ECLIPSE Hospital Claim Data Dictionary

Contents

Introduction

The purpose of this document is to provide the details of the data that is supplied in the In-patient Hospital Claim (**IHC**) request and response function available via the ECLIPSE claiming channel through Services Australia. This function allows public hospitals, private hospitals and day facilities the ability to submit a claim in relation to a patient's hospital stay and receive a response from the private health insurer. This includes claims for accommodation, theatre, and miscellaneous items such as prostheses.

The following is included:

- A diagram of the overall summary for the transmission of a hospital claim
- The structure of the IHC request
- The details of the data that can be supplied within the IHC request
- The structure of the IHC response
- The details of the data that can be supplied within the IHC response

This document should be used as a guide to provide further information on the details within the hospital claim request and response, including the intent and relevant conditions that may apply to certain data. This document aims to ensure consistency and standardised practices pertaining to data provided in hospital claim request and responses.

This document can be used to complement the relevant web services specifications supplied by Services Australia for the ECLIPSE claiming channel and the Private and Public hospital claim examples. The relevant specifications and examples can be accessed via the Services Australia Health Systems Developer Portal for authorised users. This document is not a substitute for the web services specifications. In order to develop and provide software that utilises the ECLIPSE claiming channel you must be certified by Services Australia.

This document is maintained by the industry ECLIPSE hospital working group. If you have any feedback on this document, please contact your representative on this working group.

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Legend

The following tables will assist you with interpreting the data dictionaries in this document.

The data format indicates the type of character/s the respective data item should contain.

Data Format	Description
N	Numeric
A	Alpha
A/N	Alpha and Numeric
D	Date
T	Time
ANS	Alpha, Numeric & Symbols

The obligation indicates whether provision of each data item is mandatory, must be supplied in certain conditions or optional.

Obligation	Description
M	Mandatory (data element must be present)
C	Conditional (if specified data conditions are met then element is considered mandatory)
O	Optional (if data is available it should be supplied)

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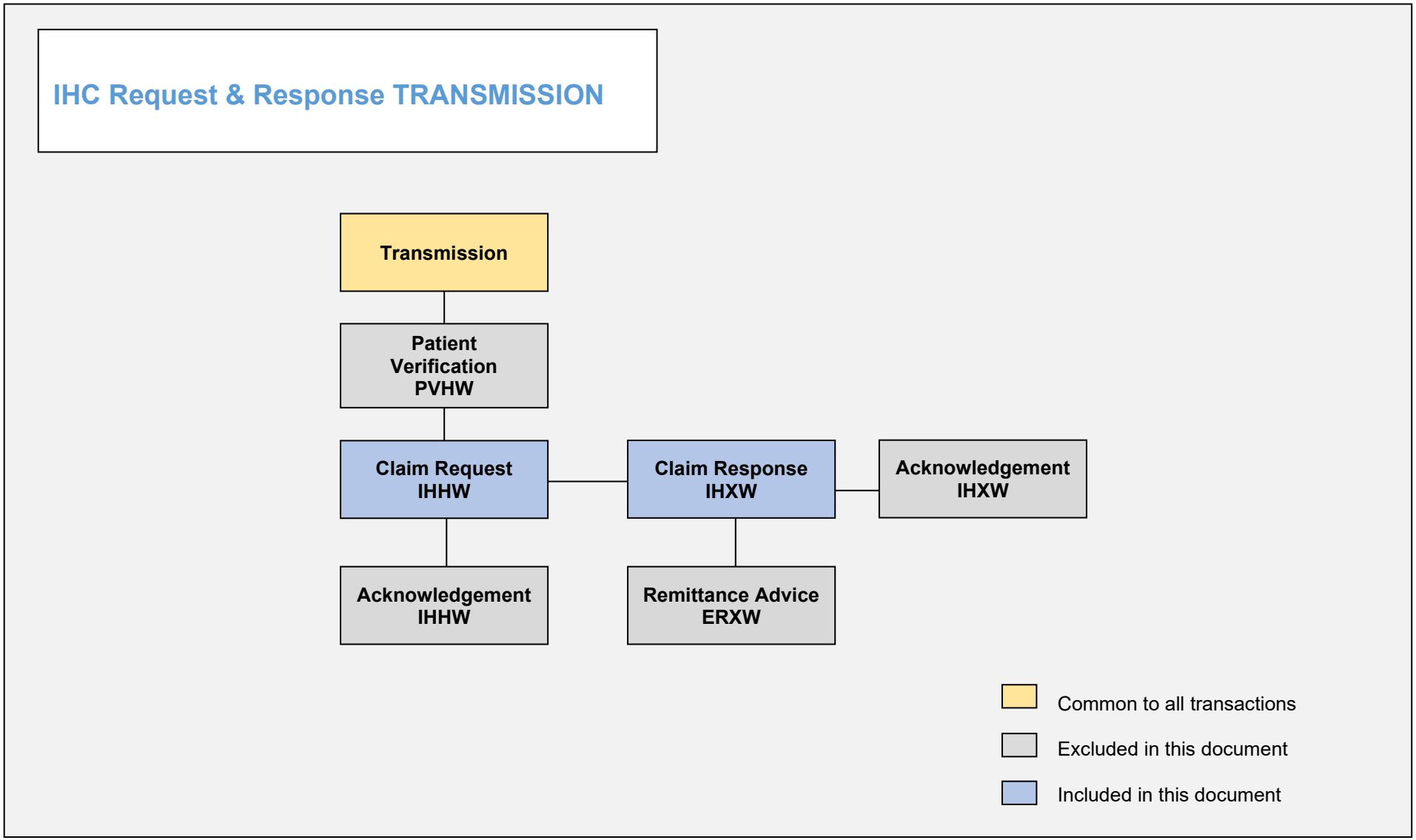
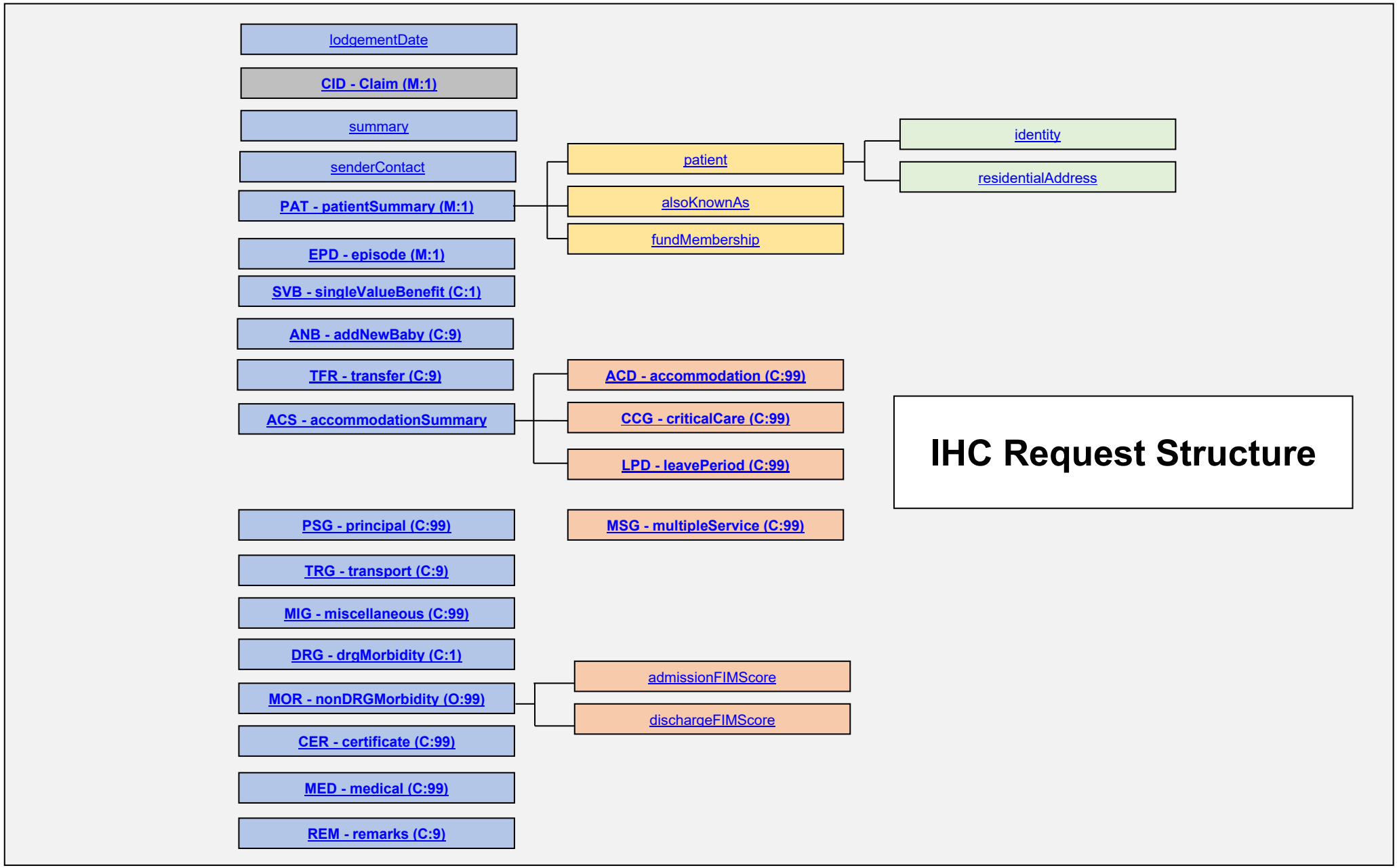


ECLIPSE Data Dictionary – Hospital Claim Request



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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
Transmission						
lodgementDate	M	1	8	Date	CCYYMMDD. This is the date Services Australia received the original IHC.	
claim (HospitalClaimType)	**M**	**1**			**This segment holds the details of the claim. The claim can be for a completed episode of care, a contiguous claim or an interim claim. It also contains the total charge for the individual claim. All other segment groups are nested within the CID segment**	
id	M	1	3	A	Value **CID** Code which identifies the Segment Group (CID).	
compensationClaimCode	M	1	1	A	Indicates if the hospital claim relates to a compensation claim. Y = Yes N = No U = Unknown	
contiguousClaimCode	M	1	1	A	N = Not in a series F = First in a series M = Neither F or L L = Last	Consistent with dischargeTypeCode. Where the value of N or L is sent then the dischargeTypeCode must be supplied. Note: The values of F,M,L are used for interim billing. Interim billing is designed to support incremental bills for a long-term single episode patient, i.e. a patient that has been in longer than 30 days.
facilityTypeCode	M	1	1	N	The type of hospital where the episode occurred. 1 = Public 2 = Private 3 = Private day facility 4 = Public day facility 9 = Other/unknown Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website.	HCP1 (Insurer) data item 34. HCP (Hospital) data item 11.

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
paymentModel	O	1	20	A/N	The payment model the claim has been structured under. This will allow insurers to identify the model used for the admission to ensure it is processed and benefits paid according to contractual arrangements. The insurer will advise if this information is required to be supplied as part of the hospital contract. Current industry examples include **EPM** and **CWO**.	Dependant on contractual arrangement between the hospital and the insurer.
previousClaimCode	O	1	1	A	Indicates if this claim is a supplement or adjustment to a previously accepted claim. A = Adjustment (for previously accepted episodes) S = Supplement (used for miscellaneous or prosthesis items that do not impact accommodation)	Only Public Hospitals can submit a claim with the value 'S'. A supplementary claim can only be submitted if the corresponding accommodation claim has been sent.
previousTransactionId	C	1	24	A/N	Transaction Id of the original IHC being adjusted.	Mandatory where previousClaimCode = A
totalChargeAmount	M	1	9	N	Total amount of the claim in cents. 0 - 999999999 - cents = SUM of totalHospitalChargeAmount plus totalMedicalChargeAmount Represented in cents (e.g. $1.00 is set as 100). Leading zeros are not accepted.	
totalHospitalChargeAmount	M	1	9	N	0 - 999999999 - cents. This is the sum of the SVB chargeAmount, Miscellaneous and Transport, ACS totalChargeAmount, PSG totalChargeAmount, MIG chargeAmount, but only where the associated charge indicator equals 'C'	
totalMedicalChargeAmount	C	1	9	N	**Note:** MED is not currently supported. It's intended use was where the hospital collects and submits the Doctor charges within the claim. 0 - 999999999 - cents. Sum of all MED repeating groups – chargeAmount but only where the associated charge indicator equals 'C'	Mandatory if Medical Service (MED) segment is set.
urgencyCode	M	1	1	N	Indicates if the treatment occurred due to the patient experiencing an accident. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. 1 = Urgency status assigned - Emergency 2 = Urgency status assigned - Elective	HCP1 (Insurer) data item 59. HCP (Hospital) data item 18.

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					3 = Urgency status not assigned 9 = Not known or not reported	
summary	**M**				**summary is nested under claim**	
accountReferenceId	M	1	20	A/N	From provider's accounts system e.g. invoice number. Note: This number together with the transaction Id will be used for remittance advices	
facilityId	M	1	8	A/N	Commonwealth Hospital Facility provider number, which is the unique identifier of a registered hospital or day care facility. Meets provider check digit routine.	
typeCode	M	1	2	A	Indicates the type of claim. PR = Private Hospital or Day Facility claim PU = Public Hospital claim	
senderContact	**O**				**senderContact is nested under claim**	If supplied emailAddress and or phoneNumber must be set
emailAddress	O	1	128	ANS	Email of contact for clarification of IHC if necessary Must contain an @ and no spaces allowed	
name	O	1	40	ANS	Name/Role/Position of the individual at the hospital for contact if clarification of IHC is necessary	
phoneNumber	O	1	19	A/N	Phone number of a contact if clarification of IHC is necessary	
patientSummary	**M**	**1**			**The PAT segment is used to define the patient information** **patientSummary is nested under claim**	
id	M	1	3	A	Value = **PAT** Code which identifies the Segment Group (PAT).	
admissionWeight	C	1	4	N	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	Mandatory if admissionDate minus dateOfBirth < 365 days Must not be set if admissionDate minus dateOfBirth is equal to or >=365 days HCP1 (Insurer) data item 39. HCP (Hospital) data item 28.

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					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 days old. Grams (0-9000) Note: Zero is acceptable. Leading Zeros not acceptable i.e. 01	
medicalRecordId	M	1	20	A/N	Individual Patient Identifier at the facility	HCP (Hospital) data item 52.
symptomAwarenessDate	O	1	8	D	Date patient first aware of symptoms/first attended GP for this condition. CCYYMMDD Must not be date in the future	
patient	**M**	**1**			**patient is nested under patientSummary**	
identity	**M**	**1**			**identity is nested under patientSummary>patient**	
dateOfBirth	M	1	8	D	The patient's Date of Birth. CCYYMMDD Must not be date in future or more than 130 years in the past	HCP1 (Insurer) data item 29. HCP (Hospital) data item 6.
familyName	M	1	40	ANS	Where patient has only one name, that name should appear in the familyName field and the word **Onlyname** be entered in the givenName field Only space, apostrophes and hyphens are acceptable special characters. Must contain at least one alpha or numeric character. Spaces must not appear before or after apostrophes, hyphens or other spaces.	
givenName	M	1	40	ANS	Where patient has only one name, that name should appear in the familyName field and the word **Onlyname** be entered in the givenName field	

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					Only space, apostrophes and hyphens are acceptable special characters. Must contain at least one alpha or numeric character. Spaces must not appear before or after apostrophes, hyphens or other spaces.	
secondInitial	O	1	1	A	The first initial of the patient's second given name.	
sex	M	1	1	N	The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code. 1 = Male 2 = Female 3 = Another term 9 = Not stated/inadequately described.	HCP1 (Insurer) data item 31. HCP (Hospital) data item 8.
residentialAddress	**M**				**residentialAddress is nested under patientSummary>patient**	
postcode	M	1	4	N	The locality of the patient's address to be used for the claim. 9999 = Unknown postcode. 8888 = Overseas postcode	HCP1 (Insurer) data item 30. HCP (Hospital) data item 7.
alsoKnownAs	**O**				**alsoKnownAs is nested under patientSummary**	If set alsoKnownAs familyName or givenName must be set
familyName	O	1	40	ANS	Only space, apostrophes and hyphens are acceptable special characters. Must contain at least one alpha or numeric character. Spaces must not appear before or after apostrophes, hyphens or other spaces.	
givenName	O	1	40	ANS	Only space, apostrophes and hyphens are acceptable special characters. Must contain at least one alpha or numeric character. Spaces must not appear before or after apostrophes, hyphens or other spaces.	
fundMembership	**M**				**fundMembership is nested under patientSummary**	
memberNumber	M	1	19	A/N	Patient's Health Fund Membership or Card number. For DVA this is the Veteran's file number.	
memberRefNumber	O	1	2	N	PHI 'Universal Patient Identifier' (UPI). The patient's individual reference number on their health fund membership card.	

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					This data may appear on a patient's fund membership card, and in conjunction with the membership number may be used to uniquely identify a patient. '00' is an acceptable value	
Organisation	M	1	3	A	The unique identifier for the health fund, as returned by the 'Get participants list'. It is the 3-character code for the health fund brand Id.	

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
episode	**M**	**1**			**The EPD segment is used for giving summary information regarding the patient's hospitalisation. episode is nested under claim**	
id	M	1	3	A/N	Value = **EPD** Code which identifies the Segment Group (EPD).	
accommodationStatusCode	M	1	1	A/N	Indicates whether the patient was admitted for the service(s) being claimed. A = Admitted Patient N = Non-Admitted Patient (eg DVA Mental Health Programs).	
admissionCategoryCode	O	1	1	N	Indicates the category of the hospital admission. 1 = acute care 2 = rehabilitation care 3 = palliative care 4 = non-acute care 5 = unqualified neonate 6 = other care.	
admissionDate	M	1	8	D	The date the patient commences and episode of care. CCYYMMDD Must not be date in future or before patients dateOfBirth	HCP1 (Insurer) data item 32. HCP (Hospital) data item 9
admissionTime	M	1	4	T	The time the patient commences an episode of care. Must not be a time in the future The admissionDate and admissionTime will be combined to check the time is not in the future	HCP1 (Insurer) data item 38. HCP (Hospital) data item 17.
anticipatedLengthOfStay	O	1	4	N	The anticipated length of the hospital stay in days. (0001-9999 valid).	
careType	M	1	2	N	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. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. Admitted care 1 Acute care 2 Rehabilitation care	HCP1 (Insurer) data item 83 HCP (Hospital) data item 20

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					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	
dischargeDate	C	1	8	D	The date the patient was discharged from hospital for the stay that will incur the attached services. CCYYMMDD Must not be a date in the future. Must not be more than 2 years in the past or before admissionDate	Mandatory if contiguousClaimCode = N or L. HCP1 (Insurer) data item 33. HCP (Hospital) data item 10.
dischargeIntentionCode	O	1	1	N	The discharge intention on admission. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. 1 = discharge to an(other) acute hospital 2 = discharge to a nursing home 3 = discharge to a psychiatric hospital 4 = discharge to a palliative care unit/hospice 5 = discharge to other health accommodation 8 = to pass way 9 = discharge to usual residence.	HCP1 (Insurer) data item 66. HCP (Hospital) data item 22.
dischargeTime	C	1		T	Time of discharge. If set, dischargeDate must also be set The dischargeDate and dischargeTime will be combined to check the time is not in the future.	Mandatory if sameDayCode = 1 or 0 HCP1 (Insurer) data item 42. HCP (Hospital) data item 31.
dischargeTypeCode	C	1	2	N	Referred to as **Mode of Separation** in HCP and HCP1. The status at discharge of the patient (discharge/transfer/death) and place to which the patient is released, as represented by a code . Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. **10** = Discharge/transfer to (an)other acute hospital **21** = Discharge/transfer to a residential aged care service, which is	Mandatory if TFR segment is set with transferCode set to S for values = **01,02,03,04 or 10,21,22,30,40.** Mandatory if contiguousClaimCode = N or L.

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					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))	HCP1 (Insurer) data item 41. HCP (Hospital) data item 30.
episodeId	M	1	15	A/N	The unique reference allocated by the hospital to identify the episode of care for the patient e.g. medical record number, unit record number or admission number.	
interHospitalContractStatus	C	1	1	N	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. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. 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.	Mandatory where claim>Summary> typeCode = PR HCP1 (Insurer) data item 87 HCP (Hospital) data item 23
lengthOfStay	C	1	4	N	1-9999 valid The actual length of stay for the patient in days	Mandatory if dischargeTypeCode is set.

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					Total length of stay from admission to discharge, i.e. includes leave days.	
mentalHealthLegalStatusCode	M	1	1	N	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. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. 1 = involuntary patient 2 = voluntary patient 9 – Not reported/unknown	HCP1 (Insurer) data item 57. HCP (Hospital) data item 24.
palliativeCareDays	M	1	4	N	The number of days a patient received palliative care during an episode Must be a numeric value (0- 9999). Note: Zero is acceptable, leading zeros are not accepted e.g. 01, 002, 0003.	HCP1 (Insurer) data item 82
palliativeCareStatusCode	C	1	1	N	An indicator of whether the episode involved palliative care. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. 1 = patient required palliative care during episode 2 = no palliative care required during episode.	Mandatory where Claim typeCode = PR HCP1 (Insurer) data item 61. HCP (Hospital) data item 25.
patientClassificationCode	M	1	2	A/N	The classification of the patient admission. Highest classification that is billed. AM = Advanced Medical ME = Medical SU = Surgical AS = Advanced Surgical OB = Obstetrics PS = Psychiatric RE = Rehabilitation NH = Nursing Home EC = Extended Care OT = Other D1 = Day Band 1	OT to be used for OVERNIGHT medical/surgical patients in Public Hospitals for non-classification states

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					D2 = Day Band 2 D3 = Day Band 3 D4 = Day Band 4	
qualifiedDaysForNewborns	C	1	5	N	The number of qualified newborn days occurring within a newborn episode of care Must be a numeric value (0- 99999). Note: Zero is acceptable, leading zeros are not accepted e.g. 01, 002, 0003.	Mandatory where careType = 7 Newborns HCP1 (Insurer) data item 79
readmissionCode	C	1	1	N	An indicator of the re-admission of a patient to hospital within 28 days of previous discharge for treatment of a similar or related condition. Note: do not include transfers from another hospital as readmissions Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. Unplanned re-admission within 28 Days 1 = Unplanned re-admission and patient previously treated this hospital 2 = Unplanned re-admission and patient previously at another hospital 3 = Planned re-admission from this or another hospital 8 = Not applicable/not known	Mandatory where Claim typeCode = PR. HCP1 (Insurer) data item 62. HCP (Hospital) data item 26.
referralSourceCode	M	1	1	N	Indicates the source of the patient's referral. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. 0 = born in hospital 1 = admitted patient transferred from another hospital 2 = Stats admission Type change 4 = from Accident/emergency 5 = community health service 6 = from Outpatients dept 7 = from nursing home 8 = by outside medical practice 9 = other.	If set to 1 there must be at least one TFR segment with the transferCode set to A. HCP1 (Insurer) data item 43. HCP (Hospital) data item 21.
sameDayCode	M	1	1	N	Indicates if the patient is treated on the same day. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. 0 = valid arrangement for overnight stay for same day procedure	Must be set to 0, 1 or 2 if accommodationStatusCode is A HCP1 (Insurer) data item 50. HCP (Hospital) data item 39.

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					1 = same day patient 2 = overnight patient other than (0) 9 = not applicable (e.g. non-admitted). Note: '9' is used for non-admitted hospital claims. It is required to facilitate claiming. It is not a HCP value.	
totalPsychiatricCareDays	C	1	5	N	The sum of the number of days or part days of stay that the person was an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit. Must be a numeric value (0– 99999). Leading zeros are not accepted.	Mandatory where patientClassificationCode = PS HCP1 (Insurer) data item 56
unplannedAdmissionICU	O	1	1	N	An indicator of whether a patient who had other surgery also had an unplanned admission to an Intensive Care Unit (ICU) following the other surgery in the same episode of admitted patient care. 1 = Yes 2 = No 9 = Not stated/inadequately described.	For future use, currently not reported in HCP.
unplannedReturnTheatre	O	1	1	N	An indicator of whether a patient had a surgical procedure/operation and required an unplanned return to the operating theatre during the same episode of admitted patient care: 1 = Yes 2 = No 9 = Not stated/inadequately described. .	For future use, currently not reported in HCP.
unplannedTheatreCode	C	1	1	N	An indicator of whether the patient required a theatre visit which was not anticipated or planned at the time of admission. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website. 1 = unplanned theatre visit 2 = no unplanned theatre visit.	Mandatory where Claim typeCode = PR. HCP1 (Insurer) data item 63. HCP (Hospital) data item 27.

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
singleValueBenefit	**C**	**1**			**The SVB segment is used for bundled inpatient accommodation only. It is used for single value benefit (i.e. episodic) arrangements and fully or partially bundled episodic billing** **singleValueBenefit nested under claim**	**Based on contractual arrangements**
id	M	1	3	A	Value = **SVB** Code which identifies the Segment Group (SVB).	
chargeAmount	M	1	9	N	The amount charged for the single value benefit in cents. 0 - 999999999 – cents Where there is a zero charge the chargeRaisedCode must = I	
chargeRaisedCode	M	1	1	A/N	Indicates if a charge has been raised or has been supplied for Information only. C = Charge Raised I = Information only	Must be set to '**I**' if Charge Amount within SVB segment is set to zero.
fromDate	C	1	8	D	Start date of the bundled inpatient accommodation. CCYYMMDD	Conditional on SVB numberOfDays being >0
numberOfDays	M	1	4	N	The number of days covered by the bundled inpatient accommodation. Zero is a valid value and would occur in the (to date rare) cases where bundled amount does not include accommodation. In the case of day procedures, value would be 0001. (0-9999 valid). If numberOfDays is >0 then SVB fromDate and toDate must be set	
serviceCode	M	1	11	A/N	The code for the service that is being charged. Note for the serviceCodeTypeCode = M the serviceCode must be a valid industry ECLIPSE Miscellaneous Code.	
serviceCodeTypeCode	M	1	1	A/N	The type of service being charged. C = MBS D = DRG I = ICD10AM M = Industry ECLIPSE Miscellaneous Code O = Other P = Prosthesis (DVA only) V = DVA Code List	

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
toDate	C	1	8	D	End date of the bundled inpatient accommodation. CCYYMMDD Must be equal to or later than SVB fromDate	Conditional on dischargeDate => 0

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
addNewBaby	**C**	**9**			**The ANB segment is used to notify the fund of a newborn baby that may or may not be on a membership** **addNewBaby is nested under claim**	**The ANB Segment is optional. A health fund cannot update the membership based on this information.**
id	M	1	8	A/N	Value = **ANBnnnnn** where N = numeric value (00001 – 000009)	
baby	**C**				**baby is nested under addNewBaby**	
dateOfBirth	M	1	8	D	The baby's Date Of Birth. CCYYMMDD	
familyName	M	1	40	ANS	The baby's Family name. Where patient has only one name, that name should appear in the familyName field and the word **Onlyname** be entered in the givenName field Only space, apostrophes and hyphens are acceptable special characters. Must contain at least one alpha or numeric character. Spaces must not appear before or after apostrophes, hyphens or other spaces.	
givenName	M	1	40	ANS	The baby's given name. Please ensure the real name for the baby is transmitted in this segment. Transmitting a standardised name from admission (e.g. TWIN 1 and TWIN 2) may cause rejections. Where patient has only one name, that name should appear in the familyName field and the word **Onlyname** be entered in the givenName field Only space, apostrophes and hyphens are acceptable special characters. Must contain at least one alpha or numeric character. Spaces must not appear before or after apostrophes, hyphens or other spaces.	
secondInitial	O	1	1	A	The first initial of the patient's second given name.	
sex	M	1	1	N	1 = Male 2 = Female 3 = Another term 9 = Not stated/inadequately described.	HCP1 (Insurer) data item 31. HCHCP (Hospital) data item 8.

					The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code.	

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
transfer	**C**	**9**			**The TFR segment is used to report the transfer of a patient between hospitals.** **Separate segments are required for each transfer in and out.** **transfer is nested under claim**	**Mandatory where referralSourceCode = 1 or dischargeTypeCode = 10 or 30**
id	M	1	8	A/N	Value = **TFRnnnnn** where n is numeric value in range 00001 – 00009 Must be valid and sequential starting with TFR00001	
facilityId	C	1	8	A/N	The Commonwealth Hospital Facility Provider Number. A unique identifier of a Registered Hospital or Day Care Facility. Where transferCode = A, it indicates this is the transferring Facility ID Where transferCode = S, it indicates this is the receiving Facility Id	Mandatory if dischargeTypeCode = 10 or 30. Must be set if transferCode = A
previousProviderDays	O	1	4	N	Number of days under the care of the previous provider. (0 - 9999 valid) Leading zeros not accepted	
previousProviderHours	O	1	2	N	Number of hours under the care of the previous provider. HH (0 – 99)	
serviceDate	M	1	8	D	The date that the transfer occurred. CCYYMMDD	
transferCode	M	1	1	A	Indicates the transfer between hospitals A = Admission from S = Separation to If transferCode set to A the facilityId in the TFR segment must be supplied	
transferTypeCode	O	1	1	A/N	Used where there is a change of classification U = Up D = Down L = Lateral i.e. medical to medical transfer between facilities X = Unknown.	

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
accommodationSummary	**C**	**1**			**The ACS segment provides a summary of accommodation and critical care details. If accommodation is included in the SVB segment, then total accommodation charges under ACS should be set to zero dollars. ACD, CCG and LPD are nested within this segment.** **accommodationSummary is nested under claim**	**This is a summary of the ACD, CCG & LPD segments. Only required where one or more of these segments exist.**
id	M	1	3	N	Value = **ACS** Code which identifies the Segment Group (ACS).	
accommodationDays	M	1	4	N	The total number of accommodation days. 1-9999 valid. Leading zeros are not accepted.	HCP1 (Insurer) data item 6
chargeRaisedCode	M	1	1	A	Indicates if a charge has been raised or has been supplied for Information only. C= Charge Raised I = Information only (latter used when actual charge already recorded in SVB, but additional detail required within this segment).	Mandatory to set to I if ACD totalChargeAmount is = 0
fromDate	M	1	8	D	The date accommodation commenced. CCYYMMDD	
leaveDays	M	1	4	N	0-9999 valid. Leading zeros not accepted Total number of leave days.	HCP1 (Insurer) data item 45. HCP (Hospital) data item 32.
nonCertifiedDaysOfStay	C	1	4	N	The number of days spent in a hospital without certification, that exceeded 35 days.	Mandatory where Claim type = PR HCP1 (Fund) data item 46 HCP (Hospital) data item 34.
numberOfDays	M	1	4	N	Actual length of stay (1-9999 valid). Leading zeros not accepted	The numberOfDays must equal the sum of the number of accommodationDays and leaveDays i.e. the total length of stay.
toDate	M	1	8	D	CCYYMMDD Must be equal to or later than ACS fromDate The date the accommodation ceased.	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
totalChargeAmount	M	1	9	N	0 - 999999999 - cents. The sum of ACS chargeAmount and CCG chargeAmount where associated charge indicator equals 'C'. The total charge of the accommodation.	Where there is a zero charge, the chargeRaisedCode must =' I'
Accommodation	**C**	**99**			**The ACD segment is used for the detailed reporting of differing periods of accommodation.** **accommodation is nested under accommodationSummary** **accommodation is nested under accommodationSummary**	**accommodation**
id	M	1	8	A/N	Value **ACDnnnnn**, Where n is numeric value in the range 00001 – 00099 Accommodation>id must be valid, sequential and unique starting from ACD00001	
bedBandCode	O	1	1	A/N	1 = Bed band 1 2 = Bed band 2 3 = Bed band 3 4 = Bed band 4 5 = Bed band 5. Indicates the bed subgrouping. Subgrouping of the patient classification required by Victorian contracted Private Hospitals	Dependant on contractual arrangement between the hospital and the insurer.
bedLevelAddOnInd	M	1	1	A	Y = Add-on N = Bed Level Indicates a bed level add on.	
bedLevelCode	M	1	2	A/N	S = Shared P = Private L = Luxury F = Fund-specified. O = Outreach/Hospital in the home Indicates the type of accommodation.	
chargeAmount	M	1	9	N	0 - 999999999 - cents The amount charged for the item in cents.	Where there is a zero charge, ACD chargeRaisedCode must equal 'I'.
chargeRaisedCode	M	1	1	A	C = Charged Raised I = Information only (used when actual charge already recorded in SVB, but additional detail required within this segment).	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					Indicates if a charge has been raised or has been supplied for information only.	
dayRate	M	1	9	N	0 - 999999999 – cents. Leading zeros not accepted The rate of the accommodation per day in cents.	
fromDate	M	1	8	D	CCYYMMDD Date the accommodation commenced.	
numberOfDays	M	1	4	N	(1-9999 valid) Leading zeros not accepted The length of stay of the accommodation in days.	
patientClassificationCode	M	1	2	A/N	The classification of the accommodation. AM = Advanced Medical ME = Medical SU = Surgical AS = Advanced Surgical OB = Obstetrics PS = Psychiatric RE = Rehabilitation NH = Nursing Home EC = Extended Care OT = Other D1 = Day Band 1 D2 = Day Band 2 D3 = Day Band 3 D4 = Day Band 4. .	OT to be used for OVERNIGHT medical/surgical patients in Public Hospitals for non-classification states
programCode	C	1	11	A/N	The industry ECLIPSE Miscellaneous Code for the Psychiatric/Rehabilitation program.	Mandatory where EPD patientClassificationCode = PS or RE and organisation does not = DVA The program code is dependent on contractual arrangement between the hospital and the insurer.
serviceCode	O	1	11	A/N	The code for the service that is being charged. Note for the serviceCodeTypeCode = M the serviceCode must be a valid industry ECLIPSE Miscellaneous Code.	Mandatory when ACD serviceCodeTypeCode is set
serviceCodeTypeCode	C	1	1	A/N	The type of service being charged. C = MBS D = DRG I = ICD10AM M = Industry ECLIPSE Miscellaneous Code (e.g. dental, cosmetic)	Mandatory when ACD serviceCode is set.

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					O = Other P = Prosthesis (DVA only) V = DVA Code List	
toDate	M	1	8	D	CCYYMMDD The date the accommodation ceased.	Must be equal to or later than ACD fromDate.
criticalCare	**C**	**99**			**The CCG segment is used for the detailed reporting of critical care where used by Private Hospitals and charged for by Public Hospitals.** **criticalCare is nested under accommodationSummary**	**Based on whether critical care is used by Private Hospitals and charged for by Public Hospitals.**
id	M	1	8	A/N	Value **CCGnnnnn** where n is numeric value in the range 00001 – 00099 Must be valid, sequential and unique starting with CCG00001	
chargeAmount	M	1	9	N	0 - 999999999 - cents. Leading zeros are not accepted The amount charged for the item in cents.	Where there is a zero charge, the chargeRaisedCode indicator must equal' I'
chargeRaisedCode	M	1	1	A	C = Charge Raised I = Information only used when actual charge already recorded in SVB, but additional detail required within this segment. Must be set to I if chargeAmount = 0 Indicates if a charge has been raised or has been supplied for information only.	Mandatory if the CC chargeAmount = 0
criticalCareAddOnInd	M	1	1	A	Y = Add on payable N = No Add on Payable Indicates if an add on is payable.	
criticalCareLevelCode	C	1	1	N	The level of critical care provided. 1 = type A 2 = type B 3 = type C.	Mandatory where CCG criticalCareTypeCode = ICU or CCU
criticalCareTypeCode	M	1	3	A/N	ICU = Intensive Care HDU = High Dependency CCU = Coronary Care SCN = Special Care Nursery PCU = Paediatric Care Unit NCU = Neonatal Care Unit ADN = Advanced Dependency Nursing TEL = Telemetry	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					The type of critical care provided.	
dayRate	M	1	9	N	0 - 999999999 - cents. Leading zeros not accepted The rate per day of the accommodation in cents.	
icuHours	O	1	4	N	HHHH (**0-9999**) The number of hours the patient spent in an intensive care unit (ICU).	
numberOfDays	M	1	4	N	(1-9999 valid). Leading zeros not accepted Number of days spent in a critical care unit (CCU).	
numberOfHours	O	1	4	N	Must be numeric (**0-9999**). Leading zeros are not accepted. The number of hours the patient spent in a critical care unit, excluding ICU. For example, CCU or SCN.	*Mandatory where CCG typeCode = CCU or SCN HCP1 (Insurer) data item 75 & 76 HCP (Hospital) data item 57 & 58.
serviceCode	C	1	11	A/N	The code for the service that is being charged. Note for the serviceCodeTypeCode = M the serviceCode must be a valid industry ECLIPSE Miscellaneous Code.	Mandatory where CCG serviceCodeTypeCode is set
serviceCodeTypeCode	C	1	1	A/N	The type of service being charged. C = MBS D = DRG I = ICD10AM M = Industry ECLIPSE Miscellaneous Code (e.g. dental, cosmetic) O = Other P = Prosthesis (DVA only) V = DVA Code List	Mandatory where CCG serviceCode is set
toDate	M	1	8	D	CCYYMMDD. The date the critical care ceased.	Must be equal to or later than CCG fromDate.
leavePeriod	**C**	**99**			**The LPD segment is used for the reporting 99 leave periods that may have occurred within the total period of hospitalisation.** **leavePeriod is nested under accommodationSummary**	**Use only if ACS leaveDays >= 1**
id	M	1	8	A/N	Value **LPDnnnnn** where n is numeric value in the range of 00001 - 00099 Leave period ids must be valid, sequential, and unique starting from LPD00001. Unique identifier for the Leave Period.	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
fromDate	M	1	8	D	CCYYMMDD The date the leave period commenced.	Cannot be after the To Date in Leave Period segment.
numberOfDays	M	1	4	N	(1-9999 valid). Leading zeros not accepted The number of days of the leave period.	

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
principal	**C**	**99**			**The PSG segment is used for the reporting and charging of all instances where a principal service or procedure is carried out during a single theatre visit. The repetitions allow for the inclusion of more than one visit during a claim period. Secondary services can be reported using the MSG segment nested within this group.** **principal is nested under claim**	**Mandatory where theatre performed for both Public and Private Hospitals. Also mandatory for Obstetrics eg Labor Ward and MBS Item used for Private Hospitals. Mandatory where EPD patientClassificationCode = SU, OB, AS D2, D3 or D4 . Should be provided by Public hospitals where DMG segment is not present.**
id	M	1	8	A/N	Value = **PSGnnnnn** where n is numeric value in the range 00001 – 00009 Leave period Id's must be valid, sequential, and unique starting from	
anaestheticTypeCode	C	1	1	A/N	L = Local G = General R = Regional I = Intravenous N = No Anaesthetic. The type of anaesthetic used.	Mandatory where EPD sameDayCode = 1 or 0.
chargeAmount	M	1	9	N	0 - 999999999 - cents. Leading zeros not accepted The amount charged for the item in cents.	
chargeRaisedCode	M	1	1	A	C = Charge Raised if PSG totalChargeAmount is >0 I = Information only (where PSG totalChargeAmount = 0). Indicates if a charge has been raised or has been supplied for information only.	Must be set to I if PSG totalChargeAmount = 0
serviceCode	M	1	11	A/N	The code for the service that is being charged. Note for the serviceCodeTypeCode = M the serviceCode must be a valid industry ECLIPSE Miscellaneous Code.	HCP1 (Insurer) data item 51. HCP (Hospital) data item 40.
serviceCodeTypeCode	M	1	1	A/N	The type of service being charged. C = MBS D = DRG I = ICD10AM	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					M = Industry ECLIPSE Miscellaneous Code (e.g. dental, cosmetic) O = Other P = Prosthesis (DVA only) V = DVA Code List	
serviceDate	M	1	8	D	CCYYMMDD The date the service was rendered to the patient.	HCP1 (Insurer) data item 52. HCP (Hospital) data item 41
serviceTime	C	1		time	HHMM (rounding to nearest hour allowed) 24-hour clock The time the service was rendered to the patient.	Mandatory if multiple PSG segments on same day.
theatreBandCode	C	1	3	A/N	National Theatre bands or WA bands LW = Labour Ward 0 (zero)= un-banded MBS item The theatre band that applies to the episode of care.	Mandatory where theatreBandTypeCode = O to indicate a Labour Ward Mandatory if PSG serviceCodeTypeCode = C
theatreBandTypeCode	C	1	1	A/N	Used to describe the theatre band list N = National Theatre Band W = WA Theatre Band O = Other (to be used for LW)	Must be set where PSG theatreBandCode is set
theatreCategoryCode	C	1	1	A/N	C = Complex S = Simple Indicates the complexity of the procedure.	Mandatory where PSG theatreBandCode is set.
theatreMinutes	C	1	4	N	Total time in minutes 0 - 9999. Leading zeros not accepted The time that the patient was in theatre in minutes.	Mandatory where EPD sameDayCode = 1 or 0. Mandatory if multiple PSG segments on same day HCP1 (Insurer) data item 53 HCP (Hospital) data item 42
totalChargeAmount	M	1	9	N	0 - 999999999 - cents. Leading zeros not accepted Where no secondary items charged (MSG), PSG totalChargeAmount = PSG chargeAmount. Where secondary items charged PSG totalChargeAmount = sum of PSG chargeAmount and all MSG chargeAmount. The total theatre costs.	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
multipleService	**C**	**99**			**MSG segment is used for the reporting of multiple or secondary services for each of the principal services reported in the PSG segment.** **multipleService is nested under principal**	**Mandatory when a supplementary theatre procedure is performed at the same time as the primary and PSG chargeAmount is less than PSG totalChargeAmount Cannot be supplied without a PSG segment.**
id	M	1	8	A/N	Value = **MSGnnnnn** where n is numeric value in the range 00001 – 00099 MultipleService Id's must be valid, sequential, and unique within the claim starting from MSG00001.	
chargeAmount	M	1	9	N	0 – 999999999 - cents. Leading zeros not accepted The amount charged for the item in cents.	
chargeRaisedCode	M	1	1	A/N	C = Charge Raised I = Information only Indicates if a charge has been raised or has been supplied for information only.	Must be set to I if MSG chargeAmount is set to zero
serviceCode	M	1	11	A/N	The code for the service that is being charged. Note for the serviceCodeTypeCode = M the serviceCode must be a valid industry ECLIPSE Miscellaneous Code.	HCP1 (Insurer) data item 54. HCP (Hospital) data item 43.
serviceCodeTypeCode	M	1	1	A/N	The type of service being charged. C = MBS D = DRG I = ICD10AM M = Industry ECLIPSE Miscellaneous Code (e.g. cosmetic) O = Other P = Prosthesis (DVA only) V = DVA Code List	
theatreBandCode	C	1	3	A/N	National Theatre bands or WA bands LW = Labour Ward 0 (zero) = un-banded MBS item The theatre band that applies to the episode of care.	Mandatory where MSG theatreBandTypeCode = O to indicate a Labour Ward Mandatory where MSG serviceCodeTypeCode = C
theatreBandTypeCode	C	1	1	A/N	Used to describe the theatre band list N = National Theatre Band	Mandatory if MSG theatreBandCode is used

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					W = WA Theatre Band O = Other (to be used for LW)	
theatreCategoryCode	C	1	1	A/N	C = Complex S = Simple Indicates the complexity of the procedure.	Mandatory if MSG theatreBandCode is used

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
transport	**C**	**9**			**This is currently not used by industry.** **The TRG segment is used for raising charges for patient transport directly related to the claim period.** **transport is nested under claim**	**This is currently not used by industry.** **Based on contractual arrangements**
id	M	1	8	A/N	Value = **TRGnnnnn** where n is numeric value in the range 00001 – 00009 Transport Id's must be valid, sequential, and unique starting from TRG00001.	
ambulanceReferenceNumber	O	1	15	ANS	The ambulance provider reference number. Can contain spaces, apostrophes, hyphens, and other special characters Spaces must not appear before or after spaces or the supplied value	
chargeAmount	M	1	9	N	0 - 999999999 – cents. Leading zeros not accepted Where = to zero charge, the chargeRaisedCode must equal 'I'. The amount charged for the item in cents.	
chargeRaisedCode	M	1	1	A/N	C = Charge Raised I = information Indicates if a charge has been raised or has been supplied for information only.	Must be set to I if TRG chargeAmount is set to zero
distanceKilometres	M	1	4	N	Kilometres (<9999). Leading zeros not accepted The distance travelled in Kilometres.	
fromLocality	M	1	40	ANS	Town, City, Suburb. Can contain spaces, apostrophes, hyphens, and other special characters Spaces must not appear after other spaces or the supplied value	
fromTime	M	1		time	HHMM (24 hr clock) The time the transport started. Must not be a time in the future. Note: Transport Service Date and Transport From Time will be combined to check the time is not in the future. The value must be a valid Australian time-zone.	
serviceDate	M	1	8	D	CCYYMMDD The date the service was rendered to the patient. Must not be in the future.	
toLocality	M	1	40	A/N	Town, City, Suburb. Can contain spaces, apostrophes, hyphens, and other special characters (/:,.:;) are acceptable	

transportHoursMinutes	M	1	4	N	HHMM The total time of the transportation.	
transportTypeCode	M	1	1	A/N	T= Taxi A = Ambulance F = Aircraft M = Mobile ICU. Indicates the type of transport used.	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
miscellaneous	**C**	**999**			**The MIG segment is used for the reporting and charging of miscellaneous items not covered elsewhere in the claim, such as prostheses.** **miscellaneous is nested under claim**	**If greater than 99 services for the same Service Code multiple MIG segments required. Based on contractual arrangements**
id	M	1	8	A/N	Value **MIGnnnnn** where n is numeric value in the range of 00001 – 00999 Miscellaneous Id's must be valid, sequential, and unique starting from MIG00001.	
chargeAmount	M	1	9	N	0 - 999999999 – cents. Leading zeros are not accepted The amount charged for the item in cents.	Where there is a zero charge, the charge indicator must equal 'I'.
chargeRaisedCode	M	1	1	A	C = Charge Raised I = Information only Indicates if a charge has been raised or has been supplied for information only.	Must be set to I if MIG chargeAmount is zero
serviceCode	M	1	11	A/N	The code for the service that is being charged. This must be an Industry standard ECLIPSE Miscellaneous Code. Miscellaneous codes can be obtained from https://privatehealthcareaustralia.org.au/resources/fund-resources/eclipse/	Items in the Prescribed List must start with PX00.
serviceDate	M	1	8	D	CCYYMMDD The date the service was rendered to the patient.	
serviceQuantity	M	1	2	N	1-99 valid. Leading zeros are not accepted The number of services provided.	
serviceRate	M	1	9	N	0 - 999999999 – cents Leading zeros are not acceptable Quote unit price for prosthesis The rate per service in cents.	
text	O	1	30	ANS	Free text – used to describe the ServiceCode Qualifies MIG serviceCode eg DHFS Prosthetic Numbers. Free text description required.	

					Can contain spaces, apostrophes, hyphens, and other special characters (/:,.:;) are acceptable Spaces must not appear before or after other spaces or the supplied value.	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
drgMorbidity	**C**	**1**			**The DMG segment is required for the collection of diagnosis and ICD codes. It is essential for episodic billing** **drgMorbidity is nested under claim**	**This is a mandatory segment where CID typeCode = PR. i.e. Private Hospitals and Day Facilities.** **This is Mandatory where CID typeCode = PU and where PSG segment is not present.**
id	M	1	3	A	Value = **DMG** Code which identifies the Segment Group (DMG)	
additionalDiagnosis	O	49	6	AN	This is the secondary diagnosis Exclude special characters eg '.' and '*'. Morphology codes should not be submitted in this field ICD-10-AM. Format NANNNN each entry should consist of: • the first (1) digit represents the condition onset flag code • next five (5) represent the additional diagnosis code. The condition onset flag is a qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care. **Values:** 1 = condition with onset during episode of admitted patient care 2 = condition not noted as arising during episode of admitted patient care 9 = not reported Principal diagnosis condition onset flags should be a 2 except where claimTypeCode = PU	Where CID typeCode = PU then default the condition onset flag to 9 HCP1 (Insurer) data item 48. HCP (Hospital) data item 37.
drgCode	C	1	4	A/N	DRG code being claimed	Mandatory for CID typeCode = PR and where contiguousClaimCode = N or L and EPD accommodationStatus = A. HCP1 (Insurer) data item 36. HCP (Hospital) data item 15.
drgVersion	C	1	3	A/N	Values 41 = version 4.1,	Mandatory for CID typeCode = PR and where

					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 The version of the DRG manual used to determine the DRG Code. Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website.	contiguousClaimCode = N or L and EPD accommodationStatus = A. HCP1 (Insurer) data item 84. HCP (Hospital) data item 65.
icdVersion	M	1	4	N	Version should be the most current version of ICD-10-AM e.g. 1011	HCP (Hospital) header data item 11
principalDiagnosis	M	1	6	AN	Exclude special characters eg '.' and '*'. Morphology codes should not be submitted in this field ICD-10-AM. Format NANNNN each entry should consist of: • the first (1) digit represents the condition onset flag code • next five (5) represent the additional diagnosis code. The condition onset flag is a qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care. **Values:** 1 = condition with onset during episode of admitted patient care 2 = condition not noted as arising during episode of admitted patient care 9 = not reported Principal diagnosis condition onset flags should be a 2 except where claimTypeCode = PU 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	HCP1 (Insurer) data item 47. HCP (Hospital) data item 36. Where claim type = PU then default the condition onset flag to 2

					episodes can be identified by ICD-10-AM Code Z38.x in the principal or additional diagnosis code field.	
procedures	O	50	7	AN	Exclude the hyphen i.e. '-'. Morphology codes can be submitted in this field Format: MBS-Extended The procedures performed on the patient.	HCP1 (Insurer) data item 49. HCP (Hospital) data item 38
ventilationHours	C	1	4	N	HHHH. (0000 is valid). The number of hours the patient was mechanically ventilated. The number of hours of mechanical ventilation is defined as: 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. Leading zero are not accepted	Mandatory where CID typeCode = PR HCP1 (Insurer) data item 40. HCP (Hospital) data item 29

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
nonDRGMorbidity	**O**	**99**			**The MOR segment is for the collection of non-DRG classifications and ANSNAP data.** **nonDRGMorbidity is nested under claim**	**For a Rehabilitation episode AND the patient is:** • **In a designated rehabilitation facility** • **In a designated rehabilitation unit** **Under a designated rehab program**
id	M	1	8	A/N	Value = **MORnnnnn** where n is numeric value in the range of 00001 – 00099 Non DRG Morbidity Id's must be valid, sequential, and unique starting from MOR00001	
ansnapClass	C	1	4	A/N	The AN-SNAP class to which the episode is assigned. AN-SNAP Class is only applicable to overnight episodes and must be reported as 4 characters. .	Mandatory when admissionFimScore>scoreCode or dischargeFIMScore>scoreCode or arocImpairmentCode or ansnapId or ansnapVersion are set AN-SNAP (Insurer) data item 8 AN-SNAP (Hospital) data item 16
ansnapId	C	1	15	A/N	A unique identifier for the AN-SNAP record that links it to the associated episode (and/or medical and prosthetic records). It is a combination of the Medical Record Number (in the Episode record) hyphen and a record number (sequential counter)	Mandatory when admissionFimScore or dischargeFimScore or arocImpairmentCode or ansnapClass or ansnapVersion are set AN-SNAP (Insurer) data item 2 AN-SNAP (Hospital) data item 3
ansnapVersion	M	1	2	A/N	The version of the AN-SNAP Classification used to report ansnapClass. 02 = AN-SNAP Version 2 03 = AN-SNAP Version 3 04 = AN-SNAP Version 4 05 = AN-SNAP Version 5	Mandatory when admissionFimScore>scoreCode or dischargeFIMScore>scoreCode or arocImpairmentCode or ansnapClass or ansnapId are set AN-SNAP (Insurer) data item 9

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website.	AN-SNAP (Hospital) data item 17
arocImpairmentCode	C	1	7	A/N	The Impairment code that best describes the primary reason for admission to the rehabilitation episode. Decimal point to be supplied. Format = XX.YYYY First two digits represent the impairment group, followed by a decimal point and then up to four digits that represent specific categories within the impairment group. If the ARIC Impairment group is only 1 digit, only send 1 digit. The AROC Impairment Category should be zero filled if is less than 4 digits. XX = the impairment group one or two numerics in the range 1-99 (leading zeros are not accepted). YYYY = specific categories within the impairment group one to four numerics in the range 0000-9999.	Mandatory when admissionFimScore>scoreCode or dischargeFimScore>scoreCode or ansnapClass or ansnapVersion are set AN-SNAP (Insurer) data item 6 AN-SNAP (Hospital) data item 14
casemixCode	O	1	11	A/N	Currently not used	
casemixCodeTypeCode	M	1	1	A/N	The non DRG casemix classification Current values are: **S** = sub/non-acute inpatient classification AN-SNAP.	
modeOfEpisodeEndInpatient	C	1	1	N	Where the patient went to at the end of their inpatient rehabilitation episode. There are two broad categories: Back into the community, Remain in the hospital system. Permissible values: 1 = Discharged to final accommodation 2 = Discharged to interim accommodation 3 = Death 4 = Discharged/Transferred to another hospital 5 = Care type change and transferred to a different ward 6 = Care type change and remained on same ward 7 = Change of care type within sub-acute/non-acute care 8 = Discharged at own risk 9 = Other and unspecified Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website.	Must not be set if sameDayCode =1 or 9 AN-SNAP (Insurer) data item 13 AN-SNAP (Hospital) data item 19
modeOfEpisodeStartInpatient	C	1	1	N	Where the patient came from when the inpatient rehabilitation episode started 1 = Admitted from usual accommodation 2 = Admitted from other than usual accommodation 3 = Transferred from another hospital	Must not be set if sameDayCode =1 or 9 AN-SNAP (Insurer) data item 12AN-SNAP (Hospital) data item 18

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					4 = Transferred from acute care in another ward 5 = Transferred from acute speciality unit 6 = Change from acute care to sub/non-acute care same ward 7 = Change of sub/non-acute care type 8 = Other 9 = Recommenced rehabilitation following suspension Current values are listed. These are subject to change, for a list of the most current values refer to the Department of Health website.	
admissionFimScore	**C**				**The FIM score on admission for each of the 18 FIM motor and cognition items. Each of the 18 items has a maximum score of 7 and a minimum score of 1** Scores are 7 – Complete independence (No helper) 6 – Modified Independence (No helper) 5 – Supervision or set up (Helper) 4 – Minimal Assistance (Helper) 3 – Moderate Assistance (Helper) 2 – Maximal Assistance (Helper) 1 – Total Assistance (Helper) **admissionFimScore is nested under nonDRGMorbidity**	Mandatory when CID sameDayCode = 2 (Overnight Patient) and when dischargeFIMScore>scoreCode or arocImpairmentCode, or ansnapClass or ansnapId or ansnapVersion are set
scoreCode	C	18	1	N	The 18 individual codes are score values for 1 = Eating 2 = Grooming, 3 = Bathing, 4 = Dressing - Upper Body, 5 = Dressing - Lower Body, 6 = Toileting, 7 = Bladder Management, 8 = Bowel Management, 9 = Transfer - bed/chair, 10 = Transfer – toilet, 11 = Transfer - tub, 12 = Walk/wheelchair 13 = Stairs, 14 = Comprehension, 15 = Expression, 16 = Social interaction 17 = Problem solving, 18 = Memory	Based on contractual arrangements AN-SNAP (Insurer) data item 4 AN-SNAP (Hospital) data item 12

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
dischargeFimScore	**C**	**18**	**1**	**N**	**The FIM score on discharge for each of the 18 FIM motor and cognition items. Each of the 18 items has a maximum score of 7 and a minimum score of 1.** Scores are 7 – Complete independence (No helper) 6 – Modified Independence (No helper) 5 – Supervision or set up (Helper) 4 – Minimal Assistance (Helper) 3 – Moderate Assistance (Helper) 2 – Maximal Assistance (Helper) 1 – Total Assistance (Helper) **dischargeFIMScore nested under nonDRGMorbidity**	**Mandatory when CID sameDayCode = 2 (Overnight Patient) and when admissionFimScore or arocImpairmentCode, or ansnapClass or ansnapId or ansnapVersion are set**
scoreCode	C	18	1	N	The 18 individual codes are score values for 1 = Eating 2 = Grooming, 3 = Bathing, 4 = Dressing - Upper Body, 5 = Dressing - Lower Body, 6 = Toileting, 7 = Bladder Management, 8 = Bowel Management, 9 = Transfer - bed/chair, 10 = Transfer – toilet, 11 = Transfer - tub, 12 = Walk/wheelchair 13 = Stairs, 14 = Comprehension, 15 = Expression, 16 = Social interaction 17 = Problem solving, 18 = Memory	Based on contractual arrangements AN-SNAP (Insurer) data item 5 AN-SNAP (Hospital) data item 13

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Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
certificate	**C**	**99**			**The CER segment is used to notify the collection of relevant certificate information needed to support the claim.** **certificate is nested under claim**	**Based on contractual arrangements**
id	M	1	8	A/N	Value = CERnnnnn where n is numeric value in the range 00001 – 00099 Certificate Id's must be valid, sequential, and unique starting from CER00001	
fromDate	M	1	8	D	CCYYMMDD. The starting date the certificate covers.	Cannot be after the To Date in Certificate segment.
issueDate	M	1	8	D	CCYYMMDD. The date the certificate was issued.	Must not be a date in the future.
issuerName	C	1	40	A/N	The name of the certifying provider. Only alpha and numeric characters, spaces, apostrophes and hyphens are acceptable. Spaces must not appear before or after apostrophes, hyphens and other spaces or the supplied values.	Must be set if typeCode = 3B and providerNumber is blank
numberOfDays	C	1	4	N	The number of days that the certificate covers. 1-9999. Leading zeros are not accepted	Mandatory if certificate typeCode = 3B and contractual arrangements with Health Funds.
providerNumber	C	1	8	A/N	The provider number of the certifying provider. Practitioner provider number must be Services Australia issued. Stem + Location + Check Digit.	Mandatory if typeCode = 3B and the provider has a providerNumber
text	C	1	500	ANS	Free form text regarding the certificate. The value must contain at least one alpha or numeric character. Spaces must not appear before or after other spaces or the supplied value.	Mandatory if typeCode = 3B, OT & C
toDate	C	1	8	D	The last date that the certificate covers. CCYYMMDD Must be equal to or later than fromDate	Conditional on TypeCode and contractual arrangements with Health Funds.
typeCode	M	1	2	A/N	The type of certificate issued. This list will be health fund driven and may change after industry consultation. **Note**: For all DVA claims a current type code certificate value is required as part of the claim. Current values are: B = Type B C = Type C 3B = Nursing Home Type Patient (Acute Care);	

					PS = Psychiatric RE = Rehabilitation NE = Neonate CC = Critical care AC = Accident. HC =Home Care IC = Intensive Care WC = Wound Care SU = Special Unit EL = Election Form PE = PEA Certificate OS = Overseas Certificate NS = Non schedule 5 prosthesis SP = Spinal surgery/neuro complex LY = Lymphoedema DE =Dental MU = Multiple Admission (Chemotherapy and Dialysis) DO = Day only for Dialysis RD = Rehabilitation Discharge/Separation AD = Ambulatory Discharge/Separation ED = Early Discharge/Separation EX = Expected Date of confinement EC = Emergency Caesar FL = Failed Labour MB = Mother and Baby OO = Obstetric Outlier AE = Antenatal Education OU = Outlier DR = Exceptional Drug (non HPPA medication) OT = Other If typeCode = 3B then providerNumber or issuerName must be set Refer to the PHA website for the list of valid codes.	

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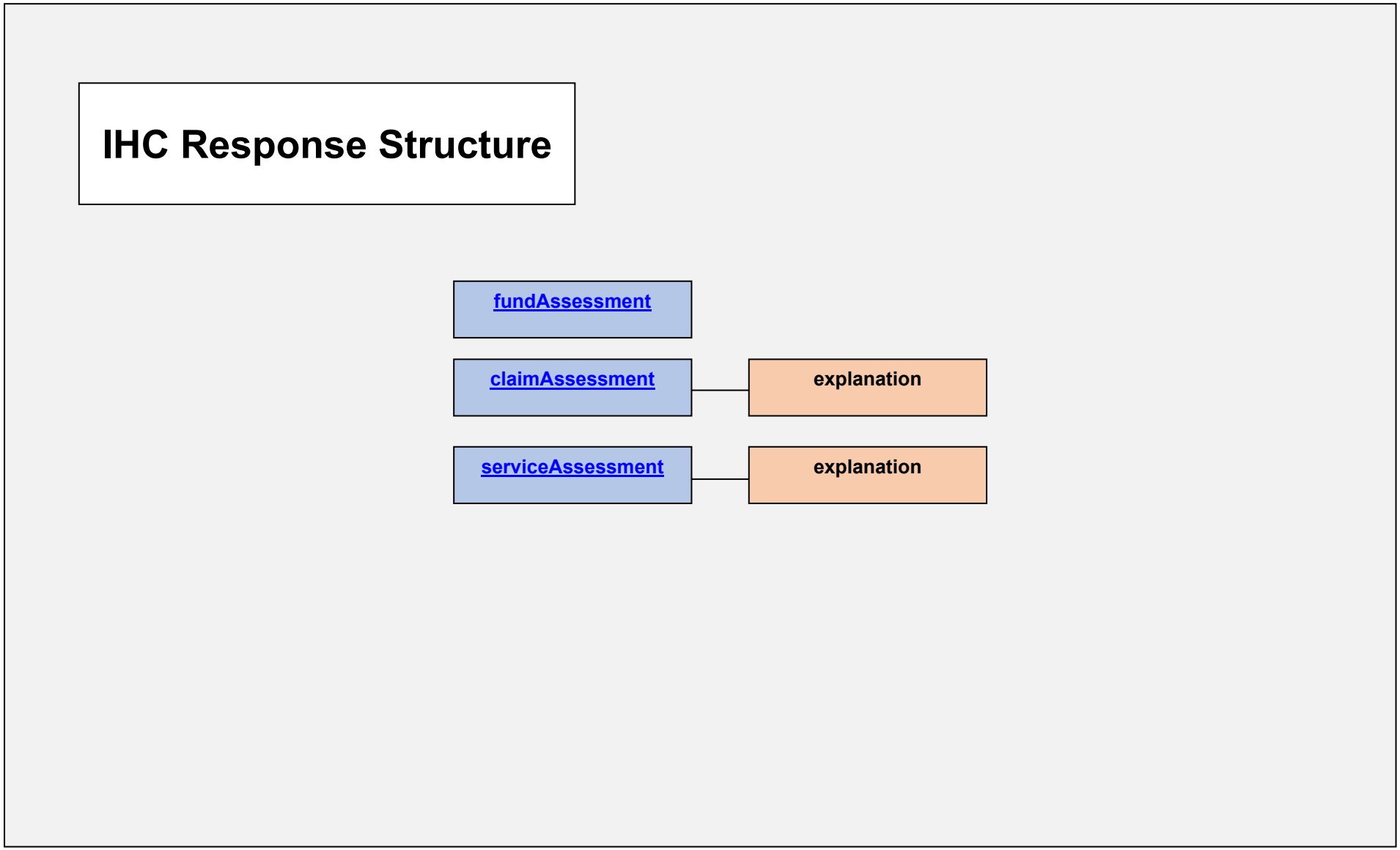
Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
medical	**C**	**99**			**This is currently not used by industry. The MED segment is used for the collection and submission of doctor's charges for in-patient services. medical is nested under claim**	**This is currently not used by industry. For medical or Allied Health Service Providers. Mandatory if totalMedicalChargeAmount is > $0.00**
id	M	1	5	A/N	Value = MEDnnnnn where n is numeric value in range of 00001 – 00099 Medical Id's must be valid, sequential, and unique starting from MED00001	
chargeAmount	M	1	9	N	0 - 999999999 - cents. Leading zeros are not accepted Where there is a zero charge, chargeRaisedCode must equal' I' The amount charged for the item in cents.	
chargeRaisedCode	M	1	1	A/N	C = Charge Raised I = Information only Must be set to I if chargeAmount = 0 Indicates if a charge has been raised or has been supplied for information only.	
payeeProvider	O	1	8	A/N	May not be a 'Medicare' provider number The provider number of the practitioner where the payment is to be directed, other than the servicing provider.	
serviceCode	M	1	11	A/N	The code of the service being charged.	
serviceCodeTypeCode	M	1	1	A/N	C = MBS .	
serviceDate	M	1	8	D	CCYYMMDD The date that the service was rendered to the patient.	
servicingProviderName	M	1	40	A/N	The name of the Servicing provider.	
servicingProviderNumber	M	1	8	A/N	May not be a 'Medicare' provider number The provider number for the medical practitioner rendering the service(s) (as allocated by Service Australia).	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
remarks	**C**	**99**			**The REM segment allows for the collection of free format text that may be needed for the processing of the claim.** **Remarks is nested under claim**	**Based on contractual arrangements**
id	M	1	8	A/N	Value = **REMnnnnn** where n is numeric value in the range of 00001 – 00099 Remarks Id must be valid, sequential, and unique starting from REM00001	
Text	M	1	500	A/N	Free form text to assist in the processing of the claim.	

ECLIPSE Data Dictionary – Hospital Claim Response



ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
fundAssessment	**M**	**1**				
accountReferenceId	M	1	20	A/N	Account Reference Id as submitted on the original claim	
assessmentCode	M	1	1	A	A = Accepted R = Rejected I = Information Only The assessment status of a claim on its return to the Hub from the private health insurer.	
coPaymentAmount	C	1	9	N	The total co-payment amount deducted from the claim (00000000 – 999999999 cents) Zero is an acceptable value	Mandatory if Claim Fund assessment Code = A
excessAmount	C	1	9	N	The total excess amount deducted from the claim (00000000- 999999999 cents). Zero is an acceptable value	Mandatory if Claim Fund assessment Code = A
facilityId	M	1	8	A/N	Facility Id as submitted on the original claim A unique identifier of a Registered Hospital or Day Care Facility.	
organisation	M	1	3	A	Fund Brand Id submitted on the original claim	
totalBenefitAmount	C	1	9	N	This is the total benefit payable after excess and co-payments have been deducted. This amount will equal the amount on the fund remittance advice (000000000 – 999999999 cents). Zero is an acceptable value	Mandatory if Claim Fund assessment Code = A. Equals the sum of the fundBenefit amount for each Service assessment.
totalChargeAmount	C	1	9	N	Total Charge amount in the CID segment in cents. (000000000 – 999999999 cents). Leading zeros are not accepted	Mandatory where fundAssessment>Code = A or R.
accommodationBenefit	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted The gross benefit paid by the Insurer for accommodation including ex-gratia benefits.	For future use to facilitate HCP data collection.
ancillaryBenefits	O	1	9	N	The total benefits paid by the Insurer for in hospital goods and services claimed under an ancillary table Value 0 -999999999 in cents. Leading zeros not accepted The total benefits paid by the Insurer for in-hospital goods and services claimed under an ancillary table.	For future use to facilitate HCP data collection
ancillaryCharges	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted	For future use to facilitate HCP data collection

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					The total charges raised for in-hospital benefits and claimed under an ancillary table.	
ancillaryCoverStatus	O	1	1	A	Y = patient has ancillary cover N= patient does not have ancillary cover An indicator of whether a patient has ancillary insurance cover at the time of admission.	For future use to facilitate HCP data collection
bundledBenefits	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted Gross bundled benefits paid by the Insurer including ex-gratia bundled benefits.	For future use to facilitate HCP data collection
coronaryCareUnitBenefits	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted The gross benefits paid by the Insurer for CCU including ex gratia CCU benefits.	For future use to facilitate HCP data collection
fundReferenceId	O	1	15	ANS	Identifier of the claim at the fund	
frontEndDeductible	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted The amount of front-end deductible (excess) deducted from the benefit, otherwise payable by the Insurer to the Hospital.	For future use to facilitate HCP data collection
hospitalContractStatus	O	1	1	A	Y = a hospital with which an insurer has a contract N = a hospital with which the insurer does not have a contract T = a hospital is paid under 2nd tier benefit arrangement B = a hospital is paid under a Bulk payment arrangement The payment arrangement that the insurer has with the hospital.	For future use to facilitate HCP data collection
hospitalInTheHomeCareBenefits	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted The gross benefits paid by the Insurer for hospital-in-the-home care services including ex-gratia and HITH patient portion charges.	For future use to facilitate HCP data collection
intensiveCareUnitBenefit	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted Intensive Care Unit (ICU) gross benefit paid by Insurer.	For future use to facilitate HCP data collection
labourWardBenefit	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted The gross benefit paid by the Insurer to the Hospital for labour ward including ex-gratia benefits paid.	For future use to facilitate HCP data collection
otherBenefits	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted	For future use to facilitate HCP data collection

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
					The gross benefit paid by Insurer for any chargeable item which cannot be specifically categorised elsewhere excluding ex-gratia benefits, television, phone calls, extra meals, FED, reversals or journal adjustments.	
personIdentifier	O	1	21	AN	This is the insurer-specific person identifier unique within a Fund regardless of any change in membership	
pharmacyBenefit	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted Gross benefit paid by Insurer for pharmacy, including ex-gratia pharmacy charges and excluding discharge medications.	For future use to facilitate HCP data collection
productCode	O	1	8	A	The product code for the patient's insurance cover at admission.	For future use to facilitate HCP data collection
prosthesisBenefit	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted Gross maximum benefit paid by Insurer for prosthesis including ex-gratia, handling fees and prosthesis benefits.	For future use to facilitate HCP data collection
specialCareNurseryBenefits	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted The gross benefit paid by the Insurer for SCN including ex-gratia SCN benefits and excluding NICU benefits paid.	For future use to facilitate HCP data collection
theatreBenefit	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted The gross benefit paid for a theatre/procedure room/angiography suite including ex-gratia theatre benefit.	For future use to facilitate HCP data collection
totalDaysPaid	O	1	4	N	Value 0 -9999. Leading zeros not accepted Total number of days for which the Fund paid benefits including days paid as a Nursing Home Type Patient	For future use to facilitate HCP data collection
totalProstheticItemBenefit	O	1	9	N	Value 0 -999999999 in cents. Leading zeros not accepted Total benefit for the prosthesis item (excluding any handling fees)	For future use to facilitate HCP data collection

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
claimAssessment					**claimAssessment nested under fundAssessment**	
elementName	O		50	AN	Details for the data element responsible for the claim rejection	
mesagePartId	O		8	A/N	Details the IHC segment being reported on. Identifies the segment which is in error Must be either three Alpha or eight alpha numeric characters with the first three alpha and last 5 numeric ie PAT, EPD ACD00001	
explanation	**C**			**Rep Group**	**This segment details the errors encountered during the validation of the incoming message by the fund, or to supply additional information regarding the delayed processing of a claim.**	**Mandatory where fundAssessment = R or I**
code	M	1	4	N	An industry defined set of explanation codes Value 1 – 4 characters long.	
text	M	1	80	A/N	An industry defined set of text assigned to the explanation codes.	

ECLIPSE Hospital Claim Data Dictionary

Data Element Name	Oblig	Rpt	Size	Format	Comment	Condition
serviceAssessment	**C**			**Rpt Group**	**This segment displays details of the fund assessment. serviceAssessment is nested under FundAssessment**	**Mandatory where Claim Fund Assessment Code = A**
chargeAmount	C	1	9	N	The charge amount as worked out by the fund (000000000 – 999999999 cents) Leading zeros not accepted	Industry agreement to always supply Based on contractual arrangement
code	C	1	11	A/N	For example, MBS item, prosthetic item etc	Industry agreement to always supply Based on contractual arrangement
description	M	1	80	ANS	The description of the service	
fromDate	C	1	8	Date	CCYYMMDD Populated with the date from for the accommodation>fromDate Must be set if toDate is set	
toDate	C	1	8	Date	CCYYMMDD Populated with the date to for the accommodation>toDate Must be set if fromDate is set	
fundBenefit	M	1	9	N	Total benefits paid for the service level This is the benefit payable after excess and co-payments have been deducted. (000000000 – 999999999 cents) Leading zeros are not accepted	
numberOfServices	O	1	3	N	Identifies the number of services.	
serviceDate	C	1	8	Date	CCYYMMDD Must be provided if date from is not set	Mandatory if fromDate is blank
explanation	**O**			**Rpt Group**	**This segment displays explanations (if required) of the service line assessment. Note you can have multiple occurrences of this segment per fund service level records.** **Explanation is nested under serviceAssessment**	**Where the Fund has reduced the normal benefit payable an explanation will be supplied.**
code	M	1	4	N		
text	M	1	80	A/N		