Hospital Casemix Protocol (HCP1)
Hospital to AHSA Version 1100
Effective for separations from 1st July 2025

Item Type & Format:
(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 description. All values must be positive.
(A) = indicates the data item contains alphanumeric characters (alphabetic, numeric and other special characters). Data must be left justified.
(D) = date DDMMYYYY
*See both Format column as well as Description & Comments column for any other special formatting requirements.

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
Hospital HCP1 Header Record								
1	Provider Number	A(8)	NNNNNNNA	Mandatory	The Commonwealth-issued hospital provider number (must be 8 characters, include leading zero)	1	8	1
2	Insurer/Group Identifier	A(3)		Mandatory	The insurer identifier selected from the list of registered private health insurers or the code for the group of insurers. Use AHS in Header record for Australian Health Service Alliance.	9	3	1
3	Disk Reference Number	A(8)		Mandatory	Number identifies the file/disk ID.	12	8	1
4	Date Prepared	D(8)	DDMMYYYY	Mandatory	The date the data was extracted by the hospital.	20	8	1
5	Number of Records	N(4)		Mandatory	The number of episodes on file/disk.	28	4	1
6	Test Flag	A(1)		Mandatory	P = Production T = Test	32	1	1
7	Resubmitted Disk	A(1)		Mandatory	Indicates if this file/disk is being resubmitted. Y = Yes N = No	33	1	1
8	Period From	D(8)	DDMMYYYY	Mandatory	The beginning of the date range for the period covered in this file.	34	8	1
9	Period To	D(8)	DDMMYYYY	Mandatory	The end of the date range for the period covered in this file.	42	8	1
10	HCP1 Version	N(4)		Mandatory	Indicates the version of HCP1. 1100	50	4	1
11	ICD Version	N(4)		Mandatory	Indicates the version of ICD-10-AM used in the dataset. 1013 = ICD-10-AM 13th edn. (effective 1 July 2025)	54	4	1
Hospital HCP1 Episode Records								
1	Insurer Membership Identifier	A(15)	Left Justify Blank Fill	Mandatory	Insurer membership identifier.	1	15	1
2	Insurer Identifier	A(3)	Left justify	Mandatory	Insurer identifier selected from the list of registered private health insurers. For current list of AHSA funds please visit our website.	16	3	1
3	Episode Identifier	A(15)	Left justify	Mandatory	Unique episode identifier for this episode of care.	19	15	1
4	Family Name METeOR: 613331	A(28)	Left justify	Mandatory	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text. In cases where the patient only has one name, it is entered in this field.	34	28	1
5	Given Name METeOR: 613340	A(20)	Left justify	Mandatory	The person's identifying name within the family group or by which the person is socially identified, as represented by text.	62	20	1
6	Date of Birth METeOR: 287007	D(8)	DDMMYYYY	Mandatory	The patient's date of birth.	82	8	1

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
7	Postcode METeOR: 611398	N(4)	Right justify Zero prefix	Mandatory	The patient's residential postcode. The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person. Codes 9999 = unknown postcode and 8888 = overseas will be used instead of METeOR codes 0097, 0098, 0099.	90	4	1
8	Sex METeOR: 741686	N(1)		Mandatory	Sex is understood in relation to sex characteristics, such as chromosomes, hormones and reproductive organs. Sex is often used interchangeably with gender, however they are distinct concepts and it is important to differentiate between them. 1 = Male 2 = Female 3 = Another term 9 = Not stated / inadequately described	94	1	1
9	Admission Date METeOR: 695137	D(8)	DDMMYYYY	Mandatory	Date on which an admitted patient commences an episode of care by either formal or statistical processes.	95	8	1
10	Separation Date METeOR: 270025	D(8)	DDMMYYYY	Mandatory	Date on which an admitted patient completes an episode of care by either formal or statistical processes.	103	8	1
11	Hospital Type	N(1)		Mandatory	The type of hospital where the episode occured. 1 Public 3 Private Day Facility 9 Other/Unknown 2 Private 4 Public Day Facility	111	1	1
12	ICU Days	N(3)	Right justify Zero prefix	Mandatory	The number of days the patient spent in one or more of the following; ICU, NICU, Paediatric ICU This does NOT include days spent in Coronary Care Units (CCU - reported separately), Special Care Nurseries (SCN - reported separately) or High Dependency Unit (HDU). Zero fill if no days spent in ICU, NICU or PICU. This field cannot be left blank.	112	3	1
13	ICU Hours METeOR: 471553	N(4)	Right justify Zero prefix	Optional	The number of completed cumulative hours (rounded down) spent in ICU, NICU or PICU. If a patient has more than one period in ICU, NICU or PICU during this episode, the total duration of all such periods is reported. Zero fill if not applicable* refer to Department of Health HCP Data Specification guide for use.	115	4	1
14	Total Psychiatric Care Days METeOR: 722678	N(5)	Right justify Zero prefix	Mandatory	The sum of the number of days or part days of stay that the patient 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.	119	5	1
15	DRG Code/Diagnosis Related Group METeOR: 729933	A(4)	Left justify	Optional	A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital, as repreesented by a code.	124	4	1
16	DRG Version (superseded)	A(2)	Blank Fill		This field has been retained as a placeholder to minimise system changes. See replacement item: 'AR DRG Version' (Item No 65)	128	2	1
17	Admission Time METeOR: 748817	N(4)	hhmm (24 hour clock)	Mandatory (Sameday patient only)	Time at which an admitted patient commences an episode of care either by formal or statistical processes. This field is only mandatory for sameday patients. Blank fill if not applicable.	130	4	1
18	Urgency of Admission METeOR: 686084	N(1)		Mandatory	Whether the admission has an urgency status assigned and, if so, whether admission occurred on an emergency basis, as represented by a code. 1 Urgency status assigned - Emergency 2 Urgency status assigned - Elective 3 Urgency status not assigned 9 Not known / not reported This field cannot be left blank.	134	1	1

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
19	Provider Number of Hospital from which transferred	A(8)	NNNNNNNA (uppercase)	Mandatory	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. Overseas hospitals to be coded as OVERSEAS. If a patient was transferred from Accident/Emergency at a different hospital from the one in which this separation occurred, then enter the Commonwealth-issued Provider number of that hospital.	135	8	1
20	Care Type METeOR: 711010	N(3)	Left justify and follow with blank space(s)	Mandatory	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. Admitted care 1 Acute care 2 Rehabilitation care 3 Palliative care 4 Geriatric evaluation and management 5 Psychogeriatric care 6 Maintenance care 7 Newborn care 11 Mental health care 88 Other admitted patient care **Care other than admitted care** 9 Organ procurement—posthumous 10 Hospital boarder	143	3	1
21	Source of Referral	N(1)		Mandatory	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	146	1	1
22	Discharge Intention on Admission	N(1)		Optional	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	147	1	1

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
23	Inter-Hospital Contracted Patient METeOR: 647105	N(1)		Mandatory	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code. **Contracted (destination) hospital** 1 = Inter-hospital contracted patient from public sector hospital; 2 = Inter-hospital contracted patient from private sector hospital; **Contracting (originating) hospital** 3 = Inter-hospital contracted patient to public sector hospital; 4 = Inter-hospital contracted patient to private sector hospital; 5 = Not inter-hospital contracted; 9 = Not stated.	148	1	1
24	Mental Health Legal Status METeOR: 727343	N(1)		Mandatory	Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period, as represented by a code. 1 = Involuntary patient 2 = Voluntary patient 9 = Not reported/unknown	149	1	1
25	Palliative Care Status	N(1)		Mandatory	An indication of whether the episode involved palliative care. 1 Patient required palliative care during episode. 2 Patient did not require palliative care during episode. Palliative Care includes care provided: - in a palliative care unit - in a designated palliative care program - 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. Mandatory for all private facilities. This item is required because some States do not statistically discharge to palliative care. Zero fill if not applicable.	150	1	1
26	Re-Admission within 28 Days	N(1)		Mandatory	An indicator of the re-admission of a patient to hospital within 28 days of previous discharge for treatment of 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	151	1	1
27	Unplanned Theatre Visit During Episode	N(1)		Mandatory	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	152	1	1
28	Birth weight of infant, neonate, stillborn METeOR: 310245	N(4)	Right justify Zero prefix	Mandatory	The first weight of the live born or stillborn 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, measured in grams. For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 gram groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured. 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 The value 9999 may be used to denote that the infant weight was unknown/not reported for a patient under 365	153	4	1

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
29	Hours of Mechanical Ventilation METeOR: 708842	N(4)	Right justify Zero prefix	Mandatory	The total number of hours an admitted patient has spent on continuous ventilator support. Continuous ventilatory support refers to the application of ventilation via an invasive artificial airway. For the purposes of this data element, invasive artificial airway is that provided via an endotracheal tube or a tracheostomy tube. Use 0000 for patients not receiving any mechanical ventilation as per the above definition. This field cannot be left blank.	157	4	1
30	Mode of Separation METeOR: 722644	N(2)	Left justify and follow with space (may also submit in old format with zero prefix)	Mandatory	The status at separation of patient (ie discharge, transfer, death) and place to which person is released: 10 Discharge/transfer to (an)other acute hospital 21 Discharge/transfer to a residential aged care service, which is not the usual place of residence 22 Discharge/transfer to a residential aged care service, which is the usual place of residence 30 Discharge/transfer to (an)other psychiatric hospital 40 Discharge/transfer to other health care accommodation (includes mothercraft hospitals) 50 Statistical discharge - type change 60 Left against medical advice/discharge at own risk 70 Statistical discharge from leave 80 Died 90 Other (includes discharge to usual residence (not including residential aged care), own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))	161	2	1
31	Separation Time METeOR: 748820	N(4)	hhmm (24 hour clock)	Mandatory (Sameday)	The time at which an admitted patient completes an episode of care either by formal or statistical processes. This field is only mandatory for sameday patients. Blank fill if not applicable.	163	4	1
32	Total Leave Days METeOR: 270251	N(4)	Right justify Zero prefix	Mandatory	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.	167	4	1
33	Provider Number of Hospital to which transferred	A(8)	NNNNNNNA (uppercase)	Mandatory	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: 10 - Discharge/transfer to an(other) acute hospital, or 30 - Discharge/transfer to a(nother) psychiatric hospital Blank fill if no hospital transfer. Overseas hospitals to be coded as OVERSEAS.	171	8	1
34	Non-Certified Days of Stay	N(4)	Right justify Zero prefix	Mandatory (ALL Private facilities)	Number of days spent in the hospital, without certification, that exceeded 35 days. Zero fill if not applicable. Mandatory for private hospitals and private day facilities.	179	4	1
35	Number of Days of Hospital-in-the-Home (HITH) Care METeOR: 686115	N(4)	Right justify Zero prefix	Mandatory (HITH Patients in Private Facilities Only)	The number of Hospital-in-the-home (HITH) care days occurring within an episode. Hospital-in-the-home (HITH) 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). 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. Fill with 0000 for patients with no HITH days. This field must not be left blank Mandatory for all private hospital and private day facility patients receiving HITH care.	183	4	1

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
36	Principal Diagnosis Code METeOR: 686100 and 793125	A(6)	NANNNN Left justify Strip hyphen, dots & morphology codes	Mandatory	Each entry should consist of: - one (1) digit that represents the Condition Onset Flag code - five (5) alphanumeric characters that represent the principal diagnosis code Condition Onset Flag (see METeOR 686100) - A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code. 1 = condition with onset during the episode of admitted patient care 2 = condition not noted as arising during the episode of admitted patient care 9 = not reported Note: All patients should report a condition onset flag code of 2 for the principal diagnosis, with the exception of newborns. Newborns in their admitted birth episode within the hospital may report a condition onset flag code of 1 or 2 for the principal diagnosis. Newborn episodes can be identified by ICD-10-AM Code Z38.x in the principal or additional diagnosis code field. Principal Diagnosis - 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. The principal diagnosis should be reported in the most current version of ICD-10-AM and selected according to the National Coding Standards.	187	6	1
37	Additional Diagnoses METeOR: 686100 and 793130	A(6)	NANNNN Left justify Strip hyphen, dots & morphology codes	Mandatory	Each entry should consist of: - one (1) digit that represents the Condition Onset Flag code - five (5) alphanumeric characters that represent the additional diagnosis code Condition Onset Flag (see METeOR 686100) - A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code. 1 = condition with onset during the episode of admitted patient care 2 = condition not noted as arising during the episode of admitted patient care 9 = not reported Additional diagnosis - A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code. Blank means no additional diagnosis codes (or not 49 repetitions).	193	6	49
38	Procedure Codes METeOR: 796208	A(7)	NNNNNNN Left Justify Strip hyphen	Mandatory	A clinical intervention represented by a code that: is surgical in nature, and/or carries a procedural risk, and/or carries an anaesthetic risk, and/or requires specialised training, and/or requires special facilities or equipment only available in an acute care setting. Blank means no ACHI procedure codes (or not 50 repetitions).	487	7	50
39	Sameday Status	N(1)		Mandatory	An indicator of whether a 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 sameday basis. 1 Sameday patient 2 Overnight patient (other than type 0 above). A blank entry is not valid for this field.	837	1	1

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
40	Principal MBS Item Number	A(14)	Left justify	Mandatory	Principal MBS item should be a valid Medical Benefits Schedule (MBS) item number and selected on the basis of: (a) the patient's 1st visit to a theatre or procedure room/coronary angiography suite; and (b) the MBS item number with the highest benefit amount. It does not relate 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. Wherever possible, any items for services (including dental) that do not have a valid MBS item should be reported in Miscellaneous Service Codes (item 53). This field should NOT contain medical consultations. A blank entry means there was no applicable MBS item number.	838	14	1
41	Principal MBS Item Date	D(8)	DDMMYYYY	Mandatory	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. Conditional item - Mandatory for all private facilities where Principal MBS item number (item 40) reported. Blank means there was no principal MBS item number. Must be supplied if principal MBS item number provided (item 40).	852	8	1
42	Minutes in Theatre or Procedure Room	N(4)	Right justify Zero prefix	Mandatory	Total time, in minutes, spent by a patient in operating theatres or procedure rooms during current episode of hospitalisation. (See Explanatory notes) Calculate 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. Should be populated if surgical ADA code provided in Miscellaneous Service Code field (item 53). Must be filled with 0000 if no time spent in operating theatre. Blank means there was no applicable MBS Item / ADA code or a public hospital. Conditional item - Mandatory for private hospitals and private day facilities where principal MBS (item 40) or Miscellaneous Service Code (item 53) is populated.	860	4	1
43	Secondary MBS Item Number	A(14)	Left justify	Mandatory	Additional MBS item numbers are all MBS items performed in theatre / procedure room / angiography suite which are not the principal MBS (item 40). The secondary MBS item numbers relate to theatre / procedure room / angiography, and not to the medical item billed by the doctor. It may not always correlate to the Procedure Codes. This field should NOT contain medical consultations. Wherever possible, any services (including dental) that do not have a valid MBS item should be reported in the Miscellaneous Service Code item (item 53). Up to 9 codes may be entered. Blank means that there was no additional MBS item number (or not 9 repetitions).	864	14	9
44	Accommodation Charge	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Accommodation charges must reflect the gross charge raised for accommodation in dollars and cents. Include ex-gratia and patient-portion accommodation where possible / relevant. Accommodation refers to private, shared or high dependency accommodation for any Accommodation Type (ie advanced surgical, surgical, medical, rehab, obstetrics and psychiatry). All episodes must have a charge 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 component in "bundled" or "accommodation" charges. They should NOT be reported as "other" charges. An entry of 000000000 means that no accommodation charges were billed and is only valid where an accommodation charge was not separately identified but was billed under another charge item All values must be greater than or equal to 0 (ie negative charges are not permitted). **AHSA EPM™ Claims & Case Payment Claims: Accommodation charges should only represent private room add-on charges, line item per-diem, psych and rehab charges where relevant.**	990	9	1

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
45	Theatre Charge	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Theatre charges must reflect the gross charge raised for theatre, procedure room or angiography suite in dollars and cents. Include ex-gratia and patient-portion theatre where possible / relevant. Zero fill if no amount charged. An entry of 000000000 means that no theatre charges were billed and is only valid where a theatre charge was not separately identified but was billed under another charge item. All values must be greater than or equal to 0 (ie negative charges are not permitted).	999	9	1
46	Labour Ward Charge	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Labour ward benefits must reflect the gross benefit paid for labour ward in dollars and cents. Include ex-gratia labour ward where possible / relevant. Zero fill if no amount paid. An entry of 000000000 means that no labour ward benefits were paid and is only valid where a labour ward benefit was not separately identified but was paid under another benefit item. All values must be greater than or equal to 0 (ie negative benefits are not permitted).	1008	9	1
47	Intensive Care Unit Charge	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	ICU charges must reflect the gross charge raised for Intensive Care Unit (ICU) in dollars and cents. Include ex-gratia and patient portion ICU where possible / relevant. ICU Charges include Intensive Care Unit (ICU), Paediatric ICU and Neonatal ICU It does NOT include High Dependency Unit (HDU), Coronary Care Unit (CCU - reported separately) or Special Care Nursery (SCN - reported separately). Zero fill if no amount charged. An entry of 000000000 means that no ICU charges were billed and is only valid where an ICU charge was not separately identified but was billed under another charge item. All values must be greater than or equal to 0 (ie negative charges are not permitted). **AHSA EPM™ Claims: ICU Charges should only represent Days of Mechanical Ventilation Charges**.	1017	9	1
48	Medical Device or Human Tissue Product Charge	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Medical Device or Human Tissue Product charge must reflect the gross Maximum Charge raised for Medical Device or Human Tissue Product in dollars and cents. Include ex-gratia Medical Device or Human Tissue Product charges and patient portion. Zero fill if no amount charged. An entry of 000000000 means that no Medical Device or Human Tissue Product charges were billed and is only valid where a Medical Device or Human Tissue Product charge was not separately identified but was billed under another charge item.	1026	9	1
49	Pharmacy Charge	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Pharmacy charges must reflect the gross charge raised for pharmacy in dollars and cents. Include ex-gratia and patient portion pharmacy where possible / relevant. Do NOT include discharge medications. Zero fill if no amount charged. An entry of 000000000 means that no pharmacy charges were billed and is only valid where a pharmacy charge was not separately identified but was billed under another charge item. All values must be greater than or equal to 0 (ie negative charges are not permitted).	1035	9	1
50	Other Charges	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Other charges must reflect the gross charge raised for any chargeable item which cannot be specifically categorised elsewhere, in dollars and cents. In other words, this category must only contain charges which may be billed to the insurer, which cannot be categorised as accommodation, theatre, labour, ICU, pharmacy, medical device or human tissue product, bundled, SCN, CCU or HITH. Do NOT include ex-gratia, television, phone calls, extra meals, FED, reversals or journal adjustments. Zero fill if no amount charged. An entry of 000000000 means that no Other charges were billed and is only valid where an Other Charge was not separately identified but was billed under another charge item. All values must be greater than or equal to 0 (ie negative charges are not permitted).	1044	9	1
51	Bundled Charges	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Bundled charges must reflect the gross bundled charge raised in dollars and cents. "Bundled" charges refer to an aggregate of 2 or more charges billed by the hospital, such as case payments by DRG or MBS. Zero fill if no amount charged. An entry of 000000000 means that no bundled charges were billed. All values must be greater than or equal to 0 (ie negative charges are not permitted). **AHSA EPM™ Claims: Bundled Charges should only represent Flagfall and Per Diem DRG Charges**.	1053	9	1

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
52	Medical Record Number	A(20)	Left justify Blank Fill	Mandatory	Medical Record Number (or Unit Record Number) that uniquely identifies the patient, regardless of the number of admissions they have had to the facility. If an AN-SNAP record is also being transmitted for this episode, the Medical Record Number in both HCP1 Episode and AN-SNAP file should be in the same format for linking purposes. (Refer AN-SNAP spec, field 3).	1062	20	1
53	Miscellaneous Service Codes	A(11)	Left justify	Mandatory	Any miscellaneous service codes (i.e. non MBS items or Australian Dental Association codes from the Australian Schedule of Dental Services and Glossary Thirteenth edition 2022) used for billing. Up to 10 codes may be entered. Blank means that there were no miscellaneous service codes or not 10 repetitions.	1082	11	10
54	Hospital-in-the-Home (HITH) Care Charges	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Hospital-in-the-home charges must reflect the gross charge raised for a Hospital-in-the-home care service in dollars and cents. Include ex-gratia and HITH patient portion charges. Zero fill if no HITH amount charged. All values must be greater than or equal to 0 (ie negative amounts are not permitted).	1192	9	1
55	Special Care Nursery Charges	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Special Care Nursery (SCN) charges must reflect the gross charge raised for SCN in dollars and cents. Include ex-gratia and patient portion SCN charges. Exclude NICU, ICU, CCU, PICU and HDU charges. Zero fill if no SCN amount charged. All values must be greater than or equal to 0 (ie negative amounts are not permitted).	1201	9	1
56	Coronary Care Unit Charges	N(9)	Right justify Zero prefix $$$$$$$cc (omit decimal point) Must be ≥ 0	Mandatory	Coronary Care Unit (CCU) charges must reflect the gross charge raised for CCU in dollars and cents. Include ex-gratia and patient portion CCU charges. Exclude ICU, NICU, PICU, SCN and HDU charges. Zero fill if no CCU amount charged. All values must be greater than or equal to 0 (ie negative amounts are not permitted).	1210	9	1
57	Special Care Nursery Hours	N(4)	Right justify Zero prefix	Optional	The number of completed cumulative hours (rounded down) spent in SCN. If a patient has more than one period in SCN during this episode, the total duration of all such periods is reported. Zero fill if not applicable* refer to Department of Health HCP Data Specification guide for use. Do NOT include hours spent in ICU, CCU, NICU, PICU, or HDU. Zero fill if no time spent in SCN.	1219	4	1
58	Coronary Care Unit Hours	N(4)	Right justify Zero prefix	Optional	The number of completed cumulative hours (rounded down) spent in CCU. If a patient has more than one period in CCU during this episode, the total duration of all such periods is reported. Zero fill if not applicable* refer to Department of Health HCP Data Specification guide for use. Do NOT include hours spent in ICU, NICU, PICU, SCN and HDU. Zero fill if no time spent in CCU.	1223	4	1
59	Special Care Nursery Days	N(3)	Right justify Zero prefix	Mandatory	The number of days the patient spent in a Special Care Nursery (SCN). Do NOT include days spent in ICU, CCU, NICU, PICU, or HDU. Zero fill if no days spent in SCN.	1227	3	1
60	Coronary Care Unit Days	N(3)	Right justify Zero prefix	Mandatory	The number of days the patient spent in a Coronary Care Unit (CCU). Do NOT include days spent in ICU, NICU, PICU, SCN or HDU. Zero fill if no days spent in CCU.	1230	3	1
61	Number of Qualified Days for Newborns METeOR: 722649	N(5)	Right justify Zero prefix	Mandatory	The number of qualified newborn days occurring within a newborn episode of care. The number of days is calculated with reference to 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 Zero fill if not applicable.	1233	5	1
62	Hospital-in-the-Home (HITH) Care Commencement Date	D(8)	DDMMYYYY	Mandatory (HITH Patients Only)	Date on which an admitted patient commences an episode of hospital-in-the-home care services. Blank fill if not applicable. Conditional item - must be provided if HITH days (item 35) > 0 and/or HITH charges (item 54) > 0.	1238	8	1

Item No.	Data Item	Type & size	Format	Required	Description & Comments	Start	Size	Repet-itions
63	Hospital-in-the-Home (HITH) Care Completed Date	D(8)	DDMMYYYY	Mandatory (HITH Patients Only)	Date on which an admitted patient completes an episode of hospital-in-the-home care services. Blank fill if not applicable. Conditional item - must be provided if HITH days (item 35) > 0 and/or HITH charges (item 54) > 0.	1246	8	1
64	Palliative Care Days	N(4)	Right justify Zero prefix	Mandatory	The number of days a patient received palliative care during an episode. Palliative Care includes care provided: - in a palliative care unit - in a designated palliative care program - 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. Where the entire episode is Palliative, provide total LOS in days. Conditional item if Palliative Care Status (item 25) = 1. Zero fill if no Palliative Care Days.	1254	4	1
65	AR DRG Version	A(3)	Left justify. For two digit codes, follow with a blank space.	CON	The version of the AR-DRG classification: 41 = version 4.1 42 = version 4.2 50 = version 5.0 51 = version 5.1 52 = version 5.2 60 = version 6.0 6x = version 6.x 70 = version 7.0 80 = version 8.0 90 = version 9.0 100 = version 10.0 110 = version 11.0 120 = version 12.0 na = version n.a Must be supplied if DRG code is provided at item 15. This field supersedes previous 'DRG version' field (Item 16).	1258	3	1

Total Record Length: 1260