


**Statutory Rules 1995 No.** 1 109

# National Health Regulations[2] (Amendment)

I, THE GOVERNOR-GENERAL of the Commonwealth of Australia, acting with the advice of the Federal Executive Council, make the following Regulations under the *National Health Act 1953*.

Dated 1 1995. 30 May

L BILL HAYDEN
Governor-General

By His Excellency's Command,

L CARMEN LAWRENCE
Minister for Human Services and Health

## 1. Amendment

1.1 The National Health Regulations are amended as set out in these Regulations.

[NOTE: These Regulations commence on gazettal: see *Acts Interpretation Act 1901*, s. 48.]

## 2. New regulations 49A and 49B

2.1 After regulation 49, insert:

### Hospital Casemix Protocol

"49A. (1) For the purposes of paragraph 73BD (2) (c) of the Act, a Hospital Casemix Protocol is set out in Schedule 7.

"(2) In the Hospital Casemix Protocol, a reference to a document is a reference to that document as in existence on the day on which this subregulation commences.

### List of Australian National Diagnosis Related Groups

"49B. (1) For the purposes of subparagraph 73BD (4) (a) (i) of the Act, the List of Australian National Diagnosis Related Groups consists of the contents of the following documents:

(a) Australian National Diagnosis Related Groups Definitions Manual Version 1.0;

(b) Australian National Diagnosis Related Groups Definitions Manual Version 2.0;

(c) Australian National Diagnosis Related Groups Definitions Manual Version 2.1—Addendum to ANDRG V2.0 Definitions Manual;

(d) Australian National Diagnosis Related Groups Definitions Manual Version 3.0.

"(2) A reference in subregulation (1) to a document is a reference to that document as in existence on the day on which this subregulation commences.".

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**3. New Schedule 7**

3.1 Add at the end of the Regulations:

## SCHEDULE 7

Regulation 49A

HOSPITAL CASEMIX PROTOCOL

### Part 1—Explanatory Notes

**Hospital Casemix Protocol: object**

1. The object of the Hospital Casemix Protocol is to specify the financial, clinical and demographic data that funds must give to the Department in respect of every episode of hospital treatment for which a charge is billed to a fund.

**Hospital Casemix Protocol: definitions**

2. In this Protocol:

**"blank filled"** means that where blank filling is a valid entry, the field is filled with blanks;

**"CCU"** means the Coronary Care Unit of a hospital;

**"CMBS"** means Commonwealth Medicare Benefits Schedule;

**"contracted doctor"** means a doctor who has entered into a medical purchaser-provider agreement under section 73BDA of the *National Health Act 1953*;

**"contracted hospital"** means a hospital that has entered into a purchaser-provider agreement under section 73BD of the *National Health Act 1953*;

**"DRG"** means Diagnosis Related Group;

**"episode"** means the period between admission and separation that a person spends in one hospital, and includes leave periods not exceeding 7 days;

[NOTE: This definition of "episode" differs from the definition set out in the NHDD.]

**"fund"** means a health benefits fund conducted by a registered organization;

**"ICD-9-CM"** means The International Classification of Diseases 9th Revision Clinical Modification (Australian Version);

**SCHEDULE 7**—continued

**"MAA"** means mandatory for all, and fields identified with this flag must contain a valid entry regardless of whether the episode occurred in a contracted hospital or a non contracted hospital;

**"MAC"** means mandatory for contracted hospitals, and fields identified with this flag must contain a valid entry. Where the episode occurred in a non contracted hospital, the field becomes optional;

**"NHDD"** means version 3 of the National Health Data Dictionary, published in May 1994;

**"OPA"** means that fields identified with this flag are optional for all hospitals;

**"OPH"** means optional for public hospitals, and fields identified with this flag are optional for public hospitals, whether contracted or not, and mandatory for private hospitals;

**"OPO"** means optional for public hospitals overnight, and fields identified with this flag are optional for public hospitals, whether contracted or not, where the patient stayed overnight;

**"overnight-stay patient"** means a person who is admitted to, and who separates from, a hospital on different dates;

**"sameday patient"** means a person who is admitted to, and who separates from, a hospital on the same date;

**"valid arrangement"** means an arrangement made under section 4C of the *National Health Act 1953*.

[NOTE: "NHTP" (nursing home type patient) is defined in subsection 3 (1) of the *Health Insurance Act 1973*.]

## How to use the Protocol: the Parts of the Protocol

3. The medical record supplied to the Department by a fund must comply with the specification set out in the File Structure: Medical Record in Part 2, and with the contents set out in Record Content: Medical Record in Part 4.

4. The hospital episode record supplied to the Department by a fund must comply with the specification set out in the File Structure: Hospital Episode Record in Part 3, and with the contents set out in Record Content: Hospital Episode Record in Part 5.

**SCHEDULE 7**—continued

**How to use the Protocol: format specifications and how the details must be sent**

5. All fields are to be initialised to blanks.

6. Blanks are not a valid entry for some fields. These fields are identified in Column 5.

7. Where identified in Column 5, blanks are a valid entry under the following conditions:

(a) the data item is optional; or

(b) specific conditions apply and these are noted in Column 5.

8. A record will be rejected by the Department if any of the following data items is coded as blank:

(a) Fund identifier in either Part 4 or 5;

(b) Link Identifier in either Part 4 or 5;

(c) Provider (hospital) code in Part 5;

(d) Total charge in Part 5;

(e) Total benefit in Part 5;

(f) Date of birth in Part 5;

(g) Postcode in Part 5;

(h) Gender in Part 5;

(i) Date admitted in Part 5;

(j) Date separated in Part 5;

(k) Separation mode in Part 5;

(l) Principal Diagnosis Code in Part 5.

9. Records not containing valid entries for items in item 8 will be rejected.

10. If 10% of records in any transmission batch are rejected all records in that transmission batch will be returned to the fund. The fund will resubmit the rejected transmission within 4 weeks from the date of receipt of rejected records.

11. Where a hospital is required to provide data to a fund, the hospital episode record must comply with the specifications set out in the File Structure: Hospital Episode Record in Part 3. The hospital must reach an agreement with the fund as to the medium on which the data must be sent.

**SCHEDULE 7**—continued

12. Where a fund gives data to the Department, the fund must give the data to the Department using:

(a) DOS formatted floppy disks; or
(b) magnetic tapes; or
(c) MVS cartridges; or
(d) other electronic media as agreed with the Department in writing.

**How to use the Protocol: data structure and specifications**

13. A fund must give data to the Department in ASCII format with a record length as stated in Parts 2 and 3 of the Protocol.

14. For the purpose of the field size column (Column 3 in Parts 4 and 5):

(a) D is a date field. Legal values are 0-9 and blanks. The format is DDMMCCYY;
(b) N is a numeric field. N fields must be right justified and left blank filled. Legal characters are 0-9 and blanks;
(c) C is a character field. C fields must be right justified and left blank filled. Legal characters are alpha, 0-9 and blanks;
(d) I is for ICD-9-CM codes. I fields must be left justified and right blank filled and should not include decimal points.

15. Data items requiring rounding are noted in Column 5 in Parts 4 and 5. Rounding takes fractions to the nearest whole number. If the fraction is 0.5 acceptable rounding is up for an odd number and down for an even number.

16. All data items should reflect the completed discharge data set.

**How to use the Protocol: how will the data transfer work**

17. A fund has the primary responsibility for giving the information set out in Column 2-Data item of Parts 4 and 5.

18. Where the fund gives data to the Department, the data must include all episodes, whether or not the episodes took place in a contracted hospital.

**SCHEDULE 7**—continued

19. Where the hospital gives data to the fund:
    (a) the data set out in items 27-56 in Part 5, Record Content: Hospital Episode Record must be sent; and
    (b) the data sent in accordance with paragraph (a) must be sent using the structure set out in items 27-56 in Part 3, File Structure: Hospital Episode Record.

[NOTE: The NHDD is published by the Australian Institute of Health and Welfare and aims to set out uniform definitions and data items to be used in the collection of health and welfare data. The definitions set out in the NHDD are endorsed by the National Health Information Management Group through the National Health Information Agreement.]

**SCHEDULE 7**—continued

## Part 2—File structure: medical record

| Column 1<br>Item No. | Column 2<br>Data Item | Column 3<br>Start Position | Column 4<br>Field size | Column 5<br>Repetitions |
|---|---|---|---|---|
| 1 | Fund identifier | 1 | 3 | 1 |
| 2 | Link identifier | 4 | 24 | 1 |
| 3 | CMBS item | 28 | 5 | 1 |
| 4 | Medical charge | 33 | 5 | 1 |
| 5 | CMBS benefit | 38 | 5 | 1 |
| 6 | Fund benefit | 43 | 5 | 1 |
| 7 | CMBS date of service | 48 | 8 | 1 |
| 8 | Contracted doctor | 56 | 1 | 1 |
| 9 | Total record length | 56 | | |

**SCHEDULE 7**—continued

## Part 3—File structure: hospital episode record

| Column 1<br>Item No. | Column 2<br>Data Item | Column 3<br>Start Position | Column 4<br>Field size | Column 5<br>Repetitions |
|---|---|---|---|---|
| 1 | Fund identifier | 1 | 3 | 1 |
| 2 | Link identifier | 4 | 24 | 1 |
| 3 | Provider (hospital) code | 28 | 8 | 1 |
| 4 | Product code | 36 | 8 | 1 |
| 5 | Hospital contract status | 44 | 1 | 1 |
| 6 | Total days paid | 45 | 4 | 1 |
| 7 | Accommodation charge | 49 | 6 | 1 |
| 8 | Accommodation benefit | 55 | 6 | 1 |
| 9 | Theatre charge | 61 | 5 | 1 |
| 10 | Theatre benefit | 66 | 5 | 1 |
| 11 | Labour ward charge | 71 | 5 | 1 |
| 12 | Labour ward benefit | 76 | 5 | 1 |
| 13 | Intensive Care Unit charge | 81 | 5 | 1 |
| 14 | Intensive Care Unit benefit | 86 | 5 | 1 |
| 15 | Prosthesis charge | 91 | 5 | 1 |
| 16 | Prosthesis benefit | 96 | 5 | 1 |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Item | Column 3<br>Start Position | Column 4<br>Field size | Column 5<br>Repetitions |
|---|---|---|---|---|
| 17 | Pharmacy charge | 101 | 5 | 1 |
| 18 | Pharmacy benefit | 106 | 5 | 1 |
| 19 | Total charge | 111 | 6 | 1 |
| 20 | Total benefit | 117 | 6 | 1 |
| 21 | Front End Deductible | 123 | 5 | 1 |
| 22 | Ancillary cover status | 128 | 1 | 1 |
| 23 | Ancillary charges | 129 | 5 | 1 |
| 24 | Ancillary benefits | 134 | 5 | 1 |
| 25 | Medical charges | 139 | 6 | 1 |
| 26 | Medical benefits | 145 | 6 | 1 |
| 27 | Date of birth | 151 | 8 | 1 |
| 28 | Postcode | 159 | 4 | 1 |
| 29 | Gender | 163 | 1 | 1 |
| 30 | Date admitted | 164 | 8 | 1 |
| 31 | Date separated | 172 | 8 | 1 |
| 32 | Hospital type | 180 | 1 | 1 |
| 33 | ICU days | 181 | 3 | 1 |
| 34 | DRG code | 184 | 3 | 1 |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Item | Column 3<br>Start Position | Column 4<br>Field size | Column 5<br>Repetitions |
|---|---|---|---|---|
| 35 | DRG version | 187 | 2 | 1 |
| 36 | Admission time | 189 | 4 | 1 |
| 37 | Admission transfer type | 193 | 1 | 1 |
| 38 | Age in years | 194 | 3 | 1 |
| 39 | Age in days | 197 | 3 | 1 |
| 40 | Neonatal admission weight | 200 | 4 | 1 |
| 41 | Hours of mechanical ventilation | 204 | 4 | 1 |
| 42 | Separation mode | 208 | 2 | 1 |
| 43 | Separation time | 210 | 4 | 1 |
| 44 | Separation transfer type | 214 | 1 | 1 |
| 45 | Acute days of stay | 215 | 4 | 1 |
| 46 | Total leave days | 219 | 4 | 1 |
| 47 | Non-acute days of stay | 223 | 4 | 1 |
| 48 | Principal diagnosis code | 227 | 5 | 1 |
| 49 | Secondary diagnoses codes | 232 | 5 | 14 |
| 50 | Principal procedure code | 302 | 4 | 1 |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Item | Column 3<br>Start Position | Column 4<br>Field size | Column 5<br>Repetitions |
|---|---|---|---|---|
| 51 | Secondary procedure codes | 306 | 4 | 14 |
| 52 | Sameday status | 362 | 1 | 1 |
| 53 | Principal CMBS item number | 363 | 5 | 1 |
| 54 | Principal CMBS date | 368 | 8 | 1 |
| 55 | Time in operating theatre (Principal CMBS) | 376 | 4 | 1 |
| 56 | Secondary CMBS item numbers | 380 | 5 | 14 |
| 57 | Total record length | 449 | | |

**SCHEDULE 7**—continued

## Part 4—Record content: medical record

| Column 1 Item No. | Column 2 Data item | Column 3 Field size | Column 4 Required | Column 5 Description of data item |
|---|---|---|---|---|
| 1 | Fund identifier | C(3) | MAA | See fund codes |
| 2 | Link identifier | C(24) | MAA | A unique identifier of an episode that links data items from this Part (Part 4) to the hospital episode record (Part 5). The fund may encrypt the membership identifier for this purpose |
| 3 | CMBS item | C(5) | MAA | The CMBS item number<br><br>Blank means there was no CMBS item billed |
| 4 | Medical charge | N(5) | MAA | The amount that the patient was billed by doctor<br><br>An entry of 0 dollars means no amount was billed |
| 5 | CMBS benefit | N(5) | MAA | The amount paid to the patient as the Medicare entitlement<br><br>An entry of 0 dollars means no amount was paid |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Description of data item |
|---|---|---|---|---|
| 6 | Fund benefit | N(5) | MAA | An amount additional to the Medicare entitlement paid by the fund to the patient<br><br>An entry of 0 dollars means no amount was paid |
| 7 | CMBS date of service | D(8) | MAA | DDMMCCYY<br><br>Blank means there was no CMBS date of service |
| 8 | Contracted doctor | C(1) | MAA | Y means the CMBS medical charge was billed by a doctor with whom the fund has a contract<br><br>N means a doctor with whom the fund has no contract<br><br>Blank means there was no CMBS item billed |

**SCHEDULE 7**—continued

## Part 5—Record content: hospital episode record

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 1 | Fund identifier | C(3) | MAA | See fund codes |
| 2 | Link identifier | C(24) | MAA | A unique identifier of an episode that links data items from this Part (Part 5) to the medical record (Part 4). The fund may encrypt membership identifier for this purpose |
| 3 | Provider (hospital) code | C(8) | MAA | The hospital provider number |
| 4 | Product code | C(8) | MAA | The product code for patient's insurance cover at separation. The fund must supply documentation of cover field values |
| 5 | Hospital contract status | C(1) | MAA | Y means a hospital with which a fund has a contract<br><br>N means a hospital with which the fund does not have a contract |
| 6 | Total days paid | N(4) | MAA | The total number of days for which benefits were paid by the fund, including days for which benefits were paid as an NHTP |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 7 | Accommodation charge | N(6) | MAA | Accommodation charges rounded to the nearest dollar. An entry of 0 dollars means that no accommodation charges were billed<br><br>Blanks are only valid where an accommodation charge was not separately identified but was billed under another charge item |
| 8 | Accommodation benefit | N(6) | MAA | Accommodation benefit rounded to the nearest dollar. An entry of 0 dollars means that no accommodation benefits were paid<br><br>Blanks are only valid where an accommodation benefit was not separately identified but was paid under another benefit item |
| 9 | Theatre charge | N(5) | MAA | Theatre charges rounded to the nearest dollar. An entry of 0 dollars means that no theatre charges were billed<br><br>Blanks are only valid where a theatre charge was not separately identified but was billed under another charge item |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 10 | Theatre benefit | N(5) | MAA | Theatre benefit rounded to the nearest dollar. An entry of 0 dollars means that no theatre benefits were paid<br><br>Blanks are only valid where a theatre benefit was not separately identified but was paid under another benefit item |
| 11 | Labour ward charge | N(5) | MAA | Labour ward charges rounded to the nearest dollar. An entry of 0 dollars means that no labour ward charges were billed<br><br>Blanks are only valid where a labour ward charge was not separately identified but was billed under another charge item |
| 12 | Labour ward benefit | N(5) | MAA | Labour ward benefit rounded to the nearest dollar. An entry of 0 dollars means that no labour ward benefits were paid<br><br>Blanks are only valid where a labour ward benefit was not separately identified but was paid under another benefit item |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 13 | Intensive Care Unit (ICU) charge | N(5) | MAA | ICU charge rounded to the nearest dollar. An entry of 0 dollars means that no ICU charges were billed.<br><br>Blanks are only valid where an ICU charge was not separately identified but was billed under another charge item |
| 14 | Intensive care unit (ICU) benefit | N(5) | MAA | ICU benefit rounded to the nearest dollar. An entry of 0 dollars means that no ICU benefits were paid<br><br>Blanks are only valid where an ICU benefit was not separately identified but was paid under another benefit item |
| 15 | Prosthesis charge | N(5) | MAA | Prosthesis charge rounded to the nearest dollar. An entry of 0 dollars means that no prosthesis charge was billed<br><br>Blanks are only valid where a prosthesis charge was not separately identified but was billed under another charge item |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 16 | Prosthesis benefit | N(5) | MAA | Prosthesis benefit rounded to the nearest dollar. An entry of 0 dollars means that no prosthesis benefit was paid<br><br>Blanks are only valid where a prothesis benefit was not separately identified but was paid under another benefit item |
| 17 | Pharmacy charge | N(5) | MAA | Pharmacy charge rounded to the nearest dollar. An entry of 0 dollars means that no pharmacy charges were billed<br><br>Blanks are only valid where a pharmacy charge was not separately identified but was billed under another charge item |
| 18 | Pharmacy benefit | N(5) | MAA | Pharmacy benefit rounded to the nearest dollar. An entry of 0 dollars means that no pharmacy benefits were paid<br><br>Blanks are only valid where a pharmacy benefit was not separately identified but was paid under another benefit item |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 19 | Total charge | N(6) | MAA | The total charge field must contain the actual total charge billed by the hospital<br><br>Total charges rounded to the nearest dollar. An entry of 0 dollars means that no charges were billed<br><br>A blank entry is not valid in this field |
| 20 | Total benefit | N(6) | MAA | The total benefits field should contain the actual total benefits paid to the hospital by the fund<br><br>Total benefits rounded to the nearest dollar. An entry of 0 dollars means that no benefits were paid<br><br>A blank entry is not valid in this field |
| 21 | Front end deductible | N(5) | MAA | The amount of FED deducted from the benefit otherwise payable by the fund to the patient<br><br>Blank means there is an FED but the amount is unknown<br><br>0 means there was no FED applicable |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 22 | Ancillary cover status | C(1) | MAA | Y means that the patient has ancillary cover<br><br>N means that the patient does not have ancillary cover |
| 23 | Ancillary charges | N(5) | OPA | The ancillary charges incurred during the episode and billed against an ancillary table |
| 24 | Ancillary benefits | N(5) | OPA | The ancillary benefits paid for charges billed as occurring during the episode |
| 25 | Medical charges | N(6) | MAA | The total Medical charges as set out in Part 4 |
| 26 | Medical benefits | N(6) | MAA | The total CMBS and Fund benefits as set out in Part 4 |
| 27 | Date of birth | D(8) | MAA | DDMMCCYY |
| 28 | Postcode | C(4) | MAA | The patient's residential postcode |
| 29 | Gender | C(1) | MAA | 1 = Male;<br>2 = Female;<br>0 = Unknown |
| 30 | Date admitted | D(8) | MAA | DDMMCCYY |
| 31 | Date separated | D(8) | MAA | DDMMCCYY |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 32 | Hospital type | C(1) | MAA | 1 = public;<br>2 = private;<br>3 = private day facility;<br>4 = public day facility;<br>9 = other |
| 33 | ICU days | N(3) | OPH | The number of days spent by the patient in:<br>ICU; and/or<br>CCU; and/or<br>neonatal intensive care; and/or<br>paediatric intensive care.<br><br>This data item does not include days spent in High Dependency Units. |
| 34 | DRG code | C(3) | OPA | Blank filled if not known |
| 35 | DRG version | C(2) | OPA | 10 = version 1;<br>20 = version 2;<br>21 = version 2.1;<br>30 = version 3 |
| 36 | Admission time | N(4) | MAA (sameday patients only) | The admission hour is based on a 24-hour clock. For example, 6:35AM is entered as 0635. |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 37 | Admission transfer type [to this hospital] | C(1) | MAC | If the patient transferred in from another hospital, the data item must indicate whether the care in the admitting hospital was more or less resource intensive per day than the care provided in the hospital from which the patient was transferred. The data item must be entered using the following codes:<br><br>Blank means there was no transfer.<br><br>U means Up Transfer: this hospital stay was more resource intensive per day.<br><br>D means Down Transfer: this hospital stay was less resource intensive per day.<br><br>L means Lateral Transfer: this hospital stay was of similar resource intensity per day.<br><br>X means transfer type unknown. |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 38 | Age in years | N(3) | MAA | The age of the patient at admission. The data item must be entered using a valid range of 0 - 124. If the patient's age was 365 days or less, then enter zeros. |
| 39 | Age in days | N(3) | MAC | The age of the patient at admission if less than 1 year of age. The data item must be entered using a valid range of 0 - 365. |
| 40 | Neonatal admission weight | N(4) | MAC | The admission weight rounded to the nearest gram for Neonates (patient age less than 29 days old). |
| 41 | Hours of mechanical ventilation | N(4) | MAC | The number of hours (rounded) for which the patient received mechanical ventilation during the episode. |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 42 | Separation mode | C(2) | MAC | 01 means separation or transfer of the patient to an acute hospital<br>02 means separation or transfer of the patient to a nursing home<br>03 means separation or transfer of the patient to a psychiatric hospital<br>04 means separation or transfer of the patient to another health facility<br>05 means statistical separation-type change<br>06 means the patient left the hospital against medical advice<br>07 means a statistical separation from leave<br>08 means the patient died<br>09 means the patient went home / other |
| 43 | Separation time | N(4) | MAA (sameday patients only) | This separation time is based on a 24-hour clock. For example, 10:35PM is entered as 2235. |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 44 | Separation transfer type [Separation from this hospital] | C(1) | MAC | If the patient was transferred to another hospital, the data item must indicate whether the care in the separating hospital was more or less resource intensive per day than the care expected to be required by the patient in the hospital to which the patient was transferred. The data item must be entered using the following codes:<br><br>Blank means there was no separation transfer<br><br>U means Up Transfer: this hospital stay expected to be less resource intensive per day<br><br>D means Down Transfer: this hospital stay expected to be more resource intensive per day<br><br>L means Lateral Transfer: this hospital stay expected to be of similar resource intensity per day<br><br>X means transfer type unknown |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 45 | Acute days of stay | N(4) | MAA | Acute days of stay are calculated:<br><br>as 1 for sameday patients; or<br><br>by subtracting the date of admission from the date of separation, and excluding any leave days. |
| 46 | Total leave days | N(4) | MAA | This data item is calculated as the sum of leave days for all leave periods during the episode.<br><br>If there are no leave days, enter 0.<br><br>Leave days exclude one-day leave periods for acute and private psychiatric hospital patients, and are subject to the following conditions: |

**SCHEDULE 7**—continued

| Column 1 | Column 2 | Column 3 | Column 4 | Column 5 |
|---|---|---|---|---|
| Item No. | Data item | Field size | Required | Coding Description |
| | | | | Patients in acute hospitals and private psychiatric hospitals who do not require treatment over a weekend or other short period may leave the hospital temporarily with the approval of the hospital or treating medical practitioner. If there is a decision that the patient will return to the same hospital within a short time to resume treatment, this absence is defined as "leave".<br><br>A patient of a public psychiatric hospital who leaves the hospital for a short period without a formal discharge is defined as being on leave from the hospital.<br><br>*[NOTE: See NHDD P27a and P4-62.]* |
| 47 | Non-acute days of stay | N(4) | MAA | This data item refers to the number of days in the hospital that exceeded 35 days without certification. |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 48 | Principal diagnosis code | I(5) | MAC | The ICD-9-CM code for the diagnosis or condition chiefly responsible for occasioning the hospital admission.<br><br>A blank entry is not valid for this field. |
| 49 | Secondary diagnosis codes | I(5)<br><br>14 times | MAC | Additional ICD-9-CM diagnosis codes for conditions other than the principal diagnosis:<br><br>that arose during the patient's stay in hospital;<br><br>that affected the patient's treatment and/or length of stay in hospital by greater than one day;<br><br>that existed at the time of the patient's admission to hospital and for which treatment was given.<br><br>*[NOTE: See NHDD P36 and ICD-9-CM under the entry Additional Diagnoses.]* |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 50 | Principal procedure code | I(4) | MAC | The ICD-9-CM procedure code for the procedure which consumed the greatest amount of hospital resources.<br><br>Blank means no ICD-9-CM procedure code was applicable<br><br>*[NOTE: See NHDD P37 and ICD-9-CM.]* |
| 51 | Secondary procedure codes | I(4)<br><br>14 times | MAC | Additional ICD-9-CM procedure codes for other procedures performed during the episode.<br><br>*[NOTE: See NHDD P38 and ICD-9-CM.]* |
| 52 | Sameday status | C(1) | MAC | 0 means patient with a valid arrangement allowing overnight stay for procedure normally performed on a sameday basis.<br><br>1 means sameday patient.<br><br>2 means overnight patient (other than type 0 above). |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 53 | Principal CMBS item number | C(5) | OPH | Principal CMBS item related to the Principal Procedure Code referred to in Item 50 in this Part.<br><br>Blank means there was no applicable CMBS item. |
| 54 | Principal CMBS date | D(8) | OPH | The date on which the principal CMBS procedure was carried out. (DDMMCCYY)<br><br>Blank means there was no Principal CMBS date. |
| 55 | Time in operating theatre (Principal CMBS) | N(4) | MAA (sameday patients only) | The time in minutes that the patient spent in the operating theatre, from the time the patient entered the operating theatre until the time the patient left the operating theatre.<br><br>Zero means no time was spent in the operating theatre.<br><br>Blank means there was no applicable CMBS item. |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Data item | Column 3<br>Field size | Column 4<br>Required | Column 5<br>Coding Description |
|---|---|---|---|---|
| 56 | Secondary CMBS item numbers | C(5)<br>14 times | OPH | Additional CMBS item numbers related to the Secondary Procedure Codes referred to in item 51 in this Part.<br><br>Blank means there was no applicable CMBS item. |

**SCHEDULE 7**—continued

## Part 6—Registered Health Benefits Organizations

| Column 1<br>Item No. | Column 2<br>Name | Column 3<br>Identifier |
|---|---|---|
| 1 | A.C.A. Health Benefits Fund | ACA |
| 2 | A.M.A Health Fund Limited | AMA |
| 3 | Army Health Benefits Society | AHB |
| 4 | Australian Health Management Pty Ltd | AHM |
| 5 | Australian Unity Friendly Society** | AUF |
| 6 | C.D.H. Benefits Fund | CDH |
| 7 | Commonwealth Bank Health Society (Friendly Society) | CBH |
| 8 | C.P.S. Health Benefits Society | CPS |
| 9 | CUA Members' Benefits Friendly Society | CUA |
| 10 | FAI Health Benefits Limited | FAI |
| 11 | Geelong Medical and Hospital Benefits Association Limited | GMH |
| 12 | Goldfields Medical Fund (Inc.) | GMF |
| 13 | Government Employees Health Fund Limited | GEH |
| 14 | Grand United Friendly Society | GUF |
| 15 | Health Care Insurance Ltd | HCI |
| 16 | Healthguard Health Benefits Fund Limited | HHB |
| 17 | Health Insurance Fund of WA | HIF |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Name | Column 3<br>Identifier |
|---|---|---|
| 18 | Hospital Benefits Association Limited* | HBA |
| 19 | Hospital Benefits Fund of Western Australia (Inc.), The | HBF |
| 20 | Hospitals Contribution Fund of Australia, Limited, The | HCF |
| 21 | Independent Order of Odd Fellows of Victoria | IOF |
| 22 | I.O.R. Australia Pty Ltd | IOR |
| 23 | Latrobe Health Services, Inc. | LHS |
| 24 | Lysaght Hospital and Medical Club, The | LHM |
| 25 | Manchester Unity Independent Order of Oddfellows Friendly Society in New South Wales | MUI |
| 26 | Medibank Private (Health Insurance Commission) | MBP |
| 27 | Medical Benefits Fund of Australia Ltd | MBF |
| 28 | Mildura District Hospital Fund | MDH |
| 29 | MIM Employees Health Fund | MIM |
| 30 | Mutual Community Ltd* | MCL |
| 31 | National Mutual Health Insurance Pty Ltd* | NMH |
| 32 | Naval Health Benefits Society | NHB |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Name | Column 3<br>Identifier |
|---|---|---|
| 33 | New South Wales Teacher's Federation Health Society | NTF |
| 34 | N.I.B. Health Funds Limited | NIB |
| 35 | Over 50's Friendly Society, The | OFF |
| 36 | Phoenix Welfare Association Limited, The | PWA |
| 37 | Queensland Teachers Union Health Society | QTU |
| 38 | Queenstown Medical Union Health Benefits | QMU |
| 39 | Railway & Transport Employees' Friendly Society Health Fund | RTE |
| 40 | Reserve Bank Health Society | RBH |
| 41 | S.G.I.C. Health Pty Limited | SGI |
| 42 | South Australian Police Employees' Health Fund Incorporated | SPE |
| 43 | South Australian Public Servants | SPS |
| 44 | St Luke's Medical & Hospital Benefits Association | SLM |
| 45 | "The Sydney Morning Herald" Hospital Fund | SMH |
| 46 | Transport Friendly Society | TFS |
| 47 | United Ancient Order of Druids | UAD |

**SCHEDULE 7**—continued

| Column 1<br>Item No. | Column 2<br>Name | Column 3<br>Identifier |
|---|---|---|
| 48 | United Ancient Order of Druids Registered Friendly Society Grand Lodge of New South Wales, The | UAF |
| 49 | Eastern District Health Fund Ltd | WDH |
| 50 | Yallourn Medical and Hospital Society, The | YMH |

[NOTES:

* Mutual Community is owned and operated by National Mutual. In Victoria, Mutual Community trades as HBA.

** Australian Natives' Association and Manchester Unity Independent Order of Oddfellows Friendly Society in Victoria now trade as Australian Unity Friendly Society.]

## NOTES

1. Notified in the *Commonwealth of Australia Gazette* on 4 1995. 30 May

2. Statutory Rules 1954 No. 35 as amended by 1957 No. 71; 1958 No. 63; 1962 Nos. 55, 70 and 113; 1965 Nos. 17, 94 and 185; 1966 No. 99; 1967 No. 86; 1969 Nos. 91 and 220; 1970 Nos. 70 and 166; 1971 Nos. 28, 76, 103 and 138; 1972 No. 79; 1973 Nos. 17, 75, 111, 221, 225 and 267; 1974 Nos. 52, 104, 105, 113 and 263; 1975 Nos. 14, 49, 66, 100, 124, 165 and 207; 1976 Nos. 113, 217 and 227; 1977 Nos. 11, 34, 51 and 112; 1978 Nos. 66, 178, 208 and 266; 1979 Nos. 59, 107, 208 and 231; 1980 Nos. 84, 292 and 309; 1981 Nos. 43, 97, 115, 232 and 318; 1982 Nos. 38, 82, 84, 250 and 284; 1983 Nos. 45, 247 and 267; 1984 Nos. 66, 161, 200, 308, 322 and 427; 1985 Nos. 86, 136, 186, 187, 206 and 288; 1986 Nos. 47, 53, 208, 330, 353 and 360; 1987 Nos. 50, 76, 100 and 310; 1989 Nos. 291, 292 and 334; 1990 Nos. 24, 86, 114, 292, 335 and 396; 1991 Nos. 40, 41, 232, 262, 263, 310 and 339; 1992 Nos. 136 and 187; 1993 Nos. 48, 85, 153, 260, 261, 273, 280 and 284; 1994 Nos. 2, 9, 106, 139, 201, 253, 256, 296, 349 and 451; 1995 Nos. 1, 14, 34 and 52.