

Validation Messages Explained

V1.0

**Queensland Hospital Admitted Patient
Data Collection
QHAPDC**

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INTRODUCTION

This appendix is designed to assist hospitals in the completion of Validation Reports. There are two categories of validation messages: 'warning' and 'fatal'. All messages that appear on a Validation Report should be checked, however warnings will appear only once (ie will not be repeated on the next validation report, unless a change is made to a record, or a fatal error exists). All fatal messages are mandatory and must either be corrected by the hospital or confirmed as correct by the hospital and then accepted as correct by the Health Statistics Unit (HSU).

Where the hospital is asked to contact HSU, hospital staff should ask to speak with their usual contact within HSU. This person will be able to either answer the query or put the call through to someone who can answer the query.

Errors are listed in numerical order under identified report types in the following pages.

Link Facility Stays Validation Report

Patient episodes are linked by HSU to form the patient's complete hospital stay. The hospital stay may relate to more than one episode. Episodes are linked using the following fields: patient id, episode start and end dates, source of referral, mode of separation and episode type. All episodes in a full hospital stay should have the same patient id but different episode numbers for each episode. A full hospital stay is identified by a linking number. The same linking number is given to each episode in the hospital stay.

Morbidity Classification

Note that all references to morbidity type in the following pages relate to the prefix for all ICD codes. These prefixes are: PD for the principal diagnosis, OD for other diagnoses, PR for procedures, EX for external causes, and M for morphologies. Responses by hospitals should follow these naming conventions. If the hospital does not use this convention, the hospital's extract program should convert the morbidity type codes used by the hospital to those required by HSU.

Symbols

The symbol | that appears in some messages in the following pages indicates a parameter. This symbol will not appear on validation reports, instead it will be replaced by further information to the error message (eg the date or invalid code that the message refers to).

Note: There may be changes to validations contained in Appendix L, including additional validations, and a subsequent version of this Appendix will be published at a later date. For additional information please email ghipsmail@health.qld.gov.au.

ACTIVITY (ACTV) ERRORS

These errors relate to patient activity, including ward transfers, leave, account variations, mother's patient identifier and qualification status changes.

ACTV H93

A patient on leave for more than 7 days should be formally discharged. Please check leave and episode end dates and/or times.

It is a requirement that patients should never be on leave for more than 7 days. Hospital staff should check all leave dates and the episode end date, and if required should formally discharge the patient on the day they first went on leave, and then re-admit them when they return from leave. The hospital can find details relating to all rules on leave in this QHAPDC manual.

ACTV H115

The patient's account class is missing as at |.

The account classification code has not been provided at the date given in the message. The hospital must provide this code. The hospital accounts department or administration section should have a list of valid codes for account classification.

ACTV H119

Part of this record is a duplicate of a record previously sent and loaded to Health Statistics Unit' table |. IT HAS NOT BEEN LOADED. Amend & resend if required.

A duplicate has been received for a particular table (the table name is given in the parameter | in the message). To find out how to amend this error refer to the below section which relates to the HSU table name stated in the message.

There are three sets of HSU tables - the load tables, work tables, and final tables. Within each set of tables twenty individual tables exist (see below definitions). The table name given in the error message will specify which table in which set (ie load, work or final) for which the duplicate message was created. Names of load tables all begin with qh_load, names of work tables all begin with qh_work, names of final tables all begin with qh (ie there is no distinguishing word as load or work to separate the final tables from other areas in the database). The final part of the table name is given in the list of tables in the previous paragraph. (Eg the account variation table in the load area is called qh_load_acct_vary. The same table in the work area is qh_work_acct_vary. In the final area, this table is called qh_acct_vary.)

If the duplicate occurs on;

Acct_vary table then two account variations have been received for the same day. Hospital staff should check the facility unique id to see what account variations exist for the episode, and check all recent amendments to account variations, to ensure the mistake was not made on the facility unique id. Check also to see if the new record was correct - the original may need to be deleted, and the new record sent again. Hospital staff should ensure that only the last account variation on any day is forwarded to HSU.

attend_dr table, then this particular code for the treating doctor has been used previously for this episode. Hospital staff should check the facility unique id to see whether the wrong code for the new doctor was used, or whether the code should have been put against a different episode.

cntrct table, then hospital staff should check all contract details for the episode indicated by the facility unique id. Also, check all recent amendments to contract details. An error could have been made in contract dates or the facility unique id. If an error has been made, the contract details should be corrected and resent.

Dva_table, hospital staff should check all Department of Veteran's Affairs details for the episode indicated by the facility unique id. Also, check all recent amendments to Department of Veteran's Affairs details. An error could have been made in the facility unique id, or more than one Department of Veteran's Affairs details record has been provided. Each episode may have only one Department of Veteran's Affairs details record. If an error has been made, the Department of Veteran's Affairs details should be corrected and re-sent.

elect_adm table, then hospital staff should check all elective admission details for the episode indicated by the facility unique id. Also, check all recent amendments to elective admission details. An error could have been made in waiting list entry number or the facility unique id. If an error has been made, the elective admission details should be corrected and resent.

elect_surgry table, then hospital staff should check all elective surgery change details for the episode indicated by the facility unique id. Also, check all recent amendments to elective surgery change details. An error could have been made in entry number, change date, or the facility unique id. If an error has been made, the elective surgery change details should be corrected and resent.

epis_care table, then the facility unique id is a duplicate within a particular load. The hospital will need to check this facility unique id to ensure that two patients have not been assigned to the one facility unique id. If a duplicate has been sent, hospital staff should check to see which of the two duplicate episodes should have been loaded, then contact HSU to ensure that the correct details exist in the database. Hospitals that send data electronically may need to check their extract programs to ensure the programs are not extracting each episode more than once.

epis_period table, hospital staff should check all nursing home type details for the episode indicated by the facility unique id. Also, check all recent amendments to nursing home care details. An error could have been made in nursing home care dates or the facility unique id. If an error has been made, the nursing home type details should be corrected and resent.

epis_score table, then hospital staff should check all DRG and MDC codes for this episode. Only one DRG and one MDC should be provided for each episode.

leave table, hospital staff should check all leave details for the episode indicated by the facility unique id. Also, check all recent amendments to leave details. An error could have been made in leave dates or the facility unique id. If an error has been made, the leave details should be corrected and resent.

mental_health table, hospital staff should check all mental health details for the episode indicated by the facility unique id. Also, check all recent amendments to mental health details. An error could have been made in the facility unique id, or more than one mental health record has been provided. Each episode may have only one mental health record. If an error has been made, the mental health details should be corrected and resent.

Morb table, hospital staff should check all diagnostic codes for the episode indicated by the facility unique id. Also, check all recent amendments to morbidity details. An error could have been made in ICD codes or the facility unique id. If an error has been made, the amendment to morbidity details should be corrected and resent. The originals will have to be deleted, and all ICD codes that are correct for the episode should be resent with the amendment.

Not_ready table, hospital staff should check all not ready for elective surgery details for the episode indicated by the facility unique id. Also, check all recent amendments to not ready for elective surgery details. An error could have been made in not ready for care dates or the facility unique id. If an error has been made, the not ready for care details should be corrected and resent.

Pal_care table, hospital staff should check all palliative care details for the episode indicated by the facility unique id. Also, check all recent amendments to palliative care details. An error could have been made in the facility unique id, or more than one palliative care record has been provided. Each episode may have only one palliative care record. If an error has been made, the palliative care details should be corrected and resent.

Pat_table, then details have already been received for that patient for the same episode start date (including time). Hospital staff should check the patient id (this can be obtained by contacting HSU), and the facility unique id. If the incorrect patient id has been used the episode should be resent with the correct patient id. If the same episode has been assigned more than one facility unique id, hospital staff should decide which facility unique id has the most accurate details. (This is the episode for which details should be kept in the HSU database.) If the facility unique id shown against this error is the one with the most accurate details, the episode must be resent after deleting the episode relating to the facility unique id with incorrect details. If the facility unique id shown against this error is considered to have the least accurate details, then the hospital need take no action.

Pat_name_addr table, then details have already been received for that patient for the same episode start date (including time). Hospital staff should check the patient id (this can be obtained by contacting HSU), and the facility unique id. If the incorrect patient id has been used the episode should be resent with the correct patient id. If the same episode has been assigned more than one facility unique id, hospital staff should decide which facility unique id has the most accurate details. (This is the episode for which details should be kept in the HSU database.) If the facility unique id shown against this error is the one with the most accurate details, the episode must be resent after deleting the episode relating to the facility unique id with incorrect details. If the facility unique id shown against this error is considered to have the least accurate details, then the hospital need take no action.

Qual_status table, then two qualification status change records have been received for the same date. Only the second qualification status for each day should be submitted. Hospital staff should check the facility unique id to see what qualification status codes exist for the episode, and check all recent amendments to qualification status, to ensure the mistake was not made on the facility unique id. Check also to see if the new record was correct - the original may need to be deleted, and the new record sent again.

Snap_adl table, then two SNAP ADL scores have been received for the same ADL type and ADL subtype. Hospital staff should check the facility unique id to see what ADL scores exist for the episode, and check all recent amendments to ADL scores, to ensure the mistake was not made on the facility unique id. Check also to see if the new record was correct - the original may need to be deleted, and the new record sent again.

Snap_epis table, then two SNAP episodes have been received for the same snap episode number. Hospital staff should check the facility unique id to see what SNAP episodes exist for the episode, and check all recent amendments to SNAP episodes, to ensure the mistake was not made on the facility unique id. Check also to see if the new record was correct - the original may need to be deleted, and the new record sent again.

tfr table, then two ward transfers have been received for the same date and time. Hospital staff should check the facility unique id to see what ward transfers exist for the episode, and check all recent amendments to ward transfers, to ensure the mistake was not made on the facility unique id. Check also to see if the new record was correct - the original may need to be deleted, and the new record sent again.

ACTV H154

To amend account variation or ward details at admission, a record should be sent in the ADM file. This ACT amend was not loaded.

An amendment record was sent in the activity details (ACT) file and the date of the amended record was the same as the episode start date. Both account variation and ward details are compulsory at admission and for this reason MUST be amended by an amendment to the admission record. Hospital staff should check the variation or transfer date and the facility unique id they are trying to amend. If the variation or transfer date or facility unique id is incorrect, the amendment should be resent with corrected details. If the hospital needs to amend the admission details, they should send an amendment for the admission (ADM) file. If the amendment record was in error, the hospital need not take action as the amendment was not loaded.

ACTV H179

This patient has not returned between the two leave dates | and |.

This error can result from missing leave dates, dates being provided in the wrong order, or incorrect leave dates. The error is caused by two or more leave records overlapping. Hospital staff should check all leave records for the episode and make sure none overlap. If necessary, hospital staff should arrange to have all leave records deleted, then re-sent.

ACTV H379

Account class indicates that patient is a banded patient. This is only valid at admission with no account class changes. Please check account class codes.

A banded patient should be a same day patient with no account variations. The hospital has provided one or more account class codes that indicate that this patient is banded. Hospital staff should check all account class codes. If the patient should be banded, the correct banded account class code should be provided at admission, and no account variations should be provided. If the patient should not be banded, all banded account class codes should be removed from the episode. A valid list of account class codes can be obtained from the Hospital's finance or accounts section.

ACTV H398

The code provided for the Nursing Home Type Flag for the period | to | is missing or invalid.

The nursing home type flag is required to allow accurate tracking of nursing home type patients. Hospital staff should check the nursing home type flag. If the patient is a nursing home type patient, the nursing home type flag should be amended. If the patient is not a nursing home type patient, the nursing home type period of care should be deleted. Valid codes for nursing home type flag can be found in this QHAPDC manual.

ACTV H400

Two nursing home type periods from | to | and | to | are overlapping.

This error can result from missing nursing home type dates, dates being provided in the wrong order, or incorrect nursing home type dates. The error is caused by two or more nursing home type records overlapping. Hospital staff should check all nursing home type records for the episode and make sure none overlap. If necessary, hospital staff should arrange to have all nursing home type records deleted, then resent.

ACTV H405

Nursing home type details are only valid for maintenance patients. Please check episode care type and nursing home type details.

Nursing home type details have been provided, but the episode care type does not indicate that this is a maintenance patient. Nursing home type details are not required for other episode care types. If the patient is a maintenance patient, the episode care type should be amended. If the patient is not a maintenance patient, nursing home details should be deleted. Valid codes for episode care type can be found in this QHAPDC manual.

ACTV H411

This patient was on leave when a nursing home type period started on |. Check leave details.

A patient cannot commence nursing home type care if they are on leave. Hospital staff should check nursing home type details and leave details. If the patient went on leave, the nursing home type care should commence when the patient returns from leave. Otherwise, the hospital should arrange to have either the nursing home type period or the leave period deleted.

ACTV H744

Mother's patient ID for this patient is missing or invalid.

The mother's patient identifier has not been provided, or the code provided is not valid. For a source of referral/transfer of 'born in hospital' the mother's patient identifier is required.

ACTV H745

Mother's patient ID cannot be null for Source of Referral/Transfer is born in Hospital.

For a source of referral/transfer of 'born in hospital' the mother's patient identifier is required.

BOARDER EPISODE (BOARD) ERRORS

These errors relate to the coding of boarder episodes.

BOARD H91

This patient is reported as being a boarder.

Please check the account class code for this admission/episode

The account classification code indicates that the patient is a boarder, but the episode of care type does not indicate a boarder. Hospital staff should check all account classification codes and care types. If the patient was a boarder for all of the episode then please amend all relevant fields to indicate this. If the patient was a boarder part of the episode then the patient must be formally separated and re-admitted as a boarder.

BOARD H96

Care type OR admission source OR mode of separation indicates the patient is a boarder, but other codes (incl fund source) are not boarder codes. Please check all fields.

If the patient is a boarder then the episode type, source of referral, mode of separation and funding source should indicate that the patient is a boarder. Hospital staff should check all details relating to a boarder admission and make the required amendments. The hospital can find the relevant codes for boarders in this QHAPDC manual.

BOARD H382

This patient is a boarder but this episode has been linked to elective entry |.

Boarders should not receive any form of treatment. If they receive treatment, they should be admitted, and should not be a boarder. If a hospital has a patient on the waiting list who comes in as a boarder, but is removed from the waiting list while they are a boarder, the elective details should not be linked to the boarder episode. Hospital staff should check the episode care type, source of referral, mode of separation, and all elective surgery details. Elective surgery details should be linked to the episode in which the patient received the treatment for which they were on the waiting list. If the patient should not have been coded as a boarder, the hospital will need to amend episode care type, source of referral and mode of separation. Valid codes for episode care type, source of referral and mode of separation can be found in this QHAPDC manual.

BOARD H384

Mental Health details have been provided but this patient is a boarder.

Episode care type indicates this patient is a boarder, but HSU has received mental health details. Mental health details should only be sent for a patient admitted or transferred to a psychiatric unit who has received psychiatric care. If the patient is a boarder, the hospital should arrange for the mental health details to be deleted. If the patient is not a boarder, the hospital should amend the episode care type, source of referral and mode of separation. Valid codes for episode care type, source of referral and mode of separation can be found in this QHAPDC manual.

BOARD H386

This patient is a boarder but has been reported as compensable as at |.

It is expected that boarders should be not compensable. Hospital staff should check the episode care type and compensable status as at the date given in the message. If the patient is not a boarder, amendments should be made to the episode care type, source of referral and mode of separation. If the patient is a boarder, compensable status should be amended. Valid codes for compensable status, episode care type, source of referral and mode of separation can be found in this QHAPDC manual.

If the patient is a boarder and is compensable, the hospital should inform HSU in writing, including the reason that a boarder is compensable.

BOARD H391

Contract details exist, but boarder or organ procurement episodes cannot be contracted to another facility.

As boarders and organ procurement episodes are not receiving care, they cannot be contracted to another facility. Hospital staff should check episode care type and contract leave details. If the patient is a boarder and has accompanied a contract patient to another facility, the boarder should be either discharged and readmitted on return, or sent on leave. If the patient is not a boarder or organ procurement, the hospital should amend episode care type, source of referral and mode of separation. Valid codes for episode care type, source of referral, mode of separation and qualification status can be found in this QHAPDC manual.

CHECK ERRORS

These errors are all warnings. They relate to items that need to be checked by the hospital to ensure data quality, but each error could relate to valid data. Hospital staff should check these errors, as they may be caused by a problem in coding.

CHECK H76

The Medicare eligibility code and country of birth could be in conflict. Please check both fields.

The country of birth indicates that the patient was born in Australia or a country with a reciprocal Medicare agreement, but Medicare eligibility code indicates the patient is not eligible for Medicare. It is unusual that a patient born in Australia (or a country with a reciprocal Medicare agreement with Australia) would not be eligible for Medicare. Hospital staff should check both the Medicare eligibility and country of birth fields. The hospital can find a list of valid codes for Medicare eligibility and country of birth in this QHAPDC manual.

CHECK H84

This patient's age has been reported as more than | years. Please check date of birth.

The patient is over 110 years old at admission. It is unusual for a patient to be older than 110 years. Hospital staff should check the birth date and the episode start and end dates.

If the patient is more than 125 years old, hospital staff should check all details and provide corrected date of birth or episode start date. If both dates are correct, the hospital should confirm with HSU in writing that the patient is over 125 years old.

CHECK H142

The original record for an amend or delete in | does not exist in the work or final tables. The amend/delete has NOT been loaded.

Hospital staff should check the specified amendment or delete the record carefully, to ensure the record has the correct facility unique id. If the delete record is correct, hospital staff should check to discover why HSU do not have a record of the episode, as the episode to be deleted was not in the database. If an amendment record is correct, then hospital staff should send the entire episode, with correct data as per the amendment(s), and hospital staff should investigate why HSU do not have a record of the original episode in the database. If a mistake has been made with the facility unique id, hospital staff should send the amendment or delete record again with the correct facility unique id.

CHECK H265

This episode has a long length of stay. Please check episode dates and leave dates.

Hospital staff should check the episode start and end dates and the episode type to ensure they are correct. Hospital staff should also check all leave dates.

CHECK H366

This patient was born in | but Indigenous Status indicates they are an Australian Aboriginal or Torres Strait Islander. Please confirm.

It is unusual for an Australian Aboriginal to be born outside Australia. It is unusual for a Torres Strait Islander to be born outside Australia or Papua New Guinea. Please check Indigenous Status and Country of Birth.

CONGENITAL (CONG) ERRORS

CONG H722

The Abortion ICD Code and O090, O091, O092 has been provided in conjunction with a specified code from chapter 15. Please specify the foetal diagnosis. Congenital Code/Foetus No Missing.

CONTRACT (CNTRCT) ERRORS

These errors relate to contract details, including contract leaves, contract referral codes, morbidity contract flag, contract role and contract type.

CNTRCT H122

Please provide the facility code for the hospital that this patient was contracted to ON.

The facility code for a hospital to which the patient has been sent for a contract service has not been provided, or is invalid at the contract leave date (as specified in the message). Hospital staff should provide the correct facility code for the contract date. The facility the patient was contracted to must have been operating at the contract date. A list of valid facility codes can be found in this QHAPDC manual.

Hospitals should note that patients should only be contracted to other hospitals. A patient cannot be contracted to a nursing home, an outpatient department or a private medical practitioner. Nor can a patient be contracted to another ward within the same hospital, this should be sent to HSU as a ward transfer. Rules relating to the reporting of contract patients can be found in this QHAPDC manual.

CNTRCT H163

This patient was not a contract patient on admission. Please check source of referral and mode of separation.

The mode of separation indicates that the patient was returned to another hospital after a contract at this hospital, but source of referral does not indicate the patient was admitted as a contract from another hospital. This is inconsistent. Hospital staff should check all codes relating to source of referral and mode of separation. If the episode was a contract for another hospital, both of these fields should indicate this. If the episode was not a contract, neither field should indicate contract status. The hospital can find valid codes for both source of referral and mode of separation in this QHAPDC manual. Rules relating to the reporting of contract patients can be found in this QHAPDC manual.

CNTRCT H165

Contract type indicates that this patient was transferred from and returned to the contracting facility, but referral and/or separation details do not confirm.

Hospital staff should check all codes relating to source of referral and mode of separation. If the episode was not a contract, neither field should indicate contract status. The hospital can find valid codes for both source of referral and mode of separation in this QHAPDC manual. Rules relating to the reporting of contract patients can be found in this QHAPDC manual.

CNTRCT H339

Separation mode indicates that the patient has been returned to the contracting facility but the contract facility ID is different at admission and separation.

If the patient is returned to the contracting facility then the transfer to/transfer from facility ID must be the same.

If the patient is transferred to another facility after the contract then the separation mode should not indicate the patient returning to the contracting facility. Check source of referral, mode of separation

and transfer to and from facility ID's. A list of valid codes for separation mode can be found in this QHAPDC manual.

CNTRCT H596

Contract Leave record is only required for contract type |(I) and role 'A', this Contract Leave record has been incorrectly provided for contract type |(I).

Contract Leave record is only required for contract type 2(ABA). Rules relating to the reporting of contract patients can be found in this QHAPDC manual.

CNTRCT H730

The Contracting Hospital Identifier is not a valid facility at the specified period.

The contracting hospital identifier is not valid at the episodes end date. Rules relating to the reporting of contract patients can be found in this QHAPDC manual.

CNTRCT H731

The Contracting Hospital Identifier must have a value for the specified Contract Role and Type.

The contracting hospital identifier has not been completed. Rules relating to the reporting of contract patients can be found in this QHAPDC manual.

CNTRCT H742

This patient's chargeable status is not public but patient is being treated under contract to a |.

This patient's chargeable status is not public but patient is being treated under contract to a public hospital or public health authority. Please check chargeable status. Rules relating to the reporting of contract patients and chargeable status can be found in this QHAPDC manual.

CNTRCT H356

There is no contract agreement between | and |.

This error indicates that the episode contains a contract leave, or source of referral or mode of separation indicate a contract to the facility listed in the message. According to HSU records, there is no official agreement for your hospital to contract patients to the facility listed in the message. Please check contract details, including contract leave, source of referral and mode of separation.

Valid codes for source of referral and mode of separation can be found in this QHAPDC manual.

If there is no contract agreement between your facility and the facility listed in the message, the patient should be transferred to the other facility as an admitted patient rather than coded as a contract.

If a contract agreement does exist between this facility and the other facility, public facilities should confirm this with their Hospital and Health Service and private facility staff should confirm this with their Chief Executive Officer. After confirming contract details, hospitals should inform HSU in writing.

Note that this error always appears with a companion error H363 - this companion gives the full name of the facility for which this hospital has no contract details.

CNTRCT H363

Hospital | is |.

This is a companion message for H356. This message is only used to give the facility number and full name of the facility for which this hospital does not have contract details. This message will never appear without H356.

CNTRCT H396

The code provided for the hospitals contract role is invalid.

Contract role must be provided to allow accurate tracking of contract patients. Hospital staff should check the contract role. The contract role should be amended if the patient is a contract patient or has been contracted. If the patient is not a contract patient or contracted, the contract role should be deleted. Valid codes for contract role can be found in this QHAPDC manual.

CNTRCT H397

The code provided for the patients contract type is invalid.

Contract type must be provided to allow accurate tracking of contract patients. Hospital staff should check the contract type. The contract type should be amended if the patient is a contract patient or has been contracted. If the patient is not a contract patient or contracted, the contract type should be deleted. Valid codes for contract role can be found in this QHAPDC manual.

CNTRCT H408

Contract role or contract type has been provided but other contract details are missing.

Either contract role has been provided and contract type is null OR contract type has been provided and contract role is null. If the patient is a contract patient, or has been contracted, both contract role and contract type are required to allow accurate tracking of contract patients. If the patient is not a contract patient and has not been contracted, all contract details should be removed. Valid codes for contract role and contract type can be found in this QHAPDC manual. Rules for the coding of contracts can also be found in this QHAPDC manual.

CNTRCT H409

The contract type indicates that this patient is a contract from Queensland Health but this facility does not have a contract with Queensland Health.

The contract role is B and the contract type is 1 - B indicating that this patient has been contracted to this facility by Queensland Health. According to HSU reference files, this facility has no contract with Queensland Health to provide treatment to public patients. Hospital staff should check all contract details.

If the contract details are correct, and this facility now has a contract with Queensland Health, the hospital should inform HSU in writing of the date the contract officially began.

CNTRCT H410

Contract details do not indicate that this patient was contracted to this facility by Qld Health. Please check contract details.

All public patients in a BOOT (Build Own Operate Transfer) hospital should be coded as being contracted to the facility by Queensland Health. As BOOT hospitals already have a contract with Queensland Health, there is no need for individual contracts with public hospitals. If the patient is a contract from a private hospital, the patient should be coded as a private patient. Hospital staff should check contract role and contract type codes. Valid codes for chargeable status, contract role and contract type can be found in this QHAPDC manual. Rules for the coding of contracts can also be found in this QHAPDC manual.

CNTRCT H416

This patient has been contracted to another facility. For what treatment was this patient contracted?

The contract role code indicates that part of the treatment for this patient was contracted to another facility. However, no contract flag was found in the morbidities to show which conditions were treated by the other facility and/or which procedures were carried out by the other facility. Please check morbidity details.

If it is difficult to code the treatment provided by the other facility, contact HSU for advice. Rules for the coding of contracts can also be found in this QHAPDC manual.

CNTRCT H417

Contract Type indicates that patient has been contracted by the Health Department, but contract role indicates that this hospital is contracting the patient.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a private hospital has a contract with the Health Department, a public hospital does not have to record contract details when sending the patient to the private hospital. If a contract exists between the two hospitals, a contract type of 2 – ABA or 3 – AB or 4 - (A)B or 5 - BA should be used instead of a contract type of 1 - B.

CNTRCT H418

Contract type indicates that this patient was sent on contract leave, but no contract leave records exist.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a contract type of 2 - ABA has been recorded, the contractor must record the patient as being on contract leave when sent to hospital B, and should not discharge the patient. If the patient has been discharged and sent to hospital B, a contract type of 3 - AB should be used.

CNTRCT H419

Source of Referral or mode of separation indicate contracts, but contract type indicates contract leave, not contract admission or discharge.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a contract type of 2 - ABA has been recorded, the contractor must record the patient as being on contract leave, and should not discharge the patient. If the patient has been discharged, a contract type of 3 - AB should be used. If the patient has been admitted at hospital A following a contract at hospital B, the contract type should be 5 - BA.

CNTRCT H420

Contract type indicates patient is contracted and will be returned to contracting facility but mode of separation or source of referral are not contract codes.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a contract type of 2 - ABA has been recorded, the contracted facility must record the patient as being admitted and discharged as a contract from another facility. If the patient has been discharged rather than sent back to the contractor, a contract type of 3 - AB should be used. If the patient has been admitted directly to this facility (and not transferred from the contractor) and then returned to the contractor, the contract type should be 5 - BA. If the patient was admitted and discharged from this facility without ever being admitted to the contractor, the contract type should be 4 - (A)B.

CNTRCT H421

Contract type indicates that this patient was sent on contract at discharge but mode of separation is not contract code.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a contract type of 3 - AB has been used, the patient should be discharged as contracted to another hospital. If the patient has not been discharged, then a contract type of 2 - ABA should be used and the patient should be put on contract leave.

CNTRCT H422

Contract type indicates this patient is contracted and will not return to contracting facility but source of referral or mode of separation do not match.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a contract type of 2 - ABA has been recorded, the contracted facility must record the patient as being admitted and discharged as a contract from another facility. If the patient has been discharged rather than sent back to the contractor, a contract type of 3 - AB should be used. If the patient has been admitted directly to this facility (and not transferred from the contractor) and then returned to the contractor, the contract type should be 5 - BA. If the patient was admitted and discharged from this facility without ever being admitted to the contracting facility (A), the contract type should be 4 - (A)B.

CNTRCT H423

Contract type indicates this patient will not be returned to contracting facility, but patient was sent to contracting facility on discharge.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a contract type of 2 - ABA has been recorded, the contracted facility must record the patient as being admitted and discharged as a contract from another facility. If the patient has been discharged rather than sent back to the contractor, a contract type of 3 - AB should be used. If the patient has been admitted directly to this facility (and not transferred from the contractor) and then returned to the contractor, the contract type should be 5 - BA. If the patient was admitted and discharged from this facility without ever being admitted to the contracting facility (A), the contract type should be 4 - (A)B.

If the contract type is 3 - AB and the patient is transferred to the contractor after treatment, the contracted facility should check to ensure that the contract type should not be 2 - ABA.

CNTRCT H424

Contract type indicates this patient was not admitted to this facility. Please check contract codes.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. Contract type 4 - (A)B should only be used when the patient was not admitted to the contracting facility (A).

CNTRCT H425

Contract type indicates this patient has been contracted but was not admitted to contracting facility. Source of referral and mode of separation do not match.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a contract type of 2 - ABA has been recorded, the contracted facility must record the patient as being admitted and discharged as a contract from another facility. If the patient has been discharged rather than sent back to the contractor, a contract type of 3 - AB should be used. If the patient has been admitted directly to this facility (and not transferred from the contractor) and then returned to the contractor, the contract type should be 5 - BA. If the patient was admitted and discharged from this facility without ever being admitted to the contracting facility (A), the contract type should be 4 - (A)B.

CNTRCT H426

Contract type indicates this patient has been admitted after a contract but source of referral does not indicate contract.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a contract type of 2 - ABA or 5 - BA has been recorded, the contractor must record the patient as being admitted following a contract at another facility.

CNTRCT H427

Contract type indicates this patient is contracted and will return to contracting facility but source of referral or mode of separation are not contract codes.

Please check contract role and contract type fields carefully, and check the rules for the coding of contracts in this QHAPDC manual. Ensure that the correct values have been stored in these fields. If a contract type of 2 - ABA has been recorded, the contracted facility must record the patient as being admitted and discharged as a contract from another facility. If the patient has been discharged rather than sent back to the contractor, a contract type of 3 - AB should be used. If the patient has been admitted directly to this facility (and not transferred from the contractor) and then returned to the contractor, the contract type should be 5 - BA. If the patient was admitted and discharged from this facility without ever being admitted to the contractor, the contract type should be 4 - (A)B.

CNTRCT H437

This patient sent on contract leave but also transferred from & or to the service provider. Please confirm the contract type, source of referral & mode of Sep.

Please check source of referral, mode of separation transfer facility codes, contract facility code and contract type. This patient was sent on contract leave (contract type ABA) but the patient was also transferred from or to the service provider. Was more than one contract performed?

Valid codes for contract type, source of referral and mode of separation can be found in this QHAPDC manual.

CNTRCT H491

Facility code for the hospital where the patient is to be contracted to must be provided. Please provide facility code of contracted hospital.

Please check that the facility code has been provided where the patient is contracted to has been provided.

CNTRCT H507

No contract details exist for this episode, but morbidity || was contracted out as an admitted procedure.

Contract code for the procedure code provided in the message indicates that treatment for the condition was contracted out to another hospital, but no contract details exist. If any treatment has been contracted out, details of the contract facility and the type of contract must be provided. Hospital staff should check contract code, contract role, contract type and transfer for contract service details. If the treatment was not contracted, the contract code should be deleted.

The hospital can find a list of valid codes for contract code, contract role and contract type in this QHAPDC manual.

CNTRCT H508

The contract | to | overlaps a period of leave from | to |.

The patient's contract record (shown in the message) overlaps with a period of leave (also shown in the message). Hospital staff should check all contract and leave dates for the episode to ensure that all dates are correct. Contract periods cannot overlap with leave periods. Appropriate amendments should be forwarded to HSU.

CNTRCT H743

Contracting Hospital Identifier has been received, but this patient does not have a |.

Hospital staff should check all contract details for the episode to ensure that all data items are correct. Further information on contract details can be found in this QHAPDC manual.

CNTRCT H825

Contracting The facility is providing contracted care (contract role = B) but the contract type was not completed, or the patient was compensable or the funding source was not contracted care. Please check these items.

If the patient is receiving treatment under contract at the contracted facility (contract role = B) then the contract type should be recorded (contract type = 1,2,3,4 or 5) and the patient should be assigned a compensable status of not compensable (code = 8) and a funding source of contracted care (code = 10). Please check contract role, contract type, compensable status and funding source. Rules relating to the reporting of contract patients, compensable status and funding source can be found in this QHAPDC manual.

CNTRCT H828

The patient has been treated in a private facility and has been assigned a public chargeable status however, the fund source is not contracted care, the contract details have not been completed or the patient does not have a compensable status of 'not compensable'. Please check all of these items.

Public patients receiving treatment in a private facility under contract should be assigned a compensable status of not compensable (code = 08) and a funding source of contracted care (code = 10). The contract role of the private facility should be contract role = B and the contract type should be code 1,2,3,4 or 5. Valid codes for these items can be found in this QHAPDC manual. Rules and guidelines for the allocation of chargeable status, compensable status, funding source, contract role and contract type can be found in this QHAPDC manual.

CNTRCT H829

The patient has been treated in a private facility under contract however, the contract type has not been completed, or the contract role of the contracted facility is not B, or the patient does not have a compensable status of 'not compensable'. Please check these items.

Patients receiving treatment in a private facility under contract should be assigned a compensable status of not compensable (code = 08) and a funding source of contracted care (code = 10). The contract role of the private facility should be contract role = B and the contract type should be code 1,2,3,4 or 5. Valid codes for these items can be found in this QHAPDC manual. Rules and guidelines for the allocation of compensable status, funding source, contract role and contract type can be found in this QHAPDC manual.

DATE ERRORS

These errors relate to all dates in the episode. They basically ensure that dates are reasonable, and all activity occurs within the episode itself.

DATE H68

Birthdate | is later than the adm/episode start date. Check both dates and ALL OTHER FIELDS (further edit checks stopped).

The birthdate is later than the episode start date, resulting in the patient's age calculation being negative. Hospital staff should check all dates within the episode, especially the birthdate and episode start date. The birthdate provided is given in the error message to make it easier for the hospital to find the error - the current year could have been used instead of the patient's actual year of birth. Hospital staff should also scan the episode to ensure no other errors exist, as full validation was not completed on this episode.

DATE H104

Episode has an invalid/missing | date and/or time. Provide correct date (and time if required). Further edit checks stopped.

The error message will tell the hospital which date is missing:

- Account vary date is the date on which an account variation occurred;
- ADL score date is the date that the activity of daily living score was completed for a SNAP patient;
- birthdate is the patient's date of birth;
- Contract end date is the date that a contract leave to another hospital finished;
- Contract start date is the date that a contract leave to another hospital commenced;
- Elective surgery change date is the date elective surgery details changed;
- Episode end date is the separation date or the episode end date;
- Episode start date is the admission date or episode start date;
- Incident date is the date on which the incident causing admission occurred;
- Leave end date is the date on which a patient leave finished;
- Leave start date is the date on which a patient leave commenced;
- List date is the date the patient was placed on waiting list for elective surgery;
- Not ready for care end date is the last date the patient was not ready for elective surgery;
- Not ready for care start date is the first date the patient was not ready for elective surgery;
- Nursing home care start date is the date a patient became a nursing home type patient;
- Nursing home care end date is the date a patient no longer qualified as a nursing home type patient.
- Planned admission date is the date the patient was booked to be admitted for elective surgery;
- Planned pre-admission clinic date is the date a patient was booked to attend a pre-admission clinic for elective surgery;
- Planned procedure date is the date the patient was booked for an elective operation;
- Procedure date is the date a procedure was performed;
- Qualification change date is the date a newborn qualification status changed;
- SNAP start date is the date a patient commenced a SNAP episode in a SNAP ward;
- SNAP end date is the date a patient completed a SNAP episode in a SNAP ward;
- Ward transfer date is the date on which a ward transfer occurred;

A hospital should provide the invalid/missing date, including the time where required. Hospital staff should also scan the episode to ensure no other errors exist, as full validation was not completed on this episode.

DATE H123

Start/Adm date time >= End/Sep date time. Check dates, times and ALL OTHER FIELDS (further edit checks stopped).

The episode end date is earlier than the episode start date, or the end time is earlier than or equal to the start time if the two dates are the same. Hospital staff should check both dates, to ensure that dates have not been transposed, or that details for two episodes have not been accidentally merged. Corrected dates should be sent to HSU, with new episodes if required. Hospital staff should also scan the episode to ensure no other errors exist, as full validation was not completed on this episode.

DATE H132

This patient has been separated after the facility has been closed.

The episode end date is greater than the date the facility closed. Hospital staff should check all dates within the episode, especially episode start and end dates.

If the facility changed to a new identifier (facility id) the patient should be discharged from the old facility id, and re-admitted to the new facility id. If the facility has closed, but the patient was not discharged on the official closure date, the facility closure date should be changed to the day the last patient was discharged.

DATE H144

The episode end date is in the future. Please check.

The episode end date (including end time) is after the date in HSU computers. Hospital staff should check the end date, and send any required amendments. If the end date is correct, hospital staff should contact HSU.

DATE H178

Leave start date and time >= leave end date and time. Please check all leave details.

This error can result from missing leave dates, dates being provided in the wrong order, or incorrect leave dates. The error is caused by the leave end date (of a particular leave record) being earlier than the leave out date. Hospital staff should check all leave records for the episode, and ensure that no dates are missing or out of order. (It is possible that two leave records have accidentally been merged into one.) If necessary, hospital staff should arrange to have all leave records deleted, then resent.

DATE H203

This record was before the cut off date and was not loaded to work or final tables. Please correct and resend this record if required.

Health Statistics Unit will only accept data (new episodes or amendments or deletions) to existing episodes for a certain time period. If a hospital sends data before this time period, HSU will not accept the data and will not allow the data to be loaded. Hospital staff should check the episode end date of the new episode. If the date is incorrect, the hospital will need to resend the entire episode with a corrected episode end date. If the episode end date is correct and is before the cutoff date, the hospital does not need to take any action. HSU will inform all hospitals by letter when a new cutoff date is implemented. The hospital can make enquires about the current cutoff date by contacting HSU.

DATE H209

Workers Compensation Incident Date must be before Separation Date.

Incident Date is the date the injury/accident/illness occurred. Hospital staff should check both the incident date and the episode end date. Further admission details can be found in this QHAPDC manual.

DATE H244

This record being amended or deleted from the database is before the cutoff date for this facility.

An amendment/deletion has been received for an episode where the episode end date is before the cutoff date. If an amendment was sent, the episode was not amended, but if a delete was sent, this episode WAS deleted from the database. Hospital staff should check the facility unique id of the amended/deleted episode. Should the facility unique id be incorrect, or an amendment is required, the hospital will need to resend the entire episode on a Patient I & D form. (This cannot be sent on tape, as it is before the cutoff date and will not be loaded. Statistical Collections and Integration will have to enter the episode manually.) Should the facility unique id be correct and the episode was deleted, the hospital does not need to take any action. HSU will inform all hospitals by letter when a new cutoff date is implemented. The hospital can make enquires about the current cutoff date by contacting HSU.

DATE H371

The end date of a contract leave is before the start date. Please check contract records.

A contract leave cannot end before it commences. Hospital staff should check all contract details, to ensure that two contracts have not been merged, or that the contract start and end dates have not been transposed.

DATE H399

The nursing home type start date > nursing home type end date. Please check all dates.

A nursing home type period cannot end before it commences. Hospital staff should check all nursing home type details, to ensure that two nursing home type periods have not been merged, or that the nursing home type start and end dates have not been transposed.

DATE H454

This patient has been admitted more than twice to this facility on this date. Please check episodes |.

Hospital staff should check admission details of these records.

DATE H456

Procedure | date is before the episode end date and Contract Type = 3 (AB). Please check the procedure date and contract type.

The procedure given in the message has been contracted out as an admitted procedure, and the contract type indicates that the patient was discharged to the service provider. However, procedure date is before the end of the episode. Contract details should indicate when the treatment took place. Check procedure date and contract details. Rules for providing contracts can be found in this QHAPDC manual.

DATE H457

Procedure | date is after the episode start date and Contract Type = 5 (BA). Please check the procedure date and contract type.

The procedure given in the message has been contracted out as an admitted procedure, and the contract type indicates the patient was admitted after being contracted out. However, the procedure date is after the admission date. Contract details should indicate when the treatment took place. Check procedure date and contract details. Rules for providing contracts can be found in this QHAPDC manual.

DATE H458

Procedure | date has been performed more than one day before the start date. Please check Procedure Date, Source of Referral and Contract Code.

A procedure date has been provided but is more than one day before the episode start date, with a Source of Referral of 02 (A&E) and Contract Code is null. It is extremely unlikely for a patient to be still in A & E after 24 hours. A corrected procedure date or corrected contract details should be sent to HSU.

DATE H463

Date for procedure | occurs while patient is on leave.

The procedure given has a date that is during a patient's leave. Hospital staff should check procedure dates and leave dates. If the procedure was contracted out, it should occur during a contract leave.

Whether the episode start and end dates are correct.

All dates for activity records - which include all occasions during this episode that the patient went on leave, was sent to another hospital for contract care, was put into a different account category, or was moved to a different ward/unit etc.

If a procedure date is outside the episode start and end dates, the patient should have a contract flag, or if a procedure was performed in A & E then it should be just prior to admission with a source of Referral code of 02(Emergency).

DATE H706

Multi Disciplinary Care Plan Date is after the Episode End Date.

The Multidisciplinary Care Plan should be documented prior to separation.

Further details about the Multidisciplinary Care Plan can be found in this QHAPDC Manual.

DATE H713

Multi Disciplinary Care Plan Date is invalid.

The Multidisciplinary Care Plan Flag is 'Y' but the Multidisciplinary Care Plan Date is null.

Further details about the Multidisciplinary Care Plan can be found in this QHAPDC Manual.

PATIENT CONSENT FOR RELEASE OF INFORMATION (CNSNT) ERRORS

These errors relate to all fields indicating if the patient consents to release of their details to agencies outside Queensland Health.

CNSNT H600

The code indicating whether the patient consents to release of their details to WorkCover Queensland is invalid.

The code indicating whether the patient consents to release of their details to WorkCover Queensland is either null or not valid at the episode end date.

If the patient has not been asked to provide consent, or the hospital is unsure of the patient's preference, this field should be coded as Unable to Obtain. Further details about Consent fields can be found in this QHAPDC Manual.

CNSNT H601

The code indicating whether the patient consents to release of their details to MAIC is invalid.

The code indicating whether the patient consents to release of their details to the Motor Accident Insurance Commission (MAIC) is either null or not valid at the episode end date.

If the patient has not been asked to provide consent, or the hospital is unsure of the patient's preference, this field should be coded as Unable to Obtain. Further details about Consent fields can be found in this QHAPDC Manual.

CNSNT H602

The code indicating whether the patient consents to release of their details to DVA is invalid.

The code indicating whether the patient consents to release of their details to the Department of Veterans' Affairs (DVA) is either null or not valid at the episode end date.

CNSNT H603

The code indicating whether the patient consents to release of their details to the Dept of Defence is invalid.

The code indicating whether the patient consents to release of their details to the Department of Defence is either null or not valid at the episode end date.

If the patient has not been asked to provide consent, or the hospital is unsure of the patient's preference, this field should be coded as Unable to Obtain. Further details about Consent fields can be found in this QHAPDC Manual.

DEPARTMENT OF VETERANS' AFFAIRS DETAILS (DVA) ERRORS

These errors relate to all data items collected for the Department of Veterans' Affairs.

DVA H403

The Department of Veterans' Affairs file number for this patient is missing or invalid.

The Department of Veterans' Affairs (DVA) file number must be provided for all DVA patients, to allow accurate tracking of all episodes requiring payment from the Department of Veterans' Affairs. Hospital staff should ensure the number is provided, and is not null. If this patient is not a DVA patient, hospital staff should ensure the DVA details are removed, and the compensable status codes are amended. Valid codes for compensable status can be found in this QHAPDC manual.

DVA H404

The Department of Veterans' Affairs card type code is missing or invalid.

The Department of Veterans' Affairs (DVA) card type code must be provided for all DVA patients, to allow accurate tracking of all episodes requiring payment from the Department of Veterans Affairs. Hospital staff should ensure the card type code is provided, and is not null. If this patient is not a DVA patient, hospital staff should ensure the DVA details are removed, and the compensable status codes are amended. Valid codes for compensable status and DVA card type can be found in this QHAPDC manual.

DVA H413

Department of Veterans Affairs details have been received, but this patient does not have a DVA Compensable Status.

Department of Veterans Affairs' (DVA) file number and card type details have been received, but the compensable status does not indicate that this patient is a DVA patient. If the patient is usually covered by DVA, but this episode is not covered, DVA file number and card type details should not be sent. DVA details are only required for episodes that are covered by DVA.

DVA H414

This is a Department of Veterans Affairs patient, but no DVA details have been received. Please supply DVA card number and colour.

Compensable status indicates that this is a Department of Veterans Affairs (DVA) patient, but no details exist in the DVA file. Hospital staff should check all DVA details, and all compensable status changes. If the patient is not a DVA patient, then compensable status should be amended. If the patient is a DVA patient, then DVA details are required. Valid codes for compensable status, and a list of required DVA details can be found in this QHAPDC manual.

DVA H595

Account class is DVA but compensable status is not DVA or vice versa.

Either: the account classification code given indicates that the patient is a DVA patient, but compensable status does not indicate DVA, OR the account classification code given indicates that the patient is not DVA, but compensable status indicates the patient is DVA. Please check compensable status and account class codes. Valid codes for compensable can be found in this QHAPDC manual. Valid codes for account class can be provided by the Hospital Finance or Accounts section.

DVA H659

Patient is a DVA or Dept of Defence patient however, the patient is not listed as Medicare eligible. Please check the compensable status and Medicare eligibility.

A Department of Veterans Affairs (DVA) or a Department of Defence patient should be recorded as Medicare eligible. Please check the Medicare eligibility field and update if necessary.

DVA H800

DVA file number | is invalid.

The DVA number is invalid and needs to be checked. The DVA number is allowed 10 characters with the first character being a State/Territory reference. Further details regarding DVA can be found in Chapter 13 of this QHAPDC Manual.

ELECTIVE SURGERY ADMISSION WAITING LIST DETAILS (EAS) ERRORS

These errors relate to all elective surgery data items.

EAS H320

The planned date for the pre-admission clinic is before the list date for entry number |. Please check dates.

Patients should be put on the waiting list before any bookings are made, including the pre-admission clinic. Therefore, the planned pre-admission clinic attendance date should always be after the list date. Hospital staff should check both dates.

EAS H321

The waiting list placement number is missing or non-numeric in table |. This record has NOT been loaded.

The patient's entry number for this admission was not provided, or the value provided is not a valid number. Each waiting list entry has a waiting list placement number unique for that patient and list entry record. The table name has been provided in the message to enable the hospital to easily identify the record with the missing entry number. If this error appears on the validation report with the table 'qh_work_elect_adm' listed, then the entry number is missing from the elective surgery admission record sent in the EAS file. If this error appears with only qh_work_elect_surgery listed, then the entry number is missing either from the change of elective surgery details (sent as an 'E' record in the ACT file). If this error has 'qh_work_not_ready' listed, then the entry number is missing from the not ready for care details, sent as an 'N' record in the ACT file. Hospital staff should identify and resend the record with the invalid entry number.

If the record is an error and should not have been sent, no action needs to be taken, as the record has not been loaded.

EAS H322

The Clinical urgency classification code (Urgency Category) is missing or invalid on | for entry |.

The patient's urgency category as at the date provided in the message was either not provided or the code provided is not valid as at the change date (provided in the message). This is a National Minimum Data Set item, and must be provided by the hospital. A list of valid codes for urgency category are contained in this QHAPDC manual.

EAS H323

The Intended Account Accommodation Code is missing/invalid on | for entry |.

The patient's intended accommodation class code was not provided or the code provided is not valid at the list date (provided in the message). The EAS Account Accommodation Code is only required on admission and not for change dates. The hospital can find a list of valid codes for intended accommodation class in this QHAPDC manual.

EAS H325

The NMDS Specialty Grouping Code is missing or invalid for entry |.

The National Minimum Data Set (NMDS) Specialty Grouping Code was not provided or the code provided is not valid at the episode end date. This is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for NMDS Specialty Grouping Code in this QHAPDC manual. The NMDS Speciality Grouping Code is mapped from the treating doctor unit upon extraction of data. This mapping must be programmed by the hospital. There is no NMDS Speciality Grouping field in HBCIS.

EAS H326

The Site Procedure Indicator is missing/invalid on | for entry |.

The patient's site procedure indicator code was not provided or the code provided is not valid at the list date (provided in the message). The EAS Site Procedure Indicator is only required on list date and not for elective change dates. Site procedure indicator is mapped to the National Procedure indicator in HQL, which is a National Minimum Data Set item. The hospital can find a list of valid codes for site procedure indicator in the latest QHAPDC manual.

EAS H327

The National Procedure Indicator is missing/invalid on | for entry |.

The patient's national procedure indicator code was not provided or the code provided is not valid at the list date (provided in the message). The EAS National Procedure Indicator is only required on list date and not for elective change dates. National procedure indicator is a National Minimum Data Set item, and must be provided by the hospital. The national procedure indicator is mapped from the site procedure code in HQL. The hospital can find a list of valid codes for national procedure indicator in this QHAPDC manual.

EAS H330

The Planned Length of Stay is missing/invalid on | for entry |.

The patients planned length of stay is missing or the value provided is not a valid number. The EAS Planned Length of Stay is only required on list date and not for elective change dates. The hospital can find a definition for the planned length of stay in this QHAPDC manual.

EAS H334

Elective surgery details are not required as facility does not have an elective surgery module as at |.

According to HSU reference data, this hospital either does not have an elective surgery module, or did not have one as at the list date or episode end date. If the hospital does not have an elective surgery module, please send a deletion for the elective surgery details. If the hospital did have an elective surgery module, please send notification of this in writing to HSU, including the date that the elective surgery module was opened.

EAS H340

The code indicating the reason for removal from the waiting list is invalid for entry |.

The code indicating reason for removal is either not provided or is invalid at the episode end date. This is a National Minimum Data Set item. The valid codes for reason for removal can be found in this QHAPDC manual or in the latest codes received from Business Application Services (BAS).

EAS H341

The date the patient was put on the waiting list must be before the episode end date check entry |.

The date the patient was put on the waiting list (listing date) MUST be before the episode end date, as the elective surgery details must be connected to the admission during which treatment occurred. Hospital staff should check the list date, the admission date and end date. Hospital staff should also note that a patient should not be put on the waiting list after being admitted in most situations.

EAS H345

Patients not ready dates must be between the list date and admission date. Check entry |.

Either the not ready for care start date is before list date or the not ready for care end date is after the admission. The only dates a patient was not ready for care that should be provided to HSU are those that occur before the admission, and will therefore affect the total number of days spent on the waiting list. Any other not ready for care periods should not be sent to HSU. The hospital should check all not ready for care dates, the list date and the admission date.

EAS H346

The last date the patient was not ready for care is before the first date not ready. Check entry |.

The not ready for care end date is before the not ready for care start date. Hospital staff should check all not ready for care details, to ensure that all records have been correctly entered.

EAS H352

This patient was placed on the waiting list before they were born. Please check birth date and listing date for entry |.

The listing date (when the patient was placed on the waiting list) is before the patient's birth date. A patient cannot be booked for elective surgery before being born. The hospital should check all dates in this episode.

EAS H364

Elective surgery details are missing for entry number |.

Elective surgery details include urgency category, unit, site specific and national procedure codes. A code for all of these items should exist for every entry onto the waiting list. This error is caused if a delete is sent for changes that occurred on the date of listing. The hospital should either - delete all details for the elective admission OR re-send the elective surgery details as at the date the patient was put on the waiting list.

EAS H365

For entry | not ready for care periods | to | and | to | are overlapping.

Not ready for care dates should include ALL dates the patient was not ready for care, from the first date to the last date. If the patient had two not ready for care periods, the second not ready for care start date should be greater than the first not ready for care end date (that is, if a patient became ready for care on a day, then was not ready for care by the end of the day, that patient is considered to be not ready for care for the entire day, therefore only a single not ready for care period should be entered). The hospital should check all not ready for care dates.

EAS H381

The list date is missing or invalid in entry |.

The date the patient was placed on the waiting list has not been provided. Hospital staff should check all details for the entry number indicated in the message. If the patient was not put on the waiting list, the elective surgery details should be deleted. Otherwise, the date the patient was put on the list must be provided.

EAS H620

The listing date is after admission date.

The date the patient was placed on the waiting list should be before the start date of the episode. Hospital staff should check the list date and admission date. Hospital staff should note that a patient should not be put on the waiting list after being admitted in most situations.

EAS H621

Urgency category change date is after admission date.

The patient's clinical urgency category has been updated after the start date of the episode. Hospital staff should note that a patient's clinical urgency category should not be updated after the patient's admission date in most situations.

EAS H622

Urgency category change date is after separation date.

The patient's clinical urgency category has been updated after the end date of the episode. Hospital staff should note that a patient's clinical urgency category cannot be updated after the patient's separation date.

EAS H623

Waiting List Entry Number | linked to episode but no procedure reported.

The admitted patient episode that has been sent is linked to an elective surgery record (with a clinical urgency category of 1, 2 or 3); however no procedure details have been reported. Hospital staff should check whether the correct admitted patient episode has been linked, whether the linked elective surgery record is correct or whether procedure details are missing from the admitted patient episode.

EAS H624

Invalid reason for removal.

The elective surgery record that is linked to this admitted patient episode has an invalid reason for removal code. Hospital staff should note that reason for removal codes 04, 05 and 06 cannot be used and should check if the code reported is correct.

EAS H629

Waiting List Entry Number | has a National Procedure Indicator of 1 whilst the Waiting List Specialty is not in 3,6,11.

The elective surgery record reported has a national procedure indicator code of 01 (cataract extraction), however, the NMDS specialty grouping is not 03 (general surgery), 06 (ophthalmology) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H630

Waiting List Entry Number | has a National Procedure Indicator of 2 whilst the Waiting List Specialty is not in 3, 11.

The elective surgery record reported has a national procedure indicator code of 02 (cholecystectomy), however, the NMDS specialty grouping is not 03 (general surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H631

Waiting List Entry Number | has a National Procedure Indicator of 3 whilst the Waiting List Specialty is not in 1,3,11.

The elective surgery record reported has a national procedure indicator code of 03 (coronary artery bypass graft), however, the NMDS specialty grouping is not 01 (cardio thoracic), 03 (general surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H632

Waiting List Entry Number | has a National Procedure Indicator of 4 whilst the Waiting List Specialty is not in 3, 4, 9, 11.

The elective surgery record reported has a national procedure indicator code of 04 (cystoscopy), however, the NMDS specialty grouping is not 03 (general surgery), 04 (gynaecology), 09 (urology) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H633

Waiting List Entry Number | has a National Procedure Indicator of 5 whilst the Waiting List Specialty is not in 3, 4, 10, 11.

The elective surgery record reported has a national procedure indicator code of 05 (haemorrhoidectomy), however, the NMDS specialty grouping is not 03 (general surgery), 04 (gynaecology), 10 (vascular surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H634

Waiting List Entry Number | has a National Procedure Indicator of 6 whilst the Waiting List Specialty is not in 3,4,11.

The elective surgery record reported has a national procedure indicator code of 06 (hysterectomy), however, the NMDS specialty grouping is not 03 (general surgery), 04 (gynaecology) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H635

Waiting List Entry Number | has a National Procedure Indicator of 7 whilst the Waiting List Specialty is not in 3, 11.

The elective surgery record reported has a national procedure indicator code of 07 (inguinal herniorrhaphy), however, the NMDS specialty grouping is not 03 (general surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H636

Waiting List Entry Number | has a National Procedure Indicator of 8 whilst the Waiting List Specialty is not in 2, 3, 11.

The elective surgery record reported has a national procedure indicator code of 08 (myringoplasty), however, the NMDS specialty grouping is not 02 (ENT surgery), 03 (general surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H637

Waiting List Entry Number | has a National Procedure Indicator of 9 whilst the Waiting List Specialty is not in 2, 3, 11.

The elective surgery record reported has a national procedure indicator code of 09 (myringotomy), however, the NMDS specialty grouping is not 02 (ENT surgery), 03 (general surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H638

Waiting List Entry Number | has a National Procedure Indicator of 10 whilst the Waiting List Specialty is not in 3, 9, 11.

The elective surgery record reported has a national procedure indicator code of 10 (prostatectomy), however, the NMDS specialty grouping is not 03 (general surgery), 09 (urology) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H639

Waiting List Entry Number | has a National Procedure Indicator of 11 whilst the Waiting List Specialty is not in 2, 3, 8, 11.

The elective surgery record reported has a national procedure indicator code of 11 (septoplasty), however, the NMDS specialty grouping is not 02 (ENT surgery), 03 (general surgery), 08 (plastic and reconstructive surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H640

Waiting List Entry Number | has a National Procedure Indicator of 12 whilst the Waiting List Specialty is not in 2, 3, 11.

The elective surgery record reported has a national procedure indicator code of 12 (tonsillectomy), however, the NMDS specialty grouping is not 02 (ENT surgery), 03 (general surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H641

Waiting List Entry Number | has a National Procedure Indicator of 13 whilst the Waiting List Specialty is not in 3, 7, 11.

The elective surgery record reported has a national procedure indicator code of 13 (total hip replacement), however, the NMDS specialty grouping is not 03 (general surgery), 07 (orthopaedic surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H642

Waiting List Entry Number | has a National Procedure Indicator of 14 whilst the Waiting List Specialty is not in 3, 7, 11.

The elective surgery record reported has a national procedure indicator code of 14 (total knee replacement), however, the NMDS specialty grouping is not 03 (general surgery), 07 (orthopaedic surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H643

Waiting List Entry Number | has a National Procedure Indicator of 15 whilst the Waiting List Specialty is not in 3, 10, 11.

The elective surgery record reported has a national procedure indicator code of 15 (varicose veins), however, the NMDS specialty grouping is not 03 (general surgery), 10 (vascular surgery) or 11 (other – surgical). Hospital staff need to check NMDS specialty grouping reported.

EAS H661

The planned procedure date | is greater than 15 years after the listing date |.

Hospital staff should check all elective surgery admission and waiting list details. Further information can be found in this QHAPDC manual.

FUNDING SOURCE (FUND) ERRORS

These errors relate to all Funding Source data items.

FUND H438

Funding Source is missing or invalid.

The Funding Source must be provided for all patients, to allow accurate tracking of the patient's payment source. Hospital staff should ensure the Funding Source value is provided, and is not null. Valid codes for funding source can be found in this QHAPDC manual.

FUND H439

Patient is Medicare eligible,public,not compensable-therefore funding source should be Australian Health Care, or Reciprocal Health Care Arrangements.

The Funding Source code must be provided for all patients, to allow accurate tracking of the patient's payment source. Hospital staff should ensure the Funding Source is provided, and is not null. If a Funding Source of 01 (Australian Health Care Agreements, public patients) is recorded, then the patient is not contracted or not covered by reciprocal health care arrangements. Therefore the patient should be in a Public Facility. Valid codes for Funding Source can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H440

Funding Source has been provided as Private Health Insurance but patient has not been listed as having Hospital Insurance.

If a Funding Source of 02 (Private Health Insurance) is recorded, then the patient must be covered by their own Private Hospital Insurance. Hospital staff should check funding source and hospital insurance. Valid codes for Funding Source can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H441

Funding Source OR Compensable Status has been provided as Worker's Comp but other code is not Worker's Compensation.

If the Worker's Compensation Board is paying for the treatment of the patient then the Funding Source and Compensable Status must both be listed as Worker's Compensation. Hospital staff should check both of these details. If the patient is not a Worker's Compensation patient, then Funding Source should be amended. If the patient is a Worker's Compensation patient, then Compensable Status details should be amended. Valid codes for Funding Source and Compensable Status can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H442

Fund Source OR Comp Status is Motor Vehicle 3rd Party OR Other Comp/3rd Party but other code is not Motor Vehicle 3rd Party. OR Other Comp/3rd Party.

If the Funding Source provided is 05 (Motor Vehicle Third Party Personal Claim), the Compensable Status must also be listed as Third Party Motor Vehicle. Hospital staff should check both Funding Source and compensable details. If the patient is not a Third Party Compensation patient, then Funding Source should be amended. If the patient is a Third Party Compensation patient, then Compensable Status details should be amended. Valid codes for Funding Source and

Compensable Status can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H443

Funding Source OR Compensable Status has been provided as Other Compensable but other code is not Other Compensation.

If the Funding Source provided is 06 (Other Compensable), the Compensable Status must also be listed as Other Compensable. Hospital staff should check both Funding Source and Compensable details. If the patient is not an Other Compensable patient, then Funding Source should be amended. If the patient is a Compensable patient, then Compensable Status details should be amended. Valid codes for Funding Source and Compensable Status can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H444

Funding Source OR Compensable Status has been provided as Department of Veterans' Affairs but other code is not Department of Veterans' Affairs.

If the Funding Source provided is 07 (DVA), the Compensable Status must also be listed as DVA. Hospital staff should check Funding Source Compensable Status and DVA details. If the patient is not a DVA patient, then Funding Source should be amended. If the patient is a DVA patient, then the Compensable Status must change and DVA details are required. Valid codes for funding source, compensable status, and a list of required DVA details can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H445

Correctional patients should have fund source of Aust Health Care, adm source/discharge status of Correctional facility, and a Correctional account class code.

Public hospitals are not to use Funding Source of 09 (Correctional Facility). The Source of Referral, Mode of Separation and Account Class must be listed as Correctional Facility (Mode of separation can also indicate died in hospital). If the patient is Correctional then the Source of Referral and Mode of Separation details should be amended. Valid codes for Funding Source, Source of Referral and Mode of Separation can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H446

Fund Source is Other Hospital or Public Authority and Contract Role has not been listed as Service Provider.

If the Funding Source provided is 10 (Other Hospital or Public Authority), the Contract Role must be listed as B (Service Provider). Hospital staff should check both Funding Source and Contract Role details. If the patient is not a Contracted Care patient, then Funding Source should be amended. If the patient is a Contracted Care patient, then Contract details should be amended. Valid codes for Funding Source Contract Role and Contract Type can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H447

Funding Source is Reciprocal Health Care Arrangements (with other countries) but Patient's State of Usual Residence is not listed as Overseas.

If the Funding Source provided is 11 (Reciprocal Health Care Arrangements – With Other Countries), the State of Usual Residence must be 0 Overseas. Hospital staff should check both Funding Source and State ID. If the patient is not an Overseas patient, then Funding Source should be amended. If the patient is an Overseas patient, then the patient's home address should be provided, and not the address of the place they are staying. Valid codes for Funding Source can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H448

Funding Source has been provided as Other but Patient's details indicate they should have a different Funding Source. Check all details.

If the Funding Source provided is 12 (Other), the other patient information shouldn't indicate a different Funding Source. Hospital staff should check Funding Source, Hospital Insurance, Compensable Status, Contract Role and the patient's home address. If the patient's Funding Source should be a different value, please amend. Valid codes for Funding Source and other listed fields can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H449

Funding Source OR Compensable Status has been provided as Department of Defence but other code is not Department of Defence.

If the Funding Source provided is 08 (Department of Defence), the Compensable Status must also be listed as Department of Defence. Hospital staff should check both Funding Source and Compensable details. If the patient is not a Department of Defence patient, then Funding Source should be amended. If the patient is a Department of Defence patient, then Compensable Status details should be amended. Valid codes for Funding Source and Compensable Status can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H450

Funding Source has been provided as Australian Health Care, but the facility is not a Public Hospital. Please check funding source.

The Funding Source code must be provided for all patients, to allow accurate tracking of the patient's payment source. Hospital staff should ensure the Funding Source is provided, and is not null. If a Funding Source of 01 (Australian Health Care Agreement, {Public Patients}) is recorded, then the patient is not contracted or not covered by reciprocal health care arrangements. Therefore the patient should be in a Public Facility. Valid codes can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC Manual

FUND H597

Funding source provided is No Charge Raised. Please confirm this is correct.

Funding Source of 13 (No charge raised) has been provided. This code is not regularly used. Hospital staff should check to confirm that the Funding Source is correct. If the patient's Funding Source should be a different value, please amend. Valid codes for Funding Source and other listed fields can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H653

Invalid Insurance Funding Code | has been supplied. Please check and update if necessary.

An invalid insurance fund source has been supplied. Please check and if incorrect update. A list of current Health Insurance Fund code is available in Appendix P.

FUND H662

An ICD code was reported indicating that continuous ventilatory support was provided to the patient for this episode, however, the actual time in hours and minutes was not provided.

If continuous ventilatory support was provided to the patient for this episode both the ICD code indicating the range of time and the actual time in hours and minutes should be provided. Please check that the ICD code supplied is correct or provide the actual time of continuous ventilatory support in hours and minutes.

FUND H663

Duration of continuous ventilatory support have been reported for this episode, however, the appropriate ICD code range was not provided.

If the actual time of continuous ventilatory support in hours and minutes is provided, the ICD code indicating the range of time should also be provided. Please check that the actual time of continuous ventilatory support in hours and minutes is correct or provide the applicable ICD code.

FUND H664

Duration of continuous ventilatory support that have been reported for this episode does not fall between the ICD code range provided.

The Hours and minutes of continuous ventilatory support that have been reported for this episode, does not fall between the ICD code range provided. Please check both the actual hours and minutes reported and the ICD code provided.

FUND H806

This patient was admitted or transferred to a |, however, the Length of Stay in ICU details were not provided, please check this record.

Hospital staff should check if the patient for this episode was admitted or transferred to a Level 6 Children's or Adult Intensive Care Unit. The total amount to time spent by an admitted patient in an approved intensive care unit (Adult Intensive Care Unit - ICU6 or Children's Intensive Care Service Level 6 - CIC6) must be provided in hours and minutes. Rules relating to the reporting of this information can be found in this QHAPDC manual.

FUND H807

The total number of hours | is greater than the admitted patient episode, please check this record.

The total number of hours in a Level 6 Children's or Adult Intensive Care Unit is greater than the admitted patient episode, please check this record. Rules relating to the reporting of this information can be found in this QHAPDC manual.

FUND H808

Facility | does not have an approved Adult Intensive Care Unit(ICU Level 6) and/or Paediatric Intensive Care Unit(CIC6).

The hospital is not listed as having an Adult Intensive Care Unit - ICU6 or Children's Intensive Care Service Level 6 - CIC6. For further information relating to the reporting of this information can be found in Appendix K of this QHAPDC manual.

FUND H809

Total time treated in an Intensive Care Unit(Level 6) can only be reported in hours and minutes HHHHMM.

The total number of hours in a Level 6 Children's or Adult Intensive Care Unit has been incorrectly recorded. Please check

FUND H822

The patient has been treated in a public facility and assigned a funding source of AHCA or Reciprocal Health Agreement but the patient was compensable, or had a private chargeable status or was not eligible for Medicare. Please check these items.

Patients receiving treatment in a public facility and assigned a funding source of AHCA or Reciprocal Health Agreement should have a compensable status of not compensable (code = 08), a public chargeable status (code = 1) and be eligible for medicare (code = 1). Valid codes for these items can be found in this QHAPDC manual. Rules and guidelines for the allocation of compensable status, chargeable status, medicare eligibility and funding source can be found in this QHAPDC manual.

FUND H823

Funding Source of 10 - Other hospital or public authority (contracted care) is not generally used for patients being treated in public facilities.

The Funding Source of 10 - Other hospital or public authority (contracted care) is not generally used for patients being treated in public facilities. The correct funding source should be provided for all patients to allow accurate reporting of the patient's payment source. If the patient's Funding Source should be a different value, please amend. Valid codes for funding source can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

FUND H827

Funding Source is 11 - Reciprocal Health Care Agreement (with other countries). Please check funding source.

A patient receiving treatment in a private facility should not be treated under a Reciprocal Health Care Agreement. A funding source of 11 (Reciprocal Health Care Arrangements – With Other Countries) is invalid and the funding source should be amended. Valid codes for Funding Source can be found in this QHAPDC manual. Rules and guidelines for the allocation of Funding Source can be found in this QHAPDC manual.

GENERAL ERRORS

These errors relate to the general patient details (eg admission, discharge and patient details) that are required for all episodes. They include all errors relating to newborn episodes and all errors relating to the crosschecking of data items.

GEN H63

I details are missing for this admission. Please provide all missing details.

There are six individual HSU tables that must contain information for every episode: **acct_vary** (account variation details); **epis_care** (general episode details as at the start of the episode); **morb** (morbidity details); **pat** (general personal details); **pat_name_addr** (patient's name and address details); and **tfr** (ward transfer details). The table name given in the error message will specify which table(s) have missing data. Other HSU tables contain activity information that is valid for some episodes, but not all episodes, therefore data does not have to be included in these tables, and they are not checked for this validation.

If data is missing from the;

acct_vary table: hospital staff should check the facility unique id to see what account variations exist for the episode, and resend any variations. The hospital will also need to send an amendment to the admission details, with the correct codes for account classification, chargeable status and compensable status at the episode start date.

epis_care table: the hospital will need to resend ALL details for this episode, as no details have been loaded.

morb table: the hospital will need to resend ALL morbidity details.

If data is missing from the **pat** table, the hospital will need to send an amendment to the patient details, with correct data for all details not relating to name and address.

pat_name_addr table: the hospital will need to send an amendment to the patient details, with correct data for all details relating to name and address.

tfr table: hospital staff should check the facility unique id to see what ward transfers exist for the episode, and resend any variations. The hospital will also need to send an amendment to the admission details, with the correct codes for admitting ward and unit at the episode start date.

Every episode of care must have morbidity, chargeable/compensable status, admission, patient, patient name/address, and ward transfer details to be grouped. If any of these details are missing for a record, hospitals need to ensure they are provided to HSU.

GEN H65

The length of stay calculation < 1. Check all dates for this episode and ALL OTHER FIELDS (further edit checks stopped).

A patient's length of stay for an episode must be greater than or equal to one day. (Note that same day patients are considered to have a length of stay of one day.) The above error is caused by an error in the dates. Hospital staff should check all date problems, as this error will be caused by inconsistencies with the episode start and end dates or with leave dates. Hospital staff should send corrected records and arrange for those in error to be deleted. Hospital staff should also scan the episode to ensure no other errors exist, as full validation was not completed on this episode. The hospital can find rules relating to length of stay in the latest QHAPDC manual.

GEN H66

Unique ID is invalid. Please provide a valid unique id for this admission/episode. Further edit checks have stopped.

The facility unique id is zero (0) or has non-numerical characters. The facility unique id MUST be unique for every episode, and must be a number. A hospital must provide the facility unique id to allow both HSU and the hospital to easily identify the episode. Hospital staff should check all data sent in the last load, arrange for the episode with the invalid facility unique id to be deleted, and send new episode details with the correct facility unique id to HSU. Hospital staff should also scan the episode to ensure that no other errors exist, as full validation was not completed on this episode.

GEN H69

The age of this patient indicates their marital status should be never married. Please check date of birth and marital status.

The patient is less than 16 years old, and the marital status code does not indicate the patient has never been married. Hospital staff should check the birthdate and the marital status codes. The hospital can find a list of valid codes for marital status in this QHAPDC manual.

Public hospitals should note that if the patient is between 12 and 15 years old and is married or in a defacto relationship, the hospital need not take action, as the episode will still be forwarded to the Pricing Strategy Team (PPT).

GEN H71

This patient has a band code but is EITHER: not a same day patient OR has connecting episodes. Check band code, dates, and referral codes.

A band code is only valid if a patient is a day-only patient, and the episode relates to a complete hospital stay. This error has been caused by either the episode start and end dates are not the same day, but a band code has been provided, source of referral and/or mode of separation indicate that episode links to another but the band code has been provided or the patient is a boarder or an organ procurement patient.

Hospital staff should check the episode start and end dates, care type, and the band code. Incorrect details should be amended. The hospital can find rules relating to the provision of band codes in this QHAPDC manual.

GEN H73

This patient has no procedure codes, but has band code |. Band code 1B is the only band code that does not require a procedure.

A band code of 1A, 2, 3 or 4 exists but no ICD code with morbidity type (prefix) PR exists. A band code relates to a procedure - hence a patient who did not have a procedure should not have a band code, and a patient with a band code of 1A, 2, 3 or 4 must have an attached procedure code. Hospital staff should check all ICD codes to ensure that all have the correct morbidity type, and all ICD codes are included for the episode. If no procedure codes exist for the episode, hospital staff should arrange for the band code to be amended or removed.

GEN H77

This patient has a Medicare number but has not been reported as eligible. Please check both fields.

A value has been provided for Medicare number, but the Medicare eligibility code does not indicate that the patient is eligible for Medicare. If a patient has a Medicare number, they must be eligible for

Medicare. If the patient is not eligible, no Medicare number should be given. Hospital staff should check both fields. The hospital can find a list of valid codes for Medicare eligibility in this QHAPDC manual.

GEN H79

Patient with a newborn episode type cannot have workers compensation. Check episode type and compensable status as at |.

Compensable status indicates that this newborn has workers compensation. As a newborn cannot be employed, the newborn therefore cannot have workers compensation.

The hospital can find a list of the relevant codes for compensation status and episode care type in this QHAPDC manual.

GEN H80

Newborns are not usually compensable. Please check compensable status and date of birth as at |.

Episode type indicates that the patient is newborn but compensable status is motor vehicle or other.

It is rare that a newborn is compensable, especially if the newborn is unqualified. Hospital staff should check the episode care type, and the compensable status at admission and all changes to compensable status (for HBCIS hospitals, this relates to all account variations). A list of valid codes for compensable status and episode type are listed in this QHAPDC manual.

GEN H82

The Medicare number | is invalid. Please provide the correct 11 digit number.

A Medicare number has been provided for the episode, but is not valid. If the invalid Medicare number is the only number the hospital has for the patient, the field should be **null or zero filled**. The Medicare number provided is given in the message to make it easier for the hospital to identify the error.

GEN H83

The transfer/contract facility is the SAME as this facility. Check ALL referral and activity details.

The facility code for the transferring facility, facility transferred to or facility contracted to is the same as the facility code for the hospital in which this episode occurred. A hospital cannot transfer a patient to itself - if a patient is transferred within a hospital, either a ward transfer or a new episode should be provided. A new episode should only be provided if the episode care type has changed as a result of the transfer. If a new episode is required, all details should be recorded as if the transfer were a new admission (using the statistical transfer codes for mode of separation and source of referral). If the episode type did not change as a result of the transfer, then the facility should record the transfer as a ward transfer and/or an account variation. Hospital staff should also check the facility code of the other hospital. A list of valid codes for episode care type, source of referral, and mode of separation; valid codes for other facilities; and further instructions on ward transfers can be found in this QHAPDC manual.

GEN H87

Indeterminate sex is only valid for neonates born without a single gender. Please check sex and date of birth.

The sex code indicates the patient has indeterminate sex, but the patient is older than 29 days. The indeterminate sex code is generally only used for neonatal patients where the sex has not been

determined. Where doubt exists (eg in the case of transsexual patients) the sex at the time of admission should be used. Hospital staff should check the sex code and the birthdate fields, and provide corrected details. The hospital can find a list of valid codes for sex in this QHAPDC manual. The QHAPDC manual also contains rules for the coding of the gender of a patient.

GEN H88

Born in hospital referral code is only valid for babies born in this facility at the start of this episode. Check birthdate and country of birth.

The episode start date is not on the same day as the birth date or country of birth is not Australia, yet the source of referral indicates that the patient is a baby born in the hospital. A baby who is in the hospital and has an episode type change should not have the 'born in hospital' source of referral code. Hospital staff should check the source of referral code, the birthdate and the episode start date. The hospital can find a list of valid codes for source of referral in this QHAPDC manual. The QHAPDC manual will also contain rules relating the use of each source of referral code.

GEN H89

A person should be between 15 and 70 years old to claim workers compensation. Check the compensable status at | and the birthdate.

The patient is less than 15 years old, or greater than 70 years old but has compensable status indicating they are on workers compensation. It is unusual for a patient who is not of an employable age to receive worker's compensation. Hospital staff should check the birthdate and all account variations, especially account details at the date given in the message. The hospital can find valid codes for compensable status

in this QHAPDC manual.

Public hospitals should note that if the hospital discovers that all codes and dates are correct then no action has to be taken, as the episode will still be forwarded to the Pricing Strategy Team.

GEN H90

This patient has not been reported as a day patient. Please check dates, planned same day flag, and referral codes.

The planned same day flag does not indicate that the patient planned to leave on the same day they were admitted, or the source of referral or mode of separation indicate that this episode links with another episode. Hospital staff should send corrected planned same day, source of referral or mode of separation details, or should inform HSU immediately if it is no longer a day only hospital. Hospital staff should also check the episode start and end dates. Valid codes for planned same day, source of referral and mode of separation can be found in this QHAPDC manual.

GEN H92

This patient is public from | but is not being treated under contract to a public hospital or public health authority. Please check chargeable status and/or source of referral.

Chargeable status indicates that the patient is a public patient, but source of referral and transfer from facility code do not indicate that the patient was treated under contract to a public hospital or health authority. A private hospital should not have public patients unless the patient is being treated under contract from a public hospital or health authority. Patients receiving free treatment should be recorded as private. Hospital staff should check the chargeable status at admission and in all account variations (and especially at the date given in the message). Hospital staff should also check source of referral and episode care type. The hospital can find valid codes for each of these fields in this QHAPDC manual. The QHAPDC manual will also include rules on when to use the various codes for these fields.

GEN H94

Weight less than | is unusual for a liveborn. Please check admission weight for this admission/episode.

The admission weight provided for the episode is less than 400 grams. It is extremely unusual for a baby under 400 grams to be live born. HSU understand that premature babies can be less than this weight and still survive, however, babies under 200 grams are usually stillborn. Hospital staff should check the admission weight. The hospital can find rules and definitions relating to admission weight in this QHAPDC manual. If the hospital has further queries, they should contact HSU.

Public hospitals should note that if the weight is correct, over 200 grams, and the baby has survived, then no action has to be taken, as this episode will still be forwarded to the Pricing Strategy Team. If the baby has survived to be admitted and is less than 200 grams, then please inform HSU in writing.

GEN H95

Day patients are usually acute. Please check the episode type and dates for this hospital stay/episode.

The episode care type indicates that the episode is not an acute episode, but a same day patient is most likely to be an acute patient. Hospital staff should check episode type, and send corrected codes if required. If the code is correct, hospital staff should send an explanation in writing to HSU. The hospital can find valid codes for episode type in this QHAPDC manual.

GEN H120

Episode type OR account class indicate this patient is a newborn, but other codes are not newborn. Check episode type and account class.

Either: the account classification code given indicates that the patient is a newborn, but episode care type does not indicate a newborn, OR the account classification code given indicates that the patient is not a newborn, but episode care type indicates the patient is a newborn. Please check episode care type and account class codes. Valid codes for episode care type can be found in this QHAPDC manual. The Hospital Finance or Accounts section can provide valid codes for account class.

GEN H130

The patient's reported surname (|) is not a true name. Please provide the patient's full name.

Public hospitals must provide patient names. Hospital staff should check their data entry - maybe the episode number or even patient id has been accidentally entered as the name, or 0 (zero) has been typed instead of O, or a character not accepted in a name has been typed. If the patient's name includes a number, that number should be provided in Roman numerals (eg John Paul II, NOT John Paul 2).

Hospital staff should re-send the patient's full name. If the hospital does not know the name of the patient, they must provide the name used in the patient's record, or give the surname as 'Unknown'. Hospital staff should also record the patient's first name as 'Unknown' in this case. If a patient has only one name, this name should be recorded as the surname.

GEN H146

If age is more than 28 days, weight is ONLY required if admission weight is less than 2500 grams.

The rules for requiring weight of a baby are as follows: If a baby is either less than 29 days old OR the baby is less than 2500 grams. If the baby does not fulfill either of these conditions, then weight is not to be given. Hospital staff should check both the birthdate and weight fields, as either could be in error. If both fields are correct, hospital staff should arrange to have the weight field removed from the episode.

GEN H147

This patient is over 1 year old and weighs less than 2500 grams. Please check date of birth and admission weight.

The patient is older than 365 days, but weighs less than 2500 grams. Hospital staff should check both the birthdate and weight fields, as either could be in error. Weight should be supplied in grams.

GEN H148

Baby is | grams. This is much heavier than most babies under 1 month. Please check birth date and admission weight.

It is unusual for a baby less than 29 days old to be larger than 6000 grams. Such an occurrence is rare enough to merit a query. Hospital staff should check the baby's birthdate (an older baby is likely to be this heavy), and the weight. The weight should be supplied in grams. The hospital is to advise HSU in writing if the birthdate and weight are correct.

GEN H161

This facility cannot accept transferred admitted patients from other facilities. Please check source of referral.

Outpatient centres or other non-inpatient facilities should not accept transferred admitted patients from other hospitals. If the facility has changed status, and can now accept transferred patients, they should inform HSU immediately. If the hospital cannot accept transferred patients from other facilities, an amendment should be made to the source of referral code. The hospital can find a list of valid codes for source of referral in this QHAPDC manual.

GEN H164

The facility this patient was transferred to cannot accept admitted patient transfers. Please check mode of separation and facility id.

Hospitals should not transfer patients (as admitted patients) to outpatient centres or other non-inpatient facilities. If the facility the patient was transferred to can accept transferred admitted patients, HSU should be informed immediately. If the facility the patient was transferred to cannot accept transferred admitted patients, an amendment should be made to the mode of separation code. The hospital can find a list of valid codes for mode of separation in this QHAPDC manual.

GEN H176

The Workers Compensation Occupation for this patient is missing.

Enter the patients Occupation.

GEN H177

Patient was discharged at same time they returned from leave. Check all leave dates.

If a patient is separated during or at the end of a leave period, then they should be discharged from the time they started the leave rather than when they finished the leave. This rule can be found in this QHAPDC manual. Hospital staff should amend leave records or change the episode end date. The hospital can find a list of valid codes for mode of separation in this QHAPDC manual.

GEN H202

This new record already exists in the database and has NOT been loaded. Please correct and resend this record if required.

Hospital staff should check all amendments or new activities sent for the facility unique id in the last load, as one of the amendments (or deletions) or new activities sent was a duplicate. This could be an activity that was resent, or a new patient record. This error can also occur if an amendment record is sent with type 'N' (ie new record) instead of type 'A' (ie amendment record). If the hospital discovers an error of this type, or if an incorrect facility unique id was used, the hospital should resend the amendment with corrected details. If the amendment is correct, the hospital may have to delete the original record and/or resend the amendment.

GEN H242

A code is required for transferring facilities only when patient has been transferred. Please check all referral/separation details.

This error occurs when a facility code has been provided for a transferring facility but source of referral indicates that patient was not transferred, OR when a facility code has been provided for facility transferred to, but mode of separation indicates that the patient was not transferred.

Hospital staff should check whether the patient was transferred in from another hospital or residential aged care service at admission. If so, the source of referral should indicate the transfer, and the facility code for the transferring hospital or residential aged care service should be given for transferring facility. If not, the source of referral should not indicate transfer, and there should be NO value for transferring facility.

Hospital staff should also check whether the patient was transferred to another hospital or residential aged care service at separation. If so, the mode of separation should indicate the transfer, and the facility code for the hospital or residential aged care service the patient was transferred to should be given for transfer to facility. If not, the mode of separation should not indicate transfer, and there should be NO value for transfer to facility.

The hospital can find a list of valid codes for source of referral and mode of separation in this QHAPDC manual. Valid codes for all facilities can also be found in this QHAPDC manual.

GEN H263

Baby's weight is invalid. Please supply weight in grams.

Weight has been supplied in kilograms (with a decimal point), or non-numerical characters have been included in the weight field. If the patient is not either less than 29 days old OR a baby weighing less than 2500 grams, the weight should be removed. If the patient is either less than 29 days old OR a baby weighing less than 2500 grams, the weight should be provided as a whole number in grams.

GEN H283

This patient had an alternative patient id of | in the extract files. Please check your patient id for this episode.

An electronic hospital has an episode where the patient id is not the same between the ADM and PAT files for a given facility unique id. The patient id given in the ADM file has been used, and all tables in the system have been updated with this patient id. Hospital staff should check their records for the facility unique id. If the patient id shown in the message is the correct patient id, then the hospital will have to send an amendment to the ADM file, with the corrected patient id included. If the patient id shown in the message is not the correct patient id, then the hospital should contact HSU to ensure that HSU have the correct patient id.

GEN H285

This episode is a duplicate of an episode already sent with unique id | patient id | start date |. This episode has not been loaded.

Another episode already exists in the database with the same patient id and episode start date and start time. Hospital staff should first check that the patient id is correct for the new episode. If the patient id is not correct, hospital staff should resend the details with the corrected patient id. If the patient id is correct, hospital staff should check all details for that patient id, and should take action as listed below:

If a new episode is being sent for the patient id, the hospital may need to send an amendment for this episode, and the new episode may have to be re-sent.

If an amendment record is being sent, hospital staff should send a new amendment. A deletion or amendment for this episode may be required, as it could be a duplicate. Hospital staff should check all details for the facility unique id given with the error, as an amendment may be required for this episode.

GEN H354

The episode care type indicates that the patient was admitted to a designated Rehabilitation Unit. Please check episode care type.

Episode care type 20 (rehabilitation delivered in a designated unit) may only be coded for a patient admitted to a recognised rehabilitation unit. According to HSU records, this hospital does not have a recognised rehabilitation unit. Please check the episode care type and inform HSU of the correct code. Valid codes for episode care type can be found in this QHAPDC manual.

If a recognised rehabilitation unit has opened in the hospital or an existing unit has recently been recognised, please inform HSU in writing.

GEN H355

The episode care type indicates that the patient was admitted to a designated Palliative Unit. Please check episode care type.

Episode care type 30 (palliative care delivered in a designated unit) may only be coded for a patient admitted to a recognised palliative care unit. According to HSU records, this hospital does not have a recognised palliative care unit. Please check the episode care type and inform HSU of the correct code. Valid codes for episode care type can be found in this QHAPDC manual.

If a recognised palliative care unit has opened in the hospital or an existing unit has recently been recognised, please inform HSU in writing.

GEN H377

| sent, but original episode has never been received. Please check episode details and if necessary contact your system administrator. The | NOT been loaded.

Change details have been sent, but the original episode was never received. The table name at the beginning of the message indicates what amendments have been sent. Hospital staff should check the facility unique id. If the episode does exist, and should have been sent, hospital staff should arrange to have the entire episode (with all amendments made) to HSU. If the episode does not exist, no action needs to be taken.

GEN H394

Country of birth has been inadequately described. Please provide full details of the patient's country of birth.

Country of birth is a National Minimum Data Set item and MUST be provided by the hospital. If the hospital are unsure how to code a particular patients country of birth, they should contact HSU. Valid codes for country of birth can be found in this QHAPDC manual.

GEN H395

Geriatric Evaluation and Management patients should be at least 65 years old.

The patient's age is under 65 years, but the episode care type indicates the patient has been admitted for Geriatric Evaluation and Management. Hospital staff should check the episode type and the birthdate. Valid codes for episode care type can be found in this QHAPDC manual. Rules for the coding of Geriatric Evaluation and Management patients can be found in this QHAPDC manual.

Public hospitals should note that if the details are correct no action needs to be taken, as this episode will still be sent to the Pricing Strategy Team.

GEN H406

Elective status should not be assigned to patients returning for a routine readmission. Check elective status and source of referral.

Patients who are routinely admitted to hospital (eg for dialysis) are neither elective nor emergency patients, therefore their elective status code should indicate that elective status has not been assigned. Hospital staff should check the source of referral and the elective status. Valid codes for elective status and source of referral can be found in this QHAPDC manual.

GEN H428

Details for | are not required before July 2000.

DVA file details, PAL file details and contract role and type are fields that were introduced at the beginning of the 2000/2001 financial year. These details are not required before this date, and therefore should not be provided.

Hospital staff should check the episode end date, DVA details, palliative care details and contract details, and amend as required.

GEN H435

This patient has a missing OR invalid Australian South Sea Islander Code.

The code indicating whether the patient is of Australian South Sea Islander descent is a required item and MUST be provided by the hospital. Valid codes for this item can be found in this QHAPDC manual.

GEN H436

Patient is an Australian South Sea Islander but Country of Birth Code is not Australia. Check Islander Code and Country of Birth Code.

A person is only eligible to be considered an Australian South Sea Islander if they are descended from South Sea Islanders brought to Queensland to work on the Cane fields, and have been born in Australia. Hospital staff should check Country of Birth and Australian South Sea Islander status.

If the patient is descended from South Sea Islanders brought to Queensland to work on the Cane fields, but was not born in Australia, they should not be coded as an Australian South Sea Islander.

GEN H460

Birth Date Estimate Code is invalid.

The birth date estimate code provided is invalid. This code should be provided only when the date of birth has been estimated. Valid codes for birthdate estimate code can be found in this QHAPDC manual.

GEN H461

Patient stay is before 01-JUL-2001 and has Aust_sth_sea_isl code. This code is not valid for this period. Please check code.

Australian South Sea Islander status was first introduced as a data item in the 2001/2002 financial year. This data item is not required before this date. Hospital staff should check episode end date and Australian South Sea Islander status.

GEN H462

Patient stay is before 01-JUL-2001 and has fund_source code. This code is not valid for this period. Please check code.

Funding Source was first introduced as a data item in the 2001/2002 financial year. This data item is not required before this date. Hospital staff should check episode end date and funding source.

GEN H464

Baby has a very low weight but is unqualified. Please confirm.

Patient is a newborn with a weight of less than 2000 grams, and is unqualified for the entire episode. It is expected that a baby with a low birthweight would require treatment and would therefore be qualified. Hospital staff should check qualification status and admission weight.

It is understood that some hospitals cannot admit qualified newborns, therefore if this is the case, hospital staff need take no action, as this episode will still be sent to the Pricing Strategy Team.

GEN H465

This patient has an account class code indicating they are a long stay patient from | but does not have a SNAP care type. Please check care type, account class and/or nursing home type details.

The account class indicates the patient is a long stay patient, but episode care type is not Rehabilitation – delivered in a designated unit (care type = 20); Palliative care – delivered in a designated unit (care type = 30); Psychogeriatric care (care type = 10); Geriatric Evaluation and Management (care type = 09); Maintenance Care (care type = 11). Hospital staff should check all account class codes and the episode care type.

Hospitals using HBCIS should note that a NHT details are derived when the account class code contains 'long stay (LS)' and a corresponding care type of 'sub and non-acute' is recorded. Should all details appear correct please contact the 'HBCIS system administrator.

GEN H466

This patient has an account class code indicating they were a long stay patient but does not have a Nursing Home Type record from | to |.

The patient has an account class indicates the patient is a long stay patient, an episode care type of sub and non- acute, but there are no Nursing Home Type records. Hospital staff should check episode care type, account class codes and nursing home records.

Hospitals using HBCIS should note that a NHT details are derived when the account class code contains 'long stay (LS)' and a corresponding care type of 'sub and non-acute' is recorded. Should all details appear correct please contact HBCIS administrator.

GEN H469

Consent for feedback contact is not null and not found in the valid list of codes as of Patient's end date. Please check consent for feedback contact.

Consent for feedback contact must be a valid code. Valid codes for this field can be found in this QHAPDC manual.

GEN H470

Facility is Public, End Date is > 01-MAR-2002 and Consent for Feedback Contact is null. Please check Consent for Feedback Contact.

Consent for Feedback Contact must be provided by all public hospitals from 01-MAR-2000. Hospital staff should check their feedback consent details.

GEN H487

ICD code | is only valid for mode of separation code | died in hospital.

Hospital staff should review the mode of separation and the ICD coding.

GEN H503

Source of referral is a correctional facility but the facility code is missing or is not a correctional facility.

The source of referral indicates the patient was transferred from a correctional facility, but the transfer from facility code is either not provided, or the code provided is not a valid correctional facility. Hospital staff should check both the source of referral and transferring facility fields. The hospital can find a list of valid codes for source of referral and correctional facilities in this QHAPDC manual or in the latest codes received from Business Application Services (BAS).

GEN H504

Separation mode is transfer to a correctional facility but the facility code is missing or is not a correctional facility.

The mode of separation indicates the patient was transferred to a correctional facility, but the transfer to facility code is either not provided or the code provided is not a valid correctional facility. Hospital staff should check both the mode of separation and transferred to facility fields. The hospital can find a list of valid codes for mode of separation and correctional facilities in this QHAPDC manual or in the latest codes received from Business Application Services (BAS).

GEN H509

If qualification status is provided, the patient must be a newborn. Check episode type and qualification status.

The patient has a qualification status code but the episode care type is not newborn. Only newborns should have a qualification status code. If a baby is admitted after they are 9 days old, they should be admitted as an acute patient or a boarder, and should not be given a qualification status code (or, for public hospitals, an account class indicating qualified newborn). These are National Minimum Data Set items. Valid codes for episode care type and qualification status can be found in this QHAPDC manual, or for public hospitals, in the latest codes received from Business Application Services (BAS).

GEN H510

This newborn is over 9 days old at admission. Please check date of birth and episode type.

A patient that is over 9 days old was admitted as a newborn. All newborns must be 9 days old or under at admission, although an acute newborn can be older than 9 days at the episode end date. If an unqualified newborn is over 9 days old and is admitted to hospital, they should be registered as a boarder. If an acute newborn is over 9 days old at admission, they should be admitted as an acute patient.

GEN H511

This patient has a qualification status change more than 9 days after birth. Please check date of birth and qualification status.

A newborn cannot have a qualification status change after they are 9 days old, as only qualification status of acute is valid for a newborn over 9 days old. Note that an unqualified newborn can change to acute on the 10th day, but no other qualification status changes are allowed after the patient is 9 days old. If an unqualified newborn did not become acute until after the 10th day, the newborn should be discharged on the 9th day and readmitted as a boarder. Then, on the day the baby became acute, they should be discharged and readmitted as an acute patient. Hospital staff can find rules for the coding of newborns and boarders in this QHAPDC manual.

GEN H512

Unqualified newborns should become boarders when they are over 9 days old. Check date of birth and qualification status.

Unqualified newborns remaining in hospital after they are 9 days old must be separated and registered as a boarder. Hospital staff should check the birthdate, and the qualification status. An unqualified newborn that is receiving treatment may become acute on the 10th day. Valid codes for qualification status can be found in this QHAPDC manual.

GEN H513

This baby's weight is too low to be discharged so soon.

This validation checks the separation mode of the patient relative to the patient days (<28) and weight (<1000 grams). The hospital can find further information on mode of separation and baby admission weight in this QHAPDC manual.

GEN H516

Details have been sent in table | for entry | but Elective Admission record not found.

An elective surgery change (E record in the ACT file) or a not ready for care period (N record in the ACT file) has been received, but no elective admission details exist for the episode (a record in the EAS file). All elective surgery items relate to the elective admission and should only be provided with that admission (E or N recorded but not loaded). The hospital should arrange for the elective admission details to be sent, or if the elective admission details have been deleted, the hospital should arrange for the attached E and N files to be deleted also.

GEN H518

The patient is 9 days old or less, but does not have newborn episode type. Check date of birth and episode type.

All newborn babies 9 days old or less must be assigned as a newborn with a qualification status provided. The hospital staff should check the date of birth and admission dates. If the patient is a newborn, the episode type must be amended to indicate this, and a qualification status should be provided (public hospitals will need to update the account class code). Valid codes for episode type and qualification status can be found in this QHAPDC manual, or for public hospitals, in the latest codes received from Business Application Services (BAS).

GEN H532

The standard ward code provided is invalid as at |. Please check code.

The standard ward code should only be provided for wards involved in the specialised collections, for example the SNAP ward. If this patient is not involved in the specialised collection, then no standard ward code should be provided. Hospital staff can find valid codes for standard ward code in this QHAPDC manual.

GEN H588

This patient was transferred from a residential aged care service, but the facility transferred from is not a residential aged care service.

The source of referral indicates the patient was transferred from a residential aged care service, but the transfer from facility code is either not provided, or the code provided is not a valid residential aged care service. Hospital staff should check both the source of referral and transferring facility fields. The hospital can find a list of valid codes for source of referral and residential aged care services in this QHAPDC manual or in the latest codes received from Business Application Services (BAS).

GEN H589

This patient was transferred to a residential aged care service, but the facility transferred to is not a residential aged care service.

The mode of separation indicates the patient was transferred to a residential aged care service, but the transfer to facility code is either not provided, or the code provided is not a valid residential aged care service. Hospital staff should check both the mode of separation and transfer to facility fields. The hospital can find a list of valid codes for mode of separation and residential aged care services in this QHAPDC manual or in the latest codes received from Business Application Services (BAS).

GEN H590

The incident that caused admission occurred after the episode start date. Please check both dates.

The incident date (ie date on which the incident causing admission occurred) should always be either before the admission date, or the same as the admission date. Hospital staff should check both the incident date and episode start date.

GEN H592

The code indicating whether the incident date was estimated is not valid.

A code has been provided indicating the incident date was estimated, but the code provided is not valid at the episode end date.

GEN H593

Incident date is not required for this episode.

Incident date is only required for data from 01 July 2002. Hospital staff should check the incident date and episode end date.

GEN H594

The country of birth code for this patient is very rare. Please confirm country of birth code.

The country code given to the patient is a very rare country of birth code. Please check the country of birth code, and if it is correct, please inform HSU in writing.

A list of valid country of birth codes can be found in this QHAPDC manual.

GEN H598

Standard Ward Code provided as at | is not valid for a Private Facility. Please check Standard Ward Code.

A list of valid standard ward codes can be found in this QHAPDC manual.

GEN H605

Facility is a private day centre but the episode is not same day or the patient has been on leave.

This validation checks that patients in a day centre are a same day episode and don't have any leaves within the episode. Patients within a private day centre must only be a same day patient. Check start and end dates of the episode. They may not have any leaves attached to this episode.

GEN H606

Patient days are more than | but patient has not had psychiatric care or nursing home type care.

Patient had a long length of stay but did not have a reason for this like psychiatric care or nursing home type care. Patient had a long length of stay for their care type. Check start and end dates, and care type.

GEN H607

Non acute newborn died in hospital but episode of care longer than |.

This validation checks that a non-acute newborn died in hospital and episode of care was longer than 1 hour. There was no acute time during the episode. Check the qualification status, start and end dates for this episode to confirm a non-acute newborn died in hospital without any acute care.

GEN H610

Episode with Admission Source of | should have an elective status of not assigned (3).

This validation checks that an episode with an admission source of episode change or born in hospital has an elective status of not assigned. Further information on admission source and elective status is available in this QHAPDC manual.

GEN H619

Criteria Led Discharge type code (CLD) has not been supplied or is not a valid code.

The Criteria Led Discharge (CLD) type code identifies if the patient was separated using criteria let discharge.

The hospital can find list of valid Criteria Led Discharge type code in this QHAPDC manual.

GEN H651

This patient is 18 or more years old and has been admitted to a children's hospital. Please check date of birth.

GEN H660

This patient's source of referral, funding source or mode of separation is reported as Correctional facility. Please check all entries.

GEN H666

The purchaser/provider ID has not been supplied or is not a valid code. The contract type is |, the contract role is | and the chargeable status is |.

The contract type, contract role and/or the chargeable status indicates a purchaser identifier or a provider identifier should be supplied.

The hospital can find additional information and list of valid purchaser/provider ID's in this QHAPDC manual.

GEN H667

The purchaser/provider ID has been supplied however, contract details have not been supplied. Please check the purchaser/provider id, contract type and role.

The purchaser identifier or a provider identifier has been supplied which indicates contracted hospital care has been provided however, the contract role and/or the contract type has not been supplied. Please check the purchaser/provider identifier, contract role and/or the contract type.

The hospital can find additional information relating to the purchaser/provider id, contract type and contract role in this QHAPDC manual.

GEN H708

The code for Preferred Language is missing or invalid. Please check.

Record the language (including sign language) most preferred by the person for communication.

A list of valid preferred language codes can be found in this QHAPDC manual.

GEN H709

The code for Interpreter Required is missing or invalid. Please check.

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

Further information on interpreter required can be found in this QHAPDC manual

GEN H711

QAS Patient Identification Number (eARF) is not valid for patients with a source of referral of 06, 20, 21. Please check eARF and source of referral.

Further information on QAS Patient Identification Number (eARF) can be found in this QHAPDC manual

GEN H718

The QAS Patient Identification Number is not numeric. Please check.

Further information on QAS Patient Identification Number (eARF) can be found in this QHAPDC manual

GEN H799

The Country of Birth code must not end in '0'. Please check.

The Country of Birth codes have been updated. Further information on interpreter required can be found in this QHAPDC manual (Appendix E).

GEN H824

The episode care type 06 – Other care should not generally be used. Please check episode care type.

Episode care type 06 (other care) should not generally be used. Please check the episode care type and if the patient's episode care type should be different, please amend. Valid codes for episode care type can be found in this QHAPDC manual. Rules and guidelines for the allocation of episode care type can be found in this QHAPDC manual.

GEN H858

If a Mother Patient ID exists then the Source of Referral/Transfer should be 09 - Born in Facility.

If the mothers patient id exists the Source of Referral/Transfer should be 09 Born in hospital.

GROUPING (GRP) ERRORS

These errors relate to problems in grouping the episodes, including failure to group episodes.

GRP H134

The DRG code provided does not match the code given by Health Statistics Unit. Please ensure that the episode has been grouped and check your Grouper version.

This error is most likely to occur because the hospital is using a different version of the grouper program to that used by HSU. Hospital staff should ensure that they have no errors in the episode. Once all errors are corrected, if the error H134 is still occurring, hospital staff should check that they have entered the correct DRG code. Hospitals can determine which version of the grouper program they should be using by contacting HSU or the Pricing Strategy Team (CIDU) or Business Application Services (BAS).

GRP H135

The MDC code provided does not match the code given by Health Statistics Unit. Please ensure the episode has been grouped and check your Grouper version.

This error is most likely to occur because the hospital is using a different version of the grouper program to that used by HSU. Hospital staff should ensure that they have no errors in the episode. Once all errors are corrected, if the error H135 is still occurring, hospital staff should check that they have entered the correct MDC code. Hospitals can determine which version of the grouper program they should be using by contacting HSU or the Pricing Strategy Team (CIDU) or Business Application Services (BAS).

GRP H136

This episode could not be sent to the grouper due to data errors. Please review all validations for this episode.

This error has occurred because the items needed to give a correct grouping code are in error, or there is an inconsistency in the ICD codes, causing the grouping program to reject the episode. Hospital staff should ensure all errors are fixed for the episode, and check all warnings. If the error H136 still occurs after all other errors are fixed, hospital staff should contact HSU.

GRP H375

Error occurred during version | DRG grouping. Episode received DRG |: |, Error |: |.

HSU grouper returned an error during grouping of the episode. The error returned by the grouper has been provided in the message to help Hospital staff locate the cause of the error. Hospital staff should fix all errors in the episode.

If no other errors exist for the episode, and hospital staff cannot find the cause of the error, they should contact HSU.

GRP H376

Error occurred during version | DRG grouping. Episode received DRG |:|.

HSU grouper successfully grouped the episode, but returned an error indicating that the DRG code returned is inadequate. Hospital staff should check all data within the episode, to ensure that all relevant information (such as ICD codes, baby admission weight, leave days) has been provided.

If no other errors have been created for the episode, and hospital staff cannot find the cause of the error, they should contact HSU.

GRP H378

A cost weight could not be assigned to this episode, as no cost weight exists for version | DRG |.

HSU was unable to assign a cost weight to this episode. This is caused by either: the grouper assigning a DRG that is not included in the Hospital Funding Model for the current year, OR the grouper has assigned a DRG that relates to procedures not usually carried out at this hospital. Hospital staff should check all ICD codes and sequencing of the codes. If errors are found, ICD codes should be deleted, and resent to HSU.

If ICD codes are correct, hospital staff do not need to take any action, as this episode will still be forwarded to the Pricing Strategy Team.

GRP H582

DRG Code has not been provided. Please group this episode.

No grouping code was provided by the hospital. Public hospitals should group all episodes before providing them to HSU. Hospital staff should check all ICD details to ensure that the episode groups correctly.

DIAGNOSIS OR MORBIDITY (ICD and ICDSEQ) ERRORS

These errors relate to the assignment of ICD-10-AM or ACHI codes, and how those codes fit in with other data items. Many of these errors relate to the Australian Coding Standards (ACS), which can be found in the ICD-10-AM book or electronic eBook.

ICD H45

The diagnostic code | has been duplicated for this admission/episode.

Condition or diagnosis codes should never be duplicated – i.e. the condition should not be recorded more than once in any episode. External causes, morphologies or procedures can be duplicated however, as it is possible for a person to have the same operation twice in one episode, or for external cause or morphology codes to relate to more than one diagnosis.. Hospital staff should check all diagnosis codes, and provide corrected codes as per the current coding standards. If you are unsure of the current coding standards should contact HSU for an explanation.

ICD H55

The ICD code || is not valid or is the wrong ICD version for this episode.

The diagnosis or procedure code/morbidity type (or diagnosis or procedure code/prefix) combination (shown in the message) is either not valid at the episode end date or was never a valid code. Hospital staff should check their records and provide correct codes at the episode end date. If hospital staff have checked the diagnosis or procedure codes and are certain that the ICD code is valid, they should contact HSU to discuss the error. Valid morbidity types (identifiers) for diagnosis or procedure codes are: PD (principal diagnosis), OD (other diagnosis), PR (procedure), EX (external cause), M (morphology). HSU will inform hospitals when a new version of diagnosis and procedure codes are to be implemented in Queensland.

ICDSEQ H67

The PD is in the wrong sequence order. Check sequences and morbidity types.

The morbidity record with sequence number 1 does not have morbidity type (identifier) PD. (Note that HSU queries this rather than automatically re-sequencing, as this could be due to a mistake in coding morbidity types rather than the sequence.) Hospital staff should check the sequencing of their morbidity codes, and should check all coding to ensure the correct morbidity type has been put against each code. Hospital staff should re-send all morbidities with the correct type and in the correct sequence, as per current coding standards. If you are unsure of the current coding standards, contact HSU for an explanation.

ICD H125

The principal diagnosis is missing. Please check all diagnoses and provide the code for the principal diagnosis.

For accurate DRG assignment, all diagnosis codes must be provided, with a specific order. The principal (first) diagnosis MUST be given as the first in the sequence, as this is the condition which was chiefly responsible for the patient's episode of care and is the main code used in the grouping of data. (Note that the principal diagnosis has a special morbidity type (identifier) of PD, which identifies it from other diagnosis codes and it should also be the first diagnosis code on the file.) Hospital staff should check all diagnosis codes for the episode, as an incorrect morbidity type may have been assigned to the ICD code that should have been the principal diagnosis. Otherwise, the principal diagnosis was not provided. Hospital staff should arrange to have the morbidity details for the episode deleted and the corrected morbidity details should be forwarded to HSU.

ICD H129

The morbidity type | is invalid. (The attached code is |.) Please check all diagnostic types.

An invalid morbidity type (identifier) has been put against a valid diagnosis or procedure code. Morbidity type indicates whether the code is a diagnosis, procedure, morphology, or external cause. The morbidity type must be valid and matched correctly with the diagnosis or procedure code to ensure that codes appear in the correct order. To ensure accurate grouping, all diagnosis or procedure code/morbidity type combinations must be valid. Valid morbidity types are as follows:

PD = Principal Diagnosis (Condition) - should always appear first

OD = Other or Secondary/Additional Diagnosis (Condition)

EX = External Cause

M = Morphology

PR = Procedure

ICD H149

There is an ICD code missing for morbidity type |. Please check all codes relating to this morbidity type.

This error only occurs when a record has been sent with a morbidity type (identifier) code, but no diagnosis or procedure code. The hospital MUST provide all diagnostic codes for each episode. Hospital staff should check all diagnosis or procedure codes, as either one code is missing, or blank records have been sent for morbidities. The hospital will need to arrange for the deletion of all morbidity records, and re-send all morbidity details for the episode.

ICD H150

The morbidity type for the ICD code | is missing. Please also check that this code is valid.

This error occurs when a record has been sent with an diagnosis or procedure code, but no morbidity type (identifier) code. The hospital MUST provide all diagnosis or procedure codes with attached morbidity type for each episode. Hospital staff should check all diagnosis or procedure codes to ensure they have the correct morbidity type, and resend corrected data. The hospital can find a list of valid morbidity types in this QHAPDC manual.

ICD H245

There is an invalid morbidity record for this patient. Please check all morbidity details.

A record exists in the morbidity table that has no ICD code and no morbidity type. Hospital staff should check all morbidity details for the episode. The hospital will need to arrange for the deletion all morbidity records, and re-send all morbidity details for the episode.

ICD H281

When sending New morbidities, you must first delete existing morbidities and then send all morbidities as New records.

The order of the morbidity records is extremely important in the QHIPS system. If a new record is sent, the system has no way of knowing where in the sequence the new morbidity should belong. For this reason, each electronic change to morbidities must include a deletion of all existing morbidity records, then re-send ALL morbidity records with all corrections made. If the hospital has any queries, they should contact HSU.

ICD H293

Newborn has qualification status of acute during episode of care, but the only code is PD Z380. Please amend qualification status or provide additional codes.

To be an acute baby, the diagnosis codes must contain more than Z38.0 Singleton born in *hospital* code. The Newborn must be receiving some form of treatment or have some type of condition to be acute

ICD H390

This patient is | but has ICD Codes indicating they have received treatment or have undergone a procedure. Please check.

Boarders and unqualified newborns should not be undergoing procedures, or have morphology or external cause codes. Hospitals staff should check episode care type, morbidity codes and qualification status (in the case of newborns). Medical conditions, procedures, morphologies and external causes should only be coded for a patient who is admitted. If the patient receives treatment and is a boarder the hospital, amend the episode care type, source of referral and mode of separation. If the patient is an unqualified newborn and is receiving treatment, the hospital should check all qualification status codes. Valid codes for episode care type, source of referral, mode of separation and qualification status can be found in this QHAPDC manual.

Public hospitals should note that if the patient is an unqualified newborn, and is receiving treatment, no action needs to be taken as the episode will still be sent to the Pricing Strategy Team.

ICD H429

The Principal Diagnosis should be immediately followed by an external cause code. Please check coding.

The Principal Diagnosis is an injury code. ICD Standards require that if an injury code is the principal diagnosis it must be immediately followed by an external cause code relating directly to that injury. Hospital staff should check all morbidity details, and arrange for current codes to be deleted and corrected details sent.

ICD H431

External cause relating to Principal Diagnosis must be immediately followed by a Place of Occurrence code.

The Principal Diagnosis is an injury code. Australian Coding Standard 2001 *External cause code use and sequencing* includes the requirement that if an injury code is the principal diagnosis it must be immediately followed by an external cause code relating directly to that injury, and the external cause must be immediately followed by the place of occurrence code. Hospital staff should check all morbidity details, and arrange for current codes to be deleted and corrected details sent.

ICD H432

External cause(s) and place of occurrence relating to Principal Diagnosis must be immediately followed by an Activity code.

The Principal Diagnosis has external cause (s) relating to it, those external causes must be followed by a Place of Occurrence and (if relevant) an Activity Code, before another diagnosis code is provided. Hospital staff should arrange for deletion and resending of all morbidity details. If you are unsure of the required coding sequence, they should contact HSU.

ICD H455

Procedure | date does not occur during contract leave but Contract Type = 2 (ABA).

The procedure provided in the message has been contracted out as an admitted procedure, and the contract type indicates that it is a contract leave. But the procedure date does not occur during any contract leaves in the episode. Check procedure date and contract details. Rules for providing contract information can be found in this QHAPDC manual.

ICD H459

Procedure Date Null but procedure | is in the mandatory block range (see QHAPDC manual for mandatory range). Check procedure date and coding.

If ICD type = PR (procedure) and the procedure code belongs to a mandatory block then a procedure date is required. Hospital staff should check to make sure the procedure was performed and correctly coded. If the procedure code is incorrect, hospital staff should arrange for all morbidity codes to be deleted, and re-send all morbidity details. If the procedure code is correct, the hospital is required to supply a procedure date.

ICD H467

The patient had procedure | on the day they either commenced or returned from leave. Please confirm.

While it is recognised that it is very possible to have a procedure on the day a leave starts or finishes, it is expected that this would be rare. Hospital staff should check leave and procedure dates, and amend them if necessary.

Public hospitals should note that if the dates are correct, no action need be taken.

ICD H489

ICD code || should not be used with code | in the same episode.

- **Heart Failure** (diagnosis codes I50.0 *Congestive heart failure* and I50.1 *Left ventricular failure*) – If both left ventricular failure and congestive heart failure are documented only I50.0 *Congestive heart failure* is assigned. Refer Coding Advice, Volume 7, No 4, December 2000.
- **Excludes Notes:** Refer to ICD-10-AM/ACHI Tabular notes for excludes conditions that may be classified elsewhere. E.g. Y95 *Nosocomial condition* should not be used with U90.0 *Healthcare associated Staphylococcus aureus bacteraemia*.

ICD H490

For ICD code || there must be | Anaesthetic codes in the | or | ranges for the same episode.

The number of electroconvulsive therapy (ECT) procedures performed is different to the total number of anaesthesia codes. Hospital staff should check all ECT related procedures codes.

ICD H505

The contract code for procedure code | | is invalid. Please check diagnostic details.

The contract code provided for the stated diagnostic details is not valid. Contract codes should ONLY be provided for treatment that has been performed by a contracted facility during a contract service. Hospital staff should check contract code details. The hospital can find a list of valid contract codes in this QHAPDC manual.

ICD H548

| Date is | the | date.

The patient has an activity outside the range created by the episode start and end dates (for example, the patient was admitted in August, but went on leave in July). This activity can be: a leave record, a procedure date, a contract record, a ward transfer record, an account variation record, a qualification status change, a nursing home type record, SNAP details, or a combination of the above records. All activity changes and leaves must relate to the episode to which they are attached. If the dates of these activity changes or leaves are outside the episode start and end dates then it is possible the hospital has made a mistake on the episode start and end dates or activity dates. Hospital staff should check the following:

Confirm whether the activities do relate to this episode, or another episode for this patient. If the activities relate to another episode, hospital staff should inform HSU of the facility unique id OR the patient id and episode start and end dates of the other episode.

ICD H549

Each admission/ episode should have only ONE principal diagnosis.

More than one diagnosis code in the episode has morbidity type (identifier) PD. All episodes must have only ONE principal diagnosis. Hospital staff should check all diagnosis codes for the episode, as one or more ICD code may have been assigned the wrong morbidity type, OR diagnosis codes for two episodes have accidentally been sent under the same facility unique ID. diagnosis codes should then be deleted and resent in the correct sequence.

ICD H550

ICD Code || is only valid for patients between | and |. This patient is |.

The diagnosis or procedure code provided in the message has failed an age validation. This diagnosis or procedure code is valid only for patients of a certain age. Please check the episode start and end dates, the patient's birth date, and all diagnosis or procedure codes.

The ICD code and associated age ranges can be viewed on the Corporate Reference Data System (http://oascrasprod.co.health.qld.gov.au:7900/pls/crd_prd/f?p=144:1:626515655065293)

ICD H551

ICD Code || is not valid for patients between | and |. This patient is |.

Patients are not allowed to have this diagnosis or procedure code if their age is between this range. The diagnosis or procedure code provided in the message has failed an age validation. This diagnosis or procedure code is not valid for patients of a certain age range. Hospital staff should check episode start and end dates, the patient's birth date, and all diagnosis or procedure codes.

The ICD code and associated age ranges can be viewed on the Corporate Reference Data System (http://oascrasprod.co.health.qld.gov.au:7900/pls/crd_prd/f?p=144:1:626515655065293)

ICD H552

For ICD Code || the patient should be |. This patient is |.

This validation checks morbidity codes against the sex of the patients. The diagnosis and procedure code provided in the message has failed a sex validation. This diagnosis and procedure code is valid only for patients of a certain sex. Hospital staff should check the patient's sex, and all diagnosis and procedure codes.

ICD H553

ICD code || is only valid for a same day episode.

The validation checks diagnosis codes that are only valid for same day episodes and checks them against the episode length, where patient is admitted and discharged on the same day. Hospital staff should check the episode start and end dates, source of referral, mode of separation and diagnosis codes.

- Z51.0 *Radiotherapy session*, Z511 *Pharmacotherapy session for neoplasm* is valid as a PD for same day episode.

ICD H555

ICD code || is only valid for episode care type |.

The diagnosis code provided in the message indicates that the patient is a boarder, OR the patient is receiving specialist treatment. The care type does not match the diagnosis code. Hospital staff should check episode care type and diagnosis codes. If the diagnosis code is incorrect, hospital staff should arrange for deletion and resending of all morbidity details.

- **Newborn** - Codes in the range liveborn infants according to place of birth (Z38.0,-Z38.8) and Z76.2 *Health supervision and care of other healthy infant and child* are only valid for episode care type 05 Newborn
- **Rehabilitation** - Care involving use of rehabilitation procedure codes in the range Z50.0-Z50.1, Z50.4-Z50.9 are only valid for an care type 20 Rehabilitation
- **Palliative** - Z51.5 *Palliative care* is valid for an care type 30 Palliative Care
- **Organ Procurement** - Donor of organs and tissue codes in the range Z52.5-Z52.7 are only valid for an care type 07 Organ Procurement
- **Boarder** - Persons encountering health services in other circumstances codes in the range Z76.3-Z76.4 are only valid for an episode type 08 Boarder
- **Maintenance** - Z75.5 *Holiday relief care* is valid for an episode type of 11 Maintenance.

ICD H556

ICD code || is only valid for source of referral |.

The validation checks the diagnosis code against the allowed source of referral for that code. The diagnosis code provided in the message indicates either the patient is a boarder, OR the patient is has arrived at the hospital in a specific manner. The source of referral does not match the diagnosis code.

Z38.0 is only valid for the source of referral code of 09 Born in hospital

Z38.3 is only valid for the source of referral code of 09 Born in hospital

Z38.6 is only valid for the source of referral code of 09 Born in hospital

Z38.1 is only valid for the source of referral code of 02 Emergency department - this hospital

Z38.4 is only valid for the source of referral code of 02 Emergency department - this hospital

Z38.7 is only valid for the source of referral code of 02 Emergency department - this hospital

ICD H557

ICD code || is not valid for source of referral |.

The validation checks diagnosis codes against source of referral code. The diagnosis code provided in the message indicates the patient has arrived at the hospital in a specific manner or as a specific type of patient which does not match the source of referral code.

Codes Z38.1 *Singleton, born outside hospital*, Z38.2 *Singleton, unspecified as to place of birth*, Z38.4 *Twin, born outside hospital*, Z38.5 *Twin, unspecified as to place of birth*, Z38.7 *Other multiple, born outside hospital*, Z38.8 *Other multiple, unspecified as to place of birth* are invalid for the source of referral code of 09 Born In Hospital.

ICD H558

ICD code || has been provided, but this code is only valid as |. Please confirm.

The validation checks diagnosis codes that can only be the PD or an OD. The diagnosis code provided in the message is to be supplied in a specific sequence (ie either as the PD or as an OD). The diagnosis code has been provided incorrectly.

Z587 *Exposure to tobacco smoke* should not be coded until the NCCH provide advice. Hospitals wishing to collect information on this diagnosis code should assign the code with an OCOI flag.

ICD H559

ICD code || is a rare code. Please confirm.

This validation prompts the hospital to check the rare diagnosis code supplied. The diagnosis code provided relates to a condition that is considered rare in Australia. Hospital staff should check and confirm the diagnosis for this rare code.

ICD H560

ICD code || has been provided contravenes coding standards. Please check ICD Code.

Current coding standards require that the diagnosis code in the message is not used for admitted patients. The code has been provided incorrectly.

Codes in the range Z81.0-Z81.8 Family history of mental and behavioural disorders are invalid for an admitted patient episode as a PD or as an OD.

Z50.2 Alcohol rehabilitation and Z50.3 Drug rehabilitation should not be assigned for inpatient episodes.

ICD H608

Psychiatric episode without a mental health ICD code.

If a patient is said to have a psychiatric episode, but does not have an associated mental health diagnosis code, an error will be received.

If patient encounter has a standard unit code (either at admission to the episode or through a unit transfer during the episode) in the range PYAA to PYZZ (Mental Health Unit) but does not have an associated mental health diagnosis code, an error will be received.

ICD H611

An episode with care type of | must have a | diagnosis |.

Hospital staff should check coding and admission details. Further information is available within this QHAPDC manual.

ICD H645

ICD code | refers to fetus' congenital anomaly, do not code on mothers record. Refer to ACS.

Hospital staff should check coding and admission details. Further information is available within this QHAPDC manual.

ICD H741

There can only be one Most Resource Intensive Condition flag set per episode for ICD Type PD or OD.

Hospital staff should check coding and admission details. Further information is available within this QHAPDC manual.

ICDSEQ H561

ICD code || must be immediately preceded by a code in the range |.

An Activity code in the range U50.00-U73.9 must have a code from the Place of Occurrence range Y92.0 - Y92.99 immediately before it.

ICDSEQ H562

ICD code || must be preceded by a code in the range |.

Check the ICD-10-AM/ACHI Tabular notes for Code First instructions

- **Morphology Code** - A Morphology code in the range M8000/0 and M9999/9 must have a neoplasm site code in the range C00 - D48, or O01.0 *Classical hydatidiform mole*, O01.1 *Incomplete and partial hydatidiform mole* O01.9 *Hydatidiform mole, unspecified*, Q85.0 *Neurofibromatosis (nonmalignant)* before it.
- **Place of Occurrence** - If the code supplied is a Place of Occurrence code in the range Y92.0 - Y92.99 it must have an External Cause code in the V01-Y8999 range before it.
- **Activity** - If an Activity code in the range U50-U739 is used, an External Cause code in the range V00.00- Y34.99 must be used before it.
- **Hyperplasia prostate** - If the code N40 Hyperplasia of the prostate and N32.0 Bladder neck obstruction appear together in the same episode the N40 must be used before the N32.0
- **Nitric oxide therapy** - 92210-00 [1889] Nitric oxide therapy should be assigned in addition to a ventilatory support code.
- **High intensity focused ultrasound [HIFUS]** – if 90908-01 [1949] *High intensity focused ultrasound [HIFUS]*, first code 90609-00 [1579] *Destruction of bone*, 90726-00 [1759] *Other destruction of breast*, 90370-00 [1046] *Other destruction of lesion of kidney*, 90299-00 [956] *Other destruction of liver*, 90408-00 [1162] *Other destruction of lesion of prostate* or 90451-00 [1263] *Other destruction of lesion of uterus*.
- **Combined ventilatory support, >= 96 hours** – if 92211-00 [571] *Management of combined ventilatory support, >= 96 hours*, first code duration of ventilation from blocks [569] *Ventilatory support* and [570] *Non invasive ventilatory support*. Note this is for neonates only. Duration of combined ventilatory support must be >= 96 hours.

ICDSEQ H563

ICD code || must be immediately followed by a code in the range |.

ECT codes should immediately be followed by a general anaesthesia procedure code (block [1910]).

ICDSEQ H564

ICD code || must be followed by a code in the range |.

- **Injury** - Diagnoses codes in S or T chapter, Examination and observation for other reasons code range Z04.1-Z04.5, or Sunburn code range L55.0 – L55.9 must be followed by an External Cause code in the range, V00.00-Y91.99 or Y95-Y98.

- **Neoplasm** - A neoplasm code in the range C00-D48, or O01.0 *Classical hydatidiform mole*, O01.1 *Incomplete and partial hydatidiform mole* O01.9 *Hydatidiform mole, unspecified*, Q85.0 *Neurofibromatosis (nonmalignant)* must be followed by a morphology code between M8000/0 and M9999/9.
- **External Cause** (Place of Occurrence) - An External Cause code in the range V00.00-Y89 must be followed with a Place of Occurrence code in the range Y92-Y92.99.
- **External Cause** (Activity) - An External Cause code in the range V00.00- Y3499 must be followed by an Activity code in the range U50.00 to U73.9.
 - **Post procedural** - diagnosis in code the below ranges must be accompanied with an EX code in the range Y83.0-Y84.9: Post procedural endocrine and metabolic disorders, not elsewhere classified E89.0-E89.9
 - Post procedural disorders of nervous system , not elsewhere classified G97.0-G97.9
 - Post procedural disorders of eye and adnexa, not elsewhere classified H59.0-H59.9
 - Post procedural disorders of ear and mastoid process, not elsewhere classified H95.0-H95.9
 - Postprocedural disorders of circulatory system, not elsewhere classified I97.0-I97.9
 - Postprocedural respiratory disorders, not elsewhere classified J95.0-J95.3 and J95.5-J95.9
 - Postprocedural disorders of digestive system, not elsewhere classified K91.0-K91.9
 - Postprocedural musculoskeletal disorders, not elsewhere classified M96.0-M96.9
 - Postprocedural disorders of genitourinary system, not elsewhere classified N99.0-N99.9.

ICDSEQ H565

ICD code || must be provided with a code in the range |.

It is expected an additional code is assigned in conjunction with the ICD code.

Burns codes

- A body percentage code in the range T31.00-T31.99 must be accompanied by a burns site companion code in T20-T25.3, T29.0-T30.3 or L55.0-L55.9.
- A burns site code in the range T20-T25.3, T29.0-T30.3 or L55.0-L55.9 must be accompanied by a companion body percentage code in the range T31.00 - T31.99.

Delivery codes

- Delivery codes in the range O80-O84 must be accompanied by a diagnosis code in the range Z37.0-Z37.9.
- The following augmentation, induction and delivery procedures require an outcome of delivery code in the range Z37.0-Z37.9.
 - 16520-00, 16520-01, 16520-02, 16520-03 [1340] *Caesarean section*
 - 90469-00 [1338] *Vacuum extraction with delivery*
 - 90468-00, 90468-01, 90468-02, 90468-03, 90468-04, 90468-05 [1337] *Forceps delivery*
 - 90467-00 [1336] *Spontaneous vertex delivery*
 - 90470-00, 90470-01, 90470-02, 90470-03, 90470-04 [1339] *Breech delivery*
 - 90465-00, 90465-01, 90465-02, 90465-03, 90465-04, 90465-05 [1334] *Medical or surgical induction of labour*
 - 90466-00, 90466-01, 90466-02 [1335] *Medical or surgical augmentation of labour*
- Outcome of delivery codes must have a companion delivery code::
 - Outcome of delivery code range Z37.0-Z37.1 with a companion delivery code from the range O80-O83.9
 - Outcome of delivery code range Z37.2-Z37.7 with a companion delivery code from the range O84-O84.9
 - Outcome of delivery code O37.9 with a companion delivery code from the range O80-O84.9.
- Obstetric laceration codes must be accompanied by postpartum suture codes:

- Obstetric laceration code in the range O70.0-O70.1 must be accompanied by postpartum suture codes in the range 90472-00 [1343] Episiotomy, 90481-00 [1344] Suture of first or second degree of perineum or 90485-00 [1344] Other suture of current obstetric laceration or rupture without perineal involvement or 90479-00 [1344] Suture of current obstetric laceration of vagina
- Obstetric laceration code in the range O70.2-O70.3 must be accompanied by postpartum suture codes in the range 90472-00 [1343], 16573-00 [1344] Suture of third or fourth degree of perineum.

Hernia

- *Repair of incarcerated, obstructed or strangulated hernia* 30615-00 [997] must be accompanied by a hernia diagnosis code in the range K40.00-K40-1, K40.10-K40.11, K4030-K4031, K40.40-K40.41, K41.0, K41.3-K41.4, K420, K21, K430, K31, K44.0-K44.1, K45.0-K45.1, K46.0-K46.1.

Obstetric procedures in the following blocks [1330] *Antepartum application, insertion or removal procedures*, [1344] *Postpartum suture*, [1345] *Postpartum evacuation of uterus*, [1346] *Correction of inverted uterus*, [1347] *Other postpartum procedures* must be accompanied by an obstetric diagnosis from O00-O08.9 or O10-O75.99 or O81-O97.9.

Pregnancy Codes - Duration of Pregnancy codes in range O090 - O099 must only be accompanied by a code from pregnancy with abortive outcome codes in the range O00.0-O07.9, O20.0 *Threatened abortion*, O36.4 *Maternal care for intrauterine death*, O42.0 *Premature rupture of membranes, onset of labour within 24 hours*, O42.11-O42.9 *Premature rupture of membranes, onset of labour after 24 hours*, O47.0 *Maternal care for intrauterine death* or O60.0-O60.3 *Preterm labour and delivery*.

Open Wound - Complications of open wound code T89.0x requires a injury, poisoning and certain other consequences of external causes companion site code in the range S00.0-T14.99.

Ophthalmic procedures - Procedures for ectropion or entropion - Block [239] must be accompanied by a diagnosis code in the range of either H02.0-H02.1 *Other disorders of eyelid* or Q10.1-Q10.2 *Congenital malformations of eyelid, lacrimal apparatus and orbit*.

Alzheimer's disease - code G30.8 *Other Alzheimer's disease* must be accompanied with code F00.2 *Dementia in Alzheimer's disease*.

Secondary neoplasm - Malignant neoplasms, stated or presumed to be secondary codes in the range C77.0-C79.88 must be accompanied by neoplasm codes in the range C00.0-C76.8 or C80.

Acute reaction to foreign substance accidentally left during a procedure T81.6 must be accompanied by Y61 *Foreign object accidentally left in body during surgical and medical care*.

Follow-up - Other specified surgical follow-up care Z48.8 must be accompanied by a code in the range A00.0-T98.3, Z39.01 *Postpartum care after hospital delivery*, Z41.1 *Other plastic surgery for unacceptable cosmetic appearance* or Z46.6 *Fitting and adjustment of urinary device*.

Dagger - The corresponding asterisk code is required.

Asterisk - The corresponding dagger code is required.

ICDSEQ H570

ICD code || cannot be provided with codes in the range |.

- **Pregnancy state, incidental** - Z33 can not be accompanied by another code from O00-O99.8 *Pregnancy, childbirth and the puerperium*. Refer ACS 1521 *Conditions complicating pregnancy*.
- **Tobacco use** - codes F17-1 and F17-2 *Mental and behavioural disorders due to tobacco (harmful use and dependence syndrome)* cannot be accompanied by Z86-43 *Personal history or tobacco use* or by Z72.0 *Tobacco use current*.
- **Cholecystitis** - codes K-81 *Cholecystitis* should not be coded with K80 *Cholelithiasis*.
- **Mental and behavioural disorders** - Harmful use codes should not be coded with other codes in the same rubric.
- **Shock** - R57.2 *Septic Shock* should not be used with R65.0-R65.3 *SIRS* codes.

- **Delivery** – Only one delivery code in the O80–O84 range should be assigned for obstetric episodes where delivery is the outcome.
- **ECT** – Only one code from block [1907] *Electroconvulsive therapy* should be assigned. The two character extension indicates the number of treatments performed in the episode of care.
- **Management of continuous ventilatory support codes**
 - 13882-00 cannot be used with the following codes:13882-01 or 13882-02 [569] *Ventilatory support.*
 - 13882-01 cannot be used with the following codes: 13882-00 or 13882-02 [569] *Ventilatory support.*
 - 13882-02 cannot be used with the following codes :13882-00 or 13882-01 [569] *Ventilatory support.*

ICDSEQ H578

ICD code || must be provided with a procedure code in the range |.

- **Pharmacotherapy session for neoplasm** - Z51.1 must be accompanied by a procedure from blocks [1920] *Administration of pharmacotherapy*, [1922] *Other procedures related to pharmacotherapy* OR a cancellation of a procedure code in the range Z53.0-Z53.9 *Persons encountering health services for specific procedures, not carried out.*
- **Delivery** – O80 can not be accompanied by procedures from blocks [1337] *Forceps delivery*, [1338] *Vacuum extraction*, [1339] *Breech delivery and extraction* and [1340] *Caesarean section.*

ICDSEQ H579

ICD code || must be provided with a diagnosis code in the range |.

- **Division of adhesions** – procedure codes must be provided with a diagnosis code for the following:
 - 30278-01 [390] *Lysis of adhesions of tongue* with Q38.39 *Other congenital malformations of tongue*
 - 36812-02 [1095] *Endoscopic division of intraluminal bladder adhesions* with N32.8 *Other specified disorders of bladder*
 - 37008-06 [1095] *Division of intraluminal bladder adhesions* with N32.8 *Other specified disorders of bladder*
 - 41683-00 [372] *Division of nasal adhesions* with J34.8 *Other specified disorders of nose and nasal sinuses* or J95.8 *Other postprocedural respiratory disorders*
 - 41683-01 [372] *Division of nasal adhesions with insertion of stent* with J34.8 *Other specified disorders of nose and nasal sinuses* or J95.8 *Other postprocedural respiratory disorders*
 - 90402-01 [1994] *Division of penile adhesions* with N47 *Redundant prepuce, phimosis and paraphimosis*, N99.8 *Other postprocedural disorders of genitourinary system* Q55.8 *Other specified congenital malformations of male genital organs*
- **Prophylactic Surgery** – It is expected that a procedure code (or Z53 *Cancelled procedure*) code be assigned where indicated by the diagnosis code Z40 *Prophylactic surgery.*

ICD H584

ICD code || is only valid for newborns with birthweight between | and | grams. This newborn has birthweight | grams.

The validation checks the diagnosis code against the baby's birth weight.

Birthweight

- P07.01 *Extremely low birth weight 499g or less* is only valid for birthweight between 0000 and 00499 grams

- P07.02 *Extremely low birth weight 500 - 749g* is only valid for birthweight between 0500 and 0749 grams
- P07.03 *Extremely low birth weight 750 - 999g* is only valid for birthweight between 0750 and 0999 grams
- P07.11 *Other low birth weight 1000 - 1249g* is only valid for birthweight between 1000 and 1249 grams
- P07.12 *Other low birth weight 1250 - 1499g* is only valid for birthweight between 1250 and 1499 grams
- P07.13 *Other low birth weight 1500 - 2499g* is only valid for birthweight between 1500 and 2499 grams.

ICD H586

ICD code ||can not be performed at facility ||. Please confirm if this facility can perform this procedure.

The procedure is a rare or specialist procedure that would not normally be performed as this type of hospital. Check the ICD procedure code and confirm that the patient has not been sent on a contract. If the patient has been sent on a contract, ensure that the contract facility code is correct. If the hospital or contracted hospital (service provider) can perform this type of procedure, they should contact HSU to check if the facility details are correct.

ICD H609

Episode with PD of | should have an elective status of not assigned (3).

The episode that has been reported has a PD of dialysis or chemotherapy should have an elective status code of 3 (not assigned). Hospital staff need to check the elective status code reported.

ICD H613

ICD code || is not valid for episode care type |.

The diagnosis code provided in the message is not an acceptable diagnosis code and another (more specific) code should be used to record the actual condition.

- **Hepatitis:** The concept of 'carrier (state) Z22.52 is no longer clinically correct ; carrier codes should never be assigned. Please refer to ACS 0104 Viral Hepatitis.
- **Emergency Use Codes:** U06 – U49 cannot be used unless advised by World Health Organisation.
- **Non-specific codes** - F99 *Mental disorder, not otherwise specified*, R68.8 *Other specified general symptoms and signs* and R69 *Unknown and unspecified causes of morbidity* should not be assigned.

ICD H614

ICD Code || does not match diagnosis site code. Please review excludes notes.

Fracture Femur Reduction – The procedure code 47528-01 [1486] *Open reduction of fracture of femur with internal fixation* and 47531-00 [1486] *Closed reduction of fracture of femur with internal fixation* should not be used when the fracture being reduced is of the proximal femur. Where proximal fractures of the femur (includes neck of femur, subcapital femur, and trochanteric) are reduced these should be coded to a different code such as 47519-00 [1479] *Internal fixation of fracture of trochanteric of subcapital femur*.

ICD H647

PD Code must have a condition present on admission indicator of 1 (or 2 if referral source is 09-Born in hospital).

If the ICD type is PD then condition present on admission indicator must be 1 (condition present on admission to the episode of care). The exception to this is neonates in their admitted birth episode in that hospital where diagnosis codes sequenced as the principal diagnosis may be assigned a CPoA of 2 (condition not present on admission) if appropriate (excludes Z38.- *Liveborn infants according to place of birth*).

ICD H648

OD Code must have a condition present on admission indicator of 1 or 2 or 9.

If the ICD type is OD then condition present on admission indicator must be either 1 (condition present on admission to the episode of care), 2 (condition arises during the current episode of care) or 9 (condition onset unknown).

ICD H649

ICD_Type M or PR must not have a condition present on admission indicator.

The CPoA indicator must not be recorded for procedure codes. The CPoA Indicator must only be recorded for diagnoses, external cause and morphology codes.

ICD H650

Other diagnosis of | has a condition present on admission indicator of 2 but no external cause codes have a condition present on admission indicator of 2.

- **Postprocedural conditions** - with a CPoA indicator of 2 are expected to have associated external cause codes with the same CPoA indicator. Refer also ACS 1904 – Procedural complications.
- **Injury conditions** – with a CPoA indicator of 2 are expected to have associated external cause codes with the same CPoA indicator.
- **Examination** - Examination and observation for other reasons codes in the range of Z041-Z0459 with a CPoA indicator of 2 are expected to have associated external cause codes with the same CPoA indicator. Refer ACS 2001 *External cause coder use and sequencing*.

ICD H652

If this patient is same day dialysis, PD should be Z491.

As per ACS 1404 *Admission for kidney dialysis*, for episodes of care where the patient is discharged on the same day as the admission or on the next day after admission, code Z49.1 *Extracorporeal dialysis* or Z49.2 *Other dialysis* as the principal diagnosis as appropriate.

ICD H655

ICD Code || must have a Condition Present on Admission indicator of 1 – Present on Admission.

It is unlikely the condition coded would have arisen during the episode of care. Please review coding and CPoA assignment. E.g. neoplasm codes, congenital codes, select external cause codes, outcome of delivery, and liveborn infants according to place of birth should all have a CPoA of 1- *present on admission*.

ICD H655 is a validation type of fatal.

ICD H656

ICD Code || usually has a Condition Present on Admission Indicator of 1 - Present on Admission indicator. Please confirm this is correct.

It is unlikely the condition coded would have arisen during the episode of care. Please review coding and CPoA assignment.

Examples of conditions expected to have a CPoA of 1 - present on admission, include selected external cause codes unlikely to occur during an episode of care, and chronic conditions such as Diabetes and asthma.

ICD H656 is a validation type of warning.

ICD H863

ICD Code || does not meet coding standards: More specific diagnosis code to be used.

A more specific diagnosis code should be used to clearly describe the patient condition. It is inadvisable to use "multiple" and "unspecified" codes.

ICD H655

ICD Code|| must have a Condition Present on Admission indicator of 1 – Present on Admission.

It is unlikely the condition coded would have arisen during the episode of care. Please review coding and CPoA assignment. E.g. neoplasm codes, congenital codes, select external cause codes, outcome of delivery, and liveborn infants according to place of birth should all have a CPoA of 1- present on admission.

ICD H656

ICD Code || usually has a Condition Present on Admission Indicator of 1 - Present on Admission indicator. Please confirm this is correct.

It is unlikely the condition coded would have arisen during the episode of care. Please review coding and CPoA assignment.

Examples of conditions expected to have a CPoA of 1- present on admission, include selected external cause codes unlikely to occur during an episode of care, and chronic conditions such as Diabetes and asthma.

EPISODE LINKING (LINK) ERRORS

These errors relate to problems in linking episodes into a complete hospital stay. To link the episodes that make up the hospital stay the episode should have the following;

- The source of referral (admission source) and mode of separation codes between the linked episodes should indicate 'status transfer'.
- The second episode should begin on the same day that the first episode ended.
- The episodes must have a different care type.

LINK H137

This episode epis id | overlaps with another episode for this patient from |, to |, epis id |.

A patient cannot be admitted more than once at any time in one hospital - hence a patient's episodes should never overlap. Hospital staff should check all episodes for the patient, and provide corrected details for all episodes to HSU. Fields that hospital staff should take special care to check are the episode start and end dates, source of referral (admission source), mode of separation and episode care type for all episodes for this patient. The hospital can find a list of valid codes in this QHAPDC manual.

LINK H139

The mode of separation indicates this episode (epis id |) should link to a following episode (|, epis id |), but the following episode cannot be linked. Please check the mode of separation in this episode and the source of referral (admission source) and/or the start date for the following episode.

An episode has been sent with a mode of separation indicating the episode should link to a following episode, but the next episode does not start on the same day and/or have the required source of referral (admission source). Hospital staff should check all episodes for the patient, and provide corrected details for all episodes to HSU. Fields that hospital staff should take special care to check are the episode start and end dates, source of referral (admission source), mode of separation and episode care type for all episodes for this patient. The hospital can find a list of valid codes in this QHAPDC manual.

LINK H140

The previous episode (epis id |) | - | has same care type as this episode (epis id |) but episodes link.

Two linked episodes (one immediately following the other) must have different episode care types. If they do not have different episode care types, then this should be ONE episode. Hospital staff should check all episodes for the patient, and provide corrected details for all episodes to HSU. Fields that hospital staff should take special care to check are the episode start and end dates, source of referral (admission source), mode of separation and episode care type for all episodes for this patient. The hospital can find a list of valid codes in this QHAPDC manual.

LINK H166

The source of referral (admission source) indicates that this episode (epis id |) should link to a previous episode, but the previous episode is missing. Please check the source of referral (admission source) in this record and the mode of separation and/or end date for the previous record.

An episode has been sent with a source of referral (admission source) indicating it should link to a previous episode however, the previous episode cannot be found. To link a hospital stay the source of referral (admission source) and mode of separation codes between the linked episodes should indicate 'status transfer', and the second episode should begin on the same day that the first episode ended.

Hospital staff should check all episodes for the patient, as one or more have incorrect source of referral (admission source) and/or mode of separation codes. Once the hospital knows which episodes should link to a stay, they should provide the corrected source of referral (admission source) and/or mode of separation codes to HSU. The hospital can find a list of valid codes in this QHAPDC manual.

LINK H190

According to our records, this patient has been resident for over three months and has not yet been discharged. Is this correct?

Health Statistics Unit has received an episode with mode of separation indicating status transfer (ie that the episode should link to a following episode). This episode was received at least three months before this report was run. The following episode in the patient's hospital stay has not yet been received by HSU. Hospital staff should check to see if the patient is still resident. If the patient is not still resident, hospital staff should either update the mode of separation in the last episode, or provide the details for the new episode. Valid codes for mode of separation can be found in this QHAPDC manual.

MENTAL HEALTH (MH) ERRORS

These errors relate to data included in the Mental Health (MEN) file. Mental health details are required for all patients admitted to a designated psychiatric unit. A single record only is required, details to be provided as at the first time during the episode that the patient is transferred to the psychiatric unit.

MH M1

Mental Health data is missing for patient admitted or transferred to psychiatric standard unit.

The standard unit code is in the range 'PYAA' to 'PYZZ' which indicates the patient has either been admitted or transferred to a designated psychiatric unit during the episode. Mental Health data should be provided to HSU for this episode. The hospital can find details of the information required in this QHAPDC manual.

MH M2

Mental Health data exists for patient not admitted or transferred to a psychiatric standard unit.

A mental health record exists for a patient but the standard unit code does NOT indicate that the patient was admitted or transferred to a designated psychiatric unit during the episode. The standard unit code must be in the range 'PYAA' to 'PYZZ'. Hospital staff should check the standard unit code for the admission and for any transfers and send amendments to HSU. The hospital can find guidelines regarding the scope of the provision of mental health details and a list of valid codes for standard unit code in this QHAPDC manual.

MH M3

The patient's type of usual accommodation is missing or invalid.

The patient's type of usual accommodation immediately prior to admission to the hospital was not provided, or the code provided is not valid at the episode end date. Type of usual accommodation is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for type of usual accommodation in this QHAPDC manual.

MH M4

The patient's employment status is missing or invalid.

The patient's employment or activity status immediately prior to admission to the hospital was not provided, or the code provided is not valid at the episode end date. Employment or activity status is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for employment or activity status in this QHAPDC manual.

MH M5

A person should be less than 18 years old to be classified as a child not at school.

The patient is 18 years old or greater, and the employment status code indicates the patient is a child not at school. Hospital staff should check the birthdate and the employment status codes. The hospital can find a list of valid codes for employment status in this QHAPDC manual.

MH M6

A person should be more than 14 years old to be classified as employed or unemployed.

The patient is less than or equal to 14 years old, and the employment status code indicates the patient is employed or unemployed. Hospital staff should check the birthdate and the employment status codes. The hospital can find a list of valid codes for employment status in this QHAPDC manual.

MH M7

The patient's pension status is missing or invalid.

The patient's pension status at the time of admission to the hospital was not provided, or the code provided is not valid at the episode end date. The hospital can find a list of valid codes for pension status in this QHAPDC manual.

MH M8

A female should be more than 59 years old to receive the aged pension.

The patient is reported as being female and less than or equal to 59 years old. The pension status code indicates the patient is receiving the aged pension. Hospital staff should check the birthdate and the pension status codes. The hospital can find a list of valid codes for pension status in this QHAPDC manual.

MH M9

A male should be more than 64 years old to receive the aged pension.

The patient is reported as being male and less than or equal to 64 years old. The pension status code indicates the patient is receiving the aged pension. Hospital staff should check the birthdate and the pension status codes. The hospital can find a list of valid codes for pension status in this QHAPDC manual.

MH M10

A person should be more than 15 and less than 65 years old to receive invalid pension, unemployment benefits or sickness benefits.

The patient's age has been calculated as either: less than or equal to 15 years; OR greater than or equal to 66 years, and the employment status code indicates the patient is receiving repatriation pension, invalid pension, unemployment benefits or sickness benefits. Hospital staff should check the birthdate and the employment status codes. The hospital can find a list of valid codes for employment status in this QHAPDC manual.

MH M11

The code indicating whether this episode is the first psychiatric inpatient episode for this patient is missing or invalid.

The patient's first psychiatric admission status for this admission was not provided, or the code provided is not valid at the episode end date. First psychiatric admission status is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for first psychiatric admission in this QHAPDC manual.

MH M12

The code for referral to further psychiatric care for this admission is missing or invalid.

The patient's referral to further care following their discharge from the hospital, or end of episode of care, was not provided or the code provided is not valid at the episode end date. Referral to further care is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for referral to further care in this QHAPDC manual.

MH M13

The mental health legal status for this admission is missing or invalid.

The patient's mental health legal status at the commencement of their psychiatric treatment in this episode was not provided or the code provided is not valid at the episode end date. Mental health legal status is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for mental health legal status in this QHAPDC manual.

MH M14

Patient admitted/transferred to psychiatric standard unit but facility did not have a designated psychiatric unit as at |.

The admission or transfer standard unit code is in the range 'PYAA' to 'PYZZ' (which indicates a mental health unit) BUT there is not a designated psychiatric unit at this facility at the date the patient was admitted (or transferred). Hospital staff should check the standard unit code for the admission and for any transfers, and send amendments to HSU. The hospital can find a list of valid codes for standard unit code and the list of hospitals that have designated psychiatric units in this QHAPDC manual.

If the hospital has a designated psychiatric unit, they should inform HSU in writing of the date that the designated psychiatric unit became operational.

MH M15

The code indicating whether the patient has had previous specialised psychiatric non-admitted treatment is missing or invalid.

The code indicating patient's previous specialised psychiatric non-admitted treatment was not provided or the code provided is not valid at the episode end date. Previous specialised non-admitted psychiatric treatment is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for previous specialised non-admitted psychiatric treatment in this QHAPDC manual.

NATIONAL LOCALITY INDEX (NLI) ERRORS

These errors relate to problems matching address data.

NLI H151

The suburb/locality, postcode and/or state is an invalid combination and cannot be matched to a geographical location. Please check Postcode: |, State: |, Suburb: | and provide corrected address details.

This is due to an invalid combination of suburb/locality, postcode and state code at the episode end date. Hospital staff should check the records, and provide a corrected address if the address is invalid.

The suburb/town line of the address should NOT include a state code if the patient lives in Australia. It should not include the word "VIA" (eg "Home Hill VIA Ayr" - this address should be "HOME HILL"). If the hospital discovers that the address is valid, they should inform HSU.

Note – for Public Hospitals using HBCIS you may need to re-file both the registration and admission screen in order to trigger an amend record to be sent to HSU.

NLI H152

The combination of suburb, postcode and state is invalid. The address is: Postcode: |, State: |, Suburb: |.

This is due to an invalid combination of suburb/locality, postcode and state code at the episode end date. Hospital staff should check their records, and provide a corrected address if the address is invalid. The suburb/town line of the address should NOT include a state code if the patient lives in Australia. It should not include the word "VIA" (eg "Home Hill VIA Ayr" - this address should be "HOME HILL"). If the hospital discovers that the address is valid, they should inform HSU.

Note – for Public Hospitals using HBCIS you may need to re-file both the registration and admission screen in order to trigger an amend record to be sent to HSU.

NATIONAL MINIMUM DATA SET (NMDS) ERRORS

These errors relate to missing or invalid data items that are included in the National Minimum Data Set.

NMDS H74

Missing or invalid code for the facility that the patient was transferred from. Please check referral details.

The source of referral indicates the patient was transferred from another hospital at admission, but the facility code for the transferring hospital has not been provided, or the facility code provided is invalid at the episode start date. If the source of referral indicates that a patient was transferred from another hospital, the code for that other hospital must also be provided. The other hospital must also be a valid, operating hospital at the episode start date. Hospital staff should check both the source of referral and transferring facility fields. The hospital can find a list of valid codes for source of referral and transferring facility in this QHAPDC manual or in the latest codes received from Business Application Services (BAS).

NMDS H75

Missing or invalid code for facility this patient was transferred to. Please check mode of separation details.

The mode of separation indicates the patient was transferred to another hospital at separation, but the facility code for the hospital that the patient was transferred to has not been provided, or the facility code provided is invalid at the episode end date. If the mode of separation indicates that a patient was transferred to another hospital, the code for that other hospital must also be provided. The other hospital must also be a valid, operating hospital at the episode end date. Hospital staff should check both the mode of separation and transferred to facility fields. The hospital can find a list of valid codes for mode of separation and transferred to facility in this QHAPDC manual or in the latest codes received from Business Application Services (BAS).

NMDS H78

The Medicare eligibility code is missing or invalid.

The Medicare eligibility code has not been provided or is not valid at the episode end date. Medicare eligibility is a National Minimum Data Set item and must be provided by the hospital. The hospital can find a list of valid codes for Medicare eligibility in this QHAPDC manual.

NMDS H81

Patient ID is missing or 0. Admission/episode number is |, date of birth is |, sex is |.

The patient id has not been provided for the episode, or is 0. Patient id is a field required for linking of episodes into hospital stays. All hospitals must provide a patient id. For further details to help identify the episode, hospitals should contact HSU. Any hospital that does not normally give patient identification (or Unit Record - UR) numbers should institute a method of doing so. The hospital can find rules relating to the provision of patient id (or UR number) in this QHAPDC manual

NMDS H86

Admission weight in grams is required for all babies less than 29 days old. Please check birth date and weight.

The patient is less than 29 days old at the episode start date and is not a boarder, but weight at the episode start date has not been provided. Admission weight is a National Minimum Data Set item, and must be provided for all admitted babies under 29 days old. Hospital staff should check the birthdate when this error is created as the current year could have been used instead of patient's actual year of birth. The hospital can find all rules relating to the provision of the admission weight in this QHAPDC manual.

NMDS H97

Please provide the patient's HOME address for this admission/ episode; including suburb, postcode and state.

The patient's home address was not provided for this episode. The home address is a National Minimum Data Set item, and must be provided by the hospital. A postal address is not acceptable as this can create an incorrect picture when dealing with statistical analysis relating to patient's home locality. The suburb/town line of the address should NOT include a state identifier if the patient lives in Australia. It should not include the word "VIA" (eg "Home Hill VIA Ayr" - this address should be "HOME HILL"). Instructions for the completion of an address can be found in this QHAPDC manual. If the hospital has further questions, they should contact HSU.

NMDS H99

The sex code is missing or invalid.

The sex code was not provided, or is invalid at the episode end date. Sex is a National Minimum Data Set item, and must be provided by the hospital. It is also required for grouping of data. The hospital can find a list of valid codes for sex in this QHAPDC manual. This QHAPDC manual includes rules on the coding of the patient's sex.

NMDS H101

The patient's marital status at the beginning of this admission/episode is missing or invalid.

Marital status code has not been provided, or the code provided is not valid at the episode end date. Marital status is a National Minimum Data Set item, and must be provided by the hospital. If the marital status changes during the episode, the hospital should provide the patient's marital status immediately prior to the start of the episode. The hospital can find a list of valid codes for marital status in this QHAPDC manual.

NMDS H102

The country of birth code is missing or invalid.

The country of birth code has not been provided, or the code provided is not valid as at the episode end date. Country of birth is a National Minimum Data Set item, and must be provided by the hospital. Hospital staff should note that the country of birth for a newborn should be Australia, even if the mother is not an Australian resident. The hospital can find a list of valid codes for country of birth in this QHAPDC manual.

NMDS H105

The patient's chargeable status as at | is missing or invalid.

The chargeable status (either at the beginning of the episode or in an account variation) was not provided or is not valid at the episode end date. Chargeable status is a National Minimum Data Set item, and must be provided by the hospital. Hospital staff should provide the chargeable status that was current for the patient at the end of the day for the date given in the message. The hospital can find a list of valid codes for chargeable status in this QHAPDC manual.

NMDS H106

The care type or type of episode code is missing or invalid.

The episode care type code has not been provided, or the code provided is not valid as at the episode end date. Episode care type is required to group data accurately. The hospital can find a list of valid codes for episode type in this QHAPDC manual.

NMDS H107

The patient's compensable status as at | is missing or invalid.

The compensable status (either at the beginning of the episode or in an account variation) was not provided or is not valid at the episode end date. Compensable status is a National Minimum Data Set item, and must be provided by the hospital. Hospital staff should provide the compensable status that was current for the patient at the end of the day for the date given in the message. The hospital can find a list of valid codes for compensable status in this QHAPDC manual.

NMDS H108

The source of referral for this admission/ episode is missing or invalid.

The source of referral code has not been provided or the code provided is invalid at the episode end date. Source of referral is needed for accurate linking of data into hospital stays, and hence must be recorded by hospitals to enable accurate provision of data relating to admissions and separations. The hospital can find a list of valid codes for source of referral in this QHAPDC manual.

NMDS H109

The hospital insurance code for this admission/ episode is missing or invalid.

The hospital insurance code has not been provided or the code provided is invalid at the episode end date. Hospital insurance is a National Minimum Data Set item, and must be provided by the hospital. Note that the hospital insurance code is independent of the chargeable status code (ie a public patient can have insurance, and a private patient can be uninsured). The hospital can find a list of valid codes for hospital insurance in this QHAPDC manual.

NMDS H110

The mode of separation at the end of this hospital stay/episode is missing or invalid.

The mode of separation has not been provided or the code provided is invalid at the episode end date. Mode of separation is needed for accurate linking of data into hospital stays, and hence must be recorded by hospitals to enable accurate provision of data relating to admissions and separations. The hospital can find a list of valid codes for mode of separation in this QHAPDC manual.

NMDS H111

Planned same day field is missing/invalid. Did the patient plan to leave on same day as admission to facility?

The planned same day code was not provided or the code provided was not valid at the episode end date. Planned same day is a National Minimum Data Set item, and must be provided by the hospital. This field relates to whether the patient intended to remain in the hospital for a single day only at the time the patient was admitted. The hospital can find valid codes for planned same day in this QHAPDC manual.

NMDS H113

The patient's name is missing. Please provide the patient's full name.

The patient's name must be provided by a public hospital. If the hospital does not know the name of the patient, they must provide the name used in the patient's record, or give the surname as 'Unknown'. Hospital staff should also record the patient's first name as 'Unknown' in this case. If a patient has only one name, this name should be recorded as the surname.

NMDS H118

What ward was this patient transferred to on |? Please also provide the unit code if applicable.

The ward at admission was not provided, or the patient had a ward transfer record that did not have the new ward code provided. All ward transfers should be provided by the hospital, including the code of the ward the patient was transferred to. Hospital staff should use their own ward code. This is generally the shortened ward name, or the hospital administration section should provide a list of valid ward codes.

NMDS H121

The episode (admission) number for this hospital stay/episode is missing.

The hospital should assign an episode number (or admission number) to all patient episodes. The hospital should decide what method they wish to use for assigning episode numbers. Episode numbers should not be used more than once within a single hospital stay (ie each episode should have a unique episode number for that patient id). Rules for the provision of the episode number can be found in this QHAPDC manual.

NMDS H145

The band code | provided for this episode is not valid.

The band code provided is not valid at the episode end date. The hospital can find a list of valid band codes in this QHAPDC manual. A patient who is not a same day patient (ie the entire hospital stay is not within a single day) cannot be allocated a band code. If a band code is not required for the episode, hospital staff should arrange to have the band code removed.

NMDS H347

The qualification status is missing or invalid for status change on |.

The code indicating the qualification status (as at the date included in the message) is not provided or is invalid at the episode end date. The qualification status is required to correctly identify newborn details. The valid codes for qualification status can be found in this QHAPDC manual.

NMDS H350

The Indigenous status is missing or invalid.

The code indicating the Indigenous status is not provided or is invalid at the episode end date. This is a National Minimum Data Set item. The valid codes for Indigenous status can be found in this QHAPDC manual.

NMDS H501

The standard unit code for is missing or invalid as at |.

The standard unit code has not been provided, or the code provided is not valid at the episode end date. Standard unit must be provided by the hospital. 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. The hospital can find a list of valid codes for standard unit in this QHAPDC manual.

The standard unit code is used to determine whether or not the patient has been admitted to a Mental Health Unit ('PYAA' to 'PYZZ') or other specialist units.

NMDS H502

The episode's elective status is missing or invalid.

The elective status code has not been provided, or the code provided is not valid at the episode end date. Elective status is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for elective status in this QHAPDC manual.

Elective status indicates whether an episode was an emergency or elective admission.

NMDS H801

| Details have been received, but | is 2.

There has been a complication in the information received. The files themselves look to be exactly as they should be except for a 'B' activity record being extracted.

ORGAN PROCUREMENT EPISODE (ORGAN) ERRORS

These errors relate to the coding of Organ Procurement episodes.

ORGAN H98

Episode type OR source of referral OR mode of separation indicates the patient is Organ Procurement but other codes are not Organ Procurement.

If the patient is an Organ Procurement patient, all three of the above fields should indicate organ procurement. Hospital staff should check episode care type, source of referral and mode of separation and make the required amendments. The hospital can find valid codes for episode care type, source of referral and mode of separation in this QHAPDC manual.

ORGAN H383

This episode is for organ procurement but has been linked to elective episode |.

Organ Procurement patients should not receive any form of treatment, other than that required to harvest the organs. If a hospital has a patient on the waiting list who dies before treatment, and is therefore removed from the waiting list, the elective details should be linked to the episode during which the patient died, and not the following organ procurement episode. Hospital staff should check the episode care type, source of referral, mode of separation, and all elective surgery details. If the patient should not have been coded as an organ procurement patient, the hospital will need to amend episode care type, source of referral and mode of separation. Valid codes for episode care type, source of referral and mode of separation can be found in this QHAPDC manual.

ORGAN H385

Mental Health details have been provided but this episode is for organ procurement.

Episode care type indicates this patient has been admitted for organ procurement, but HSU has received mental health details. Mental health details should only be sent for a patient in a psychiatric unit who is receiving psychiatric care. If the patient died during psychiatric care, the mental health details should be provided with the episode in which the patient died, and should not be provided with the organ procurement episode. If the patient has not been admitted for organ procurement, the hospital should amend the episode care type, source of referral and mode of separation. Valid codes for episode care type, source of referral and mode of separation can be found in this QHAPDC manual.

ORGAN H387

Organ Procurement patients should be public and not compensable. Please check account details as at |.

Organ procurement patients should not be compensable. Hospital staff should check the episode care type and compensable status as at the date given in the message. If the patient has not been admitted for organ procurement, amendments should be made to the episode care type, source of referral and mode of separation. If the patient has been admitted for organ procurement, compensable status should be amended. Valid codes for compensable status, episode care type, source of referral and mode of separation can be found in this QHAPDC manual.

ORGAN H389

Leave records exist, but the episode is an organ procurement episode.

Organ procurement patients cannot be sent on leave. Hospital staff should check the episode care type and leave details. If the patient has not been admitted for organ procurement, amendments should be made to the episode care type, source of referral and mode of separation. If the patient has been admitted for organ procurement, leave details should be deleted. Valid codes for compensable status, episode care type, source of referral and mode of separation can be found in this QHAPDC manual.

ORGAN H393

Organ Procurement Patients should be recorded as eligible for Medicare. Please check medicare eligibility and episode type.

Organ procurement patients should be eligible for Medicare, even if the living patient was not eligible for Medicare. Hospital staff should check the episode care type and Medicare eligibility. If the patient has not been admitted for organ procurement, amendments should be made to the episode care type, source of referral and mode of separation. If the patient has been admitted for organ procurement, Medicare eligibility should be amended. Valid codes for Medicare eligibility, episode care type, source of referral and mode of separation can be found in this QHAPDC manual.

ORGAN H430

This patient had an account variation on |, but they are an organ procurement patient.

Organ procurement patients should be public and not compensable for the entire episode, therefore there should be no account variations. Hospital staff should check the episode care type and all account variations. If the patient has not been admitted for organ procurement, amendments should be made to the episode care type, source of referral and mode of separation. If the patient has been admitted for organ procurement, the patient should be made public and not compensable from admission, and all account variations should be deleted. Valid codes for chargeable status, compensable status, episode care type, source of referral, mode of separation and rules for the coding of organ procurement patients can be found in this QHAPDC manual.

ORGAN H434

Organ Procurement Patients length of stay is usually under 24 hours. Please check start date and end date.

An organ procurement patient should only have a length of stay of approximately 24 hours. The organ procurement team aim to be on site within eight hours of the patient being pronounced deceased. It would only be under special circumstances that the patients length of stay may be longer, e.g. the relatives have to travel from overseas before the procurement treatment may begin.

If the patient is not organ procurement, the hospital should amend the episode care type, source of referral and mode of separation. If the patient is organ procurement, the hospital should check the episode start and end dates.

Hospital staff should note that if the episode is more than 72 hours and the details are correct, the hospital should inform HSU in writing on why the episode was longer than expected.

PALLIATIVE EPISODE (PAL) ERRORS

These errors relate to all palliative episode details.

PAL H401

The code indicating whether this episode is the first palliative inpatient episode for this patient is missing or invalid.

The patient's first palliative admission status for this admission was not provided, or the code provided is not valid at the episode end date. First palliative admission status is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for first palliative admission in this QHAPDC manual.

PAL H402

The code indicating whether the patient has had previous specialised palliative non-admitted treatment is missing or invalid.

The code indicating patient's previous specialised palliative non-admitted treatment was not provided or the code provided is not valid at the episode end date. Previous specialised non-admitted palliative treatment is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for previous specialised non-admitted palliative treatment in this QHAPDC manual.

PAL H412

Palliative care details are only required for palliative patients. Check episode care type.

The episode care type does not indicate that this patient is receiving palliative care, but palliative details have been received. If the patient is receiving inpatient palliative care, then the hospital should amend the episode care type. If the patient is not receiving inpatient palliative care, then the palliative care details should be deleted. Valid codes for episode care type can be found in this QHAPDC manual. Rules for the coding of palliative care details can be found in this QHAPDC manual.

PAL H415

This patient is receiving palliative care, but no palliative care details have been received.

The episode care type indicates that this patient is receiving palliative care, but no details exist in the PAL file. Hospital staff should check all palliative details, and episode care type. If the patient is not a palliative patient, then the episode care type should be amended. If the patient is receiving palliative care, then palliative details are required. Valid codes for episode care type, and a list of required palliative details can be found in this QHAPDC manual.

SUB AND NON ACUTE PATIENT EPISODE (SNAP) ERRORS

These errors relate to all Sub and Non Acute Patient (SNAP) episode data items.

SNAP H370

Patient admitted/transferred to a SNAP ward but facility did not have a designated SNAP unit as at |.

The admission or transfer standard ward code is SNAP BUT there is not a designated SNAP ward or unit at this facility at the date the patient was admitted (or transferred). Hospital staff should check the standard ward code for the admission and for any transfers, and send amendments to HSU. The hospital can find a list of valid codes for standard ward code and the list of hospitals which have designated SNAP wards in this QHAPDC manual.

If a SNAP unit has opened in the hospital, please inform HSU in writing.

SNAP H517

For the period | to | this patient was in a SNAP ward or bed, but did not have SNAP episodes.

This patient has a SNAP episode care type, and is in a SNAP ward, but there is a gap in the SNAP episodes. All patients that have a SNAP episode care type of rehabilitation (20) or palliative care (30) must have consecutive SNAP episodes for the entire episode. Hospital staff should check episode care type and SNAP details. If the patient does not have consecutive SNAP details, the patient should either: be given another episode care type code OR should have linking episodes, indicating that the episode care type has changed. The hospital can find rules regarding the coding of SNAP patients in this QHAPDC manual.

This validation will have an end date of 30 June 2014.

SNAP H520

SNAP episode number is missing or non-numerical in |. This SNAP record has not been loaded.

The patient's SNAP episode number for this admission was not provided, or the value provided is not a valid number. Each SNAP episode number has a unique number for that patient. The unique number must be a valid number and cannot be 0. Hospital staff should check all SNAP details, and resend the details with a valid SNAP episode number. If the SNAP episode should not have been sent, the hospital does not need to take action, as the SNAP details were not loaded.

SNAP H521

SNAP type is missing or invalid for SNAP episode |.

The SNAP type code has not been provided, or the code provided is invalid for the SNAP episode end date. The SNAP type code is a National Minimum Data Set item, and must be provided by the hospital. The hospital can find a list of valid codes for SNAP type in this QHAPDC manual.

SNAP H522

No ADL scores have been provided for SNAP episode |.

All SNAP episodes must have related ADL scores. Hospital staff should check all SNAP details, and ensure that the ADL scores have been entered. If ADL scores were not taken, then this score should be entered as zero '0'. Note that FIM scores cannot be set to '0', so therefore use MBI score instead. Rules for the coding of SNAP episodes can be found in this QHAPDC manual.

SNAP H523

SNAP End Date is before the Start Date for SNAP episode |. Please check SNAP dates.

This error can result from missing SNAP episode dates, dates being provided in the wrong order, or incorrect SNAP episode dates. The error is caused by the SNAP end date (of a particular snap episode) being earlier than the SNAP start date. Hospital staff should check all dates for all SNAP episodes, and ensure that no dates are missing or out of order. (It is possible that two SNAP records have accidentally been merged into one.) If necessary, hospital staff should arrange to have all SNAP episodes deleted, then re-sent.

SNAP H524

SNAP episodes | and | are overlapping. Please check all SNAP episodes.

A patient can only have one SNAP episode at a time. If the patient's SNAP type changes, the first SNAP episode should be ended and a new SNAP episode started. If the patient is transferred to another ward, the SNAP episode should be ended and a new SNAP episode started when the patient returns to the SNAP ward. Rules for the coding of SNAP episodes can be found in this QHAPDC manual.

SNAP H525

SNAP episode | started while patient was on leave. Leave dates are | to |. Please check details.

A SNAP patient must be physically in the hospital to commence a SNAP episode. If the patient is on leave then the patient should be transferred to the SNAP ward when they return from leave. If the patient is being transferred while on leave to 'free up beds' they cannot be classified as a SNAP patient.

SNAP H526

ADL scores have been provided for SNAP episode |, but SNAP episode dates have not been provided. ADL scores have not been loaded.

ADL scores have been provided in the Activity file (ACT) but no record exists in the SNAP file (SNP). ADL scores cannot exist without the SNAP episode, so they have not been loaded onto QHIPS. Hospital staff should check all SNAP details, and re-send the SNAP details. If the ADL scores should not have been sent, the hospital does not need to take action as the ADL scores have not been loaded.

SNAP H527

ADL type is missing or invalid in SNAP episode | for ADL date |.

The ADL type code has not been provided, or the code provided is not valid as at the ADL score date. The SNAP ADL type is required to group data accurately. Hospital staff can find a list of valid codes for SNAP ADL type in this QHAPDC manual.

SNAP H528

ADL sub type is missing or invalid in SNAP episode | for ADL date |.

The ADL subtype code has not been provided, or the code provided is not valid as at the ADL score date. The SNAP ADL subtype is required to group data accurately. Hospital staff can find a list of valid codes for SNAP ADL subtype in this QHAPDC manual.

SNAP H529

ADL subtype does not match ADL type in SNAP episode | for ADL date |.

Specific ADL subtype codes relate to specific ADL type codes. These are specified in this QHAPDC manual. If the ADL type and subtype are not matched this SNAP episode cannot be grouped.

SNAP H530

ADL score is missing or non-numeric in SNAP episode | for ADL date |, ADL subtype |.

The ADL score is either missing or is not a valid integer. For a list of valid ranges for ADL scores see the relevant section of this QHAPDC manual. Hospital staff should check all ADL details and resend the ADL score details.

SNAP H531

For SNAP episode number |, ADL Score provided at | is outside the valid range for ADL Subtype |.

An ADL score has been provided which is outside the valid range for the ADL type and subtype combination. This SNAP episode therefore cannot be grouped. Hospital staff should check all SNAP details to ensure the correct ADL details and ADL score have been entered. Valid ADL score ranges can be found in this QHAPDC manual.

SNAP H533

Phase type is missing or invalid for palliative SNAP episode |.

If the patient is in palliative care a phase type code is required to indicate the patients period or stage of illness. Hospital staff should check the SNAP type and phase type codes. Valid codes for SNAP type and Phase type can be found in this QHAPDC manual.

SNAP H534

Phase type has been provided but the SNAP type is not palliative care for SNAP episode |.

Phase type is only recorded for palliative patients but the SNAP type provided does not indicate that the patient is palliative. Valid codes for phase type and SNAP type can be found in the manual. If the patient is not in palliative care a phase code is not required, as this code indicates the patient's period or stage of illness.

SNAP H536

Patient is on leave during the entire time of SNAP episode |. Please check leave dates and/or times.

Patient is on leave during entire SNAP episode. A patient must be physically in the SNAP ward at least at the beginning of the SNAP episode. Please check SNAP episode dates and leave dates. If the patient is being transferred while on leave to 'free up beds' they cannot be classified as a SNAP patient. Rules for the coding of SNAP details can be found in this QHAPDC manual.

SNAP H538

Phase type is bereavement in SNAP episode |, but patient did not die during this episode.

Bereavement is only valid for a patient who has been admitted to a SNAP Unit and has died during the episode, as phase type bereavement indicates counselling for the patient's family after the patient's death. Hospital staff should check phase type and mode of separation. Valid codes for phase type and mode of separation can be found in this QHAPDC manual.

SNAP H539

SNAP Episode | (with SNAP Type |) has an invalid ADL Type provided as at | (ADL Type is |).

Specific ADL type codes relate to specific SNAP type codes. If the ADL type is not matched this SNAP episode cannot be grouped. Valid codes for ADL type and SNAP type, and rules for coding the fields together can be found in this QHAPDC manual.

SNAP H540

This episode is not a palliative episode but SNAP episode | has SNAP type of palliative.

SNAP type indicates that the patient is palliative but the episode care type does not indicate that the patient is palliative. Palliative SNAP episodes can only be provided for patients that are receiving palliative care in a designated palliative ward or unit. Please check episode type and SNAP type. Valid codes for episode type and SNAP type can be found in this manual. If the patient was not palliative during the whole episode then the episode should be broken down into two or more linking episodes.

SNAP H541

This episode is not a rehabilitative episode but SNAP episode | has a SNAP type of rehabilitative.

SNAP type indicates that the patient is rehabilitative but the episode type does not indicate that the patient is rehabilitative. Rehabilitation SNAP episodes can only be provided for a rehabilitation patient. Please check episode type and SNAP type. Valid code for episode type and SNAP type can be found in this manual. If the patient was not rehabilitative during the whole episode then the episode should be broken down into two or more linking episodes.

SNAP H542

SNAP episode | has been provided but patient does not have a SNAP episode type. Please check care type and SNAP details.

SNAP episodes can only be provided for patients in a designated ward or unit, and must be provided with a palliative, rehabilitation, maintenance, geriatric evaluation and management or psychogeriatric episodes of care. Hospital staff should check SNAP details and episode care type. If the patient was a SNAP patient, episode care type should be amended. If the patient did not have a valid SNAP episode care type, then SNAP details are not required and should be deleted.

SNAP H543

SNAP ADL Type | must be provided with subtypes |. For SNAP Episode | Subtype | is missing as at |.

Each ADL type has a range of ADL subtypes. All ADL subtypes must be provided in order to group the SNAP episode. For example, FIM ADL subtype must have both COG and MOT ADL subtype scores to allow accurate grouping. Hospital should check ADL type and all related scores. Rules for coding ADL scores can be found in this QHAPDC manual.

SNAP H544

For SNAP Episode | there was more than one ADL Type provided as at | for SNAP Type |.

Currently only one set of ADL scores are required for SNAP episodes, but this episode has duplicated ADL scores. Hospital staff should check all ADL score details and the date, and provide the actual ADL scores as at the date provided in the message. Rules for the provision of ADL scores can be found in this QHAPDC manual.

SNAP H571

ADL Date is not between SNAP episode start and end dates for SNAP episode |.

ADL scores must be taken during the SNAP episode, and cannot be allocated during a following episode. Hospital staff should check all SNAP details, to ensure that ADL scores provided for each SNAP episode do not relate to a previous or following episode. If the ADL score does relate to the current episode, hospital staff should amend the ADL dates or the SNAP episode start and end dates.

SNAP H572

Episode Type is Palliative, but SNAP Type is not Palliative for SNAP Episode |.

Only palliative SNAP episodes can be provided for a palliative episode. If a patient is alternating between a palliative ward and another type of SNAP ward, linking episodes should be created with episode care type indicating the type of care received. Otherwise, hospital staff should check the SNAP type and episode care type. Rules for the provision of SNAP details can be found in this QHAPDC manual.

SNAP H573

Episode Type is Rehabilitation, but SNAP Type is not Rehabilitation for SNAP Episode |.

Only rehabilitation SNAP episodes can be provided for a rehabilitation episode. If a patient is alternating between a rehabilitation ward and another type of SNAP ward, linking episodes should be created³ with episode care type indicating the type of care received. Otherwise, hospital staff should check the SNAP type and episode care type. Rules for the provision of SNAP details can be found in this QHAPDC manual.

SNAP H575

SNAP type is Geriatric Evaluation and Management (GEM) for SNAP episode | but episode care type is not GEM.

SNAP type indicates that the patient is undergoing Geriatric Evaluation and Management (GEM) but the episode care type does not indicate Geriatric Evaluation and Management. GEM SNAP episodes can only be provided for patients that are receiving GEM care. Please check episode type

and SNAP type. Valid code for episode type and SNAP type can be found in this manual. If the patient was not GEM during the whole episode then the episode should be broken down into two or more linking episodes.

SNAP H576

SNAP type is Psychogeriatric for SNAP episode | but episode care type is not psychogeriatric.

SNAP type indicates that the patient is psychogeriatric but the episode care type does not indicate psychogeriatric. Psychogeriatric SNAP episodes can only be provided for patients that are receiving psychogeriatric care. Please check episode type and SNAP type. Valid code for episode type and SNAP type can be found in this manual. If the patient was not psychogeriatric during the whole episode then episode should be broken down into two or more linking episodes.

SNAP H577

SNAP type is Maintenance for SNAP episode | but episode care type is not maintenance.

SNAP type indicates that the patient is a maintenance patient but the episode care type does not indicate maintenance. Maintenance SNAP episodes can only be provided for patients that are receiving maintenance care. Please check episode type and SNAP type. Valid code for episode type and SNAP type can be found in this manual. If the patient was not a maintenance patient during the whole episode then the episode should be broken down into two or more linking episodes.

SNAP H615

Patient has been assigned a care type of | | and SNAP episode has not been received. Please check care type and SNAP episode details.

This patient has a SNAP episode care type, but SNAP episode details have not been supplied. Hospital staff should check episode care type and SNAP details. The hospital can find rules regarding the coding of SNAP patients in this QHAPDC manual.

SNAP H616

SNAP episode start date is <> the start date of the episode of care. Please check SNAP and/or episode of care start date/time.

A patient's SNAP episode cannot commence prior the start date and/or time of the admission. Please check the start date and/or time of both the SNAP episode and admission. Additional information regarding SNAP episodes can be found in this QHAPDC manual

SNAP H618

Patient has been assigned a SNAP care type | | however, more than one SNAP episode has been provided. Please check all SNAP episode details.

If a SNAP care type of Geriatric Evaluation and Management care (09), Psychogeriatric care (10), Rehabilitation care (20) or Palliative care (30) assigned there can only be one SNAP episode within a single SNAP episode of care.

Additional information regarding SNAP episodes can be found in this QHAPDC manual.

SNAP H703

Multidisciplinary Care Plan Flag must be Y(Yes), N(No) or U(Unknown).

For all patients with a care type of '20 – Rehabilitation in a designated unit or '09 – Geriatric evaluation and Management' delivered in a designated SNAP unit record whether a Multidisciplinary Care Plan has been developed.

Further details about the Multi-Disciplinary Care Plan Flag can be found in this QHAPDC Manual.

SNAP H704

Multidisciplinary Care Plan Date must not be null.

If the patient has had a Multidisciplinary Care Plan developed record the date that the latest Multidisciplinary Care Plan was documented.

Further details about the Multi Disciplinary Care Plan Date can be found in this QHAPDC Manual

SNAP H705

The Proposed Principal Referral Service Code is missing or invalid.

This is the type of service that is proposed for the patient post-discharge from hospital.

Further details and valid codes for Proposed Principal Referral Service Code can be found in this QHAPDC manual.

SNAP H716

Multi Disciplinary Care Plan (MDCP) details have been provided, but this patient's Care Type is not 09 or 21. Please check Admission and MDCP details.

For all patients with a care type of '20 – Rehabilitation in a designated unit or '09 – Geriatric evaluation and Management' delivered in a designated SNAP unit record whether a Multidisciplinary Care Plan has been developed.

Further details about the Multi Disciplinary Care Plan Flag can be found in this QHAPDC Manual

SNAP H810

A rehabilitation SNAP episode details have been provided but no Primary Impairment Type code has been reported. Please check Admission and SNAP episode details.

A rehabilitation SNAP episodes exists for this patient but a Primary Impairment Type code has not been provided. Hospital staff should check if the patient was receiving rehabilitation care during this admitted patient episode of care. A valid Primary Impairment Type code must be provided for each rehabilitation SNAP episode. Rules relating to the reporting of this information can be found in this QHAPDC manual.

SNAP H811

Primary Impairment Type code has been provided but the patient was not assigned a rehabilitation SNAP type. Please check Admission and SNAP episode details.

A Primary Impairment Type code has been provided but the patient was not receiving rehabilitation care and was not assigned a rehabilitation SNAP Type. Hospital staff should check if the patient was receiving rehabilitation care as a Primary Impairment Type code should only be provided for a rehabilitation SNAP episode. Rules relating to the reporting of this information can be found in this QHAPDC manual.

SNAP H812

The Primary Impairment Type code provided was not a valid code. Please check Admission and SNAP episode details.

A Primary Impairment Type code has been provided but it is not a valid Primary Impairment Type code. For a list of valid codes please refer to the relevant section of this QHAPDC Manual. Hospital Staff should check all SNAP details for this SNAP episode. Rules relating to the reporting of this information can be found in this QHAPDC manual.

TELEHEALTH (TID) ERRORS

These errors relate to data included in the Telehealth (TID) file. A record is to be provided on the HQI Telehealth Inpatient Details file for each Telehealth Event within an episode of care as recorded on the Telehealth Inpatient Details HBCIS screen. A record should not be provided where a Telehealth event has not been recorded on the admitted patient episode of care.

TID H850

Telehealth EVENT_ID | START_DATE and TIME must be before session END_DATE and TIME.

The Telehealth event id start date and time must be before the end date and time.

TID H851

Telehealth EVENT_ID | Start and End dates and times must not be in the future.

The Telehealth event id start date, end date and times must not be in the future.

TID H852

Telehealth Telehealth EVENT_ID | RSQ Flag must be 1 or 2.

The Telehealth event id indicates if Retrieval Service Queensland (RSQ) participated in an admitted patient Telehealth event 1= Yes OR 2= No.

TID H853

Telehealth EVENT_ID | must be null when RSQ_FLAG is 1.

If the Telehealth event id Retrieval Service Queensland (RSQ) flag is 1 (Yes), then the Provider Facility must be null.

TID H854

Telehealth EVENT_ID | is invalid or a null value.

The Telehealth event id is a unique number (8 numbers) that identifies each Telehealth event within an episode of care. An error will be created if the number is invalid or null.

TID H855

Telehealth EVENT_ID | must be numeric.

The Telehealth event id must be numeric.

TID H856

TELEHEALTH_EVENT is missing, not required length or non-numerical in QH_LOAD_TELEHEALTH. This record has not been loaded.

The Telehealth event will not be loaded if the Telehealth event number is missing, not required or non-numerical.

TID H857

Telehealth EVENT_ID | is invalid.

The Telehealth event id must not be null and must not be zero.

TID H860

Telehealth EVENT_ID | must occur within the episode start and end dates.

The Telehealth event id must occur within the patients episode start and end dates.

TID H861

Telehealth EVENT_ID | must be four digits in the format HH24MI.

The Telehealth event id must in the correct format

TID H862

Telehealth EVENT_ID | must be greater than 0.

The Telehealth event id must be greater than zero.

WORKERS COMPENSATION QUEENSLAND (WCP) ERRORS

These errors relate to all Workers Compensation Queensland data items.

WCP H235

Workers Compensation Status | | is invalid.

Further information on Workers Compensation Queensland data items can be found in this QHAPDC manual.

WCP H374

Patient id or valid dates are different in | to the patient id or episode dates in qh_work_epis_care.

Further information on Workers Compensation Queensland data items can be found in this QHAPDC manual.

WCP H481

| must be 'Y' (Yes), 'N' (No) or 'U' (Unknown).

Further information on Workers Compensation Queensland data items can be found in this QHAPDC manual.