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Foreword

Hospital activity data plays a pivotal role in the provision and delivery of first class health care. Data collected from hospitals are essential in service monitoring, planning and allocation of future services, monitoring of patient safety and quality, implementation of clinical services modelling and redesign and research.

The value of hospital data is underpinned by the accuracy and timeliness of the information collected. In 2010, over 900,000 inpatient episodes of care were clinically coded and submitted to Inpatient Data Collections for incorporation into the Hospital Morbidity Data System (HMDS). Each case was passed through a rigorous quality assurance process aimed at identifying potential data errors.

Each error (termed ‘edit’) was returned to the hospital for correction or clarification prior to acceptance into the HMDS. This is to ensure that data collected are of the highest quality and standard. The correction and validation of cases at the area health service can often be an arduous task.

Inpatient Data Collections is therefore proud to present the first edition of the Hospital Morbidity Data System Edits Manual. This publication aims at providing direction and guidance for correction of the most commonly occurring edits. It also provides background information and detail on the reasoning behind each edit with the aim of providing the material required to allow education at the area health service level to reduce further errors.

While this manual is not a fully comprehensive source of information for the correction of all edits, it is hoped that it may be used as a valuable tool used to educate new staff members or as a quick reference source to facilitate the timely validation and return of inpatient data.

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How to download the edits

The Hospital Morbidity Data System Intranet Application is a web based tool used to enable authorised users access to hospital edit reports. Access to the application is granted by the Manager, Inpatient Data Collections on receipt of a completed access agreement. This agreement is available in Appendix 9 of the Hospital Morbidity Data System Reference Manual 2011 located at:


To enable access to reports, new users are assigned a username and password. In the event that your password needs to be reset, please contact Information Development and Management via email: AppsSupport@health.wa.gov.au or telephone: (08) 9222 2026.

To access the Hospital Morbidity Data System Intranet Application the user requires access to the Internet and browser software installed on their computer such as Internet Explorer or Netscape. The address to download the edit spreadsheet report is as follows:


Enter the URL above into the web browser:

- Click ‘Production’ option and the Login Prompt will be displayed.
- Enter your username and password and click ‘OK’.
- Click ‘Continue’ to go to the menu screen. Select option 2 – ‘HMDS Extract Retrieval’.
- Click the file name ‘edits spreadsheet.csv’. This report can be opened in Microsoft Excel and provides a list of all edits for the establishment and the corresponding comments from Inpatient Data Collections.

Do not hide or delete the error number column in the edit report as the error number is required to use this manual. Save the file to your hard drive before adding your comments on the spreadsheet.
How to use this document

Each edit generated has a unique error number and a short description detailing why the edit was generated. This document aims to explain why each error has occurred and provide an appropriate course of action. The edits presented in this document are sorted in ascending order by error number and contain the following information:

Error number: Refers to the specific error number for an edit. This can be obtained from the edit report located under the column titled ‘Error No’.

Error description: Refers to the system generated error message for an edit. This can be obtained from the edit report located under the column titled “Error desc”.

Why was the edit generated? Provides an explanation as to why the edit was generated.

Review data items affected: Lists the data items in the patient administration system to be reviewed in order to correct the edit. HMDS data items will be in italics. If applicable, the equivalent data item for TOPAS and then HCARe will be listed in brackets. In some instances, the documentation in the medical record may need to be reviewed. A list of data items and definitions is available at the end of this manual.

How to correct: Provides information on how to correct or confirm the edit and whether the case needs to be resent.

Source: List of resources containing additional information.
How to return edits

Once the edits have been addressed by the establishments, the responses are to be returned to Inpatient Data Collections via email (hmds.edits@health.wa.gov.au) as a Microsoft Excel spreadsheet attachment.

The Excel spreadsheet should contain all columns that were present when downloading the edits and a single additional column containing the hospital’s responses to the edit. It is important that responses are not provided in multiple columns or added as text within the email body. Columns can be hidden if they are not required by the hospital although should never be deleted.

There are two types of responses:

1. Confirmation of warning edit

The response should clearly provide reasoning for the confirmation of the edit and the associated case should not be resubmitted as an update.

EXAMPLE A - Case not resubmitted

Error Message: Diagnosis code A37.9 is a rare diagnosis
Response: Diagnosis A37.9 has been confirmed by doctor.
2. Case requires correction

The response should clearly identify the correction made, the action performed and the associated case should be resubmitted as an update.

**EXAMPLE B - Case resubmitted**

*Error Message:* Funding Source of Private Health Insurance must have insurance status of ‘Yes’

*Response:* Insurance status updated to ‘Yes’ and case resubmitted.

---

**How to resend a case in TOPAS or HCARe**

For a case to be re-submitted to HMDS, it must be opened in the Patient Administration System (TOPAS or HCARe), the changes made and re-committed:

**TOPAS**

Use the following pathway:

Select **Post Discharge**

Enter the patient’s UMRN and enter <F11>

Select the correct event to reconfirm and select <F3>

Re-open finalised event then Page Down (three times)

Select <F3> to reopen the case

Then **Select/Confirm Event Coding** and **Enter**

When the message “Confirm Coding Complete” appears enter ‘Y’ (Yes) click **Enter**

When the system requests “For Reason for Edit” enter ‘H’ (for DOH edits).

**HCARe**

Use the following pathway:

**Admission / Transfers / Separations / Clinical Details**

Select **Add/Modify Clinical Details**

Select Add/Change Transfer HA22 Details

Any changes that are made during the edit process are confirmed by entering ‘YES’ at both Confirmation and Resend Case

Then select <F10> to save.
Frequently generated edits

112: *Infant Weight* is outside the valid range

Error number: 112

Error description: *Infant Weight* is outside the valid range.

Why was the edit generated? The *Infant Weight* entered is less than 900 grams. Although this is a possible occurrence, due to the rare nature of weights under 900 grams the cases require confirmation.

Review data items affected:
- *Infant Weight* (Admission wt, Adm Wt)
- Documentation in the medical record

How to correct: This is a warning edit to identify that a weight less than 900 grams has been entered as *Infant Weight*.
- Review the medical record to verify the correct weight for the admission.
- If the weight is correct, advise Inpatient Data Collections on the edit spreadsheet that the ‘weight is correct as per medical record’ and do not resend the case.
- If the weight entered requires updating, the case will need to be resent once the correct weight has been amended in the system.

Birth Statistics for 2010 (HMDS)

<table>
<thead>
<tr>
<th></th>
<th>Births</th>
<th>Average weight (grams)</th>
<th>Percentage of births under 900 grams*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>20452</td>
<td>3342</td>
<td>0.3%</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>10173</td>
<td>3370</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>30625</td>
<td>3351</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

* As the number of births with a weight of less than 900g is a rare occurrence and these cases requires the assignment of a more complex and costly Diagnosis Related Group, validation of the weight is required.

119: *Hours CVS outside of valid range*

**Error number:** 119

**Error description:** *Hours CVS outside of valid range*

**Why was the edit generated?** The ventilatory procedure code allocated in the coding screen (e.g. 13882-01: management of continuous ventilatory support >24 and <96 hours) contradicts the number of hours entered for mechanical ventilation.

**Review data items affected:**
- *Hours Continuous Ventilatory System (CVS) (Mechanical Ventilation Hours)*
- Procedure codes
- Documentation in the medical record

**How to correct:**
- Once the correct hours of mechanical ventilation has been ascertained from the medical record, the number of hours must be verified against the allocated mechanical ventilation procedure code (see below), in compliance with Australian Coding Standard 1006 *Ventilatory Support*.
- Note that mechanical ventilation hours should be in completed hours only (e.g. 0.5 hours should be counted as 0 hours).
- In the event that the procedure code range is correct according to the documentation, the *Hours CVS* is required to be updated to a value within the given range.
- If the incorrect procedure code for mechanical ventilation has been allocated and does not reflect the correct range and the *Hours CVS* is correct, the procedure code is required to be updated to the correct ventilation range.
- In both examples the case will require updating in the system and needs to be resent.

Below is a table showing procedure codes and corresponding hours that can be allocated to *Hours CVS* data item.

<table>
<thead>
<tr>
<th>Procedure code</th>
<th>Hours CVS</th>
</tr>
</thead>
<tbody>
<tr>
<td>13882-00</td>
<td>management of CVS &lt;24 hours</td>
</tr>
<tr>
<td>13882-01</td>
<td>management of CVS &gt;24 hours and &lt; 96 hours</td>
</tr>
<tr>
<td>13882-02</td>
<td>management of CVS &gt;96 hours</td>
</tr>
</tbody>
</table>

**TOPAS correction checklist:**
1. Is the CVS hours field on the Post Discharge screen blank? If so, enter CVS hours and resubmit.
2. Do the CVS hours entered match the procedure code? If not, check the medical record, update CVS hours or procedure code in the system and resubmit.

**Source:** Australian Coding Standards - *1006 Ventilatory Support.*
120: Days of Psychiatric Care is absent

Error number: 120

Error description: Days of Psychiatric Care is not present

Why was the edit generated? Each patient admitted to a dedicated psychiatric ward is required to have the number of psychiatric days entered into the Days of Psychiatric Care data item in the system.

Review data items affected:
- Ward/Location (Ward, Ward/Bed allocation)
- Days of Psychiatric Care (Days in Psych, Psych Days)
- Documentation in the medical record

How to correct:
- If at any stage during a patient’s episode of care they have been allocated to a dedicated psychiatric ward, the number of days spent in the ward is required to be entered in to the Days of Psychiatric Care data item.
- If a patient has been correctly transferred into a dedicated psychiatric ward, the number of psychiatric days must be entered.
- If a patient has been incorrectly transferred into a dedicated psychiatric ward, the transfer must be reversed from the Patient Administration System. Resend the case once updated.
- In all above examples, the case needs to be resent.

Correction Checklist:

Was the patient correctly transferred into a dedicated psychiatric ward?

☐ Yes: add the number of days spent in the ward to the Days of Psychiatric Care data item and resend case.

☐ No: reverse the transfer in the Patient Administration System and resend case.

147: Invalid Admission Date for establishment

Error number: 147

Error description: Invalid Admission Date for establishment.

Why was the edit generated? The establishment entered into the Admitted From data item was not open at the time of the patient’s admission.

Review data items affected:
- The invalid establishment number identified in the edit comment from Inpatient Data Collections
- Admitted From (Transferring Medical Facility or Establishment/Organisation Unit)
- Documentation in the medical record

How to correct:
Review the medical record for the correct establishment that the patient was admitted from. Check for the name on the establishment list in Appendix 1A and 1B in the Hospital Morbidity Data System Reference Manual 2011: http://intranet.health.wa.gov.au/documents/docfiles/Hospital_Morbidity_Data_System_Reference_Manual.pdf

The edit is commonly generated when the establishment that has been used is no longer open. If you are unable to find the correct establishment in the establishment list contact Inpatient Data Collections on the following email address: hmds.edits@health.wa.gov.au.

Once the correct establishment has been identified, update the data item with the new value and resend the case.

Source: HMDS Reference Manual 2011 - Establishment, page 13; Appendix 1A and 1B.
148: The separating establishment value is invalid

Error number: 148

Error description: The Adm or Sep Establishment value is invalid.

Why was the edit generated? The establishment used for the Discharged To data item is unexpected.

Review data items affected:
- Discharged To (Separation To) need to be reviewed.
- Documentation in the medical record.

How to correct:
- Check the medical record to verify if the discharge facilities are correct. Inpatient Data Collections needs to be contacted if a new establishment number is required to be created. Once a new establishment number has been allocated and the data item updated, resend the case.
- If an existing establishment can be entered into the data item, use the establishment list in the HMDS Reference Manual 2011 (Appendix 1A and 1B) to identify the correct establishment number.
- The establishment list is also uploaded on a regular basis to: http://morb.health.wa.gov.au/Default.cgi?ID=Downloads.htm.

Note: The establishment numbers 4098 (Unlisted Residential Aged Care Service) and 4099 (Unlisted Other Health Care Accommodation) are temporary numbers and cannot be used as permanent default establishments, the use of these numbers will cause a case to go into edit.

Source: HMDS Reference Manual 2011 - Appendix 1A and 1B; Admitted From, page 37; Discharged To, page 113.
247: 

**Client Type is invalid for age range**

Error number: 247

Error description: Client Type is invalid for age range

Why was the edit generated? The Client Type selected is invalid for the patient’s age on admission.

A Client Type of unqualified or qualified newborn can only be selected for infants with an age of less than 10 days on the date of admission. Therefore the edits is generated when:

1. The patient is 10 days of age or greater on admission and unqualified or qualified client type has been selected.
2. The patient is 9 days of age or less on admission and unqualified or qualified client type has not been selected.

Review data items affected:
- Client Type (patient type)
- Date of Birth (DOB)

How to correct:
- Verify the DOB.
- Amend Client Type accordingly on the Patient Administration System.
- Resend the case.

Note: If changing Client Type, the Care Type data item may also require amending.

### EXAMPLE

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age on Admission = 11 days</td>
<td>Age on Admission = 11 days</td>
</tr>
<tr>
<td>Client Type = Qualified Newborn</td>
<td>Client Type = Admitted</td>
</tr>
<tr>
<td>Care Type = Newborn</td>
<td>Care Type = Acute Care</td>
</tr>
</tbody>
</table>

Source: HMDS Reference Manual 2011 - Date of Birth, page 24; Client Status, page 86; Days of Qualified Newborn Care, page 104.
247: *Client Type* is invalid for age range

Error number: 247

Error description: *Client Type* is invalid for age range

Why was the edit generated? The *Client Type* selected is invalid for the patient’s age on admission.

A *Client Type* of unqualified or qualified newborn can only be selected for infants with an age of less than 10 days on the date of admission. Therefore the edits is generated when:

1. The patient is 10 days of age or greater on admission and unqualified or qualified client type has been selected.
2. The patient is 9 days of age or less on admission and unqualified or qualified client type has not been selected.

Review data items affected:
- *Client Type* (patient type)
- *Date of Birth* (DOB)

How to correct:
- Verify the DOB.
- Amend *Client Type* accordingly on the Patient Administration System.
- Resend the case.

Note: If changing *Client Type*, the *Care Type* data item may also require amending.

**EXAMPLE**

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age on Admission = 11 days</td>
<td>Age on Admission = 11 days</td>
</tr>
<tr>
<td>Client Type = Qualified Newborn</td>
<td>Client Type = <strong>Admitted</strong></td>
</tr>
<tr>
<td>Care Type = Newborn</td>
<td>Care Type = <strong>Acute Care</strong></td>
</tr>
</tbody>
</table>

Source: HMDS Reference Manual 2011 - *Date of Birth*, page 24; *Client Status*, page 86; *Days of Qualified Newborn Care*, page 104.
347: Date of Procedure is outside the admission and separation dates

Error number: 347

Error description: Date of Procedure is outside of the admission and separation dates.

Why was the edit generated? The date allocated to the procedure in the coding screen is not within the admitted and discharged dates for the episode of care. This occurs if the case is reopened after it has been coded and the admission or discharge dates are altered.

Review data items affected:
- Admission Date
- Separation Date
- Date of Procedure
- Documentation in the medical record

How to correct:
- Review the admission, discharge and procedure dates in the medical record.
- Amend the data item(s) in the Patient Administration System with the correct dates as recorded in the medical record.

Source: HMDS Reference Manual 2011 - Admission Date, page 9; Separation Date, page 11; Date of Procedure, page 134.
350: Age is invalid for the employment status

Error number: 350

Error description: Age is invalid for the employment status

Why was the edit generated?
The value entered for employment status is not expected for the patient’s age.

This is a warning edit to indicate that the employment status selected is not expected based on the patient’s date of birth.

Review data items affected:
- Employment Status
- Date of Birth

How to correct:
- If the values are correct, then comment on the edit spreadsheet.
- If the values are incorrect, amend the data items in the Patient Administration System.
- Note that this pertains to the patient's circumstances (including age) at the time of admission and discharge.

### EXAMPLES

<table>
<thead>
<tr>
<th>Employment status</th>
<th>1: Child not at School</th>
<th>2: Student</th>
<th>3: Employed</th>
<th>4: Unemployed</th>
<th>5: Home Duties</th>
<th>6: Retired</th>
<th>7: Pensioner</th>
<th>8: Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian/Other Defence Personnel</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward of the State</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prisoner</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 year old attending Kindergarten or Pre-primary</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 year old in first grade</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 year old not attending school and not working</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45 year old retired carpenter</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled child between the age of 6-15 not able to attend school</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

351: *Marital Status* is invalid for the age category

Error number: 351

Error description: *Marital Status* is invalid for the age category

Why was the edit generated? The *Marital Status* value is not expected for the patient’s age. This edit is generated if a minor under the age of 16 years has been allocated a *Marital Status* value of ‘Married’ or a minor under the age of 16 has been allocated a *Marital Status* other than ‘Never married’.

Review data items affected:
- *Marital Status*
- *Date of Birth* (DOB)
- Documentation in the medical record

How to correct:
- The *Date of Birth* must be reviewed to ascertain that the correct date has been entered.
- If correct, *Marital Status* must be reviewed as it is unusual for a child under 16 years of age to have a marital status other than ‘Never Married’.
- If *Marital Status* or *Date of Birth* is amended, then the case will need to be resent.

Patient is less than 16 years of age therefore ‘Single’ or ‘Never Married’ must be entered in Marital Status field

361: Invalid clinician code for the Principal Diagnosis

Error number: 361

Error description: Invalid clinician code 000000 for the Principal Diagnosis Z76.2

Why was the edit generated? Boarder doctors (MBRN 000000) cannot be allocated to ‘Newborn’ Care Type.

Review data items affected:
- Clinician on Admission (First active consultant, Resp Dr)
- Clinician on Separation (Last active consultant, Separation Dr)

How to correct:
This edit is generated if a newborn (patient less than or equal to 10 days of age) has been admitted with a Boarder clinician (Medical Board Registration Number = 000000) and the Principal Diagnosis code is Z76.2.
- In these cases, if Care Type and Client Type is correct and the patient is a newborn with a Principal Diagnosis of Z76.2, the admitting and separation clinician must be the same clinician as assigned to the infant’s mother.

Alternatively if the incorrect Principal Diagnosis of Z76.2 (Health supervision and care of other healthy infant and child) has been allocated in place of the diagnosis code Z76.3 (Healthy person accompanying sick person), the clinician code of 000000 is correct:
- the diagnosis code only requires updating; and
- resend the case.

425: Principal Diagnosis contains an invalid code

Error number: 425

Error description: Principal Diagnosis contains an invalid Additional Diagnosis code.

Why was the edit generated? An incorrect Additional Diagnosis code has been sequenced with the Principal Diagnosis. Where there is a relationship between the disease and its manifestations (commonly called Dagger and Asterisk codes), the Co-Diagnosis data item is used to record the disease matching the Principal Diagnosis. The data item may also be called ‘Code Also’ or ‘Co-Diagnosis’. As per the Australian Coding Standard 0027, Dagger and Asterisk codes must be sequenced in the same order to which they appear in the Alphabetic Index.

Review data items affected:
- Diagnosis codes in the coding screen
- Code Type in the coding screen
- Documentation in the medical record

How to correct:
- Only specific codes can be used together and the edits are allocated to reflect this. Dagger and Asterisk codes are easily recognised in the ICD-10-AM Tabular List as they are often enclosed in brackets after the code description. If the Principal Diagnosis is a Dagger code then the next sequenced code must be an Asterisk code (code type 2 CA). If the Dagger code is not the Principal Diagnosis then the next sequenced code is still an Asterisk code, but is entered as an Additional Diagnosis field (code type 3 OC). Resend the case.

EXAMPLE

<table>
<thead>
<tr>
<th>A. Incorrect</th>
<th>Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD G30.9</td>
<td>PD G30.9</td>
</tr>
<tr>
<td>OC F00.9</td>
<td>CA F00.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Incorrect</th>
<th>Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD N77.3</td>
<td>PD N77.3</td>
</tr>
<tr>
<td>OC G30.9</td>
<td>OC G30.9</td>
</tr>
<tr>
<td>CA F00.9</td>
<td>OC F00.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Incorrect</th>
<th>Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD B37.3</td>
<td>PD B37.3</td>
</tr>
<tr>
<td>CA N77.3</td>
<td>CA N77.1</td>
</tr>
</tbody>
</table>

* Principal Diagnosis (PD), Code Also (CA) and Other Condition (OC) refer to the Code Type data item in the coding screen.

455: Clinician registration number on separation is blank

Error number: 455

Error description: *Clinician on Separation* must not be blank.

Why was the edit generated?
A current Medical Board Registration Number (MBRN) has not been linked to the internal clinician’s number resulting in a blank MBRN. The MBRN of the doctor responsible for discharging the patient should be reported to Inpatient Data Collections using the clinician’s current registration number obtained from the Australian Health Practitioner Regulation Agency (AHPRA) website: [http://www.ahpra.gov.au/Registration/Registers%20of%20Practitioners.aspx](http://www.ahpra.gov.au/Registration/Registers%20of%20Practitioners.aspx).

Review data items affected:
- *Clinician on Separation* (Last active consultant, Separation Doctor).

How to correct:
- Update the Patient Administration System
- Resend the case

456: Clinician registration number on admission is blank

Error number: 456

Error description: Clinician on Admission must not be blank.

Why was the edit generated? A current Medical Board Registration Number (MBRN) has not been linked to the internal clinician’s number resulting in a blank MBRN. The MBRN of the doctor responsible for discharging the patient should be reported to Inpatient Data Collections using the clinician’s current registration number obtained from the Australian Health Practitioner Regulation Agency (AHPRA) website: http://www.ahpra.gov.au/Registration/Registers%20of%20Practitioners.aspx.

Review data items affected:
- Clinician on Admission (First active consultant, Resp Doctor)

How to correct:
- Update the Patient Administration System.
- Resend the case.

Source: Australian Health Practitioner Regulation Agency - http://www.ahpra.gov.au
468: Invalid Gender for diagnosis code

Error number: 468

Error description: Diagnosis XXXXX-XX should not be used with the current gender code

Why was the edit generated? The National Casemix and Classification Centre identified expected genders for certain diagnosis codes. Edits are put in place to reflect this requirement. This edit is generated because the diagnosis code identified is not expected for the patient’s gender.

Review data items affected:
- Diagnosis code in the coding screen
- Gender
- Documentation in the medical record

How to correct:
- Review the medical record to ascertain if the correct diagnosis code has been allocated according to the clinical documentation.
- If correct, advise Inpatient Data Collections via the edit spreadsheet that the ‘diagnosis code is correct as per documentation’, do not resend the case.
- If the diagnosis code is incorrect, amend and resend the case.

EXAMPLE – Invalid gender for diagnosis code

<table>
<thead>
<tr>
<th>Error Description</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis 31524-00 should not be used with the current gender code</td>
<td>Male with subcutaneous unilateral mastectomy</td>
</tr>
<tr>
<td>Diagnosis 31518-01 should not be used with the current gender code</td>
<td>Male with simple bilateral mastectomy</td>
</tr>
</tbody>
</table>

521: Invalid age for diagnosis code

Error number: 521

Error description: Invalid age for the ICD code X00.00

Why was the edit generated? The National Casemix and Classification Centre have identified set age ranges for certain diagnosis codes. Edits are put in place to reflect this requirement.

Review data items affected:
- Date of Birth
- Diagnosis codes in the coding screen
- Documentation in the medical record

How to correct:
- Certain diagnosis codes are generally allocated to a specific age range, refer to diagnosis codes on the coding screen and check the clinical documentation to confirm the diagnosis and the patient's date of birth.
- If the code correct, Inpatient Data Collections must be advised via the edit spreadsheet by providing an explanation. Do not resend the case.
- If the code is incorrect, update and resend the case.

EXAMPLE – Invalid age for diagnosis code

<table>
<thead>
<tr>
<th>Error Description</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invalid age for the ICD code Q91.7</td>
<td>28 year old patient with Patau's syndrome</td>
</tr>
<tr>
<td>Invalid age for the ICD code N92.0</td>
<td>55 year old patient with excessive and frequent menstruation with regular cycle</td>
</tr>
</tbody>
</table>

Source: HMDS Reference Manual 2011 - Date of Birth, page 24; Principal Diagnosis, page 120; Additional Diagnosis, page 122.
566: Diagnosis code missing for required associated Additional Diagnosis

Error number: 566

Error description: ICD code X00.0 does not have an associated Additional Diagnosis

Why was the edit generated? The National Casemix and Classification Centre have identified a set of codes that require multiple coding - a diagnosis should have the associated additional diagnosis code where there is a relationship between the disease and its manifestations (commonly called Dagger and Asterisk codes).

Review data items affected:
- Diagnosis codes in the coding screen

How to correct:
- As per the Australian Coding Standard 0027 (Multiple Coding), Dagger and Asterisk codes must be sequenced in the same order to which they appear in the Alphabetic Index.
- Only specific codes can be used together and the edits are allocated to reflect this.
- Some diseases can affect two different body systems and where there is a relationship between the disease and its manifestations (commonly called Dagger and Asterisk codes), coding two diagnosis codes or multiple coding is performed to identify the relationship that exists. These codes on most occasions must be reported with their manifestation.
- Dagger and Asterisk codes are easy recognised in the ICD-10-AM Tabular List as they are enclosed in brackets after the code description.
- Re-check the pathway for the given diagnosis to identify the associated diagnosis code and update the coding screen and resend the case.
- On some occasions the associated diagnosis code is not required. In these instances advise Inpatient Data Collections that the coding is correct.
- Inpatient Data Collections will review this request and advise if any further information is required, do not resend the case.

Source: Australian Coding Standards - 0027 Multiple Coding.
624: Admitting establishment is the same as current establishment

Error number: 624

Error description: Admitting establishment cannot be the same as current establishment

Why was the edit generated? The establishment entered into the admitted from data item is the same as the establishment that the patient is admitted to.

Review data items affected:
- Admitted From (Transferring Medical Facility, Establishment/Organisation Unit)
- Documentation in the medical record

How to correct:
- Review the medical record to identify the correct establishment that the patient was admitted from.
- Update the Admitted From data item to the correct establishment and resend the case.
- If the patient has received a change in care type and a statistical admission occurred, the Establishment number should be 0944 (Reclassified this hospital), amend and resend the case.

625: Separation establishment is the same as current establishment

Error number: 625

Error description: Separation establishment cannot be the same as current establishment.

Why was the edit generated? The establishment entered into the Discharged To data item is the same as the establishment that the patient is admitted to.

Review data items affected:
- Discharged To (Separated To)
- Documentation in the medical record will need to be reviewed

How to correct:
- Review the medical record to identify the correct establishment that the patient was separated to.
- Update the Discharged To data item to the correct establishment and resend the case.
- If the patient has received a change in care type and a statistical discharge occurred, the establishment number should be 0944 (Reclassified this hospital), amend and resend the case.

631: Diagnosis code is a rare diagnosis

Error number: 631

Error description: Diagnosis code X00.00 is a rare diagnosis.

Why was the edit generated? The National Casemix Classification Centre has identified certain diagnosis codes as rare and not commonly allocated. Edits have been put in place to reflect this requirement.

Review data items affected:
- Diagnosis codes in the coding screen
- Documentation in the medical record

How to correct:
- Certain diagnosis codes are rare and not commonly allocated, refer to diagnosis codes on the coding screen and check the clinical documentation to confirm the diagnosis.
- Any ambiguity between the documentation and allocated code should be queried with the clinician.
- If the diagnosis code is correct, Inpatient Data Collections must be advised via the edit spreadsheet by providing the explanation ‘Diagnosis X00.00 has been confirmed by doctor’ and do not resend the case.
- If the code is incorrect, update and resend the case.

635: *Admitted From* and *Discharged To* combination is unexpected

**Error number:** 635

**Error description:** The *Admitted From/Discharged To* establishment combination is invalid.

**Why was the edit generated?** The combination of values entered in the *Admitted From* and *Discharged To* data items are unexpected or incompatible.

**Review data items affected:**
- *Admitted From* (Transferring Medical Facility or Establishment/Organisation Unit)
- *Discharged To* (Separation To)

**How to correct:**
- The combination of values for the *Admitted From* and *Discharged To* data items are either unexpected or incompatible.
- The documentation in the medical record needs to be reviewed, if the values for both data items are correct, Inpatient Data Collections must be advised via the edit spreadsheet by providing details on how the combination is valid. Do not resend the case.
- If one of the values requires amending update and resend the case.

**EXAMPLES - Unexpected or incompatible cases**
1. Patient admitted from Home (0900) and separated to Acacia Prison (2255)
2. Patient admitted from Home (0900) and separated to Christmas Island Immigration Detention Centre (2602).

**Source:** HMDS Reference Manual 2011 - *Admitted From*, page 37; *Discharged To*, page 113.
689: **Funding Source** and **Insurance Status** combination is invalid

Error number: 689

Error description: **Funding Source** of Private Health Insurance must have **Insurance Status** of ‘Yes’.

Why was the edit generated? The **Funding Source** data item indicates Private Health Insurance, however the **Insurance Status** entered is ‘No’.

Review data items affected:
- **Funding Source** (account type or financial class)
- **Insurance Status**
- Documentation in the medical record

How to correct:
- The documentation will need to be reviewed in the medical record to confirm if the patient has elected to be admitted as a private patient and is covered by a private health insurance fund.
- If this is the case, the **Insurance Status** must be recorded as ‘Yes’ (Y).
- In the occurrence that a **Funding Source** of private insurance has been incorrectly allocated, amend the **Funding Source** to match the **Insurance Status** of ‘No’ (N).
- Resend the case.

693: Morphology codes absent

Error number: 693

Error description: No morphology codes found

Why was the edit generated? Neoplasm diagnosis codes (C00-D48) require an associated Morphology code, M800X/X to M998X/X.

Review data items affected:
- Diagnosis codes in the coding screen
- Documentation in the medical record

How to correct:
- Review the clinical diagnosis documented to confirm that the correct neoplasm diagnosis code (C00-D48) has been allocated.
- Once this has been established, an associated Morphology code (M800X/X to M998X/X) is required to be allocated directly after the neoplasm code.
- To determine the correct Morphology code, refer to the pathways in ICD-10-AM Index and Tabular Classification.

EXAMPLE

Diagnosis: D12.4 Benign Neoplasm of the Descending Colon.
Morphology: Tubular Adenoma M8211/0

Source: Australian Coding Standards - 0233 Morphology
724: Cancer diagnosis code incompatible with Morphology code

Error number: 724

Error description: Cancer Diagnosis Code requires compatible cancer morphology code or vice versa

Why was the edit generated? A neoplasm diagnosis code (C00-D48) has been allocated with a Morphology code that is incompatible. Generally these codes are not associated or coded together and the case requires review. Alternatively, a Morphology code ending in ‘9’ (uncertain whether primary or metastatic site) has been assigned.

Review data items affected:
- Diagnosis codes in the coding screen
- Documentation in the medical record

How to correct:
- Review the documentation in the medical record, confirm the correct diagnosis and recheck the pathways in ICD-10-AM Index and Tabular Classification.
- If the neoplasm or morphology codes are incorrect, update the codes, resend the case.
- If the allocated codes are correct, advise Inpatient Data Collections on the edit spreadsheet that the ‘codes are correct as per clinical documentation.’ Inpatient Data Collections will review this request and advise if any further information is required. Do not resend the case.
- If a Morphology code ending in 9 (e.g. M8000/9) is allocated, and all efforts to gain further information such as reviewing the histology reports have been exhausted, advise Inpatient Data Collections that the codes allocated are correct and do not resend the case.
- Morphology codes ending in 9 should not be used as default codes if documentation in the medical record is pending. Any ambiguity with the clinical documentation should be queried with the clinician.

<table>
<thead>
<tr>
<th>Behaviour (last digit of morphology)</th>
<th>Description</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>/0</td>
<td>Benign neoplasms</td>
<td>D10.0 - D36.9</td>
</tr>
<tr>
<td>/1</td>
<td>Neoplasm of uncertain and unknown behaviour</td>
<td>D37.0 - D48.9</td>
</tr>
<tr>
<td>/2</td>
<td>In situ neoplasms</td>
<td>D00.0 - D09.9</td>
</tr>
<tr>
<td>/3</td>
<td>Malignant neoplasms, stated or presumed to be primary</td>
<td>C00.0 - C76.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C80.0 - C96.9</td>
</tr>
<tr>
<td>/6</td>
<td>Malignant neoplasms, stated or presumed to be secondary</td>
<td>C77.0 - C79.9</td>
</tr>
<tr>
<td>/9</td>
<td>Malignant neoplasms, uncertain whether primary or metastatic site</td>
<td>C00.0 - C76.8</td>
</tr>
</tbody>
</table>

Source: Australian Coding Standards - 0233 Morphology
726: Diagnosis inappropriate for morphology code

Error number: 726

Error description: No appropriate diagnosis found for morph code M9XXX/X. Diagnosis choice: X00.00

Why was the edit generated? A neoplasm diagnosis code (C00-D48) has been allocated with an incompatible Morphology code beginning with a ‘9’ (i.e. M900X/X to M998X/X). Generally these codes are not associated or coded together and the case requires review.

Review data items affected:
- Diagnosis codes in the coding screen
- Documentation in the medical record

How to correct:
- Review the documentation in the medical record to obtain or confirm the correct diagnosis and re-check the pathways in ICD-10-AM standards.
- If the neoplasm or morphology codes are incorrect, update the codes and resend the case.
- If the allocated codes are correct, advise Inpatient Data Collections on the edit spreadsheet that the ‘codes are correct as per clinical documentation.’
- Inpatient Data Collections will review this request and advise if any further information is required. Do not resend the case.

EXAMPLE – Inappropriate diagnosis code
- Diagnosis code C92.70 is not appropriate for morphology code M9945/3
- Diagnosis code C92.00 is not appropriate for morphology code M9861/3

750: Invalid clinician code for separation

Error number: 750

Error description: Invalid Clinician code X XXXXX for separation

Why was the edit generated? An invalid or incorrect Medical Board Registration Number (MBRN) is linked to the hospital’s internal database number for a particular clinician responsible for discharging the patient. The MBRN of the doctor responsible for discharging the patient should be reported to Inpatient Data Collections using the clinician’s current registration number obtained from the Australian Health Practitioner Regulation Agency (AHPRA) website:


Review data items affected:
- Clinician on Separation (last active consultant, Separation Doctor, Discharge Consultant)
- Medical Board Registration Number

How to correct:
- The clinician number that has generated the edit may have been entered incorrectly or the number is correct however the registration has expired.
- If the registration has expired, the clinician may have been allocated another number.
- Once the correct MBRN has been identified update the Patient Administration System and then resend the case.

Note: Inpatient Data Collections use the registration and expiry dates from the above website. The case will go into edit if the admission falls outside of the clinician’s registration period associated with the MBRN in error.

751: Invalid clinician code for admission

Error number: 751

Error description: Invalid Clinician code XXXXXX for admission

Why was the edit generated? An invalid Medical Board Registration Number (MBRN) is linked to the Hospital's internal database number for a particular clinician responsible for admitting the patient. The MBRN of the doctor responsible for admitting the patient should be reported to Inpatient Data Collections using the clinician's current registration number obtained from the Australian Health Practitioner Regulation Agency (AHPRA) website:


Review data items affected:
- Clinician on Admission (First active consultant, Resp Doctor, Admitting Consultant)
- Medical Board Registration Number

How to correct:
- The clinician number that has generated the edit may have been entered incorrectly or the number is correct however the registration has expired.
- If the registration has expired the clinician may have been allocated another number.
- Once the correct MBRN has been identified update the Patient Administration System and resend the case.

Note: Inpatient Data Collections use the registration and expiry dates from the above website. The case will go into edit if the admission falls outside of the clinician's registration period associated with the MBRN in error.

752: Invalid clinician code for procedure

Error number: 752

Error description: Invalid Clinician code XXXXXX for procedure.

Why was the edit generated? An invalid Medical Board Registration Number (MBRN) is linked to the hospital's internal database number for a particular clinician responsible for a procedure performed. The MBRN of the doctor performing a procedure should be reported to Inpatient Data Collections using the clinician’s current registration number obtained from the Australian Health Practitioner Regulation Agency (AHPRA) website:


Review data items affected:
- Clinician in the procedure coding screen
- Medical Board Registration Number
- Documentation in the medical record

How to correct:
- The clinician number that has generated the edit has been entered incorrectly or the number is correct however the registration has expired. If the registration has expired the clinician may have been allocated another number.
- Once the correct surgeon and MBRN have been identified update the Patient Administration System and resend the case.

Note: Inpatient Data Collections use the registration and expiry dates from the above website. The case will go into edit if the admission falls outside of the clinician’s registration period associated with the MBRN in error.

760: Care Type of palliative without Z51.5 diagnosis code

Error number: 760

Error description: Palliative care and Z51.5 is not present

Why was the edit generated? A Care Type of ‘23 - Palliative Care’ has been allocated without diagnosis code Z51.5.

Review data items affected:
- Care Type (Episode of care)
- Diagnosis codes in the coding screen
- Documentation in the medical record

How to correct:
- The documentation needs to be checked to ascertain the correct care type documented by the clinician.
- If Care Type is Palliative Care, then a diagnosis code of Z51.5 Palliative Care needs to be added as an Additional Diagnosis.
- If Care Type of palliative is incorrect then update the care type to the correct value as per the documentation by the clinician. In this case the diagnosis code Z51.5 should not be added. Once the relevant data item has been amended, resend the case.
- Review the case and ensure a statistical change has been correctly recorded.

Source: Australian Coding Standards - 0224 Palliative Care.
HMDS Reference Manual 2011 - Care Type, page 76; Additional Diagnosis Codes, page 122.
761: Care Type not palliative with Z51.5 diagnosis code

Error number: 761

Error description: Additional diagnosis of Z51.5 and Care Type not = 23 Palliative Care.

Why was the edit generated? An additional diagnosis code of Z51.5 (Palliative Care) has been allocated with a Care Type other than Palliative Care.

Review data items affected:
- Care Type (Episode of Care)
- Diagnosis code in the coding screen
- Documentation in the medical record

How to correct:
- The documentation needs to be checked to ascertain the correct Care Type documented by the clinician.
- If the Care Type documented in the medical record is Palliative Care then Care Type must be updated to Palliative Care. In this case the diagnosis codes do not need to be amended.
- If the Care Type is not Palliative Care and has been correctly allocated as per the clinician’s documentation, then the Additional Diagnosis of Z51.5 must be removed to correspond with the Care Type allocated.
- In both cases a data item needs to be updated and therefore the case should be resent once completed.
- Review the case and ensure a statistical change has been correctly recorded.

Source: Australian Coding Standards - 0224 Palliative Care. HMDS Reference Manual 2011 - Care Type, page 76.
762: Care Type of rehabilitation without Z50.x diagnosis code

Error number: 762

Error description: Care Type Rehabilitation and Z50.x is not present.

Why was the edit generated? The Care Type value is Rehabilitation, however there is no Z50.x diagnosis code allocated.

Review data items affected:
- Care Type (Episode of Care)
- Diagnosis Code in the coding screen
- Documentation in the medical record

How to correct:
- The documentation needs to be checked to ascertain the correct care type documented by the clinician.
- If Rehabilitation is the correct Care Type, the Principal Diagnosis must be updated to an appropriate Z50.x code.
- If the Care Type of Rehabilitation has been incorrectly allocated then the Care Type needs to be amended to correspond with care type allocated by the clinician. In this case the diagnosis codes do not need to be amended.
- In both cases a data item needs to be updated and therefore the case should be resent once completed.
- Review the case and ensure a statistical change has been correctly recorded.

Source: Australian Coding Standards - 2104 Rehabilitation.
HMDS Reference Manual 2011 - Care Type, page 76.
764: Care Type not rehabilitation with Z50.x diagnosis code

Error number: 764

Error description: Principal Diagnosis Z50.x and Care Type does not = 22 rehabilitation care

Why was the edit generated? Rehabilitation related diagnosis code (Z50.x) has been allocated as the Principal Diagnosis, however the Care Type value is not Rehabilitation.

Review data items affected:
- Care Type (Episode of Care)
- Diagnosis code in the coding screen
- Documentation in the medical record

How to correct:
- The documentation needs to be checked to ascertain the correct care type assigned by the clinician.
- If Rehabilitation is the correct Care Type, the data item must be amended to Rehabilitation. In this case, the diagnosis codes does not need to be amended.
- If the Care Type is not Rehabilitation and has been correctly allocated as per the clinician’s documentation, the Principal Diagnosis of Z50.x must be removed to correspond with Care Type allocated. Resend the case once the relevant data item is updated.
- Review the case and ensure a statistical change has been correctly recorded.

Source: Australian Coding Standards - 2104 Rehabilitation.
HMDS Reference Manual - Care Type, page 76.
765: Allied health procedure code duplicated

Error number: 765

Error description: Allied Health procedure code duplicated

Why was the edit generated? An Allied Health Procedure Code (95550-xx) has been coded more than once.

Review data items affected:
- Procedure codes in the coding screen

How to correct:
- Each general allied health procedure code can only be allocated once for an episode of care, regardless of the number of interventions that took place during the admission.
- Review the coding screen to identify which allied health procedure code has been coded more than once.
- Delete repeated codes so that only one code remains.
- Resend the case once it has been updated in the Patient Admistration System.

Source: Australian Coding Standards - 0032 Allied Health Interventions.
766: Duration of pregnancy code absent

Error number: 766

Error description: Diagnosis code indicating pregnancy without duration of pregnancy code.

Why was the edit generated? As per coding conventions, certain diagnosis codes (listed below) for obstetric cases require an additional diagnosis code O09.0 - O09.9 indicating the duration of pregnancy.

Review Data items affected:
- Diagnosis codes in the coding screen
- Documentation in the medical record

How to correct:
- Review the documentation in the medical record to identify the number of completed weeks of pregnancy on admission, e.g. 34 weeks plus 6 days is 34 completed weeks.

The following diagnosis codes require an additional code for duration of pregnancy (category O09.x)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O00-O007</td>
<td>Pregnancy with abortive outcome</td>
</tr>
<tr>
<td>O60.0-O60.3</td>
<td>Preterm delivery and labour</td>
</tr>
<tr>
<td>O36.4*</td>
<td>Fetal death in utero</td>
</tr>
<tr>
<td>O42.0-O42.9</td>
<td>Premature rupture of membranes</td>
</tr>
<tr>
<td>O20.0</td>
<td>Threatened abortion</td>
</tr>
<tr>
<td>O47.0</td>
<td>False labour</td>
</tr>
</tbody>
</table>

Required Duration Pregnancy Code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O09.0</td>
<td>&lt;5 completed weeks</td>
</tr>
<tr>
<td>O09.1</td>
<td>5-13 completed weeks</td>
</tr>
<tr>
<td>O09.2</td>
<td>14-19 completed weeks</td>
</tr>
<tr>
<td>O09.3</td>
<td>20-25 completed weeks</td>
</tr>
<tr>
<td>O09.4</td>
<td>26-33 completed weeks</td>
</tr>
<tr>
<td>O09.5</td>
<td>34-36 completed weeks</td>
</tr>
<tr>
<td>O09.9</td>
<td>Unspecified.</td>
</tr>
</tbody>
</table>

*O36.4 in certain circumstances does not require an additional duration of pregnancy code as Fetal death in utero can occur after 36 completed weeks. In these cases do not resend the case and inform Inpatient Data Collections the duration of the pregnancy on the edit spreadsheet.

768: Principal Diagnosis G30.x and F00.x incorrectly sequenced

Error number: 768

Error description: Principal Diagnosis (code type=1) G30.x should be in conjunction with code (code type=2) of F00.x.

Why was the edit generated? There is a relationship between G30.x and F00.x (commonly called Dagger and Asterisk codes). The Diagnosis Code of F00.x has not been assigned as the Co-Diagnosis when G30.x has been listed as the Principal Diagnosis.

Review data items affected:
- Code type in the diagnosis coding screen.

How to correct:
- The same principle applies to the correction of this edit as Error Number 425. Refer to instructions for Error Number 425 for full details.
- For F00.x to be assigned as an additional diagnosis (code type 3 OC), G30.x must not be the Principal Diagnosis. Check the medical record.
- If G30.x is the correct Principal Diagnosis, amend F00.x to be assigned as the co-diagnosis (code type 2 CA) and resend the case.

Example

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD G30.9</td>
<td>PD G30.9</td>
</tr>
<tr>
<td>OC F00.9</td>
<td>CA F00.9</td>
</tr>
</tbody>
</table>

* Principal Diagnosis (PD), Code Also (CA) and Other Condition (OC) refer to the Code Type data item in the coding screen.

Source: Australian Coding Standards - 0027 Multiple Coding.
769: Additional Diagnoses G30.x and F00.x incorrectly sequenced

Error number: 769

Error description: Additional Diagnosis (code type=3) G30.x should be in conjunction with additional diagnosis (code type=3) of F00.x.

Why was the edit generated? There is a relationship between G30.x and F00.x (commonly called Dagger and Asterisk codes). The diagnosis code of F00.x has been assigned as the Co-Diagnosis although the code of G30.x has not been assigned as the Principal Diagnosis.

Review data items affected:
- Code type in the diagnosis coding screen

How to correct:
- The same principle applies to the correction of this edit as Error Number 425. Refer to instructions for Error Number 425 for full details.
- For F00.x to be assigned as the Co-Diagnosis (code type 2 CA), G30.x must be the Principal Diagnosis. Check the medical record.
- If G30.x is the correct Principal Diagnosis, amend and resend the case.
- If G30.x is not the correct Principal Diagnosis, change F00.x to an Additional Diagnosis (code type 3 OC) sequenced after G30.x.
- Resend the case.

Example

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD N77.3</td>
<td>PD N77.3</td>
</tr>
<tr>
<td>OC G30.9</td>
<td>OC G30.9</td>
</tr>
<tr>
<td>CA F00.9</td>
<td>OC F00.9</td>
</tr>
</tbody>
</table>

* Principal Diagnosis (PD), Code Also (CA) and Other Condition (OC) refer to the Code Type data item in the coding screen.

Source: Australian Coding Standards - 0027 Multiple Coding.
782: Condition Onset Flag inconsistent with injury coding

Error number: 782

Error description: COF inconsistent between injury, EC, POC, ACT and X00.00.

Why was the edit generated? This edit can be generated for the following reasons:

- A diagnosis code (where external cause codes are mandatory) is allocated without the required external cause, place of occurrence and activity codes, e.g. J69.0 Pneumonitis due to food and vomit.
- The Condition Onset Flags are not the same for the External Cause, Place of Occurrence, Activity Codes and associated Diagnosis Codes.
- For HCARe users, the External Cause, Place of Occurrence and Activity Codes may not have been linked to the associated diagnosis codes.
- The External Cause, Place of Occurrence and Activity Codes have not been sequenced directly after the associated Diagnosis Codes (i.e. another unrelated diagnosis code is sequenced with the external cause, place of occurrence and activity codes with a different condition onset flag).

Review data items affected:

- Diagnosis codes in the coding screen
- Condition Onset Flag in the coding screen

How to correct:

- Review the diagnosis codes allocated for the case and identify which of the above reasons has generated the edit.
- Amend the diagnosis codes accordingly and confirm or amend the condition onset flags ensuring the External Cause, Place of Occurrence, Activity Codes and associated Diagnosis Codes are the same. Resend the case.

EXAMPLE – Condition onset flag inconsistent with coding

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Condition Onset Flag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T81.2</td>
<td>2</td>
<td>Accidental puncture and laceration during a procedure, not elsewhere classified</td>
</tr>
<tr>
<td>S37.6</td>
<td>1</td>
<td>Injury of uterus</td>
</tr>
<tr>
<td>Y60.8</td>
<td>2</td>
<td>During other surgical and medical care</td>
</tr>
<tr>
<td>Y92.22</td>
<td>2</td>
<td>Health service area</td>
</tr>
<tr>
<td>U73.9</td>
<td>2</td>
<td>Unspecified activity</td>
</tr>
</tbody>
</table>

783: *Condition Onset Flag* unexpected with diagnosis

**Error number:** 783

**Error description:** COF is inconsistent with X00.00

**Why was the edit generated?** The *Condition Onset Flag (COF)* selected is not expected for the diagnosis code allocated.

**Review data items affected:**
- *Condition Onset Flag* in the coding screen
- Documentation in the medical record

**How to correct:**
- Review the documentation in the medical record to ascertain when the diagnosis occurred.
- Either the condition arose before the episode of admitted patient care (value of 2) or the onset of the condition occurred during the episode of admitted patient care (value of 1).
- If the *Condition Onset Flag* is amended, resend the case.
- If the condition arose during the episode of care, provide a full explanation in the edit spreadsheet and do not resend the case.
- If it is unclear and the *Condition Onset Flag* cannot be clarified with the clinician, the default condition onset flag is ‘2’.

**EXAMPLES – Condition of onset flag inconsistent with diagnosis codes**

<table>
<thead>
<tr>
<th>Error Description</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>COF inconsistent with Y92.9</td>
<td>COF=1 (hospital acquired) for this Place of Occurrence code means the injury must have occurred on leave for this to be correct</td>
</tr>
<tr>
<td>COF inconsistent with Z86.43</td>
<td>A COF=1 (hospital acquired) for Z86.43 (Personal history of tobacco use disorder) has been coded in a same day admission</td>
</tr>
</tbody>
</table>

**Source:** HMDS Reference Manual 2011 - *Condition Onset Flag*, page 129.
786: Psychiatric ward on discharge requires *Mental Health Legal Status*

Error number: 786

Error description: Ward is a psych ward and MHLS is not present.

Why was the edit generated? A *Mental Health Legal Status* (MHLS) is required for patients admitted to a dedicated psychiatric ward. This edit is generated if the MHLS is absent.

Review data items affected:
- *Mental Health Legal Status* (MH Legal Status, MH Status)
- Ward location data items

How to correct:
- If the patient has been allocated to a designated psychiatric ward at any time during their admission, a MHLS value must be entered.
- If the patient was mistakenly allocated to a psychiatric ward (i.e. the patient did not physically go to a psychiatric ward) the patient's allocation to the psychiatric ward must be reversed.
- Resend the case.

797: Leave period must not be greater than 7 days

Error number: 797

Error description: A Leave Period is greater than 7 days during this admission

Why was the edit generated? Patients cannot be on leave for more than seven consecutive days and the case received has leave in excess of this.

Review data items affected:
- Admission history screen
- Documentation in the medical record

How to correct:
- Patients cannot be on leave for more than seven consecutive days. If this has occurred, the patient will be required to be discharged whilst on leave on the seventh day.
- Once updated, the case will need to be resent. In some circumstances the Patient Administration System does not always calculate the leave periods correctly when patients go on leave multiple times during an episode of care.
- In these cases, Inpatient Data Collections must be advised on the edit spreadsheet the correct dates of each leave period taken and the case does not require resending.

800: Care Type of Maintenance, Aged Care or Flexible Care requires a Principal Diagnosis code of Z74/5

Error number: 800

Error description: PDX is NOT Z75.x or Z74.x but Care Type is Maintenance, Aged Care or Flexible Care.

Why was the edit generated? Care Type of Maintenance, Aged or Flexible Care requires a Principal Diagnosis of Z75.x (problems related to medical facilities and other health care) or Z74.x (problems related to care-provider dependency).

Review data items affected:
- Care Type (Episode of care)
- Diagnosis codes in the coding screen
- Documentation in the medical record

How to correct:
- Check the clinician’s documentation in the medical record to ascertain the correct Care Type.
- If the Care Type is Maintenance, Aged or Flexible Care a Principal Diagnosis of Z75.x or Z74.x needs to be allocated in the coding screen.
- If the Care Type is incorrect the data item requires updating to the correct Care Type as per the clinical documentation.
- In these instances the Z75.x or Z74.x is not required. Resend the case once it has been updated in the Patient Administration System.

Source: Australian Coding Standards - 2105 Long Term/Nursing Home Type Inpatients, 2107 Respite Care. HMDS Reference Manual 2011 - Care Type, page 76.
801: *Principal Diagnosis* Z74/5 without the *Care Type* of Maintenance, Aged Care or Flexible Care

**Error number:** 801

**Error description:** PDX is Z75.x or Z74.x but Care Type is NOT Maintenance, Aged Care or Flexible Care

**Why was the edit generated?** A *Principal Diagnosis* of Z75.x (problems related to medical facilities and other health care) or Z74.x (problems related to care-provider dependency) requires one of the following *Care Types*: Maintenance, Aged or Flexible Care.

**Review data items affected:**
- *Care Type* (Episode of care)
- Diagnosis codes in the coding screen
- Documentation in the medical record

**How to correct:**
- Check the clinician’s documentation in the medical record to ascertain the correct *Care Type*.
- If the *Care Type* is correct the *Principal Diagnosis* of Z75.x or Z74.x must be removed as *Principal Diagnosis*.
- If the *Care Type* allocated is incorrect the data item requires updating to either Maintenance, Aged or Flexible care.
- In these instances the *Principal Diagnosis* of Z75.x or Z74.x remains as principal diagnosis.
- Resend the case once it has been updated in the Patient Admistration System.

**Source:** Australian Coding Standards.
HMDS Reference Manual 2011 - *Care Type*, page 76.
810: Invalid combination of diagnosis, outcome and procedure code (birth episode)

Error number: 810

Error description: Invalid combination of (O80-O84) / Z37.x / procedure

Why was the edit generated? An admission for a birth episode requires a combination of the three items below with an edit generated if one of these items is either incorrect or absent*

1. Delivery Diagnosis Code (O80-O84)
2. Outcome of delivery Diagnosis Code (Z37.x)
3. Delivery Procedure Code (e.g. 90467-00 Spontaneous Vertex Delivery)

* Exception to the rule: Termination of pregnancy before fetal viability (Refer to Australian Coding Standard 1511). If the outcome of a termination results in a live born infant before what is deemed fetal viability (before 20 weeks gestation and/or fetal weight less than 400grams) an outcome of delivery Z37.x can be allocated without the need for the two remaining items listed above.

Review data items affected:
- Coding screens for diagnosis and procedure codes
- Documentation in the medical record

How to correct:
- Review the documentation in the medical record to confirm if the admission was for a birth episode of care (i.e. the infant was delivered during the admission).
- Ensure all three items are present and correct if necessary and resend the case.
- If the episode of care was not for the delivery of the infant, the three items above are not required.

Source: Australian Coding Standards - 1511 Termination of Pregnancy.
HMDS Reference Manual 2011 - Principal and Additional Diagnosis, pages 120-122; Principal and Additional Procedures, pages 131-133.
Frequently Asked Questions

Q. When should I select a Care Type of ‘Newborn’?

The Care Type of ‘Newborn’ should be selected for all patients 9 days of age or less on admission. The Care Type is selected based on the patient’s age on admission and no other factors.

Patients 10 days of age or greater on admission should have a Care Type other than ‘Newborn’.

EXAMPLE A - Over 10 days
A healthy infant with a date of birth of the 7 September 2011 who accompanies their mother and is admitted to the hospital on the 19 September 2011 will have a Care Type of ‘Hospital Boarder’.

EXAMPLE B - 9 days of age or less.
A healthy infant with a date of birth of the 13 September 2011 who accompanies their mother and is admitted to the hospital on the 19 September 2011 will have a Care Type of ‘Newborn’.

Q. When should I select a Qualified or Unqualified patient type in the Patient Administration System?*

A patient with a Care Type of Newborn must have a Patient Type of ‘Unqualified’ or ‘Qualified’. If a patient has a Care Type other than ‘Newborn’ they must not have a Patient Type of ‘Unqualified’ or ‘Qualified’.

Criteria for qualified patient type:
1. Patient is admitted to a Level 2 (L2) Nursery of Neonatal Intensive Care Unit (NICU). Admission to a L2 Nursery or NICU is based on the requirement to receive this level of care, not because of bed availability.
2. Patient is admitted without their mother or the mother is admitted as a Boarder.
3. Patient is not a first born in a multiple birth.

9 days of age or less
The Patient Type should be changed to ‘Qualified’ when the patient meets one of the three criteria above. Patient Type should be changed back to ‘Unqualified’ when the patient stops meeting at least one of the three criteria above. The Patient Type must be changed to allow TOPAS to calculate qualified days correctly.
10 days of age or greater

At 10 days of age or any day after, a patient must meet the acute admission criteria to stay admitted with a Care Type of ‘Newborn’. If the patient meets the criteria of an acute admission the Patient Type is changed to ‘Qualified’ at 10 days of age and the Care Type remains as ‘Newborn’. The patient remains as ‘Newborn/Qualified’ until they no longer meet the acute admission criteria. When the patient stops meeting the criteria a statistical type change is performed to an appropriate Care Type.

*Instructions relate to TOPAS only.*
Q. Are unwell babies qualified and well babies unqualified for the Care Type?

No. Unwell babies do not automatically become qualified and well babies do not automatically become unqualified. See above for the criteria for qualified days.

Q. Once a baby is qualified do they remain qualified?

No. Patient Type of ‘Unqualified/Qualified’ is changeable in the Patient Administration System for patients up until they are 10 days of age, depending on the patient meeting one of the three qualified patient type criteria (see above).

Q. Can the Patient Type change back to unqualified on the Patient Administration System?

Yes. Patient Type can change in the Patient Administration System in patients up until they are 10 days of age based on meeting the three qualified patient type criteria (see above).

Q. Should patients be statistically changed at 10 days of age or after 10 days of age?

Patients should be statistically changed at or after day 10 if they are not receiving acute care. Once the acute episode of care is complete a statistical change is required.

Q. Do Patient Type changes require a statistical change?

Patient types are changed without a statistical type change being performed. A change of Care Type requires a statistical type change e.g. ‘Newborn’ Care Type is statistically discharged to ‘Boarder’ Care Type.

Q. How do I calculate the age on admission?

Two methods are used by most people to calculate the age on admission. Both methods return the same answer.

- When counting the days from the date of birth to the date of admission, the date of birth is counted as 0.
- When counting the days from the date of birth to date of admission, the date of birth is counted as 1 and the following day is also counted as 1. This method means that 2 days are counted as 1.

<table>
<thead>
<tr>
<th>Date</th>
<th>28/07</th>
<th>29/07</th>
<th>30/07</th>
<th>31/07</th>
<th>01/08</th>
<th>02/08</th>
<th>03/08</th>
<th>04/08</th>
<th>05/08</th>
<th>06/08</th>
<th>07/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count using 0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Count using 1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>
Q. Why are edits repeated?

Each time an admission is submitted to the Hospital Morbidity Data System the case is processed and every edit check is performed on the case submitted. The original submission of the admission is only replaced by a new submission when the case passes all edit checks. To correct the edit, the highest batch number for the admission contains the edits that require correction.

- Admission has been resubmitted when a resubmission was not required i.e. Confirmation of an age edit.
- The case may have more than one edit and only one edit has been corrected.
- The mistake causing the edit has not been corrected.

Q. Why does one admission have multiple edits?

The edits are varied and one mistake may cause multiple edits. Each edit check that fails generates one line on the edit report.

**EXAMPLE**

A patient has a date of birth of 2001 entered instead of 2011. This mistake will generate the edits listed below. Correcting the date of birth to 2011 will correct the edits below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>350</td>
<td>Age is invalid for the employment status</td>
</tr>
<tr>
<td>521</td>
<td>Invalid age for the ICD code Z38.0</td>
</tr>
<tr>
<td>475</td>
<td>The date of birth must equal the admission date</td>
</tr>
<tr>
<td>748</td>
<td>Unqualified Newborn separated after the 10th day</td>
</tr>
<tr>
<td>247</td>
<td>Client Type is invalid for age range</td>
</tr>
</tbody>
</table>
## Data Items

<table>
<thead>
<tr>
<th>Data Items</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Diagnosis</td>
<td>‘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’. (Health Data Standards Committee, 2008)</td>
</tr>
<tr>
<td>Additional Procedure</td>
<td>‘A clinical intervention represented by a code’. The order of the procedure codes should follow a given hierarchy as defined in Australian Coding Standard 0016, page 33. (Health Data Standards Committee, 2008).</td>
</tr>
<tr>
<td>Admitted From</td>
<td>Admitted From is a four digit numeric code that indicates the Establishment from which the patient is admitted or transferred.</td>
</tr>
<tr>
<td>Care Type</td>
<td>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 (other care).</td>
</tr>
<tr>
<td>Client Type</td>
<td>Further defines the nature of care provided to an admitted patient and is used to identify qualified and unqualified newborns as well as contracted services.</td>
</tr>
<tr>
<td>Clinician on admission (MBRN)</td>
<td>The Clinician on Admission is the hospital clinician who authorises the patient to be admitted to hospital.</td>
</tr>
<tr>
<td>Clinician on separation (MBRN)</td>
<td>The Clinician on Separation is the clinician who authorises the patient to be discharged from hospital.</td>
</tr>
<tr>
<td>Co-diagnosis</td>
<td>Where there is a relationship between the disease and its manifestations (commonly called Dagger and Asterisk codes), the co-diagnosis field is used to record the disease matching the Principal Diagnosis.</td>
</tr>
<tr>
<td>Condition Onset Flag (COF)</td>
<td>The focus of the COF is to identify conditions arising during the episode of admitted patient care. This is represented by two codes:</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Date of Birth enables derivation of age, at admission, for use in demographic analysis, assists in the unique identification of clients if other identifying information is missing or in question, and may be required for the derivation of other metadata items. Represented as DDMMYYYY.</td>
</tr>
<tr>
<td>Days in ICU</td>
<td>The number of days spent in a designated intensive care bed during an admission to hospital.</td>
</tr>
<tr>
<td>Discharged To</td>
<td>Discharged To identifies the place to which the patient was discharged or transferred to when they left hospital.</td>
</tr>
<tr>
<td>Employment Status</td>
<td>This is the self-reported employment status of a patient, immediately prior to admission.</td>
</tr>
<tr>
<td>Funding Source</td>
<td>The funding source is the principal source of funds for an admitted patient episode.</td>
</tr>
<tr>
<td>Hours CVS</td>
<td>Continuous ventilatory support (CVS) is the provision of mechanical respiration to assist patients with respiratory failure via an invasive artificial airway.</td>
</tr>
<tr>
<td>Infant Weight</td>
<td>The weight of all patients less than 365 days of age and weighing 9000g or less must be reported to Inpatient Data Collections. The weight can only be reported in grams.</td>
</tr>
<tr>
<td>Insurance Status</td>
<td>This data item is to determine whether the patient has hospital insurance, not their method of payment for the episode of care and is represented by 1 for Yes and 2 for No.</td>
</tr>
<tr>
<td>Marital Status</td>
<td>The marital status is a person's current relationship status in terms of a couple relationship; or for those not in a couple relationship, the existence of a current or previous registered marriage.</td>
</tr>
<tr>
<td>Mental Health Legal Status (MHLS)</td>
<td>A mental health legal status should be reported for a patient who is treated on an involuntary (1) or voluntary (2) basis under the Mental Health Act, at any time during an episode of admitted patient care while in a designated unit.</td>
</tr>
<tr>
<td>Data Items</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Number of Leave Periods</td>
<td>Number of leave periods in a hospital stay (excluding same day leave periods for admitted patients). A leave period is a temporary absence from hospital overnight, with medical approval for a period no greater than seven consecutive days.</td>
</tr>
<tr>
<td>Postcode</td>
<td>The Postcode is the numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a party (person or organisation), as defined by Australia Post.</td>
</tr>
<tr>
<td>Principal Diagnosis</td>
<td>‘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.’ (Health Data Standards Committee, 2008)</td>
</tr>
<tr>
<td>Principal Procedure</td>
<td>‘A clinical intervention represented by a code’. The order of the procedure codes should follow a given hierarchy as defined in Australian Coding Standard 0016, page 33. (Health Data Standards Committee, 2008).</td>
</tr>
<tr>
<td>Suburb</td>
<td>Residential address is the address provided for the patient’s place of usual residence. Suburb should be recorded on a separate line and match exactly to Inpatient Data Collection values.</td>
</tr>
<tr>
<td>Total Leave Days</td>
<td>Sum of the length of leave (date returned from leave minus date went on leave) for all periods within period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one Care Type.</td>
</tr>
<tr>
<td>Ward/Location</td>
<td>Ward/Location is the ward or unit within the hospital where the patient was being treated immediately prior to discharge.</td>
</tr>
</tbody>
</table>

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