Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2026-2027

Version 1.0

Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2026-2027

Published by the State of Queensland (Queensland Heath), October 2026



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1. INTRODUCTION

1.1 Overview

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

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

1.2 Purpose of the collection

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

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

1.3 Reporting requirements

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

For Hospital and Health Services (HHSs), reporting to the QHAPDC is a requirement under their Service Agreement.

This requirement is further detailed under *Section 5 (a) fulfil legislative obligations* of the related HHS Service Agreement, which outlines the data to be collected and provided to the Director-General, Queensland Health.

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

Accurate, timely, and complete QHAPDC data are critical to ensure Queensland Health fulfils its obligations under the National Healthcare Agreement[1], the National Health Reform Agreement (NHRA) - Addendum 2026-2031[2] and the National Health Information Agreement[3].

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[1] National Healthcare Agreement. Available from < National Healthcare Agreement (2024)> [accessed 30 October 2026]

[2] National Health Reform Agreement (NHRA) – Addendum 2026-2031. Available from < https://federalfinancialrelations.gov.au/agreements/national-health-reform-agreement > [accessed 30 October 2026]

[3] National Health Information Agreement. Available from < http://meteor.aihw.gov.au/content/index.phtml/itemId/182135> [accessed 30 October 2026]

Data reported to QHAPDC conform largely to the requirements of the National Health Data Dictionary[4] (METeOR) and the Queensland Health Data Dictionary (QHDD)[5], available through the Queensland Health Information Knowledgebase (QHIK)[6] available via QHEPS.

1.4 Activity based funding

Activity Based Funding (ABF) is a method of funding hospitals, whereby funding is based on the mix and volume of patients treated.

ABF is based on three key elements:

- classification of patient activity (the classification system used)
- counting the activity (the counting unit)
- costing the activity (determining a cost per counting unit) which informs the price set for the services.

The different types of activity funded by ABF are identified and counted in a standardised manner. Used effectively, these elements result in pricing and funding transparency of the public hospital system.

The Healthcare Purchasing and System Performance Division are responsible for informing the Data Services Branch (DSB) (formally Statistical Services Branch) of the collection requirements for national reporting relating to activity-based funding arrangements.

The Queensland public hospital services purchasing and funding models[7] contains information on data collection and classification along with other general information on ABF.

1.5 Activity based funding and the Medical Record

The medical record is the single source of truth outlining when care was delivered, where it was delivered, by whom and what was provided. The admission encounter documentation will be multi-disciplinary, independently written and will describe a narrative of the patient's journey through the hospital. Requirements for clinical documentation is described in the Clinical Documentation Guideline (July 2026).

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[4] National Health Data Dictionary (METeOR) Available from < https://www.aihw.gov.au/reports/technical-report/national-health-data-dictionary-version-16-2/summary> [accessed 30 October 2026]

[5] Queensland Health Data Dictionary (QHDD) Available from < https://oascrasprod.health.qld.gov.au:8443/ords/f?p=103:QHDDHOME:::NO:::> [accessed 30 October 2026]

[6] Queensland Health Information Knowledge Base (QHIK) < https://oascrasprod.health.qld.gov.au:8443/ords/f?p=103:HOME:::::> [accessed 30 October 2026]

[7] Queensland public hospital services purchasing and funding models. Available from < https://www.health.qld.gov.au/system-governance/health-system/managing/funding-model> [accessed 30 October 2026]

At all times, information recorded in a hospital's Patient Administration System that captures and reports mandated admitted patient data to the QHAPDC must be accurate to what is documented in the patient's medical record, including the clinical coding information.

Clinical coding can only be performed by suitable qualified professionals (Clinical Coders and/or Health Information Managers). Where clinical codes are entered, those performing clinical coding must be confident that evidence of documentation exists. Codes entered to describe the treatment of conditions without documented, supporting clinical evidence are not permitted. Staff performing clinical coding are required to work within the parameters of the Australian Coding Standards (ACS) with specific reference to ACS 0002 *Additional Diagnoses* and the National Clinical Coding Practice Framework.[8]

For public hospitals, the custodians of patient information in Hospital and Health services are Health Information Managers and it is their responsibility to ensure that medical records and clinical data collected meet the standards set out in state and national policy pertaining to data collection and health information. In relation to activity based funding, this extends to admission guidelines and protocols, Clinical Records Management, Clinical Coding Standards and ethical practice. At all times, it must be remembered that the International Classification of Diseases-10 (ICD-10) is utilised for a variety of purposes that extends wider than just activity-based funding. As such it is imperative that coding standards are followed to protect the integrity of the data set.

[8] HIMAA Clinical Coding Practice Network Available from < https://www.himaa.org.au/our-work/clinical-coding/clinical-coding-practice-framework/> [accessed 30 October 2026]

2. ABOUT THE COLLECTION

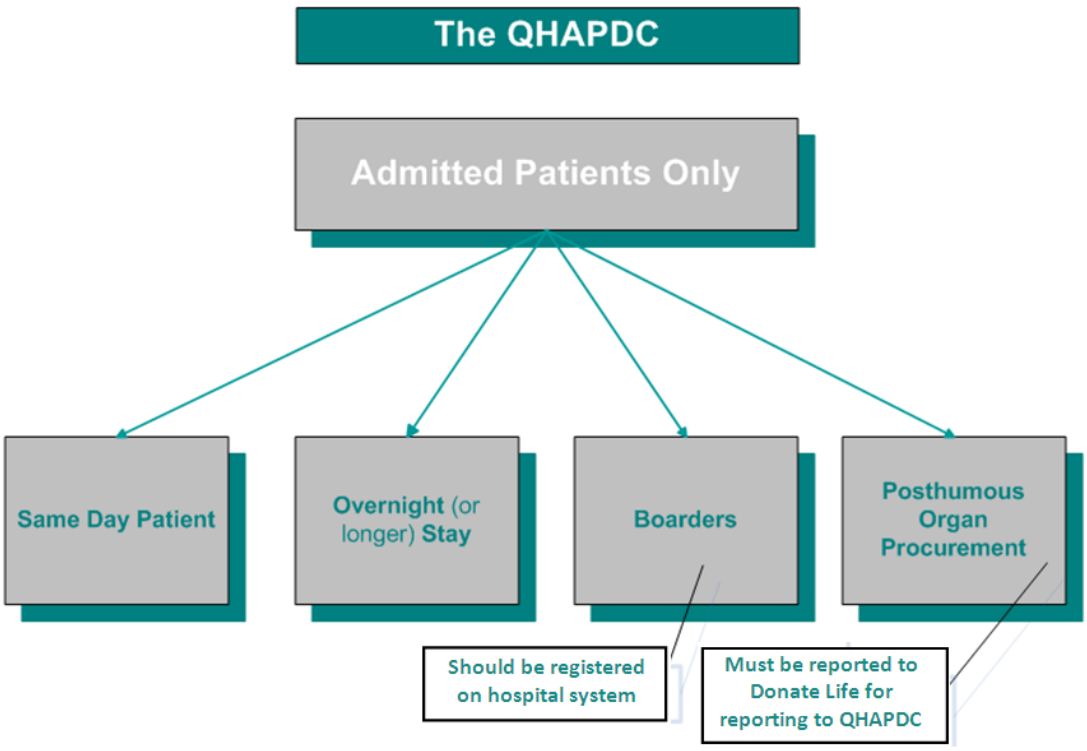
2.1 Coverage

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

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

Hospitals that are permitted to admit patients must contribute data to QHAPDC for each admission. These hospitals are the declared public hospitals, licensed private hospitals, day surgery units and public psychiatric hospitals listed in Appendix A of this manual.

Figure 1 Coverage

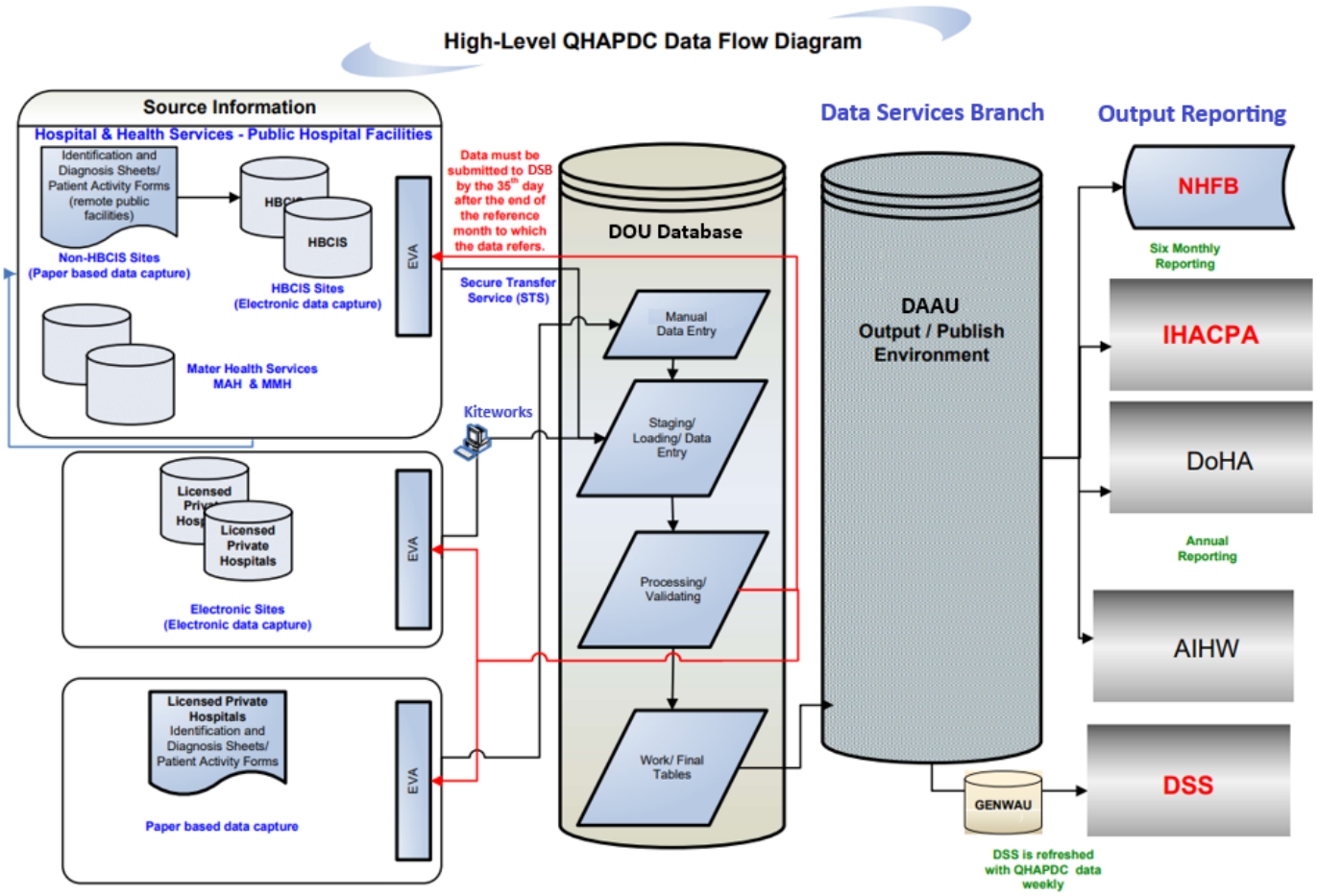


*All boarders and organ procurement donors should be registered on hospital systems and this information provided to the Data Services Branch.

2.2 Data Flow

Figure 2 Data Flow

An illustration of the data flow between public hospitals, Hospital and Health Services, licensed private hospitals and the Data Services Branch.



2.3 Confidentiality and privacy

A duty of confidentiality is imposed on all Queensland Health staff in relation to the disclosure of an individual's confidential information.

A patient's information whether it be; confidential, personal, sensitive or health, must be managed in accordance with the *Hospital and Health Boards Act 2011,* Part 7 and the *Information Privacy Act 2009*, Section 12 and Schedule 4. In some instances, Queensland Health may be required to release patient details to a funding agency for billing or debt collection purposes, e.g. WorkCover Queensland may require an injured worker's information to facilitate payment. All patients admitted to a public hospital must be asked for consent to release their personal, admission and health details for funding purposes.

*(**Note:** 'health details' refers to data items **only** and does not include; documents, or copies of documents from the patient's medical record).*

A patient admitted to a public hospital is required to complete or have completed a Patient Election Form (PEF) to:

- indicate their election to be treated as a 'public' or 'private' patient; and
- identify the funding source for the admission.

On signing the PEF, the patient consents to releasing information relating to; billing and debt recovery, to an appropriate funding agency. Information that may be released under this consent include:

Personal details	Admission details	Health details
• Name • Address • Date of Birth	• Separation/discharge date • Care type	• Diagnosis Related Group (DRG) • Nature of injury

The PEF consent applies to all episodes of care within a specific hospital stay, unless otherwise indicated by the patient. Please see the "Respecting your privacy"[9] brochure for details regarding use of a patient's personal information.

2.4 Benefits of QHAPDC

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

[9] Respecting your privacy. Available from < https://qheps.health.qld.gov.au/__data/assets/pdf_file/0029/1826273/respecting-privacy.pdf> [accessed October 30 2026]

The benefits of QHAPDC can be described as to:

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

2.5 Examples of the uses of QHAPDC data

Management

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

Administration

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

Research

- Epidemiology – QHAPDC collects the mix of socio-demographic data that are invaluable for epidemiologists, either from this system alone, or because data collected are used as the basis for other data collections (such as Cancer Registry and Queensland Perinatal Data Collection).
- Medical research – QHAPDC gives clinical staff the information that can form the basis for research projects.

- Health professional education - in hospitals that have a teaching role for any of the health professions, the data are the basis for retrieval of teaching cases and groups of similar patients for the purpose of clinical education.

Australian Government requirements

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

2.6 Audits

The potential exists for both the Federal and State Governments to institute audits of data submitted for the QHAPDC. When an audit is requested, hospitals may be required to provide evidence from the medical record to support the data submitted. The Meaningful Care Standard fact sheet provides direction to public hospitals to ensure medical record evidence is met.

In relation to clinically coded data in public hospitals, it is a mandatory requirement that submitted data is only completed by qualified personnel (Clinical Coders or Health Information Managers) and hospitals will be routinely asked to provide evidence of that their staff have the relevant qualifications.

Hospitals are strongly encouraged to publish and perform internal quality assurance auditing on all admitted patient data. The Delivery of Purchased Activity - Requirement for Quality Audits specification outlines how public hospitals should approach this.

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

Audits might involve, but are not limited to:

- Reconciling the number of separations submitted for the QHAPDC with that submitted to the Monthly Activity Collection.
- Examining the appropriateness of the admission and classification of public and private same day and overnight (or longer) stay patients within declared public hospitals. For example:
    - Medicare Eligibility – vs – Country of Birth
    - Medicare Numbers beginning with numbers other than ‘4’ where residential address is shown as Queensland
    - Account class assignment of work-related injuries
    - Account class assignment for passengers of motor vehicle accidents (MVA).
- Monitoring accuracy of the assignment of the Australian Refined Diagnosis Related Group (AR-DRG) based on appropriate coding of the diagnoses and procedures contained in a patient's record.

- Monitoring compliance with obtaining patient consent to release personal admission details and comparing the number of 'unable to obtain' flags against length of stay (LOS) and AR-DRG details.
- Comparing costs and lengths of stay in similar patients across and within declared public hospitals, to identify anomalies.
- Comparing admission and separation dates and times to what is recorded in the medical record.
- Assessing the quality of the data items such as those related to socio-demographics, ICD-10-AM or ACHI.

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

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

Hospitals are encouraged to have a detailed quality management framework in place that describes the audits that are performed on their admitted patient data. This would include a description of the scope, frequency and an accountable officer. Audit results and recommendations for improvement should be centrally stored so that evidence of audits can be provided as requested.

Changes to admitted patient data can be made throughout the year, prior to the final submission(s) by the hospital facility.

3. GUIDELINES FOR SUBMISSION OF DATA

3.1Methods of submission

Public hospitals are required to submit data electronically using an approved file format.

Private hospitals submit data electronically via the KiteWorks[10] using an approved file format. Hospitals who submit data by completing paper forms are required to complete the following forms as required –

- Hospital Identification and Diagnosis Form PHI (1)
- Hospital Identification and Diagnosis Form – Activity Page PHI (2)
- Hospital Identification and Diagnosis Form – Sub and Non-Acute Patient (SNAP) Activity PHI (3)

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

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

For the purpose of this manual, reference to public hospitals also includes Mater Adult Hospital and Mater Mothers' Hospital.

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

Example: HBCIS hospitals

HBCIS Hospitals	Example of data item = 01

Example: Other Hospitals

Other Hospitals	Example of data item = 1

[10] KiteWorks. Available from <https://sft.health.qld.gov.au> [accessed 30 October 2026]

Example: All Hospitals

All Hospitals	Example of data item = 02

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

3.2 Hospital Identification and Diagnosis Forms

Identification and Diagnosis Forms (I&D Sheets) are to be completed by private hospital facilities that are not able to report data electronically as per the required electronic file format or for missing episodes that were not previously reported to the QHAPDC. Refer to Appendix B for more detail on the electronic file format for private hospital facilities.

The following forms are to be completed as required -

- PHI (1) for all separations.
- PHI (2) for an episode of care has that has eight or more morbidity codes reported or there are changes to any activity details such as Ward, Patient leave, Contract leave, Account variation, Mental health details (for patients admitted or transferred to a designated psychiatric unit) or Nursing home type patient details.
- PHI (3) for admitted contracted public sub and non-acute patients.

Public facilities can access these forms from:

https://www.health.qld.gov.au/dsb/collections/qhapdc [accessed 30 October 2026]

Private facilities can access these forms from:
https://www.health.qld.gov.au/dsb/collections/qhapdc [accessed 30 October 2026]

For further information on the Hospital Identification and Diagnosis Forms and how to complete them, refer to Section 8 Patient activity for hospitals using paper forms.

3.3 Data quality

The QHAPDC adheres to the Queensland Health Data Quality Framework[11] and the Data Quality Dimensions used to support data quality assessments as well as ongoing measurement of data quality levels. Hospitals should ensure that the following Data Quality Dimensions guide the collection and reporting of data to the Queensland Health via the Data Services Branch (DSB):

- Accurate
- Valid
- Reliable
- Timely

[11] Queensland Health Data Quality Framework (2023). Available from <Data Quality Framework (health.qld.gov.au)> [accessed 30 October 2026]

- Relevant
- Complete
- Unique

The Data Quality Dimensions assists Hospitals in defining and identifying drivers to achieve data quality. Hospitals should ensure that the data provided is complete, consistent and undergoes regular validations and is of a high quality to ensure the DoH can fulfill its regulatory functions.

DSB cannot accept data containing a high number of validation errors. If this is identified, DSB will contact the EVA Plus Primary User for your facility via phone and/or email. The validation errors identified must be addressed on your relevant Patient Administration System to ensure that erroneous data is not reported to DSB. Once addressed DSB will be able to accept a re-submission of data.

3.4 Due dates for data submissions

3.4.1 Private (licensed) Hospital Facilities

For private facilities Section 7(4)(c) of the Regulations requires that "a report about patient identification, diagnosis and activity data must be given within 35 days after the end of each month during the term of the licence".

All private (licensed) hospital facilities in scope of the QHAPDC must submit data to DSB by the 35th day following the reference period. The table below is an example of QHAPDC reporting schedule:

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

3.4.1 Public Hospital Facilities

The Healthcare Purchasing and Funding Branch, Healthcare Purchasing and System Performance Division requested Hospital and Health Services (HHSs) increase the frequency

of submission of QHAPDC data for public hospital facilities classified as 'ABF' facilities in the Department's Funding Model From January 2025 (memorandum C-ECTF-24/20950 10/12/2024). This is to ensure more up to date data can be reported for hospitals in alignment with the Government's requirement for closer to real time data.

ABF facilities are requested to undertake at minimum:

- **A mid calendar month** extract; as well as
- **An end of month extract** of QHAPDC data to the Department.

All public hospital facilities in scope of the QHAPDC must submit their data (for the period required) to DSB by the 35th day following the reference period. The table below is an example of QHAPDC reporting schedule inclusive of the mid calendar month requirement:

Reporting Period	Partial Extract(s) Mid Calendar month Due Date(s) Public 'ABF' Facilities	Final Extract(s) Finalised Data for the period Due Date(s) All Public Hospitals
July	By 15 August (1-15 July)	4 September (16 - 31 July)
August	By 15 September (1-15 August)	5 October (16-31 August)
September	By 15 October (1-15 September)	4 November (16-30 September)
October	By 15 November (1-15 October)	5 December (16-31 October)
November	By 15 December (1-15 November)	4 January (16-30 November)
December	By 15 January (1-15 December)	4 February (16-31 December)
January	By 15 February (1-15 January)	7 March (16-31 January) '6 Mar in a leap year'
February	By 15 March (1-15 February)	4 April (16-28 February) '16-29 Feb in a leap year'
March	By 15 April (1-15 March)	5 May (16-31 March)
April	By 15 May (1-15 April)	4 June (16-30 April)
May	By 15 June (1-15 May)	5 July (16-31 May)
June	By 15 July (1-15 June)	4 August (16-30 June)

Please note, the Healthcare Funding and Purchasing Branch (HPFB) has requested that all HHS's make a best effort to submit, at minimum, by the 21st day following the reference period.

For public hospitals, National Activity Submission deadlines are published on the Healthcare Purchasing and Funding Branch intranet page. It is imperative that hospitals meet these timeframes to allow for statewide quality assurance activity prior to required submission dates.

HHSs are reminded that partial extract(s) due mid-calendar month must be contiguous and must in alignment with the start and end date for that month being partially extracted.
e.g.: Extract 1: 1/12 – 15/12/2026. Extract 2: 16/12 – 31/12/2026.

Also, extracts must not cross over multiple periods or be for more than a single calendar month.
As HHSs move to fortnightly extracts, it is understood that not all episodes with HQI Extract

errors may be fixed/cleared prior to extract. Subsequently any episodes with these error/s are not included as part of the intended period being submitted.

Episodes 'held back' as a result of HBCIS HQI Extract errors, can cause unique sequencing constraints when processed by the QHAPDC system as some may contain amendments for episodes or new episodes.

This is particularly common in the scenario where a patient's amendments pertain to an episode within a 'stack' of multiple episodes of care within that HQI extract, and that 'inserted/changed' lead episode is not part of that same periods HQI extract.

HHS Health Information staff managing/overseeing the submission of QHAPDC data to DSB are requested to ensure that the 'inserted/changed' lead episode is included in the HQI extract and not held back due to HQI Extract errors.

This will ensure that all the necessary records are included within the HQI Extract so that the QHAPDC system has the sequence of episode records required to load and process the lead and all preceding episode records (without requiring manual intervention).

Due to resource capacity DSB is not able to confirm that manual intervention will be able to completed, so it is the responsibility of the HHS to ensure these extract processes are managed.

For public hospitals a preliminary Monthly Activity Report (PH1) report is due on the 4th day of each month following the reference month. A PH1 report is an aggregate-level report summarising hospital activity for the specified reference month. For most facilities using HBCIS, the PH1 is generated and sent automatically using the 'Report Monitor' functionality in HBCIS. Public hospitals are to submit the PH1 report to the Aggregate Data Collection[12].

All non-ABF public hospitals in scope of the QHAPDC must submit data to DSB by the 35th day following the reference period. The table below is an example of QHAPDC reporting schedule:

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

[12] Aggregate Data Collection. Available from < https://healthqld.sharepoint.com/sites/HPSPD-SSBFRANC> [accessed 30 October 2026]

Note: For July data requirements, HPFB state/national reporting timeframes for the reporting of data are different to DSB reporting timeframes.

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

Hospitals that are experiencing difficulty in meeting the mandated statutory deadline are requested to contact DSB via qhipsmail@health.qld.gov.au and provide details as to background and anticipated date of receipt for the outstanding reference period.

For public hospitals, that are experiencing difficulty in supplying coded due to clinical coding workforce issues impacting deadlines, it is recommended that they also advise the State Health Information Management and Clinical Coding Support Unit via himandcodingsupport@health.qld.gov.au.

Due to the importance of activity data on state forecasting and planning, all endeavours should be made to complete the coding as close to the end of the reference month as possible.

3.5 End of year reconciliation process (Public hospitals)

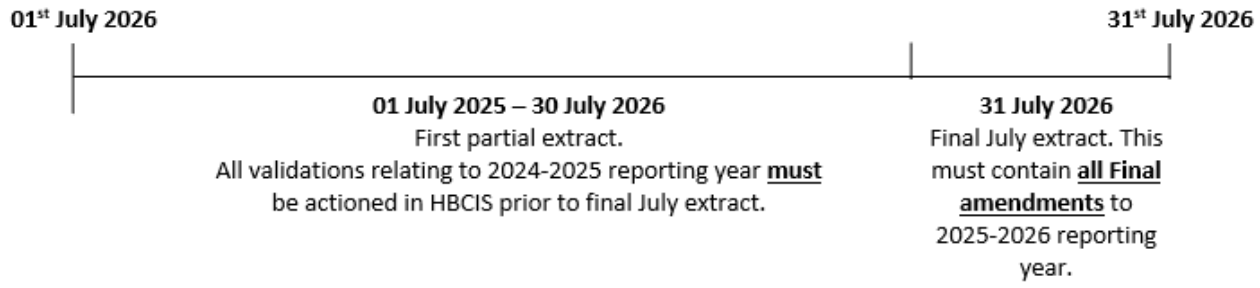
3.5.1 Final amendments

Hospitals have until the July extract (due early September) of the new financial year to submit any final amendments. To assist with the end of year reconciliation process, DSB highly recommends hospitals refrain from extracting the full month of July and instead, submit **partial** July extracts (example below).

Partial extracts are accepted by DSB and will provide hospitals with the opportunity to ensure all outstanding validations are identified and corrected and help streamline extraction and load processing times during this busy period.

If planning to undertake partial extractions, it is requested that hospitals please contact DSB prior to performing partial July extractions.

Example:



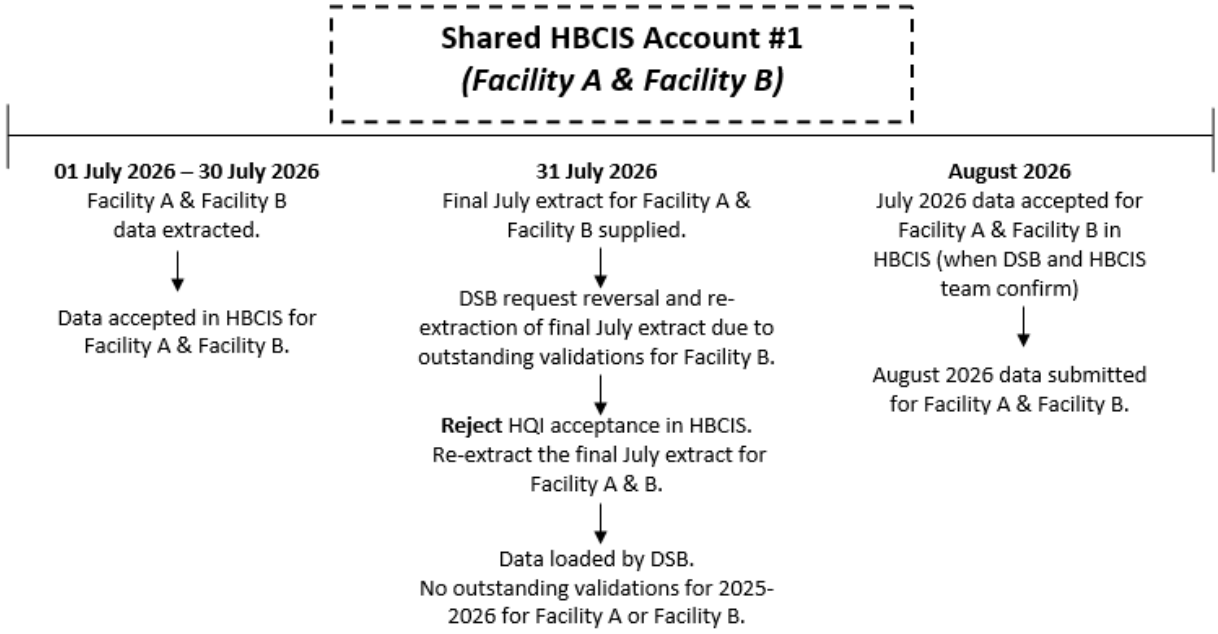
3.5.2 Data reversals

If reversals of data are required, hospitals will need to contact DSB.

Please be advised that partial acceptances of HQI data cannot be performed in HBCIS. Therefore, if a reversal is required for a HBCIS account that contains multiple hospitals, it will need to be done for each hospital from which all data will then need to be re-submitted to DSB.

Failure to follow the data reversal process will result in validation errors generating and causing records not to be loaded by DSB.

Example:



3.6 Validation checks and error correction

3.6.1 Outline

Validation errors are generated following a successful load of hospital data for a particular reference period. Facilities are notified of their errors on-line through the Electronic Validation Application (EVA).

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

3.6.2 Types of data validations

There are two types of validation message types that exist in the QHAPDC - fatal and warning.

Fatal validation messages are generated when one or more potential critical quality checks have been identified. Where a fatal validation message exists, the data in question must be confirmed and/or updated; otherwise, the episode of care will not become 'final' and consequently not be reported. If the data is not an error and is correct, a detailed explanation of why the exception is correct should be supplied to DSB. Respondents should note that the explanation is written authority for DSB to make the specified changes to the data.

Warning validation messages are generated when one or more non-critical quality checks have been identified. Generally, these checks exist where data reported is inconsistent, illogical or unusual. All warning errors must be investigated and confirmed, however, it will not stop the episode of care becoming 'final'.

3.6.3 Electronic Validation Application (EVA)

Facilities are notified of their validation messages on-line through the Electronic Validation Application (EVA). EVA provides facilities with the ability to record 'actions' that are required to rectify these validation errors. The benefits of EVA include;

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

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

The EVA user manual can be located on the DSB intranet site or internet site for Public and Private facilities.

Public hospitals - https://qheps.health.qld.gov.au/dsb/datacollections#qhapdc [accessed 30 October 2026]

Private hospitals https://www.health.qld.gov.au/dsb/collections/qhapdc [accessed 30 October 2026]

3.6.4 Resubmitting data

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

Facilities that are able to, can provide electronic amendments to separations within a financial year up to the acceptance of their July (current financial year) extract. For example, if a change is made to data for a patient separated on 3 May 2026 on HBCIS after their June data has been submitted to the DSB, then the amendment will be included in the July extract. Amendments to separations for the previous financial year cannot be submitted electronically by HBCIS hospitals after the July extract (current financial year) has been completed and accepted.

Private facilities (those unable to provide electronic amendments) can request for manual amendments to separations within a financial year up to 4th September of the next financial year. Thus, a change to data for a patient separated on 3 May 2026 can be made by the DSB up to 4th September 2027.

3.6.5 Authorising changes to data already supplied

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

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

For private hospitals, manual amendments are made each month as part of the validation process. Authorisation for amendments occurs from responses provided in EVA. Should additional changes be required at a later date, authorisation will be required.

3.7 Up-to-date records (HBCIS hospitals)

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

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

No validations will be carried out by DSB on up-to-date records.

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

3.8 Counting rules

3.8.1 Calculation of Length of Stay (LOS)

Every day a patient is an admitted patient is known as a 'patient day' or 'occupied bed day'. The length of stay (LOS) for an episode of care is the total of all 'patient days' accrued. A patient's LOS is used for invoicing purposes and to calculate when a Nursing Home Type Patient rate should be applied.

There are two ways of calculating the LOS:

1	**Retrospective** After the patient has been discharged: separation date minus admission date minus total leave days. Example: A patient was admitted on 4 January 2026 and discharged on 11 January 2026. There was one day of leave in that time. The length of stay is (11- 4) -1 = 6 days.
2	**Progressive** While still in hospital: sum of the accrued patient days at a point in time. Example: A patient was admitted on 4 January 2026. As of 8 January 2026, with no days of leave, the length of stay is 4 days.

Rules for calculating length of stay

1. The sum of 'patient days', 'contract leave' and 'leave days' must equal the number of days elapsed between admission date and separation date.
2. Patients admitted and separated on different dates,
    - count one patient day for day of admission; but
    - do not count a 'patient day' for day of separation.
3. For any given date, either a 'patient day' or 'leave day' may be counted but not both.
4. An admitted 'patient day' is measured from midnight to midnight.
5. Patients admitted and separated on the same date, count as one 'patient day'.
6. Midnight is recorded as the start of a new day (not the end of the previous day).
7. If an admitted patient goes from one hospital to another to receive treatment (as an admitted patient) and the patient has not been placed on 'contract leave', they must be separated and re-admitted on return (if applicable).

The identification and calculation of any leave days a patient has, is integral to calculating LOS.

Definition: A 'Leave Day' is a day a patient leaves or will remain away from a hospital and will be away at midnight but intends to return to hospital within seven days of departure. e.g. leaving hospital to attend a family event.

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

Example
A patient went on leave on 9 January 2026 and returned on 15 January 2026. The patient was on leave for 6 days.

Calculation rules for leave days

Note: Residential mental health care facilities should refer to the (RMHCDC) Manual for details on how Leave is to be supplied and leave days are calculated.

Also refer to section 4.10 Leave

1. For QHAPDC, leave is reported only where the patient is away at midnight.
2. 'Patient days' are not accrued when the patient is out of hospital on leave even though a bed may be 'held' for the patient during their absence.
3. A period of leave cannot exceed seven days.
4. A patient who goes on leave but does not return within the specified seven-day limit is to be formally separated from the hospital from the date that they left the hospital. The mode of separation (discharge status) is to be recorded as:

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

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

   If the patient subsequently returns to hospital, they should be treated as a new admission. This seven day maximum leave rule also applies to psychiatric hospitals.
5. The day a patient departs on leave is considered a 'leave day', the day they return is counted as a 'patient day'.
6. Calculating 'leave days' when admission and leave occur on the same day:
   i) If a patient is admitted and goes on leave on the same day, this is counted as a 'patient day'.
   ii) If a patient returns from leave and goes back on leave on the same day this is counted as a 'leave day'.
   iii) If a patient returns from leave and separated on the same day, do not count this day as either 'patient' or 'leave day'.
7. Charges should not be raised for 'leave days' even if treatment and accommodation were provided for part of the day.

8. Renal dialysis and day chemotherapy patients are not on leave between treatments; each dialysis session is a separate admission except during a course of sub-acute episode of care.
9. For QHAPDC, '**contract leave**' is reported by the hospital from which the patient is being contracted, whether the leave is same day or overnight. The patient is not required to be away at midnight.

3.8.2 Calculation of Nursing Home Type Patient (NHTP) days, (also known as 'Long Stay Patients')

A patient is classified a NHTP if they remain in hospital after 35 days and no longer require hospital type care (acute care). If the patient requires hospital type care after the 35th day an Acute Care Certificate should be completed.

The National Acute Care certificate stipulates the 35 days are calculated from the date which the patient has been continuously an overnight patient in one or more hospitals, without a break of more than seven days.

Compensable patients

Compensable third-party patients should be classified as NHTP after 35 consecutive days of hospitalisation, unless the following exclusions apply:

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

Ineligible patients

Ineligible patients remaining in hospital after the 35 consecutive days and not receiving 'acute care' should be assigned the appropriate non-acute care type (see Section 7.15 Care type). Patients are charged the applicable rate for their care according to the fee specified in the Fees and Charges Register.

Rules for calculating NHTP qualification

1. The 35-day qualifying period may accrue across more than one hospital (public or private or both) but excludes public psychiatric facilities.
2. 'Leave days' do not count in accruing the 35-day period.
3. Patients who go on leave or separate from hospital but:
    a. return to a hospital within seven days, continue to accrue the 35 days. e.g. a patient starting leave on 10 June, must return to the hospital on or before 17 June to continue to accrue days.
    b. do not return to a hospital until after the seventh day will begin to accrue the 35 days again, their date of re-admission to hospital would be day one.

4. If a patient is no longer classified as a NHTP (e.g. patient fell and broke their arm and requires acute care) the 35-day qualification period does not begin again. This patient would return to be a NHTP as soon as the acute period ceases.
5. The 35-day qualifying period does not apply if the patient was a resident of a residential care facility immediately before admission to a public psychiatric hospital. However, if the patient was a resident of a residential aged care facility and is admitted to an acute hospital, remains in hospital for more than 35 days and is not covered by an Acute Care Certificate the patient must be classified as NHTP.

4. DATA DEFINITIONS

Definitions used for the QHAPDC conform largely to the requirements of the National Health Data Dictionary (METeOR)[13] and the Queensland Health Data Dictionary (QHDD)[14].

4.1 Acute care certificates

Acute care certificates were initially developed when there were only two categories of care type – Acute and Nursing Home Type. However, additional care types have now been defined to better describe the type of care provided to admitted patients. The care type of Nursing Home Type no longer exists, as patients receiving any of the additional care types can accrue Nursing Home Type days (except those patients categorised as receiving Newborn, Organ Procurement-posthumous or Boarder 'care').

An acute care certificate can be thought of as a non-Nursing Home Type Patient certificate. That is, any patient who has been in hospital for a continuous period exceeding 35 days must be the subject of an Acute Care Certificate, or they are classified as Nursing Home Type Patient.

Currently there are two Acute Care Certificates in use:

- The National Private Patient/Public Hospital Acute Care Certificate (National Acute Care Certificate) developed by the Private Health Insurance Ombudsman in consultation with major health funds and States and Territories. This certificate is to be used for private health insurance patients but can also be used for other billable patients. It is a complex form, and explanation notes can be found using the following link: http://www.ombudsman.gov.au/__data/assets/pdf_file/0016/30184/acutecare-backgroundandexplanatorytable.pdf [accessed 30 October 2026]

  A writable pdf version of this certificate can be downloaded using the following link;

  https://qheps.health.qld.gov.au/__data/assets/pdf_file/0027/1471635/nat-acute-care-cert.pdf [accessed 30 October 2026]

- The simpler Acute Care Certificate may be used for non-private health insurance patients. This certificate can be downloaded using the following link:

  https://qheps.health.qld.gov.au/__data/assets/pdf_file/0028/1471609/acute_care.cert.pdf [accessed 30 October 2026]

More detailed information regarding these categories is available in the Queensland Hospital Admission Guidelines (https://www.health.qld.gov.au/dsb/collections/qhapdc).

[13] National Health Data Dictionary. Available from < https://www.aihw.gov.au/reports/technical-report/national-health-data-dictionary-version-16-2/summary> [accessed 30 October 2026]

[14] Queensland Health Data Dictionary. Available from < https://oascrasprod.health.qld.gov.au:8443/ords/f?p=103:QHDDHOME:::NO:::> [30 October 2026]

4.2 Admitting hospital

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

Provided it is to one of the declared public/licensed hospitals, an admitted patient is not required to occupy a bed nor is there a minimum time requirement to qualify for admission.

4.3 Admission

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

Refer to the Queensland Hospital Admission Guidelines (Appendix F) for more information.

4.3.1 Overnight or multiple day admissions

The clinical decision to admit a patient for an intended overnight or multiple day admission will be dependent on a number of factors including, but not limited to:

- severity of illness
- intensity of care required
- patient is aged nine days or less
- legal requirement to admit the patient
- other exceptional circumstances.

Ultimately, the decision to admit a patient is based on a clinical determination as to what is most appropriate for the patient.

4.3.2 Same Day Admissions

Same Day admissions are guided by criteria outlined in the Queensland Hospital Admission Guidelines (Appendix F); once again, the decision to admit a patient is based on a clinical determination as to what is most appropriate for the patient.

The conditions and requirements (including certification) for same day admissions for private patients and private patients in public hospitals are specified in the Private Health Insurance (Benefit Requirements) Rules 2011[15]. Certification for private patients is documented in the National Private Patient Hospital Claim Form[16].

[15] Private Health Insurance (Benefit Requirements) Rules 2011. Available from < https://www.legislation.gov.au/F2011L02160/latest/text> [accessed 30 October 2026]

[16] National Private Patient Hospital Claim Form. Available from < http://www.medibank.com.au/Client/Documents/Pdfs/National_Hospital_Claim_Form.pdf> [accessed 30 October 2026]

4.4 Boarders

A boarder is defined as a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. For example, a two-year-old baby who is accompanying their mother who is currently admitted is considered a boarder; as is a father accompanying his child who is admitted for a tonsillectomy or a mother accompanying a sick newborn who required admission to hospital.

A baby who remains in hospital, for example, without its mother awaiting adoption and does not require clinical care/treatment, should be separated when the baby is nine days of age and registered as a boarder when the baby is ten days of age.

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

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

When a hospital registers a boarder, the boarder should be allocated with:

- Source of Referral (admission source) = 21 Boarder
- Care type = 08 Boarder
- Mode of separation (discharge status) = 14 Boarder
- Funding Source = 12 Other funding source

Data on boarders should be submitted to the DSB.

4.4.1 Boarder who is subsequently admitted

If a boarder has been accommodated at a hospital and a change in their condition subsequently allows them to be an admission, this cannot be recorded as a change in status. Even though the hospital has previously "registered" the person as a boarder, the patient must be admitted and treated as a first-time admission. Do not use the 06 Episode change for either the Source of Referral/transfer or Mode of Separation. If the person subsequently changes back to Boarder status, they should be formally separated prior to being registered as a boarder. If an admitted patient is separated to become a boarder Mode of Separation should be recorded as 19 Other.

4.5 Change in care type

Patients changing from one care type to another, e.g. acute to maintenance within the same hospital, are to be statistically separated and re-admitted. Mode of Separation (discharge status) for the initial episode should be recorded as 06 Episode change. The subsequent episode's Source of Referral/transfer (admission source) should be recorded as 06 Episode change.

4.6 Compensable patient

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

- receiving hospital services for an injury, illness or disease; and
- the eligible person has received, or established his or her right to receive, in respect of that injury/illness, a payment by way of compensation or damages (including a payment in settlement of a claim for compensation or damages) under the law that is or was in force in a State, an internal Territory, Norfolk Island, the Territory of Cocos (Keeling) Islands or the Territory of Christmas Island, being a payment the amount of which was, in the opinion of the Minister, determined having regard to any medical expenses incurred, or likely to be incurred (whether by the eligible person or by another person), in the course of the treatment of, or as a result of, that injury (section 18(b) *Health Insurance Act 1973 (Cth)*)This includes but not limited to persons:
    - entitled to claim under Motor Vehicle Compulsory Third Party (CTP) insurance; or
    - entitled to claim under National Injury Insurance Scheme; or
    - entitled to claim under worker's compensation scheme; or
    - entitled to claim under public liability or product liability.

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

For information on Workers' Compensation Queensland refer to Section 15 Workers' Compensation Queensland (Public Hospitals Only) of this manual.

4.6.1 Motor vehicle accidents

4.6.1.1. Compulsory Third Party Insurance

Under the *Queensland Motor Accident Insurance Act 1994 (*the Queensland Motor Accident Insurance Commission (MAIC) pays a Hospital and Emergency Services Levy to Queensland Health and the Queensland Ambulance Service. This levy is intended to fund a reasonable proportion of the cost of providing public hospital and emergency services to people injured in motor vehicle accidents where the vehicle at fault was registered in Queensland. Queensland Health utilises the MAIC grant to fund HHSs according to the activity (weighted activity units) of patients treated and identified as covered by the Qld CTP scheme.

The levy does not apply to accidents that:

- occurred prior to 1 September 1994; or
- are not associated with CTP insurance (e.g. accidents involving; mobile machinery or equipment such as bulldozers, forklifts or agricultural implements); or
- were single vehicle accidents with only the driver at fault suffering injury; or
- that only involve an 'at fault' vehicle registered in a State or Territory other than Queensland.

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

- Was a motor vehicle involved in the accident?
- How was the injured person involved in the accident? E.g. passenger, driver, pedestrian
- Was another vehicle involved in the accident?
- Who was 'at fault'?
- Was the 'at fault' vehicle QLD registered?
- Did the accident occur on your way to or from work, on your lunchbreak or in the course of your employment? – Injuries occurring in these instances may give rise to a worker's compensation claim.

People admitted to hospital from motor vehicle accidents, must be classified as either ***Motor Vehicle (Queensland)MVQ/MVQI*** or ***Motor Vehicle (Other State/Territory) MVO/MVOI.***

MVQ/MVQI: where the admitted patient was injured in a motor vehicle accident and can establish negligence against an owner or driver of a Queensland registered motor vehicle.

MVO/MVOI: where the admitted patient was injured in a motor vehicle accident and can establish negligence against an owner or driver of a motor vehicle registered in a state or territory other than Queensland.

4.6.1.2 National Injury Insurance Scheme

On 1 July 2016, the *National Injury Insurance Scheme Act 2016* (Queensland) was introduced to ensure that a person who sustained a serious personal injury in a motor vehicle accident in Queensland, may be eligible to receive necessary and reasonable lifetime treatment, care and support under the National Injury Insurance Scheme Queensland (NIISQ).

To be eligible to apply for NIISQ, a person who sustained a serious personal injury needs to have been involved in a motor vehicle accident in Queensland. This scheme does not have regard to who was at fault, Medicare eligibility or where the car was registered.

For further details regarding application of the Act and the associated eligibility criteria please refer to the National Injury Insurance Scheme (Queensland) Act 2016[17].

The National Injury Insurance Agency (Qld) provides a grant to Queensland Health to fund a reasonable portion of the cost of providing public hospital and emergency services to people with an accepted NIISQ claim.

People admitted to hospital from a motor vehicle accident after 1 July 2016 and who have a valid National Injury Insurance claim must be classified as either **National Injury Insurance (Queensland) (NIIQ/NIIQI)** or **National Injury Insurance (Other State/Territory) (NIIO/NIIOI)**.

National Injury Insurance (Queensland): is used where the patient admitted to hospital who has a valid NIIS claim approved in Queensland.

[17] National Injury Insurance Scheme (Queensland) Act 2016. Available from < https://www.legislation.qld.gov.au/view/html/inforce/current/act-2016-034> [accessed 30 October 2026]

National Injury Insurance (Other State/Territory): is used where the patient is admitted to hospital who has a valid NIIS claim approved in a state or territory other than Queensland.

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

- "Was the injury a result of a motor vehicle accident?"
- "When did the accident occur (date)?"
- "Do they have a valid, admitted NIIS claim?"
- "Where and when was the claim accepted?" (which state or territory)

For more information on NIISQ refer to the information sheet FCI_007 National Injury Insurance Scheme Patients [accessed 30 October 2026] on QHEPS.

4.6.2 Compensable Third Party

Patients who may at any time receive, or establish a right to receive, compensation or damages (not covered by motor vehicle accident or workers' compensation insurers) for the injury, illness or disease for which they are receiving care and treatment.

All account class codes are listed in Appendix I.

For more information on Compensable Third Party refer to the information sheet FCI_008 Compensable Third-party patient [accessed 30 October 2026] on QHEPS.

4.6.3 Raising charges for patients in public hospitals

Patients classified as:

- ***MVQ/MVQI*** are covered by the MAIC grant, no individual charges are raised. However, if an MVQ/MVQI patient chooses to be treated as a private patient, they must obtain prior approval from their CTP insurer and are classified as Compensable Third Party private.
- NIIQ/NIIQI are covered by a grant to Queensland Health, and no individual charges are raised. NIIQ/NIIQI patients do not have the option to choose to be private under this scheme.

Patients classified as ***MVO/MVOI, NIIO/NIIOI*** or ***Compensable Third Party,*** are to have charges raised.

On admission, the patient is to be classified with the appropriate payment class. Should the hospital receive medico-legal correspondence or other evidence of a compensation claim being made, the original classification should be amended to reflect the correct status.

Patients from accidents involving vehicles from both Queensland and other states, where liability is unclear, are to be classified as Compensable Third Party and have charges raised. They may need to be reassessed after more information comes to hand or settlement has been reached.

If a patient does not have a valid NIIS claim at the time of discharge or service, they are to have the appropriate payment class code applied. Once an HHS is advised of a valid NIIS claim the payment class is to be changed to NIIQ/NIIQI or NIIO/NIIOI and an account

variation to GPMV is to be undertaken from the 'Interim Eligibility Decision Date' or the beginning of the current financial year whichever is closer.

4.7 Contracted hospital care

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

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

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

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

From 1 July 2014, contracted care details, including the provider/purchaser of the service, are required to be reported by the contracted hospital (Hospital B) where the contract type is 1 and the patient is a public patient.

Accurate recording of contracted hospital care is essential because:

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

To assist with the department's reporting obligations, hospitals must ensure contracted activity is accurately recorded in source systems prior to submitting data to the QHAPDC.

4.7.1 Scope of contracted hospital care

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

- a contracting hospital or purchaser of the service
- a contracted hospital
- the contracting hospital or purchaser making full payment to the contracted hospital for the contracted service

- the patient being physically present in the contracted hospital for the provision of the contracted service.

4.7.2 Procedures performed by a private health provider (Non-hospital)

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

See Section 4.7.11 Recording of procedures performed by a private health provider (non-hospital) and Section 9.16 Contracted procedures for further details on the use of the contract flag functionality and dummy facility identifier.

4.7.3 Other purchase care services

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

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

Note: The Australian Coding Standards (ACS*)* for ICD-10-AM and ACHI should be applied when coding all episodes. ACS 0029 *Coding of contracted procedures* notes that if a hospital treatment is carried out under a contracting arrangement existing between two hospitals; all procedures carried out under the contract are to be recorded and coded in both hospitals. The hospital not carrying out the procedure should flag the appropriate code.

See Section 4.7.11 Recording of procedure performed by private health providers (Non-hospital) for further information.

4.7.4 Location of contracted care data items on HBCIS (Public hospitals using HBCIS)

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

4.7.5 Contract role

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

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

4.7.6 Purchaser/provider identifier

Type 1 contracts

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

Type 2, 3, 4, or 5 contracts

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

4.7.7 Contract leave

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

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

Contract leave is only reported when the patient is to be returned to the contracting hospital after receiving contract care.

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

Date transferred for contract

Record the full date (ddmmyyyy) on which the patient was transferred for contract service.

Date returned from contract

Record the full date (ddmmyyyy) on which the patient returned from contract service.

Facility number contracted to

Record the facility number for the hospital to which the patient is transferred for contract service. See Appendix A for list of facilities and facility numbers.

4.7.9 Contract flag

A Contract Flag is an indicator that identifies that a procedure was performed by another hospital as a contracted hospital care service. It also indicates whether the procedure performed was an admitted or non-admitted service by recording 1 Contracted admitted procedure or 2 Contracted non-admitted procedure, against the procedure morbidity code. All procedures provided as part of a contract arrangement must be flagged using the Contract Flag. Diagnosis codes should be recorded but not flagged, unless it is to indicate that a contracted service was not carried out. See Section 9.16 Contracted procedures for more information.

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

4.7.10 Contract type

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

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

1 = B

2 = ABA

3 = AB

4 = (A)B

5 = BA

Contract Type 1 – B

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

The list of Contract Establishment Identifiers can be found in Appendix A of the QHAPDC Manual.

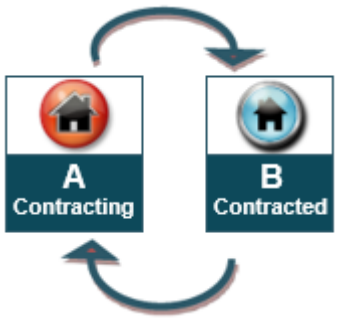


Hospital **B** records the following information:

- Appropriate Source of referral/transfer (admission source) code
- Contract Type = 1 B
- Contract Role = B Contracted hospital
- Appropriate Mode of separation (discharge status) code
- Appropriate Purchaser/provider identifier (Refer to Appendix A Contracted Hospital Care Service).

Contract Type 2 – ABA

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



Note:

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

Hospital **A** records the following information:

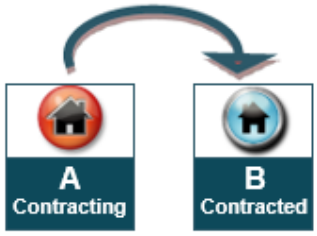
- Appropriate Source of referral/transfer (admission source)
- Admission Date: actual date admitted at A
- Contract Type = 2 ABA
- Contract Role = A Contracting hospital
- Date transferred for contract
- Date returned from contract
- Facility number contracted to
- Diagnosis and procedure codes. All procedures provided by hospital B, must have a contract flag.
    - Include any additional diagnoses identified by B (but do not flag them unless it is to indicate that a contracted service was not carried out).
- Separation date: actual date the patient left A after returning from B
- Appropriate Mode of separation (discharge status) code after returning from B
- Purchaser/provider identifier.

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

- Source of referral/transfer (admission source) = 24 Admitted patient transferred from another hospital
- Transferring from facility (extended source code) – identifier of the hospital that the patient was transferred from
- Admission date: actual date care commenced at B
- Contract Type = 2 ABA
- Contract Role = B Contracting hospital
- Diagnosis and procedure codes: only in relation to care provided by B
- Separation date: actual date separated from B
- Mode of separation (discharge status) = 16 Transferred to another hospital
- Transferring to facility is the identifier of Hospital A, the hospital contracting the admission.
- Purchaser/provider identifier.

Contract Type 3 – AB

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



Note:

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

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

- Appropriate Source of referral/transfer (admission source)
- Admission Date: actual date admitted at A
- Contract Type = 3 AB
- Contract Role = A Contracting Hospital
- Purchaser/provider identifier
- Diagnosis and procedure codes. All procedures provided by hospital B, must have a contact flag.
    - Include any additional diagnoses identified by B (but do not flag them unless it is to indicate that a contracted service was not carried out).
- Separation date: actual date separated from A
- Mode of separation (discharge status) = 16 Transferred to another hospital
- Transferring to facility; facility number of Hospital B.

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

- Source of referral/transfer (admission source) = 24 Admitted patient referred from another facility
- Transferring from facility (extended source code) – identifier of the hospital that the patient was transferred from
- Admission date: actual date of commencement of care at B
- Contract Type = 3 AB
- Contract Role = B Contracted hospital
- Purchaser/provider identifier
- Diagnosis and procedure codes: only in relation to care provided by B
- Separation date: actual date separated from B
- Appropriate Mode of separation (discharge status).

Contract Type 4 – (A)B

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



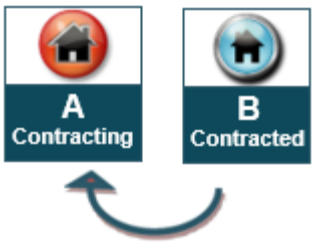
Hospital **B** records the following information:

- Source of referral/transfer (admission source) = 25 Non-admitted patient referred from another hospital
- Transferring from facility (extended source code) = identifier of the hospital that referred the patient
- Admission date: date actually admitted at B
- Contract Type = 4 (A)B
- Contract Role = B Contracted hospital
- Purchaser/provider identifier
- Diagnosis and procedure codes
- Separation date: actual date separated from B
- Appropriate Mode of separation (discharge status) code.

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

Contract Type 5 – BA

Definition: A hospital **(A)** contracts another hospital **(B)** for an admitted service prior to the patient's admission to their hospital **(A)**.



Hospital **B** records the following information:

- Source of referral/transfer (admission source) = 25 Non-admitted patient referred from another hospital
- Transferring from facility (extended source code) = identifier of the hospital that referred the patient
- Admission date: actual date admitted at B
- Contract Type = 5 BA
- Contract Role = B Contracted hospital
- Purchaser/provider identifier

- Diagnosis and procedure codes provided by B
- Separation date: actual date separated from B
- Mode of separation (discharge status) = 16 Transferred to another hospital
- Transferring to facility is the identifier of Hospital A, the hospital contracting the admission.

Hospital **A** records the following information:

- Source of referral/transfer (admission source) = 24 Admitted patient transferred from another hospital
- Transferring from facility (extended source code) = identifier of the hospital that referred the patient
- Admission date: actual date admitted at A. This should equal the date separated from B
- Contract Type = 5 BA
- Contract Role = A Contracting hospital
- Purchaser/provider identifier
- Diagnosis and procedure codes. All procedures provided by hospital B, must have a contact flag.
    - Include any additional diagnoses identified by B (but do not flag them unless it is to indicate that a contracted service was not carried out).
- Separation date: actual date separated from A
- Appropriate Mode of separation (discharge status) code.

4.7.11 Recording of procedures performed by private health providers (Non-hospital)

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

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

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

4.8 Dialysis, chemotherapy and radiotherapy

Dialysis, chemotherapy and some radiotherapy procedures are same-day accommodation procedures. Per the Counting Rules found at section 3.8 of the QHAPDC, patients admitted for same-day procedure should be admitted and discharged on the same-day, and not put on leave between same-day procedures on multiple/subsequent days.

A patient can only be admitted for one same-day accommodation procedure per day. A patient cannot be admitted as a same-day accommodation procedure whilst also admitted as an overnight patient. Neither of these limitations prevent the provision of clinically appropriate care during an admission.

4.9 Hospital in the Home (HITH) services

Hospital in the Home (HITH) in Queensland is defined as providing care in a patient's permanent or temporary residence for conditions that require ongoing clinical governance, monitoring and/or treatment, as a substitution for in-hospital admitted care.

4.91 Public hospitals (Hospital and Health Services only)

The scope of the HITH Guidelines applies to all Queensland Health staff (clinical and administrative) and all organisations and individuals acting as its agents for Queensland Health who are providing or planning to provide a HITH service.

The key feature of the Queensland HITH program is that if the patient (adult or child) is not receiving HITH, the patient would be admitted to hospital for treatment and accommodated in a hospital bed. Hospital admission criteria types include acute, sub-acute and non-acute and includes specific HITH specialised models of care such as Geriatric Evaluation and Management in the home (GEM HITH), Rehabilitation HITH (R HITH) for patients over 65 years old or over 50 years old for First Nations patients, Maintenance HITH, Maternity HITH, Palliative HITH and Mental Health HITH.

A comprehensive guideline for 'Hospital in the Home' addressing all recommendations for HITH is available at the following address:

Hospital in the Home guideline | Queensland Health [accessed 30 October 2026].

Compliance with the HITH Guideline is not mandatory, but sound patient-centric clinical reasoning consistent with high value, ethical and professional care, must exist for departing from this guideline.

Inclusion criteria

Patients should be considered for HITH if they can be treated safely outside the traditional inpatient hospital environment.

Key considerations include:

- HITH replaces full hospital admission or a component of a hospital admission. Without a HITH service, the patient would be admitted to a bed within the hospital setting for treatment as an inpatient
- patient requires clinical governance, active treatment and/or monitoring during the HITH episode of care to provide hospital substitution care
- patient requires minimum daily intervention or assessment by a HITH service to a perform clinical action or enable a clinical decision
- this clinical interaction can be delivered by various and flexible modes depending on the model of care and is not required to be face to face
- provision of a HITH service is a patient's choice and should be documented by obtaining consent from the patient or approved guardian
- the treating authorised practitioner determines that care for the patient can be safely provided and managed in the patient's permanent or temporary residence (or alternative patient preferred location and/or safe location as nominated by the HITH service), balancing risk, benefit and patient desire
- there is an appropriate and clinically safe method of communication between the patient and the HITH team
- clinical supplies/medication can be appropriately stored at care location, including refrigeration if necessary
- for paediatric patients, the approved guardian must nominate an adult to be present during the treatment of minors.
- Sub-acute HITH models of care, GEM HITH and Rehabilitation HITH provide HITH for patients aged 65 and older and for First Nation patients aged 50 years and older in accordance with the HITH inclusion criteria
- Non-acute HITH model of care, Maintenance HITH supports:
    - maintenance of functional capacity
    - patients who are awaiting additional community supports or residential care
    - length of stay up to 3 months
    - longer stays may be considered in exceptional circumstances, subject to local governance arrangements
    - a maintenance fee may be charged where a patient has been admitted for a continuous period exceeding 35 days
- As HITH patients are inpatients, the same financial eligibility criteria apply. If in doubt, consult the local Finance Team and the QHAPDC manual when considering inpatient impacts for compensable and Medicare ineligible patients, noting that:
    - Permission for HITH will need to be sought from workers compensation insurers.
    - Private patients will need to change their election to public prior to transferring to HITH.

Exclusion criteria

Patients whose care cannot be managed safely in a HITH environment.

Key considerations include:

- patients with complex care needs not amenable to HITH (inclusive of physical, cognitive and/or social care needs not able to be safely managed within the home environment)
- private patients including public hospital Medicare eligible private patients, are ineligible for HITH services, unless they change their election to public from when the HITH service commences
- non-admitted patient service events that do not fulfil the HITH requirements of hospital comparable care, that are able to be managed by a primary care provider who is available
- routine follow-up telephone calls post discharge do not constitute HITH activity.

HITH data recording

- Key performance indicators (KPI) for HITH are monitored, analysed and reported via local HHS processes. Refer to *Appendix A - Hospital in the Home (HITH) suggested key performance indicators/minimum data set*, available via the following address - https://www.health.qld.gov.au/system-governance/policies-standards/guidelines/hospital-in-the-home#appendix-a [accessed 30 October 2026].
- The medical record/chart is coded as a continuous episode of care.
- HITH episodes of care can only have a Care Type of: 01 Acute; 20 Rehabilitation; 30 Palliative; 09 Geriatric Evaluation and Management; 12 Mental Health; 11 Maintenance and 05 Newborn.
- All demographic and morbidity details are to be recorded on the Hospital Based Corporate Information System (HBCIS), in accordance with the procedure applying to normal admitted hospital patients.

Hospital in the Home: During a Pandemic

Hospital in the Home: During a pandemic, available on the Hospital in the Home webpage recommendations regarding best practice for public HITH services across Queensland in the event of a pandemic (e.g. COVID-19), which is defined as the worldwide spread of a new disease.

The purpose of this guideline is to support best practice advice, and ensure standardisation of HITH admissions, processes, and reporting during a pandemic. This guideline provides guidance to public HITH services across Queensland and should be considered in the development of local HITH processes.

Compliance is not mandatory, however sound reasoning must exist for departing from the recommendations contained within this guideline. Unless mentioned in this guideline, all other requirements under the Hospital in the Home guideline [accessed 30 October 2026] remain applicable.

Hospital in the Home: Standards of care

Hospital in the Home: Standards of Care, available on the Hospital in the Home webpage outlines the standards that define the type and quality of care to be provided by Queensland public HITH services.

It is intended to provide a foundation for clinicians to provide high quality care in their professional capacity, fulfilling their duty of care to the patient. These standards guide practice and monitor improvement in Queensland Hospital and Health Services, and ultimately give clinicians the necessary information regarding the quality of care that is required to be provided to patients.

4.9.2 HITH approval and withdrawal processes (Public patients in public hospitals only)

Approval of a HITH service

- Prospective HITH service managers should submit requests for the introduction of new HITH services to their Hospital and Health Service Chief Executive (HHS CE).
- Upon agreement by the business unit, the relevant HHS CE will seek final approval from the HHS Board Chair.
- HHS CE should undertake consultation with HHS Decision Support Units and advise the DSB of the service implementation.

Withdrawal of a HITH service

- Prospective HITH service managers should submit requests for the closure of a HITH service to their Hospital and Health Service Chief Executive (HHS CE).
- Upon agreement by the business unit, the relevant HHS CE will seek final approval from the HHS Board Chair.
- HHS CE informs the HHS Decision Support Units and the DSB of the service withdrawal.

4.9.3 HITH data recording

- All demographic and morbidity details are to be recorded on the Hospital Based Corporate Information System (HBCIS), in accordance with the procedure applying to normal admitted hospital patients.
- The medical record/chart is coded as a continuous episode of care.
- HITH episodes of care can only have a Care Type of: 01 Acute; 20 Rehabilitation; 30 Palliative; 09 Geriatric Evaluation and Management; 11 Maintenance; 12 Mental Health and 05 Newborn.

4.9.4 HITH reporting

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

Hospital in the Home Care type

Patients in public hospitals who qualify as a HITH patient must be admitted with a Care Type of: 01 Acute; 20 Rehabilitation; 30 Palliative; 09 Geriatric Evaluation and Management; 11 Maintenance; 12 Mental Health and 05 Newborn.

Hospital in the Home Ward code

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

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

In special circumstances sites may require more than one ward to be set up. In these instances, the provider initials are used and Queensland Health (mailto:HIU@health.qld.gov.au) notified.

Hospital in the Home Account class code

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

Hospital in the Home Unit code

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

Hospital in the Home Standard Ward code

All HITH wards should map to and report the Standard ward code of HOME.

Hospital in the Home allocation of beds

For public hospitals, the number of beds attached to a HOMEXX in the Ward Codes reference file will be zero.

Hospital in the Home discharging patients

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

Hospital in the Home Acute Care Certificate

An Acute Care Certificate is required for all acute HITH patients where the period of hospitalisation exceeds 35 days. Days accumulated by HITH patients are included towards determining whether an Acute Care Certificate is required. For Maintenance HITH a fee may be charged where a patient has been admitted for a continuous period exceeding 35 days and an Acute Care Certificate is no longer applicable.

Example for HBCIS hospitals

Patient is a HITH admitted patient in Hospital A and attends the Emergency Department of Hospital A for chest pains. The patient is assessed, and a clinical decision is made to admit the patient to a ward for cardiac investigations and monitoring. In this scenario, a ward transfer is performed. The patient must not be discharged and re-admitted unless there is a change in care type.

4.9.5 Private hospitals

Private licensed facilities are required to negotiate with the private funds regarding the provision of approved HITH care.

Private hospitals also provide personalised hospital in the home treatment to admitted patients in their own home.

Eligibility for HITH for private hospitals is dependent on the patient's individual treatment requirements and the private facilities clinical assessment to determine treatment is appropriate and can be safely provided in the patient's home.

Hospital in the Home Ward code

The ward code must be provided for HITH patients. Home wards are to be coded HOMEXX, where XX is optional and may be replaced by characters to identify one HOME ward from another.

Hospital in the Home Unit code

Where a hospital maintains a system of units to describe clinical specialities, these unit codes shall be entered according to current practice in order to identify the unit responsible for the patient in the HOME ward (e.g. Unit code = SURG; Ward code = HOME).

Hospital in the Home Acute Care Certificate

An Acute Care Certificate will be required for all acute and sub-acute HITH patients where the period of hospitalisation exceeds 35 days. Days accumulated by HITH patients are included towards determining whether an Acute Care Certificate is required. If an Acute Care Certificate is not completed, and the patient has been admitted to hospital for more than 35 consecutive days Nursing Home Type Patient fees may apply.

4.10 Leave

A leave patient is a patient who leaves the hospital for a short period and intends to return to the hospital to continue the current course of treatment. Under current national guidelines, an admitted patient may be granted leave for up to a maximum of seven days. For more information, refer to refer to Section 3.8 Counting rules.

Note: Residential mental health care facilities should refer to the (RMHCDC) Manual for details on providing leave details and calculation of leave days.

Date of starting leave

Record the full date (ddmmyyyy) on which the patient started leave.

Time of starting leave

Record the time on which the patient started leave.

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

Date returned from leave

Record the full date (ddmmyyyy) on which the patient returned from leave.

Time returned from leave

Record the time on which the patient returned from leave.

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

4.10.1 Contract leave

Contract leave is used to allow a patient to receive a contracted admitted or non-admitted service that is not available at the hospital where the patient is currently admitted. For more information, refer to Section 4.7.7 Contract Leave.

4.11 Multi-Purpose Health Service (MPHS) and flexible care patients (HBCIS hospitals)

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

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

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

- Discharge the patient from the acute hospital with**:**
    - Mode of separation (discharge status) of 21 Residential aged care service, which is not the usual place of residence.
    - Transferring to facility code as the facility ID of the MPHS.
- Admit the patient to the MPHS with:
    - Care type of 44 Aged Care Resident.
    - Source of referral/transfer (admission source) as 24 Admitted patient transferred from another hospital.
    - Transferring from facility (extended source code) as the facility ID of the Acute Hospital.
    - An appropriate Account class code.

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

- Discharge the patient from the MPHS with:
    - Mode of separation (discharge status) 16 Hospital Transfer Transferring to facility code as the facility ID of the Acute Hospital.
- Admit the patient to the Acute Hospital with:
    - Source of referral/transfer (admission source) code of 23 Residential Aged Care Service and Transferring from facility (extended source code) as the Facility ID of the MPHS.

Responsibility for the policy aspects of the MPHS program (including the signing of the funding agreements between Queensland Health and the Commonwealth) rests with the Service Needs, Access and Planning Branch, Health Commissioning Queensland.

Overall state-wide planning for new MPHS sites, and any associated planning, also lies with the Service Needs, Access and Planning Branch, Health Commissioning Queensland.

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

For further information regarding the set-up of MPHS on HBCIS, contact DAS Clinical, eHealth Queensland.

4.12 Newborns

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

4.12.1 Newborns - Acute qualification status

Newborn qualification status is influenced by the https://www.legislation.gov.au/C2004A00101/latest/text [accessed 30 October 2026]

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

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

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

- the baby is transferred without its mother; or
- the mother is admitted as a boarder; or
- the baby is the second of subsequent live born infant of a multiple birth; or
- the baby is admitted to an approved Intensive Care Nursery (ICN)/Special Care Nursery (SCN).

A newborn cared for on the ward and who has not been admitted or transferred into SCN or ICN cannot be qualified if they are 9 days old or less, are not the second or subsequent live born infant of a multiple birth and/or if the mother is also a patient within the facility.

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

Refer to Section 6.13 Medicare eligibility to determine the eligibility of a newborn.

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

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

Newborns that are waiting for adoption and turn ten days of age who remain in hospital without their mother, and require no clinical care/treatment, should be formally separated and then registered as boarders.

If a mother remains in hospital after the period in which she required care and is staying with a baby that is nine days old or less and requires care, the mother should be classified as a boarder, and the baby must be assigned a qualification status of “A” (Acute).

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

4.12.2 Newborns - Unqualified qualification status

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

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

4.12.3 Changes in qualification status of newborns

Should a change in the condition of a newborn result in their qualification status changing between acute and unqualified, this must be recorded as a change in qualification status. For example, an unqualified newborn is admitted to an intensive care facility or remains in hospital without its mother.

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

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

A baby born on 1 March and admitted with a care type of ’05 Newborn, remaining in hospital and still requiring clinical care when it turns 10 days old on 11 March, must have a qualification status of ‘Acute’ from 11 March until the day they are separated. If the

qualification status needs to be changed from 'Unqualified' to 'Acute', this may be done at any time on 11 March (but no later).

Example for HBCIS hospitals

On HBCIS, the start of the reporting day is 00:01, with midnight (24:00) being the end of the reporting day. As a result, a baby born at 11.20 on 1 March is one day old as of 00:01 on 2 March. A baby born at 23.20 on 1 March is also one day old as of 00:01 on 2 March. Any babies born on 1 March between 00:01 and 24:00 become 9 days old on 10 March at 00:01 and 10 days old on 11 March at 00:01.

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

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

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

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

A baby born on 1 March and admitted with an episode of care type of 05 Newborn, remaining in hospital and **not requiring clinical care** when they turn 10 days old on 11 March, must be separated on 10 March at 24:00 and registered as a boarder on 11 March at 00:01.

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

Figure 3 Newborn 9 days of age or less and **Figure 4** Newborn 10 days of age or more, summarise how to classify newborns according to the Health Insurance Act, including born before arrival at hospital or transferred to another hospital.

Example for non-HBCIS (other) hospitals

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

Any babies born on 1 March between 00:00 and 23:59 become 9 days old on 10 March at 00:00 and 10 days old on 11 March at 00:00.

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

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

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

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

A baby born on 1 March and admitted with an episode of care type of 05 Newborn, remaining in hospital and not requiring clinical care when they turn 10 days old on 11 March, must be separated on 10 March at 23:59 and registered as a boarder on 11 March at 00:00.

Figure 3 Newborn 9 days of age or less

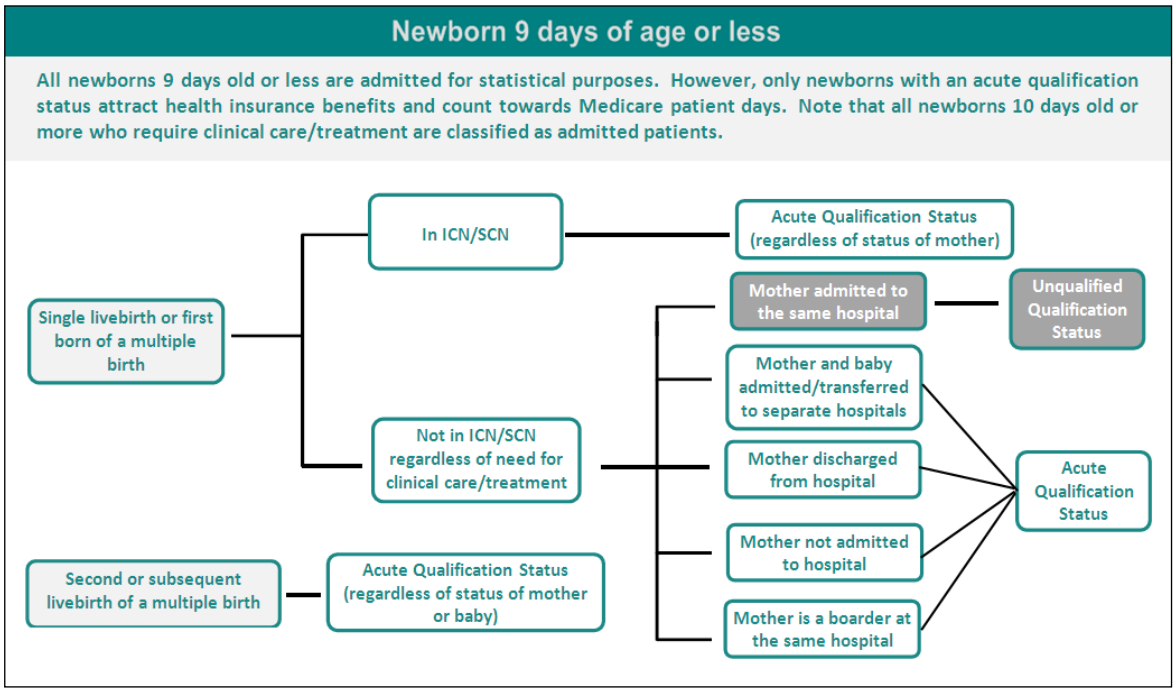
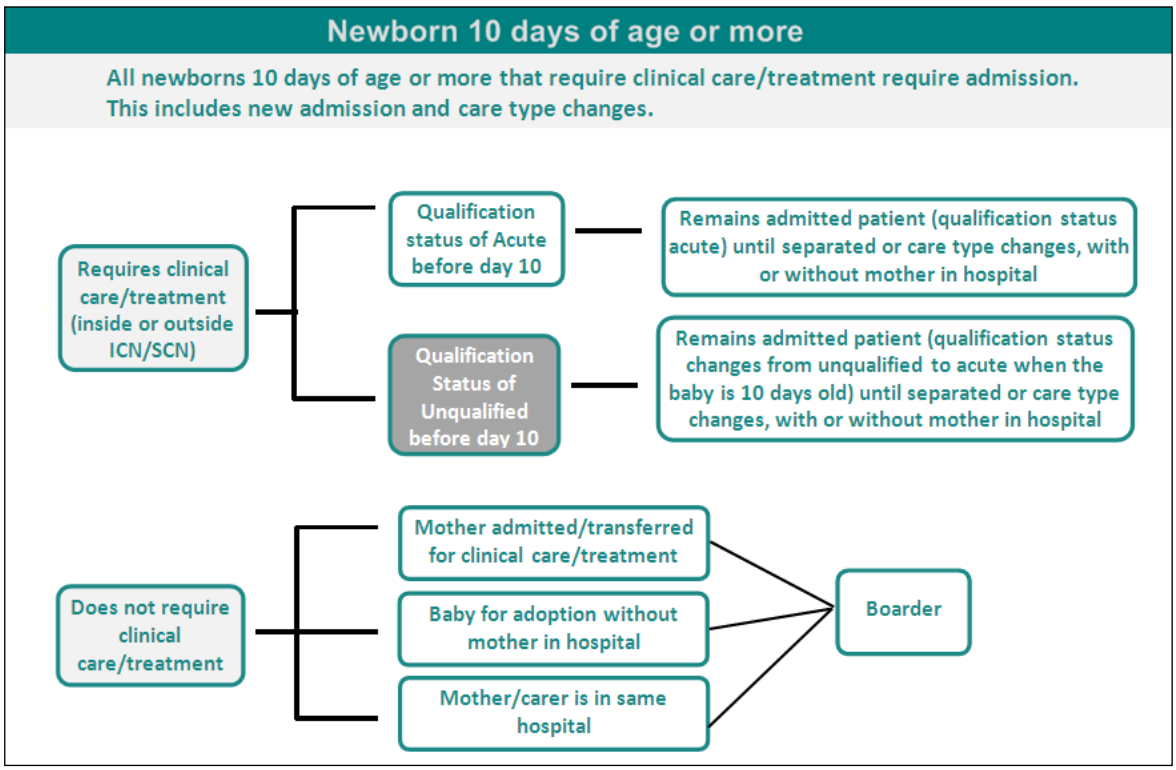


Figure 4 Newborn 10 days of age or more



4.13 Nursing home residents

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

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

4.14 Nursing Home Type Patient (NHTP)

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

A patient classified as a Nursing Home Type Patient (NHTP) must have one of the following care types:

- 09 Geriatric Evaluation and Management
- 10 Psychogeriatric
- 11 Maintenance
- 12 Mental health
- 20 Rehabilitation
- 30 Palliative

The 35 day period:

- may accrue in more than one hospital (public, private or both)
- will continue to accrue while the patient is in Hospital-In-The-Home (HITH)
- excludes treatment in public psychiatric hospitals
- excludes leave days
- commences upon admission.
- continues to accrue if a patient is separated from hospital but returns within seven days

Patients discharged from hospital whose next admission is more than seven days from the discharge date – the 35 day qualifying period recommences.

A patient admitted from a residential aged care facility to an acute hospital, commences the 35 day accrual from date of admission (refer to Section 3.8 Counting rules). Should this patient remain in hospital for more than 35 days and is not covered by an Acute Care Certificate the patient must be classified as NHTP.

An Acute Care Certificate is required for all admitted patients where the period of hospitalisation exceeds 35 days and they continue to require hospital level treatment.

If an admitted patient is classified as a NHTP but subsequently requires acute care, the qualifying period of 35 days does not start again. E.g. a patient was an acute patient, reached the 35 days and were no longer receiving acute care therefor charged the NHTP rate. Something occurs that requires acute care for a period, NHTP charges cease for the acute period, once the level of care is no longer acute they will return to being charged the NHTP.

The 35 day period does not apply if the patient was a resident of a residential care facility immediately before admission to a public psychiatric hospital.

Nursing home type patient fee rates are set in the *Private Health Insurance (Benefits Requirements) Rules 2011*, and apply to in hospital care.

Guidance for the assignment of morbidity details for a NHTP refer to the Australian Coding Standards 2105 *Long term/nursing home type inpatients* and 2117 *Non-acute care*.

Public HBCIS hospitals

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

Since 1 September 2004 any sub and non-acute patient who has a length of stay over 35 days and who is not the subject of an Acute Care Certificate can be classified as a NHTP without changing their care type.

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

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

4.15 Organ donors

4.15.1 Live donors

A live donor is admitted to an acute episode of care to donate organs or tissue. Live donors cannot be registered as an 'Organ Procurement-posthumous' care type.

4.15.2 Posthumous organ procurement

Posthumous organ and tissue procurement is the procurement of human organs and tissue for the purpose of transplantation from a donor who meets the following criteria: brain function or circulation of blood has permanently stopped, consent for organ procurement received and the patient is clinically eligible to donate organ/s.

Before a patient who has died can proceed to organ procurement, that patient should be formally separated (Mode of separation (discharge status) = 05 Died in hospital) and then registered using the codes listed below.

Note: Public hospitals utilising HBCIS do not have the capacity to register patients to the organ procurement care type.

Organ Procurement data are collected by DonateLife Queensland which is then submitted electronically to DSB.

Any hospitals performing organ procurement should contact the DSB for further information.

Episode where brain death occurs	Organ Procurement registration
Mode of Separation (discharge status) = 05 Died in Hospital.	The organ procurement registration has a; • Care Type = 07 Organ Procurement-posthumous • Source of Referral/Transfer (admission source) = 20 Organ Procurement • Funding Source = 12 (Other) • Mode of Separation (discharge status) = 13 Organ Procurement.

4.16 Overnight (or longer) stay patients

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

- has been registered as a patient at the hospital,
- has undergone a formal admission process,
- remains in hospital at midnight on the day of admission.

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

Note:

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

4.17 Patients on life support

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

Patients who remain on life support after being declared clinically dead for the purposes of organ procurement must first be formally discharged from their episode of care and subsequently registered to an 'Organ procurement-posthumous' care type. See Section 4.15 Organ donors.

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

Respite care residents (in a residential aged care service) receive residential aged care services. As such, the charges that apply to them are based on those that apply to other residents in a residential aged care service.

In the case of maintenance care patients (receiving respite care) accommodated in hospitals (not a residential aged care service) with public status, no charges can be raised for the first 35 days. After that period, if there is no Acute Care Certificate issued, they are classified as Nursing Home Type Patients (NHTP) and are charged as such.

Respite fees may differ from NHTP fees for persons occupying places in residential care facilities.

Public hospital staff should access the Fee and Charges Register[18].

4.19 Same day patients

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

- has been registered as a patient at the hospital,
- has undergone a formal admission process,
- is separated prior to midnight on the day of admission.

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

Note:

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

[18] Fee and Charges Register. Available from < https://www.health.qld.gov.au/directives/html/a#f> [30 October 2026]

- Residential mental health care facilities should refer to the (RMHCDC) manual for details on same day patients within a residential mental health care facility.

4.19.1 Day only procedure patients

Day only procedure patients are a subset of same day patients. They are patients who are admitted for, and have received;

- A Surgical, diagnostic or therapeutic procedure identified under the Same day accommodation: hospital in all States/Territories specified as Band 1A, 1B, 2, 3 and 4 in Part 2 of Schedule 3 of the Private Health Insurance (Benefit Requirements) Rules 2011[19], and have been discharged, transferred or died before midnight on the day of admission; or
- A Type C procedure (noting that Type C procedures do not normally require hospital treatment) for whom a Day Only Procedure Certificate is completed.

A day only procedure patient cannot have any related episodes during a hospital stay.

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

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

  Public patients who receive a Type C procedure with an accompanying certificate are not banded but admitted as public same day patients.

4.20 Time at hospital

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

Refer to the Queensland Hospital Admission Guidelines (Appendix F) for more information.

[19] https://www.legislation.gov.au/F2011L02160/latest/text - Private Health Insurance (Benefit Requirements) Rules 2011 [accessed 30 October 2026]

5. FACILITY DETAILS

5.1 Facility number

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

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

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

Note: Residential mental health care facilities use the same infrastructure as public acute and public psychiatric hospitals but are not considered in scope of QHAPDC. For details about data submission requirements for these facilities refer to the Appendix K.

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

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

6. PATIENT DETAILS

To assist public hospitals to accurately record key patient demographic details they should refer to the Person and Provider Identification Data Set-Definitions (PPI DSD).

Person and Provider Identification Data Set-Definitions (health.qld.gov.au)[20].

6.1 Patient identifier (UR number)

The patient identifier (UR number) is a unique record number assigned to a person for the purpose of uniquely identifying them within a healthcare facility. A patient ID number may be generated manually, or system generated. The number is used for each admission to identify the patient. The unit record number may be numeric or alphanumeric.

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

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

6.2 Family name

The patient's full family name should be recorded.

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

Registering an unnamed newborn baby

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

Baby for adoption

[20] Person and Provider Identification Data Set-Definitions (PPI DSD). Available from < Person and Provider Identification Data Set-Definitions (health.qld.gov.au)> [accessed 30 October 2026]

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

Refer to the Managing the clinical records of children available for adoption Standard[21] and Managing the clinical records of children available for adoption guideline[22] for further information.

Recording an unknown person

If family name is not known or cannot be established, the default for an unknown family name should use the following format: UNKNOWN and should be recorded as an alias name usage type as per your facilities guidelines.

Do not create a fictitious family name such as DOE as this is an actual family name.

When a person's family name becomes known, record it as the family name and make every attempt to identify whether it is the preferred and / or Medicare card family name. Keep UNKNOWN as an alias name.

HBCIS Hospitals	The default for an unknown family name should use the following format: UNKNOWN[facility abbreviation] and should be recorded as an alias name usage type. For further information about recording an unidentified client please refer to Fact sheet: Recording unknown patients[23].

6.3 Given names

A patient may have more than one given name.

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

[21] Managing the clinical records of children available for adoption Standard. Available from < https://www.health.qld.gov.au/__data/assets/pdf_file/0029/397307/qh-imp-280-4.pdf> [30 October 2026]

[22] Managing the clinical records of children available for adoption guideline. Available from < https://www.health.qld.gov.au/__data/assets/pdf_file/0029/397415/qh-gdl-280-1.pdf> [30 October 2026]

[23] Fact sheet: Recording unknown patients. Available from < https://qheps.health.qld.gov.au/__data/assets/pdf_file/0018/2144070/recording-unknown-patients.pdf> [30 October 2026]

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

HBCIS Hospitals	Record the one name in the family name field and record a full stop "." in the given name field.

Consideration shall be given to the unnecessary use of non-alphanumeric characters and symbols, which should be avoided wherever possible due to implications on system functionality.

Registering an unnamed newborn baby

An unnamed newborn baby is to be recorded using the mother's given name in conjunction with 'baby of'. For example, if the given name of the baby's mother is Fiona, then record 'baby of Fiona' in the given name field for the baby. Where the character field length doesn't allow the use of 'baby of', B-O may be used. "B-O' maps to 'Baby of' in the national standards.

There are known issues with the use of the forward slash (/) in B/O when recording 'Baby of' in some Queensland Health Information Systems. Where character field length doesn't allow the use of 'Baby of', B-O may be used. Please refer to the Recording non-alphanumeric characters in person and provider identification data fact sheet: Recording of non-alphanumeric characters in person and provider identification data

Baby for adoption

The word 'adoption' should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name with a new UR Number, and the record should not be linked to the birth record. This should be the current practice. Any old references to adoption in patient registers (for names) should also be changed to UNKNOWN. Refer to the Managing the clinical records of children available for adoption Standard[24] and Managing the clinical records of children available for adoption guideline[25] for further information.

Recording an unknown person

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

[24] Managing the clinical records of children available for adoption Standard. Available from < https://www.health.qld.gov.au/__data/assets/pdf_file/0029/397307/qh-imp-280-4.pdf> [accessed 30 October 2026]

[25] Managing the clinical records of children available for adoption guideline. Available from < https://www.health.qld.gov.au/__data/assets/pdf_file/0029/397415/qh-gdl-280-1.pdf> [30 October 2026]

HBCIS Hospitals	If a person's given name is not known, the following format should be used: [current year YY][unique code] For further information about recording an unidentified client please refer to Fact sheet: Recording unknown patients[26].

6.4 Date of birth

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

Example

For 5 September 1959, record:

0	5	0	9	1	9	5	9

HBCIS hospitals

- If the day of birth is unknown, use ** and then enter the month and year.
- If the month of birth is unknown, use ** for the month value.
- If the year of birth is unknown, estimate the year from the age of the patient.
- If the age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients, use the year 1970).

Example

If a patient is admitted in 2026 does not know their exact date of birth but knows that they are 98 years of age, record the date of birth as follows:

*	*	*	*	1	9	2	8

Although provision is made for recording an unknown date of birth (using **/**/1970), every effort should be made during the course of the admission to determine (and record) the patient's actual date of birth. The patient's date of birth is an important requirement for the correct identification of the individual and the accurate assignment of a Diagnosis Related Group (DRG) at a later date.

For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under two years should be reported to the nearest three month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child

[26] Fact sheet: Recording unknown patients. Available from < https://qheps.health.qld.gov.au/__data/assets/pdf_file/0018/2144070/recording-unknown-patients.pdf> [30 October 2026]

who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. As per your facility documentation guidelines an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.

Other hospitals

- If the day of birth is unknown, use 15.
- If the month of birth is unknown, use 06.
- If the year of birth is unknown, estimate the year from the age of the patient.
- If the age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients, use the year 1970).

Example

If a patient is admitted in 2026 does not know their exact date of birth but knows that they are 98 years of age, record the date of birth as follows:

1	5	0	6	1	9	2	8

Although provision is made for recording an unknown date of birth (using 15/06/1970), every effort should be made during the course of the admission to determine (and record) the patient's actual date of birth. The patient's date of birth is an important requirement for the correct identification of the individual and the accurate assignment of a Diagnosis Related Group (DRG) at a later date.

For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under two years should be reported to the nearest three month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. As per your facility documentation guidelines an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.

6.5 Estimated date of birth flag

The Estimated date of birth flag indicates whether the patient’s date of birth has been estimated.

For public hospitals, if an asterisk has been used in place of either the day or the month, then an Estimated date of birth flag of 1 Estimated will be allocated when data are submitted to the DSB.

For data accuracy, a record with an Estimated date of birth flag of 1 Estimated, should be followed up and corrected where possible prior to the patient’s separation from the facility.

6.6 Sex and Gender

A patient's sex is based on their sex characteristics such as their chromosomes, hormones and reproductive organs. While typically based upon the sex characteristics observed and recorded at birth or infancy, this may change over the course of a patient's lifetime (Australian Bureau of Statistics (ABS) 2020).

Gender is a social and cultural concept relating to social and cultural differences. Sex and gender are often used interchangeably. However, they are two distinct concepts (ABS 2020).

The DSB reports data for the data element Sex according to the definition and permissible values in the National Health Data Dictionary, which are aligned with those used by the ABS. Sex is relevant to morbidity in a range of subject areas (e.g. cancer).

Persons may identify with a gender other than the sex they were assigned at birth, or as a gender that is not exclusively male or female. It is recommended that the gender a person identifies with is reflected in their personal records. As such, reasonable steps should be taken to ensure personal information is accurate, relevant and current, which includes sex and gender information.

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

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

	Code	Description
Other Hospitals	1	Male
	2	Female
	3	X
	9	Not Stated/Inadequately Described

Code 3 X- Persons who have mixed or non-binary biological characteristics (if known), or a non-binary sex assigned at birth. The value meaning of 'X' has been assigned to Code 3 for this value domain, which replaces 'Other' for the superseded value domain Sex code N. Terms such as 'indeterminate', 'intersex', 'non-binary', and 'unspecified' are variously used to describe the 'X' category of sex. The label 'X' is used because a more descriptive term has not been widely agreed within the general community.

Code 3 X, must be confirmed if reported.

To ensure that Queensland can continue to report Sex rather than Gender data to meet national reporting requirements, DSB has implemented a Gender field within its QHAPDC data repository.

Should EVA validations determine that there is a possible issue with the data provided for Sex for an episode of care that could be related to Gender being reported, DSB will contact the facility to determine whether Sex or Gender information was provided.

If the facility advises that Gender has been reported in the Sex field, then the Sex and Gender data items in DSB's QHAPDC data repository will be amended to reflect the correct values. Until the new ABS standards on sex and gender become part of the standards for national reporting, DSB is utilizing the same value domain for Sex as mentioned above for the recording of Gender.

For further information regarding the process for updating and capturing Sex and Gender data items please contact DSB.

6.7 Country of birth

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

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

HBCIS Hospitals	Record a code listed in Appendix E

Other Hospitals	Record a code listed in Appendix E.

6.8 Marital status

A Marital status is a person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.

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

	HBCIS Admission Source		Extracted/mapped by HQI as	
HBCIS Hospitals	**Code**	**Description**	**Code**	**Description**
	A	Separated	5	Separated
	D	Divorced	4	Divorced
	F	De facto	2	Married (registered and de facto)
	M	Married	2	Married (registered and de facto)
	N	Not stated	9	Not stated/unknown
	NM	Never Married	1	Never Married
	W	Widowed	3	Widowed

	Code	Description
Other Hospitals	1	Never Married
	2	Married (registered and de facto)
	3	Widowed
	4	Divorced
	5	Separated
	9	Not stated/unknown

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

6.9 Indigenous status

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

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

The Indigenous status of a newborn should be ascertained according to the wishes of the mother and/or father. It is not sufficient to automatically assign a newborn the Indigenous

status of the mother. For example, where the mother is non-Indigenous and the father is Indigenous, the parents may wish to identify the baby as being of Indigenous origin.

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

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

HBCIS Hospitals

HBCIS Admission Source		Extracted/mapped by HQI	
Code	**Description**	**Code**	**Description**
11	Aboriginal but not Torres Strait Islander origin	1	Aboriginal but not Torres Strait Islander origin
12	Torres Strait Islander but not Aboriginal origin	2	Torres Strait Islander but not Aboriginal origin
13	Both Aboriginal & Torres Strait Islander origin	3	Both Aboriginal & Torres Strait Islander origin
14	Not Aboriginal nor Torres Strait Islander origin	4	Neither Aboriginal nor Torres Strait Islander origin
29	Not Stated/Unknown – No follow up required	9	Not Stated
39	Not stated/Unknown – Follow up required	9	Not Stated

Other Hospitals

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

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

6.10 Australian South Sea Islander status

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

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

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

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

	HBCIS Admission Source		Extracted/mapped by HQI	
HBCIS Hospitals	**Code**	**Description**	**Code**	**Description**
	Y	Yes	1	Yes
	N	No	2	No
	U	Not stated/Unknown	9	Not stated/Unknown

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

Data providers should be aware that:

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

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

6.11 Address of usual residence

6.11.1 Number and street of usual residence

The collection of the address details of a patient is critical for patient follow up and as a means of reporting information about the geographic location of the residence of a patient. A patient may have one address or many addresses. For reporting purposes, the permanent residential address should be recorded and submitted to DSB. Residential addresses that include a reference to a post office (PO) box will not be accepted.

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

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

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

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

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

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

Patients admitted to hospital without a permanent address that are currently living within a residential mental health care facility should have the address of that facility recorded as their usual residence.

Baby for adoption

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

6.11.2 Locality

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

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

Interstate and overseas patients

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

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

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

Unknown locality

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

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

Baby for adoption

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

No fixed address

Record - No fixed address. Note that locality, postcode and state codes must all be recorded as No fixed address.

At sea

Record - At sea.

6.11.3 Postcode

Record the postcode of the residential address of the patient.

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

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

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

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

Where the patient has no fixed address, use the correct postcode. Note that locality, postcode and state codes must all be recorded as No fixed address.

Unknown postcode

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

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

Baby for adoption

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

6.11.4 Australian state/territory of usual residence

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

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

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

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

Where the patient has no fixed address, use the correct State/Territory code. Note that locality, postcode and state codes must all be recorded as No fixed address.

Unknown state

If the state of usual residence is unknown (e.g. an unconscious patient is unable to provide the information or no fixed address), use code 9 Not stated/unknown/no fixed address/at sea.

Baby for adoption

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

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

6.11.5 Statistical local area

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

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

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

6.12 Patient telephone numbers (Public hospitals)

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

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

Recording of telephone numbers (including mobile phone numbers) should capture the most appropriate contact details for a patient. This may result in the recording of a mobile phone number in a home, business and mobile telephone number form fields where appropriate.

The types of contact numbers that can be recorded are:

Home Number

- This is the patient's home telephone number.
- Home telephone numbers should:
    - be recorded as, prefix plus telephone number. For example, 0731822660
    - not include non-numeric characters or spaces. For example, Ext123 or #123.

- For overseas patients, the country access code should be included at the beginning of the number.

Business Number

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

Mobile Number

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

6.13 Medicare eligibility

This item records whether the patient is eligible to be treated as a Medicare eligible patient. The majority of non-admitted and admitted patients will fall into this category. Reference should be made to the https://www.humanservices.gov.au/individuals/subjects/how-enrol-and-get-started-medicare/enrolling-medicare [accessed 05 June 2026] for full current information:

In summary, anyone can enrol in Medicare if they live in Australia, and is either;

- an Australian citizen; or
- a New Zealand citizen living permanently in Australia**.**
  Note: people visiting from New Zealand are covered under Reciprocal Health Care Agreement; or
- an Australian permanent resident; or
- applying for permanent residency (criteria apply); or
- a temporary resident covered by a ministerial order.

Citizen's or permanent residents of any of the following islands may also enrol:

- Cocos (Keeling) Islands
- Christmas Island
- Lord Howe Island
- Norfolk Island

From 1 July 2016 Australian citizens on Norfolk Island and other nationals who become permanent residents following assessment by the Department of Immigration and Border protection are eligible for Medicare benefits and pharmaceutical benefits. This includes New

Zealand nationals who are permanent residents of Norfolk Island. For further information refer to;

- https://www.regional.gov.au/territories/norfolk_island/ [accessed 30 October 2026]

Patients presenting for treatment should provide evidence of Medicare eligibility. It is recommended a valid, current Medicare card be sighted along with photographic identification of the patient for verification.

Patients not born in Australia who do not produce a valid Medicare card are considered Medicare ineligible until evidence of eligibility is produced.

6.13.1 Newborns

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

6.13.2 Interim Medicare cards

'INTERIM' Medicare cards (blue) are issued with a 'valid to' date to persons, including visitors, who have been determined to be eligible, and eligible persons awaiting permanent residence status. There are no restrictions with the 'INTERIM' card. Persons holding these cards have the same entitlements/access to Medicare as Australian permanent residents.

6.13.3 Reciprocal Health Care Agreement (RHCA)

The Australian Government has signed RHCAs with the Governments of New Zealand, the United Kingdom, the Republic of Ireland, Sweden, the Netherlands, Finland, Italy, Belgium, Malta, Slovenia and Norway. These agreements entitle eligible visitors to Australia access to limited subsidised health services for medically necessary treatment. RHCAs are not designed to replace private travel health insurance for overseas travel. 'Medically Necessary Treatment' is treatment for ill health or injury that is required prior to a patient's departure from Australia.

For current details refer to:
https://www.humanservices.gov.au/individuals/services/medicare/reciprocal-health-care-agreements/when-you-visit-australia [accessed 30 October 2026]

RHCA agreements cover:

- Medically necessary care as a public patient in a public hospital including inpatient and outpatient services
- Some Pharmaceutical Benefits Scheme (PBS) prescription medicines at the general rate
- Medicare benefits for medically necessary out-of-hospital treatment (except for New Zealand and the Republic of Ireland)

Cover under a RHCA commences on the day of arrival in Australia, the end date depends on the agreement with the originating country:

- Cover ends the day they leave Australia
    - New Zealand visitors
- Cover ends on the date their visa expires for:
    - The Republic of Ireland
    - United Kingdom
- Cover ends when the first of the following expires, the European Health Insurance Card or their visa or their country's Health Insurance card
    - Belgium
    - Slovenia
    - Norway
    - The Netherlands
- Cover ends when the first of the following expires, their visa or their country's Health Insurance
    - Finland
    - Sweden
- Cover ends after 6 months, or when their Visa expires whichever comes first
    - Italy
    - Malta

RHCAs don't cover:

- Holders of the following visas
    - 405 investor retirement visa holders; or
    - 410 retirement visa that was applied for after 1/12/98
- Students from Finland, Malta, Norway or the Republic of Ireland
- The following:
    - care that is not clinically essential
    - medicines not on PBS
    - PBS medicines for IVF
    - Pre-planned or elective treatment
    - Private hospitalisation
    - Assisted Reproductive Technology
    - Ambulance travel
    - Care from an Allied Health Professional unless it's in the Chronic Disease Management Scheme
    - Glasses or contact lenses, hearing aids and other devices

- Prosthesis
    - For patients electing to be private
    - As outlined in the National Health Reform Agreement clause G1(d)
- Costs someone else is responsible for e.g. an insurer, employer or government agency
- Cosmetic surgery
- Home nursing
- Health checks for life insurance, superannuation joining a friendly society

6.13.4 Overseas Students

Overseas students on a visa from United Kingdom, Sweden, the Netherlands, Belgium, Slovenia, New Zealand or Italy are covered by Medicare through the reciprocal healthcare arrangements. The Australian Government requires all visitors on student visas (other than from the countries mentioned above) to be registered for Overseas Student Health Cover (OSHC) as a condition of entry.

6.13.5 Exceptions

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

- patients with Defence Force personnel entitlements
- compensable patients e.g. Workers' Compensation, Motor Vehicle Accident and other third party
- entitled veterans (Department of Veterans' Affairs)
- Nursing Home Type Patients
- Due to *Health Insurance Act 1973* Section 19 (2) people who are in custody are ineligible for Medicare for the duration of their incarceration. Please note that there are some exemptions to this legislation for a small number of s100 medicines.

For public hospitals, the payment class field in HBCIS is used to derive Medicare eligibility. Codes are as follows:

	HBCIS Source		Extracted/mapped by HQI as	
	Code	**Description**	**Code**	**Description**
HBCIS Hospitals	CS	Correctional Services	1	Eligible
	CU	Unsighted Medicare Card	1	Eligible
	DD	Department of Defence	1	Eligible
	DVA	Department of Veterans Affairs	1	Eligible
	MC	Medicare	1	Eligible
	MVO	Motor Vehicle Other	1	Eligible
	MVOI	Motor Vehicle Other Ineligible	2	Not Eligible
	MVQ	Motor Vehicle Queensland	1	Eligible
	MVQI	Motor Vehicle Queensland Ineligible	2	Not Eligible
	NE	Not Eligible	2	Not Eligible
	NIIQ	National Injury Insurance Queensland	1	Eligible
	NIIQI	National Injury Insurance Queensland Ineligible	2	Not Eligible
	NIIO	National Injury Insurance Other	1	Eligible
	NIIOI	National Injury Insurance Other Ineligible	2	Not Eligible
	RC	Reciprocal Country	1	Eligible
	TPE	Third Party Eligible	1	Eligible
	TPI	Third Party Ineligible	2	Not Eligible
	TST	Torres Strait Treaty	2	Not Eligible
	WCO	Workers Compensation Other	1	Eligible
	WCOI	Workers Compensation Other Ineligible	2	Not Eligible
	WCQ	Workers Compensation Queensland	1	Eligible
	WCQI	Workers Compensation Queensland Ineligible	2	Not Eligible

	Record the Medicare eligibility of the patient using one of the following codes:	
Other Hospitals	**Code**	**Description**
	1	Eligible for Medicare
	2	Not eligible for Medicare
	9	Not stated/unknown

Note: The Department of Defence (DD) has a responsibility for the medical wellbeing of their personnel. DD personnel requiring admission should have a 'Defence Approval Number (DAN) and an 'Entitled Personnel Identification Number (EPID). If this number is unavailable due to the treatment being through an Emergency Department, this should be noted on the

invoice. DD personnel are to be admitted as private patients, and the cost of their care is charged to the DD health solutions.

6.14 Medicare number

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

The 11 digit Medicare Number is comprised of:

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

All of these digits need to be recorded for a complete Medicare card number (if available). Card details can be provided digitally and should be accompanied with photo Identification.

If the Medicare number is not available the patient's Medicare eligibility is determined through the associated Medicare eligibility data element (1 = Eligible, 2 = Not eligible).

If the Medicare number is unavailable this field should be left blank, the number should be entered when available.

Note: public hospitals can report the mother's Medicare number for their baby in HBCIS using the birth registration module.

In HBCIS when the baby is registered via the birth registration screen, the mothers Medicare number and end date can be transferred to the baby's record with the Medicare ID/Exp number (field 40) changed to "0" on baby's registration.

All Hospitals	If the patient is eligible for Medicare, record the Medicare number from the patient's Medicare card, for example: 0 5 0 9 1 9 5 9 9 9 1 If the patient is eligible for Medicare, but has not yet registered with Medicare, the field can be left blank. If the patient is not eligible for Medicare or if eligibility for Medicare is not known, leave blank.

A patient's Medicare number should always be checked and updated appropriately.

6.15 Contact for feedback indicator (HBCIS hospitals)

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

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

This field was instituted in 2002 in response to the emerging Privacy Principles and related legislation. It is no longer required as Section 150(a) of the *Hospital and Health Boards Act 2011*[27] (the Act) makes provision for health services to obtain patient details from their patient record for evaluating, managing, monitoring or planning health services. In addition, section 150(b) of the Act allows these details to be provided to an independent organisation contracted to contact the patient and obtain this feedback (as long as the organisation is prescribed for this purpose in the *Hospital and Health Boards Regulation 2023*[28].

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

If this field is **non-mandatory** at your site:

Patients should not be requested to sign a 'Feedback Consent Form' and you should not ask them verbally for consent to obtain their personal details and to contact them for feedback on the services they receive.

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

If this field is **mandatory** at your site:

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

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

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

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[27] Hospital and Health Boards Act 2011. Available from < <https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2011-032> [accessed 30 October 2026]

[28] Hospital and Health Boards Regulation 2023. Available from < <https://www.legislation.qld.gov.au/view/whole/html/asmade/sl-2023-0100> [accessed 30 October 2026]

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

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

7. ADMISSION DETAILS

7.1 Admission date

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

Example

For a patient admitted on 3 July 2026 record:

0	3	0	7	2	0	2	6

7.2 Admission time

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

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

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

Example

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

0	**3**	**1**	**0**

Admission for patient admitted at 6:05 p.m.

1	**8**	**0**	**5**

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

Example 1:

If a patient arrives at the admission desk for an elective procedure, the admission time will be the time the patient's administrative details are collected.

Example 2:

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

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

7.3 Admission number

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

Other Hospitals	Either the admission number is automatically by the system or is recorded from the Admission Register. Use leading zeros as necessary.

7.4 Chargeable status

Upon admission to hospital a patient must elect to be either a public patient or a private patient.

A public patient is a patient who:

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

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

A private patient is a patient who:

- elects to be treated by a doctor of their choice.

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

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

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

	S in account class is Shared

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

Note: Residential mental health care facilities should refer to the (RMHCDC) Manual for guidelines on coding chargeable status.

Ineligible for Medicare

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

Queensland public hospitals are to provide Medicare ineligible patients with a choice to be treated as a public or private patient. Different fees apply depending on the option chosen. Refer to the *Queensland Health Fees and Charges Register*[29].

Compensable

A patient who is compensable (e.g. entitled to receive compensation for their hospital treatment) does not have access to hospital treatment 'free of charge'. However, they do have the right to elect to be treated either by a hospital nominated doctor ("public") or by a doctor of their choice ("private"). If a compensable patient has elected to be treated privately, they will be responsible for all charges if the compensation claim is rejected, or the insurer does not provide prior approval of the private status.

Compensable patients will have charges raised on their behalf with the appropriate insurer e.g. workers' compensation or be identified as accessing an appropriate grant e.g. the MAIC or NIISQ grant.

Department of Veterans' Affairs (DVA)

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

[29] Queensland Fees and Charges Register. Available from < https://www.health.qld.gov.au/directives/html/a#f> [accessed 30 October 2026]

access to private doctors, hence account class codes are available that recognise a veteran's choice of doctor.

Reciprocal Health Care Agreements (RHCA)

The Australian Government has signed RHCAs with the governments of the United Kingdom, Republic of Ireland, New Zealand, Sweden, the Netherlands, Belgium, Finland, Norway, Slovenia, Malta and Italy which entitles the patient to public hospital services 'free of charge' for 'essential' medical treatment while visiting Australia. A patient relying on a RHCA to cover the cost of their hospital stay must elect to be a public patient. Conditions such as the level and period of cover vary between the different Agreements. For more information see the Services Australia[30] website.

If a patient from a country with a RHCA with Australia, elects to be treated by a doctor of their choice i.e. a private patient, then they are ineligible for Medicare and do not have a right to access hospital care 'free of charge'. They will be coded as private ineligible patient and have charges raised regardless of whether the treatment was for 'essential' medical treatment or not.

Refugees

A refugee is a person whose asylum claim has been successful and who has received a refugee protection visa. Refugees are Medicare eligible and as such may choose to be treated as a public patient. If the person chooses to be treated as a private patient, they will be charged as a Medicare eligible patient for admitted and/or outpatient services.

For more details refer to:

- Services for refugees and asylum seekers[31] information sheet.

Asylum Seekers

On 29 July 2017 the Queensland Government announced Medicare ineligible Asylum seekers would be provided with access to public health services at no charge to the individual. Although no costs should be charged to the Medicare ineligible asylum seeker, costs may be recovered from a third party such as the Health Care Australia (HCA) or a Status Resolution Support Service (SRSS) provider depending on the Asylum seekers eligibility.

For full details refer to:

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[30] Services Australia. Available from < https://www.servicesaustralia.gov.au/individuals/services/medicare/reciprocal-health-care-agreements/when-you-visit-australia> [accessed 30 October 2026]

[31] Refugee and asylum seekers information sheet. Available from < https://www.health.qld.gov.au/public-health/groups/multicultural/refugee-services/refugee-and-asylum-seeker-services> [30 October 2026]

- Fees and charges for healthcare services | Health service directive [32]; and
- People seeking Asylum – Information for HHSs [accessed 30 October 2026] information sheet.

Detainees

Detainees are not eligible for Medicare although Health Care Australia (HCA) are contracted by the Department of Border Protection to facilitate and pay for a specific range of health services, not all health services are covered.

Torres Strait Treaty

Papua New Guinea (PNG) nationals are considered Medicare Ineligible. Under the 'Project Agreement on Healthcare and Disease Prevention in the Torres Strait Islands' the Commonwealth Government agrees to provide a funding contribution to Queensland Health for the provision of healthcare to patients designated in the Torres Strait Treaty. Therefore, those PNG nationals designated under the Treaty are funded and should not have any fees raised against them.

Papua New Guinea nationals not covered by the Treaty are to have fees raised for their healthcare as a Medicare ineligible patient.

For more details refer to:

- Revenue Information Sheet - Torres Strait Treaty / Papua New Guinea Patients [accessed 30 October 2026]
- https://www.dfat.gov.au/geo/torres-strait/Pages/the-torres-strait-treaty[33]

Newborns

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

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

Boarders

A boarder is not admitted but is generally registered by the hospital. If the boarder is accompanying a patient, then their chargeable status will be the same as that patient. However, for public hospitals the policy with respect to charging these patients is at the discretion of the Hospital and Health Service. If Hospital and Health Services decide to charge, then a fee can be charged for meals and reasonable accommodation costs. (It is

[32] Fees and Charges for Health Care Services Fees and Charges. Available from < Fees and charges for healthcare services | Health service directive | Queensland Health> [30 October 2026]

[33] The Torres Strait Treaty. Available from <https://www.dfat.gov.au/geo/torres-strait/Pages/the-torres-strait-treaty> [30 October 2026]

recommended that fees do not exceed the daily maintenance rates as detailed in the *Queensland Health Fees and Charges Register*[34]).

Hospital insurance status

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

For example:

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

7.5 Account class (HBCIS hospitals)

The account class identifies the billing classification of the patient, i.e. it determines the patient's daily bed charge.

The most common codes used are as follows:

	Code	Description
HBCIS Hospitals	GPE	General Public Eligible
	GRE	General Private (Single-Room) Eligible
	GSE	General Shared Eligible

A list of account class codes appears in Appendix I.

Residential mental health care facilities should refer to the RMHCDC Manual for guidelines and a list of valid mental health account class codes.

The account class changes forwarded to the DSB are to reflect the last account class for that day. The account class is used to derive the compensable status, same day band and chargeable status of the patient. For further information refer to Section 7.8 Compensable status, Section 7.6 Same day banded procedures, Section 7.4 Chargeable status and Section 4.4 Boarders.

Newborns

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

[34] Queensland Health Fees and Charges Register. Available from <https://www.health.qld.gov.au/directives/html/a#f > [accessed 30 October 2026]

Same day banded patient

Same day banded patients cannot have an account class change. If a patient is admitted as a same day banded patient but remains in hospital overnight or longer (no longer a same day banded patient), then the admission account class must be updated. This can be done by recording an account class variation and selecting a 'Y' (yes) to the prompt to update the admission account class or by deleting and re-entering the admission with the appropriate account class applicable. Generally, only staff in the Accounts/Patient Billing area can carry out account variations.

Ineligible persons

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

Prisoners

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

7.6 Same day banded procedures (Private patient same-day accommodation procedure cases)

All day only surgical and non-operative procedures can be allocated a number as per the Commonwealth Medicare Benefits Schedule (MBS). These are called MBS numbers. Based on MBS numbers and other factors, procedures can be categorised into one of four different bands. For private patients, both in public and private hospitals, the bands are used as a basis to determine the level of charges. Bands are also used to determine whether patients are admitted as day only patients, or otherwise.

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

Do not allocate a band if the procedure was performed as a day only episode within a longer hospital stay. Band is for stand-alone same day only hospital stays.

HBCIS Hospitals	This data item is not entered separately as it is derived from the item account class (B1A; B1B; B2; B3; B4) and translated to 1A, 1B, 02, 03 and 04. If a patient changes from day only to overnight or longer, the

	admission account class must be altered, rather than recording an account class variation. Usually, only accounts staff can do this.

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

Definitions and information on each band can be found in the current version of the *Private Health Insurance (Benefit Requirements) Rules 2011*:[accessed 30 October 2026]

Code 1A – Band 1A

Band 1A is a definitive list of procedures including gastrointestinal endoscopy, certain minor surgical item and non-surgical procedures that do not normally require anaesthetic.

Code 1B – Band 1B

Band 1B relates to professional attention that embraces all other day only admission to hospital not related to bands 2, 3 or 4. Bands 2, 3 and 4 are determined by the anaesthetic type and theatre time.

Code 2 – Band 2

Band 2 means procedures (other than band 1) carried out under local anaesthetic with no sedation.

Code 3 – Band 3

Band 3 means procedures (other than band 1) carried out under general or regional anaesthesia or intravenous sedation with a theatre time (actual time in theatre) of less than one hour.

Code 4 – Band 4

Band 4 means procedures (other than band 1) carried out under general or regional anaesthesia or intravenous sedation with a theatre time (actual time in theatre) of one hour or more.

7.7 Qualification status

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

Record the qualification status on admission. If the qualification status of the newborn changes after admission, then, the change in qualification status is recorded.

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

7.8 Compensable status

This item records that a patient has an entitlement to claim compensation for their hospitalisation, usually as a result of the patient being in an accident. **Note**: that although this status is recorded at the time of admission, there are times when the compensation claim fails, and the patient reverts to not compensable.

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

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

	Code	Description
Other Hospitals	1	Workers' Compensation Queensland)
	2	Workers' Compensation (Other)
	3	Compensable Third Party
	4	Other Compensable
	5	Department of Veterans' Affairs
	6	Motor Vehicle (Queensland)
	7	Motor Vehicle (Other)
	8	None of the above
	9	Department of Defence

Code 1 - Workers' Compensation Queensland

A patient is entitled to claim compensation under the *Queensland Workers Compensation and Rehabilitation Act 2003*. This includes worker injury claims managed by WorkCover Queensland and those Queensland firms who are self-insured.

Code 2 - Workers' Compensation (Other)

A patient entitled to claim damages under a Workers' Compensation Act other than Queensland's (e.g. an employee of the Commonwealth, an interstate company or national organisation insured under the workers' compensation act of another State or Territory.

Code 3 - Compensable Third Party

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

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

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

Victims of criminal acts are not considered compensable, therefore do not fall into this category.

Code 4 - Other compensable

This is used for other compensable patients.

Code 5 - Department of Veterans' Affairs

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

Code 6 - Motor Vehicle (Queensland)

This is used where the patient admitted to hospital from a motor vehicle accident can establish negligence against an owner or driver of a Queensland registered motor vehicle. Where the person has suffered a serious injury, they may be covered under the National Injury Insurance Scheme (Queensland) and do not have to establish negligence against an owner or driver of a Queensland registered motor vehicle.

Code 7 - Motor Vehicle (Other)

This is used where the patients admitted to hospital from a motor vehicle accident can establish negligence against an owner or driver of a motor vehicle registered in a state or territory other than Queensland or where the patient is a driver-at-fault covered under a motor vehicle policy for drivers at fault. Where the person has suffered a serious injury, they may be covered under the National Injury Insurance Scheme of the State where the accident occurred, they do not have to establish negligence against the driver at fault.

Code 9 - Department of Defence

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

Code 8 - None of the above

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

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

7.9 Boarder status

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

Registering boarders from a reciprocal country:

CARE TYPE	08	BOARDER
SOURCE OF REFERRAL	21	BOARDER
MODE OF SEPARATION	14	BOARDER
ELECTIVE STATUS	3	NOT ASSIGNED
FUNDING SOURCE	12	OTHER
PAYMENT CLASS	RC	(HBCIS ONLY)
ACCOUNT CLASS	GPB	(HBCIS ONLY)

7.10 Incident date (HBCIS hospitals)

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

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

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

Incident date (regardless of the compensable status of the patient at the time of their admission), should be recorded when the injury or illness for which the patient is being treated appears to have been the result of either:

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

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

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

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

- If the day of the incident is unknown, use ** for the first two values.
- If the month of the incident is unknown, use ** for the third and fourth values.

Example

For 5 July 2026, record:

0	5	0	7	2	0	2	6

- If the year of the incident is unknown, an estimate must be provided.

Example

If a patient does not know the exact incident date, but knows that it was sometime in 2026 record the incident date as:

*	*	*	*	2	0	2	6

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

7.11 Incident date flag (HBCIS hospitals)

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

7.12 Source of referral/transfer (admission source)

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

	HBCIS Admission Source		Extracted/mapped by HQI	
	Code	**Description**	**Code**	**Description**
HBCIS Hospitals	01	Pvt medical pract (not psych)	01	Pvt Med. Pract. Not Psych'rist
	02	Emergency department	02	Emergency department
	03	Outpatient department	03	Outpatient department
	06	Episode change	06	Episode change
	08	Outborn	02	Emergency department
	09	Born in hospital	09	Born in hospital
	10	Retrieval from another hosp	24	Admitted Pt Trans Fr Other Hos
	14	Other health care establish.	14	Oth health care establishment
	15	Private psychiatrist	15	Private psychiatrist
	16	Correctional facility	16	Correctional facility
	17	Law enforcement agency	17	Law enforce. Agency. Police/CT
	18	Community service	18	Community service
	19	Retrieval not from other hosp	02	Emergency department –
			20	Organ Procurement (Not available on HBCIS at this stage)
	21	Boarder	21	Boarder
	22	Routine readm no referral req	19	Routine readm not req referral
	23	Res. aged care service	23	Residential aged care service
	24	Admt pt trans from other hos	24	Admitted pt trans fr another hos
	25	Non-admtd pt ref from other hos	25	Non-adm pt ref fr another hosp
	29	Other – valid from 1.8.94	29	Other
	30	Planned Emergency	30	Planned Emergency
	31	Residential mental health care facility	31	Resid Mental Hlth Care Fac
	32	Change of reference period (RMHCDC only)	32	Change of reference period (RMHCDC only)
	33	Rapid Access – this hospital	33	Rapid Access – this hospital
	34	Rapid Access – other Queensland Health facility or service	34	Rapid Access – other Queensland Health facility or service

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

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

The following rules are to be used in the allocation of appropriate source of referral/transfer (admission source) codes. For Residential Mental Health Care Facilities, please refer to the RMHCDC manual for guidelines on coding source of referral.

Code 01 – Private medical practitioner (excluding psychiatrist)

Used for patients referred to the hospital admission office by a private doctor other than a psychiatrist. Such patients will generally be private shared or private single patients whose admission will have been arranged by their treating doctor or dentist.

Example: A patient attends a specialist (other than a psychiatrist) in the specialist's rooms. The specialist has admitting rights at the hospital. The patient is booked for admission and is admitted. The source of referral is 01 Private medical practitioner (not psychiatrist).

Code 02 – Emergency department – this hospital

Used for patients who present to the Emergency or Casualty Department of the hospital and are subsequently admitted to the same facility immediately following their emergency consultation. They will generally not be booked patients. For example, use this code for patients who are transported by the Royal Flying Doctor Service for an unplanned (not booked) admission or for babies (qualified and unqualified) born on the way to hospital.

The following codes available on HBCIS are mapped to 02 Emergency department – this hospital;

- 08 Out born - For babies (qualified and unqualified) who were born on the way to hospital and have not been admitted at any other hospital
- 19 Retrieval not from other hospital - Used when a patient has been brought to the hospital from any place other than another hospital by a retrieval team.

Example 1: A patient is seen in the rooms of their local medical officer (general practitioner). The patient is sent to your hospital's outpatient department or emergency department for review by hospital staff and is admitted. The source of referral is 03 Outpatient - this hospital or 02 Emergency department - this hospital.

Example 2: A patient comes from their place of permanent residence in an aged care service to the outpatient department or emergency department for review by hospital staff and is admitted. The source of referral is 03 Outpatient Department - this hospital; or 02 Emergency department - this hospital.

Code 03 – Outpatient department – this hospital

Used for patients who have attended an outpatient clinic at the hospital and are subsequently referred for admitted patient treatment. They will generally be booked patients. Patients who are transported by the Royal Flying Doctor Service to attend outpatients, and are then booked for admission, use this code. For unplanned (not booked) admissions refer to code 02 Emergency department - this hospital.

Example 1: A patient is seen in the rooms of their local medical officer (general practitioner). The patient is sent to your hospital's outpatient department or emergency department for review by hospital staff and is admitted. The source of referral is 03 Outpatient - this hospital or 02 Emergency department - this hospital.

Example 2: A patient comes from their place of permanent residence in an aged care service to the outpatient department or emergency department for review by hospital staff and is admitted. The source of referral is 03 Outpatient Department - this hospital; or 02 Emergency department - this hospital.

Code 06 – Episode change

Used for statistical admissions where the patient has previously been admitted to an episode care type during this hospital stay and is now changing their care type (e.g. acute to maintenance). Do not use this code for a registered boarder or a residential mental health consumer changing status to become an admitted patient. For public hospitals using I&D Sheets to 'batch' information to a central hospital for data entry into HBCIS, and for private hospitals using I&D Sheets, a new I&D Sheet will need to be completed for the patient with a source of referral/transfer code of 06 – Episode Change and the new care type.

Care is to be taken by facilities to ensure the admission time of the statistical admission allows for contiguous episode creation. For example, a patient who is statistically admitted on 1 March 2026 at 10:01am should have been statistically separated on 1 March 2026 at 10:00am.

Code 09 – Born in hospital

Used for babies born at this hospital during this episode only.

Code 14 – Other health care establishment

Used for patients who are admitted from, alcohol and drug centres, or other health care establishments.

Code 15 – Private psychiatrist

Patients referred to the hospital admission office by a psychiatrist.

Code 16 – Correctional facility

Used for patients who, have been referred to the hospital from a correctional facility.

Note: The facility code of the correctional facility must be recorded in the transferring from facility (extended source code) field. Refer to Section 7.13 Transferring from facility (extended source code).

Code 17 – Law enforcement agency

Used for patients who, have been referred to the hospital from a law enforcement agency (other than a correctional facility) such as the police or courts.

Code 18 – Community service

Used for patients who, have been referred to the hospital by a community health service.

Code 19 – Routine readmission

Used for patients who are not admitted through outpatients or the emergency department for planned treatment (e.g. renal dialysis patients, chemotherapy patients directly presenting to the ward for planned treatment).

Code 20 – Organ Procurement

Used to register donors (who have been declared brain dead) for the purpose of procurement of human tissue. This code is not available on HBCIS.

Code 21 – Boarder

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

Code 23 – Residential Aged Care Service

Used for patients who, are transferred to this hospital for further care and treatment, from a residential aged care service where they are usually a resident. A residential aged care service includes former public and private nursing homes and hostels, but not independent living units. Refer to 14 Other health care establishment.

Note: The facility code of the Residential Aged Care Service must be recorded in the transferring from facility (extended source code) field. Refer to Section 7.13 Transferring from facility (extended source code).

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

Code 24 – Admitted patient transferred from another hospital

Used for all patients who are transferred from another hospital (including psychiatric hospitals), for continuation of their admitted patient care or treatment at this hospital. This code may also be used for patients who are transferred from hospitals interstate or overseas.

Note: The following code available on HBCIS is mapped to 24 Admitted patient transferred from another hospital;

- 10 Retrieval from another hospital - Used when a patient has been brought to the hospital from another hospital by a retrieval team. For further information on retrievals, contact Retrieval Services Queensland[35].

Note: The facility code of the other hospital must be recorded in the transferring from facility (extended source code) field. Refer to Section 7.13 Transferring from facility (extended source code).

Code 25 – Non-admitted patient referred from another hospital

Used for all patients who are referred from another hospital (including psychiatric hospitals), for continuation of their care or treatment at this hospital.

Note: The facility code of the other hospital must be recorded in the transferring from facility (extended source code) field. Refer to Section 7.13 Transferring from facility (extended source code).

Code 29 – Other

Used for patients who are admitted under circumstances that does not fit any other category. For example, a person who is currently a boarder at a hospital, becoming ill and is subsequently admitted. It is expected that this code will rarely be used.

Code 30 – Planned Emergency (for Public Hospitals only)

Used for all patients requiring Category E emergency surgery.

[35] Retrieval Services Queensland. Available from <https://qheps.health.qld.gov.au/rsq> [accessed 30 October 2026]

Example: A patient attends the hospital's emergency department or outpatient department and is assessed as requiring emergency surgery within 10 days. The patient is triaged as Category E (defined as: non-critical – patient is sent home to return for scheduled emergency surgery within 10 days of the decision for surgery being made). The patient is discharged to home to wait for surgery. When the patient presents for admission for the planned Category E surgery, the source of referral/transfer is code 30 Planned emergency.

Code 31 – Residential Mental Health Care Facility

Used for patients transferring from a residential mental health care facility providing treatment in a community-based setting, including Community Care Units, Step Up Step Down Units and Youth Residential Rehabilitation Units.

Note: The facility code of the residential mental health care facility must be recorded in the Transferring from facility (extended source code) field. Refer to Section 7.13 Transferring from facility (extended source code).

Code 32 – Change of reference period

Used for consumers in residential mental health care facilities only. Refer to the RMHCDC Manual for further details.

Code 33 – Rapid Access – this hospital

Used for patients who have attended Rapid Access service or clinic at this hospital and are subsequently referred for admitted patient treatment at this hospital.

Code 34 – Rapid Access – other Queensland Health facility or service

Used for all patients who have attended and are referred from a Rapid Access service or clinic from another Queensland Health facility or service for continuation of their care or treatment at this hospital.

Note: The facility code of the Queensland Health facility or service must be recorded in the Transferring from facility (extended source code) field. Refer to Section 7.13 Transferring from facility (extended source code).

7.13 Transferring from facility (extended source code)

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

- 16 Correctional facility
- 23 Residential Aged Care Service
- 24 Admitted patient transferred from another hospital

- 25 Non-admitted patient referred from another hospital
- 31 Residential mental health care facility
- 34 Rapid Access – other Queensland Health facility or service

All Hospitals	Record the facility number/extended source code of the hospital, residential aged care service, residential mental health care facility or correctional facility that transferred or referred the patient to this hospital for admission.

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

7.14 Mother's patient identifier

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

7.15 Care type

The term Care Type refers to the nature of the treatment/care provided to a patient during an episode of care. Only one type of care can be assigned at a time. In cases when a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned.

Episode of care

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

Each episode is reported to the DSB on its completion. Episode of care changes can be identified through the use of code 06 Episode change, in the Source of referral/transfer (admission source) and/or Mode of separation (discharge status) data items.

Note that a person allocated to an 07 Organ procurement-posthumous care type, 08 Boarder or 44 Aged care resident (HBCIS only) care type can NOT have 06 Episode change as the Source of referral/transfer (admission source) or Mode of separation (discharge status) data items.

In order for the DSB to undertake analyses of patient hospital stays, it is necessary to link episodes of care. This can be done by firstly identifying the patient's formal separation from hospital (i.e. mode of separation (discharge status) is not code 06 Episode change). If the source of referral/transfer (admission source) is also not code 06 Episode change, then the patient had only one episode for the hospital stay. The majority of patients do not have a

mode of separation (discharge status) of 06 Episode change. If, however the source of referral/transfer (admission source) is code 06 Episode change, then the patient's previous separation is found (where the date of the new admission equals the date of the previous separation).

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

Care type changes

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

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

It is highly unlikely that, for care type changes involving subacute or mental health care types, more than one change in care type will take place within a 24-hour period. Changes involving subacute or mental health care types are unlikely to occur on the date of formal separation.

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

Other Hospitals	Record the type of episode using one of the following numerical codes	
	Code	**Description**
	01	Acute care
	05	Newborn care
	06	Other admitted patient care
	07	Organ procurement-posthumous
	08	Hospital Boarder
	09	Geriatric Evaluation and Management
	10	Psychogeriatric care
	11	Maintenance care
	12	Mental Health care
	20	Rehabilitation care
	30	Palliative care

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

Care Type 01 - Acute care

Acute care is care in which the principal clinical purpose or treatment goal is to:

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

Acute care excludes care which meets the definition of mental health care.

Care Type 05 – Newborn care

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

- Newborns who turn 10 days of age and do not require clinical care are separated. If they remain in the hospital, they are designated as boarders.
- Newborns who turn 10 days of age and require clinical care continue in a newborn episode of care until separated.
- Newborns aged less than 10 days and not admitted at birth (e.g. transferred from another hospital) are admitted with a newborn care type.
- Newborns aged greater than 9 days, not previously admitted (e.g. transferred from another hospital) have a care type of either 08 Boarder or 01 Acute.

- Within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day.
- A newborn is qualified when it meets at least one of the criteria detailed in the newborn qualification status.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as acute (qualified) patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.

See Section 4.12 Newborns for further information on newborns.

Care Type 06 - Other admitted patient care

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

Care Type 07 - Organ procurement-posthumous

Organ procurement-posthumous is the procurement of human tissue for the purpose of transplantation from a donor whose brain function or circulation of blood has permanently stopped. See Section 4.15.2 Posthumous organ procurement.

Any diagnoses and procedures related to this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

Care Type 08 – Hospital Boarder

A boarder is a person who is receiving food and/or accommodation in a hospital, but for whom the hospital does not accept responsibility for treatment and/or care.

Boarders are not admitted to the hospital; however, a hospital may register a boarder. Boarders are ‘admitted’ in HBCIS using specific boarder codes. Babies in hospital at age 9 days or less cannot be boarders; they are admitted patients with each day of stay deemed to be either qualified or unqualified.

Care Type 09 – Geriatric Evaluation and Management (GEM)

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

Geriatric evaluation and management is:

- delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management; and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological,

emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

GEM excludes care which meets the definition of mental health care.

Care Type 10 – Psychogeriatric care

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

Psychogeriatric care is:

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

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

Psychogeriatric care excludes care which meets the definition of mental health care.

Care Type 11 – Maintenance care

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

Maintenance care excludes care which meets the definition of mental health care.

Care Type 12 – Mental health care

Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient’s mental disorder. Mental health care:

- is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health;
- is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and
- may include significant psychosocial components, including family and carer support.

Care Type 20 - Rehabilitation care

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or

participation restriction due to a health condition. The patient will be capable of actively participating:

Rehabilitation care is:

- delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.

Rehabilitation care excludes care which meets the definition of mental health care.

Care Type 30 – Palliative care

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

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

Palliative care excludes care which meets the definition of mental health care.

Sub and non-acute care is a collective term for the following care types that have been described above:

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

7.16 Elective patient status

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

Admissions for which an elective status is 3 Not assigned, are:

- admissions for normal delivery (obstetric)
- admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient

- statistical admissions (that is, where there is an episode change during this hospital stay)
- planned readmissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

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

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

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

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

7.17 QAS patient identification number (eARF)

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

It should be noted that the number is only unique to a patient event NOT a person. That is, a person receives a new eARF number each time they are attended to/ transported by QAS. If

more than one QAS team attend a patient, all clinical details are transferred to the tablet of the team who transports the patient, so each patient is allocated only one eARF number per patient event.

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

Record the QAS Patient Identification Number if the patient was transported to the hospital by the QAS team and the patient is subsequently admitted. A maximum of 12 numeric characters is allowed.

7.18 Planned same day

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

<table>
<tr><td rowspan="5">All Hospitals</td><td colspan="2">Record, in the specified field, the planned duration of the patient's stay using one of the following codes</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>N</td><td>No, planned to stay at least one night</td></tr>
<tr><td>Y</td><td>Yes, planned to be separated from the hospital on the same day</td></tr>
<tr><td colspan="2">This item documents the intent. If the patient has been recorded as "N" and dies or is discharged unexpectedly on the day they are admitted, the code remains the same.
This information will generally be obtained from a booking form or other details available from the treating doctor</td></tr>
</table>

Residential mental health care facilities should refer to the RMHCDC manual for guidelines on the Planned same day item.

7.19 Treating doctor at admission (Public hospitals)

For all separations from 1 July 2015, it will be mandatory for all public hospitals to provide the code to identify the doctor (up to 6 characters) who is chiefly responsible for treating the patient on admission.

7.20Treating doctor at separation (Public hospitals)

For all separations from 1 July 2015 it will be mandatory for all public hospitals to provide the code to identify the doctor (up to 6 characters) who is chiefly responsible for treating the patient on separation.

7.21 Admission unit

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

7.22 Standard unit code

Record the standard unit code from the list prepared by the DSB (Appendix J) to describe the unit to which the patient was admitted or transferred to. For HBCIS hospitals, the standard unit codes are generally mapped from the treating doctor units. HBCIS hospitals are to note that where the standard unit code may change between units, the treating clinician may not. HBCIS hospital are advised to update the treating clinician as part of the transfer requirements in HBCIS. For other hospitals, this is generally mapped from the treating doctor on the basis of their specialisation.

7.23 Admission ward

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

A maximum of six characters is allowed.

7.24 Standard ward code

Public facilities are required to record the standard ward codes from the below pre-defined list. The majority of standard ward codes have been developed to align with the existing Clinical Services Capability Framework (CSCF) and public hospitals should refer to their completed CSCF self-assessment documentation when assigning these standard ward codes.

Standard ward codes are assigned and maintained at the ward level. For HBCIS hospitals, the standard ward code can be maintained using the HBCIS Ward/Bed Categories Screen and associated standard ward code reference files.

A standard ward code of STKU can be assigned to assist in identifying certain defined patients admitted or transferred to wards or beds that have been assessed and approved by the Statewide Stroke Clinical Network as designated stroke units. The Statewide Stroke Clinical Network has agreed to take responsibility for assessing units that wish to utilise this code in order to ensure compliance with the stroke unit definition.

Reporting of standard ward codes were initially required to identify patients admitted or transferred to a ward assigned to a designated SNAP unit in public facilities and designated rehabilitation and palliative units in private facilities. From 1 July 2012, public facilities commenced recording additional standard ward code information.

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

HBCIS		
Code	**Description**	**Explanation**
CCU4	Coronary Care Unit – Level 4	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously Coronary Care Unit (CCU) Level 1 in the CSCF version 2.
CCU5	Coronary Care Unit – Level 5	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously CCU Level 2 in the CSCF version 2.
CCU6	Coronary Care Unit – Level 6	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously CCU Level 3 in the CSCF version 2.
CHEM	Chemotherapy	Used for reporting of a discrete area assigned for chemotherapy treatment.
CIC4	Children's Intensive Care Service – Level 4	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2
CIC5	Children's Intensive Care Service – Level 5	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2
CIC6	Children's Intensive Care Service – Level 6	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously Paediatric Intensive Care Unit (PICU) in the CSCF version 2.
DIAL	Renal Dialysis	Used for reporting of a discrete area assigned for renal dialysis treatment.

EDST	Emergency Department Short Term Treatment Area	An Emergency Department Short Term Treatment Area is: • A unit designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the emergency department (ED); • where ongoing assessment and treatment is provided, but need for inpatient admission is unlikely • with specific admission and discharge criteria and policies • designed for short term stays no longer than 48 hours or shorter where specified by local policy • physically separated from the ED acute assessment area • have a static number of beds with oxygen, suction, patient ablution facilities; and not a temporary ED overflow area nor used to keep patients solely awaiting an inpatient bed nor awaiting treatment in the ED.
EMER	Emergency	Emergency Department (excluding Observation Ward)
HOME	Hospital in the Home	Credentialed services funded and/or provided to admit patients in their home environment.
ICU4	Intensive Care Unit – Level 4	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously Intensive Care Unit (ICU) Level 1 in the CSCF version 2.
ICU5	Intensive Care Unit – Level 5	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously ICU Level 2 in the CSCF version 2.
ICU6	Intensive Care Unit – Level 6	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously ICU Level 3 in the CSCF version 2.
MATY	Maternity	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2.
MENA	Specialised Mental Health Acute Psychiatric	A ward that has been assigned to a Specialised Mental Health Psychiatric Unit for the provision of acute psychiatric care.
MENC	Specialised Mental Health Acute Crisis Care	A ward that has been assigned to a Specialised Mental Health Psychiatric Unit for the provision of acute crisis care.
MENN	Specialised Mental Health Non-Acute Psychiatric	A ward that has been assigned to a Specialised Mental Health Psychiatric Unit for the provision of non-acute psychiatric care.
MENR	Residential Mental Health Care	A ward that has been assigned to a Residential Mental Health Care Unit facility, including but not limited to Community Care Units.

MIXC	Mixed Wards – Critical Care	Hospitals that have wards with mixed critical care specialisation/s should use a standard ward code of MIXC. This will highlight that the ward has a Critical Service capability of a mixed nature.
MIXG	Mixed Wards – Non-Critical Care Service Types	Hospitals that have wards with mixed specialisation/s of a non-critical care nature should use a standard ward code of MIXG. Examples: maternity/gynaecology ward, chemotherapy/surgical, medical/general acute. General Wards that do not have any specialisation should be assigned to a 'NORM' Standard Ward Code (see below).
NORM	General Wards	General Wards that do not have any specialisation.
NSV4	Neonatal Service – Level 4	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously Neonatal Service Level 2 (SCN) in the CSCF version 2.
NSV5	Neonatal Service – Level 5	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously Neonatal Service Level 2 (SCN) in the CSCF version 2.
NSV6	Neonatal Service – Level 6	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2. This service capability level was previously Neonatal Service Level 3 (NICU) in the CSCF version 2.
PAED	Paediatric	Refer to the Queensland Health Clinical Services Capability Framework (CSCF) version 3.2.
SDU5	Specialised Dementia Unit Level 5 and above	SDU5 Specialised Dementia Unit Level 5 and above A designated secure unit assessed and approved by QDAF Clinical Network against PROVIDE Model of Care criteria, and at Level 5 and above as per Queensland Health Clinical Services Capability Framework (CSCF) version 3.2, Geriatric Services Note: updated code to be included in October 2026 HBCIS release.
SNAP	Sub and Non-Acute Patient	A ward that has been assigned to a designated SNAP Unit.
STKU	Stroke Unit	A designated Stroke Unit which has been assessed and approved by the Statewide Stroke Clinical Network.
TRNL	Transit Lounge	A dedicated area used as an interim waiting area for admitted patients waiting discharge, bed allocation on admission, or an outpatient appointment. The transit lounge is suitable for patients awaiting transport home or to another facility, waiting for discharge medications and/or letters, awaiting minor procedures before discharge, awaiting final dose of IV antibiotics and post removal of epidural catheter (4 hour observation period)

VCAR	Virtual Care	Services provided to admitted patients in their home environment under a virtual care model. Virtual care is real-time virtual exchange of images and information to provide care. Virtual care is for patient's requiring hospital-level admitted patient treatment that can be provided via a virtual modality.

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

Other Hospitals		
Code	**Description**	**Explanation**
SNAP	Sub and Non-Acute Patient	A ward that has been assigned to a designated SNAP Unit.

7.25 Contract role

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

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

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

	Record the following codes to indicate your hospital's role;	
All Hospitals	**Code**	**Description**
	A	Hospital A (contracting hospital)
	B	Hospital B (contracted hospital)

7.26 Contract type

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

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

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

All Hospitals	Record the following codes to indicate the contract type under which the patient is being treated	
	Code	**Description**
	1	B
	2	ABA
	3	AB
	4	(A)B
	5	BA

7.27 Purchaser/provider identifier

Type 1 contracts

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

Type 2, 3, 4 or 5 contracts

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

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

7.28 Baby admission weight

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

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

Please note, if hospitals enter a 'default' weight of 9000, a validation message will be generated in EVA for (H148 - Baby admission weight is XXXX grams and age is less than or equal to 28 days. This is much heavier than most babies under 1 month. Please check birth date and admission weight). The hospital then has the opportunity to provide a valid reason as to why the baby was not weighed.

7.29 Separation date

Example

For a patient who was discharged on 24 July 2026, record:

2	4	0	7	2	0	2	6

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

For deceased patients, the separation date should be recorded as the date the patient died, not when the patient left the clinical area or hospital.

7.30 Separation time

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

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

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

Example

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

0	9	1	0

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

1	8	0	5

For deceased patients, the separation time should be recorded as the time the patient died, not when the patient left the clinical area or hospital.

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

7.31 Mode of separation (discharge status)

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

	HBCIS		Extracted/mapped by HQI as:	
	Code	**Description**	**Code**	**Description**
HBCIS Hospitals	01	Home/usual residence	01	Home/usual residence
	04	Oth. Health care establishment	04	Oth health care establishment
	05	Died in hospital	05	Died in hospital
	06	Episode change	06	Episode change
	07	Discharged at own risk	07	Discharged at own risk
	09	Non-return from leave	09	Non-return from leave
	12	Correctional facility	12	Correctional facility
			13	Organ Procurement (Not available on HBCIS at this stage)
	14	Boarder	14	Boarder
	16	Hospital Transfer	16	Transferred to another hosp
	17	MediHotel	17	Medi-Hotel
	19	Other – Valid from 1.8.94	19	Other
	21	Residential aged care service, which is not the usual place of residence	21	Residential aged care service, which is not the usual place of residence
	22	Residential aged care service, which is the usual place of residence	22	Residential aged care service, which is the usual place of residence
	31	Residential Mental Health Care Facility	31	Resid Mental Hlth Care Fac
	32	Change of reference period (RMHCDC only)	32	Change of reference period (RMHCDC only)

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

Code	Description
01	Home/usual residence
04	Other health care establishment
05	Died in hospital
06	Episode change
07	Discharged at own risk
09	Non return from leave
12	Correctional facility
13	Organ Procurement
14	Boarder
16	Transferred to another hospital
17	Medi-Hotel
19	Other
21	Residential aged care service, which is not the usual place of residence
22	Residential aged care service, which is the usual place of residence
31	Residential mental health care facility
32	Change of reference period (RMHCDC only)

Use the guidelines listed below to determine the correct mode of separation. For Residential Mental Health Care Facilities, please refer to the RMHCDC manual for additional guidelines on coding mode of separation.

Code 01 – Home/usual residence

Used for those patients who return to their usual residence following their current hospital stay. If the patient is usually a resident of a boarding house, commercial hostel, independent living unit or other institution, use this category.

- If the patient's usual residence is an aged care service, do not use this category; use 22 – Residential aged care service, which is the usual place of residence.
- If the patient is being transferred from the hospital to a residential aged care service for the first time, do not use this category; use 21 Residential aged care service, which is not the usual place of residence.
- If the patient is usually a resident of a residential mental health care service, do not use this category; use 31 Residential mental health care facility.

Code 04 – Other health care establishment

Used for patients who, are transferred to alcohol and drug centres or other health care establishments.

Code 05 – Died in hospital

Used when the patient died during their hospitalisation.

Code 06 – Episode change

Used for statistical separations where the patient is to continue the hospital stay but is now changing the type of episode of care (e.g. Acute to Maintenance). Do not use this code for registered boarders or residential mental health care consumers changing status to become an admitted patient. For hospitals using I&D sheets, a new I&D Sheet will need to be completed for the patient with a source of referral/transfer code of 06 Episode Change and the new care type.

Care is to be taken by facilities to ensure the separation time of the statistical separation allows for contiguous episode creation. For example, a patient who is statistically separated on 1 March 2021 at 10:00am, should be then statistically admitted on 1 March 2021 at 10:01am.

Code 07 – Discharged at own risk

Used for patients who abscond or leave hospital against medical advice. Note that this must be documented in the patient's medical record in order to be reported. If the patient was on leave at the time the patient is to be discharged from the date they left the hospital and the current leave entry must be deleted and not reported to the QHAPDC.

Code 09 – Non return from leave

Used when a patient goes on leave and does not return to the hospital. Note that the patient is to be discharged from the date that they left the hospital and the current leave entry must be deleted and not reported to the QHAPDC.

Code 12 – Correctional facility

Used when a patient is separated to a correctional facility.

Note: The facility code of the correctional facility must be recorded in the transferring to facility code. Refer to Section 7.32 Transferring to facility.

Code 13 – Organ Procurement

Used for denoting the cessation of an organ procurement registration. This code is not available on HBCIS.

Code 14 – Boarder

Used for denoting the completion of a boarder registration.

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

Code 16 – Transferred to another hospital

Used for patients who, are transferred to another hospital for continuation of their admitted care and management. The second hospital undertakes full responsibility for the patient. Note that this code may be used for patients transferred to hospitals which are interstate or overseas.

Note: The facility code of the other hospital must be recorded in the transferring to facility field. Refer to Section 7.32 Transferring to facility.

Code 17 – Medi-hotel

Accommodation arranged and paid for by the facility that is used for accommodating patients post discharge where the patient is, awaiting transport, receiving on-going treatment/investigation as a non-admitted patient (includes minimal (low) care nursing) or receiving a course of treatment (such as chemotherapy) and requires accommodation close to the hospital between treatments.

Code 19 – Other

Used for patients who, are separated under circumstances that do not fit any other category. It is expected this code will be rarely used.

Code 21 – Residential aged care service, which is not the usual place of residence

Used for patients who are discharged to a residential aged care service which is not their usual place of residence.

Note: The facility code of the residential aged care service must be recorded in the transferring to facility field. Refer to Section 7.32 Transferring to facility.

Code 22 – Residential aged care service, which is the usual place of residence

Used for patients who are discharged to a residential aged care service which is their usual place of residence.

Code 31 – Residential mental health care facility

Used for patients transferred to a residential mental health care facility providing treatment in a community-based setting, including Community Care Units, Step Up Step Down Units and Youth Residential Rehabilitation Units.

Note: The facility code of the residential mental health care facility must be recorded in the Transferring to facility (extended source code) field. Refer to Section 7.32 Transferring to facility.

Code 32 – Change of reference period

This code is valid only for residential mental health care facilities. Refer to RMHCDC Manual for further details.

7.32 Transferring to facility

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

- 12 Correctional facility
- 16 Transferred to another hospital
- 21 Residential aged care service, which is not the usual place of residence
- 31 Residential mental health care facility

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

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

7.33 Hospital insurance

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

For example:

- A patient may have hospital insurance but elects to be admitted as a public patient on this occasion.

- An uninsured patient may elect to be treated privately on this occasion and meet the hospital and clinician charges themselves.

HBCIS Hospitals	HBCIS		Extracted and mapped by HQI a	
	Code	Description	Code	Description
	Y	Hospital insurance	7	Hospital insurance
	N	No hospital insurance	8	No hospital insurance
	U	Not stated/unknown	9	Not stated/unknown

Other Hospitals	Code	Description
	7	Hospital insurance
	8	No hospital insurance
	9	Not stated/unknown

Definitions of hospital insurance status are as follows:

Code 7 – Hospital insurance

Used when the patient has health insurance that covers accommodation charges.

Code 8 – No hospital insurance

Private health insurance.

Code 9 – Not stated/unknown

Used when the patient is unable to identify level of insurance held (e.g. an unconscious patient is unable to provide the information).

7.34 Health fund (HBCIS hospitals)

At the time of admission to a facility, it is important to correctly identify and capture a patient's hospital insurance status, and where applicable their associated health fund information. A dedicated field for the capture of a patient's health fund information currently exists in HBCIS.

It should be noted that the health fund information should only be provided where a patient has hospital level insurance with their health fund.

Health fund is captured by selecting the relevant code from the corporate standardised list of health insurance fund codes in HBCIS (where the patient is currently insured for their hospital accommodation as a private patient).

If the health fund code is supplied, then the health fund cover corporate set of codes must be reviewed to select the correct identifier for the patient's hospital insurance.

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

- If the health fund code is supplied and the patient has valid hospital insurance (Hospital Insurance and/or Hospital Insurance plus Extras), hospital insurance status must be 'Y'.
- If no health fund is supplied and the patient does not have hospital insurance, hospital insurance status must be 'N'.
- If the health fund code is supplied and the patient does not have hospital Insurance, but has exclusions or extras only, hospital insurance status must be 'N'.
- If the health fund code is supplied and the patient has valid hospital insurance, but is on a waiting period, hospital insurance status must be 'U'. Where 'U' is identified, the waiting period will need to be checked.

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

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

The list of private health funds, contained in Appendix P is revised annually by the Revenue Strategy and Support Unit.

7.35 Funding source

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

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

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

Further clarification of some of the funding sources is provided below.

Code 01 – Health service budget (not covered elsewhere)

Medicare eligible patients for whom there is no other funding arrangement.

- Do not use for overseas visitors who are covered by Reciprocal Health Care Agreements and elect to be treated as public admitted patients.
- Includes prisoners from correctional facilities.

Code 02 – Private health insurance

Patients who are funded by private health insurance, including, travel insurance for Medicare eligible patients. If patients receive any funding from private health insurance, choose Code 02, regardless of whether it is the majority source of funds.

- Do not use for overseas visitors for whom travel insurance is the major funding source.
- Do not use for residential mental health care consumers, as residential mental health care is not covered by private hospital insurance. For further details refer to the RMHCDC Manual.

Code 03 – Self funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

Code 07 – Department of Veterans' Affairs

To be used when Department of Veterans' Affairs patients have elected to use their entitlements under the Repatriation Health Card (Gold or White). See Section 13 Department of Veterans' Affairs Patients, for further information.

Code 10 – Other hospital or public authority (contracted care)

Patients receiving treatment under contracted arrangements with another hospital (inter-hospital contracted patient) or a public authority (e.g. a state or territory government). See Section 4.7 Contracted hospital care, for further information.

Code 11 – Health service budget (due to eligibility for Reciprocal Health Care Agreement)

Patients who are overseas visitors from countries covered by Reciprocal Health Care Agreements. See Section 7.4 Chargeable status; Reciprocal Health Care Agreements, for further information.

- Overseas visitors who are covered by a reciprocal health care agreement and elect to be treated as a private patient are not eligible to be funded under the reciprocal health care agreement. The applicable funding source should be recorded.

Code 12 – Other funding source

It can include the following patients:

- Overseas visitors where travel insurance is the major source of funding
- Organ procurement registrations
- Boarders
- Those patients whose episodes are majority funded by a private company as part of a clinical trial
- Those patients whose episodes are majority funded by the public trustee
- Those patients whose episodes are majority funded by donations/pledge payments

Code 13 – Health service budget (no charge raised due to hospital decision)

Patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory.

This includes Papua New Guinea (PNG) nationals who are covered under the Torres Strait Treaty - https://qheps.health.qld.gov.au/__data/assets/pdf_file/0041/2259689/PNG_TorresStrait-_treaty_patients.pdf [accessed 30 October 2026].

Also includes patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are for medical services bulk-billed to Medicare), and patients for whom a charge is raised but is subsequently waived.

Unqualified newborns (unqualified status for the entire episode of care) should be assigned the same funding source as the mother. However, the Medicare eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother. For example, if the mother is an ineligible person, but the father is eligible for Medicare, then the newborn will be eligible for Medicare.

7.36 Consent to release patient details (HBCIS hospitals)

From time-to-time Queensland Health may release patient details to certain funding agencies to facilitate payment for the patient's treatment by these agencies. Current legislation does not permit Queensland Health to release patient details without the patient's specific consent.

When a patient presents for admission to a public hospital, they make an election to be treated as a public or private patient. This election is recorded on the Patient Election Form (PEF). At the time of making this election, the patient indicates whether or not they consent to the release of their personal, admission, and health details to the funding agencies listed on the PEF.

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

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

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

Funding agencies to which details could be released are:

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

Personal details that could be released include:

- Name
- Address
- Date of Birth/Age.

Admission details that could be released include:

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

Health details that could be released include:

- Diagnosis Related Group (DRG)
- Nature of Injury.

- **Note:** this consent does not include the release of any documents or copies of documents from the patient's medical record

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

7.37 Preferred language (Public hospitals)

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

From 1 July 2011 a new classification was introduced for the recording of preferred language. The new language classification is a modified version of the Australian Bureau of Statistics Australian Standard Classification of Languages (ASCL), Second Edition (ABS Cat. No. 1267.0) and allows the use of synonyms and sub-languages which map to a core language category (e.g. Sardinian to Italian). This enhancement greatly improves how preferred language is recorded and facilitates better supply of interpreter services in public health care facilities. Any queries or requests to add a language should be directed to Queensland Health Multicultural Services.

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

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

See Appendix G for the list of HBCIS Language codes.

7.38 Interpreter required (Public hospitals)

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

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

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

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

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

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

In some instances, a patient may indicate that they do not need an interpreter but the health professional (health clinician) trying to conduct an assessment is concerned about the patient's ability to communicate in English. In this situation, the health professional should not assume that information has been conveyed to the patient on the *Queensland Languages Services Policy*[36] regarding their right to an interpreter.

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

If the patient continues to disagree, the health professional should find out whether there are any specific reasons why the patient does not wish to have an interpreter. The health professional should explain that interpreters are bound by the professional Code of Conduct which includes confidentiality of patient information. If the patient is concerned about this,

[36] Queensland Language Services Policy. Available from https://www.publications.qld.gov.au/dataset/language-services-policy/resource/8600a6d0-2a8a-4f54-9c7b-ce4794101105> [accessed 30 October 2026]

or the sensitive nature of the appointment (this can be an issue for smaller communities), the health professional can request that an interstate interpreter be booked via video conference or telephone. This should be noted in the patient's file.

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

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

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

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

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

7.39 Length of stay in an intensive care unit

The total number of hours and minutes a patient has spent in a Level 6 intensive care unit is to be reported by hospitals that have an approved adult intensive care unit (For Public Hospital – standard ward code ICU6) or an approved children’s intensive care service (For Public Hospital – standard ward code CIC6). The total number of hours and minutes a patient has spent in a Level 4 and 5 children’s intensive care unit or intensive care unit (For Public Hospital – standard ward code ICU4, ICU5, CIC4 or CIC5) is calculated following reporting to the Data Services Branch.

7.39.1 Calculating length of stay in an intensive care unit

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

- Arrival date and time, of the patient in the intensive care unit.

End the calculation with one of the following:

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

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

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

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

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

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

7.40 Criteria led discharge type (Public hospitals)

Criteria led discharge is the discharge of patients by nursing, allied health and junior medical staff who have the necessary knowledge, skills and competencies to review patients and initiate inpatient discharge. The process is supported by predetermined criteria which are developed with multi-disciplinary agreement and approved by the senior doctor who has the ultimate clinical responsibility for the patient.

Guidelines are available Criteria Led Discharge | Queensland Health [accessed 30 October 2026]

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

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

7.41 Nicotine Withdrawal Management Pathway (Public hospitals)

The Nicotine Withdrawal Management Pathway (previously known as Smoking Cessation Clinical Pathway) is an evidence-based decision support tool for staff to assist a patient to quit smoking, vaping, or other nicotine products (not TGA approved), and record nicotine dependence or nicotine withdrawal, AND to assist a patient to prevent or manage nicotine withdrawal while in the hospital.

In-scope patients must:

- be 18 years of age or more at the time of admission

Exclusions:

- Patient episode Care Type Code = 08 Boarder; or 07 Organ procurement-posthumous
- Patient episode mode of separation/discharge status = 05 Died in hospital; or
- Same day admissions with a principal diagnosis of ICD-10-AM code Z51.1 *Pharmacotherapy session for neoplasm*, Z49.1 *Extracorporeal dialysis* or Z49.2 *Other dialysis*.

7.41.1 Smoking Status

Refers to whether the patient self-identifies as being a current user of tobacco, vapes, or other nicotine products (not TGA approved) in the past 30 days at the time of the episode of admitted patient care.

	Code	Description
HBCIS Hospitals	1	Reported as a current smoker within the last 30 days
	2	Reported not a smoker
	9	Not Reported

Code 1 – Reported as a current smoker within the last 30 days

A current smoker is defined as any patient who is self-identified as having used tobacco, vapes, or other nicotine products (not TGA approved) in the past 30 days, for example tobacco smoking, chewing tobacco, liquid nicotine, nicotine pouches etc. Use of TGA approved nicotine replacement therapy (NRT) in the absence of tobacco smoking, vaping, or other nicotine products (not TGA approved) within the last 30 days is not classified as a current smoker.

Code 2 – Reported not a smoker

A patient is regarded as a not a smoker for example, ex-smoker, non-smoker or has ceased using tobacco, vapes, other nicotine products (not TGA approved) within a period greater than 30 days.

Code 9 – Not reported

Used when there is no record of smoking status in the patient record.

7.41.2 Nicotine Withdrawal Management pathway completed

Indicates whether a Nicotine Withdrawal Management Pathway has been completed during the episode of admitted patient care for a patient who self-identifies as being a current user of tobacco, vapes, other nicotine products (not TGA approved) in the past 30 days.

	Code	Description
HBCIS Hospitals	Y	Yes
	P	Partial
	N	No

Code Y – Yes

The mandatory items and signature log on a Nicotine Withdrawal Management Pathway form have been completed for the patient who self-identifies as being a current user of tobacco, vapes, other nicotine products (not TGA approved) in the past 30 days.

Code P – Partial

Some of the mandatory items on a Nicotine Withdrawal Management Pathway form have been completed for the patient who self-identifies as being a current user of tobacco, vapes, other nicotine products (not TGA approved) in the past 30 days.

Code N – No

None of the mandatory items on a Nicotine Withdrawal Management Pathway form have been completed for the patient who self-identifies as being a current user of tobacco, vapes, other nicotine products (not TGA approved) in the past 30 days, or no pathway is available within the patient record.

8. PATIENT ACTIVITY FOR H OSPITALS USING PAPER FORMS

This entire section refers to the action required by hospitals who submit data by completing paper forms. The forms required to be completed (as applicable) are:

- Hospital Identification and Diagnosis Form PHI (1)
- Hospital Identification and Diagnosis Form – Activity Page PHI (2)
- Hospital Identification and Diagnosis Form – Sub and Non-Acute Patient (SNAP) Activity PHI (3)

8.1 Hospital Identification & Diagnosis Form PHI (1)

For instructions on how to complete the data items contained on the Hospital Identification and Diagnosis Form PHI (1) refer to chapter 4, 5, 6, 7, 9, 13 and 14 of this manual.

8.2 Hospital Identification and Diagnosis Form – Activity Page PHI (2)

This form is only required to be completed when:

- An episode has eight or more morbidity codes or
- There are changes to the following activity:
    - Ward details
    - Patient leave details
    - Contract leave details
    - Account variation details
    - Qualification status change details
    - Mental health details
    - Nursing home type patient details

For instructions on how to complete this form, refer to Section 8.3 Completion of the Hospital Identification and Diagnosis Form – Activity Page PHI (2)

Note: This form is to be submitted to DSB with the corresponding Hospital Identification and Diagnosis Form PHI (1).

8.3 Completion of the Hospital Identification and Diagnosis Form – Activity Page PHI (2)

8.3.1 Patient Identification Data

Complete the following patient identification details on the form by transcribing the same details from the Hospital Identification and Diagnosis Form PHI (1) for this admission.

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

8.3.2 Additional Diagnostic Codes

The Hospital Identification and Diagnosis Form PHI (1) provides for the recording of diagnostic codes. If more codes need to be reported, complete the additional coding boxes on the Hospital Identification and Diagnosis Form – Activity Page PHI (2). If necessary, you may attach more than one PHI (2) form to allow recording of an unlimited number of diagnostic codes. Patient identification data must be completed for all forms used.

8.3.3 Ward Details

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

For example, a patient may initially be admitted to the Intensive Care Unit and later transferred to the general medical ward. This should be recorded on the Hospital Identification and Diagnosis Form – Activity Page PHI (2).

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

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

Ward

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

Unit

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

Standard unit code

Record the standard unit code prepared by the DSB to describe the unit to which the patient was transferred.

Standard ward code

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

Date of transfer

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

Example

For a patient who was transferred on 29 July 2026, record;

2	9	0	7	2	0	2	6

Time of transfer

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

Example

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

1	8	1	0

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

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

8.3.4 Patient Leave

Leave occurs when an admitted patient leaves the hospital between treatments in hospital for a period of not more than seven days and intends to return for the hospital to continue the current course of treatment. Patient day charges are not raised whilst the patient is on leave, nor are the days on leave counted as patient days. See calculation of leave days in Section 4.10 Leave and Section 3.8 Counting Rules.

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

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

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

If the number of leave episodes exceeds two and cannot be recorded on the Hospital Identification and Diagnosis Form – Activity Page PHI (2) (as there is only space to record two leave episodes), use a second PHI (2) form, and complete patient identification data on all forms used.

Only report the leave to the DSB if the patient is away at midnight.

Date of starting leave

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

Example

For a patient who started leave on 24 July 2026, record;

2	4	0	7	2	0	2	6

Time of starting leave

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

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

Example

For a patient started leave at 6.10 p.m., record;

1	8	1	0

Date returned from leave

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

Example

For a patient who returned from leave on 29 July 2026, record;

2	9	0	7	2	0	2	6

Time returned from leave

Record the time the patient returned from leave. Use the 24-hour clock to record the return from leave. Times are between 0000 (midnight) and 2359. Note that 0000 (midnight) is the start of a new day.

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

Example

For a patient returned from leave at 6.10 p.m., record;

1	8	1	0

8.3.5 Contract Leave

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

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

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

See Section 4.7 Contracted hospital care for further details on contracted hospital care and contract leave.

Date transferred for contract

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

Example

For a patient who was transferred for contract service on 24 July 2026 record;

2	4	0	7	2	0	2	6

Date returned from contract

Record the full date (ddmmyyyy) on which the patient returned from contract service. Use leading zeros where necessary. Used for contract type ABA. See Section 4.7.10 Contract Type.

Example

For a patient who returned from contract service on 24 July 2026 record;

2	4	0	7	2	0	2	6

Facility number contracted to

Record the facility number for the hospital to which the patient is transferred for contract service. See Appendix A for list of facilities and facility numbers.

8.3.6 Account Variation

Chargeable status change

Record the new (amended) chargeable status of the patient using one of the following codes:

All Hospitals	Codes	Description
	1	Public
	2	Private shared
	3	Private single

Date of change

Record the full date (ddmmyyyy) on which the patient changed chargeable status. Use leading zeros where necessary.

Example

For a patient who changed chargeable status on 24 July 2026 record;

2	4	0	7	2	0	2	6

Compensable status change

Record the updated compensable status of the patient using one of the following codes:

All Hospitals	Codes	Description
	1	Workers' Compensation Queensland
	2	Workers' Compensation (other)
	3	Compensable Third Party
	4	Other Compensable
	5	Department of Veterans' Affairs
	6	Motor Vehicle (Qld)
	7	Motor Vehicle (Other)
	8	None of the above
	9	Department of Defence

Note: Compensable patients who are to be admitted for a same day band procedure are to be charged the compensable rate.

For definitions and examples refer to Section 7.8 Compensable status and Section 4.6 Compensable patient.

Date of change

Record the full date (ddmmyyyy) on which the patient changed compensable status. Use leading zeros where necessary.

Example

For a patient who changed compensable status on 24 July 2026, record;

2	4	0	7	2	0	2	6

8.3.7 Qualification Status Change

Record the new (amended) qualification status for the newborn using one of the qualification status codes.

	Codes	Description
All Hospitals	A	Acute
	U	Unqualified

Date of change

Record the full date (ddmmyyyy) on which the qualification status change occurred. Use leading zeros where necessary.

Example

For a newborn who had a change in qualification status on 24 July 2026, record;

2	4	0	7	2	0	2	6

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

For further information on newborns and qualification status refer to Section 4.12 Newborns and Section 7.7 Qualification status.

8.3.8 Mental Health Details

This is required for all admitted episodes where the designated Standard unit code is in the range of PYAA to PYZZ (Mental Health Unit). The following mental health details are required;

- Type of usual accommodation
- Employment status
- Pension status
- First admission for psychiatric treatment
- Referral to further care
- Mental health legal status indicator

- Previous specialised non-admitted treatment

Mental health details do not have to be reported for boarders who are registered as being in a PYAA to PYZZ standard unit code.

For further information, refer to Section 10 Mental Health Details.

8.3.9 Nursing Home Type Patient

Nursing Home Type Flag

A Nursing home type flag is recorded every time a patient is classified as a nursing home type patient (i.e. does not have an Acute Care Certificate completed). See Section 4.1 Acute care certificate, Section 4.14 Nursing Home Type Patients and Section 7.15 Care type.

Start date

Record the full date (ddmmyyyy) on which the patient was classified as a Nursing Home Type patient.

Example

For a patient who was classified as a NHT patient on 20 July 2026 record;

2	0	0	7	2	0	2	6

End date

Record the full date (ddmmyyyy) on which the patient ceased being classified as a Nursing Home Type patient.

Example

For a patient who ceased being classified as a NHT patient on 23 August 2026 record;

2	3	0	8	2	0	2	6

8.4 Hospital Identification and Diagnosis Form – Sub and Non-Acute Patient (SNAP) Activity PHI (3)

The Hospital Identification and Diagnosis Form PHI (3) was developed in 2017-2018 by DSB to assist facilities with the recording of SNAP information. It is only required to be completed for publicly contracted sub and non-acute patients. As a result, when using this form, the following information is to be recorded:

- SNAP episode number

- Start date
- End date
- SNAP type
- ADL date
- ADL type
- ADL subtype
- ADL subtype score
- Phase Type
- Multidisciplinary care plan flag
- Multidisciplinary care plan date
- Proposed principal referral service
- Primary impairment type.

For further information refer to Section 12. SUB AND NON-ACUTE PATIENT (SNAP) DETAILS – (PUBLIC AND PRIVATE HOSPITALS)

9. MORBIDITY DETAILS

For the admitted patient data collection, morbidity details include the recording of codes for diagnoses (disease), chronic conditions, signs and symptoms, abnormal findings, social circumstances, external causes of injury or disease, poisonings, adverse effects, complications, misadventures, morphology and procedural information in relation to a patient's episode of admitted care (including hospital in the home). Morbidity details are collected using codes from the International Statistical Classification of Disease and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI), Thirteenth Edition.

The ICD-10-AM and ACHI classifications enable the translation of diagnoses, procedures and other health problems from words in the primary clinical record into an alphanumeric code. All diagnoses (conditions) and procedures should be coded as per the Australian Coding Standards (ACS).

The National Centre for Classification in Health (NCCH) has led the Australian Consortium for Classification Development (ACCD), in collaboration with the University of Western Sydney and KPMG, in the development of ICD-10-AM/ACHI/ACS of Eleventh Edition. From 1 July 2019, ongoing support and development of Eleventh Edition was managed by the Independent Health and Aged Care Pricing Authority (IHACPA). The cycle for ICD-10-AM/ACHI/ACS changed from a 2 year to 3 year cycle during Eleventh Edition. Each ICD-10-AM/ACHI/ACS edition will be used for 3 years from 1 July 2019.

The IHACPA is also responsible for the continued development of the Australian Refined Diagnosis Related Groups (AR-DRG) classification system. The AR-DRGs are a classification system that provides a clinically meaningful way of relating the number and types of patients treated in admitted episode of care to the resources required in treatment. The AR-DRGs group patients with similar diagnoses requiring similar services by the facility. The Diagnosis Related Groups (DRG) grouper is a specially designed computer software that assigns patient episodes of care (via ICD-10-AM, ACHI and other statistical data collection items) to DRGs, according to the DRG classification. It should be noted that whilst an unlimited number of ICD-10-AM and ACHI codes can be recorded for an episode of care, only a defined number of codes (100 diagnosis and 100 procedure) are passed into the grouper. The sequence of codes specified by the hospital will be retained by the DSB. Note that punctuation marks (such as: . , - or /) can be used in the recording but should not be used in reporting ICD-10-AM/ACHI data. The only non-numeric characters that are to be used when recording diagnosis details are A to Z.

Clinical coding data is critical information that supports system performance management, health service planning, clinical governance, safety and quality, clinical research, national reporting, and funding of the Queensland Health system.

To ensure quality coded data is provided:

- Admitted patient episodes of care should be coded in the current version of ICD-10-AM/ACHI rather than mapped from alternate versions or classifications,
- The current ACS should be applied to the coded data for the episode.
- All current errata to the ACS should be observed.
- Current National Coding Advice are binding and should be observed.
- Current clinical advice published by the Clinical Coding Authority of Queensland are binding and should be observed.

Clinical coding audit, whether conducted internally or externally, will apply the current ACS, National Coding Advice and CCAQ clinical coding rules.

Clinical Coding is a specialist skill undertaken by suitably qualified professionals, Clinical Coders, or Health Information Managers. Personnel undertaking Clinical Coding are to maintain contemporary knowledge of the ACS and the Clinical Coding Practice Framework.

Evidence of clinical documentation including queries raised to support the clinical coding process and allocation of the appropriate codes should be stored by the hospital for audit purposes.

The final assignment of clinical codes remains the decision of the treating clinician. As a default position, Clinical Coders should assign to an admission the principal diagnosis and principal procedure as described by the treating clinical team on the discharge summary.
A contract procedure flag is used by the purchasing hospitals to indicate a procedure performed by a contracted hospital or other health care provider (non-hospital). It also indicates whether the procedure was performed as an admitted or non-admitted service. See Section 9.16 Contracted procedures for more information regarding the flags used for contracted procedures.

The Clinical Coding Resource Material (CCRM) presents information about morbidity related resource materials to support high quality morbidity data.
For specific queries relating to clinical classification coding using ICD-10-AM/ACHI/ACS, contact the Quality Assurance & Intelligence Team, DSB at DataQuality@health.qld.gov.au.

9.1 ICD-10-AM/ACHI code identifier

The ICD-10-AM/ACHI code identifier indicates whether an ICD-10-AM/ACHI code is a principal or other diagnosis, external cause, morphology or intervention.

	Code	Description	*Extracted and mapped by HQI as*
HBCIS Hospitals	P	Primary	PD
	A	Associated	OD
	C	Complication	OD
	U	Unknown/Uncertain	OD
	PR	Intervention	PR

<table>
<tr><td rowspan="7">Other Hospitals</td><td colspan="2">Each morbidity code is to be prefixed by a diagnosis, external cause, morphology or intervention code identifier. The codes should be left adjusted and followed by trailing blanks.

Record the diagnosis, external cause, morphology or intervention code identifier using the following codes:</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>PD</td><td>Principal diagnosis</td></tr>
<tr><td>OD</td><td>Other diagnosis</td></tr>
<tr><td>EX</td><td>External cause</td></tr>
<tr><td>M</td><td>Morphology</td></tr>
<tr><td>PR</td><td>Intervention</td></tr>
</table>

All diagnosis (PD/OD), external cause (EX) and morphology (M) codes are to be sequenced before all intervention (PR) codes.

9.2 Cluster coding

Cluster coding is a mechanism of linking related diagnosis codes through use of a diagnosis cluster identifier (DCID) that enhances the value of coded data. The DCID is an identifier for each ICD-10-AM code to indicate the relationship of that condition to other conditions within an episode of admitted patient care Diagnosis Cluster Identifier [37]. The identifier can maintain the link between codes as the data is collected, validated, processed and analysed.

Cluster coding and DCID was implemented on 1 July 2025 with commencement of ICD-10-AM Thirteenth Edition. ACS 0004 Diagnosis cluster identifier (DCID) provides guidance on the purpose and application of cluster coding.

IHACPA may consider expanding the conditions eligible for cluster coding in future editions of the ICD-10-AM classification.

Clustering of codes in Thirteenth Edition are allocated the following DCID values:

	DCID	Description
All Hospitals	A-ZZ	**Diagnosis cluster** A diagnosis cluster identifies the following: • conditions caused by an external cause • manifestations, complications, or sequela arising from the external cause • codes for the external cause • codes from Chapter 21 *Factors influencing health status and contact with health services* (Z00-Z99) related to the diagnosis cluster.

[37] Diagnosis cluster identifier. Available from <https://meteor.aihw.gov.au/content/824084> [accessed 30 October 2026]

	0	**Chronic condition cluster** The chronic condition cluster identifies conditions assigned in accordance with ACS 0003 *Supplementary Codes for chronic conditions*.
	8	**Code not clustered** DCID 8 represents a code that has not been allocated to a diagnosis cluster or chronic condition cluster.
A DCID is only required for diagnosis codes with an ICD Type of PD, OD, EX or M.		

Example 1:

DCID	Code identifier	ICD-10-AM code	Code description
A	PD	S52.30	*Fracture of shaft of radius, part unspecified*
A	EX	V03.1	*Pedestrian injured in collision with car, pick-up truck or van, traffic accident*
A	EX	Y92.49	*Place of occurrence, unspecified public highway, street or road*
A	EX	U72	*Leisure activity, not elsewhere classified*
8	OD	J44.1	*Chronic obstructive pulmonary disease with acute exacerbation, unspecified*
8	OD	Z72.0	*Tobacco use, current*
0	OD	U82.3	*Supplementary code for hypertension*
0	OD	U86.2	*Supplementary code for arthritis and osteoarthritis [primary]*

Example 2:

DCID	Code identifier	ICD-10-AM code	Code description
A	PD	M16.4	*Post traumatic coxarthrosis, bilateral*
A	EX	T93.1	*Sequelae of fracture of femur*
A	EX	Y85.0	*Sequelae of motor-vehicle accident*
B	OD	K59.0	*Constipation*
B	EX	Y45.0	*Opioids and related analgesics causing adverse effects in therapeutic use*
B	EX	Y92.24	*Place of occurrence, health service area, this facility*
8	OD	J96.99	*Respiratory failure unspecified, type unspecified*

Further information on the implementation of cluster coding is outlined in the IHACPA Frequently asked questions (FAQs)[38].

[38] Implementation of cluster coding – Frequently Asked Questions < Frequently_asked_questions_Implementation_of_cluster_coding_October_2024.PDF> [accessed 30 October 2026].

9.3 Principal diagnosis

The principal diagnosis (PD) is defined as 'the diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code" (METeOR data element identifier 793125[39]). Please refer to ACS 0001 *Principal diagnosis* for further information.

The phrase 'after study' is the evaluation of findings to establish the condition that was chiefly responsible for occasioning the episode of care.

Findings evaluated may include information gained from the history of illness, any mental status evaluations, specialist consultations, physical examination, diagnostic tests or procedures, any surgical procedures, any pathological or radiological examination or other interventions. The condition established after study may or may not confirm the provisional diagnosis.

The principal diagnosis is to be coded using the current edition of ICD-10-AM at the separation date.

Only one condition may be nominated as the principal diagnosis. If there are multiple diagnoses, any of which meet the criteria for principal diagnosis, please refer to ACS 0001 *Principal diagnosis*, regarding two or more conditions equally meeting the definition for principal diagnosis.

ACS 0050 *Unacceptable principal diagnosis codes* notes that there are some ICD-10-AM codes that must never be assigned as a principal diagnosis including but not limited to all external cause, morphology and procedure codes.

9.4 Additional (other) diagnoses (sequelae, complications and supplementary chronic conditions)

Additional diagnoses are often described as co-morbidities and/or complications. A co-morbid condition is 'A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance

(FAQs). Available from <https://www.ihacpa.gov.au/sites/default/files/2024-11/Frequently_asked_questions_Implementation_of_cluster_coding_October_2024.PDF> [accessed 30 October 2026]

[39] Principal diagnosis. Available from < https://meteor.aihw.gov.au/content/793125> [accessed 30 October 2026]

at a health care establishment, as represented by a code.' (METeOR data element identifier 793130[40]).

For coding purposes, co-morbid conditions or complications should be interpreted as additional diagnoses where they fulfil the requirements of ACS 0002 *Additional diagnoses* or other specialty coding standards.

For rehabilitation and palliative care episodes of care, from 1 July 2020 diagnosis codes Z50.- *Care involving use of rehabilitation procedures* and Z51.5 *Palliative care* must be sequenced immediately after the related conditions.

Example 1:

Sequencing rehabilitation and palliative care codes.

Scenario: Patient is admitted to the Rehabilitation Unit post hip replacement for osteoarthritis. During the episode of care, the patient required alteration of their antihypertensive medication due to uncontrolled hypertension. The patient has ulcerative colitis and a history of smoking.

Code identifier	ICD-10-AM code	Code description
PD	M16.1	*Other primary coxarthrosis*
OD	Z96.64	*Presence of hip implant*
OD	Z50.9	*Care involving use of rehabilitation procedure, unspecified*
OD	I10	*Essential (primary) hypertension*
OD	Z86.43	*Personal history of tobacco use disorder*
OD	U84.2	*Supplementary code for ulcerative colitis*

Note:

Z50.3 Care involving use of rehabilitation procedure, unspecified is sequenced after the osteoarthritis and presence of hip implant as this is related to the conditions for which the patient was admitted for rehabilitation care.

Please refer to Section 9.16 Contracted procedures for further information.
ACS 0049 *Disease codes that must never be assigned* includes those ICD-10-AM codes that must never be assigned for admitted patient morbidity coding.

ACS 0003 *Supplementary codes for chronic conditions* relates to a discrete list of chronic conditions that are present on admission but do not meet ACS 0001 *Principal diagnosis* or

[40] Additional diagnosis. Available from < https://meteor.aihw.gov.au/content/793130> [accessed 30 October 2026]

0002 *Additional diagnosis* and other general and specialty coding standards, coding conventions and coding rules.

Supplementary chronic condition codes within the code range of U78 - U88 are to be assigned a Condition onset flag status of '1 – Present on admission to the episode of patient care' (see Section 9.11 Condition onset flag for more information). These codes should also be sequenced after all other ICD-10-AM codes – including external cause and morphology codes.

The chronic condition codes are for use in Australia to generate data which will be utilised to review the coding of additional diagnoses. These codes are mapped in the grouper software so as not to be included in the grouping for DRG allocation.

An example of how to assign and sequence supplementary chronic condition codes is as follows:

Example 2:

Sequencing supplementary chronic condition codes.

Scenario: Patient is admitted with hip pain after falling downstairs at home. On x-ray, a fracture of the subcapital section of the femur is documented by the treating doctor in the clinical notes. The patient has a history of hypertension, obesity, chronic kidney disease - stage 4 and chronic obstructive pulmonary disease. During the episode of care, the patient's antihypertensive medications are modified to control the hypertension. No other conditions were treated.

Code identifier	ICD-10-AM code	Code description
PD	S72.03	*Fracture of subcapital section of femur*
EX	W10.9	*Fall on and from other and unspecified stairs and steps*
EX	Y92.09	*Place of occurrence, other and unspecified place in home*
EX	U73.9	*Unspecified activity*
OD	I10	*Essential (primary) hypertension*
OD	U78.1	*Supplementary code for obesity*
OD	U83.2	*Supplementary code for chronic obstructive pulmonary disease*
OD	U87.1	*Supplementary code for chronic kidney disease, stage 3 - 5*

Note:

- External cause codes W10.9, Y92.09 and U73.9 relate to the principal diagnosis (S72.03) and are assigned together.
- Hypertension (I10) is coded as an additional diagnosis rather than a supplementary code for chronic conditions as the condition received treatment (modification of antihypertensive medication) during the episode of care (ACS 0002 *Additional diagnoses*).
- The chronic conditions obesity, chronic obstructive pulmonary disease and chronic kidney disease (stage 4) were not treated during the episode of care and therefore are

assigned a corresponding supplementary chronic condition code and are sequenced last.

9.5 External cause sequencing

The external cause (EX) describes the precipitating event or accident leading to a procedural complication, injury or poisoning. The external cause codes are listed in the range U50-U73 and V00-Y98 and are generally represented by three groups of codes sequenced in the following order (as required), External cause (V00-Y89), Place of occurrence (Y92), and Activity (U50-U73).

External cause codes in the range V00 to Y89 must be accompanied by a Place of occurrence code (Y92), while external cause codes in the range V00 to Y34 must also be accompanied by an Activity code (U50-U73).

ACS 2001 *External cause code use and sequencing* requires external cause codes be linked to a particular diagnosis (except Y90-Y91 and Y95-Y98). An external cause code may be used in conjunction with any diagnosis code in ICD-10-AM but **must** be used with codes from S00-T98, Z04.1-Z04.5 and for complications and abnormal reactions, which are classified outside the injury chapter (S00-T98).

The use of external cause permits the classification of environmental events and circumstances as the cause of injury, poisoning and other adverse effects. Where an external cause code is utilised, it is intended that it shall be used in addition to a code from another chapter of the Classification indicating the nature of the condition. While the condition may be classifiable to Chapter 19 *Injury, poisoning and certain other consequences of external causes* (S00–T98), other conditions such as procedural complication may be classified in Chapters 1 to 18.

Categories for sequelae of external causes of morbidity and mortality are included at Y85–Y89.

The following ACS include further information about external cause codes:

- ACS 0303 *Anticoagulant use and abnormal coagulation profile*
- ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycaemia* (for hypoglycaemia)
- ACS1309 *Dislocation or complication of joint prosthesis*
- ACS 0901 *Poisoning*
- ACS 1902 *Adverse effects*
- ACS 1903 *Two or more drugs taken in combination*
- ACS 1904 *Procedural complications*
- ACS 1906 *Current and old injuries*
- ACS 1909 *Adult and Child Abuse*
- ACS 1912 *Sequelae of injuries, poisoning, toxic effect and other external causes*
- ACS 1923 *Contact with venomous/nonvenomous creatures*
- ACS 1924 *Difficult intubation*
- ACS 2001 *External cause code use and sequencing*
- ACS 2005 *Poisoning and injuries – indication of intent*

- ACS 2008 *Perpetrator of assault, abuse and neglect*
- ACS 2009 *Mode of pedestrian conveyance.*

To allow for data analysis and linkage, Queensland Health requires that where a diagnosis requires an external cause code, that the data are recorded and reported in the following way.

- Where the principal diagnosis requires external cause codes, the external cause codes are to be sequenced directly after the principal diagnosis, then followed by other diagnosis codes (Examples 1, 2 and 9).
- Where there are multiple diagnosis codes that require the same external cause codes related to the same event – including the principal diagnosis, the principal diagnosis code is to be assigned with the external cause codes, followed by the remaining related diagnosis codes and repeated external cause codes again (Examples 3 and 4).
- Where there are multiple diagnosis codes that require different external cause codes – including the principal diagnosis, the principal diagnosis code is to be assigned with the external cause codes, followed by the remaining diagnosis codes and related external cause codes (Examples 5, 6 and 7).
- If there are multiple diagnosis codes that require the same external cause codes – including the principal diagnosis, but an additional diagnosis code such as Z50.9 *Care involving use of rehabilitation procedure, unspecified* is required, the above principles are applied and the additional diagnosis code is sequenced after the diagnosis they relate to (Example 9).
- Where the additional diagnosis requires external cause codes, the external cause codes are to be sequenced directly after the related additional diagnosis, then followed by other diagnosis codes (Examples 8, 10, 11 and 12).
- Where there are multiple additional diagnosis codes that require the same external cause codes but occur as different events – the external cause codes should be sequenced following the last of the additional diagnosis codes that it relates to (Example 13).

ACHI codes are not included in the following examples.

Principal diagnosis with external cause codes

Example 1: On admission single diagnosis (principal diagnosis) requires external cause codes.

Scenario: A patient is admitted after sustaining an open wound to the right ankle from a nonvenomous snake bite whilst hiking in the bush track.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	S91.0	*Open wound of ankle*	1
EX	W59.0	*Bitten or crushed by nonvenomous snake*	1
EX	Y92.84	*Place of occurrence, forest*	1

EX	U64.1	*Activity, hiking*	1

Example 2: On admission single post procedure complication (principal diagnosis) requires external cause codes.

Scenario: A patient is admitted for a post-operative haemorrhage for a previously performed procedure at another facility.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	T81.0	*Haemorrhage and haematoma complicating a procedure, not elsewhere classified*	1
EX	Y83.9	*Surgical procedure, unspecified*	1
EX	Y92.23	*Place of occurrence, health service area, not specified as this facility*	1

Example 3: On admission two diagnoses (principal and additional diagnoses) all require external cause codes.

Scenario: A patient is admitted with a postprocedural wound infection after an internal fixation of screw to the left neck of femur. Clinical notes document Klebsiella pneumoniae. The procedure was performed at this facility.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	T84.6	*Infection and inflammatory reaction due to internal fixation device [any site]*	1
EX	Y83.17	*Surgical operation with implant of orthopaedic internal device as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure*	1
EX	Y92.24	*Place of occurrence, health service area, this facility*	1
OD	B96.1	*Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified to other chapters*	1
EX	Y83.17	*Surgical operation with implant of orthopaedic internal device as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure*	1
EX	Y92.24	*Place of occurrence, health service area, this facility*	1

Example 4: On admission three diagnoses (principal and additional diagnoses) require external cause codes.

Scenario: A patient is admitted with fracture to left shaft of clavicle, left fracture of cuneiform (foot) and right fracture of lower end of tibia after falling from their mountain bike while

riding in a forest.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	S42.02	*Fracture of shaft of clavicle*	1
EX	V18.0	*Pedal cyclist injured in noncollision transport accident, driver, nontraffic accident*	1
EX	Y92.84	*Other specified place of occurrence, forest*	1
EX	U66.01	*Activity mountain cycling*	1
OD	S92.23	*Fracture of cuneiform, foot*	1
OD	S82.38	*Other fracture of lower end of tibia*	1
EX	V18.0	*Pedal cyclist injured in noncollision transport accident, driver, nontraffic accident*	1
EX	Y92.84	*Other specified place of occurrence, forest*	1
EX	U66.01	*Activity mountain cycling*	1

Example 5: On admission three diagnoses (principal and additional) require external cause codes (difference in external cause codes).

Scenario: A patient is admitted after an intentional overdose involving Panadeine Forte and alcohol at home.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	T39.1	*Poisoning by 4-Aminophenol derivatives*	1
EX	X60	*Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics*	1
EX	Y92.09	*Place of occurrence, other and unspecified place in home*	1
EX	U73.81	*Intentional self-harm*	1
OD	T40.2	*Poisoning by narcotics and psychodysleptics [hallucinogens], Other opioids*	1
EX	X62	*Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified*	1
OD	T51.0	*Toxic effect of ethanol*	1
EX	X65	*Intentional self-poisoning by and exposure to alcohol*	1
EX	Y92.09	*Place of occurrence, other and unspecified place in home*	1
EX	U73.81	*Intentional self-harm*	1

Example 6: On admission six diagnoses (principal and additional) require external cause codes.

Scenario: A patient is admitted with an open wound infection of the thigh with vancomycin resistant *E.Coli* and methicillin resistant *Staphylococcus aureus* pathology confirmed and clinician documented.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	S71.1	*Open wound of thigh*	1
EX	X59	*Exposure to unspecified factor*	1
EX	Y92.9	*Unspecified place of occurrence*	1
EX	U73.9	*Unspecified activity*	1
OD	T89.02	*Open wound with infection*	1
OD	B96.2	*Escherichia coli [E. coli] as the cause of diseases classified to other chapters*	1
OD	Z15.41	*Resistance to vancomycin*	1
OD	B95.6	*Staphylococcus aureus as the cause of diseases classified to other chapters*	1
OD	Z14.02	*Resistance to beta-lactamase resistant [second generation] penicillins*	1
EX	X59	*Exposure to unspecified factor*	1
EX	Y92.9	*Unspecified place of occurrence*	1
EX	U73.9	*Unspecified activity*	1

Example 7: On admission two diagnoses (principal and additional) require different external cause codes.

Scenario: A patient is admitted after a fall (same level) at home in the kitchen where they sustain a laceration to the volar surface of their right forearm. The fall was due to hypotension from previously prescribed antihypertensive medication.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	S51.88	*Open wound of other parts of forearm*	1
EX	W18.9	*Unspecified fall on same level*	1
EX	Y92.04	*Place of occurrence, kitchen*	1
EX	U73.9	*Unspecified activity*	1
OD	I95.2	*Hypotension due to drugs*	1
EX	Y52.5	*Other antihypertensive drugs, not elsewhere classified causing adverse effects in therapeutic use*	1
EX	Y92.23	*Place of occurrence, health service area, not specified as this facility*	1

Example 8: On admission two diagnoses, the second a sequelae (additional) requires external cause codes.

Scenario: Malunion following a fracture of left radius caused by falling from a ladder in their garden while trimming a tree.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	M84.03	*Malunion of fracture, forearm*	1
OD	T92.1	*Sequelae of fracture of forearm and upper arm*	1
OD	Y86	*Sequelae of other accidents*	1
EX	Y92.01	*Place of occurrence, outdoor areas*	1

Example 9: On admission (for Rehabilitation) single diagnosis (principal diagnosis) requires external cause codes.

Scenario: A patient is admitted for rehabilitation after acute surgical treatment of a fracture of left intertrochanteric femur from falling down internal stairs at home. The patient's medication for osteoporosis of left hip and hypertension were also reviewed and adjusted during the episode of care. The patient also has Type 2 diabetes mellitus.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	S72.11	*Fracture of intertrochanteric section of femur*	1
EX	W10.9	*Fall on and from other and unspecified stairs and steps*	1
EX	Y92.07	*Place of occurrence, indoor living areas, not elsewhere classified*	1
EX	U73.9	*Unspecified activity*	1
OD	Z50.9	*Care involving use of rehabilitation procedure, unspecified*	1
OD	M81.95	*Unspecified osteoporosis, pelvic region and thigh*	1
OD	I10	*Essential (primary) hypertension*	1
OD	E11.9	*Type 2 diabetes mellitus without complication*	1

Additional diagnoses with external cause codes

Example 10: On admission, only the additional diagnosis (Condition onset flag =1) requires external cause codes.

Scenario: A patient is admitted with asthma and also receives clinical care and treatment for a laceration to the right hand sustained from an unspecified sharp object.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	J45.9	*Asthma, unspecified*	1
OD	S61.9	*Open wound of wrist and hand, part unspecified*	1
OD	W26.9	*Contact with unspecified sharp object(s)*	1
EX	Y92.9	*Unspecified place of occurrence*	1
EX	U73.9	*Unspecified activity*	1

Example 11: During an episode of care a procedural complication (Condition onset flag =2) requires external cause codes.

Scenario: A patient is admitted for acute appendicitis. While undergoing a laparoscopy procedure, the patient sustains a puncture to the small intestine.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	K35.8	*Acute appendicitis, other and unspecified*	1
OD	K91.63	*Accidental puncture and laceration of intestine during a procedure*	2
EX	Y60.0	*Unintentional cut, puncture, perforation or haemorrhage during surgical operation*	2
EX	Y92.24	*Place of occurrence, health service area, this facility*	2

Example 12: During an episode of care an additional diagnosis (Condition onset flag =2) unrelated to the principal diagnosis requires external cause codes.

Scenario: A patient is admitted for pneumonia which is treated with antibiotics. During the admission, the patient develops a generalised rash from the penicillin. The patient was also treated for pre-existing acute kidney injury and stage 3 chronic kidney disease. The patient also has type 2 diabetes mellitus, obesity and hypertension (not treated during this episode of care).

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	J18.9	*Pneumonia, unspecified*	1
OD	L27.0	*Generalised skin eruption due to drugs and medicaments*	2
EX	Y40.0	*Penicillins causing adverse effects in therapeutic use*	2
EX	Y92.24	*Place of occurrence, health service area, this facility*	2
OD	N17.9	*Acute kidney failure, unspecified*	1
OD	E11.29	*Type 2 diabetes mellitus with other specified kidney complication*	1
OD	E11.22	*Type 2 diabetes mellitus with established diabetic nephropathy*	1
OD	N18.3	*Chronic kidney disease, stage 3*	1
OD	E11.72	*Type 2 diabetes mellitus with features of insulin resistance*	1
OD	U78.1	*Supplementary code for obesity*	1
OD	U82.3	*Supplementary code for hypertension*	1

Example 13: During an episode of care four diagnoses require different external cause codes.

Scenario: A patient is admitted for Parkinson's Disease with dementia. On day two of the episode of care, the patient falls from their bed and sustained a fracture of the left great toe, laceration of the left knee, and sprain of left wrist joint. On day five of the episode, the patient had a second fall from their bed and sustained a laceration to their right elbow. On day six and seven, the patient had further multiple falls from their bed, and while they did not sustain any injuries, they required medical review, neurological observations and nurse specialling.

Code identifier	ICD-10-AM code	Code description	Condition onset flag
PD	G20†	*Parkinson's disease*	1
OD	F02.30*	*Dementia in Parkinson's disease, without mention of psychological or behavioural disturbance (G20+)*	1
OD	S92.4	*Fracture of great toe*	2
OD	S81.0	*Open wound of knee*	2
OD	S63.50	*Sprain and strain of wrist, part unspecified*	2
EX	W06.1	*Fall involving special purpose bed*	2
EX	Y92.24	*Place of occurrence, health service area, this facility*	2
EX	U73.9	*Unspecified activity*	2
OD	S51.0	*Open wound of elbow*	2
EX	W06.1	*Fall involving special purpose bed*	2
EX	Y92.24	*Place of occurrence, health service area, this facility*	2
EX	U73.9	*Unspecified activity*	2
OD	Z04.3	*Examination and observation following other accident*	2
OD	Z74.3	*Need for continuous supervision*	2
EX	W06.1	*Fall involving special purpose bed*	2
EX	Y92.24	*Place of occurrence, health service area, this facility*	2
EX	U73.9	*Unspecified activity*	2
OD	Z74.3	*Need for continuous supervision*	2

As there were multiple injury events, a set of external cause codes must be assigned for each event that has an associated injury/Chapter 21 code.

9.6 Place of occurrence

A Place of occurrence (EX) must be specified for all external cause codes in the range V00–Y89, to denote the place of injury, poisoning or adverse effect (METeOR data element identifier 793177[41]). To indicate the Place of occurrence, use codes from range Y92.00–Y92.9 listed in the ICD-10-AM Tabular List of Diseases.

The Place of occurrence code must be sequenced after External cause codes V00-Y89.

[41] Place of occurrence <https://meteor.aihw.gov.au/content/793177>[accessed 30 October 2026]

9.7 Activity

An Activity code (EX) is a separate code from range U50–U73 for use with External cause codes V00-Y34. These codes should not be confused with, or be used instead of, the recommended Place of occurrence code classifiable to Y92.

When multiple Activity codes apply, assign the code appearing highest in the tabular list. For example, cases where sport is undertaken during school or as part of paid work should be assigned the Activity code for sport (U50–U71).

For the code range, V00–V99 Transport accidents, where the Activity at the time of the accident is not specified as sport, leisure or working for an income, assign U73.9 *Unspecified activity*.

The Activity code is to be sequenced immediately following the Place of occurrence code. Please refer to examples Section 9.5 External cause sequencing and Section 9.6 Place of occurrence.

9.8 Morphology

For each neoplasm code, there should be a corresponding morphology code (M code). A morphology code should always be assigned directly after the neoplasm code to which it applied, i.e.:

- C00-D48 *Neoplasms*
- O01.0 *Classical hydatidiform mole*
- O01.1 *Incomplete and partial hydatidiform mole*
- O01.9 *Hydatidiform mole, unspecified*
- Q85.0 *Neurofibromatosis (nonmalignant)*.

The ICD-10-AM Tabular and Appendix A notes the M codes used in ICD-10-AM Thirteenth Edition are from The International Classification of Diseases for Oncology (ICD-O) Third Edition. Each morphology code consists of 5 digits; the first four identify the histology of the neoplasm and the fifth, following a slash or solidus, indicates its behaviour.

The Morphology code (including the behaviour) must be appropriate to the histological type of the neoplasm as displayed in the table below. For example, C50.9 *Malignant neoplasm of breast, unspecified* should have an associated morphology code ending with a /3 behaviour character. Please refer to ICD-10-AM Appendix A: *Morphology of neoplasms* for additional information.

Morphology behaviour	
Code	**ICD-10-AM Chapter 2 Neoplasm Description**
/0	D10–D36 Benign neoplasms
/1	D37–D48 Neoplasms of uncertain and unknown behaviour
/2	D00–D09 In situ neoplasms
/3	C00–C75 Malignant neoplasms, stated or presumed to be primary, of specified sites, except of lymphoid, haematopoietic and related tissue C76 Malignant neoplasm of other and ill-defined sites C80 Malignant neoplasm without specification of site C81–C96 Malignant neoplasms of lymphoid, haematopoietic and related tissue D45 Polycythaemia vera D46 Myelodysplastic syndromes
/6	C77 Secondary and unspecified malignant neoplasm of lymph nodes C78 Secondary malignant neoplasm of respiratory and digestive organs C79 Secondary malignant neoplasm of other and unspecified sites

A morphology code must never be the principal diagnosis. A morphology code should always be assigned directly after the neoplasm(s) to which it relates.
For instances where a /6 Metastatic neoplasm morphology and neoplasm is recorded, a /3 primary neoplasm morphology and neoplasm should also be recorded even though the primary site may not be treated.

9.9 Morphology code sequencing

Example 1:

Where there is one neoplasm with more than one histological term with different morphology codes, assign only the morphology code with the highest number.

For example, neoplasm of upper-inner quadrant of breast with M8503/3 *Intraductal papillary adenocarcinoma with invasion* and M8510/3 *Medullary carcinoma NOS*:

Code identifier	ICD-10-AM code	Code description
PD	C50.2	*Malignant neoplasm of breast upper inner quadrant of breast*
M	M8510/3	*Medullary carcinoma NOS*

Example 2:

Where there are two neoplasm sites with the same neoplasm code, and different morphology codes, sequence the morphology code with the highest number first.
For example, M8090/3 *Basal cell carcinoma NOS* of chin and M8070/3 Squamous cell carcinoma NOS of eyebrow:

Code identifier	ICD-10-AM code	Code description
PD	C44.3	*Malignant neoplasm of skin of other and unspecified parts of face*
M	M8090/3	*Basal cell carcinoma NOS*

M	M8070/3	*Squamous cell carcinoma NOS*

Example 3:

Where there are two (or more) different neoplasms with the same morphology code, the appropriate morphology code should be sequenced directly after the last neoplasm site code.

If one of the neoplasm codes is the principal diagnosis (PD), the morphology code should be assigned twice, immediately following the PD, then again following the last applicable neoplasm site code(s).

For example, M8140/3 *Adenocarcinoma NOS* of main bronchus, caecum, and breast unspecified:

Code identifier	ICD-10-AM code	Code description
PD	C34.0	*Malignant neoplasm of main bronchus*
M	M8140/3	*Adenocarcinoma NOS*
OD	C18.0	*Malignant neoplasm of caecum*
OD	C50.9	*Malignant neoplasm of breast, unspecified part*
M	M8140/3	*Adenocarcinoma NOS*

This is the same for where the PD is one of multiple metastases.

For example, M8140/6 *Adenocarcinoma, metastatic* of liver, intrathoracic lymph nodes and intra-abdominal lymph nodes:

Code identifier	ICD-10-AM code	Code description
PD	C78.7	*Secondary malignant neoplasm of liver and intrahepatic bile duct*
M	M8140/6	*Adenocarcinoma, metastatic NOS*
OD	C77.1	*Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes*
OD	C77.2	*Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes*
M	M8140/6	*Adenocarcinoma, metastatic NOS*
OD	C16.0	*Malignant neoplasm of cardia*
M	M8140/3	*Adenocarcinoma NOS*

9.10 Clinical Intervention (Procedure)

Clinical interventions (METeOR data element identifier 824102[42]) are coded using The Australian Classification of Health Interventions (ACHI). Whilst there is no limit to the number

[42] Procedure code. Available from < https://meteor.aihw.gov.au/content/824102> [accessed 30 October 2026]

of procedures that can be recorded for an admitted patient episode of care, there are only a defined number (100) of procedures that are passed into the grouper. It is possible to have duplicate codes in this section, for example, bilateral cataract extraction requires two codes to represent the bilateral aspect of the procedure. Please refer to ACS 0020 *Bilateral/multiple procedures* for further information.

All significant clinical interventions undertaken from the time of admission to the time of separation should be coded as per the relevant ACS. Please refer to ACS 0016 *General procedure guidelines*, ACS 0042 *Procedures normally not coded, 0044 Pharmacotherapy* and ACS 0029 *Coding of contracted procedures* for further information.

Significant clinical interventions include diagnostic and therapeutic procedures. Also include any procedures that were performed under contract with another contracted hospital, HHS, health authority or private health provider (non-hospital) and use the contract flag to identify whether they were performed on an admitted or non-admitted basis. Typically, those procedures noted within ACS 0042 *Procedures normally not coded* are not coded, but in certain circumstances these procedures may be required to be coded, such as if cerebral anaesthesia is required in order for the procedure to be performed.

Procedures performed in the hospital emergency department, or elsewhere, that precede the admission time should not be coded in the admitted patient episode of care.

9.11 Condition onset flag

The Condition onset flag (COF) is a data item that indicates the presence of a condition (diagnosis) on admission to an episode of admitted patient care. It is a means of differentiating those conditions which arise during, from those arising before, an admitted patient episode of care and may inform prevention strategies particularly in relation to complications of clinical care. The COF value is to be applied to the PD, OD(s), supplementary chronic condition, external cause and morphology codes.

The COF (previously called Condition Present on Admission (CPoA)) has been collected in Queensland for all separations from 1 July 2006 and is now assigned for all diagnosis codes i.e. principal diagnosis, other diagnoses, external cause and morphology codes. Three values were implemented, 1 - Condition present on admission to the episode of admitted patient care, 2 - Condition arose during the episode of admitted patient care and 9 - Condition onset unknown/ uncertain on admission to the episode of admitted patient care.

On 1 July 2008, the national data element *'Episode of admitted patient care – condition onset flag*' (COF) was mandated for collection in the Admitted Patient Care National Minimum Data Set. Unfortunately, when the national standard was introduced, it reversed the meaning of the codes already used in Queensland and only values 1 and 2 were included. Queensland

Health decided to retain the original Queensland data element (Condition Present on Admission (CPoA)) with all three values rather than risk quality issues and confusing coders by reversing the meanings for the values.

From 1 July 2019, the Queensland data element name changed from 'Condition Present on Admission' to 'Condition onset flag' as the difference in the data element name was causing confusion for Clinical Coders and was not in alignment with the related ACS 0048 *Condition Onset Flag*.

Note: The data element values did not change – only the name of the data element. Queensland Health ensures that the data supplied conforms to the national standard for national reporting purposes.

From 1 July 2020, the COF value 9 - Condition onset unknown/uncertain on admission to the episode of care was end-dated in order to more closely align with national standards.
The relationship between the data element values is shown in the table below. Refer below for full description of each COF value.

COF Permissible Value	COF (Queensland)	Relationship to the COF (National) as shown in ACS 0048
1	Condition **present** on admission to the episode of care	COF – value 2 Condition not noted as arising during the episode of care
2	Condition **arose** during the episode of care	COF – value 1 Condition with onset during the episode of care

The definitions of the COF values are identical for all systems. They are:

Condition present on admission (value = 1):

A condition previously existing or suspected on admission to the current episode of care such as the presenting problem, a comorbidity or chronic disease. See ACS 0048 *Condition onset flag* for examples.

Condition arose during the episode of care (value = 2):

A condition which arose during the current episode of admitted patient care and would not have been present or suspected on admission. See ACS 0048 *Condition onset flag* for examples.

9.11.1 Assigning the Condition onset flag

The COF does not alter the application of existing coding conventions, practices and ACS. See ACS 0048 *Condition onset flag* for further information. Assignment of the COF is a secondary process that should be applied only to those conditions already selected for coding in accordance with ACS. A COF value must be assigned with each ICD-10-AM diagnosis code.

It is advised the most straightforward method to determine the COF value for each diagnosis code is to determine whether the condition present on admission to the episode.

Yes (value = 1)
No (value = 2).

Please refer to ACS0048 *Condition Onset Flag* for guidelines on applying the Condition Onset Flag.

9.12 Submission of Condition onset flag

Dependent on which coding decision support tool, patient administration system or paper form a hospital will use to collect the ICD-10-AM codes, the method of assigning the '1' or '2 value for the COF will differ. Regardless of the method of assigning the indicator, all facilities must submit the data item to Queensland Health in the same format.

The valid values for this data item are:

Value	Description
1	Condition present on admission to the episode of care
2	Condition arose during the episode of care

HBCIS Hospitals	**Extracted and submitted to DSB via HQI**		
	HBCIS Code	**Description**	**COF value**
	P	Condition present on admission	1 or
	P	Condition present on admission	2 (neonates only)
	A	Condition present on admission	1
	C	Condition not present on admission	2
		Procedure	Null

Other Hospitals	Each diagnosis morbidity code is to be flagged by an ICD-10-AM code Condition onset flag. Record the Condition onset flag using the following values:		
	Code Identifier	**Description**	**COF value**
	PD	Principal diagnosis	1 or
	PD	Principal diagnosis	2 (neonates only)
	OD	Other diagnosis	1 or 2
	EX	External cause	1 or 2
	M	Morphology	1
	PR	Procedure	Null

9.13 Continuous ventilatory support

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

CVS data is used for many purposes including performance reporting, morbidity and mortality reviews, Activity Based Funding, resource planning and service utilisation.

For the purposes of coding CVS starts when:

- The patient is intubated anywhere in the hospital, or
- When CVS is started via the patient's tracheostomy, or
- At the time of admission, for those patients who were already intubated and ventilated when they were admitted.

CVS ends when:

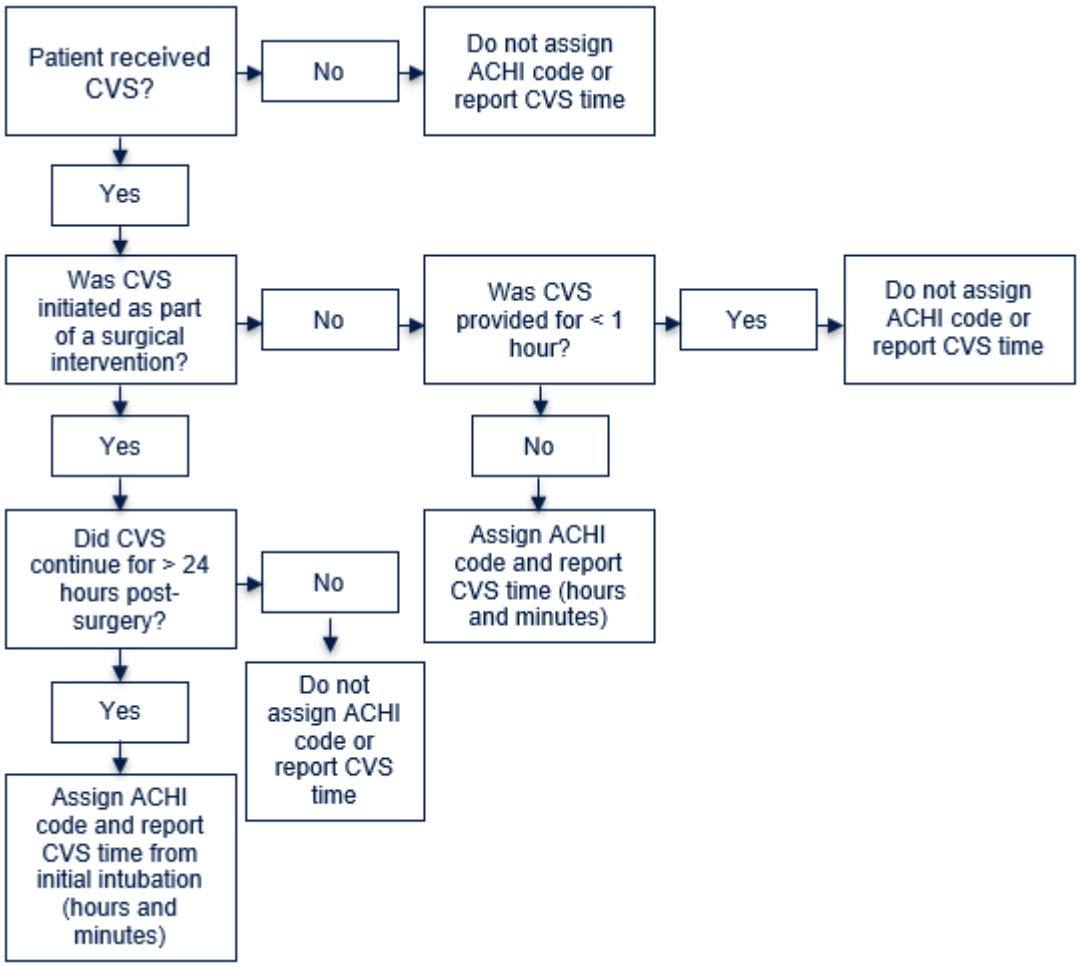
- When the patient is extubated (the endotracheal tube is removed), or
- When the CVS is ceased after any period of weaning, or
- The CVS via the patient's tracheostomy is stopped, or
- When the patient is discharged, transferred from the hospital or dies, or
- When there is a change in episode type (e.g. The patient is transferred from acute care to rehabilitation).

For QHAPDC, CVS duration is reported in total hours and minutes for each patient episode, unlike ICD-10-AM where it is reported in cumulative completed hours. For example, in QHAPDC when total CVS time is reported as 24 hours and 15 minutes, for coding purposes it is assigned in completed cumulative 24 hours i.e. 13882-00 *Management of continuous ventilatory support, 24 hours or less*.

Please refer to ACS 1006 *Ventilatory Support* for guidance on the classification of CVS.
For neonates, please refer to ACS 1615 *Interventions for neonates* for guidance on the classification of CVS.

HBCIS Hospitals	CVS is reported as the total time in hours and minutes with the associated ACHI procedure code. The time value is recorded in the Inpatient ICD Coding entry screen, Field 07. The time value is to be recorded in HBCIS with the : separator. Leading zeros are not required. The time value will be reported as a numeric string in the format HHHHHMM (without the : separator). The hours and minutes will be right-justified with leading zeroes omitted e.g. 14 hours and 8 minutes will be reported as 1408.

Figure 5 Continuous ventilatory support flow chart



Scenario 1:

Patient admitted for surgery at 11:00 hrs.
Intubation and CVS begin at 11:00 hrs, surgery completes at 13:00 hrs, and CVS continues in ICU until extubation on Day 2 at 13:30 hrs.
Total CVS time: 26:30.

Code identifier	ICD-10-AM code	Code description
PR	13882-01	*Management of continuous ventilatory support, more than 24 hours but less than 96 hours*

Scenario 2:

Patient admitted at 10:00 hrs.
CVS initiated at 11:05 hrs before emergency surgery. Surgery begins at 11:30, ends at 13:05 with extubation at 13:05 hrs.
Total CVS time: 2:00.

Code identifier	ICD-10-AM code	Code description
PR	13882-00	*Management of continuous ventilatory support, 24 hours or less*

Scenario 3:

Patient admitted at 10:00 hrs.
CVS initiated at 11:00 hrs before emergency surgery. Surgery begins at 11:30, ends at 12:30 with extubation at 12:30 hrs.
Total CVS time: 1:30.

Code identifier	ICD-10-AM code	Code description
PR	13882-00	*Management of continuous ventilatory support, 24 hours or less*

Scenario 4:

Patient admitted for elective surgery at 10:00 hrs
Prior to surgery the patient's condition deteriorates, CVS is initiated at 11:00 hrs and continues until extubation on Day 2 at 11:30 hrs. Patient is discharged without surgery.
Total CVS time: 24:30.

Code identifier	ICD-10-AM code	Code description
PR	13882-00	*Management of continuous ventilatory support, 24 hours or less*

Scenario 5:

Patient admitted at 15:00 hrs
CVS initiated at 16:00 hrs and the patient transferred to another facility at 16:45 hrs.
Total CVS time: Less than 1 hour.
No CVS ACHI code or time is reported.

Scenario 6:

Patient admitted at 10:00 hrs
CVS initiated at 12:00 hrs, extubation at 18:00 hrs. On Day 2 CVS re-commenced at 13:30 hrs and patient is then transferred at 14:20 hrs.
Total CVS time: 6 hours (Day 1: 6:00, Day 2: < 1 hour).

Code identifier	ICD-10-AM code	Code description
PR	13882-00	*Management of continuous ventilatory support, 24 hours or less*

9.14 Australian Refined Diagnosis Related Group (AR-DRG)

If the hospital has the ability to group on site using the AR-DRG system:

HBCIS Hospitals	The DRG will be assigned automatically.
Other Hospitals	Record the AR-DRG code.

Note: From 1 July 2012 the Australian Refined Diagnosis Related Group (AR-DRG) codes are not required to be supplied by private facilities. The AR-DRG and major diagnostic category codes are automatically derived by DSB's processing system (using the ICD-10-AM and ACHI data supplied).

From 1 July 2020, Australia moved to a 3 year cycle for AR-DRG (previously had been a two year cycle).

It is important to use the AR-DRG version compatible with the ICD-10-AM and coding standards for the current year. Public hospitals will group to DRG Version 12 for 2026-2027. The DSB will continue to group to multiple versions for time series analysis.

9.15 Major diagnostic category (MDC)

If the hospital has the ability to group on site using the AR-DRG:

HBCIS Hospitals	The MDC will be assigned automatically.
Other Hospitals	Record the MDC code.

Note: From 1 July 2012 the Major Diagnostic Category (MDC) codes are not required to be supplied by private facilities. The AR-DRG code and MDC codes are automatically derived by DSB's processing system (using the ICD-10-AM/ACHI data supplied).

It is important to use the AR-DRG version compatible with the ICD-10-AM, ACHI and coding standards for the current year.

9.16 Contracted procedures

Contracted procedures are flagged with an indicator that designates that a procedure was performed by another hospital (public/private) or **private health provider (non-hospital)** as a contracted service, either as an admitted or non-admitted service. Diagnoses identified

from the contracted episode of care should be coded. However, these diagnosis codes should not be flagged as contracted, unless it is to indicate that a contracted service was not carried out or where there is no valid procedure code available for the contracted service.

The recording and coding of contracted procedures is supported by ACS 0029 *Coding of contracted procedures*.

	Record the following codes to flag a contact service	
All Hospitals	**Code**	**Description**
	1	Contracted admitted procedure
	2	Contracted non-admitted procedure **or procedure performed by a private health provider (non-hospital).** See Section 4.7.11 Recording of procedures performed by private health providers (Non-hospital).

Example:

A patient is admitted to Hospital A suffering an acute myocardial infarction. Once the patient has been stabilised, the patient is transferred (contract leave) to Hospital B (admitted) for a coronary angiography with left heart catheterisation with left ventriculography.

During the procedure, it is diagnosed that the patient has significant coronary artery disease in the left anterior descending coronary artery. The procedure progresses to a percutaneous insertion of 1 transluminal stent into single coronary artery. Post operatively (two hours later) the patient is transferred back to Hospital A to continue to receive care. The patient continues to recover, receives physiotherapy and is discharged from Hospital A two days later.

Procedure	Hospital A	Hospital B
I21.2 *Acute transmural myocardial infarction of other sites*	Code assigned	Code assigned
I25.11 *Atherosclerotic heart disease of native coronary artery*	Code assigned	Code assigned
38218-00 [668] *Coronary angiography with left heart catheterisation*	Code assigned – contract flag of 1 Contracted admitted procedure	Code assigned
59903-00 [607] *Left ventriculography*	Code assigned – contract flag of 1 Contracted admitted procedure	Code assigned
38306-00 [671] *Percutaneous insertion of 1 transluminal stent into single coronary artery*	Code assigned – contract flag of 1 Contracted admitted procedure	Code assigned
95550-03 [1916] *Allied health intervention, physiotherapy*	Code assigned	

If the interventional cardiology procedures in the above scenario had been performed at Hospital B as a non-admitted care, rather than an admitted episode of care, the procedures performed at Hospital B would be flagged at Hospital A as 2 Contracted non-admitted procedures.

9.17 Date of intervention

This data element provides valuable information on the timing of the procedure in relation to the episode of care, and in particular allows accurate information on pre and post-operative lengths of stay. It also allows a measurement of time between procedures; this is of particular interest given initiatives to encourage day of admission surgery and day only procedures.

If a procedure falls within the mandatory block range as listed below, enter the date the procedure was performed. This information should be provided by the patient's attending clinician and be recorded in the patient's medical record.

Where a procedure is performed multiple times on different dates, and the Australian Coding Standards (ACS) direct that the procedure is to be coded once only (e.g. pharmacotherapy for neoplasms blood products), the date allocated is the date when the procedure was first performed.

Block ranges requiring the recording of a procedure date:

[1]	to	[1059]
[1062]	to	[1821]
[1825]	to	[1866]
[1869]	to	[1892]
[1894]	to	[1912]
[1920]	to	[2016]
[8888]	to	[8889]

10. MENTAL HEALTH

10.1 Mental health details

The scope of this section is for all admitted patient episodes where the standard unit code (either at admission to the episode or through a unit transfer during the episode) is in the range PYAA to PYZZ (Mental Health Unit). These patients should have one record completed for the episode of care. No record would be completed if there were no standard unit codes in this range in the episode recorded. Those hospitals that have specialised mental health services are listed in Appendix K.

Mental health details must be reported by residential mental health care facilities. Refer to the RMHCDC manual for further guidelines for the provision of mental health details.

Mental health details do not have to be reported for boarders who are registered as being in a PYAA to PYZZ standard unit code.

10.1.1 Type of usual accommodation

The type of physical accommodation the patient lived in prior to admission to the hospital.

All Hospitals	Record the following codes to indicate the type of usual accommodation	
	Code	**Description**
	1	House or flat
	2	Independent unit as part of retirement village or similar
	3	Hostel or hostel type accommodation
	4	Psychiatric hospital
	5	Acute hospital
	6	Residential mental health care facility
	7	Other accommodation
	8	No usual residence

10.1.2 Employment status

Self-reported employment status, as defined by the categories given below, immediately prior to admission to the hospital.

Note: This item refers to self-reported status. As a guide, unemployed refers to someone not in paid employment and who is actively seeking paid employment. People who have retired from paid employment, whether or not they are now in receipt of any form of pension or benefit may be recorded as Other, Home duties or Student as self-reported by the patient. The person's pension status is collected separately by the Pension status item. See Section 10.1.3 Pension Status.

All Hospitals	Record the following codes to indicate the employment status	
	Code	**Description**
	1	Child not at school
	2	Student
	3	Employed
	4	Unemployed
	5	Home duties
	6	Pensioner
	8	Other

10.1.3 Pension status

The pension status of a patient refers to whether or not a patient is in receipt of a pension at the time of admission to hospital. It also details the nature of the pension held by the patient. This does not imply that the pension is necessarily the recipient's main source of income.

Please note that the broad heading of 'Pensions' encompasses a range of related pensions and allowances. For example:

- The term Invalid Pension includes the Disability Support Pension.
- The term Unemployment Benefit includes Jobseeker Allowance and Youth Allowance.
- The term Aged Pension includes Mature Age Allowance and Mature Age Partner Allowance.

All Hospitals	Record the following codes to indicate the pension status of the patient	
	Code	**Description**
	1	Aged
	2	Repatriation
	3	Invalid
	4	Unemployment benefit
	5	Sickness benefits
	7	Other
	8	No pension/benefit

10.1.4 First admission for psychiatric treatment

First admission for psychiatric treatment is the status of the episode in terms of whether it is a first or subsequent admission, at any hospital for any condition, for psychiatric treatment, whether in an acute or psychiatric hospital.

All Hospitals	Record the following codes to indicate the first admission for psychiatric treatment	
	Code	**Description**
	1	No previous admission for psychiatric treatment
	2	Previous admission for psychiatric treatment

Note: previous care in a residential health care facility providing treatment in a community-based setting should not be counted as a previous admission for psychiatric treatment, as consumers in residential mental health care facilities are not classified as admitted patients.

10.1.5 Referral to further care

Referral to further care by health service agencies/facilities following discharge from the hospital (or episode of care). Many psychiatric patients have continuing needs for post-discharge care.

Where a patient has been referred to more than one type of ongoing care, the principal provider of continuing care should be entered, that is, the person or facility who is primarily responsible for managing the patient's ongoing care.

All Hospitals	Record the following codes to indicate the place to which the patient is referred	
	Code	**Description**
	01	Not referred
	02	Private psychiatrist
	03	Other private medical practitioner
	04	Mental health/alcohol and drug facility - admitted patient
	05	Mental health/alcohol and drug facility - non-admitted patient
	06	Acute hospital - admitted patient
	07	Acute hospital - non-admitted patient
	09	General Practitioner
	10	Residential mental health care facility
	08	Community health program
	29	Other
	98	Not Applicable

Residential mental health care facilities should refer to the RMHCDC manual for guidelines on providing referral to further care.

Code 01 Not referred

Used for patients who were not referred to further care. This includes patients who left against medical advice or did not return from leave and therefore did not receive any referrals for ongoing care.

Note: the following scenarios should use code 98 'Not Applicable':

- patients who died during their care; or
- patients remaining in at the end of the reporting period for residential mental health care facilities

Code 02 Private psychiatrist

Used for patients who will receive ongoing care from a private psychiatrist.

Code 03 Other private medical practitioner

Used for patients who will receive ongoing care / management from a private medical practitioner who specialises in a field other than psychiatry and is not practising as a general practitioner.

Code 04 Mental health / alcohol and drug facility – admitted patient

Used for patients who are referred to a designated specialised mental health facility or a specialised alcohol and drug treatment facility. This includes specialised mental health units in acute hospitals, and psychiatric hospitals.

Code 05 Mental health / alcohol and drug facility – non-admitted patient

Used for patients who are referred to a specialist mental health facility or a specialised alcohol and drug treatment facility. This includes outpatients or ambulatory programs run out of specialised units in acute hospitals or psychiatric hospitals, and services provided through a community mental health service or a community alcohol and other drug treatment service. Note: It does not include residential mental health care facilities, as these are captured in Code 10 below.

Code 06 Acute hospital – admitted patient

Used for patients who are transferred to an acute hospital (including an acute ward in the same hospital) for an acute condition. This includes patients receiving care for a mental health condition in a hospital that does not have a designated specialised mental health unit, and consumers receiving care for a non-mental health condition. It also includes patients who had a care type change for management of an acute condition.

Code 07 Acute hospital – non-admitted patient

Used for patients who are referred to an outpatient or ambulatory program run from an acute hospital. This includes consumers receiving care for a mental health condition in a hospital that does not have a specialised mental health service, and patients receiving care for a non-mental health condition.

Code 08 Community health program

Used for patients who are referred to a community health program that is not a specialised community mental health service or a specialised community alcohol and other drug treatment service.

Code 09 General practitioner

Used for patients who will receive their ongoing care / management from a general practitioner, or a specialist practising as a general practitioner. This does not include registered psychiatrists.

Code 10 Residential mental health care facility

Used for patients who are transferred to a facility that meets the criteria for a residential mental health care facility. This includes Community Care Units, Step Up Step Down Units, and Youth Residential Rehabilitation Units. If the facility does not meet the criteria for a residential mental health care facility, referral to further care should be coded as ’29 Other’.

Code 29 Other

Used for all care that does not meet the conditions of other codes. This includes referral to facilities managed by private or charity based organisations. It also includes referrals to private allied health practitioners, including private psychologists.

Code 98 Not applicable

This code can only be reported if the patient has died during the episode, or by residential mental health care facilities unless the patient has died.

10.1.6 Mental health legal status indicator

Whether a person is treated on an involuntary basis under the relevant mental health legislation: at any time during an episode of admitted patient care or an episode of residential care, or at the time of contact for treatment as a patient/client by a community based service, as represented by a code. This is collected at separation from the hospital (or episode of care).

All Hospitals	Record the following codes to indicate the mental health legal status indicator	
	Code	**Description**
	1	Involuntary patient for any part of the episode
	2	Voluntary patient for all of the episode

10.1.7 Previous specialised non-admitted treatment

Previous specialised non-admitted treatment is the status of the episode in terms of whether the patient has had a non-admitted service contact for psychiatric treatment, prior to this admission. A non-admitted service contact may occur at any non-admitted specialised mental health service, including hospital mental health outpatient clinics, community mental health services, and residential mental health services.

	Code	**Description**
All Hospitals	1	Patient has no previous non-admitted service/contacts for psychiatric treatment
	2	Patient has previous non-admitted service/contacts for psychiatric treatment

11. ELECTIVE SURGERY DETAILS (PUBLIC HOSPITALS)

Elective surgery details are collected by public hospitals listed in Appendix K (Elective Surgery Hospitals – Public Hospitals table). HBCIS hospitals collect elective surgery details through the Elective Admission Management module (EAM). The scope of this collection includes all patients admitted to hospital for an elective procedure, for which they have been placed on a waiting list. The purpose of the link between the waiting list and relevant admission episode is to provide a more complete picture of elective procedural care, that is, the information collected from the time a patient was placed on a waiting list through to separation from hospital. When a patient is admitted to hospital, it is possible to link to a waiting list entry (where one exists). If a patient has a waiting list status in EAM of admitted, treated or removed, the waiting list entry can be linked to the patient episode. Not all admitted patients will have waiting list details, but all elective surgery patients should have a waiting list entry. Some admitted patients with a corresponding waiting list entry may be admitted as an emergency. This can occur if a patient had been on the waiting list and their condition deteriorated before they were admitted for their planned elective surgery, so presented as an emergency patient and treated for their planned procedure.

11.1 HQI extract and waiting list entries

The HQI extract will include EAM items only where they are linked to admission episodes. Only the waiting list entries that were completed (treated or removed) during an admission need to be linked.

Mandatory conditions for acceptance in the HQI extract (apart from separated, coded and grouped) are that the EAM entry has been linked and that the waiting list status is two (2) or greater, being treated or removed. EAM entries that have a waiting list status of A - Admitted and are linked will be flagged as errors in the extract. Such entries need to have their status updated to either treated or removed.

Data items in the extract will be validated against the corporate reference files by the DSB. It is crucial therefore that reference files are up to date.

11.2 Elective admission details

11.2.1 Entry number

Each waiting list entry has a placement number unique within the patient identifier. This number is from field 02 of the Waiting List Entry screen and is generated by HBCIS.

11.2.2 Surgical specialty (previously known as NMDS Specialty Grouping)

The Surgical specialty is the specialty of the unit to which the patient is assigned upon their admission for elective surgery. Surgical specialties are derived from mapping Planned Unit codes to one of the 12 Surgical specialties. Generally, in Queensland public hospitals, the patient is assigned to a treating doctor, who is mapped to a treating doctor unit, which is

mapped to a standard unit code, which is mapped to a surgical specialty. All mappings are done on a 'best fit' basis, reflecting the majority of activity within a unit.

	HBCIS Waiting List Specialty		Extracted/mapped by HQI	
	Code	**Description**	**Code**	**Description**
HBCIS Hospitals	01	Cardio Thoracic	01	Cardiothoracic Surgery
	02	ENT Surgery	02	Ear, Nose and Throat Surgery
	03	General Surgery	03	General Surgery
	04	Gynaecology	04	Gynaecology
	05	Neurosurgery	05	Neurosurgery
	06	Ophthalmology	06	Ophthalmology
	07	Orthopaedic Surgery	07	Orthopaedic Surgery
	08	Plastic and Reconstructive	08	Plastic and Reconstructive Surgery
	09	Urology	09	Urology
	10	Vascular Surgery	10	Vascular Surgery
	11	Other Surgical	11	Other Surgical
	51	Gastroenterology	90	Non-Surgical
	52	Respiratory Medicine	90	Non-Surgical
	53	Cardiology	90	Non-Surgical
	54	Dental	90	Non-Surgical
	55	Psychiatry	90	Non-Surgical
	56	General Medicine	90	Non-Surgical
	57	Radiology	90	Non-Surgical
	58	Renal Medicine	90	Non-Surgical
	59	Oncology	90	Non-Surgical
	60	Neurology	90	Non-Surgical
	69	Other Non Surgical	90	Non-Surgical

11.2.3 Reason for removal

The reason for removal is derived by HBCIS from the waiting list status field. The waiting list status codes from the corporate reference file are mapped to one of the seven reason for removal codes upon extract.

	HBCIS Waiting List Status		Extracted/mapped by HQI	
	Code	**Description**	**Code**	**Description**
HBCIS Hospitals	0	Active – awaiting booking	N/A	Not extracted/mapped by HQI
	1	Booked	N/A	Not extracted/mapped by HQI
	11	Patient requested to be removed	05	Surgery not required or declined
	12	Consultant removed patient	05	Surgery not required or declined
	13	Patient cancelled booking	05	Surgery not required or declined
	14	Unfit for surgery	05	Surgery not required or declined
	16	FTA preadmission	N/A	Not extracted/mapped by HQI
	17	FTA surgery	N/A	Not extracted/mapped by HQI
	2	Treated	01	Admitted and treated as an elective patient for awaited procedure in this hospital
	27	Equipment failure/unavailable	N/A	Not extracted/mapped by HQI
	3	Emergency, treated as	02	Admitted and treated as an emergency patient for awaited procedure in this hospital
	34	Data entry error	N/A	Not extracted/mapped by HQI
	4	No longer requires treatment	05	Surgery not required or declined
	44	Natural disaster	N/A	Not extracted/mapped by HQI
	45	Removed due to audit/policy	05	Surgery not required or declined
	46	Transferred to non-QH facility	04	Treated elsewhere for awaited procedure (not on behalf of this hospital or state/territory)
	47	Transferred to other QH facility for treatment	06	Transferred to another hospital for awaited procedure (on behalf of this hospital or the state / territory)
	6	Treated elsewhere	04	Treated elsewhere for awaited procedure (not on behalf of this hospital or state/territory)
	7	Patient could not be located	03	Could not be contacted
	8	Deceased	03	Could not be contacted
	99	Other	99	Not stated/unknown
	A	Admitted	N/A	Not extracted/mapped by HQI

11.2.4 Listing date

This is the date the patient was placed on the waiting list for elective surgery. This date is from field 03 of the Waiting List Entry screen and is entered by the user.

11.2.5 Urgency category

This is a code that indicates the urgency with which the patient requires elective procedural care, as determined by the treating clinician. It is the final change on any day to the clinical urgency category in field 23 of the Waiting List Entry screen.

	HBCIS Clinical Urgency Category		Extracted/mapped by HQI	
	Code	**Description**	**Code**	**Description**
HBCIS Hospitals	1	Cat 1 – within 30 days	1	Elective surgery – category 1
	2	Cat 2 – within 90 days	2	Elective surgery – category 2
	3	Cat 3 – routine	3	Elective surgery – category 3
	4	Other – category 1	4	Other – category 1
	5	Other – category 2	5	Other – category 2
	6	Other – category 3	6	Other – category 3
	9	Surveillance procedure	9	Surveillance procedure
	E	Emergency priority category	N/A	Not extracted/mapped by HQI

11.2.6 Accommodation (Intended)

This is a code to indicate the planned type of physical accommodation for the patient as at the date placed on the waiting list, whether the patient plans to be treated as a public or private patient. This intended accommodation is from field 24 of the Waiting List Entry screen. The item does not relate to the patient's hospital insurance status or the actual accommodation after admission.

	Code	**Description**
HBCIS Hospitals	P	Public
	R	Private Single
	S	Private Shared

11.2.7 Planned primary procedure (previously known as Primary planned procedure code)

This is the primary procedure for which the patient has been placed on the waiting list, as represented by a code.

The planned primary procedure code is a seven character ACHI code and is from field 27 of the Waiting List Entry screen.

11.2.8 Intended procedure

The intended procedure is a three-digit code for the procedure for which a patient has been placed on an elective surgery waiting list. The code is derived by DSB from the planned primary procedure code provided in Field 27 of the Waiting List entry screen. The list of intended procedure codes are available from https://meteor.aihw.gov.au/content/810837 [accessed 30 October 2026].

11.2.9 Planned length of stay

This is the expected or intended length of stay required when the patient will be admitted to receive the treatment for which they were placed on the waiting list. The QHAPDC receives the value collected at the time the patient was placed on the waiting list. This is from field 25 of the Waiting List Entry screen. Note that a planned same day admission is recorded as a D and is converted to zero when extracted to the DSB.

11.2.10 Planned procedure/operation date

This is the most recent planned procedure date for the patient for their reported waiting list entries. The data are collected from field 03 of the Booking Entry screen in EAM. This field is mandatory for patients with a waiting list status of 02 Treated.

11.3 Activity record details

11.3.1 Activity code

If a patient was not ready for surgery for a period while they were on the waiting list, or any changes occur to a patient's urgency category, then a date of change of the item is reported in the activity file, using the relevant activity code. This activity code is generated by HBCIS. All periods of not ready for surgery and the latest value on the particular day following any changes to urgency categories will be forwarded to the DSB.

HBCIS Hospitals	Code	Description
	N	Not ready for surgery
	E	Elective Surgery Items

11.3.2 Not ready for surgery

Entry number

Each waiting list entry has a placement number unique within the patient identifier. The entry number in the Activity Record Details file must match with the corresponding entry number in the Elective Admission Details file. This number is from field 02 of the Waiting List Entry screen and is generated by HBCIS.

Start date not ready for surgery

Each waiting list entry may have one or more periods where the patient is not ready for surgery. The date not ready for surgery is the first date in this period that the patient will not be ready for surgery and is from field 05 of the Waiting List Entry screen. Not ready for surgery patients are those who are not in a position to commence treatment.

Last date not ready for surgery

Each waiting list entry may have one or more periods where the patient was not ready for surgery. The last date not ready for surgery is the final date in a period that the patient is not ready for surgery and is from field 06 of the Waiting List Entry Screen.

11.3.3 Elective surgery items

Entry number

Each waiting list entry has a placement number unique within the patient identifier. The entry number in the Activity Records Details file must match with the corresponding entry number in the Elective Admission Details file. This number is from field 02 of the Waiting List Entry screen and is generated by HBCIS.

Urgency category

This is the latest urgency category value on the particular day following any changes to the clinical urgency category from field 23 of the Waiting List Entry screen. It indicates the urgency with which the patient requires elective procedural care, as determined by the treating clinician.

	HBCIS Clinical Urgency Category		Extracted/mapped by HQI	
	Code	**Description**	**Code**	**Description**
HBCIS Hospitals	1	Cat 1 – within 30 days	1	Elective surgery – category 1
	2	Cat 2 – within 90 days	2	Elective surgery – category 2
	3	Cat 3 – routine	3	Elective surgery – category 3
	4	Other – category 1	4	Other – category 1
	5	Other – category 2	5	Other – category 2
	6	Other – category 3	6	Other – category 3
	9	Surveillance procedure	9	Surveillance procedure
	E	Emergency priority category	N/A	Not extracted/mapped by HQI

Date of change

The date of change for any elective admission data item in the Activity Records Details file will be recorded. The date of change is entered by the user upon inserting new data into fields 22 - 26 of the Waiting List Entry screen.

12. SUB AND NON-ACUTE PATIENT (SNAP) DETAILS – (PUBLIC AND PRIVATE HOSPITALS)

12.1 SUB and NON-ACUTE patient (SNAP) details

Public hospitals are required to report SNAP details for all Sub and Non-Acute episodes of care regardless of whether the patient is in a designated SNAP Unit or not.

Private hospitals are required to report SNAP data for all public Sub and Non-Acute patients (irrespective of whether the patient is being treated in a designated unit).

SNAP validations will be based on care type, not admission to a designated SNAP ward/bed.

The Australian National Sub and Non-Acute Patient (AN-SNAP) Classification System has been implemented to better inform service planning, purchasing, and clinical management. The scope of this collection includes all admitted patient episodes with the following care types:

- 09 Geriatric Evaluation and Management care;
- 10 Psychogeriatric care
- 11 Maintenance care
- 20 Rehabilitation care
- 30 Palliative care

Please also refer to the Sub and Non-Acute Care Data Entry Guidelines for Admitted Patients[43].

12.2 SNAP details

12.2.1 SNAP episode number

Each set of SNAP details should be assigned a unique SNAP episode number. This number will form part of each record's unique identifier when the SNAP details are forwarded to the DSB.

Maintenance SNAP episode – There must be a least one SNAP episode within a single maintenance episode of care. See Section Maintenance SNAP type.

Geriatric Evaluation and Management, Psychogeriatric, Rehabilitation and Palliative SNAP episodes – There can only be one within a single SNAP episode within a single sub-acute care type.

[43] Sub and Non-Acute Care Data Entry Guidelines for Admitted Patients. Available from https://qheps.health.qld.gov.au/dsb/datacollections> [30 October 2026]

12.2.2 SNAP type

The SNAP Type is a classification of a patient's care type based on their characteristics, primary treatment goal and evidence.

The codes for each SNAP Type are validated against valid sub and non-acute episode types.

Geriatric evaluation and management SNAP type

Geriatric Evaluation and Management (GEM) is provided for a person with complex multi-dimensional medical problems associated with disabilities and psychosocial problems, usually (but not always) an older person.

Geriatric Evaluation and Management SNAP types can only be used in conjunction with a care type of 09, Geriatric Evaluation and Management Care.

There can only be one SNAP episode within a single GEM episode of care.

Geriatric SNAP Type	Definition
GEM	Geriatric Evaluation and Management

Psychogeriatric SNAP type

Psychogeriatric care is provided to persons with age-related organic brain impairment with significant behavioural disturbance or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance.

The Psychogeriatric SNAP types can only be used in conjunction with a care type of 10, Psychogeriatric Care.

There can only be one SNAP episode within a single Psychogeriatric episode of care

Psychogeriatric SNAP Type	Definition
PSG	Psychogeriatric

Maintenance SNAP type

Maintenance is provided for a person with a disability who, following assessment or treatment, does not require further complex assessment or stabilisation.

Patients with a care type of maintenance care often require care over an indefinite period.

Maintenance SNAP types can only be used in conjunction with a care type of 11, Maintenance Care.

There must be at least one SNAP episode (with a unique SNAP episode identifier) within a single Maintenance episode of care.

Where there are multiple SNAP episodes within a single Maintenance episode of care, they must be contiguous and have different SNAP types.

Example:
Patient Admitted: 01 August 2026
Patient Discharged: 10 August 2026
Care Type: 11 – Maintenance
First SNAP episode 1 (SNAP Type – MCO)
SNAP Start Date: 01 August 2026
SNAP End Date: 05 August 2026
Second SNAP episode 2 (SNAP Type – MNH)
SNAP: Start Date 06 August 2026
SNAP End Date 10 August 2026

Maintenance SNAP Type		
Code	**Description**	**Definition**
MNH	Maintenance - Nursing Home Type	The patient is waiting placement in a residential aged care facility. Note: MNH SNAP Type should not be confused with the Nursing Home Type Patient (NHTP) class used for accounting purposes. See Section 4.14 Nursing Home Type Patients (NHTP) for further information on NHTPs.
MCO	Maintenance Care (Convalescent)	Following assessment and/or treatment the patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. Under normal circumstances the patient would be discharged but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged. Examples may include: – Patients awaiting the completion of home modifications essential for discharge. – Patients awaiting the provision of specialised equipment essential for discharge. – Patients waiting for rehousing. – Patients waiting for supported accommodation such as hostel or group home bed. Patients for whom community services are essential for discharge but are not yet available.
MOT	Maintenance Care (Other Maintenance)	Any other reason the patient may require a maintenance episode other than those already stated.
MRE	Maintenance - Respite	A patient who is not waiting for residential care and the primary reason for admission is the short-term unavailability of the patient's usual care arrangements. Examples may include: – Admission due to carer illness or fatigue. – Planned respite due to carer unavailability. – Short term closure of care facility. – Short term unavailability of community services.

Rehabilitation SNAP type

Rehabilitation care is provided for a person with an impairment, disability or handicap.

Rehabilitation SNAP types can only be used in conjunction with a care type of 20, Rehabilitation.

There can only be one SNAP episode within a single Rehabilitation episode of care

Rehabilitation SNAP Type		
Code	**Description**	**Definition**
RAL	Amputation of Limb	Single upper extremity above the elbow, Single upper extremity below the elbow, Single lower extremity above the knee, Single lower extremity below the knee, Double lower extremity above the knee, Double lower extremity above/below the knee, Double lower extremity below the knee, Partial foot, Other amputation not from trauma.
RAR	Arthritis	Rheumatoid Arthritis, Osteoarthritis, Other Arthritis.
RBD	Brain Dysfunction	Non–Traumatic – Sub-arachnoid haemorrhage, Anoxic brain damage, Other non-traumatic brain dysfunction, Traumatic - Open Injury, Closed Injury.
RBU	Burns	Burns.
RCA	Cardiac	Following recent onset of new cardiac impairment, Chronic cardiac insufficiency, Heart and heart/lung transplant.
RCD	Congenital deformities	Spina Bifida, Other Congenital deformities.
RDD	Developmental Disabilities	Developmental disabilities (excluding Cerebral Palsy).
RDE	Debility	Re-conditioning following surgery, Reconditioning following medical illness, Cancer rehabilitation.
RMT	Major Multiple Trauma (MMT)	Brain and spinal cord injury, Brain and multiple fracture/amputation, Spinal and multiple fracture/amputation, Other multiple trauma.
RNE	Neurological	Multiple Sclerosis, Parkinsonism, Polyneuropathy, Guillian-Barre, Cerebral Palsy, Neuromuscular disorders, Other neurological conditions.
ROA	Orthopaedic conditions, all other	Includes: Soft tissue injury.
ROF	Orthopaedic conditions, fractures	Includes: Fracture of hip - unilateral, Fracture of hip – bilateral, Fracture of shaft of femur, Fracture of pelvis, Fracture of knee, Fracture of lower leg or ankle or foot, Fracture of upper limb, Fracture of spine, Fracture of multiple sites, Other orthopaedic fracture.
ROI	Other Disabling Impairments	Lymphoedema, Conversion disorder, Other disabling Impairments – that cannot be classified into a specific group.

ROR	Orthopaedic conditions, replacement	Includes: Hip replacement unilateral or bilateral, Knee replacement – unilateral or bilateral, Knee and hip replacement – same or different side, Shoulder replacement.
RPS	Pain Syndromes	Neck pain, Back pain, Extremity pain, Headache, Multi-site pain, Other pain.
RPU	Pulmonary	Chronic obstructive pulmonary disease, Lung transplant, Other pulmonary.
RSC	Spinal Cord Dysfunction	Non-Traumatic spinal cord dysfunction - Incomplete paraplegia, Complete paraplegia, Incomplete C1-4 quadriplegia, Incomplete C5-8 quadriplegia, Complete C1-4 quadriplegia, Complete C5-8 quadriplegia, Other non-traumatic spinal cord dysfunction, Traumatic spinal cord dysfunction - Incomplete paraplegia, Complete paraplegia, Incomplete C1-4 quadriplegia, Incomplete C5-8 quadriplegia, Complete C1-4 quadriplegia, Complete C5-8 quadriplegia, Other non-traumatic spinal cord dysfunction.
RST	Stroke	Left Body Involvement, Right Body Involvement, Bilateral Involvement, No Paresis, Other Stroke.

Palliative care SNAP type

Palliative care is provided for a person with an active, progressive, life limiting disease with little or no prospect of cure. Palliative care may include the assessment or management of the physical, psychological or emotional needs of the patient.

The Palliative care SNAP type can only be used in conjunction with a care type of 30, Palliative Care.

There can only be one SNAP episode within a single SNAP episode of care.

Palliative SNAP Type	Definition
PAL	Palliative Care

Complete listing of valid SNAP Type Codes

	Code	Description
All Hospitals SNAP Type	GEM	Geriatric Evaluation and Management
	MCO	Maintenance - Convalescent Care
	MNH	Maintenance - Nursing Home Type
	MOT	Maintenance - Other
	MRE	Maintenance - Respite
	PAL	Palliative care
	PSG	Psychogeriatric
	RAL	Rehabilitation - Amputation of Limb
	RAR	Rehabilitation - Arthritis
	RBD	Rehabilitation - Brain Dysfunction

	RBU	Rehabilitation - Burns
	RCA	Rehabilitation - Cardiac
	RCD	Rehabilitation - Congenital Deformities
	RDD	Rehabilitation - Development Disabilities
	RDE	Rehabilitation - Debility
	RMT	Rehabilitation - Major Multiple Trauma
	RNE	Rehabilitation - Neurological
	ROA	Rehabilitation - Orthopaedic all other
	ROF	Rehabilitation - Orthopaedic conditions, fractures
	ROI	Rehabilitation - Other disabling impairments
	ROR	Rehabilitation - Orthopaedic conditions, replacement
	RPS	Rehabilitation - Pain Syndromes
	RPU	Rehabilitation - Pulmonary
	RSC	Rehabilitation - Spinal Cord Dysfunction
	RST	Rehabilitation - Stroke

12.2.3 SNAP class assignment

The assignment of a SNAP episode to a particular end class within the AN-SNAP classification is based on a set of variables captured as part of the inpatient episode. All adult overnight SNAP episodes require a valid ADL score to be classified under AN-SNAP. If an ADL is not reported the episode is assigned as 'ungroupable' under the relevant care type e.g. Rehabilitation Care, Maintenance Care etc.

Same day episodes do not require an ADL for classification, nor do overnight paediatric episodes.

The methodology uses the first set of reported ADL scores for each Maintenance, Rehabilitation, Psychogeriatric and Geriatric Evaluation and Management episode.

For Palliative Care episodes, the AN-SNAP class is derived at the start of each Palliative Care Phase and uses the ADL reported for that Phase.

AN-SNAP classes are derived by the DSB.

12.2.4 SNAP start date

For Maintenance SNAP episodes – The start date of the **first** SNAP episode must be the same as the start date of the episode of care.

For Geriatric Evaluation and Management, Psychogeriatric, Rehabilitation and Palliative SNAP episodes - The start date of the SNAP episode must be the same as the start date of the episode of care.

Each SNAP episode must meet the definition for sub and non-acute admitted patient care, as identified by the SNAP types.

12.2.5 SNAP end date

For Maintenance SNAP episodes – The end date of the **last** SNAP episode must be the same as the end date of the episode of care.

For Geriatric Evaluation and Management, Psychogeriatric, Rehabilitation and Palliative SNAP episodes - The end date of the SNAP episode must be the same as the end date of the episode of care.

Each SNAP episode must meet the definition for sub and non-acute admitted patient care, as identified by the SNAP types.

12.2.6 Multidisciplinary care plan flag

A multidisciplinary care plan is required for patients with a rehabilitation, geriatric evaluation and management, psychogeriatric or palliative SNAP type.

The multidisciplinary care plan refers to a series of documented and agreed initiatives/treatment (specifying program goals, actions and time frames) which has been established through multidisciplinary consultation (including the patient/carers where appropriate).

Record whether a multidisciplinary care plan has been developed.

	Code	Description
All Hospitals	Y	Yes
	N	No
	U	Unknown

12.2.7 Multidisciplinary care plan date

If the patient has had a multidisciplinary care Plan developed record the date that the latest multidisciplinary care plan was documented. This should be reported for patients with a rehabilitation, geriatric evaluation and management, psychogeriatric or palliative SNAP type.

12.2.8 Primary impairment type

The primary impairment type is the primary reason for the admission to the SNAP episode. This should only be reported for all rehabilitation SNAP types.

Refer to Appendix O for a list of primary impairment type codes.

12.2.9 Proposed principal referral service

Patients with a rehabilitation, geriatric evaluation and management, psychogeriatric or palliative SNAP type should have the proposed principal referral service recorded on separation of the SNAP episode. This is the type of service that is proposed for the patient post-discharge from hospital. If there is more than one referral service proposed record the principal service.

Record the proposed principal referral service:

	Code	Description
All Hospitals	001	No service is required
	101	Community/home based rehabilitation
	102	Community/home based palliative
	103	Community/home based geriatric evaluation and management
	104	Community/home based – respite
	105	Community/home based – psychogeriatric
	106	Home and community care
	107	Community aged care package, extended aged care in the home
	108	Flexible care package
	109	Transition care program (includes intermittent care service)
	110	Outreach Service
	111	Community/home based – nursing/domiciliary
	198	Community/home based – other
	201	Hospital based (admitted) – rehabilitation
	202	Hospital based (admitted) – maintenance
	203	Hospital based (admitted) – palliative
	204	Hospital based (admitted) – geriatric evaluation and management
	205	Hospital based (admitted) – respite
	206	Hospital based (admitted) – psychogeriatric
	207	Hospital based (admitted) – acute
	208	Hospital based - non-admitted services
	298	Hospital based – other
	998	Other service
	999	Not stated/unknown service

12.2.10 Clinical assessment only indicator

From 1 July 2017, the clinical assessment only indicator will no longer be reported. Note: the field will remain in the HBCIS SNAP Entry Screen, however the indicator will not be incorporated into the extract for DSB.

12.2.11 Activity of Daily Living (ADL) type

ADL tools are used to objectively measure the physical, psychosocial, vocational and cognitive functions of an individual with a disability. There are a number of ADL tools, so the type used to code the patient's functions needs to be recorded. There are different ADL tools for different SNAP type codes.

	Code	Description	For SNAP Type Codes
All Hospitals	FIM	Functional Independence Measure	Rehabilitation and GEM
	HON	Health of the Nation Outcome Scales	Psychogeriatric
	RUG	Resource Utilisation Group	Palliative & Maintenance

	SMM	Standardised Mini Mental State Examination (SMMSE)	GEM (optional)

12.2.12 Activity of Daily Living (ADL) sub-type

The ADL sub-type refers to the domain that is being measured within the tool (i.e. cognitive, motor, behaviour etc).

From 1 July 2016, all the subscale scores for the FIM and HoNOS are to be reported with the optional reporting of subscale scores for the SMM (for GEM patients only). Reporting for the RUG remains unchanged (i.e. only the total score is required).

	ADL sub-Type	Description	ADL Score	
			Min	Max
FIM	EAT	Eating	1	7
	GRM	Grooming	1	7
	BTH	Bathing	1	7
	DRU	Dressing - upper body	1	7
	DRL	Dressing - lower body	1	7
	TLT	Toileting	1	7
	BDR	Bladder management	1	7
	BWL	Bowel management	1	7
	TBC	Transfers - bed/chair/wheelchair	1	7
	TTL	Transfers - toilet	1	7
	TBS	Transfers - bath/shower	1	7
	LWW	Locomotion - walk/wheelchair	1	7
	LST	Locomotion - stairs	1	7
	MOT	**Motor (total)**	**13**	**91**
	CMP	Comprehension	1	7
	EXP	Expression	1	7
	SOC	Social interaction	1	7
	PRS	Problem solving	1	7
	MEM	Memory	1	7
	COG	**Cognitive (total)**	**5**	**35**
HoNOS	BEH	Behavioural disturbance	0	4
	NAS	Non-accidental self injury	0	4
	DDU	Problem drinking or drug use	0	4
	CGP	Cognitive problems	0	4
	PID	Probs due physical illness or disability	0	4
	HAD	Problems assoc hallucinations/delusions	0	4
	DPS	Problems assoc depressive symptoms	0	4
	OMB	Other mental & behavioural problems	0	4
	SSR	Problems social or support relationships	0	4
	ADL	Problems with activities of daily living	0	4

	ADL sub-Type	Description	ADL Score	
	LVC	Overall problems with living conditions	0	4
	WLQ	Probs work/leisure & quality day envmnt	0	4
	TOT	**HoNOS Total**	**0**	**48**
SMM	ORT	Orientation - time	0	5
	ORP	Orientation - place	0	5
	MIM	Memory - immediate	0	3
	LAT	Language/attention	0	5
	MSH	Memory - short	0	3
	LMW	Language/memory - long (wristwatch)	0	1
	LMP	Language/memory - long (pencil)	0	1
	LAV	Language/abstract think/verbal fluency	0	1
	LNG	Language	0	1
	LAC	Language/attention/comprehension	0	1
	ACD	Att/comp/fol comnds/construct (diagram)	0	1
	ACP	Att/comp/construct/fol comnds (paper)	0	3
	TOT	**SMM Total**	**0**	**30**
RUG	**TOT**	**Resource Utilisation Group (Total)**	**4**	**18**

An ADL score of 999 is valid when an assessment has not been undertaken (or for a same day episode) for sub and non-acute separations on or after 1 July 2016.

12.2.13 Activity of Daily Living (ADL) score

At least one set of ADL scores must be provided for each SNAP episode to enable classification into the AN-SNAP classification.

The ADL score is the actual numerical rating reported for the ADL tool being used to measure the patient's functional ability.

More than one ADL score per SNAP episode can be recorded; however, only one ADL score per day may be recorded. All ADL scores should be supplied to the DSB.

The Health of the Nation Outcome Scale (HoNOS) requires the reporting the 12 subscale scores and the total score.

The Functional Independence Measure (FIM) requires the reporting of the 18 subscale scores and a total cognition and motor score.

Note: Paediatric SNAP episodes do not require an ADL score for paediatric classes to be assigned, a score of 999 is valid.

The Resource Utilisation Group (RUG) only requires a total score to be reported.

The Standardised Mini Mental State Examination (SMM) that is optional for GEM patients requires 12 subscale scores and a total score.

12.2.14 Further information on ADL assessments

ADL scores for each adult overnight SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL type and ADL sub-type.

For all SNAP episodes*:*

- Multiple ADL scores can be reported (but the first score reported is the one used to determine the AN-SNAP class).
  - For example, a patient may undergo an assessment during the middle of their stay, in addition to assessments on admission and discharge of the SNAP episode. In this scenario, the episode would contain three sets of ADL Scores.
- ADL Scores can be entered retrospectively.
  - For example, an ADL assessment may be completed on day two of the episode, but the scores may not be available for entry into the hospital patient system until day 7. The scores can be retrospectively entered with the appropriate date (i.e. the date the assessment was done).
- Clinical guidelines for the timing of ADL assessments should be adhered to wherever possible.

12.2.15 ADL date

The date of the ADL score must not be before the start date of the SNAP episode or after the end date of the SNAP episode.

12.2.16 Phase type

The phase type denotes the stage of the patient's illness or situation. A phase type code should only be reported for palliative care SNAP episodes.

	Code	Description
All Hospitals	01	Stable
	02	Unstable
	03	Deteriorating
	04	Terminal care

Code 01 – Stable phase

Patient problems and symptoms are adequately controlled by established plan of care and;

- Further interventions to maintain symptom control and quality of life have been planned and
- Family/carer situation is relatively stable and no new issues are apparent.

Code 02 – Unstable phase

An urgent change in the plan of emergency treatment is required because;

- Patient experiences a new problem that was not anticipated in the existing plan of care, and/or
- Patient experiences a rapid increase in the severity of a current problem; and/or
- Family / carers circumstances change suddenly impacting on patient care.

Code 03 – Deteriorating phase

The care plan is addressing anticipated needs but requires periodic review because

- Patients overall functional status is declining and
- Patient experiences a gradual worsening of existing problem and/or
- Patient experiences a new but anticipated problem and/or
- Family/carers experience gradual worsening distress that impacts on the patient care.

Code 04 – Terminal care phase

Death is likely within days.

Palliative care phases are not sequential and a patient may move back and forth between phases within a single Palliative Care episode.

Further information on SNAP data entry is available in the Sub and Non-Acute Care Data Entry Guidelines for Admitted Patients [44].

[44] Sub and Non-Acute Care Data Entry Guidelines for Admitted Patients. Available from https://qheps.health.qld.gov.au/dsb/datacollections#qhapdc> [accessed 30 October 2026]

13. DEPARTMENT of VETERANS' AFFAIRS PATIENTS

The Department of Veterans' Affairs (DVA) has a charter to serve members of Australia's veteran and defence force communities, war widows and widowers, widows and dependants, through programs of care, compensation, commemoration and defence support services.

13.1 DVA card type

Eligibility for hospital treatment funded by the DVA is established by confirming that the patient holds a Gold Card or a valid White Repatriation Health Card.

Eligibility only applies for the card-holder, that is, the person whose name appears on the Card. If spouses of veterans are eligible, they will hold their own Gold or White Card.

Repatriation Health Cards issued to eligible veterans and other beneficiaries are as follows:

Gold Card

A Repatriation Health card provided to an entitled person by the DVA, which identifies the entitled person as being entitled to treatment for all injuries and diseases.

White Card

It is necessary to contact DVA by phone on 1300 550 457 (Metro) or 1800 550 457 (regional) to confirm a patient's eligibility for treatment as an 'entitled person' under the DVA Arrangement. DVA will not accept financial responsibility if the patient's treatment needs are considered unrelated to specific war-caused injuries, diseases etc for which the white card was issued.

All Hospitals	Code	Description
	Gold	Gold Card
	White	White Card

INELIGIBLE CARDS

Orange Card

A Repatriation Pharmaceutical Benefits card gives cardholders access to an extended range of prescription medicines and ancillary items available under the Repatriation Pharmaceutical Benefits Scheme.

The Orange Card does not entitle persons to admission to hospital or a day procedure centre (Day Hospital Facility) under DVA contractual arrangements and does not provide any medical or allied health treatment entitlements, including residential mental health care.

Pensioner Concession Card

The pensioner concession card does not entitle cardholders to medical and other treatment at the DVA's expense.

13.2 DVA file number

Ensure the name of the patient matches the name on the DVA card. Record the patient's DVA identification number. Do not leave a space between the characters and numbers. That is, record QX123 not QX 123.

13.3 Hospital Services Arrangement (Public hospitals)

13.3.1 DVA arrangement

The Hospital Services Arrangement between the Commonwealth of Australia, acting through the Department of Veterans' Affairs, the Repatriation Commission, and the Military Rehabilitation and Compensation Commission, (collectively, acting through the Department of Veterans' Affairs) and the state of Queensland, acting through Queensland Health, governs the provision of hospital services to eligible veterans and dependants from, at, and on behalf of Queensland public hospitals.

This is a commercially viable agreement based on the principle of National Efficient Price (NEP) based payment. DVA revenue is allocated to Hospital and Health Services in accordance with the Health Care Purchasing and Activity Based Funding Framework.

Services covered under the Hospital Services Arrangement include three broad types, namely:

- acute casemix-funded admitted patient services
- sub- and non-acute admitted patient services
- non-admitted services.

13.3.2 Election

The DVA promotes its system of health care for entitled persons and advises entitled persons to present their Repatriation Health Cards at Queensland public hospitals to access treatment services provided under the Hospital Services Arrangement.

This Arrangement recognises that entitled persons may be directly referred to Queensland public hospital services of their choice, with choice of doctor being subject to the doctor having admitting rights for private patients.

For entitled persons unable to access their choice of doctor, Queensland public hospital staff should support entitled persons access private doctors through the provision of advice regarding available private doctors.

On choosing to be funded by DVA, DVA patients also authorise information from their clinical records to be disclosed to the DVA and the Repatriation Commission/Rehabilitation and Compensation Commission.

All DVA patients are considered to have the same status as private patients i.e. public hospital services are to be provided on a private patient basis with, at least, shared ward accommodation.

It is recognised that not all hospitals have access to private doctors, hence account class codes are available that recognise a veteran's choice to be DVA funded but not to choose their own doctor (i.e. for public facilities the 'DVA public' account class codes e.g. GPEDVA). Residential mental health care facilities should refer to the RMHCDC manual for account class codes for DVA consumers.

DVA Repatriation health care arrangements provide the following benefits for entitled persons electing to use their DVA health care entitlements;

Repatriation Health Card - for all conditions (Gold Card)

The DVA will pay for:

- treatment in hospital on a private patient basis for all medical conditions in shared ward accommodation as a private patient in a public hospital
- all hospital and medical fees (non-medical expenses, e.g. phones, TV, newspapers and so on, are not included).

Repatriation Health Card - For specific conditions (White Card)

DVA will with prior approval, pay for:

- all hospital and medical treatment for war or service-caused accepted disabilities (non-medical expenses, e.g. phones, TV, newspapers and so on, are not included) in shared ward accommodation on a private patient basis.
- treatment for general disabilities including malignant cancer, pulmonary tuberculosis, anxiety and any mental health condition under the Non-Liability Health Care (NLHC) depending on eligibility.

Hospital staff must contact DVA on 1300 550 457 (Metro) or 1800 550 457 (regional) to confirm that the patients proposed treatment relates to an accepted disability.

13.3.3 Overview of payment arrangements

- Payment arrangements for admitted services cover all eligible admitted patient services normally provided to private patients with shared accommodation (including single room where clinically necessary) and choice of doctor in public hospitals.
- Medicare Australia (acting on behalf of DVA) pays relevant medical practitioners who are exercising their right to private practice separately to the Hospital Services Arrangement for admitted patient medical specialist consultations and services including diagnostic and imaging services, and general practice at rates agreed by DVA.
- Payment for admitted patient separations is based on the National Weighted Activity Unit (NWAU) and applicable National Efficient Price (NEP). Payment for some categories of patients, like mental health non-admitted patients, may be blocked

funded under the currently negotiated agreement as at the time of publication of this manual.

- Privately referred and privately treated non-admitted entitled persons are billed direct to the DVA by the provider and paid separately by the DVA.

13.3.4 Compensation cases

Hospital staff shall use reasonable endeavours to ascertain from an entitled person any compensable incapacity for which an entitled person is being, or is to be, treated. The DVA will not be responsible for treatment costs for compensable patients, i.e. motor vehicle accidents.

13.3.5 Nursing home type patients

If the hospitalisation of an entitled person exceeds a continuous period of 35 days, it is necessary to review the entitled person's status and either:

- An Acute Care Certificate is given by a medical practitioner and retained on the patient medical record for audit and/or reconciliation purposes; or
- The entitled person is reclassified to a nursing home type patient.

If an entitled person is reclassified as a nursing home type patient, Queensland Health is required under the Arrangement to ensure that the patient is assessed and an appropriate discharge plan is developed, including where appropriate an assessment by an Aged Care Assessment Team, and that the appropriate post-acute support or residential care is then arranged. Refer Section 13.3.6 Patient contributions and co-payments.

Entitled persons who are reclassified to nursing home type patients are charged a patient contribution, in accordance with the provisions of the Health Insurance Act 1973.

Patient contributions are raised directly against DVA patients, however contributions relating to prisoners of war and Victoria Cross recipients are raised against the DVA.

13.3.6 Patient contributions and co-payments

- Hospitals shall not raise any charges direct on an entitled person except where care is provided for under the Arrangement.
- This provision shall not prevent hospitals providing personal services, including television and/or telephone services to entitled persons. However, any cost is to be borne by the entitled person.
- Entitled persons will not be charged for pharmaceuticals provided while they receive services as admitted patients.
- On discharge, Hospitals should supply the quantity and type of medication that is clinically appropriate for the Entitled person's condition to cover the time until the Entitled Person's first planned post-discharge appointment with their treating doctor. However, they may be charged for pharmaceuticals as Non-Admitted Patients at a level consistent with the Pharmaceutical Benefits Scheme statutory co-payments.

- Entitled persons who are reclassified to nursing home type patients are charged a patient contribution, in line with the provisions of the Health Insurance Act 1973. Hospitals raise patient contributions direct from patients, except contributions relating to prisoners of war and Victoria Cross recipients, which are raised against the DVA.

Billing arrangements (HBCIS Only)

Invoicing	Fees raised against	Fees raised by		
		Revenue Strategy and Support Unit	Hospital/ Service providers	HSSA Pathology QLD
Admitted Patient Services				
Hospital services fee (excluding ward medical; imaging; pathology and prosthetics)	DVA	✓		
Medical practitioners exercising their right to private practice for admitted patients medical specialist consultations and services including diagnostic and imaging services, and general practice at rates agreed by DVA.	Medicare Australia		✓	
Patient contributions raised in accordance with the Health Insurance Act 1973 for nursing home type patients (long-stay patients)	Patient		✓	
Pathology Services (excluding services provided in emergency and outpatient departments)	Medicare Australia			✓
Patient contributions for Prisoners of War (POW)	DVA		✓	
Non-admitted services				
Privately referred and privately treated non-admitted entitled persons	DVA		✓	
Patient co-payments for pharmaceuticals issued on discharge, and non-admitted services, for hospitals participating in the Pharmaceutical Benefits Scheme (PBS) Access Program.	Patient		✓	
Other non-admitted patient services (excluding services provided to privately referred and privately treated non-admitted patients) to cover medical, nursing, diagnostic, allied health, professional services and ED services.	DVA	✓		

13.4 HBCIS admission and registration entry guidelines

Accurate completion of HBCIS fields - Admission and Registration Screens is crucial.

	Field	Data Entry
HBCIS Hospitals	Registration Pay Class	DVA
	Health Fund	DVA
	Health Schedule	Enter Card Type (GOLD or WHITE)
	Health Fund Cover	Defaults to Nil
	Health Fund Number	Blank
	DVA No	Enter DVA Number – no spaces
	DVA Type	Enter Card Type (G or W)
	Acc. Class	Enter appropriate DVA Account Class Code
	Admission Pay Class	DVA
	Consent	Y or N or U
	Hospital Insurance	Y or N
	Funding Source	07

13.5 HBCIS DVA account class code entry guidelines

The following account class codes relate specifically for DVA admitted patients. Residential mental health facilities should refer to the RMHCDC manual for account class codes to be used for DVA residential consumers.

	Account Class		Account Class Description
HBCIS Hospitals	DVA Public	GPEDVA	General Public DVA
		GPEDVASD	General Public DVA – Same Day
		GPRCDVA	General Public Respite Care DVA (Hospital only)
		GPRCDVASD	General Public Respite Care DVA – Same Day
	DVA Private	GSEDVA	General Shared Eligible DVA
		GSEDVASD	General Shared Eligible DVA – Same Day
		GSRCDVA	General Shared Respite Care DVA (Hospital only)
		GSRCDVASD	General Shared Respite Care DVA – Same Day

14. PALLIATIVE CARE

Additional information is to be collected for patients admitted to a Care type of 30 Palliative.

14.1 First admission for palliative care treatment

The first admission for palliative care treatment is the status of the episode in terms of whether it is a first or subsequent admission, at any hospital for any condition, for palliative care treatment.

	Code	Description
All Hospitals	1	No previous admission for palliative care treatment
	2	Previous admission for palliative care treatment

Example 1

A patient is admitted for palliative care treatment at Hospital A. It is the first time that this patient has ever been admitted for palliative care treatment. The status for this admission is 1 – No previous admission for palliative care treatment.

Example 2

A palliative care patient is transferred from Hospital A to the Palliative Care Unit at Hospital B. As the patient was admitted at both hospitals for palliative care, the status for this admission is 2 – Previous admission for palliative care treatment.

Example 3

A patient is admitted for palliative care treatment related to COPD. Ten years ago, that patient received palliative care treatment for cancer. The status for this admission is 2 – Previous admission for palliative care treatment.

Example 4

A patient that has previously been receiving palliative care treatment is admitted as an acute patient for treatment of a bone fracture related to neoplastic disease. During the acute episode of care the patient receives palliative care (documented) so the associated palliative care diagnosis code should be assigned. The status for this admission is not required as this is an acute episode of care.

14.2 Previous specialised non-admitted palliative care treatment

Previous specialised non-admitted palliative care treatment is the status of the episode in terms of whether the patient has had a previous non-admitted service contact for palliative care treatment.

All Hospitals	Code	Description
	1	Patient has **no** previous non-admitted service/contacts for palliative care treatment
	2	Patient has previous non-admitted service/contacts for palliative care treatment

15. WORKERS' COMPENSATION QUEENSLAND (PUBLIC HOSPITALS ONLY)

15.1 Background

WorkCover Queensland insures most employers in Queensland. However, there are number of self-insured employers in Queensland which manage their own workers' compensation claims. A list of Queensland workers' compensation self-insurers (self-insurers) can be found on the Worksafe website: https://www.worksafe.qld.gov.au/claims-and-insurance/self-insurance/list-of-self-insured-employers [accessed 30 October 2026].

The Public Health Services Table of Costs (accessed at https://www.workcoverqld.com.au/service-providers/working-with-workcover/fees [accessed 30 October 2026] describes the services, prices and business rules relating to the provision of Queensland public hospital services to Queensland workers' compensation public patients.

This table of costs is used for both WorkCover Queensland and Queensland self-insurer patients. It should **not** be used for workers' compensation patients from other States/Territories or Comcare patients.

The following information refers to workers covered under the *Workers' Compensation and Rehabilitation Act 2003 (Qld)*, who have a valid workers' compensation claim and have elected to be treated publicly.

Note: Some Queensland employees may be covered by a worker's compensation scheme in another state or by the Commonwealth scheme (Comcare). Refer to the Comcare website for more information. http://www.comcare.gov.au/ [accessed 30 October 2026].

The scope of services for the Queensland workers' compensation arrangement includes:

- Admitted patient services
- Non-admitted services:
    - Outpatients (Medical and Allied Health)
    - Emergency departments.
- Medical reports and records
- Inter-facility transfers.

The Hospital and Health Services are responsible for identifying and billing the insurer for services provided.

Under the National Health Reform Agreement, compensable patients are not considered as eligible persons who are entitled to access public hospital services 'free of charge'. "Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by Queensland" (National Health Reform Agreement G:3).

Workers' compensation claimants (electing public patient status) deemed to have an invalid claim for workers' compensation are entitled to revert to public patient status in accordance with the provisions of the National Health Reform Agreement.

Data relating to all compensable patients is captured and retrieved from the HBCIS compensable screen.

15.2 Data elements

The data elements have been collected in the HBCIS compensable screen and used at a local level. These data elements are used to substantiate the hospital's claim for reimbursement for costs of providing treatment for compensable injuries.

• Accident/Incident date • Nature of injury • Insurer • Insurer address • Employer • Employer address • Claim Number	Fields must be linked to the relevant admitted episodes

Specific elements in the Compensable screen will be forwarded to the DSB via monthly HQI Extracts.

15.3 Criteria for collection

Patients who have been assigned a payment class of Workers Compensation Queensland (WCQ) and Workers Compensation Queensland Ineligible (WCQI) in the HBCIS Admission screen are required to have relevant data elements completed in the Compensable screen. Links must be created between the compensable screen and the relevant admitted and non-admitted treatment services.

An episode of care may only have one link to a compensable screen. However, each compensable screen may be linked to many admitted episodes or non-admitted occasions of service.

15.4 HBCIS screen

The data elements are collected via the existing HBCIS Compensable screen. Users will be prompted to collect the data upon filing the HBCIS Admission Screen (the system will flip to the Compensable screen). Alternatively, the Compensable screen is available via the menu options and can be completed during the episode of care if required.

Hospitals that do not use HBCIS will need to complete a Motor and Work Injury Interview Questionnaire and provide this information to the facility that records their data.

15.5 HBCIS reports

Two HBCIS Reports are available to assist hospital staff:

- Compensable Admissions Report: as the data items are extracted via the HQI Extract, this report will assist staff to identify incomplete data and unlinked admissions prior to the Extract.
- Compensable Appointments Report: where HBCIS Appointment Scheduling module is used, this report lists services that are linked to information in a relevant compensable screen and can be used to assist with raising charges for an invoice. The report can be run to show services that are not linked which require further attention.

Contact your HBCIS Administrator to have the reports loaded into HBCIS.

15.6 HQI extract

The WCQ data elements are extracted via HQI and forwarded to the DSB. The HQI Extract Errors Report identifies any episodes with incomplete fields from the HBCIS Compensable screen. The DSB Validation Report also identifies episodes with incomplete or invalid data elements.

15.7 HBCIS compensable screen data elements

15.7.1 Compensable Record Number

Each Compensable Screen will be automatically assigned a unique number.

When the compensable details are forwarded to the DSB, this number will form part of each episode's unique identifier. This functionality will only work where episodes have been linked to the compensable screen.

15.7.2 Compensable Payment Class

WCQ where the patient's employer is insured by WorkCover Queensland or one of the Queensland workers' compensation self-insurers regulated. Patients classified as workers' compensation other (WCO) are billed locally and consequently are not included in the Queensland workers' compensation extract file to DSB.

15.7.3 Incident date

This is the date the injury/accident/illness occurred. For late onset illness, it is the date the patient was first assessed by a doctor for the injury/illness. See Section 7.10 Incident date (HBCIS hospitals).

15.7.4 Incident Time

This is the time the injury/accident occurred.

15.7.5 Location

This is the location of the incident/accident. For example, “Logan Rd corner Nursery Rd Mt Gravatt” or “At office on stairs address 12 Edward St, Brisbane City.”

15.7.6 Nature of injury

This field is used to specify the bilateral (left or right arm/leg/etc) location and type of injury. This information is considered critical as clinical codes do not record the bilateral nature of injuries. Also, state a summary of the diagnoses or provisional diagnoses provided by the treating medical practitioner. This is required because no diagnoses codes are given to insurers for non-admitted services. This information must be recorded here and is required by insurers.

15.7.8 Occupation

Enter the patient’s occupation.

15.7.9 Item

These items are used to record the details of the employer, insurer, solicitor or other authority. Multiple items may be entered. For example, item 1 might record employer details and item 2 record insurer details.

15.7.10 Code

Indicate the financially responsible party: A - Authority responsible, E - Employer, I - Insurer, P - Patient, or S - Solicitor. This represents the code for the details you are about to enter. For a valid WCQ claim you need to enter the employer so type E to enter employer details. Enter details about the insurer and solicitor if known.

15.7.11 Field 12 – 17 Details of financially responsible party

Employer details (name and address) are required. If possible, enter the insurer (code I) and solicitor (code S) details also as separate items (see fields 10 and 11).

15.7.12 Assign bill to

Identify the financially responsible party. A - Authority responsible, E - Employer, I - Insurer, P - Patient, S - Solicitor. For WC patients this is normally ‘I’ for insurer even if the details are unknown.

15.7.13 Status 1

Enter details about where the accident occurred. AW (At Work), FW (going home From Work), TW (going To Work).

15.7.14 Status 2

Identify the patient's role in the accident if relevant. C (Cyclist), D (Driver), MC (Motor Cyclist), PA (Passenger), PD (Pedestrian).

15.7.15 Claim number

This field is used to record the insurance claim number. The insurer will provide the patient with a claim number when the patient makes a claim. The hospital needs to record this claim number as it provides evidence of the worker's consent to release information to the insurer. This allows hospitals to bill for non-admitted services.

If the claim number is not known or cannot be established, record 'U' for unknown.

16. TELEHEALTH (PUBLIC HOSPITALS ONLY)

16.1 Admitted patient (inpatient) telehealth activity

Videoconferencing technology is used to deliver clinical services to admitted patients.

Admitted patient telehealth events can be captured on the HBCIS Telehealth Inpatient Details (TID) entry screen and viewed at the patient level on the TID enquiry screen.

Admitted patient telehealth events can be captured on the TID entry screen by the admitting facility only.

Admitted patient telehealth event details are submitted to QHAPDC upon patient separation. A separation can be a formal separation (including discharge, transfer or death) or a statistical separation (episode type changes). Long stay patient telehealth event/s will not be submitted to QHAPDC until the patient has undergone a formal or statistical separation.

Note: Non-admitted patient (outpatient) telehealth service events are out of scope for TID screen and the QHAPDC. Non-admitted patient telehealth service events may be reported via the Queensland Non-Admitted Patient Data Collection (QHNAPDC) where scope requirements are met.

16.1.1 Telehandover case conference

From 01 July 2020 'Telehandover case conference' events (Telehealth Event type code 25) may be reported on the TID entry screen.

Telehandover is a formal clinical case conference negotiation, where multidisciplinary teams utilise videoconference to provide clinical handover for admitted patients transferring between healthcare facilities.

Admitted patients requiring rehabilitation or ongoing care can benefit from Telehandover. Although they are encouraged to attend and participate, the patient may or may not be present during their Telehandover case conference.

Telehandover aligns with the National Safety and Quality Health Standard: "Communicating for Safety (NSQHS)"[45] and improves exchange of patient information, timeliness of care planning and continuity of appropriate medical care.

Multidisciplinary team means three or more healthcare providers of different disciplines participate in the Telehandover. The total number healthcare providers contributing to the Telehandover across all participating facilities contribute to the total count of healthcare providers. Healthcare providers may be of the same profession (i.e. medical, nursing or allied health), however they must be of different disciplines to be counted separately. Although they may attend the Telehandover case conference, neither the patient nor their carer can be counted toward the minimum of three care providers.

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[45] National Safety and Quality Health Standard: "Communicating for Safety" (NSQHS). Available from <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard>[accessed 30 October 2026]

A Telehandover involves videoconference between two different healthcare facilities:

- "Provider" facility refers to the facility where the patient is admitted at the time of the Telehandover event.
- "Recipient" facility refers to the facility to which the patient is intended to be transferred.

The reporting entity for Telehandover events is the Provider facility (i.e. the facility where the patient is admitted at the time of their Telehandover event).

The Provider facility is responsible for capturing the details of the Telehandover case conference in the HBCIS TID entry screen.

From 01 July 2022, an enhancement to the TID entry screen which supports the capture of recipient-end details of a TeleHandover will be available. The enhanced TID entry screen features three new fields, enabling the reporting of recipient end details: 10 Recipient Facility, 11 Recipient Type and 12 Recipient Unit where Field 04 Event type is set to 25 (Telehandover) and Field 06 Start date is on or after 1 July 2022.

If Field 04 Event Type is not 25 (Telehandover) or Field 06 Start Date is before 01 July 2022, then the new Telehandover fields 10 Recipient Facility, 11 Recipient Type and 12 Recipient Unit will be skipped and unavailable for input.

If Field 04 Event Type is changed from 25 (Telehandover) to another valid Telehealth event type, then any data entered into fields 10 Recipient Facility, 11 Recipient Type and 12 Recipient Unit will be cleared.

Example 3 in section 16.8 Admitted patient telehealth reporting scenarios provides an example of how a telehandover event occurring on or after 1 July 2022 should be reported on the TID entry screen.

Telehandover events that occurred before 1 July 2022 are recorded differently. Please refer to QHAPDC manual 2021-2022, Chapter 16 for instructions.

16.2 Telehealth session and telehealth event

A telehealth session[46] is the transmission and receipt of real-time audio and visual information via videoconference systems between participating sites.

A telehealth event is an interactive, real-time clinical activity provided for an admitted patient within a telehealth session.

A telehealth session may involve one or more admitted patient/s with each patient having a telehealth event. A telehealth event may occur more than once during an admitted patient episode of care.

Unintentional disconnection and reconnection must not be reported as separate telehealth sessions. The start of a telehealth session is defined in section 16.4 Start of a telehealth session. The end of a telehealth session is defined in section 16.5 End of a telehealth session.

[46] Telehealth session. [accessed 30 October 2024]

16.3 Telehealth event scope

A telehealth event[47] should be captured via the TID entry screen, when the following criteria are met:

- The interaction was between one or more healthcare provider(s) with an admitted patient delivered via videoconference.
- The telehealth event contained therapeutic/clinical content and resulted in a dated entry in the patient's medical record;
- The patient or patient representative was present during a ward round, clinical consultation, or consultation with Retrieval Services Queensland (RSQ), Telehealth Emergency Management Support Unit (TEMSU) or Royal Flying Doctors Service (RFDS);
- The patient or patient representative may or may not be present during a case conference or Telehandover case conference. However, there must be a minimum of three formal care providers from different disciplines.

Telehealth activity that is not eligible for capture in the TID entry screen includes videoconferences for the purposes of:

- Clinical education; and
- Activity related to non-admitted patients (outpatients)*.

**Note: Non-admitted patient telehealth activity can be captured in the Queensland Non-Admitted Patient Data Collection (QHNAPDC).*

16.4 Start of a telehealth session

A telehealth session begins when a successful connection via videoconference systems is established between the participating sites.

A successful connection between videoconference systems is when real-time audio and visual data are transmitted and received by videoconference systems at participating sites involved in a telehealth session and interactive real-time clinical activity for an admitted patient commences.

If the videoconference systems are unintentionally disconnected and a successful reconnection is made, then the time of successful reconnection should not be allocated as the start time of another telehealth session.

16.5 End of a telehealth session

A telehealth session ends when the connection via videoconference system is intentionally disconnected between participating sites.

If the videoconference systems are unintentionally disconnected and a successful reconnection is made, then the time of unintentional disconnection should not be allocated

[47] Telehealth event. [accessed 30 October 2026]

as the end time of a telehealth session. However, if the videoconference systems are unintentionally disconnected and reconnection is not successful, then the time of disconnection should be allocated as the end time of a telehealth session.

More than one telehealth session and telehealth event may occur on the same day for the same admitted patient.

16.6 Telehealth admitted patient details – entry screen

The TID entry screen is in the Admission, Discharge and Transfer (ADM) module of HBCIS and can be accessed from the HBCIS Entry and Enquiry Menu.

If the TID entry screen is not displayed on the Entry and Enquiry Menu, please contact your local HBCIS facilitator to arrange access.

Fig 16.6.1 Telehealth Inpatient Details Entry Screen as at 1 July 2024

```
                  1
         1    2    3    4    5    6    7
0123456789012345678901234567890123456789012345678901234567890123456789
0 ADM2.S762     TELEHEALTH INPATIENT DETAILS ENTRY        415 LOGON-QLDWRK
1
2 01 Telehealth Session Id [     ]
3
4 02 Provider Facility    [    ]
5 03 Provider Type        [      ]
6 04 Event Type           [ ]
7 05 Provider Unit        [   ]
8 06 Start Date           [       ] 07 Start Time [    ]
9 08 End Date             [       ] 09 End Time   [    ]
10 10 Recipient Facility  [       ]
11 11 Recipient Type      [       ]
12 12 Recipient Unit      [   ]
13                                  Page    of
14                        Name            D.O.B.   Sex  Event#
15 13 Patient Number      [         ]
16
17
18
19
20
21
22 Enter Field Number or Code                Filed
23
0123456789012345678901234567890123456789012345678901234567890123456789
         1    2    3    4    5    6    7
```

16.6.1 Telehealth session identifier

The telehealth session identifier [accessed 30 October 2026] is a system generated six-digit number known as the Telehealth session ID. A telehealth session ID is allocated to each new telehealth session.

16.6.2 Provider facility

The facility code that identifies the facility delivering clinical activity, for an admitted patient telehealth session. Valid facility numbers are located in QHAPDC Appendix A.

From 1 July 2018 the TID entry screen supports the capture of telehealth events provided by Retrieval Services Queensland (RSQ), Telehealth Emergency Management Support Unit (TEMSU) and the Royal Flying Doctors Service (RFDS) via the Field 02 'Provider Facility reference file'.

The following facility codes have been added to Field 02 'Provider Facility' reference file:

Facility Code	Facility Name
90073	ROYAL FLYING DOCTOR SERVICE BRISBANE BASE
90074	ROYAL FLYING DOCTOR SERVICE BUNDABERG BASE
90075	ROYAL FLYING DOCTOR SERVICE CAIRNS BASE
90076	ROYAL FLYING DOCTOR SERVICE CHARLEVILLE BASE
90077	ROYAL FLYING DOCTOR SERVICE LONGREACH BASE
90078	ROYAL FLYING DOCTOR SERVICE MOUNT ISA BASE
90079	ROYAL FLYING DOCTOR SERVICE ROCKHAMPTON BASE
90080	ROYAL FLYING DOCTOR SERVICE TOWNSVILLE BASE
70028	RETRIEVAL SERVICES QUEENSLAND
70027	TELEHEALTH EMERGENCY MANAGEMENT SUPPORT UNIT

If any of the above listed facility codes are entered in Field 02 'Provider Facility' then: Field 03 'Provider Unit' will be skipped and unavailable for input either from the Command Line or via the up-arrow key from the subsequent field; and Field 04 'Event Type' will be auto-populated as 20 'Clinical Consultation' (although changes to this field are allowed); and the curser will skip to Field 05 'Provider Type' requiring user entry.

16.6.3 Provider unit

The standard unit code that identifies the clinical unit of the provider facility, for an admitted patient telehealth session. See Appendix J for a list of valid standard unit codes.

Exception for Telehandover case conference: Where the TID screen field: 04 Event Type is "25 - Telehandover case conference", enter the facility unit that identifies the clinical unit of the Recipient facility.

16.6.4 Provider type

Provider type represents the type of health professional that provides a service to an admitted patient.

From 1 July 2019, the provider type field has been expanded to an 8 digit field to enable the speciality of the telehealth provider to be entered. Accurate identification and reporting of the Telehealth Service Provider Type will ensure sustainability of these models of care through Queensland's funding model allocations. See Appendix Q for a list of valid provider type codes.

Exception for Telehandover case conference: Where the TID entry screen field:04 Event Type is "25 - Telehandover case conference", enter the Provider Type that identifies the lead health professional at the Recipient facility.

16.6.5 Telehealth event types

Telehealth event type[48] represents the type of activity that is delivered during an admitted patient telehealth event. The codes and description for Telehealth event types in HBCIS are:

	HBCIS		Extracted/mapped by HQI as:	
	Code	**Description**	**Code**	**Description**
HBCIS Hospitals	19	Ward round	01	Ward round
	20	Clinical consultation	02	Clinical consultation
	21	Discharge planning case conference	03	Discharge planning case conference
	22	Cancer care case conference	04	Cancer care case conference
	23	Psychiatric case conference	05	Psychiatric case conference
	24	Multidisciplinary case conference	06	Multidisciplinary case conference
	25	Telehandover case conference	25	Telehandover case conference
	98	Other	98	Other
	99	Not stated/unknown	99	Not stated/unknown

Code 01 – Ward round

Ward round delivered via videoconference.

Code 02 – Clinical consultation

Clinical consultation delivered via videoconference. Includes Retrieval Service Queensland (RSQ), Royal Flying Doctors Service (RFDS) or Telehealth Emergency Management Support Unit (TEMSU).

Code 03 – Discharge planning case conference

Code 04 – Cancer care case conference

Code 05 – Psychiatric case conference

Code 06 – Multidisciplinary case conference

Codes 03, 04, 05 and 06 relate to case conferences delivered via videoconference for the purpose of establishing and coordinating the management of care needs for the patient. A

[48] Telehealth event type. Available from < https://qhdd.health.qld.gov.au/ords/f?p=103:210:::::P210_MD_TYPE_GUID,P210_MR_GUID:D2840284A6761A97E05400144FF88D90,D5E41958A5241F77E05400144FF88D90&cs=11661056FA93D595E5AF42ED5F299D2D8 > [accessed 30 October 2026]

case conference requires the involvement of a minimum of three formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient.

Although they may attend the case conference, the patient or personal carer do not count toward the minimum of three care providers.

Code 25 – Telehandover case conference

From 01 July 2020 'Telehandover case conference' events may be reported.

Telehandover is a formal clinical negotiation, where multidisciplinary teams utilise videoconference to provide clinical handover for inpatients transferring between healthcare facilities.

A Telehandover case conference requires the involvement of a minimum of three formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient.

Although they may attend the case conference, neither the patient nor their carer can be counted toward the minimum of three care providers.

Code 98 – Other

Other type of clinical activity delivered via videoconference.

Code 99 – Not stated/unknown

Not stated or unknown type of clinical activity delivered via videoconference.

16.6.6 Start date

The date the telehealth session commenced.

Enter the full date (ddmmyyyy) the telehealth session commenced. Use leading zeros where necessary. The start date must not be before the admission date or after the discharge date for any patient within the telehealth session.

Example

For a Telehealth session start date of 3 July 2026, record:

0	3	0	7	2	0	2	6

16.6.7 Start time

The time the telehealth session commenced.

Use the 24-hour clock to record the start time of the telehealth session. The start time must not be before the admission time or after the discharge time for any patient within the telehealth session.

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value

should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

Example

Telehealth session start time at 3:10 a.m.

0	3	1	0

Telehealth session start time at 6:05 p.m.

1	8	0	5

16.6.8 End date

The date the telehealth session ended.

Enter the full date (ddmmyyyy) the telehealth session ended. Use leading zeros where necessary. The end date must not be before the admission date or after the discharge date for any patient within the telehealth session.

Example

For a Telehealth session end date of 3 July 2026, record:

0	3	0	7	2	0	2	6

16.6.9 End time

The time the telehealth session ended.

Use the 24-hour clock to record the end time of the telehealth session. The end time must not be before the admission time or after the discharge time for any patient within the telehealth session.

Please note that the DSB will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs. The time of 24:00 will then be converted when the record is loaded onto the DSB processing system. Hospitals should note that if this value is submitted, a H848 validation (A time value of 2400 has been reported for |. Please confirm if the reported value should be | 23:59 or | 00:00.) will generate and display on EVA. Hospitals will then need to confirm with DSB the correct time.

Example

Telehealth session end time at 3:10 a.m.

0	3	1	0

Telehealth session end time at 6:05 p.m.

1	8	0	5

16.6.10 Recipient facility

This field is applicable only where the event type is 25 Telehandover and the Start date of the telehealth event is on or after 01 July 2023.

Recipient facility represents the facility code that identifies the facility receiving admitted patient telehealth session with an event type of 25: Telehandover. Valid facility numbers are located in Appendix A.

If Field 04 Event type is not 25 (Telehandover) or Field 06 Start date is before 01 July 2023, then Recipient facility will be skipped and unavailable for input.

If Field 04 Event type is changed from 25 (Telehandover) to another valid Telehealth event type [accessed 30 October 2026] then any data entered into field Recipient facility will be cleared.

16.6.11 Recipient type

This field is applicable only where the event type is 25 Telehandover and the Start date of the telehealth event is on or after 01 July 2022.

Recipient type represents the type of health professional that receives an admitted patient telehealth session with an Event type of 25: Telehandover.

Please refer to Appendix Q for a list of valid Recipient type codes.

If Field 04 Event type is not 25 (Telehandover) or Field 06 Start date is before 01 July 2022, then Recipient type will be skipped and unavailable for input.

If Field 04 Event type is changed from 25 (Telehandover) to another valid Telehealth event type [accessed 30 October 2026], then any data entered into field Recipient type will be cleared.

16.6.12 Recipient unit

This field is applicable only where the Event type is 25 Telehandover and the Start date of the telehealth event is on or after 01 July 2022. Recipient unit is the standard unit code that identifies the clinical unit of the recipient facility, for an admitted patient telehealth session with an Event type of 25: Telehandover. See Appendix J for a list of valid standard unit codes.

If Field 04 Event type is not 25 (Telehandover) or Field 06 Start date is before 01 July 2023, then Recipient unit will be skipped and unavailable for input.

If Field 04 Event type is changed from 25 (Telehandover) to another valid Telehealth Event type, then any data entered into field Recipient unit will be cleared.

16.6.13 Patient number

The Unit Record Number (URN) and Episode ID (Admission number) for patient/s in the telehealth session.

If the episode ID is not entered the most recent episode for the patient will be displayed on the screen.

Example

For a Patient URN of 00012345 and Episode ID (Admission number) of 2, record:

0	0	0	1	2	3	4	5	-	2			

16.7 Telehealth admitted patient details – enquiry screen

Telehealth events related to specific patients can be viewed on the TID enquiry screen.

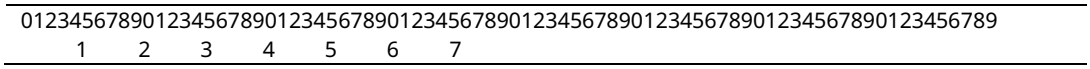
The TID enquiry screen is located in the Admission, Discharge and Transfer module HBCIS and can be accessed from the HBCIS Entry and Enquiry Menu and located via a command Line option (TELE) from the HBCIS:

- Patient Admission screen
- Patient Discharge screen
- Patient Condition screen

The TID enquiry screen in HBCIS is as follows:

```
          1       2       3       4       5       6       7
012345678901234567890123456789012345678901234567890123456789012345678901234567890123456789
0   ADM2.S???         ADMITTED PATIENT TELEHEALTH REPORT          419 LOGON-QLDWRK
1
2   01 Start Date              [dd mmm yy]
3   02 End Date                [dd mmm yy]
4
5   03 Print Code Descriptions? Y/N [x]
6
7
8
9
10
11
12
13
14
```

Enter Field Number or Code Filed



16.8 Admitted patient telehealth reporting scenarios

Scenario 1: Admitted patient ward round	
There are three patients admitted to the General Medical ward at Boonah Hospital. The Pharmacist at the Ipswich Hospital, uses videoconference to deliver daily ward rounds, providing advice and support to the Boonah Hospital treating team and patients. The Ipswich and Boonah teams meet via videoconference for the pharmacy ward round on 18 August 2026, the patients are seen consecutively. The ward round commences at 08:00 and finishes at 09:30.	
Provider	Ipswich Hospital
Recipient	Boonah Hospital
Reporting Entity	**Boonah Hospital**
Explanation	The patients are admitted to Boonah Hospital. Therefore, Boonah is the reporting entity and will report the ward round on the TID screen, identifying Ipswich Hospital as the Provider Facility.
HBCIS TID entry screen	01: Telehealth Session ID – Auto filled 02: Provider Facility: 00015 (Ipswich Hospital) 03: Provider Type: 20008540 AH-PHARMACIST 04: Event Type: 19 Ward Round 05: Provider Unit: GENM (General Medical) 06: Start Date: 18/08/2026 07: Start Time: 08:00 08: End Date: 18/08/2026 09: End Time: 09:30 10: Recipient Facility: Null 11: Recipient Type: Null 12: Recipient Unit: Null 13: Patient Number: UR and Episode ID for patient 1 UR and Episode ID for patient 2 UR and Episode ID for patient 3

Scenario 2: Admitted patient ad-hoc clinical consultation	
An admitted patient at Kilcoy Hospital demonstrates increased urination, increased hunger, general confusion and blackouts. The treating clinician orders a BSL blood test and contacts the RBWH endocrinology team for advice. The endocrinologist based at the RBWH uses videoconference to provide an ad-hoc clinical consultation to the patient and treating team at Kilcoy Hospital. The RBWH provides a clinical consultation via videoconference to the patient and treating team at Kilcoy on 01 September 2026 from 16:00 and finishes at 16:30.	
Provider	RBWH Hospital
Recipient	Kilcoy Hospital
Reporting Entity	**Kilcoy Hospital**
Explanation	The patients are admitted to Kilcoy Hospital. Therefore, Kilcoy is the reporting entity and will report the clinical consult on the TID entry screen
HBCIS TID entry screen	01: Telehealth Session ID – Auto filled 02: Provider Facility: 00201 (Royal Brisbane & Women's Hospital) 03: Provider Type: 20008201 MO-SPEC-ENDOCRINOLOGIST 04: Event Type: 20 Clinical Consultation 05: Provider Unit: ENDO (Endocrinology and Diabetes) 06: Start Date: 01/09/2026 07: Start Time: 16:00 08: End Date: 01/09/2026 09: End Time: 16:30 10: Recipient Facility: Null 11: Recipient Type: Null 12: Recipient Unit: Null 13: Patient Number: patient UR and episode ID.

Scenario 3: Telehandover occurring on or after 01 July 2022	
The patient has been admitted to Cardiology Ward at Mackay Base Hospital, for the duration of an acute phase of their illness. The multidisciplinary treating team at Mackay has assessed that it is clinically appropriate for the patient to be transferred back to Sarina Hospital General Medical ward, closer to the patient's home. The Mackay multidisciplinary treating team initiates and schedules a Telehandover via videoconference with Sarina Hospital. The aim of the Telehandover is to ensure continuity of care and provide an opportunity for the Sarina Hospital treating team to ask questions related to the ongoing care of the patient. The patient has requested to be present during the Telehandover. The multidisciplinary team at Mackay is made up of three healthcare providers: cardiologist, physiotherapist and nurse. The multidisciplinary team at Sarina is made up of two healthcare providers: a doctor, physiotherapist and nurse. The Mackay and Sarina teams meet via videoconference for the Telehandover on 6 July 2026 from 10:00 and finish at 10:30.	
Provider	Mackay Base Hospital (*Telehandover Provider Facility)*
Recipient	Sarina Hospital *(Telehandover Recipient facility)*
Reporting Entity	**Mackay Base Hospital**

Explanation	• Admitted patient telehealth events can only be captured by the facility where the patient is admitted.
	  ○ In this case, the patient is admitted to Mackay Base Hospital at the time of the Telehandover event, so the Mackay Base Hospital team will report the telehandover on the TID entry screen.
	• If the Event Type is 25 – Telehandover, the Recipient facility details must be reported on the TID entry screen in the new TID fields: Recipient Facility, Recipient Type and Recipient Unit.
	  ○ Sarina Hospital is the Recipient facility in this Telehandover scenario. This means Mackay Base Hospital will report the details of Sarina Hospital in the new recipient fields: Recipient Facility, Recipient Type and Recipient Unit
	• The details of the Provider facility (in this case Mackay Base Hospital) will be captured in the fields: Provider Facility, Provider Unit and Provider Type.

HBCIS TID entry screen	01: Telehealth Session ID – Auto filled 02: Provider Facility: 00175 (Sarina Hospital) 03: Provider Type: 20008208 MO-SPEC-MEDICINE-GENERAL 04: Event Type: 25 Telehandover case conference 05: Provider Unit: GENM (General Medical) 06: Start Date: 06/07/2026 07: Start Time: 10:00 08: End Date: 06/07/2026 09: End Time: 10:30 10: Recipient Facility: 00175 (Sarina Hospital) 11: Recipient Unit: GENM (General Medicine) 12: Recipient Type: 20008208 MO-SPEC-MEDICINE-GENERAL 13: Patient Number: patient UR and episode ID.

Abbreviations

Abbreviation	Description
A	Authority
ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACCD	Australian Consortium for Classification Development
ACHI	The Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADL	Activity of Daily Living
AIHW	Australian Institute of Health and Welfare
AN-SNAP	Australian National Sub and Non-Acute Patient
AMI	Acute Myocardial Infarction
AN-DRG	Australian National Diagnosis Related Group
AR-DRG	Australian Refined Diagnosis Related Group
AROC	Australian Rehabilitation Outcomes Centre
ASCL	Australian Standard Classification of Languages
ASGC	Australian Statistical Geographical Classification
ASGS	Australian Statistical Geographical Standard
AW	At Work
C	Cyclist
CCF	Congestive Cardiac Failure
CCU	Coronary Care Unit
CMBS	Commonwealth Medicare Benefits Schedule
COPD	Chronic Obstructive Pulmonary Disease
COF	Condition onset flag
CSCF	Clinical Services Capability Framework
CTP	Compulsory Third Party
CVS	Continuous Ventilatory Support
D	Driver
DSB	Data Services Branch (formally known as Statistical Services Branch)
DCCSDS	Department of Communities, Child Safety and Disability Services
DD	Department of Defence (Australian)
DoHA	Department of Health and Ageing
DRG	Diagnosis Related Groups
DSS	Decision Support System
DVA	Department of Veterans' Affairs
E	Employer
E. Coli	Escherichia Coli
EAM	Elective Admission Module
eARF	Electronic Ambulance Report Form
ETT	Endotracheal Tube

EVA	Electronic Validation Application
EX	External Cause
FAMMIS	Finance and Material Management Information System
FIM	Functional Independence Measure
FMPM	Financial Management Practices Manual
FW	(going home) From Work
GEM	Geriatric Evaluation and Management
HBCIS	Hospital Based Corporate Information System
HHS	Hospital and Health Services
HHS CE	Hospital and Health Service Chief Executive
HITH	Hospital in the Home
HoNOS	Health of the Nation Outcome Scale
HQI	Homer Queensland Interface
I	Insurer
ID	Identifier
I&D Sheet	Identification and Diagnosis Sheet
ICD-10-AM	International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICD-O	International Classification of Diseases - Oncology
ICN	Intensive Care Nursery
ICU	Intensive Care Unit
IHACPA	Independent Health and Aged Care Pricing Authority
IPPB	Intermittent Positive-Pressure Breathing
IPPV	Intermittent Positive-Pressure Ventilation
KPI	Key Performance Indicators
LOS	Length of Stay
M	Morphology
MAC	Monthly Activity Collection
MAIA	Motor Accident Insurance Act 1994
MAIC	Motor Accident Insurance Commission
MC	Motor Cyclist
M code	Morphology code
MDC	Major Diagnostic Category
METeOR	Metadata Online Registry
MI	Myocardial Infarction
MMT	Major Multiple Trauma
MoU	Memorandum of Understanding
MPHS	Multi-Purpose Health Service
MRIC	Most Resource Intensive Condition
MRSA	Multi-resistant Staphylococcus Aureus
MVA	Motor Vehicle Accident
NCCH	National Centre for Classification in Health
NEP	National Efficient Price
NHA	National Health Care Agreement

NHDD	National Health Data Dictionary
NHFB	National Health Funding Body
NHTP	Nursing Home Type Patient
NICU	Neonatal Intensive Care Unit
NMDS	National Minimum Data Set
NWAU	National Weighted Activity Unit
OD	Other Diagnosis
OSHC	Overseas Student Health Cover
P	Patient
PA	Passenger
PAS	Patient Admission System
PAWS	Patient Acuity Weighted System
PBS	Pharmaceutical Benefits Scheme
PD	Principal Diagnosis
PEF	Patient Election Form
PICU	Paediatric Intensive Care Unit
POW	Prisoner of War
PR	Procedure
PTSD	Post Traumatic Stress Disorder
QAS	Queensland Ambulance Service
QHAPDC	Queensland Hospital Admitted Patient Data Collection
QHDD	Queensland Health Data Dictionary
QHEPS	Queensland Health Electronic Publishing Service
QHIK	Queensland Health Information Knowledgebase
RHCA	Reciprocal Health Care Agreement
RMHC	Residential Mental Health Care
RMHCDC	Residential Mental Health Care Data Collection
RSQ	Retrieval Services Queensland
RUG	Resource Utilisation Group
S	Solicitor
SA2	Statistical Area Level 2
SCC	Squamous Cell Carcinoma
SCN	Special Care Nursery
SEAP	Secure External Access Portal
SIPs	Surgically Implanted Prosthetics
SLA	Statistical Local Area
SMM	Standardised State Mini Mental Examination
SNAP	Sub and Non Acute Patient Classification
STS	Secure Transfer Service
TID	Telehealth Inpatient Details
TW	(going) To Work
UDG	Urgency Disposition Groups
UR	Unit Record
URG	Urgency Related Groups

UTI	Urinary Tract Infection
URN	Unit Record Number
WAU	Weighted Activity Unit
WCO	Workers' Compensation Other
WCQ	Workers' Compensation Queensland
WCQI	Workers' Compensation Queensland Ineligible