objective decision-making.

The benefits of QHAPDC can be described as to:

- Assist hospital management to:
    - track resource allocation through the provision of casemix data, and
    - monitor average lengths of stay and occupancy rates.
- Assist research into diseases and health related problems by providing clinical and socio-demographic data profiles of patients over a period.
- Provide information for quality assurance and utilisation review.
- Improve the costing of hospital outputs by the identification of different users of various services within the hospital.
- Improve the ability to maximise revenue.

2.5 Examples of the uses of QHAPDC data

Management

- Strategic planning - can identify admission trends for any of the data items collected. Health services provision is therefore more likely to meet the needs of the community.
- Resource allocation - data to enable management to examine priorities in hospital resource allocation.
- Performance measurement - managers can measure performance upon the delivery of services.
- Benchmarking - comparison with like facilities.
- Optimise Queensland Health's own source of revenue through the identification of fee-paying patients and provision of relevant treatment information to support funding claims.

Administration

- Quality assurance - professionals are assisted in the conduct of health care related quality assurance programs.
- Resource requirements - data allows for the examination of resource requirements for individual and specialty groups within a facility.
- Patient management - clinical staff are assisted to develop standard criteria for clinical management of similar groups of patients.

Research

- Epidemiology – QHAPDC collects the mix of socio-demographic data that are invaluable for epidemiologists, either from this system alone, or because data collected are used as the basis for other data collections (such as Cancer Registry and Perinatal Statistics).
- Medical research – QHAPDC gives clinical staff the information that can form the basis for research projects.
- Health professional education - in hospitals that have a teaching role for any of the health professions, the data are the basis for retrieval of teaching cases and groups of similar patients for the purpose of clinical education.

Australian Government requirements

- The Department of Health is obliged to ensure that it fulfils its obligations under the National Health Information Agreement, National Healthcare Agreement and the National Health Reform Agreement in relation to the provision of admitted services. QHAPDC data are used to substantiate the number of patient days (occupied bed days) for public and private patients in declared public hospitals and licensed private hospitals, and other key information.

2.6 Audits

The potential exists for both the Federal and State Governments to institute audits of data submitted for the QHAPDC.

Depending on the purpose and nature of the audit, they are often conducted by agencies that are external to the hospital and focus on the quality of financial, statistical and clinical data. Audits should occur at many levels, including; at the point of coding, data entry, processing, report production and overall monitoring of the health system activity.

Audits should be random (where individual cases are selected randomly) and targeted (where it is suspected or known that errors are likely to have occurred).

Audits might involve:

- Reconciling the number of separations submitted for the QHAPDC with that submitted to the Monthly Activity Collection.
- Examining the appropriateness of the admission and classification of public and private same day and overnight (or longer) stay patients within declared public hospitals. For example:
    - Medicare Eligibility – v – Country of Birth;
    - Medicare Numbers beginning with numbers other than '4' where residential address is shown as Queensland;
    - Account class assignment of work-related injuries;
    - Account class assignment for passengers of motor vehicle accidents (MVA).
- Monitoring accuracy of the assignment of the Australian Refined Diagnosis Related Group (AR-DRG) based on appropriate coding of the diagnoses and procedures contained in a patient's record.
- Monitoring compliance with obtaining patient consent to release personal admission details and comparing the number of 'unable to obtain' flags against length of stay (LOS) and Diagnosis Related Group DRG details.
- Comparing costs and lengths of stay in similar patients, across and within declared public hospitals, to identify anomalies.
- Assessing the quality of the data items (socio-demographic or International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification codes).

With the implementation of Activity Based Funding, such audits will also focus on the adequacy of the control environment to ensure hospital funding levels are verifiable.

3. GUIDELINES FOR SUBMISSION OF DATA

3.1 Methods of submission

Public hospitals are required to submit data electronically using an approved file format. Some smaller and more remote sites may use Identification and Diagnosis Sheets (MR056 (B) - Part One) and Patient Activity Forms (MR056 (B) - Part Two) however, these forms are required to be converted into an electronic format suitable for submission by the HHS or nominated hospital and submitted to HSU.

Private hospitals submit data electronically via the Secure External Access Portal (SEAP) using an approved file format or by completion of Identification and Diagnosis Sheets (PHI - Part One) and Patient Activity Forms (PHI - Part Two) reported directly to the HSU. If data are being submitted using I&D Sheets then only completed months are to be forwarded.

Appendix B contains both public and private hospital file formats and validation rules and Appendix C contains copies of the current paper collection forms.

The information system used in public hospitals is known as HBCIS (Hospital Based Corporate Information System). All patient separations and patient days (or occupied bed days) that occur in public hospitals are recorded via direct or indirect access to an operational HBCIS system. HBCIS data are extracted and mapped or grouped to meet the QHAPDC needs. The software used to achieve compatibility is the Homer Queensland Interface (HQI).

Throughout this manual examples of the required data items are listed. Public hospitals that use HBCIS should refer to examples titled 'HBCIS hospitals'. Private hospitals and other public hospitals without direct access to HBCIS should refer to the examples titled 'other hospitals'. Where the data items are the same for all hospitals refer to the examples titled 'all hospitals'.

Example: HBCIS hospitals

HBCIS Hospitals	Example of data item = 01

Example: Other Hospitals

Other Hospitals	Example of data item =1

Example: All Hospitals

All Hospitals	Example of data item = 02

Note - where differences occur between HBCIS and the requirements for QHAPDC the example will also provide the HQI mapping.

3.2 Paper forms

Identification and Diagnosis Sheets and Patient Activity Forms are to be typed or completed in blue or black ballpoint pen. Words and figures must be legible and within the confines of the designated field. As the forms are multi-part sets, hospitals must press firmly to obtain a clear copy. The forms have been designed using NCR (no carbon required) paper. Care should be taken to ensure that extraneous imprints are not inadvertently made on the NCR copies. The bottom copy is sent to the HSU (private hospitals only).

3.2.1 Ordering I&D Forms

All private hospitals can obtain forms by contacting their QHAPDC contact in the Health Statistics Unit.

All public hospitals can access forms through the Health Statistics Unit web page: http://qheps.health.qld.gov.au/hsu/home.htm

3.3 Data Quality

Hospitals must ensure that data are of high quality prior to submission to HSU. HSU will not accept data containing high numbers of validation exceptions. When a high number of validation exceptions occur the hospital will be advised. In order for HSU to process this data the validation exceptions must be corrected (on HBCIS or relevant information system), re-extracted and submitted to HSU.

3.4 Due dates for data submissions

QHAPDC data are collected on a monthly basis, and finalised on a financial year basis.

For public hospitals a preliminary PH1 report is due on the 4th day of each month following the reference month. A PH1 report is an aggregate-level report summarising hospital activity for the specified reference month. For most facilities using HBCIS, the PH1 is generated and sent automatically using the 'Report Monitor' functionality in HBCIS.

All hospitals in scope must submit QHAPDC to HSU by the 35th day following the reference period.

The table below is an example of QHAPDC reporting schedule:

Reporting Period	Finalised Data Due Date All Hospitals
July	4 September
August	5 October
September	4 November
October	5 December
November	4 January
December	4 February
January	7 March (6 in a leap year)

February	4 April
March	5 May
April	4 June
May	5 July
June	4 August

HSU monitor the timeliness and quality of data supplied by public and private hospitals. For private hospitals it is a requirement to supply data as part of a licencing agreement. Noncompliance may result in these issues being escalated to the Office of the Chief Health Officer for follow-up with hospitals.

3.5 Validation checks and error correction

3.5.1 Outline

Validation exceptions are generated following a successful load of hospital data for a particular reference period. Public hospitals using HBCIS are notified of their exceptions on-line through the Electronic Validation Application (EVA Plus). Private hospitals receive a 'validation report' sent via secure e-mail.

It is anticipated that in the near future private hospitals (with access to the internet) will also be able to also access their validation exceptions on-line through the Electronic Validation Application (EVAPlus).

A full list of Validations and explanation of messages can be found in Appendix L.

3.5.2 Types of data quality checks

There are two types of validation exceptions that exist in the QHAPDC, fatal and warnings.

Fatal validation exceptions are triggered when one or more critical errors have been identified. Where a fatal validation exception exists the data in error must be updated otherwise the episode of care will not become 'final' and consequently not be reported. If the data is not in error and is in fact correct a detailed explanation of why the exception is correct should be supplied to HSU.

Warning validations exceptions are triggered when one or more non-critical errors have been identified. Generally these exceptions exist where data reported is inconsistent, illogical or unusual. All warning exceptions must be investigated and confirmed however will not stop the episode of care becoming 'Final'.

3.5.3 Electronic Validation Application (EVA Plus)

HBCIS Hospitals are notified of their exceptions on-line through the QHAPDC Electronic Validation Application (EVAPlus) which displays on a secure Queensland Health Electronic Publishing Service (QHEPS) website. EVA Plus provides facilities with the ability to record 'actions' that are required to rectify these validation errors. The EVAPlus is designed to streamline and replace the 'validation reports' process, with additional benefits including:

- Errors are available for actioning almost immediately after data is loaded. Once actioned HSU are able to immediately process further requests such as error mapping.
- More than one user can access and be actioning the errors at the same time.
- Errors can be filtered/sorted to only show specific validation types e.g. EAS errors.

Data are required to be updated in HBCIS and any amendments are sent to the HSU as part of the next extract of data. Validations should be actioned on EVA Plus and HBCIS prior to the next month's data extract. This is to ensure amendments are included in the next month extraction and errors will not be regenerated in EVA Plus.

The EVAPlus user manual can be located on the HSU Intranet site.
http://qheps.health.qld.gov.au/hic/dsu_collections.htm

3.5.4 QHAPDC Validation reports

Private Hospitals receive their validation exceptions through a validation report that is sent by secure e-mail. Completed reports must be provided to the HSU within one week (7 days) of receipt of the report. In the space provided on the report the hospital must detail the required amendment. If no amendment is required the reason the data is correct should be listed. Corrections listed on the returned report are made manually at the HSU and must be finalised before the next month's data is loaded. Any errors that were not corrected from this month will appear on the next month's Validation Report.

It is anticipated that in the near future Private Hospitals will also be able to also access their Validation exceptions on-line through the Electronic Validation Application (EVAPlus).

All validation reports contain the following minimum information;

- message date – the date the report was created by HSU
- Patient ID - is the patient's UR number supplied by the hospital.
- Facility Unique ID
- admission or episode start date,
- the discharge or episode end date,
- message type (fatal or warning),
- message text
- message code.

It is recommended that hospitals maintain a record of validation reports with completed responses.

3.5.5 Resubmitting data

It is recognised that hospitals may wish to amend data already submitted (for example, a change in ICD-10-AM codes or compensable status).

HBCIS hospitals can provide amendments to separations within a financial year up to the acceptance of their August (current financial year) extract. For

example if a change is made to data for a patient separated on 3 May 2014 on HBCIS after their July data has been submitted to the Health Statistics Unit, then the amendment will be included in the August extract. Amendments to separations for the previous financial year cannot be submitted electronically by HBCIS hospitals after the August extract (current financial year) has been completed and accepted.

Paper hospitals can make amendments to separations within a financial year up to 21 September of the next financial year. Thus, a change to data for a patient separated on 3 May 2014 can be accepted by the Health Statistics Unit up to 21 September 2014.

3.5.6 Authorising changes to data already supplied

Data that is required to be manually updated by HSU requires hospital authorisation. Authorisation can be in the form of an email and must contain the details of the patient episode and the reason for the amendment. Emails should be sent to qhipsmail@health.qld.gov.au.

For public hospitals manual amendments are only made to data that cannot be made by the HBCIS hospital.

For private hospitals manual amendments are made each month as part of the validation process. Authorisation for amendments occurs from responses listed in the validation report. Should additional changes be required at a later date authorisation will be required. Authorisation can be in the form of an email and must contain the details of the patient episode and the reason for the amendment. Emails should be sent to qhipsmail@health.qld.gov.au.

3.6 Up-to-Date Records (HBCIS hospitals)

When the HBCIS HQI extract generates data for separated patients for an extract period, data will also be generated on patients admitted during, or prior to, the extract period but who have not separated in the extract period.

This process allows for basic data (admission date, date of birth, sex, etc) to be available for patients remaining in hospital over a long period. Data for these patients is referred to as ‘up-to-date’ records.

No validations will be carried out by Health Statistics Unit on up-to-date records.

Once the patient is separated, the up-to-date record will be amended with the separation date and processed/validated in the same way as all other separated records.

3.7 Counting rules

3.7.1 Calculation of Length of Stay (LOS)

Every day the patient is an admitted patient is known as a patient day (sometimes referred to as an occupied bed day). The LOS of an episode of care is the total of all the patient days accrued during a particular episode.

There are two ways of calculating the LOS:

1	**Retrospective** (after the patient has been discharged): separation date minus admission date minus total leave days. Example: A patient was admitted on 4 January 2014 and discharged on 11 January 2014. There was one day of leave in that time. The length of stay is (11- 4) -1 = 6 days.
2	**Progressive** (while still in hospital): sum of the accrued patient days at a point in time. Example: A patient was admitted on 4 January 2014. As of 8 January 2014, with no days of leave the length of stay is 4 days.

Calculation rules for length of stay

The following rules are used to ensure the calculation of length of stay is consistent;

1. The sum of patient days, contract leave and leave days must equal the number of days elapsed between admission date and separation date.
2. For any given date, either a patient day or any type of leave day may be counted, but not both.
3. Patient days are not accrued when the patient is out of hospital on leave even though a bed may be "held" for the patient during his/her absence.
4. For patients admitted and separated on different dates, count one patient day for day of admission; do not count a patient day for day of separation.
5. For patients admitted and separated on the same date, count one patient day; no leave days. The length of stay is one day.
6. A same day patient cannot go on overnight leave.
7. A period of leave cannot exceed seven days.
8. Normally, the day of going on leave is counted as a leave day, and the day of returning from leave is counted as a patient day.
9. When, on the same date, a patient is admitted and goes on leave, count this day as a patient day. When, on the same date, a patient returns from leave and again goes on leave, count this day as a leave day. When, on the same date, a patient returns from leave and is separated, do not count this day as either a patient day or a leave day.
10. For QHAPDC, leave is reported only where the patient is away at midnight. Midnight is recorded as the start of a new day (not the end of the previous one).
11. If an admitted patient goes from one hospital to another to receive treatment (as an admitted patient) and the patient has not been placed on contract leave, he/she must be separated and re-admitted on return (if applicable).
12. Patients cannot be charged for "leave days" even if they had treatment and accommodation for part of that day.

Counting rules for contract leave

For QHAPDC, contract leave is reported by the hospital from which the patient is being contracted, whether the leave is same day or overnight. The patient is not required to be away at midnight.

3.7.2 Calculation of leave days

The number of leave days is calculated as the date the patient returned from leave minus the date the patient went on leave during a period of treatment or care. A day is measured from midnight to midnight.

The day the patient goes on leave is counted as a leave day. The day the patient returns from leave is a day of admitted care (patient day) and is not counted as a leave day. Whilst on leave no patient day charges are raised, nor are patient days calculated.

Example
A patient went on leave on 9 January 2014 and returned on 15 January 2014. The patient was on leave for 6 days.

In order to continue the accrual of the patients 35 day qualifying period the period of leave cannot exceed seven days. Therefore, a patient starting leave on Monday, 10 June, must return to the hospital on or before Monday, 17 June.

A patient who goes on leave but does not return within the specified seven-day limit is to be formally separated from the hospital from the date that he/she left the hospital. The mode of separation (discharge status) is to be recorded as:

HBCIS Hospitals	Discharge status: 09 Non-return from leave.

Other Hospitals	Mode of separation: 09 Non-return from leave.

If the patient subsequently returns to hospital, he/she is to be treated as a new admission. This seven day maximum leave rule also applies to psychiatric hospitals.

Calculation Rules for Leave Days

The calculation rules for the leave days in which the patient is out of hospital are as follows.

1. The sum of patient days and leave days must equal the number of days elapsed between admission date and separation date.
2. For any given date, either a patient day or a leave day may be counted, but not both.
3. Patient days are not accrued when the patient is out of hospital on leave, even though a bed may be "held" for the patient during his/her absence.
4. A same day patient cannot go on overnight leave.
5. A period of leave cannot exceed seven days.
6. Renal dialysis and day chemotherapy patients are not on leave between treatments; each dialysis session is a separate admission.

7. Normally, the day of going on leave is counted as a leave day, and the day of returning from leave is counted as a patient day.
8. When, on the same date, a patient is admitted and goes on leave, count this day as a patient day. When, on the same date, a patient returns from leave and again goes on leave, count this day as a leave day. When, on the same date, a patient returns from leave and is separated, do not count this day as either a patient day or a leave day.
9. For QHAPDC, leave is reported only where the patient is away at midnight. If an admitted patient goes from one hospital to another to receive same day treatment (as an admitted patient) and this is not on contract, they must be discharged and re-admitted on return (if applicable).
10. Patients cannot be charged for a "leave day" even if they had treatment and accommodation for part of that day.

3.7.3 Calculation of Nursing Home Type Patient (NHTP) days

A patient should be classified as a NHTP after 35 consecutive days of hospitalisation and are **not** subject to an Acute Care Certificate.

Compensable third party patients should be classified as NHTP after 35 consecutive days of hospitalisation, unless the following exclusion applies;

- An Acute Care Certificate has been issued
- Australian Government Minister for Health and Minister for Sport has issued a notice declaring the patient as a NHTP

If an ineligible person remains in hospital for an extended period and is not receiving 'acute' care, then they should be assigned an appropriate non-acute care type (see section 7.15 Care type). Public patients will be charged the applicable rate for their care according to the fee specified in the Fees and Charges Register.

Note that the 35-day qualifying period may accrue across more than one hospital (public or private or both) and includes extended treatment facilities but excludes public psychiatric facilities.

Patients who go on leave or are separated from hospital, but return within seven days, may continue accruing the 35 days. Patients who leave hospital and do not enter another hospital for at least seven days will begin at day one towards the 35-day qualifying period on their next admission to hospital.

Note that leave days and days out of hospital do not count in accruing the 35 days.

Calculation of NHTP days when patient on leave

The rules for the calculation of the leave days in which the patient is out of hospital and patient days that count towards the 35 day qualifying period are as follows:

1. The day the patient leaves the hospital is considered day one of the leave days.
2. The day the patient returns to the hospital is not counted as a leave day, but as a day of admitted care (patient day). This patient day counts towards the 35-day qualifying period for calculation of nursing home type patients.

Therefore, a patient starting leave on Monday, 10 June, must return to the hospital on or before Monday, 17 June, in order to continue the accrual of his/her qualifying period.

If a patient is no longer classified as NHT (e.g. patient broke arm and requires acute care) the 35 day qualifying period does not begin again.

4. DATA DEFINITIONS

Definitions used for the QHAPDC conform largely to the requirements of the National Online Data Dictionary (METEOR) and the Queensland Health Data Dictionary.

4.1 Acute care certificates

The Acute Care Certificate was originally developed at a time when only two categories of care type were defined – Acute and Nursing Home Type. However, a number of additional sub and non-acute care types have now been defined, to better describe the various types of care being provided to admitted patients. The care type of Nursing Home Type no longer exists, as patients receiving any of the new sub and non-acute care types can accrue Nursing Home Type days (except those patients categorised as receiving Newborn, Organ Procurement or Boarder 'care').

Given this, the Acute Care Certificate can be thought of as a "non Nursing Home Type Patient" certificate. That is, any patient who has been in hospital for a continuous period exceeding 35 days must be the subject of an Acute Care Certificate, or they are to be classified as accruing Nursing Home Type days – that is, they become a Nursing Home Type Patient.

More detailed information regarding these categories is available in the Queensland Health Admission Criteria in Appendix F of this manual.

4.2 Admitting Hospital

All declared public hospitals and licensed private hospitals and day surgery units (listed in Appendix A) are entitled to admit patients. Public psychiatric hospitals may also admit patients and are required to supply data to the QHAPDC.

If a doctor with admitting rights at one of these hospitals believes he/she has a patient that requires or warrants admission, the patient must meet the criteria set out below. Provided it is to one of the declared public/licensed hospitals, an admitted patient is not required to occupy a bed nor is there a minimum time requirement to qualify for admission.

4.3 Admission criteria

Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision, based upon specified criteria, that a patient requires same-day or overnight care or treatment. This care and/or treatment can occur in hospital and/or in the patient's home (for hospital-in-the-home patients).

In general, a patient can be admitted if one or more of the following apply:

- The patient's condition requires clinical management and/or facilities are not available in their usual residential environment.
- The patient requires observation in order to be assessed or diagnosed.
- The patient requires at least daily assessment of their medication needs.
- The patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room, without specialised support facilities and/or expertise being available (e.g. cardiac catheterisation).
- There is a legal requirement for admission (e.g. under child protection legislation).
- The patient is aged nine days or less.

Clause 8 of Schedule 3 of the Private Health Insurance (Benefit Requirements) Rules 2011 (Type C Procedures) may be used as a guide for the medical services not normally requiring admitted hospital treatment. This clause also contains the list of Type C exclusions.

It is requested that all Boarders are registered and the data submitted to the Health Statistics Unit. Refer to section 4.4 Boarders.

More detailed information regarding Queensland Health's admission criteria can be found at Appendix F.

4.4 Boarders

A boarder is defined as a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. For example, a two-year-old baby who does not meet the criteria for admission, accompanying their mother who is currently admitted is considered a boarder; as is a father accompanying his child who is admitted for a tonsillectomy or a mother accompanying a sick newborn who required admission to hospital. A baby who remains in hospital without its mother awaiting adoption and does not require clinical care/treatment should be separated when the baby is nine days of age and registered as a boarder when the baby is ten days of age.

Boarders receive no formal care or treatment and are therefore not considered admitted patients. However, boarders are within the scope of this collection and the Health Statistics Unit has collected information regarding boarders since 1 July 1999. Hospitals should register such people and forward this information to the Health Statistics Unit.

If a boarder meets the criteria for admission they should be formally admitted.

When a hospital registers a boarder, the boarder should be allocated with a Source of Referral/transfer = 21 (boarder), a Care Type of episode = 08 (boarder) and a Mode of separation = 14 (boarder). Data on boarders should be submitted to the Health Statistics Unit.

4.4.1 Boarder who is subsequently admitted

If a boarder has been accommodated at a hospital and a change in their condition subsequently allows them to be an admission under the minimum criteria, this cannot be recorded as a change in status. Even though the hospital has previously "registered" the person as a boarder, the patient must be admitted and treated as a first-time admission. Do not use the 06 care type change for either the source of referral/transfer or mode of separation. If the person subsequently changes circumstances again, they should be formally separated prior to being registered as a boarder once more. If an admitted patient is separated to become a boarder the '19–other' mode of separation code should be recorded.

4.5 Change in care type

Patients changing from one care type to another, e.g. acute to maintenance within the same hospital, are to be statistically separated and re-admitted. They have a change of care type and are recorded as such by using a code 06 in the source of referral/transfer and mode of separation data items.

4.6 Compensable patient

A compensable patient is defined as an eligible person who is:

- is entitled to claim damages under Motor Vehicle Third Party insurance or
- is entitled to claim damages under worker's compensation or
- has an entitlement to claim under public liability or common law damages.
- receiving hospital services for an injury, illness or disease; and
- entitled to receive or has received a compensation payment in respect of an injury, illness or disease; or if the individual has died – the individual's estate, provided that the order under sub-section 6(2) of the *national Health Insurance Act 1973*, dated 11 January 1984 remains in force, or a replacement order remains in force (National Healthcare Agreement 2012).

Entitled veterans and Australian Defence Forces personnel are not compensable in the strict interpretation of the word, but are patients for whom another agency (Department of Veterans' Affairs or Department of Defence respectively) has accepted responsibility for the payment of any charges relating to their episode of care.

4.6.1 Motor vehicle accidents

The *Queensland Motor Accident Insurance Act 1994 (MAIA)* commenced on 1 September 1994. This Act established a system whereby the Queensland Motor Accident Insurance Commission (MAIC) levies Compulsory Third Party (CTP) Insurers a Hospital and Emergency Services Levy, to fund a reasonable proportion of the cost of public hospital and emergency services and people who are injured in motor vehicle accidents, who use such services and who are claimants or potential claimants under the Compulsory Third Party Scheme..

The levy for public hospital and emergency services is fixed under Schedule 3 of the *Queensland Motor Accident Insurance Regulation 2004*.

The levy does not apply to accidents that:

- occurred prior to 1 September 1994; or
- are not associated with CTP insurance (for example, accidents involving: mobile machinery or equipment such as bulldozers and forklifts; or agricultural implements); or
- involved single vehicle accidents with only the driver suffering injury; or
- only involved vehicles registered in States other than Queensland.

People admitted to hospital from motor vehicle accidents occurring after 1 September 1994, must be classified as either ***Motor Vehicle (Queensland)*** or ***Motor Vehicle (Other).***

Motor Vehicle (Queensland): This is used where the patient admitted to hospital from a motor vehicle accident can establish negligence against an owner or driver of a Queensland registered motor vehicle.

Motor Vehicle (Other): This is used where the patient admitted to hospital from a motor vehicle accident can establish negligence against an owner or driver of a motor vehicle registered in a State or Territory other than Queensland.

People admitted to hospital from motor vehicle accidents occurring before 1 September 1994, and who: have established the right to claim, or have received settlement for a compensation claim, or intend suing under a public liability claim, must be classified as ***Other Third Party***.

Compensable Third Party: Patients who may at any time receive, or establish a right to receive, compensation or damages (not covered by MAIC or Queensland workers' compensation) for the injury, illness or disease for which they are receiving care and treatment.

To ensure that a patient's compensable status is correctly recorded, the following questions should be asked of the patient or accompanying person:

- "Was it a single or multiple vehicle collision?"
- "Were the vehicles registered in Queensland or elsewhere?"
- "When did the accident occur (date)?"
- "Did the accident occur while on your way to or from work?"

4.6.2 Raising Charges for Patients in Public Hospitals

Patients classified as ***Public Motor Vehicle (Queensland)*** will have no individual charges raised since they are covered by the levy bulk payment. However, if a motor vehicle Queensland patient chooses to be treated as a private patient they must obtain prior approval from their CTP insurer and are classified as Compensable Third Party private.

Patients classified as ***Motor Vehicle (Other)*** or ***Other Third Party*** are to have charges raised.

On admission the patient can be, classified as Motor Vehicle Accident and should be amended where necessary when medico-legal correspondence or other evidence to the contrary is obtained by the hospital. However, if the patient is the driver of single vehicle accident they cannot be classified as Motor Vehicle Accident.

Patients from accidents which involve vehicles from both Queensland and other States, and where the liability is dubious or where there is the possibility of shared liability, are to be classified as Compensable Third Party and charges raised. They may need to be reassessed after a settlement has been reached.

4.7 Contracted hospital care

With respect to the collection of this data item for the QHAPDC, the purchaser of hospital care services can be either a hospital (public or private) jurisdiction, Hospital and Health Service or other external purchaser. The provider of health care services must be a hospital (public or private) or a private day facility.

With respect to the collection of this data item for the QHAPDC, the purchaser of services is referred to as the contracting hospital or the contracting jurisdiction, Hospital and Health Service or other external purchaser, and the provider of services is referred to as the contracted hospital.

So, contracted hospital care is provided to a patient under an agreement between a purchaser of services and a contracted hospital.

From 1 July 2012 contracted care details were expanded to allow for the collection of the hospital facility number of the other hospital involved for each contracted episode of care (ie. Hospital B) where contract type is 2, 3, 4 or 5.

From 1 July 2014 contracted care details will be required to be reported by the contracted hospital (hospital B) where the contract type is 1 and the patient is a public patient.

Accurate recording of contracted hospital care is essential because:

- funding arrangements require that the DRG assigned to a patient accurately reflects the total treatment provided, even where part of the treatment was provided under contract;
- funding arrangements requires that potential double payments are identified and avoided;
- unidentified duplication in the reporting of separations, patient days and procedures must be avoided to enable accurate analyses as required for funding, casemix, resource use and epidemiological purposes; and
- national reporting requires the details of contracted public patients attending private hospitals to be reported.

4.7.1 Scope of Contracted Hospital Care

To be in scope, contracted hospital care must involve **all** of the following:

- a contracting hospital or purchaser of the service;
- a contracted hospital;
- the contracting hospital or purchaser making full payment to the contracted hospital for the contracted service; and
- the patient being physically present in the contracted hospital for the provision of the contracted service.

4.7.2 Procedures Performed by a Private Health Provider (Non-hospital)

Whilst not falling within the scope of contracted hospital care, to ensure consistency in the reporting of patient care, it is strongly recommended that procedures performed by a private health provider (non-hospital) (i.e. not a licensed hospital) are coded. Private health providers include those organisations that would not have a Queensland Health facility number, but deliver services such as physiotherapy, radiology and pathology.

See Section 4. Recording of Procedures Performed by a Private Health Provider (non-hospital) and 9.17 Contract Flag for further details on the use of the contract flag functionality and dummy facility identifier.

4.7.3 Other Purchase Care Services

The following are considered to be out of scope of contracted hospital care services:

- Hospital care services provided to a patient in a separate facility during their episode of care, for which the **patient** is directly responsible for paying.
- Pathology or other investigations performed at another location on specimens gathered at the contracting hospital.
- Hospital care services purchased from your hospital by an organisation that is not a hospital or a jurisdiction, Hospital and Health Service and other external purchaser.

Note: The ICD-10-AM *Australian Coding Standards* should be applied when coding all episodes. The allocation of diagnosis codes and procedure codes are not affected by the contract status of an episode. In particular, procedures that would not otherwise be coded should not be coded solely because they were performed at a contracted hospital.

4.7.4 Location of Contracted Care Data Items on HBCIS (Public Hospitals using HBCIS)

Data Item	HBCIS Screen Location	Triggered By
Contract Type	Contracted Care Screen	Leave Category = C Funding Source = 10
Contract Role		
Purchaser/Provider Identifier		Contract type = 2, 3, 4, or 5 and Contract role is 'A' or 'B'
		Contract type = 1 and Contract role = B and Is a public patient
Date Transferred for Contract Service	Patient Leave Screen	Leave Category = C
Date Returned from Contract Service		
Contract Leave		
Contract Procedure Flag	Inpatient ICD Coding Screen	

4.7.5 Contract Role

Contract role identifies whether a hospital is the contracting hospital (purchaser of hospital care) or the contracted hospital (provider of an admitted or non-admitted service).

A	Hospital **A** is the contracting hospital.
B	Hospital **B** is the contracted hospital.

4.7.6 Purchaser/Provider Identifier

Type 1 contracts

Record the contract identifier of the jurisdiction, Hospital and Health Service or other external provider who has purchased the public service when the contract type is 1 and the contract role = B.

Type 2, 3, 4, or 5 contracts

Record the identifier of the other hospital involved in the contracted care. The other hospital identifier is required where the contract type is 2, 3, 4, or 5 and the contract role is 'A' or 'B'.

4.7.7 Contract Leave

Contract leave is a period spent as an admitted patient at a contracted hospital, during an episode where the patient is also admitted to the contracting hospital. A patient **cannot** be admitted to two facilities at the same time, unless they are on **contract leave.**

A patient can go on contract leave for services that are same day or overnight (or longer). If there is **no agreement** between the two facilities, then the patient must be **formally separated/transferred** if they are to be admitted to the second facility.

Contract leave days are reported only by the contracting hospital and are treated as patient days and included in the length of stay at that hospital. Patients going on contract leave are **not separated**.

See also Section 8.3.5 Out on Contract Leave for more information.

4.7.8 Contract Flag

A Contract Flag is an indicator that designates that a procedure was performed by another hospital as a contracted hospital care service. It also indicates whether the procedure performed was an admitted or non-admitted service by using a code of **1** (contracted admitted procedure) or **2** (contracted non-admitted procedure). All procedures provided as part of a contract arrangement must be flagged using the Contract Flag. Diagnosis codes should be recorded but not flagged, unless it is to indicate that a contracted service was not carried out. See Section 9.17 Contract Flag for more information.

Since 1 July 1999, HBCIS hospitals have been able to use the Contract Flag functionality without placing a patient on contract leave.

4.7.9 Types of Contracted Hospital Care

There are five contract types, which are described below. In these examples, the contracting hospital is termed Hospital **A**. The contracted hospital is termed Hospital **B**.

The various contract types are represented by one of the following numerical values:

1 = B
2 = ABA
3 = AB
4 = (A)B
5 = BA

Contract Type 1 - B

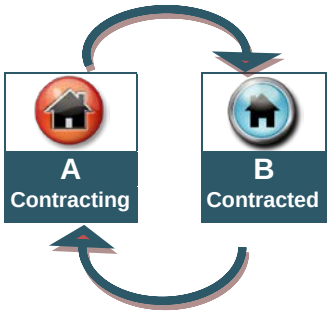
Definition: Admission as a same day patient or overnight (or longer) stay patient to a public or private hospital under contract to a jurisdiction, Hospital and Health Service or another external purchaser.

Hospital **B** records the following information:

- Appropriate Admission Source/Source of Referral code
- Contract Type code 1 (Contract Type B)
- Contract Role code B (Hospital B)
- Appropriate Discharge/Separation Code
- Identifier of the purchaser of the public contracted service

Contract Type 2– ABA

Definition: One hospital (A) contracts with another hospital **(B)** to provide an admitted or non-admitted service. The patient is admitted to Hospital A and placed on contract leave prior to admission to hospital B.



Note:

- Where the service is a **non-admitted** service provided at hospital **B**, **B** does **not** admit the patient.
- The patient must be admitted to a hospital A prior to the service provided at Hospital B
- If the patient does not return to Hospital **A**, see the procedure for Contract Type 3 **(AB)**.

Hospital **A** records the following information

- Appropriate Admission Source/Source of Referral
- Admission Date: actual date admitted at A
- Contract Type code 2 (Contract Type ABA)
- Contract Role code A (Hospital A)
- Contract establishment identifier (Destination/Extended Source Code) of Hospital B
- Date patient transferred for contract service (contract leave)

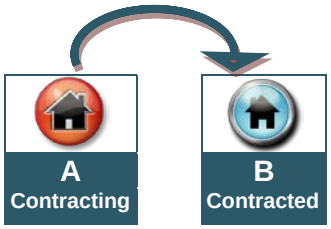
- Date patient returned from contract service (contract leave)
- Diagnosis and procedure codes. Include any additional diagnoses identified by B (but do not flag them unless it is to indicate that a contracted service was not carried out) , and all procedures provided by B (each with a contract flag of 1 or 2)
- Discharge/Separation date: actual date the patient left A after returning from B
- Appropriate Discharge Status/Mode of Separation code after returning from B
- Other Hospital Identifier is required

Hospital **B** (only if admitted by Hospital **B**) records the following information;

- Admission Source/Source of Referral code 24
- Admission date: actual date care commenced at B
- Contract Type code 2 (Contract Type ABA)
- Contract Role code B (Hospital B)
- Transferring from Facility (Extended Source Code) – identifier of hospital that the patient was transferred from
- Diagnosis and procedure codes: only in relation to care provided by B
- Discharge/Separation date: actual date separated from B
- Discharge Status/Mode of Separation code 16
- Other Hospital Identifier is the identifier of Hospital A, the hospital contracting the admission. In the majority of cases this will be the same identifier as that provided for the Transferring from Facility (Extended Source Code) data item

Contract Type 3 – AB

Definition: One hospital (A) contracts with another hospital (B) to provide an admitted or non-admitted (or outpatient) service. The patient does not return to A and is not placed on contract leave.



Note:

- Where the service is a non-admitted service provided at hospital **B**, **B** does not admit the patient.
- The patient is not placed on contract leave to attend hospital **B**.

Hospital **A** records (irrespective of the original intention for the patient to return or not) the following information;

- Appropriate Admission Source/Source of Referral
- Admission Date

- Contract Type code 3 (Contract Type AB)
- Contract Role code A (Hospital A)
- Contract establishment identifier (Destination/Extended Source Code) of Hospital B
- Diagnosis and procedure codes. Include any additional diagnoses identified by B (but do not flag them unless it is to indicate that a contracted service was not carried out) , and all procedures provided by B (each with a contract flag of 1 or 2)
- Discharge/Separation date: actual date separated from A
- Discharge Status/Mode of Separation code 16
- Other Hospital Identifier is required

Hospital **B** records (If admitted by **B**) the following information;

- Admission Source/Source of Referral code 24
- Admission date: actual date of commencement of care at B
- Contract Type code 3 (Contract Type AB)
- Contract Role code B (Hospital B)
- Transferring from Facility (Extended Source Code) – identifier of hospital that the patient was transferred from
- Diagnosis and procedure codes: only in relation to care provided by B
- Discharge/Separation date: actual date separated from B
- Appropriate Discharge Status/Mode of Separation code
- Other Hospital Identifier is the identifier of Hospital A, the hospital contracting the admission. In the majority of cases this will be the same identifier as that provided for the Transferring from Facility (Extended Source Code) data item

Contract Type 4 - (A)B

Definition: Admission as a same day or overnight (or longer) stay to a hospital (B) under contract from another hospital (A).

Note: Hospital **A** does not record an admission.

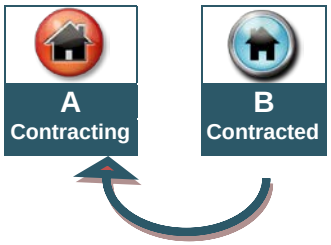
Hospital **B** records the following information;

- Admission Source/Source of Referral 25
- Admission date: date actually admitted at B
- Contract Type code 4 (Contract Type (A)B)
- Contract Role code B (Hospital B)
- Transferring from Facility (Extended Source Code) – identifier of hospital that referred the patient

- Diagnosis and procedure codes
- Discharge/Separation date
- Appropriate Discharge Status/Mode of Separation code
- Other Hospital Identifier is the identifier of Hospital A, the hospital contracting the admission. In the majority of cases this will be the same identifier as that provided for the Transferring from Facility (Extended Source Code) data item

Contract Type 5 – BA

Definition: A contracts **B** for an admitted service prior to the patient's admission to **A**.



Hospital **B** records the following information:

- Admission Source/Source of Referral code 25
- Admission date: actual date admitted at B
- Contract Type code 5 (Contract Type BA)
- Contract Role code B (Hospital B)
- Transferring from Facility (Extended Source Code) – identifier of hospital that referred the patient
- Diagnosis and procedure codes provided by B
- Discharge/Separation date: actual date separated from B
- Discharge Status/Mode of Separation code 16
- Other Hospital Identifier is the identifier of Hospital A, the hospital contracting the admission. In the majority of cases this will be the same identifier as that provided for the Transferring to Facility (Extended Source Code) data item

Hospital **A** records the following information:

- Admission Source/Source of Referral code 24
- Admission date: actual date admitted at A. This should equal the date separated from B
- Contract Type code 5 (Contract Type BA)
- Contract Role code A (Hospital A)
- Contract establishment identifier (Extend Source/Extended Source Code) of Hospital B
- Diagnosis and procedure codes. Include any additional diagnoses identified by B (but do not flag them unless it is to indicate that a contracted service was not carried out) , and all procedures provided by B (each with a contract flag of 1 or 2)

- Discharge/Separation date: actual date separated from A
- Appropriate Discharge Status/Mode of Separation code
- Other Hospital Identifier is required

Recording of Procedures Performed by Private Health Providers (Non-hospital)

Private health providers who deliver services such as physiotherapy, radiology and pathology that are not licensed as a hospital, do not have a Queensland Health facility number.

Private health providers (non-hospital) do not fall within the scope of the National 'Contracted Hospital Care' data item. However, to ensure consistency in the reporting of patient care, it is strongly recommended that these types of arrangements are recorded. *ACS 0029 Coding of Contracted Procedures* states that where treatment is carried out under a contracting arrangement that exists, all procedures carried out under the contract are to be recorded and coded. This coding standard overrides *ACS 0042 Procedures Normally Not Coded* when a contracted procedure is performed.

Procedures performed by private health providers (non-hospital) should be recorded by using the 'contract flag' functionality and dummy facility identifier of 99998. Procedures performed within a hospital by a private health provider (non-hospital) should also be coded and flagged using this functionality.

4.8 Dialysis, chemotherapy and radiotherapy

Dialysis and chemotherapy are day benefit procedures and the patients can be admitted. It is usual practice in Queensland that they should be admitted, often to a recliner chair in a declared public hospital. Radiotherapy is not a day benefit procedure, and patients coming to a facility specifically for radiotherapy would normally be treated on a non-admitted (outpatient) basis. If a patient has already been admitted to hospital and has radiotherapy, the radiotherapy session does not alter his/her admission status. A patient should be admitted and discharged for each day benefit procedure and, not be put on leave in between multiple day benefit procedures.

4.9 Hospital in the home (HITH) services

Hospital in the Home (HITH) provides care in the patient's permanent or temporary residence, for acute conditions requiring clinical governance, monitoring and/or input that would otherwise require treatment in the traditional inpatient hospital bed. The admission criterion is governed by the authorising practitioner and as such the HITH program is focused exclusively on acute admitted care substitution.

Hospital in the Home (HITH) is a priority commitment for the Queensland Government. The Blueprint for better healthcare in Queensland, launched in 2013, outlined the increased use of HITH as substitute model for traditional inpatient hospital care. HITH has the potential to provide patients with greater

choice in their care, improve access to health services, equal or better patient care outcomes, and improve efficiencies in service delivery. For these reasons, Queensland Health is keen to promote the ongoing development of HITH for suitable patient cohorts to meet increasing demand for hospital care as the population continues to grow and age.

NB: Queensland Department of Health (DoH) has entered a private partnership arrangement with two private providers from 01/01/2014. These vendors are Silver Chain and Blue Care. For details on how Hospital and Health Services are to record these arrangements, refer to 4.9.4 HITH reporting requirements..

4.9.1 Hospital and Health Services (HITH) Guidelines and Criteria

A comprehensive HITH Guideline addressing all recommendations for HITH is available at the following address.
http://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-379.pdf.

The scope of the HITH Guidelines includes all Queensland Health (DoH) employees (permanent, temporary and casual) and all organisations and individuals acting as its agents for the Queensland Department of Health (including Visiting Medical Officers and other partners, contractors and Senior Medical Officers).

Both Queensland Health services and contracted services are to follow the HITH guidelines when providing these services to patients under the governance and accountability of Queensland Department of Health

Inclusion criteria

- Care substitutes full hospital admission or a component of a hospital admission. Without a HITH service, the patient would be admitted to hospital for treatment in a traditional acute hospital bed.
- Each patient is identified as requiring clinical governance, active treatment and / or monitoring during the HITH episode of care.
- All patients require a minimum daily intervention or assessment by the HITH service.
- A comparable level of care to that provided in the acute inpatient setting is to be provided by the HITH service to meet all patient needs.
- A treating authorised practitioner agrees that care for a patient with an acute condition can be safely provided and managed in the patient's permanent or temporary residence.
- The patient consents to transfer of care. This is to be documented and evidenced in the patient medical record. http://qheps.health.qld.gov.au/caru/hith/
- Patient has no known allergy to medication prescribed during the HITH episode of care.
- Telephone with dial out facilities.
- Working refrigerator with suitable storage room (if required to store medications).

- For paediatric patients, a guardian must be available and a nominated adult is to be present during treatment of minors.
- Department of Veteran Affairs (DVA) funded patients, 3rd party insurance funded patients, workers compensation funded patients and Non Medicare eligible patients.

NB: Revenue Strategy and Support Unit, Queensland Health, in consultation with private providers, is investigating the possibility of private insurance contracts over the next 12 months.

Exclusion criteria

- Complex care needs not amenable to a HITH service. These include physical, cognitive and/or social care needs that exceed the capability of available support networks (including carers and health care providers).
- Public hospital Medicare eligible private patients whose accommodation charges are funded by private health insurance.

  NB: Public hospital patients who elect to receive admitted patient care as private and who are subsequently treated by HITH services will be required to change their election to public from the point at which the HITH service commences.
- Venous access device maintenance only.
- Wound care and drain management which does not require daily intervention, ongoing clinical intervention and clinical governance.
- Preadmission care for planned or elective admissions that can be managed by the primary care provider.
- Follow-up telephone calls post discharge are not counted as HITH activity.

HITH data recording

- Key performance indicators (KPI) for HITH are monitored, analysed and reported via local HHS processes.
- The medical record/chart is coded as a continuous episode of care.
- HITH episodes of care can only be an ‘acute’ care type (code: ‘01’).
- All demographic and morbidity details are to be recorded on the Hospital Based Corporate Information System (HBCIS), in accordance with the procedure applying to normal admitted hospital patients.

4.9.2 HITH Approval & Withdrawal processes (Public Patients in Public hospitals only)

Approval of a HITH services

1. Prospective HITH service managers should submit requests for the introduction of new Hospital In The Home services to their Hospital and Health Service Chief Executive (HHS CE).
2. Upon agreement by the business unit, the relevant HHS CE will seek final approval from the HHS Board Chair.

3. HHS CE should undertake consultation with HHS Decision Support Units and advise the Health Statistics Unit (HSU) of the service implementation.

Withdrawal of a HITH service

1. Prospective HITH service managers should submit requests for the closure of a Hospital In The Home services to their Hospital and Health Service Chief Executive (HHS CE).
2. Upon agreement by the business unit, the relevant HHS CE will seek final approval from the HHS Board Chair.
3. HHS CE informs the HHS Decision Support Units and the Health Statistics Unit (HSU) if the service withdrawal.

4.9.3 HITH Approval & Withdrawal processes (Private hospital facilities)

Private licensed facilities are required to negotiate with the private funds regarding the provision of approved Hospital In The Home care.

4.9.4 Hospital in the Home (HITH) Reporting

Only approved HITH services (as per the above processes) are to report HITH data in the QHAPDC.

Hospital in the Home Care Type

Patients in public hospitals who qualify as a HITH patient must be admitted with an acute care type (code 01).

Hospital in the Home Admitting Ward

HITH patients can be admitted directly to a *Home* ward from the Emergency Department, Outpatients Department, General Practitioner or may be transferred from a hospital ward to the *Home* ward.

Hospital in the Home Source of referral

For Public Hospitals, patients admitted directly to a 'Home' ward, the Source of Referral (field 59) on the HBCIS Patient Admission screen must be either Emergency (code 02) or Outpatient (code 03). Source of referral can be any valid corporate code when patients are transferred from another hospital ward to the *Home* ward.

Hospital in the Home Account Class Code

For Public Hospitals the HBCIS HITH Account Class Codes should be allocated as per the Queensland Health Fees and Charges Resister for any Public Eligible, Department of Veteran's Affairs, Compensable Third Party, Workers' Compensation, Motor Vehicle Accident and Ineligible episodes of care where the patient was admitted to or transferred to a HITH ward. The HITH Account Class assigned is to take effect from the date the patient commences their treatment under the HITH Model of Care. The Account Class Code allocated to patients for their proceeding inpatient period of care is to remain unchanged

Hospital in the Home Standard Ward Code

Home wards will be coded HOMEXX, where XX is optional and may be replaced by characters to identify one Home ward from another.

For Queensland Health Hospital In The Home services that are provided on behalf of the Queensland Health by a private or not for profit organisation, *HOMEPX* is to be utilised, where *'P'* denotes a private or not for profit organisation and *'X'* is the to represent the first letter of the provider. For example;

- *HOMEPS* refers to HOME Partnership Silver Chain
- *HOMEPB* refers to HOME Partnership Blue Care.

Hospital in the Home Unit Code

For Public hospitals, unit codes will be entered according to current practice in order to identify the unit responsible for the patient in the HOME ward (e.g. Unit code = SURG; Ward code = HOME). The admitting medical officer must also be evident in HBCIS.

Hospital in the Home Allocation of beds

For Public hospitals, the number of beds attached to a HOME XX in the Ward Codes Reference file will be zero.

Hospital in the Home Discharging Patients

For Public hospitals, the separation process (HBCIS Patient Discharge Screen) for HITH patients is as per standard separation process for admitted patents.

Hospital in the Home Acute Care Certificate

Public hospital patients can only be classified as acute, an Acute Care Certificate is required for all HITH patients where the period of hospitalisation exceeds 35 days. Days accumulated by HITH patients are included towards determining whether an Acute Care Certificate is required.

4.10 Leave

A leave patient is a patient who leaves the hospital for a short period and intends to return to the hospital to continue the current course of treatment. Under current national guidelines, an admitted patient may be granted leave for up to a maximum of seven days. Same day patients are not generally placed on leave.

4.10.1 Contract leave

Contract leave is used to allow a patient to receive a contracted admitted or non-admitted service that is not available at the hospital where the patient is currently admitted. For more information, refer to Section 3.8.1 - Counting rules for contract leave.

4.11 Multi-Purpose Health Service (MPHS) and Flexible Care Patients (HBCIS hospitals)

The joint Commonwealth-State Multi Purpose Health Service (MPHS) program provides a flexible approach to the provision of health and aged care services in small rural communities. It typically involves the amalgamation of services ranging from acute hospital care to residential aged care, community health, home and community care and other health related services. This amalgamation of services is used to provide flexible care.

Although there is no legislative requirement for Aged Care Assessment Team (ACAT) assessment prior to a client being provided flexible care, it is suggested that ACAT assessment is used as a standardised and agreed approach to establishing a need for flexible care.

If flexible care is provided to a patient currently admitted to an acute hospital the following process applies;

- Discharge the patient from the acute hospital with a discharge status of **15 – Residential Aged Care Service.**
- The extended source code is the facility ID of the MPHS.
- Admit the patient to the MPHS with an admission type of **44 – Aged-Care** resident, an admission source of **24 – Admitted patient transferred from another hospital** and an appropriate account class code.
- The extended source code is the facility ID of the Acute Hospital.

If a patient of an MPHS needs to be admitted to an acute facility for treatment the following process applies;

- Discharge the patient from the MPHS with a discharge status of **16 – Hospital Transfer.**
- The extended source code is the facility Id of the Acute Hospital.
- Admit the patient to the Acute Hospital with an admission source code of **23 - Residential Aged Care Service**
- The extended source code will be the Facility ID of the MPHS
- Refer to Appendix A for list of current Facilities and Facility IDs.

Responsibility for the policy aspects of the MPHS program (including the signing of the funding agreements between Queensland Health and the Commonwealth) rests with Strategic Policy, Funding and Intergovernmental Relations Branch, Policy, System Policy and Performance Division.

Overall statewide planning for new MPHS sites, and any associated planning, lies with the Policy and Planning Branch , System Policy and Performance Division.

Planning at the local level (including implementation, monitoring and reporting) of new and existing MPHS sites is the responsibility of the relevant Hospital and Health Services.

For further information regarding the set-up of MPHS on HBCIS, please contact, Systems Integration Management, Health Services Information Agency.

4.12 Newborns

Previously a newborn was recorded as being either acute or unqualified, and a change in status resulted in a statistical discharge and readmission. However, as an unqualified episode of care is not a phase of treatment a 'newborn' care type has been developed, which is clinically more meaningful and allows for a DRG allocation to a single episode.

All babies nine days old or less should be admitted as a newborn episode of care. A newborn episode of care is initiated when the patient is nine days old or less at the time of admission and continues until the care type changes or the patient is separated. At any time during their stay the newborn has a qualification status of either acute or unqualified.

4.12.1 Newborns - Acute Qualification Status

A newborn can be allocated an acute qualification status if the newborn is nine days old or less and meets at least one of the following criteria:

- the newborn is the second or subsequent live born infant of a multiple birth; or
- the newborn is admitted to a special care facility in a hospital, being a facility approved by the Australian Government Health Minister for the purpose of the provision of special care (i.e. a 'special care nursery'); or
- the newborn is in hospital without its mother.

If a baby is nine days old or less and is transferred to another hospital, it is to be admitted as a newborn with an appropriate qualification status by the receiving hospital. For example, the baby is to be admitted as a newborn with a qualification status of acute, if;

- the baby is transferred without its mother; or
- the mother is admitted as a boarder; or
- the baby is the second of subsequent live born infant of a multiple birth; or
- baby is admitted to an intensive care facility in the receiving hospital;

. For newborns with an admission qualification status of acute, the parent/s or legal guardian/s must elect whether the baby is to be treated as a public or private patient. It is possible for the mother and the baby to be classified differently.

Refer to Section 6.16 Medicare Eligibility to determine the eligibility of a newborn.

All newborns remaining in hospital who still require clinical care when they turn ten days of age must have a qualification status of acute. Newborns who turn nine days of age and who do not require clinical care on day ten must be separated.

Babies who are not admitted at birth (e.g. transferred from another hospital) and aged greater than nine days are either boarders or admitted with an acute care type.

Newborns who are waiting for adoption and turn ten days of age, remain in hospital without their mother, and require no clinical care/treatment, should be formally separated and then registered as boarders (on and before nine days of age, they are classified according to the normal rules).

If a mother remains in hospital after the period in which she required care and is staying with a baby that is nine days old or less and requires care the mother should be classified as a boarder and the baby must be assigned an acute qualification status.

Only acute newborn days are eligible for health insurance benefit purposes and should be counted under the National Healthcare Agreement (NHA). Unqualified newborn days should not be counted under the NHA and are not eligible for Health insurance benefit purposes. Stillborn babies are not admitted, but should be registered (providing this meets the Queensland Births, Deaths and Marriages Registration Act).

4.12.2 Newborns - Unqualified Qualification Status

A newborn has a qualification status of unqualified, if the newborn is nine days old or less and does not meet the criteria for being admitted as a newborn with a qualification status of acute. An unqualified baby may be born in the hospital or before arrival at hospital, and or transferred after birth to another hospital with its mother. A newborn may or may not require clinical care/treatment, but where care/treatment is required and delivered outside an approved Intensive Care Nursery (ICN)/Special Care Nursery (SCN) facility, the qualification status of a newborn is unqualified, unless the mother is discharged. (Refer to Section 4.12.1 Newborns with an acute qualification status).

Under the NHA, Newborns with a qualification status of unqualified (classified as either public or private patients) are not eligible for health insurance benefit purposes and therefore cannot be charged.

4.12.3 Changes in Qualification Status of Newborns

Sometimes a change in the condition of a newborn results in their qualification status changing between acute and unqualified: e.g. an unqualified newborn is admitted to an intensive care facility or remains in hospital without its mother. This must be recorded as a change in qualification status.

All changes in qualification status must be recorded. If more than one change of qualification status occurs on a single day, then the final qualification status for that day should be provided to the Health Statistics Unit.

A baby born on 1 March and admitted to hospital prior to 11 March must be admitted with a care type of ’05 – Newborn’.

A baby born on 1 March and admitted with a care type of ‘05 – Newborn’, and remaining in hospital and still requiring clinical care when it turns 10 days old on 11 March, must have a qualification status of ‘Acute’ from 11 March until the day it is separated. If the qualification status needs to be changed from ‘Unqualified’ to ‘Acute’, this may be done at any time on 11 March (but no later).

Example for HBCIS Hospitals

On HBCIS, the start of the reporting day is 00:01, with midnight (24:00) being the end of the reporting day. As a result, a baby born at 11.20 on 1 March is one day old at the start of 2 March, that is at 00:01 on 2 March. A baby born at 23.20 on 1 March is also one day old at the start (00:01) of 2 March.

Any babies born from the start (00:01) to the end (24:00) of 1 March become 9 days old at the start (00:01) of 10 March and 10 days old at the start (00:01) of 11 March.

HBCIS Hospitals	
Baby born between 00:01 and 24:00 on 1st March	Born
00:01 and 24:00 2nd March	**1** day old
00:01 and 24:00 3rd March	**2** days old
00:01 and 24:00 4th March	**3** days old
00:01 and 24:00 5th March	**4** days old
00:01 and 24:00 6th March	**5** days old
00:01 and 24:00 7th March	**6** days old
00:01 and 24:00 8th March	**7** days old
00:01 and 24:00 9th March	**8** days old
00:01 and 24:00 10th March	**9** days old
00:01 and 24:00 11th March	**10** days old

Therefore, a baby born on 1 March and admitted to hospital on 11 March is 10 days old, and must be admitted with an episode of care type of '01 - Acute'.

A baby born on 1 March and admitted to hospital prior to 11 March must be admitted with an episode of care type of '05 – Newborn'.

A baby born on 1 March and admitted with an episode of care type of '05 – Newborn', and remaining in hospital **and requiring clinical care** when it turns 10 days old on 11 March, must have a **qualification status** of 'Acute' from 11 March until the day it is separated. If the qualification status of the Newborn episode needs to be changed from 'Unqualified' to 'Acute', this may be done at any time on 11 March (but no later).

A baby born on 1 March and admitted with an episode of care type of '05 – Newborn', remaining in hospital and **not requiring clinical care** when it turns 10 days old on 11 March, must be separated at the end of 10 March and registered as a boarder at the start of 11 March. That is, the date and time of separation from the 'Newborn' episode of care would be 10 March at 24:00, and the date and time of the registration of the 'Boarder' episode of care would be 11 March at 00:01.

Please note that the HSU will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the HSU processing system.

Figure 3 and 4 summarises how to classify newborns according to the Health Insurance Act, including born before arrival at hospital or transferred to another hospital.

Example for Non-HBCIS (other) Hospitals

For hospitals other than HBCIS hospitals, the start of the reporting day should be midnight (00:00), with 23:59 being the end of the reporting day. As a result, a baby born at 11.20 on 1 March is one day old at the start of 2 March, that is at 00:00 on 2 March. A baby born at 23.20 on 1 March is also one day old at the start (00:00) of 2 March.

Any babies born from the start (00:00) to the end (23:59) of 1 March become 9 days old at the start (00:00) of 10 March and 10 days old at the start (00:00) of 11 March.

Other Hospitals	
Baby born between 00:00 and 23:59 on 1st March	Born
00:00 and 23:59 2nd March	**1** day old
00:00 and 23:59 3rd March	**2** days old
00:00 and 23:59 4th March	**3** days old
00:00 and 23:59 5th March	**4** days old
00:00 and 23:59 6th March	**5** days old
00:00 and 23:59 7th March	**6** days old
00:00 and 23:59 8th March	**7** days old
00:00 and 23:59 9th March	**8** days old
00:00 and 23:59 10th March	**9** days old
00:00 and 23:59 11th March	**10** days old

Therefore, a baby born on 1 March and admitted to hospital on 11 March is 10 days old, and must be admitted with an episode of care type of '01 - Acute'.

A baby born on 1 March and admitted to hospital prior to 11 March must be admitted with an episode of care type of '05 – Newborn'.

A baby born on 1 March and admitted to hospital with a care type of '05 – Newborn', and remains in hospital requiring clinical care, when the baby turns 10 days old on 11 March, must have a qualification status of 'Acute' from 11 March until the day it is separated. If the qualification status of the Newborn episode needs to be changed from 'Unqualified' to 'Acute', this may be done at any time on 11 March (but no later).

A baby born on 1 March and admitted to hospital with an episode care type of '05 – Newborn', **and remains in hospital** when the baby turns 10 days old on the 11 March, and does **not require clinical care** must be separated at the end of 10 March and registered as a boarder at the start of 11 March. That is, the date and time of separation from the 'Newborn' episode of care would be 10 March at 23:59, and the date and time of the registration of the 'Boarder' episode of care would be 11 March at 00:00.

Figure 3 Newborn 9 days of age or less

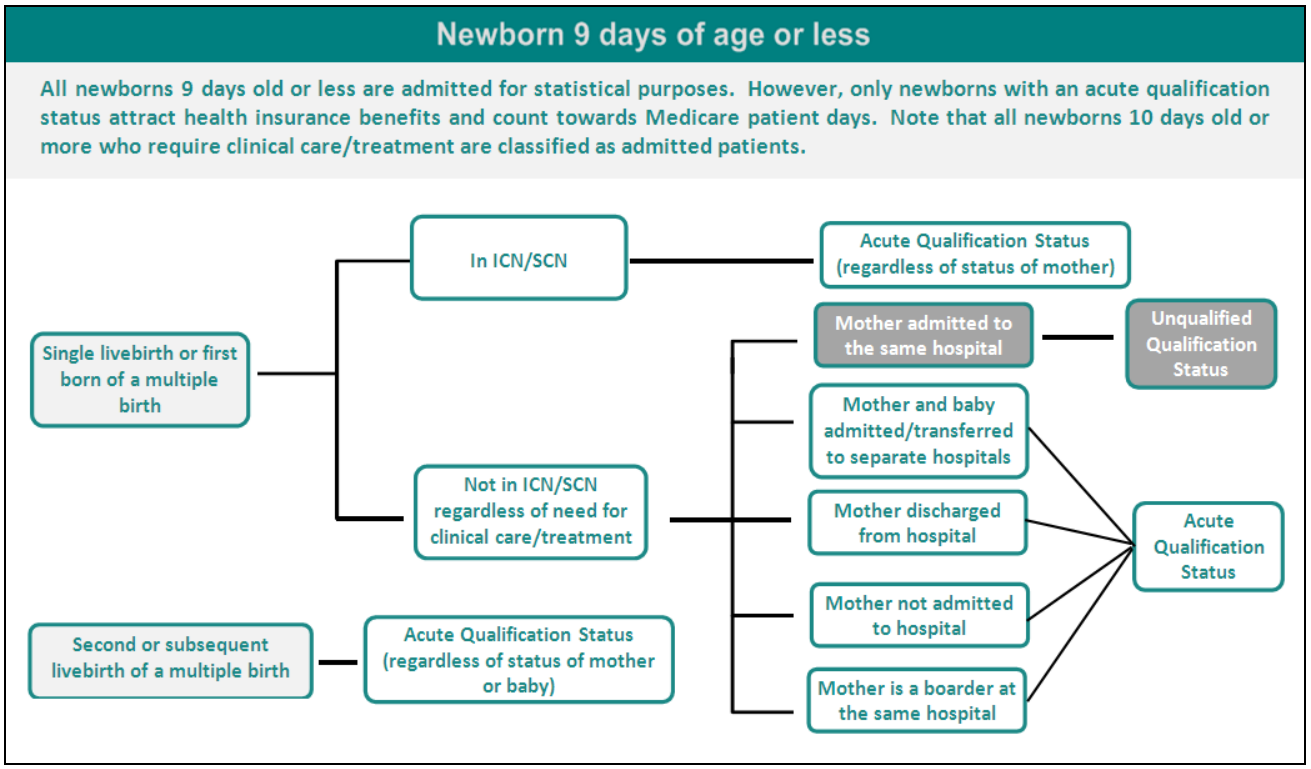
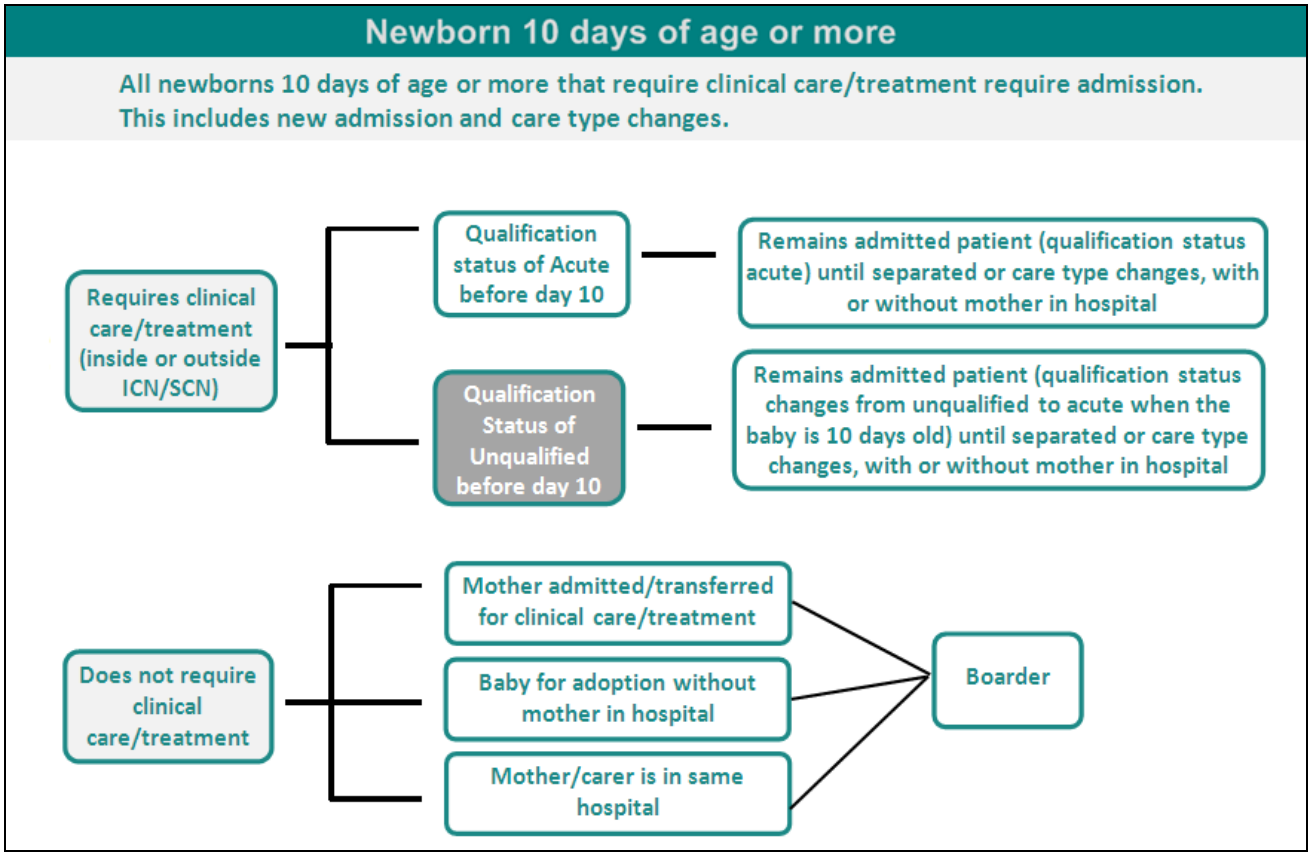


Figure 4 Newborn 10 days of age or more



4.13 Nursing home residents

A nursing home resident is a person who has been classified as such and occupies a designated nursing home bed. Nursing homes now come under the general classification of Residential Aged Care Service – which also includes nursing hostels, but not independent living units.

A resident of a nursing home is not generally expected to leave the nursing home to live anywhere else, although it is possible for a nursing home resident to require treatment in an acute hospital (for example, following a fall and sustaining an injury that requires acute care). The resident is then admitted to the acute hospital for the duration of the treatment. The patient will be discharged back to his/her nursing home as a nursing home resident after treatment is complete.

4.14 Nursing Home Type Patient (NHTP)

A patient is a NHTP if they have been in hospital for a continuous period exceeding 35 days and are not the subject of a current Acute Care Certificate.

A patient classified as a Nursing Home Type Patient (NHTP) must have a care type of sub and non-acute. A NHTP can **NOT** have any of the following care types;

- '01 – Acute',
- '05 – Newborn',
- '07 – Organ procurement', and
- '08 – Boarder'

The 35 day period:

- may accrue in more than one hospital (public, private or both)
- excludes treatment in public psychiatric hospitals
- excludes leave days
- commences upon admission

The 35 day period does not apply if the patient was a resident of a residential care facility immediately before admission to a public psychiatric hospital. If however the patient was a resident of a residential aged care facility and is admitted to an acute hospital, remains in hospitalfor more than 35 day and is not covered by an Acute Care Certificate the patient must be classified as NHTP.

An Acute Care Certificate is required for all admitted patients where the period of hospitalisation exceeds 35 days and the patient is not classified as a NHTP. If a patient is (re) classified as a NHTP but subsequently requires acute care, the qualifying period of 35 days does not start again.

Public HBCIS Hospitals

Prior to 2004 a patient classified as a NHTP must have had a care type of Maintenance. As a result any patient with a care type other than Maintenance who had a length of stay over 35 days and who was not the subject of an Acute Care Certificate had to have their care type changed to Maintenance before they could be classified as a NHTP.

Since 1 September 2004 any sub and non-acute patient who has a length of stay over 35 days and who is not the subject of an Acute Care Certificate can be classified as a NHTP without changing their sub and non-acute care type. This modification means that the patient's care type should only need to be changed (via a statistical separation and re-admission) as a result of a clinical assessment of the treatment they are receiving, rather than as a result of the administrative process required to classify them as a NHTP.

For public hospitals this allows a fee to be raised in HBCIS by changing the patient's account class code to an appropriate 'long stay' account class code. This change in account class code will still designate the patient as a NHTP for the purposes of the QHAPDC.

This policy modification means that the patient's care type should only need to be changed (via a statistical separation and admission) as a result of a clinical assessment of the treatment they are receiving, rather than as a result of the administrative process required to raise a fee.

4.15 Organ donors

4.15.1 Live Donors

A live donor is admitted to an acute episode of care to donate organs. Live donors cannot be registered as a posthumous care type.

4.15.2 Posthumous Organ Procurement

Posthumous organ procurement is the procurement of human tissue for the purpose of transplantation from a donor who meets the following criteria: brain death, consent for organ procurement received and the patient is clinically eligible to donate organ/s.

Before a patient who has died can proceed to organ procurement, that patient should be formally separated (separation mode = 05) and then registered using the codes listed below (i.e. code 06 episode change for Source of referral/transfer or Mode of separation should not be used).

Note: Public Hospitals utilising HBCIS do not have the capacity to register patients to the organ procurement care type. The Organ Procurement Team that carries out the organ procurement will manually complete an Identification and Diagnosis sheet for that episode. This identification and diagnosis sheet will be forwarded to the Health Statistics Unit where it will be coded and entered onto the QHAPDC for inclusion in the data for the hospital at which the procurement episode took place. **Public hospitals**

performing organ procurement should contact the Health Statistics Unit for further information.

Episode where brain death occurs	Organ Procurement registration
The episode of care where brain death occurs has a Mode of Separation code of Died in Hospital (05).	The organ procurement registration has a; • Care Type of Organ Procurement (07) and, • Source of Referral/Transfer code of 20 – Organ Procurement' and • Mode of Separation code of 13 - Organ Procurement.

4.16 Overnight (or longer) stay patients

An overnight (or longer) stay patient is a patient who is admitted to and separated from the hospital on different dates. This patient:

- has been registered as a patient at the hospital;
- meets the minimum criteria for admission;
- has undergone a formal admission process;
- remains in hospital at midnight on the day of admission.

Boarders are excluded from this definition (see Section 4.4 Boarders).

Note:

- An overnight stay patient in one hospital cannot be concurrently an admitted patient in another hospital, unless they are on contract leave. If not on contract leave, a patient must be discharged from one hospital and admitted to the other hospital on each occasion of transfer.
- Treatment provided to an intended same day patient who is subsequently classified as an overnight stay patient shall be regarded as part of the overnight episode.

4.17 Patients on life support

Patients who are on life-support are considered 'admitted patients' until they have been declared clinically dead after which time they should be formally discharged.

Patients who remain on life support after being declared clinically dead for the purposes of organ procurement must first be formally discharged from their episode of care and subsequently registered to an 'Organ procurement' care type.

4.18 Patients in outpatients or emergency departments

Patients attending emergency or outpatient departments in a hospital, for a procedure that meets the criteria for admission, should be formally admitted.

4.19 Respite care patients and respite care residents in a residential aged care service

Respite care residents (in a residential aged care service) receive residential aged care services. As such, the charges that apply to them are based on those that apply to other residents in a residential aged care service. In the case of maintenance care patients (receiving respite care) accommodated in hospitals (not a residential aged care service) with public status, no charges can be raised for the first 35 days. After that period, they are classified as Nursing Home Type Patients (NHTP) and are charged as such. Respite fees may differ from NHTP fees for persons occupying places in residential care facilities. Public Hospital staff should access the Fee and Charges Register on the Revenue Strategy and Support Unit website.

4.20 Same day patients

A same day patient is a person who is admitted to hospital and separated on the same date. This patient:

- has been registered as a patient at the hospital;
- meets the minimum criteria for admission;
- has undergone a formal admission process;
- is separated prior to midnight on the day of admission.

Boarders are excluded from this definition (see Section 4.4 Boarders)

Note:

- Same day patients may be either intended to be separated on the same day, or intended overnight stay patients who were separated, died or were transferred on their first day in hospital.
- Treatment provided to an intended same day patient who is subsequently classified as an overnight stay patient shall be regarded as part of the overnight episode.
- Data on same day patients are derived by a review of admission and separation dates. The data excludes patients who were to be discharged on the same day but were subsequently required to stay in hospital for one night or more.

4.20.1 Day Only Procedure Patients

Day only procedure patients are a subset of same day patients. They are patients who are admitted for, and have carried out a Day Only Surgical and Diagnostic Service as specified in Band 1A, 1B, 2, 3 and 4 as listed in Part 2 of Schedule 3 of the Private Health Insurance (Benefit Requirements) Rules 2011, and have been discharged, transferred or died before midnight on the day of admission; or Type C exclusion patients for whom a Day Only Procedure Certificate is completed. A day only procedure patient cannot have any related episodes during a hospital stay.

The following notes may help clarify some issues regarding banding of day only procedure patients.

- Public and Private patients admitted for observation who are separated before midnight on the day of admission are not banded.
- Public and Private patients who die on the day of admission, prior to any procedure being performed, are not banded.
- Private patients who received a Type C procedure with an accompanying certificate can only be banded as Band 1B, irrespective of anaesthetic type or theatre time.
- Public patients who receive a Type C procedure with an accompanying certificate are not banded but admitted as public same day patients.

4.20.2 Non admitted patients

It is the policy of Queensland Health that all patients that meet the criteria for admission should be admitted, unless there are clear clinical reasons for treating the patient on a non-admitted basis. This allows comparisons with other hospitals within the State and across Australia. However, a patient may meet the criteria for same day admission but the practitioner may wish to treat him/her on an outpatient basis.

4.20.3 Examples distinguishing between same day and non-admitted patients

- A same day patient meets the criteria for admission and is admitted and separated on the same day. Patients who receive a procedure which would not normally warrant admission but should the clinical determination deem that an admission is necessary, a Day Only Certification must be completed by the attending medical practitioner, for public as well as for private patients. For example, if a private patient requires admission for a plaster cast or removal of sutures, they are admitted on Band 1B with the appropriate certification. If a public patient requires the same procedure, the admission must be certified and can be banded, however, it is not necessarily a requirement for public patients to be banded.
- A non-admitted patient receives a service that is often simpler and less prolonged than that given to a same day patient. Whether the patient actually occupies a bed or how long the patient is in attendance are not relevant to classifying patients to one of these categories.
- If a patient is admittedfor an intended procedure, but the intended procedure is cancelled, the admission should also be cancelled (i.e. deleted from your system) where possible. If the admission is still clinically determined as required, then the patient should be formally admitted (refer to Appendix F).
- Patients who attend psychiatric day or partial day care programs at public hospitals (i.e. ‘day program patients’) should be recorded as non-admitted occasions of service patients, not as same day admissions. Use of same day admissions is only valid where patients meet the conditions as described earlier in this section.
- Patients who attend psychiatric day or partial day care programs at private hospitals can be admitted.

4.21 Time at hospital

The length of time a patient spends in areas such as an Outpatient or Emergency Department is no indication of the need to admit the patient. Admission is allowed only on the basis that the medical practitioner decides the patient should be admitted and the patient meets one of the admission criteria.. The concept of "four hours" does not apply. The patient should be admitted at the time indicated by the medical practitioner, not at the time the patient arrived in the Outpatients or Emergency Department.

5. FACILITY DETAILS

5.1 Facility number

The facility number is a numerical code that uniquely identifies each Queensland Health care facility. Health care facilities are public and private hospitals (which includes: acute hospitals, hospital outposts, day surgery units, outpatient centres and psychiatric hospitals), multi-purpose health Services (MPHS), and residential aged care services (which includes public and private nursing homes and hostels – but not independent living units). Public hospitals, licensed private hospitals and day surgery units and public psychiatric hospitals which can admit patients are listed in Appendix A of this manual.

Private hospitals submitting data electronically must zero-fill this field for their hospital; HBCIS hospitals allocate their facility number automatically when data is extracted using HQI.

Only public acute hospitals, public psychiatric hospitals, licensed private hospitals, and licensed day surgery units are required to submit data for the QHAPDC. All these hospitals are able to admit patients, although not all actually do so. Patients moving between hospitals are counted as separate admissions and separations.

Residential aged care service residents moving to a bed at another facility should be discharged from the first facility and admitted to the receiving facility as a patient from the date they occupy the bed at that facility. Their stay in the residential aged care service is not part of the QHAPDC.

Residential aged care service residents should not to be confused with a person's status as a NHTP in one of the facilities that provides data for the QHAPDC. Refer to Section 4.14 Nursing Home type patients for a detailed description of the differences.

6. PATIENT DETAILS

To assist public hospitals to accurately record key patient demographic details they should refer to the Client Identification Data Set Specification October 2008.

http://qheps.health.qld.gov.au/clinical_info_mgt/docs/cidss/qh_cidss_v201.pdf

6.1 UR number

The unit record (UR) number is a unique number allocated to each patient by the hospital. Allocation of a UR number might be done manually or computer generated. The number is used for each admission to identify the patient. The unit record number may be numeric or alphanumeric.

HBCIS Hospitals	In some hospitals, the number is allocated automatically, in others it is obtained from a manual UR register and entered manually. If the patient already has a number, search the patient master index and select the correct number. If the number is known, record the exact number. No leading zeros or filler digits are required as these will be inserted automatically when data are extracted using HQI.

Other Hospitals	All spaces in the field should be filled, using leading zeros where necessary. For example:								
	UR A6841602	A	6	8	4	1	6	0	2
	UR 68259	0	0	0	6	8	2	5	9

6.2 Family name

The patient's full family name should be recorded.

If family name is not known or cannot be established, record UNKNOWN.

Some people do not have a family name and a given name. They have only one name by which they are known. If the patient has only one name, record it as the family name.

Registering an unnamed newborn baby

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother.

Baby for adoption

The word ‘adoption’ should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name with a new UR number, and the record should not be linked to the birth record. This should be the current practice. Any old references to adoption in patient registers (for names) should also be changed to UNKNOWN. Refer to the QH Clinical Records – Adoption Policy and Adoption Record Instruction for further information.

6.3 Given names

A patient may have more than one given name.

A patient’s full given name(s) should be recorded. Where applicable it is essential that the given names are recorded for the first 3-recorded given names of a patient and desirable for the fourth and subsequent given names.

If given name is not known or cannot be established, record UNKNOWN.

Some people do not have a family name and a given name and they have only one name by which they are known. If the patient has only one name, record it as the family name.

Registering an unnamed newborn baby

An unnamed (newborn) baby is to be registered using the mother’s given name in conjunction with the prefix ‘B/O’. For example, if the given name of the baby’s mother is FIONA, then record ‘B/O FIONA’ in the given name field for the baby. ‘B/O’ maps to ‘Baby of’ in the national standards.

Baby for adoption

The word ‘adoption’ should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name with a new UR Number, and the record should not be linked to the birth record. This should be the current practice. Any old references to adoption in patient registers (for names) should also be changed to UNKNOWN. Refer to the QH Clinical Records – Adoption Policy and Adoption Record Instruction for further information.

6.4 Date of birth

Record the date of birth of the patient using the full date (i.e. ddmmyyyy) and leading zeros where necessary.

Example

For 5 September 1959, record

0	5	0	9	1	9	5	9

HBCIS Hospitals

- If the day of birth is unknown, use ** and then enter the month and year.
- If the month of birth is unknown, use ** for the month value.
- If the year of birth is unknown, estimate the year from the age of the patient.
- If the age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients, use the year 1900).

Example

If a patient is admitted in 2007 does not know his/her exact date of birth but knows that he/she is 91 years of age, record the date of birth as follows:

*	*	*	*	1	9	1	6

Although provision is made for recording an unknown date of birth (using **/**/1900), every effort should be made during the course of the admission to determine (and record) the patient's actual date of birth. The patient's date of birth is an important requirement for the correct identification of the individual and the accurate assignment of a Diagnosis Related Group (DRG) at a later date.

Other Hospitals

- If the day of birth is unknown, use 15.
- If the month of birth is unknown, use 06.
- If the year of birth is unknown, estimate the year from the age of the patient.
- The age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients, use the year 1900).

Example

If a patient is admitted in 2007 does not know his/her exact date of birth but knows that he/she is 91 years of age, record the date of birth as follows:

1	5	0	6	1	9	1	6

Although provision is made for recording an unknown date of birth (using 15/06/1900), every effort should be made during the course of the admission to determine (and record) the patient's actual date of birth. The patient's date of birth is an important requirement for the correct identification of the individual and the accurate assignment of a Diagnosis Related Group (DRG) at a later date.

6.5 Estimated date of birth flag

The Estimated Date of Birth Flag indicates whether the patient's date of birth has been estimated.

If an asterisk has been used in place of either the day or the month, then a Date of Birth Flag of '1 – Estimated' will be allocated when data is submitted to the Health Statistics Unit.

6.6 Sex

Record the code for the sex of the patient using one of the following codes:

	Code	Description	Extracted/mapped by HQI as	
HBCIS Hospitals	M	Male	1	Male
	F	Female	2	Female
	I	Indeterminate/Intersex	3	Indeterminate/Intersex

	Code	Description
Other Hospitals	1	Male
	2	Female
	3	Indeterminate/Intersex

A patient's sex may change during their lifetime as a result of procedures (known alternatively as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment) or due to the patient choosing to self-identify themselves differently. Throughout this process, which may be over a considerable period of time, the patient's sex could be recorded as either Male or Female.

Code 3 indeterminate or intersex, refers to a patient, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason. Note that Indeterminate will generally only be used for neonatal patients where the sex has not been determined.

Code 3 indeterminate or intersex, should be confirmed if reported for people aged 90 days or greater.

6.7 Country of birth

Record the country of birth of the patient using the numerical codes found in Appendix E. For example:

- if the patient was born in Australia, use code 1101;
- if the patient was born in New Zealand, use code 1201.

HBCIS Hospitals	Record the code.

Other Hospitals	Record the code.

6.8 Marital status

Record the current marital status of the patient using one of the following codes:

HBCIS Hospitals

Code	Description	Extracted/mapped by HQI as	
A	Separated	5	Separated
D	Divorced	4	Divorced
F	De facto	2	Married/de facto
M	Married	2	Married/de facto
N	Not stated	9	Not stated/unknown
NM	Never Married	1	Never Married
W	Widowed	3	Widowed

Other Hospitals

Code	Description
1	Never Married
2	Married/de facto
3	Widowed
4	Divorced
5	Separated
9	Not stated/unknown

Separated means those people who are legally separated or socially separated, but not persons who are temporarily living apart (e.g. construction workers living in hostels or camps).

6.9 Religion

This information is not reported to the Health Statistics Unit for QHAPDC; it is for hospital use only. The list of codes for HBCIS appears in Appendix H.

HBCIS Hospitals	Record the numerical code number of the religion

6.10 Indigenous Status

Improving the health of Queensland's Aboriginal and Torres Strait Islander populations is a priority for the Queensland Health. The accurate identification of Aboriginal and Torres Strait Islander patients in Department of Health data collections assures the complete measurement of both Indigenous health status and the effectiveness of intervention programs. Indigenous status can also be used to determine some aspects of facility funding and be used to facilitate contact with Indigenous Liaison Officers if requested or required.

Indigenous status must only be assigned on the basis of self-identification or the identification by their next of kin, close family member, carer, guardian, or power of attorney. It should also be noted that identification for individuals can be changed for each admission, therefore the patient or their representative should be given the opportunity to identify each time they present.

The Indigenous status of a newborn should be ascertained according to the wishes of the mother and/or father. It is not sufficient to automatically assign a newborn the Indigenous status of the mother, for example, where the mother is non-Indigenous and the father is Indigenous, the parents may wish to identify the baby as being of Indigenous origin.

Those people who have not already completed their details on the admission form must be asked if they identify as being of Australian Aboriginal and/or Torres Strait Islander origin: "Are you of Aboriginal and/or Torres Strait Islander origin?" The responses of those people answering "Yes" should be clarified to determine if they identify as being of Aboriginal origin only, Torres Strait Islander origin only or both. Where the patient is unable to provide this information, their next of kin, close family member, carer, guardian or power of attorney must be asked if the patient is of Australian Aboriginal and/or Torres Strait Islander origin.

Data providers must record the Indigenous status of the patient using one of the following codes:

	Code	Description	Extracted/mapped by HQI as	
HBCIS Hospitals	11	Aboriginal but not Torres Strait Islander origin	1	Aboriginal but not Torres Strait Islander origin
	12	Torres Strait Islander but not Aboriginal origin	2	Torres Strait Islander but not Aboriginal origin
	13	Both Aboriginal & Torres Strait Islander origin	3	Both Aboriginal & Torres Strait Islander origin
	14	Not Aboriginal nor Torres Strait Islander origin	4	Neither Aboriginal nor Torres Strait Islander origin
	19	Not Stated	9	Not Stated

	Code	Description
Other Hospitals	1	Aboriginal but not Torres Strait Islander origin
	2	Torres Strait Islander but not Aboriginal origin
	3	Both Aboriginal & Torres Strait Islander origin
	4	Neither Aboriginal nor Torres Strait Islander origin
	9	Not Stated

Data providers should be aware that a person's Indigenous status cannot (and should not) be determined by observation. For data accuracy, the patient, the carer or next of kin should be asked the question directly.

All Queensland hospitals should regard improving the quality of Indigenous status data as a priority. For more information, please contact the Statistical Analysis and Linkage Team, Health Statistics Unit on 3234 1969.

6.11 Australian South Sea Islander status

The Queensland Government recognised Australian South Sea Islanders as a distinct cultural group in September 2000. Australian South Sea Islanders are the Australian born descendants of predominantly Melanesian people who were bought to Queensland between 1863 and 1904 from eighty Pacific Islands, but primarily Vanuatu and Solomon Islands. The government gave a commitment to recognise Australian South Sea Islanders in government service provision.

The accurate identification of Australian South Sea Islander patients in Department of Health data collections is also crucial to measuring their health status and the effectiveness of intervention programs.

All persons admitted to hospitals should be asked the following question: "Are you of Australian South Sea Islander ancestry?" This question must be asked of all admitted patients. Where the patient is unable to provide this information, for example, when a baby or child is admitted to hospital, the parent or guardian should be asked whether the child is of Australian South Sea Islander ancestry.

Data providers must record the Australian South Sea Islander status of the patient using the following codes:

	Code	Description	Extracted/mapped by HQI as	
HBCIS Hospitals	Y	Yes	1	Yes
	N	No	2	No
	U	Not stated/Unknown	3	Not stated/Unknown

	Code	Description
Other Hospitals	1	Yes
	2	No
	9	Not stated/Unknown

Data providers should be aware that:

1. Patients born outside of Australia are highly unlikely to be of Australian South Sea Islander status although there may be instances of the child of an Australian South Sea Islander being born overseas;
2. Patients born in Samoa, Tonga, or Fiji (sometimes referred to as Pacific Islanders) or their Australian born descendants are not to be recorded as having Australian South Sea Islander status;
3. Patients born in countries such as Vanuatu or the Solomon Islands are not Australian South Sea Islanders (even though these are the major islands from which the original South Sea Islanders came). Only descendants of the original South Sea Islanders qualify;

4. Some patients will have Indigenous as well as Australian South Sea Islander ancestry. They may identify as either or both;
5. A person's Australian South Sea Islander status cannot (and should not) be determined by observation. For data accuracy, the patient, their carer, or next of kin must be asked the question directly.

6.12 Address of usual residence

6.12.1 Number and street of usual residence

The collection of the address details of a patient is critical for patient follow up and as a means of reporting information about the geographic location of the residence of a patient. A patient may have one address or many addresses. Each address should be recorded and the associated Address Type applied.

It is encouraged that the following set of rules be applied for the capture of addresses on two address lines:

Address line 1 - All the elements of the address before the street number, for example:

- a house, complex, building or property name
- a flat or unit number

Address line 2 - The street number, street name and street type or postal delivery details

If the address line is not known or cannot be established, record UNKNOWN.

Although provision is made for recording an unknown address every effort should be made during the course of the admission to determine (and record) a patient's address details.

Baby for adoption

The Department of Communities, Child Safety and Disability Services (DCCSDS) or the foster carer will advise the relevant Queensland Health facility with regard to the correct address details for correspondence from Queenland Health during the transitional period. This will usually be either the foster carer or the DCCSDS.

6.12.2 Address of usual residence

Address of usual residence' is required to be reported as part of the QHAPDC. 'Address of usual residence' is derived from two data elements, the Address line and the Address Type, where the address type is 'Accommodation – Permanent'. The combination of these two data elements are used to indicate a patient's usual residential address.

HBCIS Hospitals	HBCIS hospitals have the option to record three types of addresses: **Permanent**: (Accommodation – permanent) this code is used to indicate a patient's usual residential home address. The usual residential address is the place where the patient permanently lives or as per the electoral roll. **Temporary**: (Accommodation – temporary) this code is used to indicate where the patient is resident for a temporary period. If the patient is temporarily residing with relatives, in a hotel or place other than their home, where the patient might be staying temporarily before or after a period of hospitalisation or for a patient who usually resides overseas. **Mailing**: (Mailing or Postal) an address that is for correspondence purposes only, for example PO Box numbers.

6.12.3 Locality

The locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.

This data item may be used to describe the location of a patient. It can be a component of a street or postal address.

Interstate and overseas patients

It is particularly important to record the correct addresses for patients who live interstate or overseas. This is for patient follow up and to support funds that may be transferred between state health departments for patients who are treated outside their state of usual residence.

If the patient lives interstate, the locality for both permanent and temporary addresses should be recorded.

Attention should be taken to ask the patient if the address provided is their permanent address.

Unknown locality

If the locality is unknown (e.g. an unconscious patient is unable to provide the information), record UNKNOWN. Do not leave the field blank.

Although provision is made for recording an unknown locality every effort should be made during the course of the admission to determine (and record) a patient's locality details.

Baby for adoption

The DCCSDS or the foster carer will advise the relevant Queensland Health facility with regard to the correct address details for correspondence from Queensland Health during the transitional period. This will usually be either the foster carer or the DCCSDS.

No fixed address

Record no fixed address.

At sea

Record at sea.

6.12.4 Location of usual residence

'Location of usual residence' is required to be reported as part of the QHAPDC. 'Location of usual residence' is derived from two data elements, the Locality and the Address Type, where the address type is 'Accommodation – Permanent'. The combination of these two data elements are used to indicate a patient's usual residential address.

6.12.5 Postcode

Record the postcode of the address of the patient.

If the patient is not a resident of Australia, or has no fixed address, use one of the following supplementary codes:

All Hospitals

Code	Description
9301	Papua New Guinea
9302	New Zealand
9399	Overseas other (not PNG or NZ)
9799	At sea
9989	No fixed address
0989	Not stated or unknown

Please note that it is particularly important to record the country of residence accurately for patients from Papua New Guinea and New Zealand.

For Australian External Territory addresses, the postcode and State ID are to be used. Australian External Territories include the following: Christmas Island, Cocos (Keeling) Islands, Jervis Bay and Norfolk Island.

Unknown postcode

If a postcode is unknown (e.g. an unconscious patient is unable to provide the information), record code **0989 Not stated or unknown**. Do not leave the field blank.

Although provision is made for recording an unknown or not stated postcode (using code 0989), every effort should be made during the course of the admission to determine (and record) a patient's postcode.

Baby for adoption

The DCCSDS or the foster carer will advise the relevant Queensland Health facility with regard to the correct address details for correspondence from Queensland Health during the transitional period. This will usually be either the foster carer or the DCCSDS.

6.12.6 Postcode of usual residence

'Postcode of usual residence' is required to be reported as part of the QHAPDC. 'Postcode of usual residence' is derived from two data elements, the Postcode and the Address Type, where the address type is 'Accommodation – Permanent'. The combination of these two data elements are used to indicate a patient's usual residential address.

HBCIS Hospitals	Should automatically assign the postcode once the user enters the locality.

6.12.7 Australian state/territory of usual residence

This item is required because the first number of a postcode is not always an indication of the State of a patient's address.

Record the code that corresponds to the State/Territory of the relevant address of a patient. Note: do not rely on the postcode for this information as there are some Queensland postcodes for patients who live over the border in other States such as New South Wales.

All Hospitals

Code	Description
0	Overseas
1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	Not stated/unknown/no fixed address/at sea

For Australian External Territory addresses, the actual postcode and State ID are to be used rather than a supplementary postcode and State ID. Australian External Territories include the following: Christmas Island, Cocos (Keeling) Islands, Jervis Bay and Norfolk Island.

Unknown state

If the state of usual residence of the usual address is unknown (e.g. an unconscious patient is unable to provide the information or no fixed address), use code 9.

Baby for adoption

The Department of Communities, Child Safety and Disability Services (DCCSDS) or the foster carer will advise the relevant QH facility with regard to the correct address details for correspondence from QH during the transitional period. This will usually be either the foster carer or the DCCSDS.

HBCIS Hospitals	Should automatically assign the State ID once the user enters the patient's suburb/town and postcode of usual residence.

6.12.8 Statistical local area

From 1 July 2012, Queensland Health implemented the new Australian Bureau of Statistics (ABS) geographical standard.

The Australian Statistical Geographical Standard (ASGS) has replaced the Australian Statistical Geographical Classification (ASGC) as the national geographical standard. The ASGS provides a more flexible and consistent method for defining Australia's statistical geography and has replaced Statistical Local Area (SLA) with Statistical Area Level 2 (SA2) as the general-purpose medium-sized area.

Facilities are not required to provide a SA2 code as this will be derived centrally by the HSU.

6.13 Patient telephone numbers (public hospitals)

The collection of the telephone details of a patient is desirable for patient follow up and to facilitate the conduct of patient satisfaction surveys at a later date.

The types of contact numbers that can be recorded are;

Home Number

- This is the patient's home telephone number.
- Home telephone numbers should:
  - be recorded as prefix plus telephone number. For example 0731822660
  - not include non-numeric characters or spaces. For example Ext123 or #123
- For overseas patients, the country access code should be included at the beginning of the number.

Business Number

- This is the patient's business telephone number.
- Business telephone numbers should:
  - be recorded as prefix plus telephone number. For example: 0731822660
  - not include non numeric characters or spaces. For example: Ext123 or #123.
- For overseas patients, the country access code should be included at the beginning of the number

- If the patient only has a mobile telephone (i.e. does not have a home/business landline telephone), these fields should be left empty and the mobile telephone number entered into the 'Mobile Number' field.

Mobile Number

- This is the patient's mobile phone number.
- Mobile telephone numbers should:
  - be ten numeric characters (an international number cannot be entered)
  - not include non numeric characters (dashes, brackets or a prefix). For example: +419-531-888

These fields are not mandatory, but it is desirable to obtain this information if possible. If any field does not apply, it should be left blank.

6.14 Occupation

This information is not reported to the Health Statistics Unit for QHAPDC; it is for hospital use only.

6.15 Emergency contact name/address/telephone number

Record the contact details of a relative or friend of the patient, who may be contacted by the hospital in an emergency.

This information is not reported to the Health Statistics Unit for QHAPDC; it is for hospital use only.

6.16 Medicare eligibility

This item records whether the patient is eligible to be treated as a Medicare patient. The majority of non-admitted and admitted patients will be eligible for Medicare. Eligibility for Medicare Card is defined as everyone who lives in Australia – excluding Norfolk Island residents – is eligible for a Medicare card if they:

- hold Australian citizenship
- hold New Zealand citizenship (documentation required)
- have been issued with a permanent visa
- have applied for a permanent visa (excludes an application for a parent visa), have permission to work in Australia or can prove relationship to an Australian Citizen – other requirements may also apply

Visitors to Australia from a country that has a Reciprocal Health Care Agreement with Australia are also eligible for medically necessary treatment as a public patient.

(see Medicare website: http://www.humanservices.gov.au/customer/enablers/medicare/medicare-card/eligibility-for-medicare-card)Patients presenting for treatment should

provide evidence of Medicare eligibility. Where patients are not born in Australia and do not produce a valid Medicare card, then these patients are to be considered as ineligible until evidence of eligibility is produced. It is recommended to sight all Medicare cards. The Medicare Card must be valid and current. It is important that photographic identification of the patient is obtained to ensure that the Medicare card does, in fact, belong to the patient.

Reciprocal Health Care Agreements (RHCA) are currently in place with New Zealand, the United Kingdom, the Netherlands, Kingdom of Norway, Sweden, Finland, Italy, Malta Ireland, Slovenia and Belgium.

Residents from New Zealand the United Kingdom, the Republic of Ireland, Sweden, Finland or Norway are eligible for the duration of their legal stay in Australia.

Visitors from Belgium, the Netherlands or Slovenia need their European Health Insurance card to enrol in Medicare. They are eligible until the expiry date shown on the card, or for the length of authorised stay in Australia, that that is an earlier date.

A visitor from Malta or Italy and resident and citizen of those countries are coved for a period of six months from the date of arrival in Australia.

A person covered by a RHCA is eligible for Medicare for services for treatment that is medically necessary. Medically essential treatment means any ill health, condition or injury which requires treatment before the patient returns home. RHCA's do not include pre-arranged or elective treatment, or treatment as a private patient in a public or private hospital. Special Medicare cards are issued to patients from reciprocal health care countries that are endorsed with a 'valid to' date and 'Visitor RCHA'.

The agreement with New Zealand (for those visitors arriving after September 1999) and the Republic of Ireland are restricted to public hospital care only. They are not issued with 'Visitor RHCA' cards as they are not entitled to access out-of-hospital benefits.

With the exception of New Zealand, the Agreements provide diplomats and their families with full Medicare cover for the term of their stay, which is not restricted to immediately necessary treatment.

The Australian Government requires all visitors on student visas (except Belgium, New Zealand, Norway and Sweden) be registered for Overseas Student Health Cover (OSHC) as a condition of entry. Overseas students on a visa from United Kingdom, Sweden, Netherlands, Belgium, Slovenia, New Zealand or Italy are covered by Medicare through the reciprocal healthcare arrangements. Students from Norway, Finland Malta and the Republic of Ireland are not covered by the reciprocal healthcare arrangements. For further information on overseas visitors, please view the following website - http://www.humanservices.gov.au/customer/enablers/medicare/reciprocal-health-care-agreements/health-care-for-visitors-to-

Medicare cards (blue) issued with the word 'INTERIM' and a 'valid to' date are issued to persons, including visitors, who have been determined to be eligible, and eligible persons awaiting permanent residence status. There are no

restrictions with the 'INTERIM' card. Persons holding these particular cards have exactly the same entitlements/access to Medicare as Australian permanent residents.

It should also be noted that some patients can be both an 'eligible person' and either personally or are third party liable for the payment of charges for hospital services received; for example:

- patients with Defence Force personnel entitlements
- compensable patients e.g. Workers' Compensation, Motor Vehicle Accident and other third party.
- a newborn will usually take the eligibility status of the mother. However, the eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother.
- Entitled veterans (Department of Veterans' Affairs)
- Nursing Home Type Patients

HBCIS Hospitals

Codes for payment class are:

Code	Description	Extracted/mapped by HQI as
CS	Correctional Services	1 Eligible
CU	Unsighted Medicare Card	1 Eligible
DD	Department of Defence	1 Eligible
DVA	Department of Veterans Affairs	1 Eligible
MC	Medicare	1 Eligible
MVO	Motor Vehicle Other	1 Eligible
MVOI	Motor Vehicle Other Ineligible	2 Not Eligible
MVQ	Motor Vehicle Queensland	1 Eligible
MVQI	Motor Vehicle Queensland Ineligible	2 Not Eligible
NE	Not Eligible	2 Not Eligible
RC	Reciprocal Country	1 Eligible
TPE	Third Party Eligible	1 Eligible
TPI	Third Party Ineligible	2 Not Eligible
WCO	Workers Compensation Other	1 Eligible
WCOI	Workers Compensation Other Ineligible	2 Not Eligible
WCQ	Workers Compensation Queensland	1 Eligible
WCQI	Workers Compensation Queensland Ineligible	2 Not Eligible

Other Hospitals

Record the Medicare eligibility of the patient using one of the following codes:

Code	Description
1	Eligible for Medicare
2	Not eligible for Medicare
9	Not stated/unknown

Note:

Members of the Department of Defence are eligible to have a Medicare number and can claim on Medicare but are not encouraged to do so. Their medical wellbeing is the responsibility of the Department of Defence. Department of Defence personnel that require admission require a referral number issued by

the Department of Defence. If this number is unknown it can be obtained by contacting the Department of Defence. Department of Defence personnel are to be admitted as private patients, and the cost of their care is charged to the Defence Force.

6.17 Medicare number

A Medicare Number is a personal identifier allocated by Medicare Australia to eligible persons under the Medicare Scheme.

The 11 digit Medicare Number comprises:

- a card number (8 digits);
- a check digit (1 digit);
- an issue number (1 digit); and
- a person number (1 digit).

All of these digits need to be recorded for a complete Medicare card number.

Where a patient does not have a Medicare card or the card is not available, unknown or unidentified, record 0's in the designation/number field.

HBCIS Hospitals

Enter the Medicare number. A checking algorithm is part of HBCIS and ensures that a valid Medicare number is recorded.

Code	Description
C-U	where Medicare Number is unknown
N-E	where patient is Ineligible
P-N	where patient is currently a prisoner
UNN	for unnamed neonates

Note that Medicare Suffix will display the first three letters of patient's given name on entry of a valid Medicare number. However record

Other Hospitals

If the patient is eligible for Medicare, record the Medicare number from the patient's Medicare card, for example:

0	5	0	9	1	9	5	9	9	9	1

If the patient is eligible for Medicare, but has not yet registered with Medicare, record the number 0000/00000/00.
If the patient is not eligible for Medicare or if eligibility for Medicare is not known, leave blank.

6.18 Payment class code (HBCIS hospitals)

The payment class in HBCIS is used to derive Medicare eligibility. Codes are as follows:

	Codes for payment class are:		
	Code	Description	Extracted/mapped by HQI as
HBCIS Hospitals	CS	Correctional Services	1 Eligible
	CU	Unsighted Medicare Card	1 Eligible
	DD	Department of Defence	1 Eligible
	DVA	Department of Veterans Affairs	1 Eligible
	MC	Medicare	1 Eligible
	MVO	Motor Vehicle Other	1 Eligible
	MVOI	Motor Vehicle Other Ineligible	2 Not Eligible
	MVQ	Motor Vehicle Queensland	1 Eligible
	MVQI	Motor Vehicle Queensland Ineligible	2 Not Eligible
	NE	Not Eligible	2 Not Eligible
	RC	Reciprocal Country	1 Eligible
	TPE	Third Party Eligible	1 Eligible
	TPI	Third Party Ineligible	2 Not Eligible
	WCO	Workers Compensation Other	1 Eligible
	WCO	Workers Compensation Other Ineligible	2 Not Eligible
	WCQ	Workers Compensation Queensland	1 Eligible
	WCQ	Workers Compensation Queensland Ineligible	2 Not Eligible

6.19 Contact for feedback indicator (HBCIS hospital)

To help Queensland Health provide even better services, feedback from patients is important. This feedback helps Queensland Health review services, plan effectively, and identify areas that need improvement.

The HBCIS field 'Feedback Consent' can be set to **either mandatory or non-mandatory at individual sites.** However, it is no longer required to be collected and no longer required for patients to be asked the question at individual sites. Therefore it is preferable that the field is set to non-mandatory.

This field was instituted in 2002 in response to the emerging Privacy Principles and related legislation. It is no longer required as Section 150(a) of the *Hospital and Health Boards Act 2011* (the Act) makes provision for health services to obtain patient details from their patient record for evaluating, managing, monitoring or planning health services. In addition, section 150(b) of the Act allows these details to be provided to an independent organisation contracted to contact the patient and obtain this feedback (as long as the organisation is prescribed for this purpose in the *Hospital and Health Boards Regulation 2012*).

To continue asking patients in this way for prior consent to be contacted for feedback may compromise the ability of health services to collect reliable, representative patient feedback. Patients always have the option to decline to provide feedback when initially contacted to participate in a specific survey.

If this field is **non-mandatory** at your site:
Patients should not be requested to sign a 'Feedback Consent Form' and you should not ask them verbally for consent to obtain their personal details and to contact them for feedback on the services they receive.

Nothing should be entered into the HBCIS in the field 'Feedback Consent'.

If this field is **mandatory** at your site:
Whenever a patient attends the facility, they should be requested to sign the 'Feedback Consent Form' that asks them for a 'Yes' or 'No' response to the statement 'I agree to be contacted so you can ask for my comments on the care I received'. If this form is not completed, you will need to ask the patient 'Do you consent to Queensland Health obtaining your personal details from your health care record to contact you and to ask for your feedback on the services you received at this facility?'

In either instance, the patient's response is to be recorded on HBCIS in the field 'Feedback Consent'.

In some instances the patient will be unable to provide the consent. This may occur in instances similar to those where they are unable to complete a 'Patient Election Form (PEF)' (e.g. they are unconscious or in a critical condition on arrival) and all admission information is collected later. If you are unable to obtain the patient's consent upon admission, please follow your facility's procedure for when admission information cannot be collected at the time of admission.

If the patient's details are recorded as 'Unknown' on the patient registration screen, you may register the consent as 'U - unable to obtain' in the 'Feedback Consent' field. However, this is not a default setting, and is not to be used for any reason other than the person can not physically or legally provide consent. Note however that 'U – unable to obtain' must be entered on reaching the 12 month expiry of consent until such time that the patient can be asked for their consent again and a new consent form signed accordingly. (It is a common user error to re-enter the existing status without the patient being asked.)

	Code	Description
HBCIS Hospitals	Y	Yes
	N	No
	U	Unable to obtain

7. ADMISSION DETAILS

7.1 Admission date

Record the full date (that is, ddmmyyyy) of admission to hospital. Use leading zeros where necessary.

Example

For a patient admitted on 3 July 2014 record

0	3	0	7	2	0	1	4

7.2 Admission time

Use the 24-hour clock to record the time of admission. Times are between 0000 (midnight), which is the start of the day, and 2359, which is the end of a day.

HBCIS hospitals: currently HBCIS will not accept 0000 as midnight. A system parameter setting at each site dictates if 24:00 can be a valid entry. If an actual event occurs at midnight and the parameter is set to 'Y' then record 24:00. If an actual event occurs at midnight and the parameter is set to 'N' record 23:59.

Example

Admission time for a patient admitted at 3:10 a.m

0	3	1	0

Admission for patient admitted at 6:05 p.m

1	8	0	5

The admission time is the time at which a medical practitioner makes the decision that the patient should be admitted, noting that this may not be the time the patient arrived at the facility.

Example 1:
Patient arriving at the Admission desk for an elective procedure. The admission time will be the time the patients administrative details are collected.

Example 2:

A patient arrives at the Emergency Department at 7 pm. At 11 pm, the treating medical practitioner decides that the patient requires admission to the hospital. The admission time for the acute episode of care will be 11 pm.

If the patient's time of admission is unknown, use an estimate. Ensure the time is before any period of leave or patient activity.

7.3 Admission number

HBCIS Hospitals	Allocated automatically by the system and it is known as the episode number

Other Hospitals	Record the admission number from the Admission Register. Use leading zeros as necessary.

7.4 Chargeable status

On admission to hospital, an eligible patient must elect to be as either a public or private patient.

A public patient is a patient who:

- elects to be treated as a public patient, and so cannot choose the doctor who treats them, or
- is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.

A public patient who is allocated single room accommodation due to clinical need is still a public patient.

A private patient is a patient who elects to be treated by a doctor of their choice.

Their chargeable status is shared, unless they request and are accommodated in a single room in which case their chargeable status is ‘private single’.

A private patient allocated single-room accommodation due to clinical need, rather than by choice, is still a private shared patient rather than a private single patient.

HBCIS Hospitals	This data item is not entered separately as it is derived from the second digit of the account class **P** in account class is Public **R** in account class is Private **S** in account class is Shared

Other Hospitals	Record the chargeable status of the patient using one of the following codes	
	Code	Description
	1	Public
	2	Private shared
	3	Private single

Ineligible for Medicare

A patient who is ineligible for Medicare does not have access to hospital treatment ‘free of charge’.

Queensland Public Hospitals are to provide Medicare ineligible patients with a choice to be treated as a public or private patient. Different fees apply depending on the option chosen. Refer to the Queensland Health *Fees and Charges Register*.

Compensable

A patient who is compensable (e.g.entitled to receive compensation for their hospital treatment) does not have access to hospital treatment 'free of charge'. However, they do have the right to elect to be treated either by a hospital nominated doctor ("public") or by a doctor of their choice ("private").

Compensable patient, charges will be raised on behalf of the patient either directly or indirectly through bulk-funding arrangements for their public hospital care, regardless of public or private chargeable status.

If a compensable patient has elected to be treated privately they will be responsible for all charges if the compensation claim is rejected or the insurer does not provide prior approval of the private status.

Department of Veterans' Affairs

A patient who holds a Gold or White Repatriation Health Care Card can choose to use or not to use the benefits of their entitlement card. All eligible DVA patients who elect to have the DVA fund their hospitalisation, will also need to decide on whether they wish to have a public or private doctor manage their treatment. It is recognised that not all public hospitals have access to private doctors, hence account class codes are available that recognise a veteran's choice of doctor.

Reciprocal Health Care Agreements

The Australian Government has signed Reciprocal Health Care Agreements (RCHA) with the governments of the United Kingdom, Republic of Ireland, New Zealand, Sweden, the Netherlands, Belgium, Finland, Norway, Slovenia, Malta and Italy which entitles the patient to public hospital services 'free of charge' for 'essential' medical treatment while visiting Australia. A patient relying on a RHCA to cover the cost of their hospital stay must elect to be a public patient. Conditions such as period of cover vary between the different Agreements. For more information see Department of Human Services [6]website.

If a patient from a country with a RHCA with Australia elects to be treated by a doctor of their choice i.e. a private patient, then they are ineligible for Medicare and do not have a right to access hospital care 'free of charge'.

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[6] Department of Human Services [6]website
http://www.humanservices.gov.au/customer/enablers/medicare/reciprocal-health-care-agreements/health-care-for-visitors-to-australia

Newborns

A newborn with a qualification status of unqualified will generally have the same chargeable status as their mother.

The chargeable status of a newborn with a qualification status of acute will depend on the election made by their mother on its behalf.

A newborn will usually take the Medicare eligibility status of the mother. However, the Medicare eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother. For example, if the mother is an ineligible person, but the father is eligible for Medicare, then the newborn will be eligible for Medicare.

Boarders

A boarder is not admitted, but is generally registered by the hospital. If the boarder is accompanying a patient, then their chargeable status will be the same as that patient. However, for public hospitals the policy with respect to charging these patients is at the discretion of the Hospital and Health Service. If Hospital and Health Services decide to charge, then a fee can be charged for meals and reasonable accommodation costs (fees will need to be raised in FAMMIS). With regard to accommodation costs, it is recommended that fees do not exceed the daily maintenance rates as detailed in the Queensland Health Fees and Charges Register.

Hospital Insurance Status

The chargeable status of a patient cannot be assumed on the basis of their hospital insurance status. The funding arrangements between the Australian Government and the Queensland Government make it very clear that every eligible patient should make an informed choice to receive public hospital services as a public or private patient. The Patient Election Form documents this choice.

For example:

- A patient may have hospital insurance but elect to be treated as a public patient.
- An uninsured patient may elect to be treated as a private patient and meet the hospital and clinical charges themselves.

7.5 Account class (HBCIS hospitals)

The account class identifies the billing classification of the patient, i.e. it determines the patient's daily bed charge (see also Section 7.4 Chargeable Status). The most common codes used are as follows:

	Code	Description
HBCIS Hospitals	GPE	General Public Eligible
	GRE	General Private Eligible
	GSE	General Shared Eligible

A list of account class codes appears in Appendix I.

NOTE: If a patient is admitted as a same day banded patient, but remains in hospital overnight or longer, then the admission account class must be updated. This can be done by recording an account class variation and selecting a 'Y' (yes) to the prompt to update the admission account class or by deleting and re-entering the admission with the appropriate account class applicable. Generally, only staff in the Accounts/Patient Billing area can carry out account variations.

If a newborn changes status between unqualified and acute (also known as "qualified"), then the account class must be changed. Hospitals should use xxQ for newborns with a qualification status of acute and xxUQ for newborns with a qualification status of unqualified when assigning an account class code.

Same day banded patients cannot have an account class change. However, other patients are able to have account class changes. The account class changes forwarded to the Health Statistics Unit are to reflect the last account class for that day. The account class is used to derive the compensable status of the patient. For further information refer to section Section 7.8 compensable, Section 7.6 day band information, Section 7.4 chargeable status and boarders.

Ineligible Persons

Ineligible persons admitted to Intensive Care Unit and/or Coronary Care Units are admitted to these units using the appropriate account class code. This eliminates the need for journal adjustments to correct the daily fee.

Prisoners

Prisoners have their own admission account class code. Please ensure this code is used together with the admission and discharge source codes indicating 'Correctional Facility'. The Medicare suffix must be P-N and the Funding Source is (01) (Correctional facilities do not pay Queensland Health for the treatment of prisoners).

7.6 Same day banded procedures

All day only surgical and non-operative procedures can be allocated a number as per the Commonwealth Medicare Benefits Schedule. These are called CMBS numbers. Based on CMBS numbers and other factors, procedures can be categorised into one of four different bands. For private patients, both in public and private hospitals, the bands are used as a basis to determine the level of charges. Bands are also used to determine whether patients are admitted as day only patients, or otherwise. Please refer to the Admission Criteria in Appendix F for further clarification on how bands affect the admission process.

Patients who receive a procedure that would not normally warrant admission, may be admitted with a Day Only Procedure Certificate issued by the attending medical practitioner. Bands can only be determined reliably on patient separation when the procedure that was performed is known, and a CMBS number has been given. The band is only required for private patient day

benefit procedure cases by the Health Statistics Unit. However, hospitals may, but are not required to, supply bands for public patients.

Do not allocate a band if the procedure was performed as a day only episode within a longer hospital stay (involving statistical admission and/or separation for a change in episode type). Band is only for stand-alone day only hospital stays.

Definitions and information on each band can be found in the current version of the Private Health Insurance (Benefit Requirements) Rules[7].

Band 1A	Band 1A is a definitive list of procedures including gastrointestinal endoscopy, certain minor surgical items and non-surgical procedures that do not normally require anaesthetic.
Band 1B	Band 1B relates to professional attention that embraces all other day only admission to hospital not related to bands 2, 3 or 4. Bands 2, 3 and 4 are determined by the anaesthetic type and theatre time.
Band 2	Band 2 means procedures (other than band 1) carried out under local anaesthetic with no sedation.
Band 3	Band 3 means procedures (other than band 1) carried out under general or regional anaesthesia or intravenous sedation with theatre time (actual time in theatre) less than one hour.
Band 4	Band 4 means procedures (other than band 1) carried out under general or regional anaesthesia or intravenous sedation with theatre time (actual time in theatre) of one hour or more.

HBCIS Hospitals	This data item is not entered separately as it is derived from the item account class (B1A; B1B; B2; B3; B4) and translated to 1A, 1B, 02, 03 and 04. If a patient changes from day only to overnight or longer, the admission account class must be altered, rather than recording an account class variation. Usually accounts staff can only do this.

Other Hospitals	The band is required only for private patient, day benefit procedure cases. You may leave the field blank if the patient is not a private patient. A band code should not be provided if the patient is not a day benefit patient. Record the band using one of the following codes:	
	Code	Description
	1A	Band 1A
	1B	Band 1B
	2	Band 2
	3	Band 3
	4	Band 4

[7] Private Health Insurance (Benefit Requirements) Rules. Accessed from <http://www.comlaw.gov.au/Details/F2014C00204> [16 April 2014]

7.7 Qualification status

All babies 9 days old or less should be admitted with a newborn care type. On admission the newborn will have a qualification status of either acute (qualified) or unqualified (see 4.12 Newborns).

Record the qualification status on admission. If the qualification status of the newborn changes after admission then the change in qualification status is recorded.(see 8.3.8 Qualification Status changes).

Other Hospitals	Record the following codes to indicate the qualification status of the newborn	
	Code	Description
	A	Acute
	U	Unqualified

7.8 Compensable status

This item records information when the patient's hospitalisation is to be paid for by a compensable third party, usually as a result of the patient being in an accident. Note that although this is recorded at the time of admission, in the belief that the patient will be entitled to compensation, there are times when the compensation claim fails, and the patient reverts to not compensable.

For a more detailed explanation of compensable status, refer to the definitions in 4.6 compensable status.

HBCIS Hospitals	This data item is not entered separately as it is derived from the item account class. The letters from the account class are:	
	TP	Compensable Third Party
	WC	Workers' Compensation Queensland
	MV	Motor Vehicle (Queensland)
	MVO	Motor Vehicle (Other)
	DVA	Department of Veterans' Affairs
	DD	Department of Defence
	Note: Department of Veterans' Affairs and Department of Defence patients are classified as Compensable An activity change is recorded automatically as a result of any changes made to the account class	

Other Hospitals	Code	Description
	1	Workers' Compensation Queensland)
	2	Workers' Compensation (Other)
	6	Motor Vehicle (Queensland)
	7	Motor Vehicle (Other)
	3	Compensable Third Party
	4	Other Compensable
	5	Department of Veterans' Affairs
	9	Department of Defence
	8	None of the above
	A Patient Activity Form should be completed for all patients whose compensable status changes during an admission, and submitted with their Diagnosis Sheet.	

DEFINITIONS

Workers' Compensation Queensland

A patient is entitled to claim compensation under the Queensland Workers Compensation and Rehabilitation Act 2003. This includes workers injury claims managed by WorkCover Queensland and those Queensland firms who are self-insured. The Regulator is responsible for:

- regulating the workers' compensation scheme,
- monitoring the compliance of insurers under the Act,
- monitoring the performance of insurers under the Act including the consistent application of this Act; and
- deciding applications relating to self-insurance.

Workers' Compensation (Other)

Patient is entitled to claim damages under a Workers' Compensation Act other than Queensland (e.g. if an employee of the Commonwealth or an Interstate Company or national organisation not self-insured under the Queensland *Workers Compensation and Rehabilitation Act 2003*.).

Motor Vehicle (Queensland)

This is used where the patient admitted to hospital from a motor vehicle accident can establish negligence against an owner or driver of a Queensland registered motor vehicle.

Motor Vehicle (Other)

This is used where the patients admitted to hospital from a motor vehicle accident can establish negligence against an owner or driver of a motor vehicle registered in a State or Territory other than Queensland or where the patient is a driver-at-fault covered under a motor vehicle policy for drivers at fault.

CompensableThird Party

This is used for patients admitted to hospital for the treatment of an injury, illness or disease sustained in:

- A motor vehicle accident that occurred prior to 1 September 1994.
- Accidents that are not associated with Compulsory Third Party (CTP) insurance and are not covered by workers' compensation insurance. For example, accidents involving: mobile machinery or equipment such as bulldozers and forklifts; or agricultural implements.
- Motor vehicle accidents where liability is unclear, or where there is a possibility of shared liability.

It also may be used for patients seeking to claim against public liability insurance, and who do not fit into any of the other categories.

Victims of criminal acts are not considered compensable so a charge is not to be raised for their treatment.

Other compensable

Is used for other compensable patients.

Department of Veterans' Affairs

Entitled veterans whom the Department of Veterans' Affairs has accepted responsibility for the payment of any charges relating to his/her episode of care. This relates to all Gold Card holders and those White Card holders for specific illness or injury. White Card holders should not be classified as DVA patients unless they are receiving care or treatment for a recognised and accepted by DVA as a compensable condition.

Department of Defence

Australian Defence Force personnel whom the Department of Defence has accepted responsibility for the payment of any charges relating to his/her episode of care. This relates to permanent and part-time members. Part-time members should only be classified as Department of Defence where they seek and receive treatment for an injury or illness sustained while serving in the Defence Forces (e.g. Regular, Reserve Forces and Cadets).

None of the above

The patient cannot be classified as compensable under any of the above categories, or their compensable status is unknown.

Note for public hospitals using HBCIS compensable and ineligible patients, who are to be admitted for a day only band procedure are charged the compensable/ineligible rate and are NOT banded. It is unnecessary, therefore, to record a band for them.

7.9 Boarder status

See the definition of a boarder in Section 4.4. From 1 July 1999 data for boarders are required to be submitted for the QHAPDC.

Registering boarders from a reciprocal country:

PAYMENT CLASS	RC	(HBCIS ONLY)
ACCOUNT CLASS	GPB	(HBCIS ONLY)
ADM SOURCE	21	BOARDER
ADM TYPE	08	BOARDER
ADM STATUS	3	NOT ASSISGNED
FUNDING SOURCE	12	OTHER

7.10 Incident date (HBCIS only)

The date on which the injury, accident or illness associated with the episode of care occurred.

In the case of late onset of injury or illness, the incident date is the date that the patient was first assessed by a doctor or, where appropriate, a dentist for the injury or illness.

Incident Date is required to assist in the validation of a patient's hospital treatment against any claims they may make for compensation with WorkCover Queensland or the Motor Accident Insurance Commission.

Incident Date should be recorded when the injury or illness for which the patient is being treated appears to have been the result of either:

- working for an income; or
- a road traffic accident;

Regardless of the compensable status of the patient at the time of their admission.

When a patient is being registered at a hospital for treatment, ask one of the following questions:

- Following an accident or injury, ask the patient "On what date did the accident or injury occur?"
- In the case of late onset of injury or illness, ask the patient "On what date were you first assessed by a doctor or dentist for this injury or illness?"

Record the incident date using the full date (i.e. ddmmyyyy) and leading zeros where necessary.

Example

For 5 July 2014, record

0	5	0	7	2	0	1	4

- If the day of the incident is unknown, use ** for the first two values.
- If the month of the incident is unknown, use ** for the third and fourth values.
- If the year of the incident is unknown, an estimate must be provided.

Example

If a patient does not know the exact incident date, but knows that it was sometime in 2014 record the incident date as:

*	*	*	*	2	0	1	4

Although provision is made for recording estimates of the day and month of the incident date, every effort should be made during the course of the admission to determine (and record) the actual incident date.

7.11 Incident date flag (HBCIS only)

This data item does not appear on any HBCIS screens. It is automatically generated for extract if an '*' is used in any of the Incident Date fields.

7.12 Source of referral/transfer (admission source)

The source of referral/transfer indicates the referral point of a patient immediately before they are admitted either formally (hospital admission) or statistically (type of episode change). Record the source of referral/transfer using one of the following codes:

HBCIS Hospitals

HBCIS Admission Source		Extracted/mapped by HQI	
Code	Description	Code	Description
01	Private medical practitioner (excl. psychiatrist)	01	Private medical practitioner (excl. psychiatrist)
15	Private psychiatrist	15	Private psychiatrist
02	A&E	02	Emergency department - this hospital
03	Outpatient department	03	Outpatient department - this hospital
24	Admitted patient transferred from another hospital	24	Admitted patient transferred from another hospital
25	Non-admitted patient referred from another hospital	25	Non-admitted patient referred from another hospital
23	Residential aged care service	23	Residential aged care service
06	Episode change		Episode change
08	Outborn	02	Emergency department –this hospital
09	Born in hospital	09	Born in hospital
10	Retrieval from another hospital	24	Admitted patient transferred from another hospital
16	Correctional facility	16	Correctional facility
17	Law enforcement agency	17	Law enforcement agency
18	Community service	18	Community service
19	Retrieval not from other hospital	02	Emergency department – this hospital
14	Other health care establishment	14	Other health care establishment
22	Routine readmission not requiring referral	19	Routine readmission not requiring referral
29	Other	29	Other
		20	Organ Procurement (Not available on HBCIS)
21	Boarder	21	Boarder

Other Hospitals

Code	Description
01	Private medical practitioner (excl. psychiatrist)
15	Private psychiatrist
02	Emergency department - this hospital
03	Outpatient department - this hospital
24	Admitted patient transferred from another hospital
23	Residential aged care service
06	Care type change
09	Born in hospital
16	Correctional facility
17	Law enforcement agency
18	Community service
14	Other health care establishment
19	Routine readmission not requiring referral
29	Other
20	Organ Procurement
21	Boarder
25	Non-admitted patient referred from other hospital

Note: The scope of the QHAPDC does not include Military Hospitals. Therefore patients requiring admission following treatment at a Military Hospital should not be coded as a transfer from another hospital.

The following rules are to be used in the allocation of appropriate source of referral/transfer (admission source) codes.

Code	Description	Explanation
01	Private medical practitioner (excluding psychiatrist)	Used for patients referred to the hospital admission office by a private doctor other than a psychiatrist. Such patients will generally be private shared or private single patients whose admission will have been arranged by their treating doctor or dentist.
15	Private psychiatrist	Patients referred to the hospital admission office by a psychiatrist.
02	Emergency department - this hospital	Used for patients who present to the Emergency or Casualty Department of the hospital and are subsequently admitted to the same facility immediately following their emergency consultation. They will generally not be booked patients. For example, use this code for patients who are transported by the Royal Flying Doctor Service for an unplanned (not booked) admissionor for babies (qualified and unqualified) born on the way to hospital.
03	Outpatient department - this hospital	Used for patients who have attended an outpatient clinic at the hospital and are subsequently referred for admitted patient treatment. They will generally be booked patients. Patients who are transported by the Royal Flying Doctor Service to attend outpatients, and are then booked for admission, use this code. For unplanned (not booked) admissions refer to code 02 Emergency department - this hospital.
24	Admitted patient transferred from another hospital	Used for all patients who are transferred from another hospital (including psychiatric hospitals) for continuation of their admitted patient care or treatment at this hospital. This code may also be used for patients who are transferred from hospitals interstate or overseas.
25	Non-Admitted Patient referred from other hospital	Used for all patients who are referred from another hospital (including psychiatric hospitals) for continuation of their care or treatment at this hospital.
23	Residential Aged Care Service	Used for patients who are transferred to this hospital for further care and treatment from a residential aged care service where they are usually a resident. A residential aged care service includes former public and private nursing homes and hostels – but not independent living units (refer to '14 Other health care establishment').
06	Care Type change	Used for statistical admissions where the patient has previously been admitted to an episode of care during this hospital stay, and is now changing the type of episode of care (e.g. acute to maintenance). Do not use this code for a registered boarder changing status to become an admitted patient. For public hospitals using I&D Sheets to 'batch' information to a central hospital for data entry into HBCIS, and for private hospitals using I&D sheets, a new I&D Sheet will need to be completed for the patient with a source of referral/transfer code of '06 – Episode Change' and the new care type.
09	Born in hospital	Used for babies born at this hospital during this episode only.
16	Correctional facility	Patients who have been referred to the hospital from a correctional facility.

17	Law enforcement agency	Patients who have been referred to the hospital from a law enforcement agency (other than a correctional facility) such as the police or courts.
18	Community service	A patient whose admission to the hospital has been arranged by a community health service.
19	Routine readmission (22 on HBCIS)	Used for patients who are not admitted through outpatients or the emergency department for planned treatment (e.g. renal dialysis patients, chemotherapy patients directly presenting to the ward for planned treatment).
14	Other health care establishment	Used for patients who are admitted from alcohol and drug centres, or other health care establishments.
29	Other	Used for patients who are admitted under circumstances that does not fit any other category. Such as a person who is currently a boarder at a Hospital becoming ill and is admitted. However, it is expected that this code will rarely be used.
20	Organ Procurement (not on HBCIS)	Used to register donors (who have been declared brain dead) for the purpose of procurement of human tissue.
21	Boarder	Used to register a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
HBCIS Only Codes		
08	Outborn	For babies (qualified and unqualified) who were born on the way to hospital and have not been admitted at any other hospital. Extracted and mapped by HQI as '02 Emergency department – this hospital'.
10	Retrieval from another hospital	Used when a patient has been brought to the hospital from another hospital by a retrieval team. Extracted and mapped by HQI as '24 - Admitted patient transferred from another hospital'.
19	Retrieval not from other hospital	Used when a patient has been brought to the hospital from any place other than another hospital by a retrieval team. Extracted and mapped by HQI as '02 Emergency department – this hospital'.

Examples

1. A patient attends a specialist (other than a psychiatrist) in the specialist's rooms. The specialist has admitting rights at the hospital. The patient is booked for admission and is admitted.

   The source of referral is 01 Private medical practitioner (not psychiatrist).

2. A patient is seen in the rooms of their local medical officer (general practitioner). The patient is sent to your hospital's outpatient department or emergency department for review by hospital staff and is admitted.

3. The source of referral is 03 Outpatient - this hospital; or 02 Emergency department - this hospital.

4. A patient comes from their place of permanent residence in an aged care service to the outpatient department or emergency department for review by hospital staff and is admitted. The source of referral is 03 Outpatient Department - this hospital; or 02 Emergency department - this hospital.

5. A patient comes from their place of permanent residence in a residential aged care service to the hospital ward. The source of referral is 23 Residential Aged Care Service.

7.13 Mothers patient identifier

Record the mother's patient identifier (UR number) for those babies born in hospital. That is, this data item is must be recorded when the patient's source of referral/transfer (admission source) is '09 – Born in hospital'.

7.14 Transferring from facility (extended source code)

The facility number must be recorded when this hospital receives a transferred patient for ongoing care or a referred patient for an admitted service. That is, this item is mandatory if the patient's source of referral/transfer (admission source) is:

All Hospitals	Record the extended source code of the hospital, residential aged care service, or correctional facility that transferred or referred the patient to this hospital for admission.	
	Code	Description
	24	Admitted patient Transferred from another hospital
	16	Correctional facility
	23	Residential Aged Care Service
	25	Non-admitted patient referred from other hospital

See Appendix A for a list of facilities and their facility numbers, including the facility number to be used when a patient is transferred from a facility in another state/territory or from overseas.

7.15 Care type

The term Care Type refers to the nature of the treatment/care provided to a patient during an episode of care.

Episode of Care

An episode of care refers to a particular phase of treatment (reflected by the care type) rather than to each individual patient day. There may be more than one episode of care within the one hospital stay period. An episode of care ends when the principal clinical intent of care changes (i.e. the care type changes) or when the patient is formally separated from the hospital.

Each episode is reported to the Health Statistics Unit on its completion. Episode of care changes can be identified through the use of code 06 in the source of referral/transfer and/or mode of separation data items.

Please note that a person allocated to an organ procurement episode type or boarder episode type can NOT have 06 in the source of referral/transfer or mode of separation data items.

In order for the Health Statistics Unit to undertake analyses of patient hospital stays, it is necessary to link episodes of care. This can be done by firstly

identifying the patient's formal separation from hospital (i.e. mode of separation is not code 06). If the source of referral/transfer is also not code 06, then the patient had only one episode for the hospital stay. The majority of patients do not have a mode of separation of 06. If however the source of referral/transfer is code 06, then the patient's previous separation is found (where the date of the new admission equals the date of the previous separation).

The source of referral/transfer is checked, and if necessary, this process of linking continues until the source of referral/transfer indicates a true hospital admission (i.e. code is not 06). This process of linking records makes it critical for hospital staff to ensure that for any patient who changes episode, the correct codes are used for the type of episode, source of referral/transfer, and mode of separation. It is also critical that the UR Number is the same for all episodes and that the date of separation for an episode change is the same as the date of admission for the next episode within a hospital stay.

Persons with mental illness may fall into any one of the episode of care types, and their classification is dependent upon the principal clinical intent of the care received.

Care Type Changes

It is essential that any change in care type reflects a clear change in the type or goal of care provided. For example, a reduction in the intensity of acute care does not necessarily trigger a care type change to rehabilitation or GEM if the patient is not yet receiving that care.

Patients who receive acute same-day intervention(s) during the course of a subacute episode of care do not change care type. Instead, procedure codes for the acute same-day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the subacute episode of care.

HBCIS Hospitals	This data item is entered separately. The following codes are entered onto the admission screen	
	Code	**Description**
	01	Acute
	20	Rehabilitation
	30	Palliative
	05	Newborn
	09	Geriatric Evaluation and Management
	10	Psychogeriatric
	11	Maintenance
	06	Other care
	07	Organ Procurement (Not available on HBCIS at this stage)
	08	Boarder
	44	Aged Care Resident
	Code 44 is not extracted as part of HQI as it can only be used for aged care residents. Aged Care residents are not part of the scope of QHAPDC	

Other Hospitals	Record the type of episode using one of the following numerical codes	
	Code	**Description**
	01	Acute
	20	Rehabilitation
	30	Palliative
	05	Newborn
	09	Geriatric Evaluation and Management
	10	Psychogeriatric
	11	Maintenance
	06	Other care
	07	Organ Procurement
	08	Boarder

Definitions of the types of episodes of care for an admitted patient are as follows:

Care Type 01 - Acute

Acute care is care in which the principal clinical intent or treatment goal is one or more of the following:

- manage labour (obstetric);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care);
- reduce severity of an illness or injury;
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and or
- perform diagnostic or therapeutic procedures.

Sub and non-acute care is a collective term for the following care types:

All Hospitals	**Code**	**Description**
	20	Rehabilitation
	30	Palliative
	09	Geriatric Evaluation and Management
	10	Psychogeriatric
	11	Maintenance

Care Type 20 - Rehabilitation

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating:

Rehabilitation care is:

- delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and

- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.

Care Type 30 – Palliative

Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is:

- delivered under the management of or informed by a clinician with specialised expertise in palliative care, and
- evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

Care Type 09 Geriatric Evaluation and Management (GEM)

Geriatric evaluation and management is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions relating to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Geriatric evaluation and management is:

- delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management; and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

Care Type 10 -Psychogeriatric care

Psychogeriatric care is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related organic brain impairment or a physical condition.

Psychogeriatric care includes:

- delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care,
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient and includes

negotiated goals within indicative time frames and formal assessment of functional ability.

Psychogeriatric care is not applicable if the primary focus of care is acute symptom control.

Care Type 11 - Maintenance care

Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care often require care over an indefinite period.

Care Type 05 - Newborn

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated. The following points should be noted:

- Patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders.
- Patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated.
- Patients aged less than 10 days and not admitted at birth (e.g. transferred from another hospital) are admitted with a newborn care type;
- Patients aged greater than 9 days not previously admitted (e.g. transferred from another hospital) are either boarders or admitted with an acute care type;
- Within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day.
- A newborn is qualified when it meets at least one of the criteria detailed in the newborn qualification status.
- Within a newborn episode of care, each day after the baby turns 10 days of age is counted as acute (qualified) patient day.
- Newborn qualified days are equivalent to acute days and may be denoted as such. See 4.12 Newborns for further information on newborns.

Care Type 06 - Other care

Other admitted patient care is care where the principal clinical intent does not meet the criteria for any of the above.

Care Type 07 - Organ procurement

Organ procurement – posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead. See Section 4.15.2 Posthumous Organ Procurement

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the

relevant ICD-10-AM ACS. These patients are not admitted to the hospital but are registered by the hospital.

Care Type 08 - Boarder

Hospital Boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Boarders are 'admitted' in HBCIS using specific Boarder codes. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

7.16 Elective patient status

An elective admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and which can be delayed for at least 24 hours.

Admissions for which an elective status is usually not assigned are:

- admissions for normal delivery (obstetric);
- admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient;
- statistical admissions; and
- planned readmissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

An emergency admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and which should occur within 24 hours.

Although the following list is not definitive an emergency patient would qualify as one of the below:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or
- suffering from suspected acute organ or system failure; or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- suffering from a drug overdose, toxic substance or toxin effect; or
- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or

- suffering an acute condition which represents a significant threat to the patients physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

All Hospitals	Record the following codes to indicate the elective patient status	
	Code	**Description**
	1	Emergency admission
	2	Elective admission
	3	Not assigned

7.17 QAS patient identification number (EARF)

The electronic Ambulance Report Form (eARF) number is a unique identifier for patient events attended by the Queensland Ambulance Service (QAS). Each QAS team has a portable tablet PC that they use to record clinical details about each patient attended. Each tablet PC is allocated a unique set of eARF numbers and when a new patient template is opened on the computer/electronic tablet device an eARF number is automatically allocated to the patient.

It should be noted that the number is only unique to a patient event NOT a person. That is, a person receives a new eARF number each time they are attended to/ transported by QAS. If more than one QAS team attend a patient, all clinical details are transferred to the PC of the team who transports the patient so each patient is allocated only one eARF number per patient event.

The eARF number is included on the form that the QAS transporting team print out and leave at the hospital when they deliver a patient.

Record the QAS Patient Identification Number if the patient was transported to the hospital by the QAS team and the patient is subsequently admitted.

7.18 Planned same day

This item is used to indicate whether it is planned for the patient to be discharged before midnight on the same day as he/she is admitted. Such patients will generally be admitted for a Day Benefit procedure. If the patient ultimately remains in hospital longer than one day, this data item remains as originally recorded. It may be used for quality assurance studies to investigate reasons for the change in plan.

All Hospitals	Record, in the specified field, the planned duration of the patient's stay using one of the following codes	
	Code	**Description**
	Y	Yes, planned to be separated from the hospital on the same day
	N	No, planned to stay at least one night
	This item documents the intent. If the patient has been recorded as "N" dies or is discharged unexpectedly on the day he/she is admitted, the code remains the same. This information will generally be obtained from a booking form or other details available from the treating doctor	

7.19 Recent discharge (HBCIS hospitals)

This item is used by hospitals to determine whether the patient has been discharged from any hospital in the last seven days.

This information is not reported to the Health Statistics Unit for QHAPDC; it is for hospital use only. It is useful because fees charged to the patient may depend on whether the patient has been an admitted patient in any declared hospital within the seven days before this admission. In addition, if the patient has been admitted in any hospital, this may affect eligibility for acute care entitlements.

HBCIS Hospitals	Record the number of days in the specified field "Days Carried Forward".

If yes, which hospital?

This information is not reported to the Health Statistics Unit for QHAPDC; it is for hospital use only.

HBCIS Hospitals	Record the name of the previous hospital in the specified field ***other hospital***

Total length of stay without breaks of more than seven days in previous hospitals.

This information is not reported to the Health Statistics Unit for QHAPDC; it is for hospital use only.

HBCIS Hospitals	Calculated automatically

7.20 Treating doctor

This data item is collected for hospital use only it is not required by the Health Statistics Unit. Record the hospital code to describe the individual doctor chiefly responsible for treating the patient.

7.21 Admission unit

Record the hospital code to indicate the unit to which the patient was admitted. A maximum of four characters is allowed.

7.22 Standard unit code

Record standard unit code selected from the list prepared by the Health Statistics Unit (see Appendix J) to describe the unit to which the patient was admitted/transferred. For HBCIS hospitals, the standard unit codes are generally mapped from the treating doctor units. For other hospitals, this is generally mapped from the treating doctor on the basis of his/her specialisation.

7.23 Admission ward

Record the code to indicate the specific ward to which the patient is admitted. Use the codes prepared by the hospital, as the Health Statistics Unit does not have a predetermined list of codes for hospitals.

All Hospitals	A maximum of six characters is allowed

7.24 Standard ward code

Reporting of standard ward codes were initially required in order to identify patients admitted or transferred to ward assigned to a designated SNAP unit in public facilities and designated rehabilitation and palliative units in private facilities. See Appendix K for a list of facilities that have designated SNAP or rehabilitation units.

Public facilities are now required to record additional standard ward codes and are to ' use the HBCIS Ward/Bed Categories Screen and associated standard ward code reference files. Standard ward codes are assigned and maintained at the ward level.

The majority of standard ward codes have been developed to align with the existing Clinical Services Capability Framework (CSCF) and public hospitals should refer to their completed CSCF self-assessment documentation when assigning these standard ward codes.

From 1 July 2012, public facilities record additional standard ward code information to identify any high level service capability (using the latest CSCF categories as prescribed in version 3) eg: intensive care unit - level 4.

It should also be noted that from 1 July 2012 public facilities can assign wards or beds that have been assessed and approved by the Stroke Clinical Network as designated stroke units.

A standard ward code of STKU has been added to the HBCIS standard ward code reference file to assist in identifying certain defined patients admitted or transferred to a ward or bed assigned to an assessed and appropriately approved stroke unit. The Stroke Clinical Network has agreed to take responsibility for assessing units that wish to utilise this code in order to ensure compliance with the stroke unit definition.

Record the following ward/bed category codes to indicate the Standard Ward Code:

HBCIS		
Code	**Description**	**Explanation**
CCU4	Coronary Care Unit – Level 4	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously CCU Level 1 in the CSCF version 2.
CCU5	Coronary Care Unit – Level 5	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously CCU Level 2 in the CSCF version 2.
CCU6	Coronary Care Unit – Level 6	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously CCU Level 3 in the CSCF version 2.
CHEM	Chemotherapy	Used for reporting of a discrete area assigned for chemotherapy treatment.
CIC6	Children's Intensive Care Service – Level 6	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously Paediatric Intensive Care Unit (PICU) in the CSCF version 2.
DIAL	Renal Dialysis	Used for reporting of a discrete area assigned for renal dialysis treatment.
EMER	Emergency	Emergency Department (excluding Observation Ward)
HOME	Hospital in the Home	Credentialed services funded and/or provided to admitted patients in their home environment.
ICU4	Intensive Care Unit – Level 4	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously ICU Level 1 in the CSCF version 2.
ICU5	Intensive Care Unit – Level 5	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously ICU Level 2 in the CSCF version 2.
ICU6	Intensive Care Unit – Level 6	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously ICU Level 3 in the CSCF version 2.
MATY	Maternity	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.
MENA	Specialised Mental Health Acute Psychiatric	A ward that has been assigned to a Specialised Mental Health Psychiatric Unit for the provision of acute psychiatric care.
MENN	Specialised Mental Health Non-Acute Psychiatric	A ward that has been assigned to a Specialised Mental Health Psychiatric Unit for the provision of non-acute psychiatric care.
MIXC	Mixed Wards – Critical Care	Hospitals that have wards with mixed critical care specialisation/s should use a standard ward code of MIXC. This will highlight that the ward has a Critical Service capability of a mixed nature.
MIXG	Mixed Wards – Non-Critical Care Service Types	Hospitals that have wards with mixed specialisation/s of a non-critical care nature should use a standard ward code of MIXG. Examples: maternity/gynaecology ward, chemotherapy/surgical, medical/general acute. General Wards that do not have any specialisation should be assigned to a 'NORM' Standard Ward Code.
NORM	General Wards	General Wards that do not have any specialisation – for HBCIS use only.

NSV4	Neonatal Service – Level 4	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously Neonatal Service Level 2 (SCN) in the CSCF version 2.
NSV5	Neonatal Service – Level 5	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously Neonatal Service Level 2 (SCN) in the CSCF version 2.
NSV6	Neonatal Service – Level 6	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3. This service capability level was previously Neonatal Service Level 3 (NICU) in the CSCF version 2.
OBSV	Observation	A designated observation ward within an Emergency Department as defined by the ED Clinical Networks.
PAED	Paediatric	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.
SNAP	Sub and Non-Acute Patient	A ward that has been assigned to a designated SNAP Unit.
STKU	Stroke Unit	A designated Stroke Unit which has been assessed and approved by the Stroke Clinical Network.

Record the following code to indicate the appropriate Standard Ward Code (where applicable):

Other Hospitals	
Code	**Explanation**
SNAP	A ward that has been assigned to a designated SNAP Unit.

7.25 Contract role

A contract patient receives care that is provided under an agreement between a purchaser of services and a provider of services. For the purposes of this data item, the purchaser of services will be a public or private hospital or a private day facility (contracting hospital), and the provider of services will be a public or private hospital or a private day facility (contracted hospital). Admitted or non-admitted services can be provided.

The contract role data item identifies whether your hospital is the purchaser of the services being provided for the episode of care (contracting hospital) or the provider of the services being provided (contracted hospital).

Refer to Section 4.7 Contracted Hospital Care for further information on recording contracted hospital care.

All Hospitals

Record the following codes to indicate your hospital's role**;**

Code	Description
A	Hospital A (contracting hospital)
B	Hospital B (contracted hospital)

7.26 Contract type

A contract patient receives care that is provided under an agreement between a purchaser of services and a provider of services. For the purposes of this data item, the purchaser of services can be a public or private hospital (contracting hospital) or a jurisdiction, hospital and health service or other external

purchaser, and the provider of services can be a public or private hospital or a private day facility (contracted hospital). Admitted or non-admitted services can be provided.

There are five contract types. In each case, the contracting hospital is termed Hospital A, and the contracted hospital is termed Hospital B.

Refer to Section 4.7 Contracted Hospital Care for further information on recording contracted hospital care.

All Hospitals

Record the following codes to indicate the contract type under which the patient is being treated

Code	Description
1	B
2	ABA
3	AB
4	(A)B
5	BA

7.27 Purchaser/Provider identifier

Type 1 contracts

Record the identifier of the purchaser of the public contracted services where the contract type is 1 and the contract role is 'B'. Appendix A contains a list of valid purchaser identifiers.

Type 2, 3, 4 or 5 contracts

The hospital identifier should be recorded for the other hospital involved in the contract. The other hospital identifier is required where contract type is 2, 3, 4, or 5 and the contract role is 'A' or 'B'.

Refer to Section 4.7 Contracted Hospital Care for further information on recording the other hospital involved in the contract.

7.28 Baby admission weight

Record the admission weight (grams) of neonates who are under 29 days or weigh less than 2500 grams at the time of admission. The admission weight is defined as the weight of the neonate on the day admitted, unless this is the day of birth, in which case the admission weight is taken as the birth weight.

In circumstances where babies have not been weighed a 'dummy' weight is currently being used by some hospitals. In order to standardise this procedure and to allow for the identification of 'dummy' weights, hospitals should enter the weight as 9000, in these cases.

Hospitals should note that this practice will produce an Error on the Validation Report (H148 - Baby is XXXX grams. This is much heavier than most babies under 1 month. Please check birth date and admission weight). The hospital can no longer provide a 'dummy weight of 9000 without providing a valid reason as to why the baby was not weighed.

7.29 Separation date

At separation, record the full date (that is, ddmmyyyy), using leading zeros where necessary.

Example

For a patient who was discharged on 24 July 2014, record

2	4	0	7	2	0	1	4

7.30 Separation time

Use the 24-hour clock to record the time of separation. Times are between 0000 (midnight) and 2359. Note that midnight is the start of a new day, not the end of the previous one.

HBCIS hospitals: currently HBCIS will not accept 0000 as midnight. A system parameter setting at each site dictates if 24:00 can be a valid entry. If an actual event occurs at midnight and the parameter is set to 'Y' then record 24:00. If an actual event occurs at midnight and the parameter is set to 'N' record 23:59.

Example

For a patient discharged at 9:10 a.m., record

0	9	1	0

For a patient died at 6:05 p.m., record

1	8	0	5

If the patient's time of separation is unknown, estimate the separation time. It must not be before the time of admission or during a time when the patient is on leave.

7.31 Mode of separation (discharge status)

The mode of separation (discharge status) indicates the place to which a patient is referred immediately following formal separation from hospital, or indicates whether this is a statistical separation due to a change in the type of episode of care.

HBCIS Hospitals

HBCIS		Extracted/mapped by HQI as:	
Code	**Description**	**Code**	**Description**
01	Home/usual residence	01	Home/usual residence
16	Hospital Transfer	16	Transferred to another hospital
15	Residential Aged Care Service	15	Residential Aged Care Service
04	Other health care accommodation	04	Other health care accommodation
05	Died in hospital	05	Died in hospital
06	Care Type change	06	Care type change
07	Discharged at own risk	07	Discharged at own risk
09	Non-return from leave	09	Non-return from leave
12	Correctional facility	12	Correctional facility
17	Medi-Hotel	17	Medi-Hotel
19	Other	19	Other
13	Organ Procurement (Not available on HBCIS at this stage)		
14	Boarder	14	Boarder

Other Hospitals

Record the mode of separation using one of the following numerical codes:

Code	Description
01	Home/usual residence
16	Transferred to another hospital
15	Residential Aged Care Service
04	Other health care accommodation
05	Died in hospital
06	Care type change
07	Discharged at own risk
09	Non-return from leave
12	Correctional facility
17	Medi-Hotel
19	Other
13	Organ Procurement
14	Boarder

Use guidelines listed in the below table to determine the correct mode of separation

Code	Description	Explanation
01	Home/usual residence	Used for those patients who return to their usual residence following the current hospital stay. If the patient is usually a resident of a boarding house, commercial hostel, aged care service, independent living unit or other institution, use this category. However, if the patient is being transferred from the hospital to a residential aged care service for the first time, do not use this category; use 15 Residential Aged Care Service.
16	Hospital Transfer	Used for patients who are transferred to another hospital for continuation of their admitted care and management. The second hospital undertakes full responsibility for the patient. Note that this code may be used for patients transferred to hospitals which are interstate or overseas.
15	Residential Aged Care Service	Used for patients who are discharged to a residential aged care service for the first time (i.e. the residential aged care service is not where they lived prior to their admission to hospital). A residential aged care service includes former public and private nursing homes and hostels – but not independent living units (refer to '01 Home/usual residence' for patients being returned to a residential aged care service).
05	Died in hospital	Used when the patient died during his/her hospitalisation.
06	Care Type change	Used for statistical separations where the patient is to continue the hospital stay, but is now changing the type of episode of care (e.g. Acute to Maintenance). Do not use this code for registered boarders changing status to become an admitted patient. For public hospitals using I&D Sheets to 'batch' information to a central hospital for data entry into HBCIS, and for private hospitals using I&D sheets, a new I&D Sheet will need to be completed for the patient with a source of referral/transfer code of '06 – Episode Change' and the new care type.
07	Discharged at own risk	Used for patients who abscond or leave hospital against medical advice.
09	Non-return from leave	Used when a patient goes on leave and does not return to the hospital within seven days. Note that the patient is to be discharged from the date that he/she left the hospital.
12	Correctional facility	Patient separated to a correctional facility.
17	Medi-hotel	Accommodation arranged and paid for by the facility that is used for accommodating patients post discharge where the patient is: awaiting transport; receiving on-going treatment/investigation as a non-admitted patient (includes minimal (low) care nursing) or receiving a course of treatment (such as chemotherapy) and requires accommodation close to the hospital between treatments.
04	Other health care accommodation	Used for patients who are transferred to alcohol and drug centres or other health care establishments.

19	Other	Used for patients who are separated under circumstances that do not fit any other category. It is expected this code will be rarely used.
13	Organ Procurement (not on HBCIS)	Used to denote the cessation of an organ procurement registration.
14	Boarder	Used to denote the completion of a boarder registration.

Particular care should be taken when entering mode of separation codes for patients being transferred to another facility. Incorrect code application may affect Queensland Health's ability to obtain funding for services provided to compensable, entitled veterans, and/or defence force personnel in relation to Queensland Ambulance Service (QAS) inter-facility transfers.

7.32 Transferring to facility

Record the facility number (extended source code) for the hospital, residential aged care service, or correctional facility to which the patient is transferred or referred as an admitted patient. This item is mandatory if the mode of separation (discharge status) is:

- Hospital Transfer (16)
- Correctional facility (12)
- Residential Aged Care Service (15)

HBCIS Hospitals	Record the extended source code of the hospital, residential aged care service, or correctional facility to which the patient is being transferred for admission.

Other Hospitals	Record the facility number of the hospital, residential aged care service, or correctional facility to which the patient is being transferred for admission.

Appendix A contains a list of facilities and their facility numbers including the facility number to be used when a patient is transferred or referred.

7.33 Separation number

This information is not reported to the Health Statistics Unit for QHAPDC; it is for hospital use only.

HBCIS Hospitals	Not recorded.

Other Hospitals	Record the separation number as recorded in the discharge register

7.34 Hospital insurance status

This data item is used to record whether patients have hospital level health insurance, irrespective of their chargeable status for this admission. That is, they may not elect to be admitted as private patients on this occasion, but the fact that they have hospital insurance should be recorded.

For example:

- A patient may have hospital insurance, but elects to be admitted as a public patient on this occasion.
- An uninsured patient may elect to be treated privately on this occasion, and meet the hospital and clinician charges himself/herself.

	Record the insurance status of the patient using these codes			
HBCIS Hospitals	**Code**	**Description**	**Definition**	Extracted and mapped by HQI as
	Y	Hospital insurance	Used when the patient has health insurance that covers accommodation charges	7 Hospital insurance
	N	No hospital insurance	Private health insurance	8 No hospital insurance
	U	Not stated/ unknown -	Used when the patient is unable to identify level of insurance held.	9 Not stated/ unknown -

	Record the insurance status of the patient using one of the codes below		
Other Hospitals	**Code**	**Description**	**Definition**
	7	Hospital insurance	Used when the patient has health insurance that covers accommodation charges
	8	No hospital insurance	Private health insurance
	9	Not stated/ unknown	Used when the patient is unable to identify level of insurance held. (e.g. an unconscious patient is unable to provide the information).

7.35 Health fund (HBCIS hospitals)

At the time of admission to a facility, it is important to correctly identify and capture a patient's 'Hospital Insurance - Status' (Y/N) and where applicable their associated 'Hospital Insurance - Health Fund' information'. A dedicated field for the capture of a patient's 'Hospital Insurance - Health Fund' information' currently exists in HBCIS.

It should be noted that the 'Hospital Insurance - Health Fund' information should only be provided where a patient has hospital level insurance with their health fund.

Capture of 'Hospital Insurance - Health Fund' information is done by selecting the relevant code from corporate standardised list of health insurance fund

codes in HBCIS (where the patient is currently insured for their hospital accommodation as a private patient).

If the Health Fund code is supplied, then the Health Fund Cover corporate set of codes must be reviewed to select the correct identifier for the patients Hospital Insurance.

The entered Health Fund codes are validated against the data item Hospital Insurance (Y/N/U). Depending on the selection from the “Health Fund Cover” code set the Hospital Insurance will be validated against the Y, N or U as follows:

- If a Health Fund code is supplied, the patient has valid Hospital Insurance – Hospital Insurance and/or Hospital Insurance plus Extras – Status must be ‘Y’.
- If no Health Fund is supplied, the patient does not have Hospital Insurance – Hospital Insurance – Status must be ‘N’.
- If a Health Fund code is supplied, the patient has Hospital Insurance, but has Exclusions or Extras Only – Status must be ‘N’.
- If a Health Fund code is supplied, the patient has valid Hospital Insurance, but is on a waiting period – Status must be ‘U’. Where ‘U’ is identified, the waiting period will need to be checked.

Historically health funds over time have merged with other funds, changed their trading name/s, become subsidiaries of larger funds or ceased to exist.

To ensure that the corporate standardised list of health insurance fund codes in HBCIS is current, the Statewide Own Source Revenue Unit are maintaining an updated list of fund mergers, acquisitions, cessations and change of trading names for quarterly HBCIS uploads.

The list of private health funds contained in Appendix P are revised annually by the Statewide Own Source Revenue Unit.

7.36 Funding source

The Funding Source is the expected principal source of funding for accommodation charges for the episode. The major funding source should be recorded if there is more than one source of funding, (e.g. Nursing Home Type Patients).

If there is an expected funding source followed by a finalised active funding source (for example, in relation to compensation claims), then the actual funding source known by the end of the reporting period should be recorded.

All Hospitals	Record the following codes to indicate the principal source of funds for the episode	
	Code	**Description**
	01	Health service budget (not covered elsewhere)
	02	Private health insurance
	03	Self-funded
	04	Worker's compensation
	05	Motor vehicle third party personal claim
	06	Other compensation (incl: Public liability, common law and medical negligence)
	07	Department of Veterans' Affairs
	08	Department of Defence
	10	Other hospital or public authority (contracted care)
	11	Health service budget (due to eligibility for Reciprocal Health Care
	12	Other funding source
	13	Health service budget (no charge raised due to hospital decision)
	99	Not known

- Medicare eligible patients who elect to be treated as public patients should have a funding source of '01' – Health Service Budget (not covered elsewhere) (Public patients – not contracted or not covered by reciprocal health care agreements),
- Organ Procurement registrations should have a funding source of '12' – Other.
- Patients receiving an admitted contracted service should have a funding source of '10' – 'Other hospital or public authority (contracted service)' recorded by the contracted hospital (hospital B) – see Section 4.7.
- Self-funded includes episodes funded by the patient, by the patient's family or friends, or by other benefactors.
- HBCIS only: Correctional Facility (09) should not be used for prisoners at this stage. All prisoners should be recorded as (01) Health Service Budget (not covered elsewhere).
- Department of Veterans' Affairs should be used when Department of Veterans' Affairs patients have made an election to use their entitlements under their Repatriation Health Card (Gold or White). See Section 13.
- Compensable patients should be recorded as Workers' Compensation, Motor Vehicle or Third Party personal claim as appropriate.
- Overseas visitors for whom travel insurance is the major funding source should be recorded as 'Other'.
- Overseas visitors who are covered by a reciprocal health care agreement and elect to be treated as a public patient should be recorded as 'Reciprocal Health Care Agreements (other countries)'.
- Overseas visitors who are covered by a reciprocal health care agreement and elect to be treated as a private patient are not eligible to be funded under the reciprocal health care agreement. The applicable funding source should be recorded.
- Boarders should be recorded as 'Other'.

- Unqualified newborns (unqualified status for the entire episode of care) should be assigned the same funding source as the mother. However, the Medicare eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother. For example, if the mother is an ineligible person, but the father is eligible for Medicare, then the newborn will be eligible for Medicare.
- In Queensland public hospitals, admitted patients who are Medicare ineligible and have obtained asylum seeker status, follow the process as documented in the Financial Management Practices Manual (FMPM).
- For private hospitals, the Health Service Budget (no charge raised due to hospital decision) category should also include patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are for medical services bulk-billed to Medicare) and patients for whom a charge is raised but is subsequently waived.

7.37 Consent to release patient details (HBCIS hospitals)

From time to time Queensland Health may need to release patient details to certain funding agencies to ensure that, where appropriate, the patient's treatment is funded by these agencies. Current legislation does not permit Queensland Health to release a patient's details without the patient's specific consent to release the details for a specific purpose.

The consent to release patient details data items indicate whether or not the patient consents to the release of personal, admission, and health details to the funding agencies listed on the Patient Election Form (PEF). This does not include any documents in the patient's medical record or copies of any documents in the patient's medical record.

The status of each of the consent data items will apply to all episodes of care within a particular hospital stay, unless otherwise indicated by the patient. If a patient wishes to change the status of any or all of their consents, a new Patient Election Form is required.

The funding agencies to which details could be released are:

- Department of Veterans Affairs (DVA)
- Queensland workers' compensation insurers including WorkCover Queensland and Queensland self-insurers
- Department of Defence
- Motor Accident Insurance Commission (MAIC)

The personal details that could be released include:

- Name
- Address
- Date of Birth/Age

The admission details that could be released include:

- Admission date
- Discharge Date
- Episode Type
- Account Class
- Incident Date

The health details that could be released include:

- Diagnosis Related Group (DRG)
- Nature of Injury

When a patient presents for admission to a public hospital, they can elect to be treated as a public or private patient. They make their election by completing and signing the appropriate section of the PEF. At the time of making this election, they should also indicate whether or not they consent to the release of their personal, admission, and health details to the funding agencies listed on the PEF.

In some instances the patient will be unable to complete a PEF (e.g. they are unconscious or in a critical condition on arrival). If the patient is unable to complete a PEF upon admission, please follow your facility's procedure for collecting information after admission.

If the patient's details are recorded as 'Unknown' on the patient registration screen, you may code 'Unable to obtain' against each of the consent data items. However, 'Unable to obtain' is not a default setting, and is not to be used for any reason other than the person cannot physically or legally provide their consent.

HBCIS Hospitals	Record the following codes to indicate whether or not the patient consents to the release of details to Workers' Compensation Queensland (recorded as Q COMP), Motor Accident Insurance Commission (MAIC), Department of Veterans' Affairs (DVA) and Department of Defence (DD).	
	Code	**Description**
	Y	Yes
	N	No
	U	Unable to obtain

7.38 Preferred language (public hospitals)

One of the aims of the Queensland Government Multicultural Action Plan is to improve the data collection and analysis of Multicultural data items to better inform service planning and evaluation. Two additional items, 'Preferred Language' and 'Interpreter Required' were included for reporting by public hospitals from 1 July 2007.

From 1 July 2011 a new classification was introduced for the recording of Preferred Language. The new language classification is a modified version of the Australian Bureau of Statistics Australian Standard Classification of

Languages (ASCL), Second Edition (ABS Cat. No. 1267.0) and allows the use of synonyms and sub-languages which map to a core language category (e.g. Sardinian to Italian). This enhancement greatly improves how preferred language is recorded and facilitates better supply of interpreter services in public health care facilities. Any queries or requests to add a language should be directed to Queensland Health Multicultural Services.

The question that should be asked is “What is your preferred language for communicating when receiving health care services?”

Record the language (including sign language) most preferred by the person for communication. This may be a language other than English even where the person can speak fluent English.

HBCIS Hospitals	Record the preferred language of the patient.

See Appendix G for the list of HBCIS Language codes.

7.39 Interpreter required (public hospitals)

One of the aims of the Queensland Health Strategic Plan for Multicultural Health is to improve the data collection and analysis of Multicultural data items to better inform service planning and evaluation. Two additional items, ‘Preferred Language’ and ‘Interpreter Required’ were included for reporting by public hospitals from 1 July 2007.

The question that should be asked is “Do you require an interpreter?”

If a patient answers “No” as their family or friend will interpret for them, health staff (administrative staff) must inform the patient that this practice is against the Queensland Health Language Services Policy which states that family and friends should only be used for interpreting emergency cases, when a qualified interpreter or a bilingual health worker is not available.

If a patient answers “No” and the health staff member asking the question is concerned about the patient’s ability to communicate, the staff member should explain that to assist health professionals (health clinicians) to communicate health information effectively, they must be sure that this information is understood. Health staff should say “It may be easier to understand health information in the language in which you are the most comfortable” (i.e. their preferred language). The patient should also be informed that interpreter services are provided at no cost to patients

The health staff member should then ask the patient “I would like to organise an interpreter to help us communicate. Do you agree?”

If the patient agrees the data item “Need for an interpreter” should be changed to “Yes”.

In some instances a patient may indicate that they do not need an interpreter but the health professional (health clinician) trying to conduct an assessment is concerned about the patient’s ability to communicate in English. In this situation, the health professional should not assume that information has been

conveyed to the patient on the *Queensland Government Languages Services Policy 2011* regarding their right to an interpreter.

The health professional should state that they are concerned that they are not effectively communicating and that they are not sure that they understand what the patient is saying. The health professional should state to the patient that "Under the Queensland Government Languages Services Policy I am required to ensure that we are able to understand what we are each saying as some of the information we discuss may be complex (due to specific health vocabulary in English) and affects your health care. I would like to organise an interpreter to help us communicate. Do you agree?"

If the patient continues to disagree, the health professional should find out whether there are any specific reasons why the patient does not wish to have an interpreter. The health professional should explain that interpreters are bound by the professional Code of Conduct which includes confidentiality of patient information. If the patient is concerned about this, or the sensitive nature of the appointment (this can be an issue for smaller communities), the health professional can request that an interstate interpreter be booked via video conference or telephone. This should be noted in the patient's file.

The HBCIS option "Unknown" should be used rarely, for example in emergencies when staff is unable to ascertain whether an interpreter is needed (i.e. patient is unconscious).

If the patient agrees, the data item "Need for an interpreter" should be changed to "Yes".

If a patient refuses an interpreter after the explanations have been provided, staff must document the discussion and the reason for proceeding with the appointment without an interpreter in the patient's health record.

Record whether an interpreter service is required by or for the patient.

HBCIS Hospitals	HBCIS		Extracted and mapped by HQI as	
	Code	Description	Code	Description
	Y	Interpreter needed	1	1 Interpreter needed
	N	Interpreter not needed	2	2 Interpreter not needed
	U	Unknown	9	9 Unknown

7.40 Length of stay in intensive care unit

From 1 July 2013 the total number of hours and minutes a patient has spent in an intensive care unit is to be reported by hospitals that have either an approved level 6 adult intensive care unit (standard ward code ICU6) or an approved level 6 children's intensive care service (standard ward code CIC6) as listed in the Clinical Services Capability Framework (CSCF). In the CSCF a level 6 children's intensive care service is the only designated paediatric intensive care unit (PICU).

ADULT INTENSIVE CARE UNIT, LEVEL 6

The unit must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for patients in need of intensive care services and have extensive backup laboratory and clinical service facilities to support the tertiary referral role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period; or care of a similar nature.

CHILDREN'S INTENSIVE CARE SERVICE, LEVEL 6

The service must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care; and have extensive backup laboratory and clinical service facilities to support this tertiary role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period to infants and children less than 16 years of age; or care of a similar nature.

For the purposes of calculating the length of stay in an intensive care unit, begin the calculation with the following:

- Arrival of the patient in the intensive care unit.

End the calculation with one of the following:

- Discharge, death or transfer of a patient from the intensive care unit; or
- Change of episode type.

Where an episode of admitted patient care involves more than one period spent in an intensive care unit, the total number of hours is to be reported for all periods during the episode of care.

The time spent in an operating theatre or in a coronary care unit is not counted.

Where there is a contracted service episode, Hospital A will report the total duration spent in the intensive care unit of Hospital B in addition to any length of time spent in Hospital A. Hospital B will only report the total time spent in the intensive care unit in Hospital B.

HBCIS Hospitals	For Public Hospitals this will be reported as the total time in hours and minutes that the patient was admitted to a ward or bed assigned a standard ward/bed category of 'ICU6' or 'CIC6', plus any time spent in ICU on contract leave. The total hours are calculated automatically by HBCIS from the patient's ward/bed occupancy plus any time reported as Contracted ICU (i.e. data recorded in Field 05 'Contracted ICU' within the CONTRACTED CARE screen (screen ID: ADM2.S626)). The value will be reported as a numeric string in the format HHHHHMM (without the : separator). Both the hours and minutes will be right-justified with leading zeroes, e.g. 14 hours and 8 minutes will be reported as 0001408.

Other Hospitals	Record the time the patient has spent in an adult or children's intensive care unit.

7.41 Duration of continuous ventilatory support

From 1 July 2013 the total number of hours and minutes a patient has been on continuous ventilatory is to be reported.

7.41.1 What is continuous ventilatory support (CVS)?

- CVS or invasive ventilation refers to the application of ventilation via an invasive artificial airway, such as that provided via an endotracheal tube (ETT) or a tracheostomy tube. With CVS, the patient receives continuous variable degrees of assistance to meet respiratory requirements in an uninterrupted continuous fashion.
- The assignment of an ICD-10-AM procedure code identifies the mode of CVS and length of time for which CVS is provided.

7.41.2 Calculating the duration of continuous ventilatory support

- The rules for calculating the duration of CVS are as per Australian Coding Standard (ACS) 1006 Ventilatory Support, beginning with the initiation of ventilatory support, tracheostomy or admission of a ventilated patient; and ending with cessation of CVS, or separation.
- For Queensland facilities, the duration of CVS is the total time a patient has spent on continuous ventilatory support during a single episode of admitted patient care, expressed as hours and minutes[8].
- Separate periods of CVS should be added together.
- Weaning of CVS is included in the calculation of duration of CVS.

7.41.3 When to code and calculate continuous ventilatory support

- All CVS not initiated as part of a surgical procedure should be assigned a ventilatory support procedure code and have time calculated/reported - even where the CVS is for less than 60 minutes (excluding patient transfers – see below).
- CVS that is initiated during surgery and continues for > 24 hours post surgery should be assigned a ventilatory support procedure code and have time calculated/reported.

7.41.4 When not to code continuous ventilatory support

- Ventilatory support that is provided to a patient during surgery is associated with anaesthesia and is considered an integral part of the surgical procedure. The patient may remain on CVS for some hours while recovering following surgery. For those cases where ventilation is initiated during surgery and

[8] Queensland Health Data Dictionary, http://oascrasprod.co.health.qld.gov.au:7900/pls/qhik_prd/qhik_main_menu.entire_page, accessed 7 January 2013

continues for **≤ 24 hours post surgery**, the time should not be reported and a ventilatory support procedure code should not be assigned.

- CVS/intubation where the duration is for < 1 hour prior to the patient being transferred to another facility should not be assigned a ventilatory support procedure code or time reported.

For the purposes of calculating the duration of continuous ventilatory support, begin calculation with one of the following:

- Initiation of continuous ventilatory support. For example, for patients with endotracheal intubation and subsequent initiation of continuous ventilatory support, begin counting at the time of intubation. Patients with a tracheostomy, begin counting at the point when continuous ventilatory support is begun; or
- Admission of a ventilated patient. For those patients admitted with continuous ventilatory support, begin counting the duration at the time of the admission.

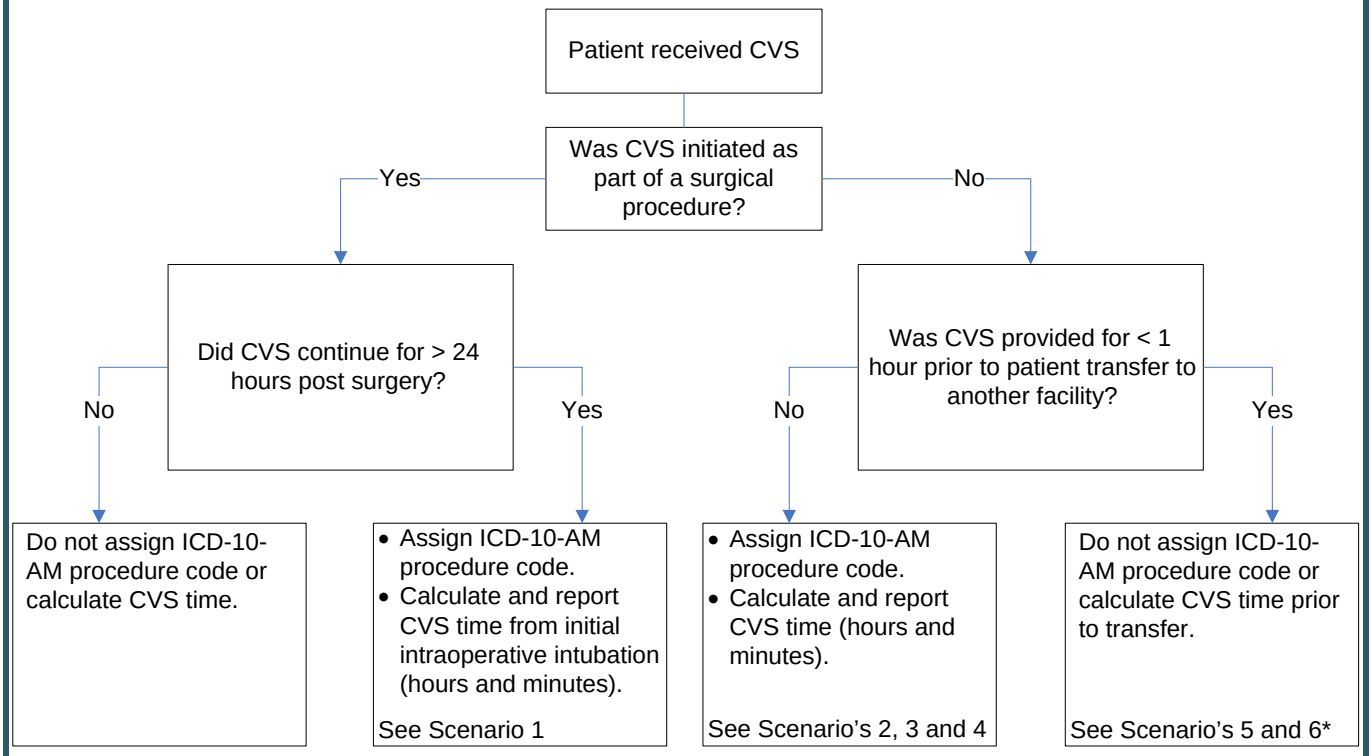
End the calculation with one of the following:

- Extubation (e.g. removal of endotracheal tube);
- Cessation of continuous ventilatory support after any period of weaning. For tracheostomy patients, the tracheal tube may not be withdrawn for days after discontinuation of continuous ventilatory support. Therefore, the duration would end with the cessation of continuous ventilatory support;
- Discharge, death of transfer of a patient on continuous ventilatory support; or
- Change of episode type.

Subsequent periods of continuous ventilatory support should be added together where it meets the ACS criteria. For example, if a patient is on continuous ventilatory support on the first day of their admission (not associated with a surgical procedure), then again on the fourth day of their admission (not associated with a surgical procedure), the hours should be added together.

If there is a period of less than 1 hour between cessation and then restarting of ventilatory support, continue counting the duration. If there is removal and immediate replacement of airway devices, continue counting the duration.

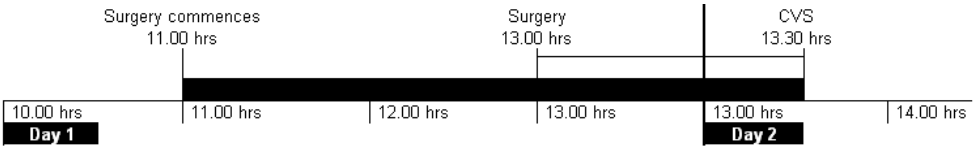
Figure 5 Continuous ventilatory support flow chart



*Note: Scenario 6 - Where the event meets the ACS *1006 Continuous Ventilatory Support* criteria for calculation and coding of CVS, assign the ICD-10-AM procedure code, and calculate and report the CVS time. If there is a further period of CVS that is provided for < 1 hour prior to transfer to another facility, do not include the pre-transfer CVS time in the ICD-10-AM procedure code duration or calculation and reporting of total CVS time (hours and minutes).

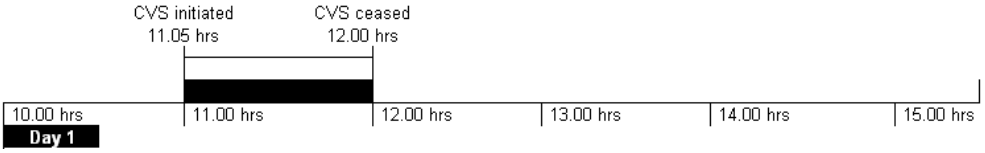
Scenario 1:

A patient is admitted for a surgical procedure. On the day of admission (Day 1), the patient is intubated and CVS commenced as part of the surgical procedure at 11.00 hrs. The surgical procedure is completed at 13.00 hrs and the patient is transferred to the Intensive Care Unit with CVS continuing. CVS continues overnight and the patient is extubated (CVS ceasing) at 13.30 hrs on Day 2. As the patient received ventilatory support for > 24 hours post operatively (Day 2: 13.30 hrs minus Day 1: 13.00 hrs = 24.30), the total CVS time (Day 2: 13.30 hrs minus Day 1: 11.00 hrs = 26.30) and associated ventilatory support procedure code (13882-01 *Management of continuous ventilatory support, > 24 and < 96 hours*) should be recorded and reported.



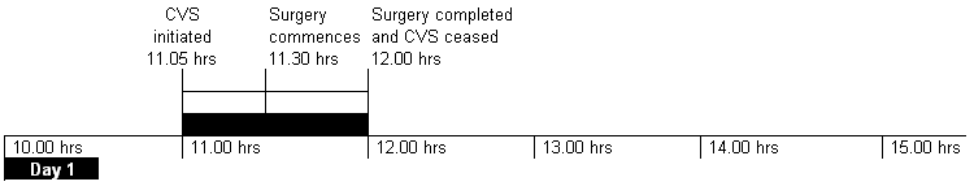
Scenario 2:

A patient is admitted at 10.00 hrs. At 11.05 hrs, the patient's condition suddenly deteriorates and continuous ventilatory support (CVS) is commenced. The patient's condition rapidly improves and the patient is extubated (CVS ceased) at 12.00 hrs. The total CVS time of 55 minutes (12.00 hrs minus 11.05 hrs) and associated ventilatory support procedure code (13882-00 *Management of continuous ventilatory support, ≤ 24 hours*) should be recorded and reported.



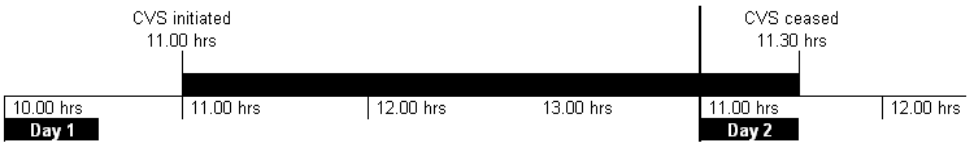
Scenario 3:

A patient is admitted at 10.00 hrs in a serious condition and requires urgent surgery. At 11.05 hrs, prior to going to surgery, the patient's condition suddenly deteriorates with intubation and ventilatory support required. While being provided ventilatory support, the patient is transferred to the operating theatre with a surgical procedure commencing at 11.30 hrs. The surgical procedure is completed at 12.00 hrs and the patient is extubated (CVS ceased). As ventilatory support commenced prior to the surgical procedure, the CVS time 55 minutes (12.00 hrs minus 11.05 hrs). and associated ventilatory support procedure code (13882-00 *Management of continuous ventilatory support, ≤ 24* hours) should be recorded and reported.



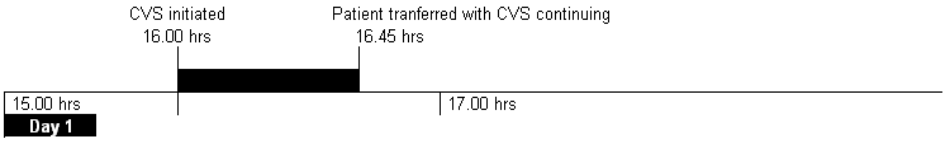
Scenario 4:

A patient is admitted at 10.00 hrs for an elective procedure. At 11.00 hrs on the day of admission (Day 1) prior to going to surgery, the patient's condition suddenly deteriorates and continuous ventilatory support (CVS) is initiated. On Day 2 at 11.30 hrs the patient is extubated (CVS ceased). The patient is discharged without having undergone the elective procedure. The total CVS time of 24 hours and 30 minutes (Day 2: 11.30 hrs minus Day 1: 11.00 hrs) and the associated ventilatory support code (*13882-00 Management of continuous ventilatory support, ≤ 24 hours*) should be recorded and reported.



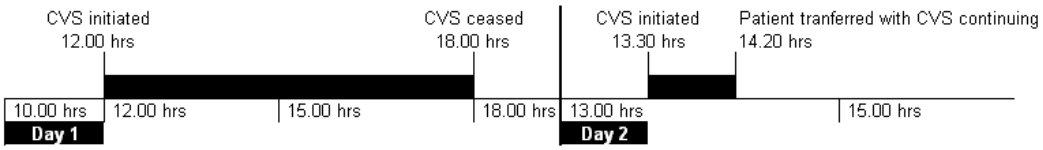
Scenario 5:

A patient is admitted at 15.00 hrs in a serious condition. At 16.00 hrs on the day of admission, the patient's condition suddenly deteriorates and continuous ventilatory support (CVS) is commenced. At 16.45 hrs the patient is transferred to a different facility with ongoing ventilatory support. Neither the CVS time nor a ventilatory support code is recorded or reported.



Scenario 6:

A patient is admitted at 10.00 hrs in a serious condition. At 12.00 hrs on the day of admission (Day 1), the patient's condition suddenly deteriorates and continuous ventilatory support (CVS) is commenced. At 18.00 hrs on the day of admission (Day 1), the patient is extubated (CVS ceased). At 13.30 hrs on Day 2, the patient required re-commencement of CVS and is transferred to another facility 50 minutes later whilst still on CVS. The total CVS time of 6 hours (Day 1: 18.00 hrs minus Day 1: 12.00 hrs = 6.00) and the associated ventilatory support code (*13882-00 Management of continuous ventilatory support, ≤ 24 hours*) should be recorded and reported. The CVS time prior to transfer is not counted or reported.



HBCIS Hosptials	For Public Hospitals CVS will be reported as the total time in hours and minutes that the patient spent on ventilatory support during the admission. As well as the associated ACHI procedure code The timevalue is recorded in the Admitted patient ICD Coding entry screen, Field 08. The time value will be reported as a numeric string in the format HHHHHMM (without the : separator). Both the hours and minutes will be right-justified with leading zeroes, e.g. 14 hours and 8 minutes will be reported as 0001408

7.42 Criteria led discharge type

From 1 January 2014 public hospitals have been required to record criteria led discharge type date. Staff using HBCIS will need to identify if the patient was separated using criteria let discharge and if so, what the discipline was of the clinician who initiated the separation of the patient.

	Record the discipline of the clinician who initiated the separation	
HBCIS Hosptials	**Code**	**Description**
	01	Not CLD – Authorised (Admitting) Practitioner
	02	Junior Doctor – CLD
	03	Nurse – CLD
	04	Midwife – CLD
	05	Nurse Practitioner
	06	Physiotherapist
	07	Occupational Therapist
	08	Social Worker – CLD
	09	Psychologist
	10	Speech Pathologist
	11	Dietitian – CLD
	12	Pharmacist – CLD
	99	Other - CLD

8. PATIENT ACTIVITY FOR HOSPITALS USING PAPER FORMS

This entire section refers to the action required by both public and private hospitals who submit data by completing paper forms. The forms required to be completed are;

- Identification and Diagnosis sheets and
- Patient Activity forms to submit data.

8.1 Identification & Diagnosis Sheets

For instruction on how to complete the data items contained on Identification & Diagnosis (I& D) sheet refer to chapter 4, 5, 6 and 7 of this manual.

8.2 Patient Activity Forms

The patient Activity Form is to be completed for each occasion of activity change including, when the patient accrues NHT days, or when additional diagnostic codes are to be recorded. Note that the Patient Activity Form is to be submitted to the Health Statistics Unit with the corresponding Identification and Diagnosis Sheet.

For HBCIS hospitals, activity changes are derived automatically when other key items are changed, that is, when alterations are made to account class and leave; ward/unit transfers; and contract leave.

Note that HBCIS will not accept 0000 as midnight. If an actual event occurs at midnight, use 2400. Where hospitals are using 2400 as a default, please use 2359.

8.3 Completion of Patient activity form

8.3.1 Patient identification data

Complete the following patient identification details on the Patient Activity Form by transcribing the same details from the Identification and Diagnosis Sheet for this admission.

Facility number
UR number
Admission number
Admission date
Admission time
Surname
Given name(s)
Sex
Date of birth

8.3.2 Additional diagnostic codes

The Identification and Diagnosis Sheet provides for the recording of diagnostic codes. If more codes need to be reported, complete the additional coding boxes on the patient activity form. If necessary, you may attach more than one patient activity form to allow recording of an unlimited number of diagnostic codes. Patient identification data must be completed for all forms used.

8.3.3 Ward/unit transfer

A ward/unit transfer is recorded every time the patient moves from one ward or unit to another for a different level of care, within the same hospital.

For example, a patient may initially be admitted to the Intensive Care Unit and later transferred to the general medical ward. This should be recorded on the Patient Activity Form.

A ward/unit transfer must be recorded for the date of transfer.

Record the code for the relevant field (ward, unit) together with the date and time of the transfer.

Ward

Record the code to indicate the specific ward to which the patient is transferred. Use the codes prepared by the hospital, as the Health Statistics Unit does not have a predetermined list of codes for hospitals. A maximum of six characters is allowed.

Unit

If the hospital maintains a system of units to describe clinical specialities or combinations of wards, record the hospital's code to indicate the unit to which the patient was transferred. A maximum of four characters is allowed. If submitting a change for unit, then a unit must have been recorded on admission.

Standard unit code

Record the standard unit code prepared by the Health Statistics Unit to describe the unit to which the patient was transferred. For HBCIS hospitals, this is mapped from the treating doctor units to align with the standard unit codes. For paper hospitals, this is mapped from the treating doctor on the basis of his/her specialisation.

Standard ward code

Public facilities with a designated SNAP unit and private facilities with a designated rehabilitation or palliative care unit are required to record a standard ward code of 'SNAP' if the patient has been admitted or transferred to a ward that has been assigned to a designated SNAP unit (public facilities) or a designated rehabilitation and palliative units (private facilities)). See Appendix K for a list of facilities that have designated SNAP, rehabilitation and palliative care units.

Since 1 July 2007 public facilities have been required to record additional standard ward codes via the HBCIS Ward/Bed Categories Screen and reference files. Standard ward codes can be assigned and maintained at an individual bed level or at the ward level. The additional standard ward codes have been developed to align with the existing service capability framework and hospitals should refer to their completed CSCF documentation when assigning the appropriate standard ward codes.

	Codes	Description
HBCIS Hosptials	CCU4	Coronary Care Unit – Level 4
	CCU5	Coronary Care Unit – Level 5
	CCU6	Coronary Care Unit – Level 6
	CHEM	Chemotherapy
	CIC6	Children's Intensive Care Service – Level 6
	DIAL	Renal Dialysis
	EMER	Emergency
	HOME	Hospital in the Home
	ICU4	Intensive Care Unit – Level 4
	ICU5	Intensive Care Unit – Level 5
	ICU6	Intensive Care Unit – Level 6
	MATY	Maternity
	MENA	Specialised Mental Health Acute Psychiatric
	MENN	Specialised Mental Health Non-Acute Psychiatric
	MIXC	Mixed Wards – Critical Care
	MIXG	Mixed Wards – Non-Critical Care Service Types
	NORM	General Wards
	NSV5	Neonatal Service – Level 5
	NSV6	Neonatal Service – Level 6
	OBSV	Observation
	PAED	Paediatric
	SNAP	Sub and Non-Acute Patient
	STKU	Stroke Unit

Date of transfer

Record the full date (that is, ddmmyyyy) on which the transfer occurred. Use leading zeros where necessary.

Example

For a patient who was transferred on 29 July 2014, record;

2	**9**	**0**	**7**	**2**	**0**	**1**	**4**

Time of transfer

Use the 24-hour clock to record the time of transfer. Times are between 0000 (midnight) and 2359. Note that 0000 (midnight) is the start of a new day.

HBCIS hospitals: currently HBCIS will not accept 0000 as midnight. If an actual event occurs at midnight, use 2400. Where hospitals are using 2400 as a default please use 2359.

Example

For a patient transferred at 6.10 p.m., record;

1	8	1	0

If the patient's time of transfer is unknown, estimate the time. It should not be before the date and time of admission or after the date and time of separation.

8.3.4 Out on leave

Leave occurs when the patient leaves the hospital between treatments in hospital for a period of not more than seven days, and intends to return for the hospital to continue the current course of treatment. No patient day charges are raised whilst the patient is on leave nor are the days on leave counted as patient days. See calculation of leave days in Section 4.10 Leave.

If a patient who goes on leave fails to return within the seven-day limit, a separation should be recorded on the relevant admission form, to take effect from the date the patient left the hospital to go on leave.

If the patient subsequently returns to the hospital, a new admission is to be recorded. Any leave details are to be deleted in this instance.

Hospitals may report 'leave' for boarders if administrative practices at the hospital require boarders who are temporarily away from the hospital to be put on leave.

If the number of leave episodes exceeds two, and cannot be recorded on the Patient Activity Form (as there is only space to record two leave episodes) use a second Patient Activity Form and complete patient identification data on all forms used.

Only report the leave to the Health Statistics Unit if the patient is absent at midnight.

Date of starting leave

Record the full date (that is, ddmmyyyy) on which the patient started leave. Use leading zeros where necessary.

Example

For a patient who started leave on 24 July 2014, record;

2	4	0	7	2	0	1	4

Date returned from leave

Record the full date (that is, ddmmyyyy) on which the patient returned from leave. Use leading zeros where necessary.

Example

For a patient who returned from leave on 29 July 2014, record;

2	9	0	7	2	0	1	4

8.3.5 Out on contract leave

Contract leave occurs when a patient is referred to another hospital for an admitted or non-admitted service under a contract agreement. It is intended that the patient return to the first hospital. Patients who do not return to the first hospital must have their contract leave cancelled and be formally discharged.

If no contract agreement exists between two facilities for the service/s required, the patient must either be:

- transferred to the second facility if they are to receive an admitted service; or
- placed on 'normal' leave if they are to receive a non-admitted service.

See Section 4.7.3 for further details on contracted hospital care and contract leave.

Date of starting contract service

Record the full date (that is, ddmmyyyy) on which the patient was transferred for contract service. Use leading zeros where necessary. Only to be used when the patient is to be returned to the contracting hospital after receiving contract care.

Example

For a patient who was transferred for contract service on 24 July 2014 record;

2	4	0	7	2	0	1	4

Facility number destination contracted to

Record the facility number for the hospital to which the patient is transferred for contract service. See Appendix A for list of facilities and facility numbers.

Date returned from contract leave

Record the full date (that is, ddmmyyyy) on which the patient returned from contract service. Use leading zeros where necessary. Used for contract type ABA. See Section 4.7.9 Types of Contracted Care..

Example

For a patient who returned from contract service on 24 July 2014 record;

2	4	0	7	2	0	1	4

8.3.6 Nursing home type patients

Nursing Home Flag

A Nursing Home type flag is recorded every time a patient is classified as a nursing home type patient (i.e. does not have an Acute Care Certificate completed). See 4.1 Acute Care Certificate, 4.14 Nursing Home Type Patients and 7.15 Care Type.

Date Commencement NHT Care (Start Date)

Record the full date (that is ddmmyyyy) on which the patient was classified as a Nursing Home Type patient.

Example

For a patient who was classified as a NHT patient on 20 July 2014, record;

2	0	0	7	2	0	1	4

Date Ceased NHT Care (End Date)

Record the full date (that is ddmmyyyy) on which the patient ceased being classified as a Nursing Home Type patient.

Example

For a patient who ceased being classified as a NHT patient on 23 August 2014, record;

2	3	0	8	2	0	1	4

8.3.7 Activity table changes

Chargeable status change

Record the new (amended) chargeable status of the patient using one of the following codes:

	Codes	Description
All Hospitals	1	Public
	2	Private shared
	3	Private single

Date of (chargeable status) change

Record the full date (that is, ddmmyyyy) on which the patient changed chargeable status. Use leading zeros where necessary.

Example

For a patient who changed chargeable status on 24 July 2014, record;

2	4	0	7	2	0	1	4

Compensable status change

Record the new (amended) compensable status of the patient using one of the following codes:

All Hospitals	Codes	Description
	1	Workers' Compensation Queensland
	2	Workers' Compensation (other)
	6	Motor Vehicle (Qld)
	7	Motor Vehicle (Other)
	3	Compensable Third Party
	4	Other Compensable
	5	Department of Veterans' Affairs
	9	Department of Defence
	8	None of the above

Note that compensable patients who are to be admitted for a same day band procedure are to be charged the compensable rate.

Definitions and examples

Refer to Section 7.8 Compensable Status and Section 4.6 for Compensable Status definition.

Date of (compensable status) change

Record the full date (that is, ddmmyyyy) on which the patient changed compensable status. Use leading zeros where necessary.

Example

For a patient who changed compensable status on 24 July 2014, record;

2	4	0	7	2	0	1	4

8.3.8 Qualification status changes

Record the new (amended) qualification status for the newborn using one of the qualification status codes.

Code	Description
A	Acute
U	Unqualified

Record the full date (that is, ddmmyyyy) on which the qualification status change occurred. Use leading zeros where necessary.

Example

For a newborn who had a change in qualification status on 24 July 2014, record;

2	4	0	7	2	0	1	4

All changes of qualification status must be provided. If more than one change of qualification status occurs on a single day, then the final qualification status for that day should be provided to the Health Statistics Unit.

For further information on newborns and Qualification Status refer to Sections 4.12 Newborns and 7.7 Qualification Status.

HBCIS Hospitals	The qualification status of newborn is derived from the account class code in HBCIS to submit a change in qualification status, a change in account class code needs to be submitted

8.3.9 Sub and Non Acute Care Type (SNAP)

From 1 July 2014 public hospitals will be required to report SNAP details for all l Sub and Non-Acute patients including scoring to be recorded for all age groups (including paediatric patients) and have SNAP episodes created regardless of whether they are in a designated SNAP Unit or not.

Private hospitals will be required to report SNAP data for all public Sub and Non-Acute patients (irrespective of whether the patient is being treated in a designated unit).

SNAP validations will be based on care type, not admission to a designated SNAP ward/bed.

Record the following information on the Patient Activity Form;

- SNAP episode no
- Start date
- End date
- SNAP type
- ADL type
- ADL subtype
- Score
- Phase Type
- ADL date
- Multidisciplinary care plan flag
- Multidisciplinary care plan date
- Proposed principal referral service
- Primary impairment type

For further information refer to section 12 SNAP

9. MORBIDITY DETAILS

Morbidity details include the recording of codes for diagnoses (disease); signs and symptoms; abnormal findings; social circumstances; external causes of injury or disease; morphology and; procedural information in relation to a patient's episode of admitted care (including hospital in the home). Morbidity details are collected using codes from the *International Statistical Classification of Disease and Related Health Problems, 10th Revision, Australian Modification* (ICD-10-AM), Eighth Edition, and the *Australian Classification of Health Interventions* (ACHI), Eighth Edition.

The ICD-10-AM and ACHI system enables the translation of diagnoses and procedures and other health problems from words in the primary clinical record into an alphanumeric code. All diagnoses (conditions), procedures and other health problems should be coded as per the Australian Coding Standards (ACS).

The National Centre for Classification in Health (NCCH) is leading the Australian Consortium for Classification Development (ACCD), in collaboration with the University of Western Sydney and KPMG, in the ongoing development of the AR-DRG Classification System (which includes ICD-10-AM/ACHI/ACS and AR-DRGs).

AR-DRGs are a patient classification system that provides a clinically meaningful way of relating the types of patients treated in a hospital to the resources required by the hospital. A DRG grouper is specially designed computer software that assigns patient episodes of care (via ICD-10-AM, ACHI and other statistical collection items) to DRGs, according to the DRG classification. It should be noted that whilst unlimited number of ICD-10-AM and ACHI codes can be recorded for an episode of care, only a defined number of codes (99) are passed into the grouper. The sequence of codes specified by the hospital will be retained by the HSU. Note that punctuation marks (such as: . , - or /) can be used in the recording but should NOT be used in reporting the ICD-10-AM. The only non-numeric characters that are to be used when recording diagnosis details are A to Z.

A Contract Flag is used by the purchasing hospitals to indicate a procedure performed by a contracted hospital or health care providers (non-hospital) It also indicates whether the procedure was performed as an admitted or non-admitted service. See Section 9.17 Contract Flag for more information regarding contract flags.

For specific queries relating clinical classification coding using ICD-10-AM/ACHI, contact the Statistical Standards and Strategy Unit (SSU), Health Statistics Unit (HSU), GPO Box 48, BRISBANE 4001 or via e-mail at DQSTD@health.qld.gov.au.

9.1 ICD-10-AM code identifier

The Code Identifier indicates whether an ICD-10-AM/ACHI code if for a principal or other diagnosis, procedure, external cause or morphology.

HBCIS Hospitals

Code	Description	*Extracted and mapped by HQI as*
P	Primary	PD
A	Associated	OD
C	Complication	OD
U	Unknown/Uncertain	OD
PR	Procedure	PR

Other Hospitals

Each morbidity code is to be prefixed by an ICD-10-AM code identifier. The codes should be left adjusted and followed by trailing blanks.

Record the ICD-10-AM code identifier using the following codes:

Code	Description
PD	Principal Diagnosis
OD	Other Diagnoses
EX	External Cause
M	Morphology
PR	Procedure

9.2 Principal diagnosis

The Principal Diagnosis (PD) is defined as “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 healthcare establishment, as represented by a code”. (METeOR data element identifier 514273). Please refer to ACS 0001 Principal Diagnosis for further information.

The phrase "after study" is the evaluation of findings to establish the condition that was chiefly responsible for occasioning the episode of care.

Findings evaluated may include information gained from the history of illness, any mental status evaluations, specialist consultations, physical examination, diagnostic tests or procedures, any surgical procedures, and any pathological or radiological examination. The condition established after study may or may not confirm the provisional diagnosis.

The principal diagnosis is to be coded using the current edition of ICD-10-AM.

Only one condition may be nominated as the principal diagnosis. If there are multiple diagnoses, any of which meet the criteria for principal diagnosis, please refer to ACS 0001 Principal Diagnosis, regarding two or more conditions equally meeting the definition for principal diagnosis.

Note that external cause, morphology and procedure codes must not to be used as a principal diagnosis.

9.3 Additional (other) diagnoses (sequelae and complications)

Additional or other diagnoses are to be coded using the current edition of ICD-10-AM.

Additional diagnoses are often described as co-morbidities and/or complications. A co-morbid condition is “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.” (METeOR data element identifier 514271).

For coding purposes, co-morbid conditions or complications should be interpreted as additional diagnoses where they fulfil the requirements of ACS 0002 Additional Diagnoses or other specialty coding standards.

Those public hospitals that are piloting the two data elements, the Most Resource Intensive Condition (MRIC) Indicator and the Non Australian Coding Standard Compliant (NACSC) Indicator, please refer to 9.14 Other co-morbidity of interest (OCOI) indicator (HBCIS Hospitals) for other information pertaining to co-morbid conditions.

Hospitals are to code any diagnoses that were determined at another hospital through contracted exploratory/diagnostic procedures. Diagnosis codes should only be flagged as contract where there is no valid procedure code available for the contracted service or where the code is used is to indicate that a contracted service was not carried out. Please refer to Section 9.17 Contract Flag for further information.

9.4 Morphology

For each neoplasm code, there should be a corresponding morphology code (M code). The M codes used in ICD-10-AM Eight Edition are from The International Classification of Diseases for Oncology (ICD-O) Third Edition. Each morphology code consists of 5 digits; the first four identify the histology of the neoplasm and the fifth, following a slash or solidus, indicates its behaviour.

The Morphology code (including the behaviour) must be appropriate to the histological type of the neoplasm as displayed in the table below. For example a primary neoplasm of the breast (ICD-10-AM code C50.9) should have an associated morphology code ending with a /3 behaviour character. Please refer to ICD-10-AM Volume 1, Appendix A: *Morphology of neoplasms* for additional information.

Morphology Behaviour Code	Morphology Behaviour Description	ICD-10-AM neoplasm code
/0	Benign neoplasms	D10–D36
/1	Neoplasms of uncertain and unknown behaviour	D37–D48
/2	In situ neoplasms	D00–D09
/3	Malignant neoplasms, stated or presumed to be primary	C00–C76 , C80–C96
/6	Malignant neoplasms, stated or presumed to be secondary	C77–C79
/9	Malignant, uncertain whether primary or metastatic site	

A morphology code must never be the principal diagnosis. A morphology code should always be assigned directly after the neoplasm(s) to which it relates.

For instances where a /6 Metastatic neoplasm morphology and neoplasm is recorded a /3 primary neoplasm site.

Where there are two (or more) different neoplasms with the same morphology code, the appropriate morphology code should be sequenced directly after the last neoplasm site code. However, if one of the neoplasm codes is in the PD position, the morphology code should be assigned twice, immediately following the PD, then again following the second neoplasm site code(s) in the OD position (refer example 3 below).

9.5 Morphology code sequencing

Example 1:
One Neoplasm with Two Histological Terms with different morphology codes.

Where there is one neoplasm with two histological terms with different morphology codes (e.g. Intraductal papillary adenocarcinoma M8503/3 and medullary carcinoma M8510/3 in a malignant neoplasm of the breast C50.2), code only the morphology code with the highest number.

Example 1 – Code String	
Code	**Description**
PD C50.2	Malignant neoplasm of breast upper inner quadrant of breast
M M8510/3	Medullary carcinoma

Example 2:
Two Separate Neoplasms with the Same Diagnosis Code but Different Morphology Codes.

The neoplasm diagnosis code should not be repeated when two different sites have the same diagnosis code (e.g. skin of cheek and skin of nose). All the related morphology codes should be reported, with the highest number sequenced first.

Example 2 – Code String	
Code	**Description**
PD C44.3	Malignant neoplasm of skin of other and unspecified parts of face
M M8090/3	Basal cell carcinoma NOS
M M8070/3	Squamous cell carcinoma NOS

Example 3:
Two (or more) neoplasms with different diagnosis codes with the same morphology code.

If there are two (or more) site codes with the same morphology and one of the site codes is the PD (e.g. adenocarcinoma of the main bronchus, the caecum and the breast), the appropriate morphology codes should be sequenced directly after the PD. The second site code (s) should then follow with the morphology, even if it is the same as the morphology related to the PD.

Example 3 – Code String	
Code	**Description**
PD C34.0	Malignant neoplasm of main bronchus
M M8140/3	Adenocarcinoma NOS
OD C18.0	Malignant neoplasm of caecum
OD C50.9	Malignant neoplasm of breast, unspecified
M M8140/3	Adenocarcinoma NOS

9.6 Procedure

Procedures are coded using the ICD-10-AM Australian Classification of Health Interventions (ACHI). Whilst there is no limit to the number of procedures that can be recorded for an admitted patient episode of care, there are only a defined number (49) of procedures that are passed into the grouper. It is possible to have duplicate codes in this section, for example, bilateral cataract extraction requires two codes to represent the bilateral aspect of the procedure. Please refer to ACS 0020 Bilateral/Multiple Procedures for further information.

All significant procedures undertaken from the time of admission to the time of separation should be coded as per the Australian Coding Standards. Significant procedures include diagnostic and therapeutic procedures. Also include any procedures that were performed under contract with another contracted hospital, HHS, health authority or private health provider (non-hospital) and use the contract flag to identify whether they were performed on an admitted or non-admitted basis. Procedures performed in the hospital emergency department, or elsewhere, that precede the admission time should not be coded in the admitted patient episode.

The definition of a significant procedure (METeOR data element identifier 514040) is a clinical intervention which is represented by a code that:

- is surgical in nature and/or;
- carries a procedural risk and/or;
- carries an anaesthetic risk and/or;
- requires specialist training, and/or
- requires special facilities or equipment or specialised training.

The sequencing of procedure codes should be determined using the following hierarchy:

- procedure performed for treatment of the principal diagnosis
- procedure performed for treatment of an additional diagnosis
- diagnostic / exploratory procedure related to the principal diagnosis
- diagnostic / exploratory procedure related to an additional diagnosis for the episode of care.

Please refer to ACS 0016 General Procedure Guidelines, ACS 0042 Procedures Normally Not Coded and ACS 0029 Coding of Contracted Procedures for further information.

9.7 External cause sequencing

The external cause describes the precipitating event or accident leading to an injury or poisoning. External causes are coded using the current edition of the ICD-10-AM. The external cause codes are listed in the range U50-Y98 and are generally represented by three groups of codes, External Cause (V00-Y89), Place of occurrence (Y92), and Activity (U50-U73).

Coding guidelines require that external cause codes(s) be linked to a particular diagnosis (except Y90-Y91 and Y95-Y98). An external cause code may be used in conjunction with any diagnosis code in ICD-10-AM but must be used with codes from S00-T98 and Z041-Z045 and for complications and abnormal reactions, which are classified outside the injury chapter (S00-T98).

The use of external cause permits the classification of environmental events and circumstances as the cause of injury, poisoning and other adverse effects. Where an external cause code is utilised, it is intended that it shall be used in addition to a code from another chapter of the Classification indicating the nature of the condition. Most often, the condition will be classifiable to Chapter 19, Injury, poisoning and certain other consequences of external causes (S00–T98). Other conditions that may be stated to be due to external causes are classified in Chapters 1 to 18.

Categories for sequelae of external causes of morbidity and mortality are included at Y85–Y89.

To allow for data linkage, The Department of Health requires that where a diagnosis requires an external cause code, that the data is recorded and reported in the following way:

- If the principal diagnosis requires an external cause code(s) the external cause code(s) should be sequenced directly after the principal diagnosis then followed by other diagnosis code(s).
- An external cause code(s) that relates to other (additional) diagnosis codes should be reported following the last of the other diagnosis codes that it relates to, even if that external cause code is the same as the one that relates to the principal diagnosis.
- Additionally, diagnosis codes requiring morphology codes are sequenced directly after diagnosis codes requiring external cause codes
- All other diagnosis codes that do not require an external cause code(s) or require a morphology code(s) should be sequenced after all codes that do require an external cause code(s) or require a morphology code(s).

Examples of how to sequence codes to enable the linkage to diagnoses are as follows:

Example 1:

External Cause Unrelated to Principal Diagnosis

Scenario: Patient presents to hospital with appendicitis. During the episode of care, the patient fell off a chair and bruised their hip.

Example 1 – Code String	
Code	**Description**
PD K37	Unspecified appendicitis
OD S70.0	Contusion of hip
EX W07.9	Fall involving unspecified chair
EX Y92.22	Health service area
EX U73.9	Unspecified activity
Procedure codes as required	

Note:

- EX W07.9, Y92.22, U73.9 relate to the OD S70.0.

Example 2:

Multiple injuries/poisoning with different external cause, Place of Occurrence and Activity Codes

Scenario: Patient presents to hospital with a subcapital fracture of the femur after a fall at home. The patient has a past history of CCF. Whilst in hospital, the patient fell out of bed whilst asleep and lacerated his elbow. On day 2, the clinician carried out a biopsy upon a lesion on the patient's face. The histology came back as an SCC. On day 3, the patient became breathless and it was diagnosed that he had a recurrence of his CCF. The patient did not improve and progressed to an acute anterior wall MI.

Example 2 – Code String	
Code	**Description**
PD S72.03	Fracture of subcapital section of femur
EX W19	Unspecified fall
EX Y92.09	Other and unspecified place in home
EX U73.9	Unspecified activity
OD S51.0	Open wound of elbow
EX W06.1	Fall involving special purpose bed
EX Y92.22	Health service area
EX U73.2	Injury or poisoning occurring while resting, sleeping, eating or engaging in other vital activities
OD C44.3	Malignant neoplasm of skin of other and unspecified parts of face
M M8070/3	Squamous cell carcinoma NOS
OD I21.0	Acute transmural myocardial infarction of anterior wall
OD I50.0	Congestive heart failure
Procedure codes as required	

Note:

- EX W19, Y92.09, U73.9 relate to PD S72.03;
- EX W06.1, Y92.22, U73.2 relate to OD S51.0;
- M M8070/3 is related to OD C44.3 and codes requiring Morphology codes are sequenced directly after codes requiring external cause codes;
- ODs I21.0 and I50.0 do not relate to any external cause codes and are therefore sequenced last.

Example 3:

Multiple injuries/poisonings with different external cause, same place of occurrence and activity codes

Scenario: A type 2 diabetic patient presents to hospital after an accidental over-dose of valium, amoxicillin and panadol. Whilst in hospital, the patient's diabetes became difficult to control and required additional monitoring.

Example 3 – Code String	
Code	**Description**
PD T42.4	Poisoning by benzodiazepines
EX X41	Accidental poisoning by and exposure to narcotics and psychodysleptics
EX Y92.9	Unspecified place of occurrence
EX U73.9	Unspecified activity
OD T36.0	Poisoning by penicillins
EX X44	Accidental poisoning by and exposure to other and unspecified drugs
OD T39.1	Poisoning by 4-Aminophenol derivatives
EX X40	Accidental poisoning by and exposure to nonopioid analgesics
EX Y92.9	Unspecified place of occurrence
EX U73.9	Unspecified activity
OD E11.65	Type 2 Diabetes mellitus with poor control
Procedure codes as required	

Note:

- EX X41, Y92.9, U73.9 relate to PD T42.4;
- EX X44 relates to OD T36.0;
- EX X40 relates to OD T39.1;
- EX Y92.9 and U73.9 relate to both OD T36.0 and T39.1 and therefore are placed after the T36.0, X44, T39.1 and X40;
- ODs not related to external cause – E11.65 are sequenced last

Example 4:

Multiple injuries/poisonings with the same external cause, same place of occurrence and activity

Scenario:Patient presents to hospital with a fracture of the surgical neck of humerus and a laceration to the shin after falling down the steps at home. During the episode of care, the patient's asthma was reviewed and the patient's asthma medications were changed.

Example 4 – Code String	
Code	**Description**
PD S42.22	Fracture of surgical neck of humerus
EX W10.9	Fall on and from other and unspecified stairs and steps
EX Y92.09	Other and unspecified place in home
EX U73.9	Injury or poisoning occurring while engaging in unspecified activity
OD S81.88	Open wound of other parts of lower leg
EX W10.9	Fall on and from other and unspecified stairs and steps
EX Y92.09	Other and unspecified place in home
EX U73.9	Injury or poisoning occurring while engaging in unspecified activity
OD J45.9	Asthma, unspecified
Procedure codes as required	

Note:

- Where the PD requires a set of external cause codes these external codes are to be sequenced directly after the PD code;
- EX W10.9, Y92.09, U73.9 relate to PD S42.22;
- The same set of external cause codes must then be repeated for any ODs to which they relate;
- EX W10.9, Y92.09, U73.9 relate to OD S81.88;
- ODs not related to the external causes are sequenced last.

Example 5:

External cause unrelated to principal diagnosis with a sequelae

Scenario:

Patient presents to hospital for management of chronic airflow obstruction as a sequelae from previous tuberculosis. Whilst in hospital it was noticed that the patient was hypokalaemic. The clinician decided that this was a side effect of the patient's loop diuretics. The loop diuretic was ceased and the patient was discharged home on day 4.

Example 5 – Code String	
Code	**Description**
PD J44.9	Chronic Obstructive Pulmonary Disease
OD E87.6	Hypokalaemia
EX Y54.4	Loop [high-ceiling] diuretics causing adverse effects in therapeutic use
EX Y92.22	Health service area
OD B90.9	Sequelae of respiratory and unspecified tuberculosis
Procedure codes as required	

Note:

- EX Y54.4, Y92.22 relate to OD E87.6
- OD B90.9 shows that J44.9 is a sequelae of respiratory and unspecified tuberculosis.

Example 6:

External cause unrelated to principal diagnosis including morphology

Scenario:

Patient with a history of hypertension was admitted for rehabilitation after a cerebral infarction. The patient had residual hemiplegia, dysarthria and dysphasia all of which required increased clinical care and monitoring. The patient was on a regimen of bromocriptine for a benign prolactinoma. During the episode of care, the patient suffered from significant hypotension that was linked to the bromocriptine. The patient's medications were adjusted accordingly.

Example 6 – Code String	
Code	**Description**
PD Z50.9	Care involving use of rehabilitation procedure, unspecified
OD I95.2	Hypotension due to drugs
EX Y46.7	Antiparkinsonism drugs
EX Y92.22	Health service area
OD D35.2	Benign neoplasm, pituitary gland
M M8271/0	Prolactinoma
OD I63.9	Cerebral infarction, unspecified
OD G81.9	Hemiplegia, unspecified
OD R47.1	Dysarthria and anarthria
OD R47.0	Dysphasia and aphasia
OD I10	Essential hypertension
Procedure codes as required	

Note:

- The PD has no relationship to the external causes.
- ODs that require an external cause code should be sequenced highest in the string and prior to ODs that do not require an external cause(s)
- EX Y46.7, Y92.22 relate to OD I95.2
- M M8271/0 is related to D35.2 and codes requiring morphology codes are sequenced directly after codes requiring external cause codes
- OD codes I63.9, G81.9, R47.1, R47.0 and I10 do not relate to the external cause codes and therefore should be sequenced last.

Example 7:

External cause unrelated to principal diagnosis with companion codes

Scenario:

Patient presents to hospital with an escherichia (E. coli) urinary tract infection. During the episode of care the patient fell off a chair and sustained a sub-trochanteric fracture of the femur.

Example 7 – Code String	
Code	**Description**
PD N39.0	Urinary tract infection, site not specified
OD S72.2	Subtrochanteric fracture
EX W07.9	Fall involving unspecified chair
EX Y92.22	Health service area
EX U73.9	Unspecified activity
OD B96.2	E. coli as cause of diseases classified to other chapters
Procedure codes as required	

Note:

- EX W07.9, Y92.22 and U73.9 relate to OD S72.2
- OD B96.2 relates to PD N39.0 however, B96.2 is sequenced after the codes requiring external cause codes.

Example 8:

Additional Injury code to further describe the Injury

Scenario:

Type 2 diabetic patient presents to hospital with severe abdominal pain. Patient has a history of hypertension. Patient is sent to theatre for exploratory laparotomy. During surgery, the ascending colon is inadvertently nicked. No reason for the abdominal pain is diagnosed.

Example 8 – Code String	
Code	**Description**
PD R10.4	Other and unspecified abdominal pain
OD T81.2	Accidental puncture and laceration during a procedure, NEC
OD S36.51	Injury of ascending [right] colon
EX Y60.4	Unintentional cut, puncture perforation or haemorrhage during endoscopic examination
EX Y92.22	Health service area
OD E11.9	Type 2 diabetes mellitus without complication.
Procedure codes as required	

Note:

- OD S36.51 is assigned to further describe OD T81.2
- EX Y60.4 and Y92.22 relate to both T81.2 and S36.51 (which is used to further describe T81.2)
- OD E11.9 does not relate to the external cause codes so is sequenced last.

Example 9:

Post procedural complication as the principal diagnosis with an additional chapter code to fully represent the complication

Scenario:

Patient presented to hospital with acute cholecystitis that was subsequently defined as both the principal diagnosis for the episode and a post procedural complication relating to a previous procedure.

Example 9 – Code String	
Code	**Description**
PD K91.8	Other post procedural disorders of digestive system, not elsewhere classified.
EX Y83.8	Other surgical procedures
EX Y92.22	Health service area
OD K81.0	Acute cholecystitis
EX Y83.8	Other surgical procedures
EX Y92.22	Health service area

Note:

- EX Y83.8 and Y92.22 relate to both the PD and the OD. Therefore they are coded twice

Example 10:
Post procedural complication as an additional diagnosis with an additional chapter code to fully represent the complication

Scenario:

Patient presented to hospital for management of their obesity. Whilst in hospital it was identified that the patient was experiencing acute cholecystitis as a direct result of a previous procedure. The patient was commenced on antibiotics for the cholecystitis.

Example 10 – Code String	
Code	**Description**
PD E66.9	Obesity, unspecified
OD K91.8	Other post procedural disorders of digestive system, not elsewhere classified.
OD K81.0	Acute cholecystitis
EX Y83.8	Other surgical procedures
EX Y92.22	Health service area

Note: The external cause codes Y83.8 and Y92.22 relate to both K91.8 and K81.0 and are sequenced after the two related ODs.

9.8 Place of occurrence

A Place of Occurrence must be specified for ALL External Cause codes in the range V00–Y89, to denote the place of injury or poisoning. To indicate the Place of Occurrence, use codes from range Y92.00–Y92.9 listed in the ICD-10-AM Tabular List of Diseases.

The Place of Occurrence code must be sequenced following the External Cause code(s) V00-Y89.

9.9 Activity

An Activity code is a separate code from range U50–U73 for use with External Cause codes V00-Y34. These codes should not be confused with, or be used instead of, the recommended place of occurrence code classifiable to Y92.

When multiple Activity codes apply, assign the code appearing highest in the tabular list. For example, cases where sport is undertaken during school or as part of paid work should be assigned the activity code for sport (U50–U71).

For the code range, V00–V99 Transport accidents, where the Activity at the time of the accident is not specified as sport, leisure or working for an income, assign U73.9 *Unspecified activity*.

Please also refer to section 9.8 Place of Occurrence. The Activity code is to be sequenced immediately following the Place of Occurrence code. Please refer to examples in section 9.5 Morphology Code Sequencing and section 9.7 External Cause Sequencing.

EXAMPLE

W51	Striking against or bumped into another person
Y92.83	Other specified place of occurrence, beach (Place of occurrence code)
U72	While engaged in leisure activity, NEC (activity code)

9.10 Condition present on admission indicator

The Condition Present on Admission (CPoA) indicator is a data item that indicates the presence of a condition (diagnosis) on admission to an episode of admitted patient care. It is a means of differentiating those conditions which arise during, from those arising before, an admitted patient episode of care and may inform prevention strategies particularly in relation to complications of medical care.

The CPoA has been collected in Queensland for all separations from 1 July 2006 and is now assigned for all diagnosis codes i.e. Principal Diagnosis, Other Diagnoses, External Cause and Morphology codes. On 1 July 2008, the national data element *'episode of admitted patient care – condition onset flag*' (COF) was mandated for collection in the Admitted Patient Care National Minimun Data Set. Unfortunately when the national standard was introduced it reversed the meaning of the codes already used in Queensland. The Queensland Department of Health decided to retain the original Queensland data element (CPoA) rather than risk quality issues and confusing coders by reversing the meanings for the values. The Queensland Department of Health ensures that the data supplied conforms to the national standard for national reporting purposes.

The relationship between the data element values is shown in the table below. Refer below for full description of each CPoA value.

CPoA Permissable Value	CPoA (Queensland)	Relationship to the COF (National)
1	Condition **present** on admission to the episode of admitted patient care	COF- value 2 Condition not noted as arising during the episode of admitted patient care
2	Condition **arose** during the episode of admitted patient care	COF – value 1 Condition with onset during the episode of admitted patient care
9	Condition **onset unknown/ uncertain** on admission to the episode of admitted patient care	
9	NA	COF – value 9 Condition onset flag not reported

The definitions of the CPoA indicator values are identical for all systems. They are:

Condition Present on Admission (Indicator Value '1'):

A condition previously existing or suspected on admission to the current episode of admitted patient care such as the presenting problem, a comorbidity or chronic disease. Includes:

- A condition that has not been documented at the time of admission, but clearly did not develop after admission (e.g. newly diagnosed diabetes mellitus, malignancy and morphology).
- A previously existing condition that is exacerbated during the current episode of admitted patient care (e.g. atrial fibrillation, unstable angina).
- A condition that is suspected at the time of admission and subsequently confirmed during the current episode of admitted patient care (e.g. pneumonia, acute myocardial infarction (AMI), stroke, unstable angina).
- A condition impacting on obstetric care arising prior to admission (e.g. venous complications, maternal disproportion).
- For neonates, this also includes the condition(s) in the birth episode arising before the labour and delivery process (e.g. prematurity, birth weight, talipes, clicking hip).
- Disease status or administrative codes not arising during the episode of admitted patient care (e.g. history of tobacco use, duration of pregnancy, colostomy status).
- Outcome of delivery (Z37,-) and place of birth (Z38,-) codes.

Condition arose during the episode of admitted patient care (Indicator Value '2'):

A condition which arose during the current episode of admitted patient care and would not have been present or suspected on admission. Includes:

- A condition resulting from misadventure during surgical or medical care in the current episode of admitted patient care (e.g. accidental laceration during procedure, foreign body left in cavity, medication infusion error).
- An abnormal reaction to, or later complication of, surgical or medical care arising during the current episode of admitted patient care (e.g. postprocedural shock, disruption of wound, catheter associated urinary tract infection (UTI)).
- A condition newly arising during the episode of admitted patient care (e.g. pneumonia, rash, confusion, UTI, hypotension, electrolyte imbalance).
- A condition impacting on obstetric care arising after admission, including complications or unsuccessful interventions of labour and delivery or prenatal/postpartum management (e.g. labour and delivery complicated by fetal heart rate anomalies, postpartum haemorrhage).
- For neonates, this also includes the condition(s) in the birth episode arising during the birth event (i.e. the labour and delivery process) (e.g. respiratory distress, jaundice, feeding problems, neonatal aspiration, conditions associated with birth trauma, newborn affected by delivery or intrauterine procedures).

- Disease status or administrative codes arising during the episode of admitted patient care (e.g. cancelled procedure, multi-resistant Staphylococcus aureus (MRSA)).

Condition onset Unknown/Uncertain on Admission to the episode of admitted patient care (Indicator Value '9'):

A condition where the clinical documentation does not support the assignment of '1' (Condition Present on Admission) or '2' (Condition not Present on Admission).

Assigning the condition present on admission indicator

Coders should note that the introduction of the CPoA does not alter the application of existing coding conventions, practices and Australian Coding Standards (ACS) in any way. Assignment of the indicator is a secondary process that should be applied only to those conditions already selected for coding in accordance with ACS. Coders must record a '1' (present on admission) or a '2' (not present on admission) or a '9' (Unknown/Uncertain) value against each ICD-10-AM diagnosis code.

Coders are advised that the most straightforward method to determine the Condition Present on Admission value for each diagnosis code is to ask the question "Was the condition present on admission to the episode?":

- Yes (Indicator value of '1') or
- No (Indicator value of '2') or
- Unknown/Uncertain (Indicator value of '9').

With the exception of neonates, the principal diagnosis code is always assigned a CPoA of 1 (condition present on admission).

Neonates in their admitted birth episode in that hospital may have a principal diagnosis assigned as a CPoA of 2 (condition not present on admission) if appropriate. Examples of conditions that may arise during the admitted episode for a neonate (i.e. labour and delivery process) include neonatal: respiratory distress; jaundice; feeding problems; aspiration conditions associated with birth trauma; or newborn affected by delivery or intrauterine procedures.

For combination codes (see ACS 0015 Combination codes) where a diagnosis within the code meets the criteria of CPoA 2, and is not represented by another code with a CPoA 2 value, then assign CPoA 2 to the combination code.

The CPoA value assigned to external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code. Injuries which occur during the admitted episode of care but not on the hospital grounds (e.g. hospital in the home or when a patient is on authorised leave) should be assigned a CPoA of 2 as 'arising during the episode of admitted patient care'. Note: unauthorised leave does not fall under the responsibility of the health care provider and conditions arising during this time should be assigned a CPoA of 1.

The CPoA value assigned to morphology codes should match that on the corresponding neoplasm code.

The CPoA value on aetiology and manifestation (dagger and asterisk) codes should be appropriate to each condition and therefore the dagger and asterisk codes may be assigned different CPoA values.

Where an admission has multiple admitted patient episode 'care type' changes (e.g. acute to rehabilitation), CPoA assignment should be relevant to each episode.

Note: Codes do not have to be sequenced in groups according to the CPoA value.

Coding Examples

All conditions in the following examples would be considered as:

1. Conditions Present on Admission to the episode of admitted patient care

Example 1

Patient admitted with a fractured humerus from a motorbike collision.

Example 2

Re-admission one week post discharge for post-operative wound infection.

Example 3

Diabetes newly diagnosed during the current episode of care, and requiring treatment, further investigation or additional nursing care.

Example 4

Atrial fibrillation usually controlled on digoxin that becomes uncontrolled during admission requiring treatment.

Example 5

Patient admitted with a UTI. On admission, the patient was breathless, hypoxic and pyrexic. On day 1, the patient was diagnosed as having had pneumonia on admission. (Both the UTI and the pneumonia are present on admission).

Example 6

A child who is admitted for dental treatment because their autism prevented them being seen in a non-admitted setting. (Both the dental condition and autism meet criteria for coding in the first instance and were both present on admission.)

Example 7

During an episode of care, a patient is diagnosed with a squamous cell carcinoma (SCC) of the forearm. The SCC is removed during the same episode of care. (The SCC and its associated morphology code are deemed present on admission.)

Example 8

A neonate is born with congenital hip dysplasia (The congenital hip dysplasia is present on admission CPoA value - 1)

Example 9

A Z37 Outcome of Delivery code is allocated to a mother's record. (The Z37 code is present on admission)

Example 10

A Z38 code relating to the place of birth is allocated to a newborn's record. (The Z38 code is present on admission)

Example 11

Patient is admitted with uncontrolled Type 2 diabetes. The patient is known to have chronic kidney disease stage 3 but no other complications of the diabetes. The patient develops acute kidney failure during the episode.

- The uncontrolled diabetes is present on admission (CPoA value – 1)
- The acute kidney failure is not present on admission (CPoA value – 2)
- The diabetes with acute kidney failure is present on admission (CPoA value – 1)
- The diabetes with chronic kidney disease is present on admission (CPoA value – 1)
- The diabetes with chronic kidney disease is present on admission (CPoA value – 1)
- The chronic kidney disease, stage 3 is present on admission (CPoA value 1).

Certain conditions in the following examples would be considered as:

2. Conditions arose during the episode of admitted patient care

Example 1

A medical patient admitted for treatment of ischaemic heart disease and develops pneumonia during the hospital stay.

- The ischaemic heart disease is present on admission. (CPoA value – 1).
- The pneumonia is not present on admission. (CPoA value – 2).

Example 2

A dementia patient who sustains a fracture due to a fall from bed while in hospital.

- The dementia is present on admission.
- The fracture, external cause, place of occurrence and activity are all not present on admission.

Example 3

Patient experienced an accidental laceration of a blood vessel occurring during coronary artery bypass graft surgery.

- The coronary artery disease is present on admission. (CPoA value – 1).
- The laceration, external cause, place of occurrence and activity are all not present on admission. (CPoA value – 2).

Example 4

- Patient experienced an adverse drug reaction occurring during an admission for asthma. The asthma is present on admission. (CPoA value – 1).
- The adverse effect, external cause and place of occurrence are all not present on admission. (CPoA value – 2).

Example 5

Patient experienced a wound infection which followed an appendicectomy in the current episode of care.

- The appendicitis is present on admission. (CPoA value – 1).
- The wound infection, organism, external cause and place of occurrence are all not present on admission. (CPoA value – 2).

Conditions in the following examples would be considered as:

3. Condition onset Unknown/Uncertain on admission to the episode of admitted patient care

Example 1

Obstetric patient noted as Group B strep carrier (antenatally) on Day 3 of admission and there is no adequate documentation to reliably support the assignment of value ’1’ (Present on admission) or value ’2’ (Not present on admission).

- The group B strep carrier onset is unknown or uncertain so the CPoA Indicator has a value of ’9’.

Example 2

On day 3 of an episode of care, the nursing staff notice that the patient has a skin tear. The skin tear is dressed and is to be reviewed daily. There is no adequate documentation to reliably support the assignment of value ‘1’ (Present on admission) or value ’2’ (Not present on admission).

- The onset of the skin tear is unknown or uncertain so the CPoA Indicator has a value of ’9’.

9.11 Submission of condition present on admission indicator

Dependent on which PAS or paper form a hospital will use to collect the ICD codes, the method of assigning the ‘1’, ‘2’ or ‘9’ value for the Condition Present on Admission Indicator will differ. Regardless of the method of assigning the indicator, all facilities must submit the data item to Queensland Health in the same format.

For example, in the HBCIS ICD Morbidity Coding Module, coders will use the code prefixing functionality to determine if a code is a ‘1’, ‘2’ or ‘9’ as follows:

- A code which is prefixed by a P, PE, and/or PM, will indicate that a CPoA of 1 (the condition was present on admission) has been assigned.
- A code which is prefixed by an A, AE and/or AM will indicate that a CPoA of 1 (the condition was present on admission) has been assigned.

- A code prefixed by a C and/or CE will indicate a CPoA of 2 (the condition was not present on admission) has been assigned.
- A code prefixed by U and/or UE will indicate a CPoA of 9 (it is unknown/uncertain whether the condition arose during the admission) has been assigned.

The valid values for this data item are:

Value	Description
1	Condition Present on Admission to the episode of admitted patient care
2	Condition arose during the episode of admitted patient care
9	Condition onset Unknown/Uncertain on admission to the episode of admitted patient care

HBCIS Hospitals

Extracted and submitted to HSU via HQI.

HBCIS Code	Description	Condition Present on Admission Indicator values
P	Condition Present on Admission	1 or
P	Condition Present on Admission	2 (neonates only)
A	Condition Present on Admission	1
C	Condition not Present on Admission	2
U	Unknown/Uncertain when the condition arose	9
	Procedure	Null

Other Hospitals

Each diagnosis morbidity code is to be flagged by an ICD-10-AM code Condition Present on Admission indicator.

Record the Condition Present on Admission Indicator using the following values:

ICD CODE Identifier	Description	Condition Present on Admission Indicator values
PD	Principal Diagnosis	1 or
PD	Principal Diagnosis	2 (neonates only)
OD	Other Diagnoses	1, 2 or 9
EX	External Cause	1, 2 or 9
M	Morphology	1
PR	Procedure	Null

9.12 Most resource intensive condition (MRIC) indicator (HBCIS hospitals)

From 1 July 2008, an opt-in pilot for recording the Most Resource Intensive Condition (MRIC) was launched in public HBCIS hospitals. There will be only one code or code concept (inclusive of non-morbidity codes such as external cause codes and morphology codes) that will have the MRIC allocated in any single episode of care.

Please Note-only those public, HBCIS hospitals that have been approved to collect the MRIC Indicator should do so.

With the introduction of the ICD-10-AM, the ability to identify the condition which is the most resource intensive was removed from clinical coding practice in Australia. In ICD-9-CM, if two or more conditions were present, each of which

qualified as principal, the diagnosis for which the investigation or treatment was the most resource intensive would be chosen.

A number of countries continue to capture and/or flag condition that are deemed to be clinically significant and resource intensive.

In ICD-10-AM, the concept of the main diagnosis was replaced by the concept of principal diagnosis as described in Section 9.2 Prinicpal Diagnosis. Please also refer to ACS 001 *Principal diagnosis* for further information.

This change has not only changed data reporting in Australia; it has decreased Australia's ability to internationally compare data.

The implementation, and consequent identification, of the MRIC Indicator enables:

1. The identification of the condition that better explains the Length of Stay (LOS) and the resource usage in an episode of care;
2. The ability to further match with the Condition Present on Admission (CPoA) Indicator to allow for better risk assessment and management, where the Principal Diagnosis (PD) and the condition identified as the MRIC are not the same. Where the CPoA indicator of '2' (i.e. not present on admission) is applied to the a co-morbidity and the condition is also identified as the MRIC; this will indicate that the condition for which the most resources were expended, was not present on admission;
3. The ability to compare the actual Diagnostic Related Group (DRG) with potential DRG where the PD and the condition identified as the MRIC are not the same. For analytical purposes, the potential DRG could be produced by replacing the MRIC with the PD in grouper calculations;
4. International data comparison;
5. Further development of the Australian Coding Standard 0001 – Principal Diagnosis.

In principle support for these new data elements has been received from the Queensland Coding Committee.

9.13 Assigning the most resource intensive condition (MRIC) indicator

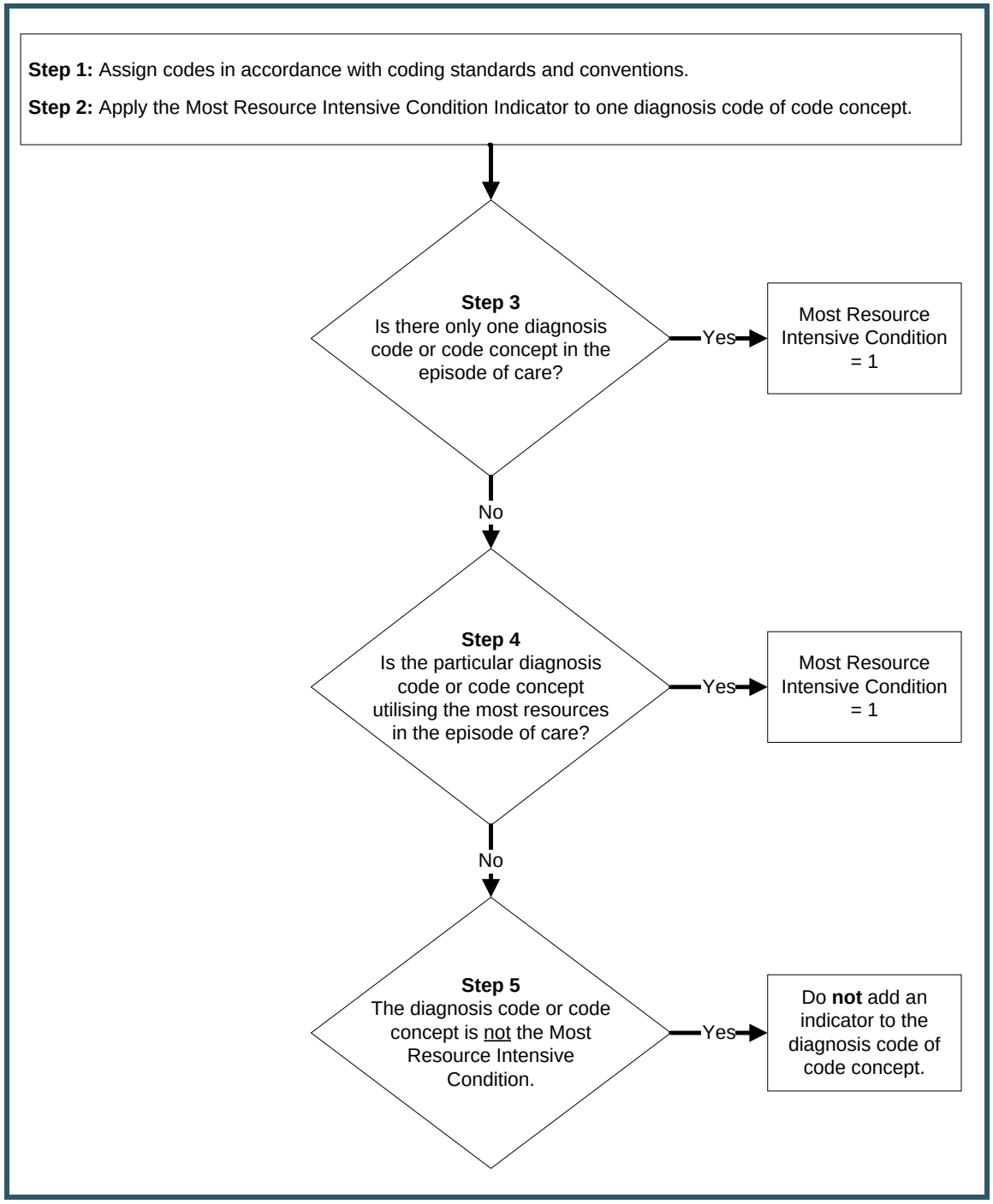
Coders should note that the application of the MRIC indicator does not alter the application of existing coding conventions, practices and the Australian Coding Standards (ACS) in any way. Assignment of the indicator is a secondary process that should be applied only to a condition that has already been selected for coding in accordance with the ACS.

The MRIC is identified by the coder from the documentation in the medical record at the end of an episode of care.

There will be only one code or code concept (inclusive of non-morbidity codes such as external cause codes and morphology codes) that will have the MRIC allocated in any single episode of care.

Where there is only a single code or code concept allocated in an episode of care, this code, or code concept, is both the Principal Diagnosis and the MRIC.

Figure 6 Assigning the most resource intensive condition (MRIC) indicator flowchart



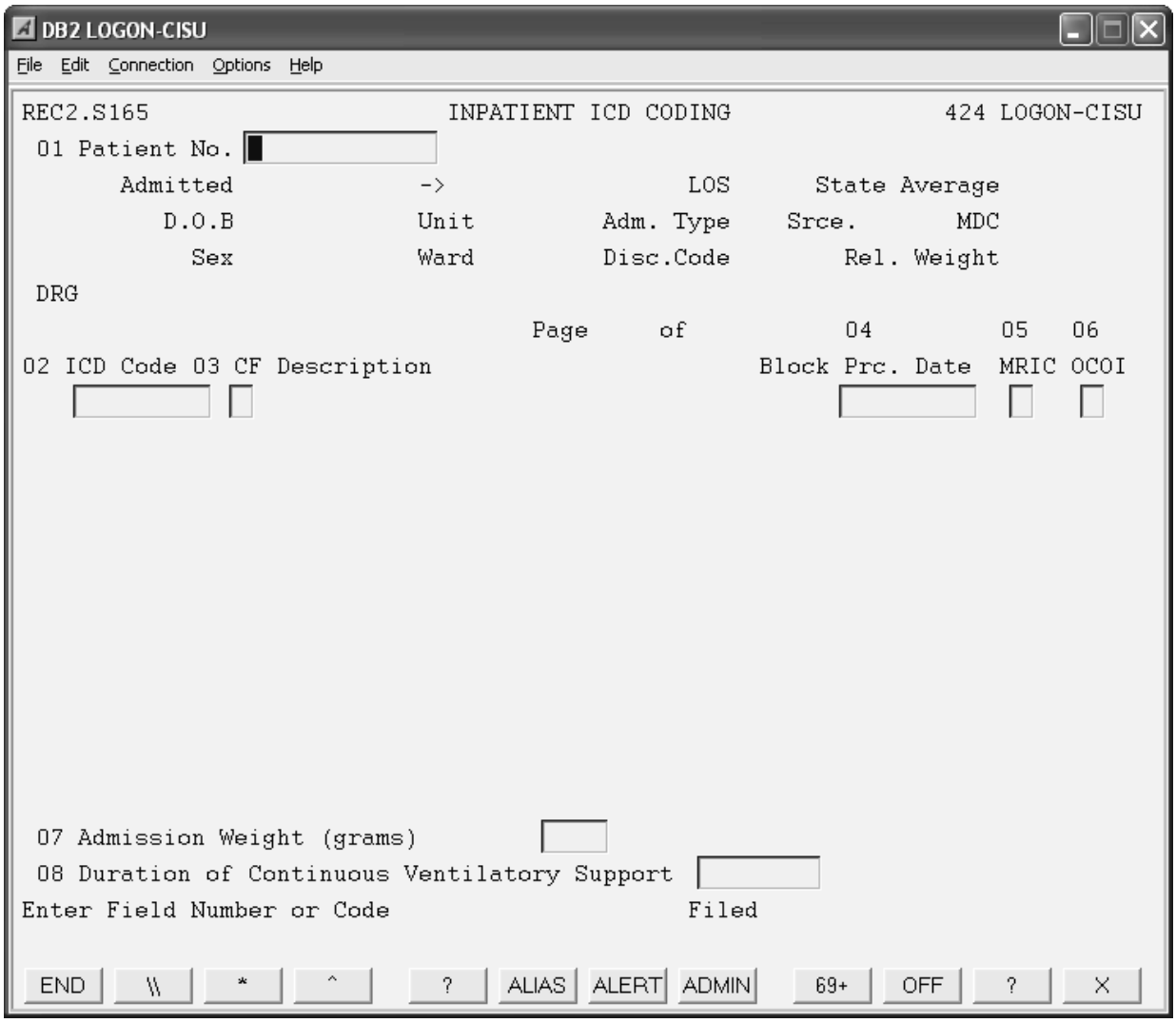
Where there are two or more morbidities potentially meeting the definition of MRIC in an episode of care, the clinician should be asked to indicate which morbidity best meets the definition.

If no further information is available, code the first mentioned morbidity that fulfils the criteria of the definition as the MRIC.

Coders must record a '1' (Most Resource Intensive Condition) value against one, and only one, ICD-10-AM diagnosis code or code concept per episode of care.

In the HBCIS ICD Morbidity Coding Module, a field has been added to allow for manual allocation of the MRIC indicator.

HBCIS Example:



Note: In accordance with the definitions, where there is only one diagnosis code or code concept (i.e. including external cause codes and morphology codes) allocated to any episode of care, the MRIC indicator is allocated to the single diagnosis or single code concept. Where there are two or more diagnosis codes or code concepts that potentially meet the criteria for the MRIC, firstly consult the clinician. Where this is not possible, assign the MRIC to the first mentioned morbidity that potentially meets the criteria for the MRIC.

Coding Examples

Most Resource Intensive Condition (value of '1')

Example 1

Patient admitted with renal failure. No other diagnosis codes allocated.

Renal failure is the MRIC.

Example 2

Patient admitted for diabetic foot ulcers. On day 3, when the ulcers were nearly healed, the patient fell over and fractured their femur. Patient was sent to theatre for a hemiarthroplasty. The patient was in hospital for an additional 15 days.

Fractured femur is the MRIC (significantly increased LOS and utilised significant resource for the prosthetic).

Example 3

Patient admitted with acute on chronic renal failure. During the admission, the patient had a severe myocardial infarction. Patient stayed in hospital for 10 days.

All conditions could be the MRIC. Consult with the clinician regarding allocation of the MRIC. Where clinical consultation is not possible, allocate the MRIC indicator to the first mentioned morbidity that meets the MRIC criteria.

Example 4

Neonate develops jaundice on day three. Biliblanket applied. Baby kept in hospital for an additional 4 days due to severe jaundice.

Neonatal jaundice is the MRIC.

Example 5

Patient presents in labour, post dates. After a vaginal delivery, the patient had a large postpartum haemorrhage. Patient was rushed to theatre for control of the bleeding. The obstetricians were unable to control the bleeding and an emergency hysterectomy was performed. Patient was discharged on day 7.

Postpartum haemorrhage is the MRIC.

Example 6

Patient admitted to hospital after a motor vehicle accident. The patient was found to have a large subdural haematoma, bilateral open fractured shaft of the tibia, unilateral undisplaced fracture of the shaft of the fibula. During the episode of care, the patient went to theatre for open reduction and fixation of both tibias. The patient returned to theatre on two separate occasions for debridement of their open fracture. The haematoma resolved without intervention.

Open fracture shaft of the tibia is the MRIC.

Example 7

Patient presents to hospital with abdominal pain, jaundice, weight loss and nausea. Computed tomograph (CT) indicates a large mass on the head of the pancreas. The patient proceeded to emergency exploratory laparotomy. At laparotomy, the surgeon noticed lesions on the liver and the peritoneum. Frozen section biopsies of the patient's pancreas showed adenocarcinoma. Further biopsies were taken of the liver and the peritoneum and they showed metastatic adenocarcinoma. It was decided to progress immediately to Whipple's procedure. Post-operatively, the patient developed paralytic ileus and had a nasogastric tube inserted. Patient discharged on day 11.

Pancreatic cancer is the MRIC.

Whilst the PD must be sequenced first, the sequencing of the other codes should be in accordance with the ACS and/or coding convention and the Queensland guidelines for sequencing external cause and morphology codes. Please refer to Section 9.7 for External Cause and Section 9.5 for Morphology Sequencing.

The valid values for this data item are:

1 Most Resource Intensive Condition
Null. Not the Most Resource Intensive Condition (not recorded, not collected and not reported)

HBCIS Hospitals	One, and only one, diagnosis code or code concept is to be flagged by a Most Resource Intensive Condition Indicator		
	HBCIS Code	**Description**	**Most Resource Intensive Condition Indicator values**
	P	Principal Diagnosis	1 or null
	A	Condition Present on Admission	1 or null
	C	Condition Not Present on Admission	1 or null
	U	Unknown/Uncertain when a Condition arose	1 or null
	PE	External Cause associated with the Principal Diagnosis	1 or null
	AE	External Cause related to a Condition Present on Admission	1 or null
	CE	External Cause associated with a Condition Not Present on Admission	1 or null
	UE	External Cause associated with a Condition where it is unknown/uncertain when the Condition arose	1 or null
	PM	Morphology associated with the Principal Diagnosis	1 or null
	AM	Morphology related to Condition Present on Admission	1 or null
		Procedure	Null

<table>
<tr><td rowspan="8">Other Hospitals</td><td colspan="3">One, and only one, diagnosis morbidity code or code concept is to be flagged by a Most Resource Intensive Condition Indicator</td></tr>
<tr><td colspan="3">Record the Most Resource Intensive Condition Indicator using the following values:</td></tr>
<tr><td>HBCIS Code</td><td>Description</td><td>Most Resource Intensive Condition Indicator values</td></tr>
<tr><td>PD</td><td>Principal Diagnosis</td><td>1 or null</td></tr>
<tr><td>OD</td><td>Other Diagnosis</td><td>1 or null</td></tr>
<tr><td>EX</td><td>External Cause</td><td>1 or null</td></tr>
<tr><td>M</td><td>Morphology</td><td>1 or null</td></tr>
<tr><td>PR</td><td>Procedure</td><td>Null</td></tr>
</table>

9.14 Other co-morbidity of interest (OCOI) indicator (HBCIS hospitals)

From 1 July 2008, an opt-in pilot for recording of the ‘Other Co-morbidity of interest (OCOI) indicator’ was launched in public HBCIS hospitals. The OCOI as a standard is referred to as the Non Australian Coding Standard Compliant (NACSC) Indicator in the Queensland Health Data Dictionary and is referred to as such further on in this manual. The NACSC Indicator allows for collection of diagnosis codes where they do not meet the criteria for clinical coding as described by the Australian Coding Standards (ACS). Any diagnosis codes that are allocated a NACSC Indicator will not be included in grouper calculations.

Please Note:Only those public HBCIS hospitals that have been approved to collect the NACSC Indicator should do so.

Clinical coding of additional diagnoses is guided by the standardACS 0002 Additional Diagnoses. The Additional Diagnosis standard states that an additional diagnosis will only be coded where it fulfils the following:

“For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:

- commencement, alteration or adjustment of therapeutic treatment
- diagnostic procedures
- increased clinical care and/or monitoring”

Where a clinical coder cannot find sufficient clinical documentation supporting allocation of the ICD-10-AM code, the diagnosis is not coded. Clinical documentation within the medical record can vary greatly in clarity, legibility, specificity and general clinical coder "friendliness". Due to differences in these factors, the same patient with the same co-morbidities could be coded with significant variation.

Additionally, clinicians assume that documenting a condition will result in that condition being coded. Without documented evidence of treatment or increased nursing care and/or monitoring, this may not be the case.

Currently, some hospitals are coding conditions of local importance to clinicians and others for “risk factors”, co-morbidities of interest and other research conditions potentially contravening the ACS. With no alternative functionality

available, these coded conditions would be included in DRG calculations. These hospitals have indicated an interest in being able to allocate codes for these conditions of interest and have them excluded from DRG calculations.

The ability to identify Non Australian Coding Standard Compliant (NACSC) diagnosis codes through the use of this indicator would allow for:

- Enhanced ability to understand the complexity of QH patients;
- Enhanced ability to examine the frequency of certain co-morbidities;
- Enhanced refinement of the Australian Coding Standards.

The indicator will distinguish these conditions and enable their exclusion from Diagnostic Related Group (DRG) calculations. In addition, the implementation of the NACSC Indicator also provides for hospitals to fulfil their own clinical coding requirements and not breach the Coding Standards.

Assigning the non-Australian coding standard compliant (NACSC) Indicator

In HBCIS and the 3M Codefinder the NACSC indicator is known as the Other Co-morbidity of Interest (OCOI) Indicator.

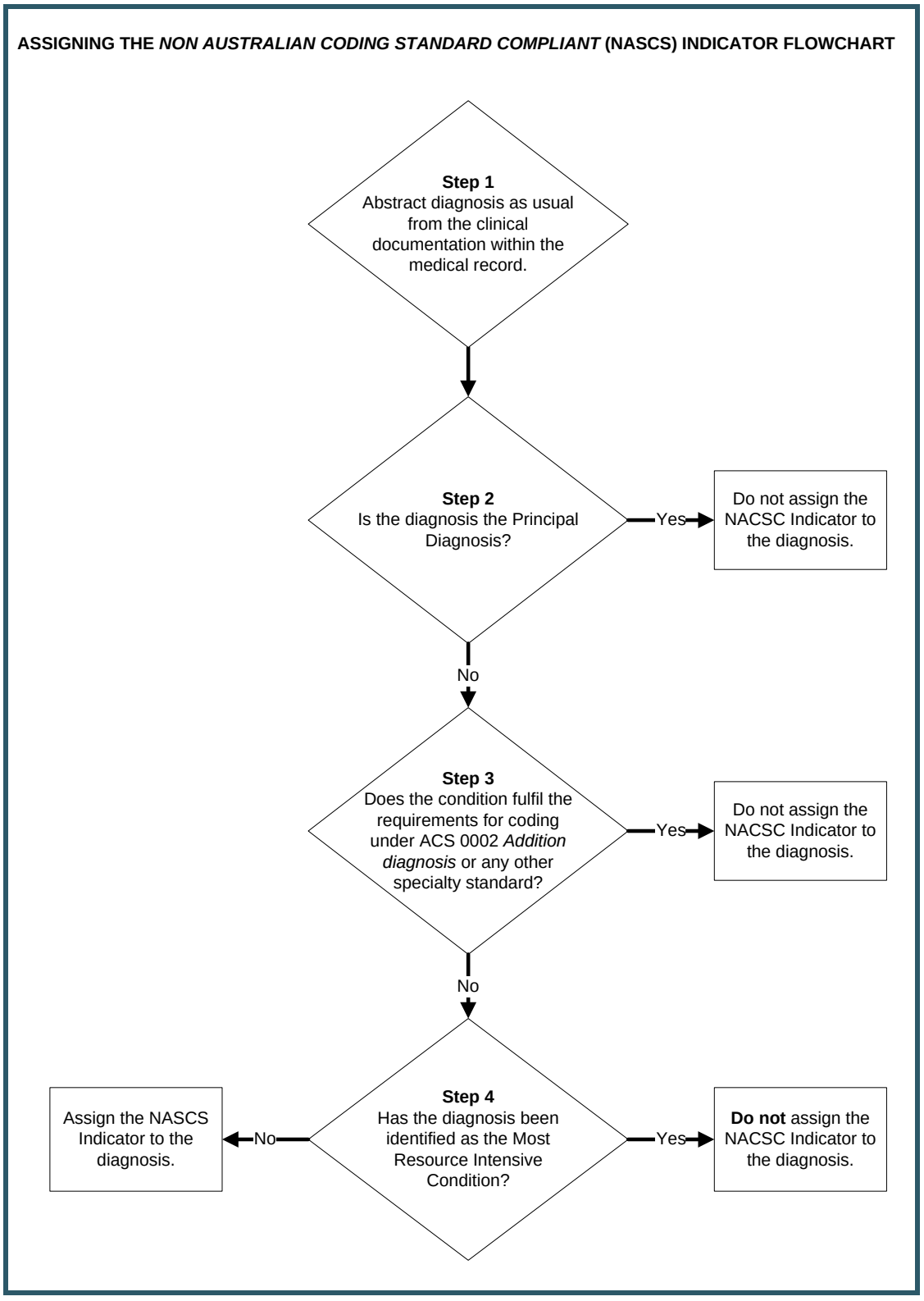
Coders should note that the application of the NACSC indicator does alter the application of the Australian Coding Standards (ACS), particularly the Additional Diagnosis standard (ACS 0002). A NACSC indicator is applied to a diagnosis, which is noted in the clinical documentation but the diagnosis does not fulfil the requirements for coding under the ACS.

There can be none, one or many codes or code concepts (inclusive of non-morbidity codes such as external cause codes and morphology codes) that will have the NACSC Indicator allocated in a single episode of care.

A diagnosis that is identified as the Principal Diagnosis or is identified as the Most Resource Intensive Condition (MRIC) cannot also be identified as a NACSC diagnosis.

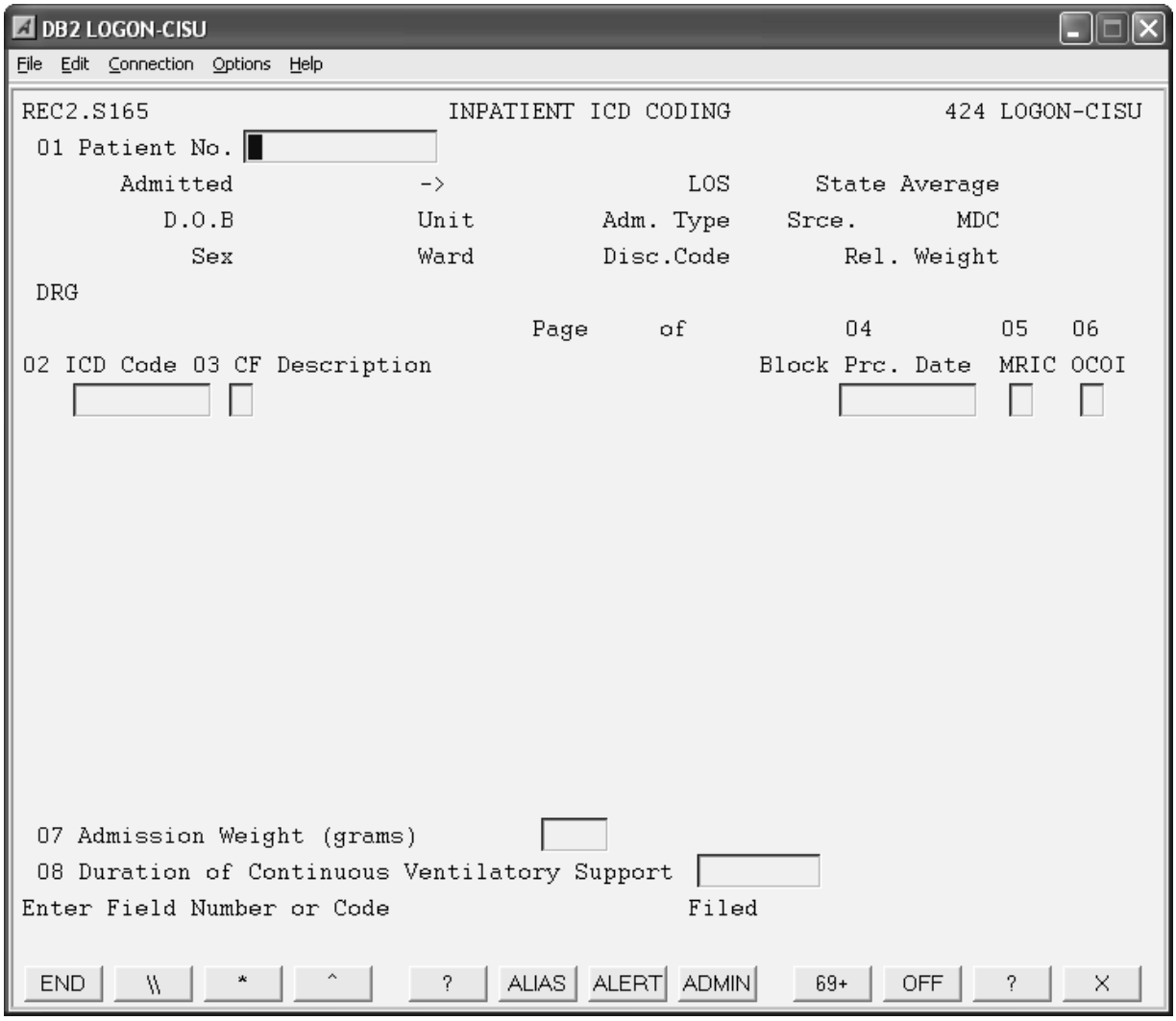
Where a “code also” instruction exists for a particular ICD diagnosis code that has been identified as an NACSC diagnosis, these additional diagnosis codes need not be allocated. The exception to this will be where the individual code(s) is/are also deemed to be “of interest”.

Figure 7 Assigning the non-Australian coding standard compliant (NACSC) Indicator flowchart



In the HBCIS ICD Morbidity Coding Module, a field has been added to allow for manual allocation of the NACSC Indicator, called 'OCOI'.

HBCIS Example:



Note: In line with the definition, a NACSC indicator cannot be allocated to the Principal Diagnosis or a diagnosis that has already been defined as the Most Resource Intensive Condition (MRIC).

Coding Examples:

Example 1

A patient is admitted with adenocarcinoma of the pancreas. The patient proceeds to a Whipple's procedure. In the clinical documentation, the clinician has written that the patient has Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation (AF), gout and chronic recurrent depression.

Conditions that meet the criteria for ACS 0001 and ACS 0002 and other specialty standards are coded.

COPD, AF, gout and chronic recurrent depression do not fulfil the requirement for coding under the ACS 0002 Additional Diagnosis or any other specialty

standard; however, they are also coded and the NACSC indicator is recorded against them.

Example 2

A patient presents with uncontrolled hypertension for review. The clinical documentation shows that the patient also has had an MI four years ago, Crohn's disease and a previously removed torted appendix. The patient is not receiving on-going treatment for the old MI.

All conditions that meet the criteria for coding under ACS 0001 and ACS 0002 and other specialty standards are coded.

The previous MI and Crohn's Disease do not fulfil the requirement for coding under the ACS 0002 Additional Diagnosis or any other specialty standard; however they are coded and the NACSC indicator is recorded against them.

Example 3

10 month old child is admitted to hospital with febrile convulsions. It is documented in the clinical documentation that the child has diffuse membranous glomerulonephritis and cerebral palsy. Whilst an inpatient, the renal specialist reviewed the child and changed the child's renal medications.

Conditions that meet the criteria for coding under ACS 0001 and ACS 0002 and other specialty standards are coded.

Cerebral palsy does not fulfil the requirement for coding under the ACS 0002 Additional Diagnosis or any other specialty standard; however, it is coded and a NACSC indicator is recorded against it.

Extracted and submitted to HSU via HQI:

	HBCIS Code	OCOI	Description	OCOI Indicator Values
HBCIS Hospitals	P		Principal Diagnosis	null
	A		Condition Present on Admission (that meets the ACS)	null
	A	1	Condition Present on Admission (that does not meet the ACS)	1
	C		Condition Not Present on Admission (that meets the ACS)	null
	C	1	Condition Not Present on Admission (that does not meet ACS)	1
	U		Unknown/Uncertain when the Condition arose (that meets the ACS)	null
	U	1	Unknown/Uncertain when the Condition arose (that does not meet the ACS)	1
	PE		External Cause associated with the Principal Diagnosis	null
	AE		External Cause associated with a Condition Present on Admission (that meets the ACS)	null
	AE	1	External Cause associated with a Condition Present on Admission (that does not meet the ACS)	1
	CE		External Cause associated with a Condition not Present on Admission (that meets the ACS)	null
	CE	1	External Cause associated with a Condition not Present on Admission (that does not meet the ACS)	1

	UE		External Cause associated with a Condition where it is Unknown/Uncertain when the Condition arose (that meets the ACS)	null
	UE	1	External Cause associated with a Condition where it is Unknown/Uncertain when the Condition arose (that does not meet the ACS)	1
	PM		Morphology associated with the Principal Diagnosis	null
	AM		Morphology associated with the Condition Present on Admission (that meets the ACS)	null
	AM		Morphology associated with the Condition Present on Admission (that does not meet the ACS)	1
			Procedure	null

Note: none, one or many diagnosis codes or code concepts can be flagged by a Non Australian Coding Standard Compliant Indicator (known as Other Comorbidity of Interest [OCOI]) Indicator in HBCIS

9.15 Australian refined diagnosis related group (AR-DRG)

If the hospital has the ability to group on site using the AR-DRG system:

HBCIS Hospitals	The group will be assigned automatically

Other Hospitals	Record the AR-DRG code.

Note: that from 1 July 2012 the Diagnosis Related Group (DRG) codes are not required to be supplied by private facilities. The DRG code and MDC code are automatically derived by SCI's processing system (using the ICD-10-AM data supplied).

It is important to use the AR-DRG version compatible with the ICD-10-AM and coding standards for the current year. Version 7.0 AR-DRG will be implemented from 1 July 2014.

9.16 Major diagnostic category (MDC)

If the hospital has the ability to group on site using the AR-DRG:

HBCIS Hospitals	The MDC will be assigned automatically

Other Hospitals	Record the MDC code

Note: that from 1 July 2012 the Major Diagnostic Category (MDC) codes are not required to be supplied by private facilities. The DRG code and MDC code are automatically derived by by SCI's processing system (using the ICD-10-AM data supplied).

It is important to use the AR-DRG version compatible with the ICD-10-AM and coding standards for the current year.

9.17 Contract flag

A Contract Flag is an indicator that designates that a procedure was performed by another hospital or **private health provider (non-hospital)** as a contracted service, either as an admitted or non-admitted service. Diagnoses identified from the contracted episode of care should be coded. However, these diagnosis codes should not be flagged as contracted, unless it is to indicate that a contracted service was not carried out or where there is no valid procedure code available for the contracted service (see Section 4.7 Contracted Hospital Care).

	Record the following codes to flag a contract service	
All Hospitals	**Code**	**Description**
	1	Contracted admitted procedure
	2	Contracted non-admitted procedure **or procedure performed by a private health provider (non-hospital).** See Section 4.7.9.6 of the QHAPDC Manual Recording of Procedures Performed by Private Health Providers (non-hospital)

9.18 Date of procedure

This data element provides valuable information on the timing of the procedure in relation to the episode of care, and in particular allows accurate information on pre and post-operative lengths of stay. It also allows a measurement of time between procedures; this is of particular interest given initiatives to encourage day of admission surgery and day only procedures.

If a procedure falls within the mandatory block range as listed below, enter the date the procedure was performed. This information should be provided by the patient's attending clinician and be recorded in the patient's medical record.

Where a procedure is performed multiple times on different dates, and the coding standards direct that the procedure is to be coded once only (e.g. pharmacotherapy), the date allocated is the date when the procedure was first performed.

Block ranges requiring the recording of a procedure date:

1	to	59
67	to	559
561	to	737
739	to	1059
1062	to	1062
1064	to	1089
1091	to	1579
1602	to	1759
1828	to	1828
1886	to	1886
1890	to	1891
1906	to	1906
1909	to	1912
1920	to	1922

10. MENTAL HEALTH DETAILS

The scope of this section is for all admitted patients episodes where the standard unit code (either at admission to the episode or through a unit transfer during the episode) is in the range PYAA to PYZZ (Mental Health Unit). These patients should have one record completed for the episode of care. No record would be completed if there were no standard unit codes in this range in the episode recorded. Those hospitals that have specialised mental health services are listed in Appendix K.

Mental health details do not have to be reported for boarders who are registered as being in a PYAA to PYZZ standard unit code.

10.1 Type of usual accommodation

The type of physical accommodation the patient lived in prior to admission to the hospital.

	Record the following codes to indicate the type of usual accommodation	
All Hospitals	**Code**	**Description**
	1	House or flat
	2	Independent unit as part of retirement village or similar
	3	Hostel or hostel type accommodation
	4	Psychiatric hospital
	5	Acute hospital
	7	Other accommodation
	8	No usual residence

10.2 Employment status

Self-reported employment status, as defined by the categories given below, immediately prior to admission to the hospital.

Note: This item refers to self reported status. As a guide, unemployed refers to someone not in paid employment and who is actively seeking paid employment. People who have retired from paid employment, whether or not they are now in receipt of any form of pension or benefit may be recorded as Other, Home duties or Student as self reported by the patient. The person's pension status is collected separately by the Pension status item. See Section 10.3 Pension Status.

	Record the following codes to indicate the employment status	
All Hospitals	**Code**	**Description**
	1	Child not at school
	2	Student
	3	Employed
	4	Unemployed
	5	Home duties
	6	Pensioner
	8	Other

10.3 Pension status

The pension status of a patient refers to whether or not a patient is in receipt of a pension at the time of admission to hospital. It also details the nature of the pension held by the patient. This does not imply that the pension is necessarily the recipient's main source of income.

Please note that the broad heading of 'Pensions' encompasses a range of related pensions and allowances. For example:

- The term Invalid Pension includes the Disability Support Pension.
- The term Unemployment Benefit includes Newstart Allowance and Youth Training Allowance.
- The term Age Pension includes Mature Age Allowance and Mature Age Partner Allowance.

	Record the following codes to indicate the pension status of the patient	
All Hospitals	**Code**	**Description**
	1	Aged
	2	Repatriation
	3	Invalid
	4	Unemployment benefit
	5	Sickness benefits
	7	Other
	8	No pension/benefit

10.4 First admission for psychiatric treatment

First admission for psychiatric treatment is the status of the episode in terms of whether it is a first or subsequent admission, at any hospital for any condition, for psychiatric, whether in an acute or psychiatric hospital.

	Record the following codes to indicate the first admission for psychiatric treatment	
All Hospitals	**Code**	**Description**
	1	No previous admission for psychiatric treatment
	2	Previous admission for psychiatric treatment

10.5 Referral to further care

Referral to further care by health service agencies/facilities following discharge from the hospital (or episode of care). Many psychiatric patients have continuing needs for post-discharge care.

All Hospitals	Record the following codes to indicate the place to which the patient is referred	
	Code	**Description**
	01	Not referred
	02	Private psychiatrist
	03	Other private medical practitioner
	04	Mental health/alcohol and drug facility - admitted patient
	05	Mental health/alcohol and drug facility - non-admitted patient
	06	Acute hospital - admitted patient
	07	Acute hospital - non-admitted patient
	08	Community health program
	29	Other

10.6 Mental health legal status indicator

This provides an indication that a person was treated on an involuntary basis under the relevant state or territory mental health legislation, at some point during the hospital stay. Involuntary patients are persons who are detained under mental health legislation for the purpose of assessment or provision of appropriate treatment or care. This is collected at separation from the hospital (or episode of care).

All Hospitals	Record the following codes to indicate the mental health legal status indicator	
	Code	**Description**
	1	Involuntary patient for any part of the episode
	2	Voluntary patient for all of the episode

10.7 Previous specialised non-admitted treatment

Previous specialised non-admitted treatment is the status of the episode in terms of whether the patient has had a previous non-admitted service contact for psychiatric treatment.

All Hospitals	**Code**	**Description**
	1	Patient has no previous non-admitted service/contacts for psychiatric treatment
	2	Patient has previous non-admitted service/contacts for psychiatric treatment

11. ELECTIVE SURGERY DETAILS (PUBLIC HOSPITALS USING HBCIS)

Elective surgery details are collected by Public Hospitals through the Elective Admission Module (EAM). The scope of this collection includes all patients admitted to hospital for an elective procedure, for which they have been placed on a waiting list. This includes all patients separated after 1 July 1997 from a public hospital with an EAM installed. The purpose of the link between the waiting list and relevant admission episode is to provide a more complete picture of elective patient care, that is, the information collected from the time a patient was placed on a waiting list through to separation from hospital. When a patient is admitted to hospital, it is possible to link to a waiting list entry (where one exists). If a patient has a waiting list status in EAM of admitted, treated or cancelled, the waiting list entry can be linked to the patient episode.

Not all patients will have waiting list details. Elective surgery patients should have a waiting list entry. Some emergency patients may also have a corresponding waiting list entry, for example, if a patient had been on the waiting list and his/her condition deteriorated before they were admitted for elective surgery, then they may present as an emergency patient for the same procedure. It is important to note that some patients will have more than one entry on the waiting list and in this instance it is necessary to identify which procedure or procedures the patient has undergone and select the appropriate entries for linking.

11.1 HQI extract and waiting list entries

The HQI extract will include EAM items only where they are linked to admission episodes. Only waiting list entries that become 'completed' (i.e. treated or cancelled) during an admission need to be linked.

Mandatory conditions for acceptance in the HQI extract (apart from separated, coded and grouped) are that the EAM entry has been linked and that the waiting list status is two (2) or greater, i.e. treated or cancelled. EAM entries having a waiting list status of A - Admitted that are linked will be flagged as errors in the extract. Such entries need to have their status updated to either treated or cancelled.

Data items in the extract will be validated against the corporate reference files by the Health Statistics Unit. It is crucial therefore that reference files are up to date.

11.2 Elective admission details

11.2.1 Entry number

Each waiting list entry has a placement number unique within the patient identifier. This number is from field 02 of the Waiting List Entry screen and is generated by HBCIS.

11.2.2 National Minimum Data Set (NMDS) speciality grouping

The NMDS specialty grouping is the area of clinical expertise held by the doctor who will perform the elective surgery. Waiting list specialties are derived from mapping Planned Unit codes to one of the 12 NMDS Specialty Grouping codes.

	Code	Description
HBCIS Hospitals	01	Cardio Thoracic
	02	ENT Surgery
	03	General Surgery
	04	Gynaecology
	05	Neurosurgery
	06	Ophthalmology
	07	Orthopaedic Surgery
	08	Plastic and Reconstructive Surgery
	09	Urology
	10	Vascular Surgery
	11	Other - Surgical
	90	Non-Surgical

11.2.3 Reason for removal

The Reason for Removal is derived, by HBCIS, from the waiting list status. The waiting list status codes, from the corporate reference file are mapped to one of the following codes upon extract.

	Code	Description
HBCIS Hospitals	01	Admitted and treated as an elective patient for awaited procedure in this hospital
	02	Admitted and treated as an emergency patient for awaited procedure in this hospital
	04	Treated elsewhere for awaited procedure
	05	Surgery not required or declined
	06	Transferred to other hospitals waiting list
	99	Not Stated/Unknown

11.2.4 Listing date

This is the date the patient was placed on the waiting list for elective surgery. This date is from field 03 of the Waiting Entry Screen and is input by the user.

11.2.5 Urgency category

The final change on any day to the clinical urgency classification in field 22. This indicates the urgency with which the patient requires elective hospital care, as determined by the treating clinician.

	Code	Description
HBCIS Hospitals	1	Elective Surgery - Category 1
	2	Elective Surgery - Category 2
	3	Elective Surgery - Category 3
	4	Other - Category 1
	5	Other - Category 2
	6	Other - Category 3

11.2.6 Accommodation (Intended)

The planned type of physical accommodation for the patient as at the date placed on the waiting list. This indicates whether the patient planned to be treated as a public or private patient. This intended accommodation is from field 23. This item does not relate to the patient's hospital insurance status or the actual accommodation after admission.

11.2.7 Site procedure indicator

This item is a planned procedure as at the date the patient was placed on a waiting list and is from field 25. The code must be a valid site procedure indicator code from the 305 codes in the corporate reference file. For a list of site procedure indicator codes see Appendix M.

11.2.8 National procedure indicator

This is an indicator of the procedure planned at the date the patient was placed on the waiting list. This item is derived, by HBCIS, from the Site Procedure Indicator that is mapped to one of the 16 National Procedure Indicator codes.

	Code	Description
HBCIS Hospitals	01	Cataract extraction
	02	Cholecystectomy
	03	Coronary artery bypass graft
	04	Cystoscopy
	05	Haemorrhoidectomy
	06	Hysterectomy
	07	Inguinal herniorrhaphy
	08	Myringoplasty
	09	Myringotomy
	10	Prostatectomy
	11	Septoplasty
	12	Tonsillectomy
	13	Total hip replacement
	14	Total knee replacement
	15	Varicose Veins
	16	Not applicable

11.2.9 Planned length of stay

This is the intended length of stay of a patient awaiting an elective admission as estimated by the responsible clinician when placed on the list. This is from field 24. Please note a planned same day admission is recorded as a 'D' and is converted to zero when extracted to the Health Statistics Unit.

11.2.10 Planned procedure/operation date

This is the most recent Planned Procedure/Operation date for the patient for their reported waiting list entries. The data is collected from field 10 'Operation/Procedure date' of the Booking Entry screen with EAM.

This field is mandatory for patients with a waiting list status of '02'..

11.3 Activity record details

11.3.1 Activity code

If a patient is not ready for care for a period while they were on the waiting list or any changes occur to a patient's urgency category, then a date of change of the item is reported in the activity file, using the relevant activity code. This activity code is generated by HBCIS. All periods of not ready for care are forwarded to the Health Statistics Unit. The final details of any changes to urgency categories on the particular day will be forwarded to the Health Statistics Unit.

HBCIS Hospitals	Code	Description
	N	Not ready for care
	E	Elective Surgery Items

11.3.2 Activity code details = N (Not ready for care)

Entry number

Each waiting list entry has a placement number unique within the patient identifier. The entry number in the activity details must match with the corresponding entry number in the Elective Admission Details file. This number is from field 02 of the Waiting List Entry screen and is generated by HBCIS.

Date not ready for care

Each waiting list entry may have one or more periods where the patient is not ready for care. The date not ready for care is the first date in this period that the patient will not be ready for care and is from field 05 of the Waiting List Entry Screen. Not ready for care patients are those who are not in a position to commence treatment.

Last date not ready for care

Each waiting list entry may have one or more periods where the patient is not ready for care. The last date not ready for care is the final date in this period that the patient is not ready for care and is from field 06 of the Waiting List Entry Screen.

11.3.3 Activity code details = E (Elective surgery items)

Entry number

Each waiting list entry has a placement number unique within the patient identifier. The entry number in the activity details must match with the corresponding entry number in the Elective Admission Details file. This number is from field 02 of the Waiting List Entry screen and is generated by HBCIS.

Urgency category

The final change on any day to the clinical urgency classification from field 22 of the Waiting List Entry Screen. This indicates the urgency with which the patient requires elective hospital care, as determined by the treating clinician.

	Code	Description
HBCIS Hospitals	1	Elective Surgery – Category 1
	2	Elective Surgery – Category 2
	3	Elective Surgery – Category 3
	4	Other – Category 1
	5	Other – Category 2
	6	Other – Category 3

Date of change

The date of change for any elective admission data item in the Activity file will be recorded. The date of change is entered by the user upon inserting new data into fields 22 - 25 of the Waiting List Entry screen.

12. SUB AND NON-ACUTE PATIENT (SNAP) DETAILS – (PUBLIC AND PRIVATE HOSPITALS)

12.1 SUB and NON-ACUTE patient (SNAP) details

From 1 July 2014 public hospitals will be required to report SNAP details for all Sub and Non-Acute episodes of care, including scoring to be recorded for all age groups (including paediatric patients) and have SNAP episodes created regardless of whether they are in a designated SNAP Unit or not.

Private hospitals will be required to report SNAP data for all public Sub and Non-Acute patients (irrespective of whether the patient is being treated in a designated unit).

SNAP validations will be based on care type, not admission to a designated SNAP ward/bed.

The Australian National Sub and Non-Acute Patient (AN-SNAP) Classification System has been implemented to better inform service planning, purchasing, and clinical management. The scope of this collection includes all admitted patient episodes with the following care types:

- (09) - Geriatric Evaluation and Management care;
- (10) - Psychogeriatric care;
- (11) - Maintenance care;
- (20) - Rehabilitation care;
- (30) - Palliative care.

12.2 SNAP details

12.2.1 SNAP Episode Number

Each set of SNAP details should be assigned a unique SNAP episode number. This number will form part of each record's unique identifier when the SNAP details are forwarded to the Health Statistics Unit.

Maintenance SNAP episode – There must be a least one SNAP episode within a single non-acute episode of care.

Geriatric Evaluation and Management, Psychogeriatric, Rehabilitation and Palliative SNAP episodes – There can only be one within a single SNAP episode within a single sub-acute episode of care.

12.2.2 SNAP Type

The SNAP Type is a classification of a patient's care type based on their characteristics, primary treatment goal and evidence.

The codes for each SNAP Type are validated against valid sub and non-acute episode types.

Geriatric Evaluation and Management SNAP Type

Geriatric Evaluation and Management is provided for a person with complex multi-dimensional medical problems associated with disabilities and psychosocial problems, usually (but not always) an older person.

Geriatric Evaluation and Management SNAP types can only be used in conjunction with a care type of 09, Geriatric Evaluation and Management Care.

There can only be one SNAP episode within a single SNAP episode of care.

Geriatric SNAP Type	Definition
GEM	Geriatric Evaluation and Management
GAO	Geriatric Evaluation and Management - Assessment only
GSD	Geriatric Evaluation and Management - Planned Same Day

Psychogeriatric SNAP Type

Psychogeriatric care is provided to persons with an age-related organic brain impairment with significant behavioural disturbance or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance.

The Psychogeriatric SNAP types can only be used in conjunction with a care type of 10, Psychogeriatric Care.

There can only be one SNAP episode within a single SNAP episode of care

Psychogeriatric SNAP Type	Definition
PSA	Psychogeriatric – Assessment only
PSG	Psychogeriatric

Maintenance SNAP Type

Maintenance is provided for a person with a disability who, following assessment or treatment, does not require further complex assessment or stabilisation

Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care often require care over an indefinite period.

Maintenance SNAP types can only be used in conjunction with a care type of 11, Maintenance Care.

There must be at least one SNAP episode within a single non-acute episode of care.

If there is more than one SNAP episode then these must be contiguous.

Contiguous SNAP episodes must have different SNAP types.

Example:

Patient Admitted: 01 August 2014

Patient Discharged: 10 August 2014

SNAP Type: 11 – Maintenance

First SNAP episode 1

SNAP Start Date: 01 August 2014

SNAP End Date: 05 August 2014

Second SNAP episode 2

SNAP: Start Date 06 August 2014

SNAP End Date 10 August 2014

Maintenance SNAP Type		
Code	**Description**	**Definition**
MAO	Maintenance – Assessment Only	
MNH	Maintenance - Nursing Home Type	The patient has been in hospital for a continuous period exceeding 35 days, does not have a current acute care certificate and is waiting placement in a residential aged care facility. Note: MNH SNAP Type should not to be confused with the Nursing Home Type Patient (NHTP) class used for accounting purposes. See 4.14 Nursing Home Type Patients (NHTP) for further information on NHTPs.
MRE	Maintenance - Respite	A patient who is not waiting for residential care and the primary reason for admission is the short-term unavailability of the patient's usual care arrangements. Examples may include: Admission due to carer illness or fatigue. Planned respite due to carer unavailability. Short term closure of care facility. Short term unavailability of community services.

MCO	Maintenance Care (Convalescent)	Following assessment and/or treatment the patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. Under normal circumstances the patient would be discharged but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged. Examples may include: Patients awaiting the completion of home modifications essential for discharge. Patients awaiting the provision of specialised equipment essential for discharge. Patients waiting for rehousing. Patients waiting for supported accommodation such as hostel or group home bed. Patients for whom community services are essential for discharge but are not yet available.
MOT	Maintenance Care (Other Maintenance)	Any other reason the patient may require a maintenance episode other than those already stated.

Rehabilitation SNAP Type

Rehabilitation care is provided for a person with an impairment, disability or handicap.

Rehabilitation SNAP types can only be used in conjunction with a care type of 20, Rehabilitation.

There can only be one SNAP episode within a single SNAP episode of care

Rehabilitation SNAP Type		
Code	**Description**	**Definition**
RAO	Assessment only	The person is seen on one occasion only for assessment and/or treatment and no further intervention by this service/team are planned.
RCD	Congenital deformities	Spina Bifida, Other Congenital deformities.
RPU	Pulmonary	Chronic obstructive pulmonary disease, Lung transplant, Other pulmonary.
RST	Stroke	Left Body Involvement, Right Body Involvement, Bilateral Involvement, No Paresis, other Stroke.
RBD	Brain Dysfunction	Non–Traumatic – Sub-arachnoid haemorrhage, Anoxic brain damage, Other non-traumatic brain dysfunction, Traumatic -Open Injury, Closed Injury.
RNE	Neurological	Multiple Sclerosis, Parkinsonism, Polyneuropathy, Guillian-Barre, Cerebral Palsy, Neuromuscular disorders, Other neurological conditions.

RSC	Spinal Cord Dysfunction	Non-Traumatic spinal cord dysfunction - Incomplete paraplegia, Complete paraplegia, Incomplete C1-4 quadriplegia, Incomplete C5-8 quadriplegia, Complete C1-4 quadriplegia, Complete C5-8 quadriplegia, Other non-traumatic spinal cord dysfunction, Traumatic spinal cord dysfunction - Incomplete paraplegia, Complete paraplegia, Incomplete C1-4 quadriplegia, Incomplete C5-8 quadriplegia, Complete C1-4 quadriplegia, Complete C5-8 quadriplegia, Other non-traumatic spinal cord dysfunction.
RAL	Amputation of Limb	Single upper extremity above the elbow, Single upper extremity below the elbow, Single lower extremity above the knee, Single lower extremity below the knee, Double lower extremity above the knee, Double lower extremity above/below the knee, Double lower extremity below the knee, Partial foot, Other amputation not from trauma.
RDE	Debility	Re-conditioning following surgery, Reconditioning following medical illness, Cancer rehabilitation.
RPS	Pain Syndromes	Neck pain, Back pain, Extremity pain, Headache, Multi-site pain, Other pain.
ROF	Orthopaedic conditions, fractures	Includes: Fracture of hip - unilateral, Fracture of hip – bilateral, Fracture of shaft of femur, Fracture of pelvis, Fracture of knee, Fracture of lower leg or ankle or foot, Fracture of upper limb, Fracture of spine, Fracture of multiple sites, Other orthopaedic fracture.
ROR	Orthopaedic conditions, replacement	Includes: Hip replacement unilateral or bilateral, knee replacement – unilateral or bilateral, Knee and hip replacement – same or different side, , Shoulder replacement.
ROA	Orthopaedic conditions, all other	Includes: Soft tissue injury.
RCA	Cardiac	Following recent onset of new cardiac impairment, Chronic cardiac insufficiency, Heart and heart/lung transplant.
RMT	Major Multiple Trauma (MMT)	Brain and spinal cord injury, Brain and multiple fracture/amputation, Spinal and multiple fracture/amputation, Other multiple trauma.
RBU	Burns	Burns.
ROI	Other Disabling Impairments	Lymphoedema, Conversion disorder, Other disabling Impairments – that cannot be classified into a specific group.
RAR	Arthritis	Rheumatoid Arthritis, Osteoarthritis, Other Arthritis.
RDD	Developmental Disabilities	Developmental disabilities (excluding Cerebral Palsy).

Palliative Care SNAP Type

Palliative Care is provided for a person with an active, progressive, life limiting disease with little or no prospect of cure. Palliative care may include the assessment or management of the physical, psychological or emotional needs of the patient.

The Palliative Care SNAP type can only be used in conjunction with a care type of 30, Palliative Care.

There can only be one SNAP episode within a single SNAP episode of care

Palliative Care SNAP Type	
Code	**Definition**
PAA -	Palliative Assessment only
PAL	Palliative Care

Complete listing of valid SNAP Type Codes

All Hospitals SNAP Type	Code	Description
	RAO	Rehabilitation - Assessment only
	RCD	Rehabilitation - Congenital Deformities
	ROI	Rehabilitation - Other disabling impairments
	RST	Rehabilitation - Stroke
	RBD	Rehabilitation - Brain Dysfunction
	RNE	Rehabilitation - Neurological
	RSC	Rehabilitation - Spinal Cord Dysfunction
	RAL	Rehabilitation - Amputation of Limb
	RPS	Rehabilitation - Pain Syndromes
	ROF	Rehabilitation – Orthopaedic conditions, fractures
	ROR	Rehabilitation – Orthopaedic conditions, replacement
	ROA	Rehabilitation - Orthopaedic all other
	RCA	Rehabilitation - Cardiac
	RMT	Rehabilitation - Major Multiple Trauma
	RPU	Rehabilitation - Pulmonary
	RDE	Rehabilitation - Debility
	RDD	Rehabilitation - Development Disabilities
	RBU	Rehabilitation - Burns
	RAR	Rehabilitation - Arthritis
	GAO	Geriatric Evaluation and Management - Assessment only
	GEM	Geriatric Evaluation and Management
	GSD	Geriatric Evaluation and Management - Planned Same Day
	MAO	Maintenance – Assessment only
	MRE	Maintenance - Respite
	MNH	Maintenance - Nursing Home Type
	MCO	Maintenance - Convalescent Care
	MOT	Maintenance - Other
	PSG	Psychogeriatric
	PSA	Psychogeriatric – Assessment only
	PAL	Palliative care
	PAA	Palliative – Assessment only

12.2.3 SNAP Group Classification

The SNAP group classification is a summary of the various SNAP care types allocated to patients, by grouping together homogeneous SNAP episodes. This provides a means of relating the number and types of SNAP patients treated in a hospital to the resources required by the facility. It also allows meaningful comparisons to be made of SNAP units' effectiveness and efficiency.

The SNAP group classification is derived from the first set of ADL scores for each Maintenance, Rehabilitation. Psychogeriatric and Geriatric Evaluation and Management SNAP episodes .

For Palliative Care SNAP episodes the SNAP group classification is derived at the start of each Phase Type.

Each patient's SNAP group classification will be derived by the Health Statistics Unit.

12.2.4 SNAP Start Date

For Maintenance SNAP episodes – The start date of the **first** SNAP episode must be the same as the start date of the episode of care.

For Geriatric Evaluation and Management, Psychogeriatric, Rehabilitation and Palliative SNAP episodes - The start date of the SNAP episode must be the same as the start date of the episode of care.

Each SNAP episode must meet the criteria for sub and non-acute admitted patient care, as identified by the SNAP types.

12.2.5 SNAP End Date

For Maintenance SNAP episodes – The end date of the **last** SNAP episode must be the same as the end date of the episode of care.

For Geriatric Evaluation and Management, Psychogeriatric, Rehabilitation and Palliative SNAP episodes - The end date of the SNAP episode must be the same as the end date of the episode of care.

Each SNAP episode must meet the criteria for sub and non-acute admitted patient care, as identified by the SNAP types.

12.2.6 Multidisciplinary Care Plan

A Multidisciplinary Care Plan is required for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type.

The Multidisciplinary Care Plan refers to a series of documented and agreed initiatives/treatment (specifying program goals, actions and time frames) which has been established through multidisciplinary consultation (including the patient/carers where appropriate).

Record whether a Multidisciplinary Care Plan has been developed.

	Code	Description
All Hospitals	Y	Yes
	N	No
	U	Unknown

12.2.7 Multidisciplinary Care Plan Date

If the patient has had a Multidisciplinary Care Plan developed record the date that the latest Multidisciplinary Care Plan was documented. This should be reported for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type.

12.2.8 Primary Impairment Type

The Primary Impairment Type is the primary reason for the admission to the SNAP episode. This should only be reported for all rehabilitation SNAP Types.

Refer to Appendix O for a list of Primary Impairment Type codes.

12.2.9 Proposed Principal Referral Service

Patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type should have the Proposed Principal Referral Service recorded on separation of the SNAP episode. This is the type of service that is proposed for the patient post-discharge from hospital. If there is more than one referral service proposed record the principal service.

Record the Proposed Principal Referral Service:

	Code	Description
All Hospitals	001	No service is required
	101	Community/home based rehabilitation
	102	Community/home based palliative
	103	Community/home based geriatric evaluation and management
	111	Community/home based – nursing/domiciliary
	104	Community/home based – respite
	105	Community/home based – psychogeriatric
	106	Home and community care
	107	Community aged care package, extended aged care in the home
	108	Flexible care package
	109	Transition care program (includes intermittent care service)
	110	Outreach Service
	198	Community/home based - other
	201	Hospital based (admitted) – rehabilitation
	202	Hospital based (admitted) – maintenance
	203	Hospital based (admitted) – palliative
	204	Hospital based (admitted) - geriatric evaluation and management
	205	Hospital based (admitted) - respite
	206	Hospital based (admitted) – psychogeriatric
	207	Hospital based (admitted) – acute
	208	Hospital based - non-admitted services
	298	Hospital based - other
	998	Other service
	999	Not stated/unknown service

12.3 Activity record details

12.3.1 SNAP Episode Number

Each set of SNAP details for SNAP type should be assigned a unique SNAP episode number. This number will form part of each record's unique identifier when the SNAP details are forwarded to the Health Statistics Unit.

12.3.2 Activity of Daily Living (ADL) Type

ADL tools are used to objectively measure the physical, psychosocial, vocational and cognitive functions of an individual with a disability. There are a number of ADL tools, so the type used to code the patient's functions needs to be recorded. There are different ADL tools for different SNAP Type Codes.

	Code	Description	For SNAP Type Codes
All Hospitals	FIM	Functional Independence Measure	Rehabilitation and GEM
	HON	Health of the Nation Outcome Scales	Psychogeriatric
	RUG	Resource Utilisation Group	Palliative & Maintenance

12.3.3 Activity of Daily Living (ADL) Sub-Type

The ADL sub-type refers to the domain that is being measured within the tool (i.e. cognitive, motor, behaviour etc).

	Code	Description
All Hospitals	BEH	Behaviour
	ADL	Activity of daily living
	TOT	Total
	COG	Cognitive
	MOT	Motor

12.3.4 Activity of Daily Living (ADL) Score

At least one set of ADL scores must be provided for each SNAP episode.

The ADL score is the actual numerical rating reported for the ADL tool being used to measure the patient's functional ability.

More than one ADL score per SNAP episode can be recorded, however only one ADL score per day may be recorded. All ADL scores should be supplied to the Health Statistics Unit.

The Health of the Nation Outcome Scale (HoNOS) requires the reporting of a behaviour score, an activity score and a total score.

The Functional Independence Measure (FIM) requires the reporting of both a cognition score and a motor score.

The Resource Utilisation Group (RUG) only requires a total score to be reported.

	ADL Type	ADL Sub-type	Description	ADL Score	
				Min	Max
All Hospitals	HON	BEH	HoNOS (Behaviour)	0	4
		ADL	HoNOS (Activity of daily living)	0	4
		TOT	HoNOS (Total)	0	48
	RUG	TOT	Resource Utilisation Group (Total)	4	18
	FIM	MOT	FIM (Motor)	13	91
		COG	FIM (Cognitive)	5	35

12.3.5 Further information on ADL Assessments

ADL scores for each SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL type and ADL sub type.

For all SNAP episodes:

- A code of '999' is acceptable as a SNAP score when the actual ADL score is not known or cannot be determined at the time of entry.
- Multiple ADL scores are able to be reported. For example, a patient may undergo an assessment during the middle of their stay, in addition to assessments on admission to and discharge of the SNAP episode. In this scenario, the episode would contain 3 sets of ADL Scores.
- ADL Scores can be entered retrospectively, for example, an ADL assessment may be completed on day 2 of the episode, but the scores may not be available for entry into the hospital patient system until day 7. The scores can be retrospectively entered for the appropriate date.

12.3.6 ADL Date

The date of the ADL score must not be before the start date of the SNAP episode or after the end date of the SNAP episode.

12.3.7 Phase Type

The Phase Type denotes the stage of the patient's illness or situation. A Phase Type Code should only be reported for palliative care SNAP episodes. (ie. patients with a SNAP Type of PAL or PAA).

Stable phase

The person's symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned.

The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

Unstable phase

The person experiences the development of a new problem or a rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency treatment. The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multi-disciplinary team.

Deteriorating phase

The person experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.

The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.

Terminal Care Phase

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

- Profoundly weak,
- Essentially bed bound,
- Drowsy for extended periods,
- Disoriented for time and has a severely limited attention span,
- Increasingly disinterested in food and drink,
- Finding it difficult to swallow medication.

This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues. The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

All Hospitals	Code	Description
	01	Stable
	02	Unstable
	03	Deteriorating
	04	Terminal care

13. DEPARTMENT of VETERANS' AFFAIRS PATIENTS

The Department of Veterans' Affairs (DVA) has a charter to serve members of Australia's veteran and defence force communities, war widows and widowers, widows and dependants, through programs of care, compensation, commemoration and defence support services.

13.1 Card type

Eligibility for hospital treatment funded by the DVA is established by confirming that the patient holds a Gold Card or a valid White Repatriation Health Card.

Eligibility only applies for the card-holder, that is, the person whose name appears on the Card. If spouses of veterans are eligible, they will hold their own Gold or White Card.

Repatriation Health Cards issued to eligible veterans and other beneficiaries are as follows:

Gold Card

A Repatriation Health card provided to an entitled person by the DVA, which identifies the entitled person as being entitled to treatment for all injuries and diseases.

White Card

It is necessary to contact DVA on 133254 to confirm a patient's eligibility for treatment as an 'entitled person' under the DVA Arrangement. DVA will not accept financial responsibility if the patient's treatment needs are considered unrelated to specific war-caused injuries, diseases etc for which the white card was issued.

All Hospitals	Code	Description
	Gold	Gold Card
	White	White Card

INELIGIBLE CARDS

Orange Card
A Repatriation Pharmaceutical Benefits card gives cardholders access to an extended range of prescription medicines and ancillary items available under the Repatriation Pharmaceutical Benefits Scheme.

The Orange Card does not entitle persons to admission to hospital or a day procedure centre (Day Hospital Facility) under DVA contractual arrangements and does not provide any medical or allied health treatment entitlements.

Pensioner Concession Card
The pensioner concession card does not entitle cardholders to medical and other treatment at the DVA's expense.

13.2 DVA file number

Ensure the name of the patient matches the name on the DVA card. Record the patient's DVA identification number. Do not leave a space between the characters and numbers. That is, record QX123 not QX 123.

13.3 Hospital services agreement 2004-2014 (public hospitals only)

13.3.1 DVA agreement

The 2004-2014 Hospital Services Arrangement between the Commonwealth of Australia, acting through the Department of Veterans' Affairs, the Repatriation Commission, and the Military Rehabilitation and Compensation Commission, (collectively, acting through the Department of Veterans' Affairs) and the State of Queensland, acting through Queensland Health, governs the provision of hospital services to eligible veterans and dependants from, at, and on behalf of Queensland public hospitals.

This is a commercially viable agreement based on the principle of full cost recovery.

DVA revenue is allocated to Hospital and Health Services in accordance with the HealthCare Purchasing and Activity Based Funded Framework.

Services covered under the Hospital Services Arrangement include three broad types, namely:

- acute casemix-funded admitted patient services
- sub- and non-acute admitted patient services
- non-admitted services

13.3.2 Election

The Department of Veteran's Affairs (DVA) promotes its system of health care for entitled persons and advises entitled persons to present their Repatriation Health Cards at Queensland public hospitals to access treatment services provided under the Hospital Services Arrangement 2004-2014.

This Arrangement recognises that entitled persons may be directly referred to Queensland public hospital services of their choice, with choice of doctor being subject to the doctor having admitting rights for private patients.

For entitled persons unable to access their choice of doctor, Queensland public hospital staff should support entitled persons access private doctors through the provision of advice regarding available private doctors.

On choosing to be funded by DVA, all DVA patients are considered to have the same status as private patients i.e. public hospital services are to be provided on a private patient basis with, at least, shared ward accommodation.

It is recognised that not all hospitals have access to private doctors, hence account class codes are available that recognise a veteran's choice to be DVA

funded but not to choose their own doctor (i.e. for public facilities the 'DVA public' account class codes e.g. GPEDVA).

DVA Repatriation health care arrangements provide the following benefits for entitled persons electing to use their DVA health care entitlements;

Repatriation Health Card - for all conditions (Gold Card)

The DVA will pay for:

- treatment in hospital on a private patient basis for all medical conditions in shared ward accommodation as a private patient in a public hospital
- all hospital and medical fees (non-medical expenses, e.g. phones, TV, newspapers and so on, are not included)

Repatriation Health Card - For specific conditions (White Card)

DVA will with prior approval, pay for:

- all hospital and medical treatment for war or service-caused accepted disabilities (non-medical expenses, e.g. phones, TV, newspapers and so on, may not be included) in shared ward accommodation on a private patient basis
- treatment for general disabilities including malignant cancer, pulmonary tuberculosis, anxiety and/or depression or post-traumatic stress disorder (PTSD) if these conditions are accepted by DVA.
- Hospital staff must contact DVA on 1300 550 457 (Metro) or 1800 550 457 (regional) to confirm that the patients proposed treatment relates to an accepted disability

13.3.3 Overview of payment arrangements

1. Payment arrangements for admitted services cover all eligible admitted patient services normally provided to private patients with shared accommodation (including single room where clinically necessary) and choice of doctor in public hospitals.
2. Medicare Australia (acting on behalf of DVA) pays relevant medical practitioners who are exercising their right to private practice separately to the Hospital Services Arrangement for admitted patient medical specialist consultations and services including diagnostic and imaging services, and general practice at rates agreed by DVA.
3. Payment for acute, casemix funded admitted patient separations is based on the AR-DRG Version 6.0x grouping classification system. Payment for sub and non-acute admitted patient services is at a per diem rate.
4. Medicare Australia (acting on behalf of DVA) pays for the costs of Surgically Implanted Prosthetics (SIPs) incurred by entitled persons.
5. Privately referred and privately treated non-admitted entitled persons are billed direct to the DVA by the provider, and paid separately by the DVA.

13.3.4 Compensation cases

Hospital staff shall use reasonable endeavours to ascertain from an entitled person any compensable incapacity for which an entitled person is being, or is to be, treated. The DVA will not be responsible for treatment costs for compensable patients i.e. Motor vehicle accidents.

13.3.5 Nursing home type patients

If the hospitalisation of an entitled person exceeds a continuous period of 35 days, it is necessary to review the entitled person's status and either:

a) An Acute Care Certificate is given by a medical practitioner and retained on the patient medical record for audit and/or reconciliation purpose; or

b) The entitled person is reclassified to a nursing home type patient.

If an entitled person is reclassified as a nursing home type patient, Queensland Health is required under the Arrangement to ensure that the patient is assessed and an appropriate discharge plan is developed, including where appropriate an assessment by an Aged Care Assessment Team, and that the appropriate post-acute support or residential care is then arranged. Refer Section 13.3.6 for Patient Charging Arrangements.

Entitled persons who are reclassified to nursing home type patients are charged a patient contribution, in accordance with the provisions of the National Health Insurance Act 1973.

Patient contributions are raised directly against DVA patients, however contributions relating to prisoners of war, are raised against the DVA.

13.3.6 Patient contributions and co-payments

- Hospitals shall not raise any charges direct on an entitled person except where provided for under the Arrangement.
- This provision shall not prevent hospitals providing personal services, including television and/or telephone services to entitled persons. However, any cost is to be borne by the entitled person.
- Entitled persons will not be charged for pharmaceuticals provided while they receive services as admitted patients. However, under the National Health Act 1953, entitled persons may be charged at a level consistent with the Pharmaceutical Benefits Scheme statutory co-payments for pharmaceuticals provided to them on discharge, and as non-admitted patients.
- Entitled persons who are reclassified to nursing home type patients are charged a patient contribution, in line with the provisions of the Health Insurance Act 1973. Hospitals raise patient contributions direct from patients, except contributions relating to prisoners of war, which are raised against the DVA.

Billing arrangements (HBCIS Only)

Invoicing	Fees raised against	Fees raised by		
		Revenue Strategy and Support Unit	Hospital/ Service providers	HSSA Pathology QLD
Admitted Patient Services				
Hospital services fee (excluding ward medical; imaging; pathology and prosthetics)	DVA	✔		
Medical practitioners exercising their right to private practice for admitted patients medical specialist consultations and services including diagnostic and imaging services, and general practice at rates agreed by DVA.	Medicare Australia		✔	✔
Patient contributions raised in accordance with the Health Insurance Act 1973 for nursing home type patients (long-stay patients)	Patient		✔	
Pathology Services (excluding services provided in emergency and outpatient departments)	Medicare Australia			✔
Patient contributions for Prisoners of war (POW)	DVA		✔	
Surgically implanted prosthetics claims (use hospital provider number to recover costs of all claims)	Medicare Australia		✔	
Non-admitted services				
Privately referred and privately treated non-admitted entitled persons	DVA		✔	
Patient co-payments for pharmaceuticals issued on discharge, and non-admitted services, for hospitals participating in the PBS Access Program.	Patient		✔	
Other non-admitted patient services (excluding services provided to privately referred and privately treated non-admitted patients) to cover medical, nursing, diagnostic, allied health, professional services and ED services.	DVA	✔		

13.4 HBCIS entry guidelines

Accurate completion of HBCIS fields - Admission and Registration Screens is crucial.

	Field	Data Entry
HBCIS Hospitals	Registration Pay Class	DVA
	Health Fund	DVA
	Health Schedule	Enter Card Type (GOLD or WHITE)
	Health Fund Cover	Defaults to Nil
	Health Fund Number	Blank
	DVA No	Enter DVA Number – no spaces
	DVA Type	Enter Card Type (G or W)
	Acc. Class	Enter appropriate DVA Account Class Code
	Admission Pay Class	DVA
	Consent	Y or N or U
	Hospital Insurance	Y or N
	Funding Source	07

13.5 HBCIS entry guidelines

The following account class codes relate specifically for DVA admitted patients.

	Account Class		Account Class Description
HBCIS Hospitals	DVA Public	GPEDVA	General Public DVA
		GPEDVASD	General Public DVA – Same Day
		GPRCDVA	General Public Respite Care DVA (Hospital only)
		GPRCDVASD	General Public Respite Care DVA – Same Day
	DVA Private	GSEDVA	General Shared Eligible DVA
		GSEDVASD	General Shared Eligible DVA – Same Day
		GSRCDVA	General Shared Respite Care DVA (Hospital only)
		GSRCDVASD	General Shared Respite Care DVA – Same Day

14. PALLIATIVE CARE

Additional information is to be collected for palliative care patients.

14.1 First admission for palliative care treatment

The first admission for palliative care treatment is the status of the episode in terms of whether it is a first or subsequent admission, at any hospital for any condition, for palliative care treatment.

	Code	Description
All Hospitals	1	No previous admission for palliative care treatment
	2	Previous admission for palliative care treatment

Example 1

A patient is admitted for palliative care treatment at Hospital A. It is the first time that this patient has ever been admitted for palliative care treatment. The status for this admission is 1 – No previous admission for palliative care treatment

Example 2

A palliative care is transferred from Hospital A to the Palliative Care Unit at Hospital B. As the patient was admitted at both hospitals for palliative care, the status for this admission is 2 – Previous admission for palliative care treatment.

Example 3

A patient is admitted for palliative care treatment related to COPD. Ten years ago that patient received palliative care treatment for cancer. The status for this admission is 2 – Previous admission for palliative care treatment.

14.2 Previous specialised non-admitted palliative care treatment

Previous specialised non-admitted palliative care treatment is the status of the episode in terms of whether the patient has had a previous non-admitted service contact for palliative care treatment.

	Code	Description
All Hospitals	1	Patient has **no** previous non-admitted service/contacts for palliative care treatment
	2	Patient has previous non-admitted service/contacts for palliative care treatment

15. WORKERS' COMPENSATION QUEENSLAND (PUBLIC HOSPITALS ONLY)

15.1 Background

In July 2004, the Director-General and the Minister for Health communicated to relevant internal and external stakeholders, the Department's aim to progress a fee-for-service arrangement between Queensland Health and workers' compensation insurers, for workers' compensation clients receiving treatment in Queensland public hospitals as public patients.

Accordingly the fee for service arrangement was introduced from April 2005. Three years of the fee for service funding arrangement increased Queensland Health revenues from Queensland workers' compensation insurers significantly from the previous fixed grant arrangement.

In October 2008, negotiations were held between WorkCover Queensland and Queensland Health to move from fee for services arrangements, to an Annual Advance Payment arrangement for services provided by Public hospitals to injured workers whose employers are covered under WorkCover Queensland.

Commencing 1 January 2009, one advance payment, for the financial year, by WorkCover Queensland will cover the cost of Inpatient, Outpatient and Emergency Department services. It is no longer a requirement for Hospital and Health Services to bill for these services.

These arrangements do not include self-insurers listed on the Workers Compensation Regulator's web site http://www.qcomp.qld.gov.au/ . They provide workers compensation insurance for their own employees. The Fee for Service arrangement continues to apply to Queensland self-insurers.

Since 1 July 2009, Hospital and Health Services have also been responsible for Self-insurer billing.

The Public Health Services Table of Costs (accessed at http://www.qcomp.qld.gov.au/) describes the services, prices and business rules relating to the provision of Queensland public hospital services to Queensland workers' compensation public patients.

Employees employed by a Commonwealth agency may be covered under the Comcare scheme. Refer to the Comcare website for more information. http://www.comcare.gov.au/ .

Scope

The funding arrangement applies to Queensland workers, with a compensable injury or illness that have elected to be treated by a doctor nominated by the hospital (i.e. a Queensland workers' compensation public patient).

The scope of services identified in the arrangement includes:

- Admitted patient services
- Non-admitted services:
  - Outpatients (Medical and Allied Health)
  - Emergency departments
- Medical reports and records
- Inter-facility transfers

Responsibility for billing is detailed in the Tables below. This informs the collection and reporting of data at local and central levels.

Table 1 WorkCover Queensland

Services	Responsible area	Timeframe
Admitted services	Revenue Strategy and Support Unit	Annually
Non-admitted services		
Inter-facility transfers	Hospital and Health Services (HHS)	As incurred
Medical reports and reports		
Artificial prosthesis e.g. limb, arm or hand prosthesis		
Surgically implanted prosthesis over the Queensland Health surgical standard. Prior approval must be gained from WorkCover Qld.		
Pharmacy Items	HHSs/Facilities will not issue discharge pharmacy items to WorkCover patients. They will only issue private scripts. However, remote hospitals where there is no private pharmacies in the township may issue drugs to the WorkCover patients for which they can claim reimbursements from the workCover directly or through the patient.	As incurred

Table 2 Self Insurers

Services	Responsible area	Timeframe
Admitted services	Hospital and Health Services	As incurred
Non-admitted services		
Inter-facility transfers		
Medical reports and reports		
Artificial prosthesis e.g. limb, arm or hand prosthesis		
Surgically implanted prosthesis		
Pharmacy Items	HHSs/Facilities will not issue discharge pharmacy items to WComp patients. They will only issue private scripts. However, remote hospitals where there is no private pharmacies in the township may issue drugs to the WComp patients for which they can claim reimbursements from the insurer directly or through the patient.	As incurred

The success of both arrangements is reliant on the timely and accurate identification and recording of workers' compensation patients presenting at Queensland public hospitals for admitted and non-admitted services.

Under the National Health Reform Agreement, compensable patients are not considered as eligible persons who are entitled to access public hospital services 'free of charge'. "Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by Queensland" (National Health Reform Agreement G:3).

Workers' compensation claimants (electing public patient status) deemed to have an invalid claim for workers' compensation are entitled to revert to public patient status in accordance with the provisions of the National Health Reform Agreement.

Data relating to all compensable patients is captured and retrieved from the HBCIS compensable screen. The advent of the new arrangement requires the ongoing collection of compensable data.

15.2 Data elements

The data elements have been collected in the HBCIS compensable screen and used at a local level. These data elements are used to substantiate the hospital's claim for reimbursement for costs of providing treatment for compensable injuries.

• Accident/Incident date • Nature of injury • Insurer • Insurer address • Employer • Employer address • Claim Number	Fields must be linked to the relevant admitted episodes

Specific elements in the Compensable screen will be forwarded to the Health Statistics Unit via monthly HQI Extracts.

15.3 Criteria for collection

Patients who have been assigned a payment class of Workers Compensation Queensland (WCQ) and Workers Compensation Queensland Ineligible (WCQI) in the HBCIS Admission screen are required to have relevant data elements completed in the Compensable screen. Links must be created between the Compensable screen and the relevant treatment services both admitted and non-admitted.

An episode of care may only have one link to a compensable screen. However, each compensable screen may be linked to many admitted episodes or non-admitted occasions of service.

15.4 HBCIS screen

The data elements are collected via the existing HBCIS Compensable screen. Users will be prompted to collect the data upon filing the HBCIS Admission Screen (the system will flip to the Compensable screen). Alternatively, the Compensable screen is available via the menu options and can be completed during the episode of care if required.

Hospitals that do not use HBCIS will need to complete a Motor and Work Injury Interview Questionnaire and provide this information to the facility that records their data.

15.5 HBCIS reports

Two HBCIS Reports are available to assist hospital staff:

1. Compensable Admissions Report: as the data items are extracted via the HQI Extract, this report will assist staff to identify incomplete data and unlinked admissions prior to the Extract.
2. Compensable Appointments Report: where HBCIS Appointment Scheduling module is used, this report lists services that are linked to information in a relevant compensable screen and can be used to assist with raising charges for an invoice. The report can be run to show services that are not linked which require further attention.

Contact your HBCIS Administrator to have the reports loaded into HBCIS.

15.6 HQI extract

The WCQ data elements are extracted via HQI and forwarded to the Health Statistics Unit. The HQI Extract Errors Report identify any episodes with incomplete fields from the HBCIS Compensable screen. The Health Statistics Unit Validation Report also identifies episodes with incomplete or invalid data elements.

15.7 HBCIS compensable screen data elements

15.7.1 Compensable Record Number

Each Compensable Screen will be automatically assigned a unique number.

When the compensable details are forwarded to the Health Statistics Unit, this number will form part of each episode's unique identifier. This functionality will only work where episodes have been linked to the compensable screen.

15.7.2 Compensable Payment Class

WCQ where the patient's employer is insured by WorkCover Queensland or one of the Queensland self-insurers regulated by Q-COMP. Patients classified as workers' compensation other (WCO) are billed locally and consequently are not included in the Q-COMP download.

15.7.3 Incident date

This item may be referred to as Incident date. This is the date the injury/accident/illness occurred. For late onset illness, it is the date the patient was first assessed by a doctor for the injury/illness. See Section 7.10.

15.7.4 Incident Time

This item may be referred to as Incident time. This is the time the injury/accident occurred.

15.7.5 Location

This item may be referred to as Incident location. This is the location of the incident/accident. Example "Logan Rd corner Nursery Rd Mt Gravatt" or "At office on stairs address 12 Edward St, Brisbane City."

15.7.6 Nature of injury

This field is used to specify the bilateral (left or right arm/leg/etc) location and type of injury. This information is considered critical as clinical codes do not record the bilateral nature of injuries. Also, state a summary of the diagnoses or provisional diagnoses provided by the treating medical practitioner. This is required because no diagnoses codes are given to insurers for non-admitted services. This information must be recorded here and is required by insurers.

15.7.7 Occupation

Enter the patient's occupation.

15.7.8 Item

These items are used to record the details of the employer, insurer, solicitor or other authority. Multiple items may be entered. For example, item 1 might record employer details and item 2 record insurer details.

15.7.9 Code

Indicate the financially responsible party: A - Authority responsible, E - Employer, I - Insurer, P - Patient, or S - Solicitor. This represents the code for the details you are about to enter. For a valid WCQ claim you need to enter the employer so type E to enter employer details. Enter details about the insurer and solicitor if known.

15.7.10 Field 12 – 17 Details of financially responsible party

Employer details (name and address) are required. If possible, enter the insurer (code I) and solicitor (code S) details also as separate items (see fields 10 and 11).

15.7.11 Assign bill to

Identify the financially responsible party. A - Authority responsible, E - Employer, I - Insurer, P - Patient, S - Solicitor. For WC patients this is normally 'I' for insurer even if the details are unknown. Strategic Revenue Unit, Queensland Health is responsible for billing insurers for WCQ public admitted patients.

15.7.12 Status 1

Enter details about where the accident occurred. AW (At Work), FW (going home From Work), TW (going To Work).

15.7.13 Status 2

Identify the patient's role in the accident if relevant. C (Cyclist), D (Driver), MC (Motor Cyclist), PA (Passenger), PD (Pedestrian).

15.7.14 Claim number

This field is used to record the insurance claim number. The insurer will provide the patient with a claim number when the patient makes a claim. The hospital needs to record this claim number as it provides evidence of the worker's consent to release information to the insurer. This allows hospitals to bill for non-admitted services.

If the claim number is not known or cannot be established, record 'U' for unknown.

16. TELEHEALTH (HBCIS ONLY)

16.1 Admitted patient (inpatient) telehealth activity

Videoconferencing technology is used to deliver clinical services to patients in Queensland Health hospitals.

Admitted patient Telehealth activity can be captured on the HBCIS Telehealth Inpatient Details (TID) entry screen and viewed at the patient level on the TID enquiry screen.

Admitted patient Telehealth activity can be captured on the TID entry screen by the recipient facility only. The details of the provider facility and unit are captured on the TID screen by the recipient facility.

*Please note: Non-admitted patient (outpatient) Telehealth/Telemedicine occasions of service activity can be captured in the Monthly Activity Collection (MAC).

16.2 Telehealth session and telehealth event

A Telehealth session is defined as the transmission and receipt of real-time audio and visual information via videoconference systems between participating sites.

A Telehealth event is an interactive, real-time clinical activity provided to an admitted patient during a Telehealth session.

A Telehealth session may involve one or more admitted patient/s with each patient having a Telehealth event. A Telehealth event may occur more than once during an admitted patient episode of care.

16.3 Start of a telehealth session

A Telehealth session begins when a successful connection via videoconference systems is established at the participating sites.

A successful connection between videoconference systems is when real-time audio and visual data is transmitted and received by videoconference systems at participating sites involved in a Telehealth session and interactive real-time clinical activity for an admitted patient commences.

If the videoconference systems are unintentionally disconnected and a successful reconnection is made, then the time of successful reconnection should not be allocated as the start time of another Telehealth session.

16.4 End of a telehealth session

A Telehealth session ends when the connection via videoconference system is intentionally disconnected between at participating sites.

If the videoconference systems are unintentionally disconnected and a successful reconnection is made, then the time of disconnection should not be allocated as the end time of a Telehealth session. However if the video conference systems are unintentionally disconnected and reconnection id not successful, then the time of disconnection should be allocated as the end time of a Telehealth session.

A successful reconnection between videoconference systems is when real-time audio and visual data is transmitted and received by videoconference systems involved in a Telehealth session and interactive real-time activity recommences.

More than one Telehealth session and Telehealth event may occur on the same day for the same admitted patient.

16.5 Telehealth event scope

A Telehealth event should be captured in the TID entry screen, when the following criteria are met:

- Videoconference technology was used to deliver clinical activity for an admitted patient;
- The patient was an admitted patient at the facility;
- The service delivered was a substitute for face-to-face activity;
- Clinical notes were recorded in the admitted patient's medical record;
- The patient or patient representative must be present during a ward round, clinical consultation or consultation with Retrieval Services Queensland; and
- The patient or patient representative may, or may not, be present during a case conference. However there must be a minimum of two formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient.

Telehealth activity that is not eligible for capture in the TID screen includes videoconferences for the purposes of:

- Clinical education; and
- Any activity related to non-admitted patients (outpatients)*.

*Note: Non-admitted patient Telehealth/Telemedicine activity can be captured in the Monthly Activity Collection (MAC).

16.6 Telehealth admitted patient details – entry screen

The TID entry screen is located in the Admission, Discharge and Transfer (ADM) module of HBCIS and can be accessed from the HBCIS Entry and Enquiry Menu.

If the TID entry screen is not displayed on the Entry and Enquiry Menu, please contact your local HBCIS facilitator to arrange access. The TID entry screen in HBCIS is as follows:

```
          1         2         3         4         5         6         7
01234567890123456789012345678901234567890123456789012345678901234567890123456789
ADM2.S123        TELEHEALTH INPATIENT DETAILS ENTRY            410 LOGON-QLDWRK

01 Telehealth Session Id [6nnnnn]

02 RSQ?                  [x]
03 Provider Facility     [5nnnn] 45xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
04 Provider Unit         [4xxx]  25xxxxxxxxxxxxxxxxxxxxxx
05 Event Type            [2n]    40xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
06 Start Date            [dd mmm yy]
07 Start Time            [hh:mm]
08 End Date              [dd mmm yy]
09 End Time              [hh:mm]

                                                          Page nnn of nnn
                                    Name                  D.O.B.   Sex  Event#
10 Patient Number    [8xxxxxxx-4nnn] 20xxxxxxxxxxxxxxxxxx dd/mm/yy xx     2n
                    1 8xxxxxxx-4nnn] 20xxxxxxxxxxxxxxxxxx dd/mm/yy xx     2n
                    2 8xxxxxxx-4nnn] 20xxxxxxxxxxxxxxxxxx dd/mm/yy xx     2n
                    3 8xxxxxxx-4nnn] 20xxxxxxxxxxxxxxxxxx dd/mm/yy xx     2n
                    4 8xxxxxxx-4nnn] 20xxxxxxxxxxxxxxxxxx dd/mm/yy xx     2n
                    5 8xxxxxxx-4nnn] 20xxxxxxxxxxxxxxxxxx dd/mm/yy xx     2n
                    6 8xxxxxxx-4nnn] 20xxxxxxxxxxxxxxxxxx dd/mm/yy xx     2n

Enter Field Number or Code                      Filed

01234567890123456789012345678901234567890123456789012345678901234567890123456789
          1         2         3         4         5         6         7
```

16.7 Telehealth session identifier

The Telehealth session identifier is a system generated six digit number known as the Telehealth session ID. A Telehealth session ID is allocated to each new Telehealth session.

16.8 Retrieval services Queensland (RSQ)

An indicator of whether Retrieval Services Queensland (RSQ) was involved in the Telehealth session.

	An indicator of whether Retrieval Services Queensland (RSQ) were involved in the Telehealth session.		
HBCIS Hospitals	**Code**	**Description**	**Explanation**
	Y	Yes	Retrieval Service Queensland (RSQ) did participate in an admitted patient Telehealth event.
	N	No	Retrieval Service Queensland (RSQ) did not participate in an admitted patient Telehealth event.

Please note if “Y” is entered into the RSQ field, the curser will skip to the start date field. The provider facility and provider unit fields are not required to be completed, and the TID screen sets these fields to null. In addition, the event type field is not required to be completed and the TID screen sets this field to code 02: clinical consultation.

16.9 Provider facility

The facility code that identifies the facility delivering clinical activity, for an admitted patient Telehealth session. Valid facility numbers are located in QHAPDC Appendix A.

16.10 Provider unit

The standard unit code that identifies the clinical unit of the provider facility, for an admitted patient Telehealth session. Valid standard unit codes are located in QHAPDC Appendix J.

16.11 Telehealth event types

The type of activity delivered by a provider facility during an admitted patient Telehealth session. Telehealth event types can include a:

- Ward round;
- Clinical consultation;
- Discharge planning case conference;
- Cancer care case conference;
- Psychiatric case conference; and
- Multidisciplinary team case conference.

The associated codes for Telehealth event types in HBCIS and additional descriptive information are as follows:

	Code	Event Type	Description
HBCIS Hospitals	01	Ward Round	Ward round delivered via videoconference.
	02	Clinical consultation	Clinical consultation delivered via videoconference, including consultations with Retrieval Service Queensland (RSQ).
	03	Discharge planning case conference	Delivered via videoconference for the purpose of establishing and coordinating the management of the care needs of the patient.
	04	Cancer care case conference	
	05	Psychiatric case conference	
	06	Multidisciplinary case conference	
	98	Other	Other type of clinical activity delivered via videoconference.
	99	Not stated/unknown	Not stated/unknown - Not stated or unknown type of clinical activity delivered via videoconference.

Discharge planning, cancer care, psychiatric or multidisciplinary case conferences delivered via videoconference for the purpose of establishing and coordinating the management of the care needs of the patient.

A case conference requires the involvement of a minimum of two formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient and can include, but not limited to, medical practitioners, allied health professionals and community service providers or carer organisations. Although they may attend the case conference neither the patient nor informal carer, can be counted toward the minimum of two care providers.

16.12 Start date

The date of commencement of a Telehealth session.

Enter the full date (ddmmyyyy) of commencement of the Telehealth session. Use leading zeros where necessary. The start date must not be before the admission date or after the discharge date for any patient within the Telehealth session.

Example

For a Telehealth session start date of 3 July 2014 record

0	3	0	7	2	0	1	4

16.13 Start time

The time of commencement of a Telehealth session.

Use the 24-hour clock to record the start time of the Telehealth session. The start time must not be before the admission time or after the discharge time for any patient within the Telehealth session.

Example

Telehealth session start time at 3:10 a.m.

0	**3**	**1**	**0**

Telehealth session start time at 6:05 p.m.

1	**8**	**0**	**5**

16.14 End date

The date of completion of a Telehealth session.

Enter the full date (ddmmyyyy) of completion of the Telehealth session. Use leading zeros where necessary. The end date must not be before the admission date or after the discharge date for any patient within the Telehealth session.

Example

For a Telehealth session start date of 3 July 2014 record

0	3	0	7	2	0	1	4

16.15 End time

The time of completion of a Telehealth session.

Use the 24-hour clock to record the end time of the Telehealth session. The end time must not be before the admission time or after the discharge time for any patient within the Telehealth session.

Example

Telehealth session end time at 3:10 a.m.

0	**3**	**1**	**0**

Telehealth session end time at 6:05 p.m.

1	**8**	**0**	**5**

16.16 Patient number

The Unit Record Number (URN) and Episode ID (Admission number) for patient/s in the Telehealth session.

If the episode ID is not entered the most recent episode for the patient will be displayed on the screen.

Example

For a Patient URN is 00012345 and Episode ID (Admission number) is 2

0	0	0	1	2	3	4	5	-	2			

16.17 Telehealth admitted patient details – enquiry screen

Telehealth events related to specific patients can be viewed on the TID enquiry screen.

The TID enquiry screen is located in the Admission, Discharge and Transfer (ADM) module HBCIS and can be accessed from the HBCIS Entry and Enquiry Menu and located via a command Line option (TELE) from the HBCIS:

- Patient Admission screen;
- Patient Discharge screen;
- Patient Condition screen; and
- Patient Transfer screen.

The TID enquiry screen in HBCIS is as follows:

```
          1         2         3         4         5         6         7
01234567890123456789012345678901234567890123456789012345678901234567890123456789
ADM2.S758        TELEHEALTH INPATIENT DETAILS ENQUIRY          410 LOGON-QLDWRK

01 Patient No. [8xxxxxxx-4nnn] 24xxxxxxxxxxxxxxxxxxxxx,23xxxxxxxxxxxxxxxxxxxx
                               Tr. Dr.: 25xxxxxxxxxxxxxxxxxxxxxxx
                               Ward: 6xxxxx Unit: 4xxx Account Class: 9xxxxxxxx
                               Admitted: dd mmm yyyy  Discharged: dd mmm yyyy

02 Item [3nn] of [3nn]

    03 Event Id          [6nnnnn]
    04 RSQ?              [x]
    05 Provider Facility [5nnnn] 45xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
    06 Provider Unit     [4xxx]  25xxxxxxxxxxxxxxxxxxxxx
    07 Event Type        [2n]    40xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
    08 Start Date        [dd mmm yy]
    09 Start Time        [hh:mm]
    10 End Date          [dd mmm yy]
    11 End Time          [hh:mm]



Enter Field Number or Code                    Filed
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Abbreviations

Abbreviation	Description
A	Authority
ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADL	Activity of Daily Living
ADT	Admission, Discharge and Transfer
AF	Atrial Fibrillation
AN-SNAP	Australian National Sub and Non Acute Patient
AMI	Acute Myocardial Infarction
AN-DRG	Australian National Diagnosis Related Group
AR-DRG	Australian Refined Diagnosis Related Group
AROC	Australian Rehabilitation Outcomes Centre
ASCL	Australian Standard Classification of Languages
ASGC	Australian Statistical Geographical Classification
ASGS	Australian Statistical Geographical Standard
AW	At Work
C	Cyclist
CCF	Congestive Cardiac Failure
CCU	Coronary Care Unit
CMBS	Commonwealth Medicare Benefits Schedule
COPD	Chronic Obstructive Pulmonary Disease
CPoA	Condition Present on Admission
CSCF	Clinical Services Capability Framework
CT	Computed Tomography
CTP	Compulsory Third Party
CVS	Continuous Ventilatory Support
D	Driver
DCCSDS	Department of Communities, Child Safety and Disability Services
DD	Department of Defence (Australian)
DoHA	Department of Health and Ageing
DRG	Diagnosis Related Groups
DVA	Department of Veterans' Affairs
E	Employer
E. Coli	Escherichia Coli
ED	Emergency Department

EAM	Elective Admission Module
eARF	Electronic Ambulance Report Form
EX	External Cause
FAMMIS	Finance and Material Management Information System
FIM	Functional Independence Measure
FMPM	Financial Management Practices Manual
FW	(going home) From Work
GEM	Geriatric Evaluation and Management
HBCIS	Hospital Based Corporate Information System
HHS	Hospital and Health Services
HHS CE	Hospital and Health Service Chief Executive
HITH	Hospital in the Home
HoNOS	Health of the Nation Outcome Scale
HQI	Homer Queensland Interface
HSU	Health Statistics Unit
I	Insurer
I&D Sheet	Identification and Diagnosis Sheet
ICD-10-AM	International Classification of Diseases and Related Health Problems,
	10th Revision, Australian Modification
ICD-O	International Classification of Diseases - Oncology
ICN	Intensive Care Nursery
ICU	Intensive Care Unit
KPI	Key Performance Indicators
LOS	Length of Stay
M	Morphology
MAC	Monthly Activity Collection
MAIA	Motor Accident Insurance Act 1994
MAIC	Motor Accident Insurance Commission
MC	Motor Cyclist
M code	Morphology code
MDC	Major Diagnostic Category
METeOR	Metadata Online Registry
MI	Myocardial Infarction
MPHS	Multi-Purpose Health Service
MRIC	Most Resource Intensive Condition
MRSA	Multi-resistant Staphylococcus Aureus
MVA	Motor Vehicle Accident
NACSC	Non Australian Coding Standard Compliant
NCCC	National Casemix and Classification Centre
NCCH	National Centre for Classification in Health

NCR	No carbon required
NHA	National Health Agreement
NHDD	National Health Data Dictionary
NHTP	Nursing Home Type Patient
NLI	National Localities Index
NMDS	National Minimum Data Set
NOS	Not Otherwise Specified
NRC	No Carbon Required
OCOI	Other Co-morbidity of Interest
OD	Other Diagnosis
OSHC	Overseas Student Health Cover
P	Patient
PA	Passenger
PAS	Patient Admission System
PBS	Pharaceutical Benefits Scheme
PD	Principal Diagnosis
PD	Pedestrian
PEF	Patient Election Form
PICU	Paediatric Intensive Care Unit
POW	Prisoner of War
PR	Procedure
PTSD	Post Traumatic Stress Disorder
QAS	Queensland Ambulance Service
QHAPDC	Queensland Hospital Admitted Patient Data Collection
QHDD	Queensland Health Data Dictionary
QHIPS	Queensland Hospital Inpatient Processing System
Q-COMP	The Workers Compensation Regulatory Authority
RHCA	Reciprocal Health Care Agreement
RSQ	Retrieval Services Queensland
RUG	Resource Utilisation Group
S	Solicitor
SA2	Statistical Area Level 2
SCC	Squamous Cell Carcinoma
SCN	Special Care Nursery
SIPs	Surgically Implanted Prosthetics
SLA	Statistical Local Area
SNAP	Sub and Non Acute Patient Classification
SSU	Statistical Standards and Strategy
TID	Telehealth Inpatient Details
TW	(going) To Work
UDG	Urgency Disposition Groups
UoW	University of Wollongong

URG	Urgency Related Groups
UTI	Urinary Tract Infection
URN	Unit Record Number
WAN	Wide Area Network
WCO	Workers' Compensation Other
WCQ	Workers' Compensation Queensland
WCQI	Workers' Compensation Queensland Ineligible