

HCP Data from hospitals to insurers

DATA SPECIFICATIONS (HCP)

HCP INPUT FILE FORMAT (2011–12)

Header record – HCP

Item No	Data Item	Obligation	Position	Type & Size	Format	Comments
1	Provider Number	M	1-8	A(8)	NNNNNNNA	The Commonwealth-issued hospital provider number (must be 8 characters, include leading zero)
2	Insurer/Group Identifier	M	9-11	A(3)		The insurer identifier selected from the list of registered private health insurers or the code for the group of insurers (e.g. AHS for Australian Health Service Alliance).
3	Disk Reference number	M	12-19	A(8)		Number identifies the file/disk ID
4	Date Prepared	M	20-27	A(8)	DDMMYYYY	The date data was prepared by hospital
5	Number of records	M	28-31	N(4)		The number of episodes on file/disk
6	Test Flag	M	32	A(1)		T=Test, P=Production
7	Resubmitted Disk	M	33	A(1)		Indicates if the file/disk is being resubmitted Y/N
8	Period From	M	34-41	A(8)	DDMMYYYY	Period starting (separation month)
9	Period to	M	42-49	A(8)	DDMMYYYY	Period ending (separation month)
10	HCP Version	M	50-53	N(4)		HCP version 0100,0200,0201,0209,0210,0300,0400,0500,0600,0700,0800
11	ICD Version	M	54-57	N(4)		ICD version 10.1=1001, 10.2 = 1002, 10.3 = 1003, 10.4=1004, 10.5=1005, 10.6=1006, 10.7=1007

Header record – AN-SNAP

Item No	Data Item	Obligation	Position	Type & Size	Format	Comments
1	Provider Number	M	1-8	A(8)	NNNNNNNA	The Commonwealth-issued hospital provider number (must be 8 characters, include leading zero)
2	Insurer/Group Identifier	M	9-11	A(3)		The insurer identifier selected from the list of registered private health insurers or the code for the group of insurers (e.g. AHS for Australian Health Service Alliance).
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6	Test Flag	M	32	A(1)		T=Test, P=Production
7	Resubmitted Disk	M	33	A(1)		Indicates if the file/disk is being resubmitted Y/N
8	Period From	M	34-41	A(8)	DDMMYYYY	Period starting (separation month)
9	Period to	M	42-49	A(8)	DDMMYYYY	Period ending (separation month)
10	AN-SNAP HCP Version	M	50	N(4)		AN-SNAP HCP version 0500, 0700, 0800
11	Blank fill	M	54	N(4)		Blank fill
12	File Type	M	58	A(1)		S = Snap

EXPLANATORY NOTES (HCP)

Scope of Data Collection

The Hospital Casemix Protocol specifies the financial, clinical and demographic data that hospitals must provide private health insurers and private health insurers must provide the Department, in respect of each episode of admitted hospital treatment for which a benefit has been paid.

For the purposes of this collection, an episode is the period between *admission* and *separation* that a person spends in one hospital, and includes leave periods not exceeding seven days. Admission and separation can be either formal or statistical (refer to definitions).

It is preferable that each episode refer to only one care type (being the descriptor of the overall nature of a service provided). That is, if a patient's care type changes during a hospital stay, it would be preferable for the patient to be statistically separated from one episode for the first care type and statistically admitted for another episode for the new care type, so that two episode records are submitted.

All reporting requirements governing HCP data include AN-SNAP data as:

- AN-SNAP is not a stand-alone dataset but rather a supplementary file to the HCP file.
- AN-SNAP specifications are incorporated into the DoHA Hospital to Insurer HCP format.
- The requirement to supply HCP to insurers (and by implication AN-SNAP also) does not depend on the existence of a contract between the hospital and insurer but rather whether an insurer benefit is paid to a hospital for admitted episodes of hospital treatment.

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

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

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

Reporting Requirements

The hospital will provide a monthly data submission to the Insurer within 6 weeks after the end of a hospital separation month. For example, a file containing data for separations during the month of July is to be provided to insurers by mid September.

Notes about the specifications

The ***data item column*** indicates the short name for the data item and, where applicable, the reference number for the item in the National Health Data Dictionary as accessed via the Metadata Online Registry (METeOR) at: <http://meteor.aihw.gov.au/content/index.phtml/itemId/237518>

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

- M – Mandatory
- O – Optional

The **position column** indicates the position within the fixed file format that each data item is to be reported.

The **type and size column** indicates the number and type of character/s the data item should contain where:

- A indicates the data item contains alphanumeric characters (alphabetic, numeric and other special characters). Data must be left justified.
- N indicates the data item contains numeric characters (numbers 0 to 9) only. Data items must be right justified and zero-prefixed to fully fill the item unless otherwise stated in the coding description. All values must be positive.

The **format column** indicates the format of the characters of the data item:

DDMMYYYY indicates the data item contains date information where DD represents the day, MM represents the month and YYYY represents the century and year. For example, 5 July 2006 would be entered 05072006

hhmm indicates the data item contains time information based on a 24-hour clock, where hh represents the hour and mm represents the minutes. For example 2.35pm would be entered 1435.

blank fill, in relation to a data item, means that the data item is filled with blank spaces.

zero fill, in relation to a data item, means that the data item is filled with zeros.

zero prefix means that leading zeros are to be inserted if necessary to ensure that the number of characters in the entry matches the data item size specified for the item.

Charges & Benefits– supply in dollars and cents (omit decimal point) with leading zeros to fully fill item.. All values must be ≥ 0 (i.e. negative amounts are not permitted). An entry of 000000000 means that no benefit/charge was recorded. Zeros are valid when this item cannot be separately identified but was reported under another charge/benefit item.

See the coding description column for any other special formatting requirements

The **repetition column** indicates the number of times the data item is repeated within the data file.

The **coding description column** provides the definition for the data item, valid values and any additional information to clarify what data should be reported and how. If a METeOR data item exists, refer to the National Health Data Dictionary for definition and collection methods.

The **edit rules column** outlines the edit checks the Department will run the data through using the Check-It software. These are split into critical errors where data will be rejected and warnings where data will be identified.

The **error codes column** indicates the error code attributed to each of the edit checks.

Definitions/acronyms

ACHI means the Australian Classification of Health Interventions.

ADA means the Australian Dental Association.

AN-SNAP means the Australian National Sub-Acute and Non-Acute Patient Classification System.

CCU means the coronary care unit of a hospital.

contracted doctor means a doctor who has entered into an agreement with a private health insurer where the doctor agrees to accept payment by the insurer in relation to treatment provided to the insured person.

contracted hospital means a hospital which has entered into an agreement with a private health insurer to accept payment in relation to an episode of hospital treatment for an insured person under a complying health product.

DRG means the Australian Refined Diagnosis Related Group.

episode means the period of admitted patient care between a formal or statistical **admission** and a formal or statistical **separation**, characterised by only one care type..

FIM means functional independence measure and is the outcome measure used for **overnight-stay rehabilitation patients**.

formal admission, in relation to a person, means the administrative process used by a hospital to record the commencement of accommodation, care or treatment of the person.

formal separation, in relation to a person, means the administrative process used by a hospital to record the cessation of accommodation, care or treatment of the person.

HDU means the high dependency unit of a hospital.

Hospital means a facility for which there is in force a Ministerial declaration that the facility is hospital under subsection 121-5(6) of the *Private Health Insurance Act 2007*.

Hospital treatment is treatment (including the provision of goods and services) provided to a person with the intention to manage a disease, injury or condition, either at a hospital or with direct involvement of the hospital, by either a person who is authorised by a hospital to provide the treatment or under the management or control of such a person (subsection 121-5, *Private Health Insurance Act 2007*).

Exclusions to hospital treatment (eg treatment provided in an emergency department of a hospital) are specified in the Private Health Insurance (Health Insurance Business) Rules 2010, Part 3, Rule 8.

Inclusions to hospital treatment (eg some Chronic Disease Management Programs not involving prevention) are specified in the Private Health Insurance (Health Insurance Business) Rules 2010, Part 3.

Hospital-in-the-home means the provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary (METeOR glossary item ID: 327308).

Hospital-in-the-home care days means the total number of days between HiTH commencement date and HiTH completion date.

Hospital-in-the-home care visit days means the total number of days during a HiTH care episode that the patient was actually visited/received a service. This might be calculated by subtracting HiTH care completion date from HiTH care commencement date and then subtracting total leave days.

ICD-10-AM means 'The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification, published by the National Centre for Classification in Health (Australia).

ICU means the intensive care unit of a hospital.

insurer means a private health insurer.

MBS means the Medicare Benefits Schedule, comprising:

- (a) the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2005*; and
- (b) the *Health Insurance (General Medical Services Table) Regulations 2005*; and

(c) the *Health Insurance (Pathology Services Table) Regulations 2005*;
as in force from time to time, or any Regulations made in substitution for those Regulations.

METeOR (metadata online registry) for national data standards.

miscellaneous service code means any miscellaneous hospital-specific or insurer-specific non-MBS billing code.

NHDD means the (most current version of the) 'National Health Data Dictionary'.

NICU means the neonatal intensive care unit of a hospital.

overnight-stay patient means a person who is admitted to and separates from a hospital on different dates.

PHIAC means Private Health Insurance Administration Council

PICU means the paediatric intensive care unit of a hospital.

procedure means clinical intervention that is surgical in nature, carries a procedural risk, carries an anaesthetic risk, requires specialised training, and/or requires special facilities or equipment only available in an acute care setting

same-day patient means a person who is admitted to and separates from a hospital on the same date.

SCN means the special care nursery of a hospital.

special character means a character that has a visual representation but is not an alphanumeric character, ideogram or blank space.

statistical admission, in relation to a person, means the administrative process used by a hospital to record the commencement of a new episode of care that provides the person with a new care type during a single hospital stay.

statistical separation, in relation to a person, means the administrative process used by a hospital to record the cessation of an episode of care of the person during a single hospital stay.

Guide for Use

Accommodation charges/benefits - refer to private, shared or high dependency accommodation for any Accommodation Type (i.e. advanced surgical, surgical, medical, rehabilitation, obstetrics, and psychiatry). All hospital episodes must have a charge/benefit component relating to accommodation, unless it was bundled, or the hospital billed a procedure-only fee. Therefore, cases such as chemotherapy should either have a charge/benefit component in "bundled" or "accommodation" or "theatre". They should not be reported as "other".

AN-SNAP Collection – the AN-SNAP collection is a separate data collection to the episode record for rehabilitation, which provides specific information regarding the functional gains of patients undergoing rehabilitation, as well as the AN-SNAP class for overnight admitted patients. It is expected that one AN-SNAP record be reported for each overnight admitted rehabilitation program, and one AN-SNAP record be reported for an entire episode of care consisting of multiple same day visits. The AN-SNAP record should be linked to the episode with the same separation date.

AN-SNAP Class – The AN-SNAP class allocated to each overnight admitted patient is in part determined by their FIM admission score. Given the FIM is not collected for same-day patients it is impossible to allocate same-day patients an AN-SNAP class.

Bundled charges/benefits - refer to an aggregate of 2 or more charges billed by the hospital/paid by the insurer, such as case payments by DRG or MBS.

CCU charges, benefits, days and hours - exclude ICU, SCN, NICU, PICU and HDU in calculations.

Functional Independence Measure - The FIM score is used to measure functional improvement and is comprised of 18 items (13 motor items and 5 cognition items) with a maximum score of seven and a minimum score of one. Total scores can range from 18 to 126. Admission scores must be collected within 72 hours after the admission. Discharge scores must be collected within 72 hours of discharge, unless the patient died during the episode. Guide for collecting the AROC inpatient data set should be followed for scoring the FIM. This applies to AN-SNAP admission and discharge FIM scores for overnight-stay patients. The FIM is not collected for same-day patients.

Hospital-in-the-home (HITH) – Episodes which include HITH services should be reported in a manner consistent with claiming practice. For example,
(a) HITH services which are part of an admitted psychiatric program and are claimed as a single same day service must be reported as single same day episode. This includes psychiatric patients that remain in an admitted HITH program over extended periods of time.
(b) If hospital claims are submitted to insurers at the conclusion of the admitted psychiatric HITH program, then one episode must be reported spanning the length of the program.

ICU charges, benefits, days and hours - include NICU and PICU; exclude SCN, CCU or HDU in calculations.

Infant weight neonate - For live births, birth weight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birth weight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured. In perinatal collections the birth weight is to be provided for live born and stillborn babies.

Minutes in Theatre - from the time the patient entered the operating theatre or procedure room until the time the patient left the operating theatre or procedure room. For example, coronary angiography/angioplasty, lithotripsy and ECT must have minutes of operating theatre time reported, even though they are performed in a procedure room rather than a theatre.

Other charges/benefits – refer to services which cannot be categorised as accommodation, theatre, labour, ICU, pharmacy, prosthesis, bundled, SCN, CCU or HITH. It excludes ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments.

Palliative care status and days – calculations to include care provided in: a palliative care unit; a designated palliative care program; or under the principal clinical management of a palliative care physician or in the opinion of the treating doctor, when the principal clinical intent of care is palliation.

Principal MBS item - select on the basis of: (a) the patient's first visit to a theatre or procedure room/coronary angiography suite; and (b) the MBS with the highest benefit amount. The principal MBS item relates to theatre or procedure room/angiography suite, and not to the medical item billed by the doctor. It may not necessarily correlate to the Principal Procedure Code. For example, renal dialysis, coronary angiography/ angioplasty, same-day chemotherapy, lithotripsy, ECT and sleep studies must have an MBS item number reported, even though they are procedure room rather than theatre. Where possible, any services that do not have a valid MBS item should be reported in the Miscellaneous Service Code item (item 53).

Principal Item Date – The date on which the principal MBS item is carried out. If there is no principal MBS item, then the date that the first Miscellaneous Service Code item was carried out may optionally be entered.

Qualified days for newborns - The number of qualified days is calculated with reference to the date of admission, date of separation and any other date(s) of change of qualification status: the date of admission is counted if the patient was qualified at the end of the day; the date of change to qualification status is counted if the patient was qualified at the end of the day; the date of separation is not counted, even if the patient was qualified

on that day. The normal rules for calculations of patient days apply. To determine if newborn days are qualified days, see the METeOR definition for Newborn Qualification Status (Metadata glossary item 327254).

SCN charges, benefits, days and hours - exclude NICU, ICU, CCU, PICU and HDU in calculations.

Secondary MBS item - The secondary MBS items relate to theatre, and not to the medical item billed by the doctor. It may not always correlate to the Procedure Codes (ICD-10-AM). Where possible, any services that do not have a valid MBS item should be reported in the Miscellaneous Service Code item (item 53).

Theatre charges/benefits – refer to a theatre/procedure room/ angiography suite. This applies to theatre charges, benefits and minutes in theatre.

Re-admission within 28 days – Planned re-admission refers to planned re-admission within 28 days from this or another hospital. Note: do not include transfers from another hospital as re-admissions.

Data Quality

Error Codes

1st Character – represents the type of record i.e. E (episode) and A (AN-SNAP)

2nd Character – W (represents a warning where an edit rule has been identified)– the record will be accepted and insurers notified

2nd Character – E (represents an error where an edit rule has failed) – the record will be rejected and insurers notified

Further information

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

General information about the data collection including AN-SNAP, health insurer codes, reports and software

- www.health.gov.au/casemix

List of Hospital provider numbers

- <http://www.health.gov.au/internet/main/publishing.nsf/Content/hospitals2.htm>

Metadata and health dictionary specifications

- <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>

For private health insurance industry information

- www.phiac.gov.au

Commonwealth Prosthesis list

- <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-prostheseslist.htm>

DATA SPECIFICATIONS (HCP)

HCP DATA ITEM AND RECORD EDITING 2011–12

Record to be submitted to Insurers with Header record

EPISODE RECORD									
No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
1	Insurer Membership Identifier	M	1-15	A(15)	Left justify Blank fill	1	Insurer membership identifier.	Reject record if blank	EE001
2	Insurer Identifier	M	16-18	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	Reject record if not a valid insurer code	EE002
3	Episode Identifier	M	19-33	A(15)	Left justify	1	Unique episode identifier for this episode of care.	Reject record if blank	EE003
4	Family Name METeOR: 286953	M	34-61	A(28)	Left justify	1	The patient's family name. In cases where the patient only has one name, it is entered in this field.	Reject record if blank	EE004
5	Given Name METeOR: 287035	M	62-81	A(20)	Left justify	1	The patient's given name. May be blank if the patient only has one name.	Identify record if blank	EW005
6	Date of Birth METeOR: 287007	M	82-89	A(8)	DDMMYY YY	1	The date of birth of the patient.	Reject record if not in format DDMMYYYY	EE006
7	Postcode METeOR: 287224	M	90-93	N(4)		1	The patient's residential postcode. 9999 = unknown postcode 8888 = overseas	Reject record if not (a valid Australian postcode or 9999 or 8888)	EE007
8	Sex METeOR: 287316	M	94	N(1)		1	The biological sex of the patient. 1 = Male 2 = Female 3 = Intersex or Indeterminate 9 = Not stated / inadequately described	Reject record if not (1, 2, 3 or 9)	EE008
9	Admission Date METeOR: 269967	M	95-102	A(8)	DDMMYY YY	1	Date on which an admitted patient commences an episode of care by either formal or statistical processes.	Reject record if not in format DDMMYYYY	EE009

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
10	Separation Date METeOR: 270025	M	103-110	A(8)	DDMMYY YY	1	Date on which an admitted patient completes an episode of care by either formal or statistical processes.	Reject record if not in format DDMMYYYY, or if not ≥ admission date, or if MM is not same as month input in Insurer Header	EE010
11	Hospital Type	M	111	N(1)		1	The type of hospital where the episode occurred. 1 = Public 2 = Private 3 = Private Day Facility 4 = Public Day Facility 9 = Other/unknown	Reject record if not (1, 2, 3, 4 or 9). Identify if hospital type does not match provider hospital table	EE011 EW011
12	ICU Days	M	112-114	N(3)	Right justify Zero prefix	1	The number of days the patient spent in ICU, NICU or PICU. Zero fill if not applicable. * refer to guide for use.	Reject record if not numeric. Reject record if not zero for day facilities (public or private) <i>*warning for public hospitals</i>	EE012.0 <i>EW012.0*</i> EE012.1 <i>EW012.1*</i>
13	ICU Hours	O	115-118	N(4)	Right justify Zero prefix	1	The number of hours the patient spent in ICU, NICU or PICU. Zero fill if not applicable * refer to guide for use.	If present, identify if not numeric	EW013
14	Total Psychiatric Care Days METeOR: 270300	M	119-121	N(3)	Right justify Zero prefix	1	The sum of the number of days or part days of stay that the person was an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit. Zero fill if not applicable.	Reject if not numeric	EE014
15	DRG Code METeOR: 270195	O	122-125	A(4)	Left justify	1	The DRG code which describes the episode of care.	If present, identify record if not a valid DRG code for DRG version supplied at item 16.	EW015

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
16	DRG Version	O	126-127	N(2)		1	The version of the DRG classification: 31 = version 3.1 32 = version 3.2 41 = version 4.1 42 = version 4.2 50 = version 5.0 51 = version 5.1 52 = version 5.2 60 = version 6.0 mn = version m.n Must be supplied if DRG code provided at item 15.	If present, identify record if not a valid version. Identify if blank and DRG code provided at item 15.	EW016.0 EW016.1
17	Admission Time METeOR: 269972	M	128-131	N(4)	hhmm (24 hour clock)	1	Time at which an admitted patient commences an episode of care by either formal or statistical processes. Mandatory for same-day patients only.	Reject record if not in range 0000–2359 and same-day status is 1.	EE017
18	Urgency of Admission METeOR: 269986	M	132	N(1)		1	An indicator of the admission status of the patient: 1 = Urgency status assigned - Emergency 2 = Urgency status assigned - Elective 3 = Urgency status not assigned 9 = Not known/not reported	Reject record if not (1, 2, 3 or 9)	EE018
19	Provider Number of Hospital from which transferred	M	133-140	A(8)	NNNNNN NA (upper case)	1	The Commonwealth-issued hospital provider number for the hospital from which a patient has been transferred (Provider number required only when HCP item number 21 is reported as: 1- Admitted patient transferred from another hospital) Blank fill if no hospital transfer.	Reject if not (a valid 8 character Commonwealth provider number or blank)	EE019

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
20	Care Type METeOR: 270174	M	141-143	N(3)	Left justify two digit codes and follow with a blank space)	1	The type of service that the patient was initially admitted for. 10 = Acute Care 20 = Rehabilitation Care 21 = Rehabilitation Care delivered in a designated unit 22 = Rehabilitation Care according to a designated program 23 = Rehabilitation Care is the principal clinical intent 30 = Palliative Care 31 = Palliative Care delivered in a designated unit 32 = Palliative Care according to a designated program 33 = Palliative Care is the principal clinical intent 40 = Geriatric evaluation and management 50 = Psychogeriatric Care 60 = Maintenance Care 70 = Newborn Care 80 = Other admitted patient care 90 = Organ procurement - posthumous 100 = Hospital boarder	Reject record if not (10, 20, 21, 22, 23, 30, 31, 32, 33, 40, 50, 60, 70, 80, 90 or 100)	EE020
21	Source of Referral	M	144	N(1)		1	The facility from which the patient was referred: 0 = Born in hospital 1 = Admitted patient transferred from another hospital 2 = Statistical admission – care type change 4 = From Accident/Emergency 5 = From Community Health service 6 = From Outpatients department 7 = From Nursing Home 8 = By outside Medical Practitioner 9 = Other	Reject record if not (1, 2, 4, 5, 6, 7, 8 or 9)	EE021

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
22	Discharge Intention on Admission	O	145	N(1)		1	The intended mode of separation at time of admission: 1 = Discharge to an(other) acute hospital 2 = Discharge to a nursing home 3 = Discharge to a psychiatric hospital 4 = Discharge to palliative care unit/hospice 5 = Discharge to other health care accommodation 8 = To pass away 9 = Discharge to usual residence	If present, identify if not (1, 2, 3, 4, 5, 8 or 9)	EW022
23	Inter-hospital contracted patient METeOR: 270409	M	146	N(1)		1	An indicator of the status of a service provided in your hospital. 1 = Inter-Hospital contracted patient from public sector 2 = Inter-Hospital contracted patient from private sector 3 = Not contracted 9 = Not reported	Reject record if not (1, 2, 3 or 9)	EE023
24	Mental Health Legal Status METeOR: 270351	M	147	N(1)		1	An indicator that a person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the episode. Involuntary patients are persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care. 1 = Involuntary patient 2 = Voluntary patient 3 = Not permitted to be reported under the laws of a State or Territory 8 = Not applicable	Reject record if not (1, 2, 3 or 8)	EE024
25	Palliative Care Status	M	148	N(1)		1	An indicator of whether the episode involved palliative care. 1 = Patient required palliative care during episode 2 = No palliative care required during episode This item is required because some States do not statistically discharge to palliative care. * refer to the guide for use.	Identify record if not (1 or 2).	EW025

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
26	Re-admission within 28 Days	M	149	N(1)		1	An indicator of the re-admission of a patient to hospital within 28 days of previous discharge for treatment of a similar or related condition. 1 = Unplanned re-admission and patient previously treated at this hospital 2 = Unplanned re-admission and patient previously treated at another hospital 3 = Planned re-admission from this or another hospital 8 = Not applicable/ not known Note: do not include transfers from another hospital as re-admissions	Reject record if not (1, 2, 3 or 8)	EE026
27	Unplanned Theatre Visit During Episode	M	150	N(1)		1	An indicator of whether the patient required a theatre visit which was not anticipated or planned at the time of admission: 1 = Unplanned theatre visit 2 = No unplanned theatre visit	Reject record if not (1 or 2)	EE027
28	Infant Weight, Neonate, Stillborn METeOR: 269938	M	151-154	N(4)	Right justify Zero prefix	1	The first weight, in grams, of the live-born or still-born baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth. Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days. An entry of 0000 means the patient's age >= 365 days or weight was > 9000 grams. * refer to guide for use.	Reject record if not numeric. Identify if weight >9000g. Identify if weight > 0 and age >365 days <i>*warning for public hospitals</i>	EE028 <i>EW028*</i> EW028.0 EW028.1
29	Hours of Mechanical Ventilation	M	155-158	N(4)	Right justify Zero prefix	1	The total number of hours (rounded) for which the patient received mechanical ventilation in ICU, NICU, PICU or combined ICU/CCU during the episode. Zero fill if not applicable.	Reject record if not numeric <i>*warning for public hospitals</i>	EE029 <i>EW029*</i>

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
30	Mode of Separation METeOR: 270094	M	159-160	N(2)	Left justify and follow with space (may also submit in old format with zero prefix)	1	The status at separation of person (discharge/transfer/death) and place to which person is released: 1 = discharge/transfer to an(other) acute hospital 2 = discharge/transfer to a residential aged care service, unless this is the usual place of residence 3 = discharge/transfer to an(other) psychiatric hospital 4 = discharge/transfer to other health care accommodation (includes mothercraft hospitals) 5 = statistical discharge— type change 6 = left against medical advice/discharge at own risk 7 = statistical discharge from leave 8 = died 9 = other (includes discharge to usual residence, own accommodation or welfare institution (includes prisons, hostels and group homes providing primarily welfare services))	Reject record if not (1, 2, 3, 4, 5, 6, 7, 8, 9, 01, 02, 03, 04, 05, 06, 07, 08 or 09).	EE030
31	Separation Time METeOR: 270026	M	161-164	N(4)	hmm (24 hour clock)	1	Time at which an admitted patient completes an episode of care by either formal or statistical processes. Mandatory for same-day patients only.	Reject record if not in range 0000-2359 and same-day status is 1.	EE031
32	Total Leave Days METeOR: 270251	M	165-168	N(4)	Right justify Zero prefix	1	The sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay. Zero fill if not applicable.	Reject record if not numeric	EE032

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
33	Provider Number of Hospital to which transferred	M	169-176	A(8)	NNNNNN NA (uppercase)	1	The Commonwealth-issued hospital provider number for the hospital to which a patient has been transferred (Provider number required only when HCP item number 30 is reported as: 1- Discharge/transfer to an(other) acute hospital, or 3 - Discharge/transfer to a(nother) psychiatric hospital or 4 - Discharge/transfer to another health care accommodation (includes mothercraft hospitals)). Blank fill if no hospital transfer.	Reject if not (a valid 8 character Commonwealth provider number or blank).	EE033
34	Non-Certified Days of Stay	M	177-180	N(4)	Right justify Zero prefix	1	The number of days spent in the hospital, without certification, that exceeded 35 days. Zero fill if not applicable.	Reject record if not numeric. <i>*warning for public hospitals</i>	EE034 EW034*
35	Number of Hospital-in-the-home care days METeOR: 270305	M	181-184	N(4)	Right justify Zero prefix	1	The number of hospital-in-the-home care days occurring within an episode. Calculate with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and hospital-in-the-home accommodation. Zero fill if not applicable. * refer to definitions.	Reject record if not numeric. Identify record if not = HITH completed date - HITH commencement date).	EE035 EW035
36	Principal Diagnosis Code METeOR: 333838	M	185-189	A(5)	ANNNN Left justify Strip hyphen, dots & morphology codes	1	The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of admitted care. The principal diagnosis should be reported in the most current version of ICD-10-AM and selected according to the National Coding Standards.	Reject record if not a valid ICD-10-AM principal diagnosis code. Identify if Care Type = (20, 21, 22 or 23) and not Z50.? Identify if Care Type = 60 and not (Z74.2 or Z75.?)	EE036 EW036.1 EW036.2
37	Additional Diagnosis Codes METeOR: 333832	M	190-434	A(5)	NANNNN Left justify Strip hyphen, dots & morphology codes	49	A condition or complaint either co-existing with the principal diagnosis or arising during the episode of admitted care, as represented by an ICD-10-AM code. Blank means no additional diagnosis codes (or not 49 repetitions)	Reject if not (a valid ICD-10-AM code or blank). Identify if the same as 'Principal Diagnosis Code'	EE037 EW037

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
38	Procedure Codes METeOR: 333828	M	435-784	A(7)	NNNNNNN Left justify Strip hyphen	50	The procedure code, as represented by the latest version of ACHI and selected according to the National Coding Standards. Blank means no ICD-10-AM procedure codes (or not 50 repetitions)	Reject if not (a valid ICD-10-AM code or blank).	EE038
39	Same-day Status	M	785	N(1)		1	An indicator of whether the patient was admitted to the facility for an overnight stay. 0 = patient with a valid arrangement allowing for overnight stay for procedure normally performed on a same-day basis. 1 = same-day patient; 2 = overnight patient (other than type 0 above)	Reject record if not (0, 1 or 2).	EE039
40	Principal MBS Item Number	M	786-799	A(14)	Left justify	1	A valid Medical Benefits Schedule item according to the relevant MBS Schedule valid for the MBS date (Item 41). Blank means there was no applicable MBS item.	If present, reject record if not a valid MBS item from the relevant MBS Schedule valid for the service date (Item 42)	EE040
41	Principal MBS Item Date	M	800-807	A(8)	DDMMYY YY	1	The date on which; i) the principal MBS item (item 40) was carried out, or ii) (if item 40 is blank), the first Miscellaneous Service Code (item 53) was carried out. Must be supplied if principal MBS item number provided (item 40).	If present, reject record if not in format DDMMYYYYY. Reject record if date is before admission date or after discharge date Reject record if blank and item 40 is populated	EE041.0 EE041.1 EE041.2
42	Minutes of operating theatre time METeOR: 270350	M	808-811	N(4)	Right justify Zero prefix minutes	1	The time in minutes that the patient spent on their first visit to theatre/ procedure room/coronary angiography suite. Should be populated if surgical ADA code provided in Miscellaneous Service Code field (item 53). Blank means there was no applicable MBS Item / ADA code or a public hospital. Must be supplied by private hospitals and private day facilities where MBS item number (item 40) or Miscellaneous Service Code (item 53) provided. * refer to guide for use.	If present, reject record if not numeric. Identify if blank and item 40 or item 53 is populated.	EE042 EW042

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
43	Secondary MBS Item numbers	M	812-937	A(14)	Left justify	9	Additional MBS item numbers are all MBS items performed in theatre/procedure room/angiography suite, which are not the principal MBS. Blank means that there was no additional MBS item (or not 9 repetitions). *refer to guide for use.	Reject record if not (a valid MBS item number from the relevant MBS Schedule(s) current during the episode or blank)	EE043
44	Accommodation Charge	M	938-946	N(9)	Right justify Zero prefix \$\$\$\$\$cc (omit decimal point)	1	The gross amount charged for accommodation (include ex-gratia and patient portion accommodation charges). Zero fill if no amount charged. *refer to guide for use.	Reject record if not numeric or if item blank and bundled charges, ICU charge, CCU charge, SCN charge and HITH charge are ALL zero or blank.	EE044
45	Theatre Charge	M	947-955	N(9)	Right justify Zero prefix \$\$\$\$\$cc (omit decimal point)	1	The total amount charged for theatre/procedure room/angiography suite (include ex-gratia and patient portion theatre charges). Zero fill if no amount charged. *refer to guide for use.	Reject record if not numeric	EE045
46	Labour Ward Charge	M	956-964	N(9)	Right justify Zero prefix \$\$\$\$\$cc (omit decimal point)	1	The gross amount charged for labour ward (include ex-gratia and patient portion labour ward charges). Zero fill if no amount charged.	Reject record if not numeric	EE046
47	Intensive Care Unit Charge	M	965-973	N(9)	Right justify Zero prefix \$\$\$\$\$cc (omit decimal point)	1	The gross amount charged for ICU (include ex-gratia and patient portion ICU charges). Zero fill if no amount charged. *refer to guide for use.	Reject record if not numeric	EE047

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
48	Prosthesis Charge	M	974-982	N(9)	Right justify Zero prefix \$\$\$\$\$\$cc (omit decimal point)	1	The gross maximum amount charged for prosthesis (include ex-gratia prosthesis charges, handling fee and patient portion), Zero fill if no amount charged.	Reject record if not numeric	EE048
49	Pharmacy Charge	M	983-991	N(9)	Right justify Zero prefix \$\$\$\$\$\$cc (omit decimal point)	1	The gross amount charged for pharmacy (include ex-gratia and patient portion pharmacy charges, exclude discharge medications). Zero fill if no amount charged.	Reject record if not numeric	EE049
50	Other Charges	M	992-1000	N(9)	Right justify Zero prefix \$\$\$\$\$\$cc (omit decimal point)	1	The gross charge raised for any chargeable item which cannot be specifically categorised elsewhere (exclude ex-gratia charges, television, phone calls, extra meals, FED, reversals or journal adjustments). Zero fill if no amount charged. *refer to guide for use.	Reject record if not numeric	EE050
51	Bundled Charges	M	1001-1009	N(9)	Right justify Zero prefix \$\$\$\$\$\$cc (omit decimal point)	1	The gross bundled charge raised (include ex-gratia and patient portion bundled charges). Zero fill if no amount charged. *refer to guide for use.	Reject record if not numeric	EE051
52	Medical Record Number	M	1010-1029	A(20)	Left justify Blank fill	1	The Medical Record Number (or unit record number) that uniquely identifies the patient, regardless of the number of admissions they have had to the facility.	Reject record if blank	EE052
53	Miscellaneous Service Codes	M	1030-1139	A(11)	Left justify	10	Any miscellaneous service codes (i.e. non MBS items or Australian Dental Association codes) used for billing. Up to 10 codes may be entered. Blank means that there were no miscellaneous service codes or not 10 repetitions.		

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
54	Hospital-in-the-home care Charges	M	1140-1148	N(9)	Right justify Zero prefix \$\$\$\$\$\$cc (omit decimal point)	1	The gross charge raised for hospital-in-the-home care service (include ex-gratia and HITH patient portion charges). Zero fill if no amount charged.	Reject record if not numeric <i>*warning for public hospitals</i>	EE054 EW054*
55	Special Care Nursery Charges	M	1149-1157	N(9)	Right justify Zero prefix \$\$\$\$\$\$cc (omit decimal point)	1	The gross charge raised for SCN (include ex-gratia and patient portion SCN charges, exclude NICU charges). Zero fill if no amount charged. <i>*refer to guide for use.</i>	Reject record if not numeric	EE055
56	Coronary Care Unit Charges	M	1158-1166	N(9)	Right justify Zero prefix \$\$\$\$\$\$cc (omit decimal point)	1	The gross charge raised for CCU (include ex-gratia and patient portion CCU charges). Zero fill if no amount charged. <i>*refer to guide for use.</i>	Reject record if not numeric	EE056
57	Special Care Nursery hours	O	1167-1170	N(4)	Right justify Zero prefix	1	The number of hours the patient spent in a SCN. Zero fill if not applicable. <i>*refer to guide for use.</i>	If present, identify record if not numeric	EW057
58	Coronary Care Unit hours	O	1171-1174	N(4)	Right justify Zero prefix	1	The number of hours the patient spent in a CCU. Zero fill if not applicable. <i>*refer to guide for use.</i>	If present, identify record if not numeric	EW058
59	Special Care Nursery days	M	1175-1177	N(3)	Right justify Zero prefix	1	The number of days the patient spent in a SCN. Zero fill if not applicable. <i>*refer to guide for use.</i>	Reject record if not numeric. Reject record if not zero for day facilities (public or private)	EE059.0 EE059.1
60	Coronary Care Unit days	M	1178-1180	N(3)	Right justify Zero prefix	1	The number of days the patient spent in a CCU. Zero fill if not applicable. <i>*refer to guide for use.</i>	Reject record if not numeric. Reject record if not zero for day facilities (public or private)	EE060.0 EE060.1

No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
61	Number of Qualified Days for Newborns METeOR: 270033	M	1181-1184	N(4)	Right justify Zero prefix	1	The number of qualified newborn days occurring within a newborn episode of care. Zero fill if not applicable. *refer to guide for use.	Reject record if not numeric. Identify record if >0000 and (care type not newborn care)	EE061 EW061
62	Hospital-in-the-home care Commencement Date	M	1185-1192	A(8)	DDMMYY Y	1	Date on which an admitted patient commences an episode of hospital-in-the-home care services. Conditional item if HITH charges (item 54) > 0. Blank fill if not applicable.	Reject record if Hospital-In-The-Home Charges (item 54) is populated and item is blank or not in format DDMMYYYY. Reject record if commencement date > HITH completed date.	EE062.0 EE062.1
63	Hospital-in-the-home care Completed Date	M	1193-1200	A(8)	DDMMYY Y	1	Date on which an admitted patient completes an episode of hospital-in-the-home care services. Conditional item if HITH charges (item 54) > 0. Blank fill if not applicable.	Reject record if Hospital-In-The-Home Charges (item 54) is populated and item is blank or not in format DDMMYYYY. Reject record if completed date < HITH commencement date.	EE063.0 EE063.1
64	Number of Hospital-in-the-home care visit days	M	1201-1204	N(4)	Right justify Zero prefix	1	The total number of days during a HITH care episode that the patient was actually visited/received a service. Conditional item if HITH days (item 35) > 0. Zero fill if not applicable. *refer to definitions.	Reject record if not numeric or if > number of HITH days (item 35) [calculated as HITH completed date – HITH commencement date] + 1.	EE064
65	Palliative Care Days	M	1205-1208	N(4)	Right justify Zero prefix	1	The number of days a patient received palliative care during an episode. Where the entire episode is Palliative, provide the total length of stay in days. Conditional item if Palliative Care Status (item 25) = 1. Zero fill if no Palliative Care Days. *refer to guide for use.	Reject record if not numeric. Identify record if 0 and palliative care status (item 25) = 1	EE065 EW065

Total record length 1208

COLLECTION LEVEL EDIT RULES		ERROR CODE/S
Extras	Reject record if Separation date (Item 10) does not equal Admission date (Item 9) where Same-day Status (Item 40) = 1 (reject if Separation date = Admission date and Same-Day Status not equal to 1)	EE201
	Identify if the records with Hospital Type' = 2 have more than 5% with 'Unplanned Theatre Visit' = 1	EW202
	Reject record if ICU charge but no ICU days recorded and no ICU hours recorded	EE203
	Identify record if prosthesis charge but no Theatre or Bundled charge (and hospital type is private or private day facility).	EW204
	Identify record if therapeutic Principal MBS present but no Principal Procedure	EW205
	Identify record if accommodation charge exceeds \$2,000 x Length Of Stay (LOS)	EW206
	Identify record if ICU charge >\$5,000 per day	EW207
	Identify record if no charges reported (total charge=0)	EW208
	Identify if all records with 'Hospital Type' = 2 have 'Unplanned Theatre Visit' = 2 and there are greater than 100 episodes for the month.	EW209
	Identify if the records with Hospital Type' = 2 have more than 5% with 'Unplanned Theatre Visit' = 1	EW210
Identify if all records with 'Hospital Type' = 2 have 'Readmission within 28 days' = 8 and there are greater than 100 episodes for the month.	EW211	

Record to be submitted to Insurers with Header record

AN-SNAP RECORD									
No	Data Item	Obligation	Position	Type & size	Format	Repetition	Coding description	Edit Rules	Error code/s
1	Insurer Membership Identifier	M	1-15	A(15)	Left justify	1	Insurer membership identifier.	Reject record if not a valid code	AE001
2	Insurer Identifier	M	16-18	A(3)	Left justify	1	Insurer identifier selected from the list of registered private health insurers.	Reject record if blank	AE002
3	AN-SNAP Identifier	MAA	19-33	A(15)	Left justify	1	A unique identifier for this AN-SNAP record that links it to the associated episode (and/or medical and prosthetic records). It is a combination of the Medical Record Number (in the Episode record) and hyphen and a record number (sequential counter)	Reject record if blank Identify record if no hyphen in the Identifier Identify record if the characters prior to the hyphen do not match a Medical Record Number in the Episode Records	AE003 AW003.1 AW003.2
4	Family Name METeOR: 286953	M	34-61	A(28)	Left justify	1	The patient's family name. In cases where the patient only has one name, it is entered in this field.	Reject record if blank	AE004
5	Given Name METeOR: 287035	M	62-81	A(20)	Left justify	1	The patient's given name. May be blank if the patient only has one name.	Identify record if blank	AW005
6	Date of Birth METeOR: 287007	M	82-89	A(8)	DDMMYYYY	1	The date of birth of the patient.	Reject record if not in format DDMMYYYY	AE006
7	Postcode METeOR: 287224	M	90-93	N(4)	Right justify Zero prefix	1	The patient's residential postcode. 9999 = unknown postcode 8888 = overseas	Reject record if not (a valid Australian postcode or 8888 or 9999).	AE007
8	Sex METeOR: 287316	M	94	N(1)		1	The biological sex of the patient. 1 = Male 2 = Female 3 = Intersex or Indeterminate 9 = Not stated / inadequately described	Reject record if not (1, 2, 3 or 9)	AE008
9	Admission Date METeOR: 269967	M	95-102	A(8)	DDMMYYYY	1	Date on which an admitted patient commences an episode of care by either formal or statistical processes.	Reject record if not in format DDMMYYYY	AE009

10	Separation Date METeOR: 270025	M	103-110	A(8)	DDMMYYYY	1	Date on which an admitted patient completes an episode of care by either formal or statistical processes.	Reject record if not in format DDMMYYYY, or if not ≥ admission date, or if MM is not same as month of input in header.	AE010
11	Episode Type	M	111	A(1)		1	An indicator of the type of admitted rehabilitation program undertaken during the episode that relates to the AN-SNAP records. O = Overnight Admitted Patient – Assign this value for patients who stay overnight during the admitted rehabilitation program. S = Same-day Admitted Patient – Assign this value for patients who undertake an admitted rehabilitation program consisting of multiple same day visits/services. It is recommended that one AN-SNAP record is reported that covers the entire program (not separate episodes for each visit/service). In this case, Admission date = date of 1st visit/service and Separation date = date of last visit/service in the Same-day admitted program. The AN-SNAP record should be linked to the episode with the same separation date.	Reject record if not ('O' or 'S')	AE011
12	Admission FIM Item Scores	M	112-129	N(1)		18	The FIM score on admission for each of the 18 FIM motor and cognition items No Helper: Score of 7 – Complete Independence Score of 6 – Modified Independence Helper: Score of 5 – Supervision or setup Score of 4 – Minimal assistance Score of 3 – Moderate assistance Score of 2 – Maximal assistance Score of 1 – Total assistance *refer to guide for use	Reject record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O. Identify record if episode type is S and not blank fill	AE012 AW012

13	Discharge FIM Item Scores	M	130-147	N(1)		18	<p>The FIM score on discharge for each of the 18 FIM motor and cognition items.</p> <p>No Helper: Score of 7 – Complete Independence Score of 6 – Modified Independence</p> <p>Helper: Score of 5 – Supervision or setup Score of 4 – Minimal assistance Score of 3 – Moderate assistance Score of 2 – Maximal assistance Score of 1 – Total assistance *refer to guide for use</p>	<p>Reject record if not (1, 2, 3, 4, 5, 6 or 7) and episode type is O. and not Episode Mode of Separation = 8</p> <p>Identify record if episode type is S and not blank fill</p>	<p>AE013</p> <p>AW013</p>
14	AROC Impairment Codes	M	148-154	A(7)	NN.NNNN Left justify	1	<p>Enter the Impairment Code (AUS version 1) that best describes the primary reason for admission to the rehabilitation episode.</p> <p>Code as specifically as possible and where possible avoid the use of impairment group 13 - 'Other Disabling Impairments'.</p> <p>Each entry should consist of:</p> <ul style="list-style-type: none"> - two (2) digits that represent the impairment group (zero prefixed if 1 digit) - a decimal point - up to four (4) digits that represent more specific categories within impairment groups if applicable (blank fill any unused characters). 	<p>Reject record if not a valid code or if trailing zeros.</p>	<p>AE014</p>
15	Assessment Only Indicator METeOR: 339509	M	155	N(1)		1	<p>AN-SNAP has separate classes for Assessment Only episodes. Assessment only occurs when the person was seen on one occasion only for assessment and no rehabilitation treatment and no further intervention by this service team is planned to occur within the next 90 days. If a person is booked/seen for subsequent treatment within 90 days, they are not Assessment Only. If a person is booked for subsequent assessment (but not treatment), they are assessment only. Record:</p> <p>1 = Yes 2 = No</p>	<p>Reject record if not (1 or 2)</p>	<p>AE015</p>

16	AN-SNAP Class	M	156-159	N(4)		1	The AN-SNAP class to which the episode is assigned. AN-SNAP Class is only applicable to overnight episodes and must be reported as 4 characters in the following format: - "2" prefix followed by AN-SNAP version 2 class code.	Reject record if not a valid code and episode type = O Identify record if episode type = S and not blank fill.	AE016 AW016
17	SNAP Version	M	160-161	N(2)		1	The version of the AN-SNAP Classification used to report item 16. 02 = AN-SNAP Version 2	Reject record if not (01 or 02) and episode type = O Identify record if episode type = S and not blank fill. Identify if (01) and episode type = O	AE017 AW017.1 AW017.2
18	Multi-disciplinary rehabilitation plan date METeOR: 341640	M	162-169	A(8)	DDMMYYYY	1	The date a multi-disciplinary rehabilitation plan is established for an episode of admitted patient care.	Reject record if not in format DDMMYYYY	AE018
19	Discharge plan date	M	170-177	A(8)	DDMMYYYY	1	The date a discharge plan is established for an episode of admitted patient care.	Reject record if not in format DDMMYYYY	AE019

Total record length 177