nzhis

New Zealand Health Information Service

NATIONAL MINIMUM DATASET
(HOSPITAL EVENTS)

DATA DICTIONARY

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MINISTRY OF
HEALTH

MANATŪ HAUORA

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New Zealand Health Information Service

The New Zealand Health Information Service (NZHIS) is a group within the Ministry of Health responsible for the collection and dissemination of health-related data. NZHIS has as its foundation the goal of making accurate information readily available and accessible in a timely manner throughout the health sector. The vision of NZHIS is to be recognised as a leader in the provision of health information services, and to support the health sector's ongoing effort to improve the health status of New Zealanders.

Reporting environments

Reporting environments such as Business Objects and data extracts will not necessarily contain all data described in this Data Dictionary.

Publications

A complete list of NZHIS's publications is available from New Zealand Health Information Service, PO Box 5013, Wellington, or via NZHIS's web site at http://www.nzhis.govt.nz.

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Introduction

Basis   This revised dictionary builds on the information that was previously published each year in the National Minimum Dataset (NMDS) Data Dictionary.

Objectives   The objectives of the New Zealand Health Information Service (NZHIS) Data Dictionaries are to:

- describe the information available within the National Collections
- promote uniformity, availability and consistency across the National Collections
- support the use of nationally agreed protocols and standards wherever possible
- promote national standard definitions and make them available to users.

It is hoped that the greater level of detail along with clear definitions of the business rules around each element will assist with providing and using the data.

Audiences   The target audiences for NZHIS Data Dictionaries are data providers, software developers, and data users.

New format   All data element definitions in the NZHIS Data Dictionaries are presented in a format based on the Australian Institute of Health and Welfare National Health Data Dictionary. This dictionary is based on the ISO/IEC Standard 11179 *Specification and Standardization of Data Elements*—the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission.

The format is described in detail in Appendix A of this dictionary.

Changes to dictionary format   A more rigorous approach to recording changes in the data elements has been introduced in these dictionaries along with background material on the features of time-series data for each element.

In summary, the changes to the data dictionaries include:

- standardisation of the element names so that, for instance, a healthcare user's NHI number is referred to as NHI number in all collections
- elements are listed alphabetically within each table, and the tables are organised alphabetically
- each table is described
- verification rules, historical information, and data quality information are included
- alternative names for the elements are listed
- information about how the data is collected is given
- related data, and references to source documents and source organisations are included
- an alphabetical index is included
- code tables are included with the element, or a reference given to the NZHIS web site (for large or dynamic code tables).

Table of Contents

National Minimum Dataset (Hospital Events) (NMDS)

Scope	**Purpose**
	The NMDS is used for policy formation, performance monitoring, research, and review. It provides statistical information, reports, and analyses about the trends in the delivery of hospital inpatient and day patient health services both nationally and on a provider basis. It is also used for funding purposes.
	Content
	The NMDS is a national collection of public and private hospital discharge information, including clinical information, for inpatients and day patients. Unit record data is collected and stored. All records must have a valid NHI number.
	Data has been submitted electronically in an agreed format by public hospitals since 1993.
	The private hospital discharge information for publicly funded events, eg, birth events and geriatric care, has been collected since 1997. Other data is being added as it becomes available electronically.
Start date	The current NMDS was introduced in 1999. The original NMDS was implemented in 1993 and back-loaded with public hospital discharge information from 1988.
Guide for use	The NMDS has undergone many changes over the years. Some data subsets have been removed and are now held in separate collections (Cancer Register and the Mortality Collection). In other cases, additional fields have been included and events are reported in more detail than in the past. For further details refer to the NMDS Data Dictionary.
	Private hospital information is also stored in the NMDS. Publicly funded events (primarily maternity and geriatric) and surgical events from some hospitals are up-to-date. Privately funded events may be delayed.
Contact information	For further information about this collection or to request specific datasets or reports, contact the NZHIS Analytical Services team on ph 04 922 1800, fax 04 922 1897, or e-mail inquiries@nzhis.govt.nz, or visit the NZHIS web site www.nzhis.govt.nz.
Collection methods – guide for providers	Data is provided by public and the larger private hospitals in an agreed electronic file format. Paper forms and a cut-down electronic file format are also forwarded by other private hospitals.
Frequency of updates	Publicly funded hospital events are required to be loaded into the NMDS within 21 days after the month of discharge. Electronic files are received and processed almost every day at NZHIS.
	NZHIS has a team of staff who manually process private hospital electronic and paper reports.

Agency table

Table name:	Agency table

Name in database: agency_tab   ***Version:*** 1.0   ***Version date:*** 01-Jan-2003

Definition: Stores details of organisations, institutions or groups of institutions that contract directly with the principal health service purchaser to deliver healthcare services to the community.

Guide for Use: This is a reference table and is not updated via agencies' datafeeds. It is maintained internally by NZHIS.

The publicly funded secondary healthcare entities listed in this table have changed since the table was introduced. Initially the agencies were Crown Health Enterprises (CHEs), then Hospital and Health Services (HHSs), and now District Health Boards (DHBs).

The table also contains non-government organisations, private hospitals, and any organisation that reports or connects to NZHIS data collections, including organisations that deliver clinical, statistical and other services.

An agency may be omitted from the table for a number of reasons: the agency may not have been added yet; name changes are not always included in the table; the published table may not contain all agencies; or the agency may not have given its details to NZHIS. The table is continually updated. For the most recent version of the table, see the NZHIS web site http://www.nzhis.govt.nz.

An agency may have a number of:
- facilities (eg, hospitals), and
- mental health services teams (eg, alcohol and drug teams, acute inpatient mental health teams.

This table is common to many of the data collections at NZHIS.

Primary Key: Agency code

Business Key:

Relational Rules:

Agency address

Administrative status

Reference ID: A0139   ***Version:*** 1.0   ***Version date:*** 01-Jan-2003

Identifying and defining attributes

Name:	Agency address
Name in database:	agency_address
Other names:	
Element type:	Data element
Definition:	The postal address of the agency.
Context:	

Relational and representational attributes

Data type: varchar   ***Field size:*** 85   ***Layout:*** Free text

Data domain:

Guide for use:

Verification rules:

Collection method: Collected when the Agency code is assigned. Agencies are required to notify NZHIS of any change of address.

Related data:

Administrative attributes

Source document:

Source organisation:

Agency closing date

Administrative status

Reference ID: A0141

Version: 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Agency closing date

Name in database: agency_close_date

Other names: Health agency closing date

Element type: Data element

Definition: The date on which the agency closed.

Context:

Relational and representational attributes

Data type: datetime *Field size:* *Layout:* CCYYMMDD

Data domain: Valid dates

Guide for use: Some of these dates are estimated.

Verification rules:

Collection method: Agencies are required to notify NZHIS of their closing dates.

If agencies merge, a new code may be assigned or the new agency can negotiate with NZHIS to maintain the existing codes. When codes are retired, an agency closing date is recorded.

NZHIS allocates codes on request.

Related data:

Administrative attributes

Source document:

Source organisation:

Agency code

Administrative status

Reference ID: A0138   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Agency code
Name in database: agency_code
Other names: Health agency code, DHB
Element type: Data element
Definition: A code that uniquely identifies an agency. An agency is an organisation, institution or group of institutions that contracts directly with the principal health service purchaser to deliver healthcare services to the community.
Context:

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 4   *Layout:* XXXX
Data domain: See the Agency code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use: Historically, also known as CHE (Crown Health Enterprise), HHS (Hospitals and Health Services) and AHB (Area Health Board).

Between 1988 and 1993 the Agency code was assigned based on the original 1993 agency groupings.

If the facility on an event does not belong to the agency, it means that the agency has contracted a facility belonging to a different agency to treat the patient.

Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Data Access Policy on the NZHIS web site at http://www.nzhis.govt.nz/access/index.html.
Verification rules: Must be a valid code in the Agency code table.
Collection method: This is a key field for allocating purchase units.

If agencies merge, a new code may be assigned or the new agency can negotiate with NZHIS to maintain the existing codes.

NZHIS allocates codes on request. The code table is continually updated by NZHIS as hospitals open and close. See the NZHIS web site for the most recent version.
Related data:

Administrative attributes

Source document:
Source organisation: NZHIS

Agency name

Administrative status

Reference ID:　　A0137　　　　　　　　　　　　　　　*Version:* 1.0　　*Version date:* 01-Jan-2003

Identifying and defining attributes

Name:　　　　　　　Agency name

Name in database:　agency_name

Other names:　　　　Health agency name

Element type:　　　Data element

Definition:　　　　　The name of the agency.

Context:

Relational and representational attributes

Data type:　　　　　varchar　　　　*Field size:* 50　　　　*Layout:* Free text

Data domain:

Guide for use:　　　If an agency changes its name, NZHIS will update the table and a new code is not necessarily assigned. That is, the table reflects the current names, and historical data is not retained.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Agency opening date

Administrative status

Reference ID: A0140   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Agency opening date

Name in database: agency_open_date

Other names: Health agency opening date

Element type: Data element

Definition: The date on which the agency opened for business.

Context:

Relational and representational attributes

Data type: datetime   *Field size:*   *Layout:* CCYYMMDD

Data domain: Valid dates

Guide for use: Some of these dates are estimated.

Verification rules:

Collection method: Agencies are required to notify NZHIS of their opening dates.

Related data:

Administrative attributes

Source document:

Source organisation:

Agency type code

Administrative status

Reference ID: A0142   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Agency type code

Name in database: agency_type

Other names: Health agency type code

Element type: Data element

Definition: A code that categorises agencies into particular types.

Context:

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:* NN

Data domain: 01   District Health Board
                    02   Community Trust
                    09   Health Centres
                    10   Private Health Group
                    11   Cancer Screening Programme
                    12   Other publicly funded agency
                    13   Charitable trust or incorporated society
                    14   Other non-governmental agency

Guide for use: To analyse data relating to DHBs, use only records with an Agency type code of '01'. To analyse data relating to NGOs, use all other records.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Region of agency of treatment

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Region of agency of treatment
Name in database: region
Other names:
Element type: Derived data element
Definition: The former region of the central funding authority in which the agency is located.
Context:

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:* NN
Data domain: 01   HFA Northern region
                    02   HFA Midland region
                    03   HFA Central region
                    04   HFA Southern region
Guide for use: Created from NZHIS internal mapping.

                    For historical use only. The Health Funding Authority no longer exists.
Verification rules:
Collection method:
Related data:

Administrative attributes

Source document:
Source organisation:

Clinical Code table

Table name:	Clinical Code table
Name in database:	clinical_code_tab

Version: 1.1   ***Version date:*** 15-Mar-2004

Definition:
A repository of all codes contained in:
- ICD-9-CM-A 2nd Edition - Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition
- ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition
- ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition
- ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition
- ICD-O - The International Classification of Diseases for Oncology
- ICD-O-2 - International Classification of Diseases for Oncology, 2nd edition
- ICD-O-3 - International Classification of Diseases for Oncology, 3rd edition
- DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.

It also contains procedures for ICD-10-AM 1st and 2nd Editions Medical Benefits Schedule - Extended (MBS-E), which were established by the Australian Institute of Health and Welfare for payment systems.

The table contains a number of editing flags that record the attributes of each code.

Guide for Use:	A validation table.
Primary Key:	Clinical code, Clinical code type, Clinical coding system ID
Business Key:	Clinical code, Clinical code type, Clinical coding system ID
Relational Rules:	Diagnosis Procedure table

Block

Administrative status

Reference ID: ***Version:*** 1.0   ***Version date:*** 01-Jan-2003

Identifying and defining attributes

Name:	Block
Name in database:	block
Other names:	
Element type:	Data element
Definition:	The block number is a 4-digit code that groups procedure codes together.
Context:	

Relational and representational attributes

Data type:	char ***Field size:*** 4 ***Layout:***
Data domain:	
Guide for use:	This is a new field for ICD-10-AM that was not in ICD-9-CM-A.

Procedure codes in the coding books are organised on an anatomical basis, so the procedure code number is not in sequential order. To facilitate location of a procedure code this additional numbering system has been introduced.

Each procedure code has an associated block number. One block number relates to one or more procedure codes. A list of block numbers and their descriptions is available from NZHIS on request.

Only procedure codes (Clinical code type = O) have block numbers. This field is blank for other types of codes.

Verification rules:	
Collection method:	
Related data:	

Administrative attributes

Source document:

Source organisation: National Centre for Classification in Health, University of Sydney, Australia

Category

Administrative status

Reference ID: *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: Category

Name in database: category

Other names:

Element type: Data element

Definition: A code that groups ICD codes together at the 3-character level.

Context:

Relational and representational attributes

Data type: char   *Field size:* 6   *Layout:*

Data domain:

Guide for use: Contains the first 3 characters of the Clinical code.

From ICD-10-AM 1st Edition onwards, all codes have Category numbers except for procedure codes. A list of Category codes and their descriptions is available from NZHIS on request.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation: National Centre for Classification in Health, University of Sydney, Australia

Chapter

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Chapter

Name in database: chapter

Other names:

Element type: Data element

Definition: A grouping of ICD codes into chapters, for example, pregnancy, cancer, mental health.

Context:

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:*

Data domain:

Guide for use: These are the chapter headings in the ICD classification manuals. Every Clinical code except for procedures is included in a chapter.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Clinical code

Administrative status

Reference ID: A0124   *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: Clinical code

Name in database: clinical_code

Other names: Diagnosis/procedure code

Element type: Data element

Definition: A code used to classify the clinical description of a condition.

Context: Clinical information within a health event.
                      Includes codes for diagnosis, injury, cause of intentional and unintentional injury, and procedure
                      performed.

Relational and representational attributes   *Mandatory*

Data type: varchar   *Field size:* 8   *Layout:* See Collection method.

Data domain: Must be a valid code in one of the following systems:
                  - ICD-9-CM-A 2nd Edition – Australian Version of the International Classification of Diseases, 9th
                  Revision, Clinical Modification, 2nd Edition
                  - ICD-10-AM 1st Edition – The International Statistical Classification of Diseases and Related Health
                  Problems, 10th Revision, Australian Modification, 1st Edition
                  - ICD-10-AM 2nd Edition – The International Statistical Classification of Diseases and Related Health
                  Problems, 10th Revision, Australian Modification, 2nd Edition
                  - ICD-10-AM 3rd Edition – The International Statistical Classification of Diseases and Related Health
                  Problems, 10th Revision, Australian Modification, 3rd Edition
                  - DSM-IV – Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.

Guide for use: Depending on the context, this is also known as Diagnosis/procedure code (external cause), and
                  Morphology code.

                  From 1 July 1995, this field contains the Clinical code as supplied by the provider.

                  ICD-9-CM (TO 30 JUNE 1995)
                  In ICD-9-CM all codes have at least 3 digits and most have 4 or 5. Standard practice was to use a filler
                  4th digit of '9' for codes with only 3 digits and for codes which have a 5th digit but no 4th digit.

                  ICD-9-CM-A (1 JULY 1995 ONWARDS)
                  In 1995 codes were mapped to ICD-9-CM-A, and the place of occurrence, which had been separate,
                  was mapped onto the 5th digit of the E code.

                  Also, codes that only had 3 digits no longer required a filler digit: the fields for 4th and 5th digits could
                  be left blank. ICD-9-CM-A codes which had a 5th digit but no 4th digit could have a filler 4th digit of '0'
                  (zero) entered.

                  E codes were mandatory for codes between 800 and 999. The location field and code E849 were not
                  used. Instead, the digit to indicate place of occurrence of external cause of injury was recorded as the
                  5th digit for the following ranges of 4 digit 'E' codes: E810-E829, E846-E848, E850-E869, E880-E928,
                  E950-E958, E960-E968, E980-E988.

                  ICD-10-AM 1ST EDITION (1 JULY 1999 ONWARDS)
                  In ICD-10-AM, codes V01 to Y98 were used to classify environmental events and circumstances as
                  the external cause of injury, poisoning and other adverse effects. (It was intended that the nature of
                  the condition would be indicated separately using the appropriate code, usually codes between S00
                  and T98.)

                  1. Place of Occurrence Code
                  The following 4th-character subdivisions of the external cause code were used with categories W00 to
                  Y34 (except Y06 and Y07) to identify where the external cause occurred:
                  0 = home
                  1 = residential institution
                  2 = school, other institution, and public administrative area
                  3 = sports and athletics area
                  4 = street and highway
                  5 = trade and service area

6 = industrial and construction area
7 = farm
8 = other specified places
9 = unspecified place

2. Activity Code
The following 5th-character subdivision of the external cause code was used with categories V01 to Y34 to indicate the activity of the injured person at the time the event occurred. (This subclassification was used in addition to the 4th-character subdivisions indicating place of occurrence of events classifiable to W00-Y34.)
0 = while engaged in sports activity
1 = while engaged in leisure activity
2 = while working for income
3 = while engaged in other types of work
4 = while resting, sleeping, eating or engaging in other vital activities
8 = while engaged in other specified activities
9 = during unspecified activity

3. Example of the external cause code, place of occurrence and activity code:
Diagnosis type allocated by provider system - Description - ICD-10-AM code
A - # L shaft tibia and fibula, closed - S82.21
B - Laceration L elbow - S51.0
B - Contusion scalp - S00.05
O - Closed reduction of # tibia and fibula - 47564-00
E - Tripped over hose while gardening at home - W01.03*

* The 4th character represents 'home' as place of occurrence; the 5th character represents 'gardening' as activity.

Notes:
1. From July 1999 both ICD-9-CM-A and ICD-10-AM 1st Edition are recorded. From July 2001, ICD-10-AM 2nd Edition is recorded. From July 2004, ICD-10-AM 3rd Edition is also recorded, ie, the clinical code is stored in all versions.
2. Clinical codes are reported without decimal points or hyphens. The formats above are how the codes appear in the coding manual.

Verification rules: Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.

Demographic and administrative data (eg, Sex, Date of birth, Event end type) is checked to ensure it is consistent with the Clinical code, as specified by the editing flags held against each Clinical code on the Clinical Code table.

Collection method: From ICD-10-AM 2nd Edition onwarrds, procedures are NNNNNNN, and diagnoses and injuries are ANNNN. In ICD-9-CM-A, procedures are NNNN, and all diagnoses except supplementary conditions are NNNNN.

Since 1 July 2004, the current ICD version is ICD-10-AM 3rd Edition.

Up to 99 diagnosis/procedure codes may be provided. No decimal points or extra characters should be included in the Clinical codes, for example, the ICD-10-AM 2nd Edition code 30496-02 should be sent as 3049602.

In the context of cancer patients, the NMDS will accept only the first four digits of morphology diagnosis codes. From 1 July 2000, morphology code M9990 will no longer be accepted: M8000 should be used instead.

EXTERNAL CAUSES OF MORBIDITY
An external cause code is mandatory with codes from S00 to T98, as well as for Z03.6 and Z04.1-Z04.5.

Place of occurrence and activity have unique codes rather than using 4th and 5th character extensions as was done with ICD-10-AM 1st Edition:
- Y92 (Place of occurrence) codes should be assigned in addition to all external codes in the range V01-Y89.
- Y93 (Activity) codes should be assigned in addition to all external cause codes in the range V01-Y34.
Note: Accident date is optional for Y92 and Y93 codes.

The Event supplementary information field can be used to record additional information about the accident location.

Related data: Diagnosis/procedure description
Clinical coding system ID
Clinical code type
Diagnosis type

Administrative attributes

Source document: Refer to the Official NCCH Australian Version of ICD-9-CM-A, Second Edition, Volumes 1 to 4, and the International Classification of Diseases for Oncology (ICD-O) Version 2.

For ICD-10-AM, refer to ICD-10-AM, the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, Ist Edition (4 volumes), 2nd Edition (4 volumes) or 3rd Edition (5 volumes).

Source organisation: National Centre for Classification in Health, University of Sydney, Australia

Clinical code description

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Clinical code description

Name in database: clinical_code_description

Other names:

Element type: Data element

Definition: The description of the Clinical code.

Context:

Relational and representational attributes

Data type: varchar   *Field size:* 70   *Layout:* Free text

Data domain:

Guide for use: NZHIS's version of the long description of the Clinical code.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Clinical code type

Administrative status

Reference ID: A0125   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Clinical code type

Name in database: clinical_code_type

Other names:

Element type: Data element

Definition: A code denoting which section of the clinical code table the clinical code falls within.

Context: Clinical information.

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 1   *Layout:* A

Data domain: A   Diagnosis
                 B   Injury
                 D   DSM-IV
                 E   External cause of injury
                 M   Morphology (pathology)
                 O   Operation/procedure
                 V   Supplementary classification/health factors

Guide for use: Previously known as Clinical code table type.

                       This field is required to differentiate between different sections of the clinical code table. In ICD-9-CM-A code values could be repeated in different sections of the table. For example, '0101' is a diagnosis code as well as a procedure code.

Verification rules: Must be a valid code in the Clinical Code Type code table.

                       Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.

Collection method:

Related data: Clinical coding system ID
                       Diagnosis type
                       Clinical code

Administrative attributes

Source document:

Source organisation:

Clinical coding system ID

Administrative status

Reference ID: A0126   *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name:	Clinical coding system ID
Name in database:	clinical_code_system
Other names:	
Element type:	Data element
Definition:	A code identifying the clinical coding system used for diagnoses and procedures.
Context:	Clinical information.

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 2   *Layout:* NN

Data domain:
01   ICD-9
02   ICD-9-CM
03   Read
04   ICPC
05   Old AMR codes
06   ICD-9-CM-A
07   DSM IV (for MHINC only)
10   ICD-10-AM 1st Edition
11   ICD-10-AM 2nd Edition
12   ICD-10-AM 3rd Edition

Guide for use: Previously known as Diagnosis coding system code.

Code '03' (Read) is used for primary care and not reported in the NMDS.

Code '02' (ICD-9-CM) was used between 1988 and 1995. When code '06' (ICD-9-CM-A) was introduced, the database was mapped to this new code. From July 1999 data was submitted in either ICD-9-CM-A or ICD-10-AM 1st Edition, and mapped so that it was held in both systems. Data for code '02' no longer exists in the database.

Between 1 July 2001 and 30 June 2004, data was submitted in '11' (ICD-10-AM 2nd Edition) and mapped to ICD-9-CM-A and '10' (ICD-10-AM 1st Edition). All records in '10' continue to be mapped back to earlier classification versions where mappings exist.

From 1 July 2004 data is submitted in '12' (ICD-10-AM 3rd Edition) and mapped to '11' (ICD-10-AM 2rd Edition). Mappings from '11' to '10' and '10' or earlier classifications continues to be performed, where mappings exist.

Verification rules: Must be a valid code in the Clinical Coding System code table.

Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.

Collection method: From 1 July 2004 data should be submitted using ICD-10-AM 3rd Edition, that is, the Clinical coding system ID should be '12'.

Related data: Diagnosis type
Clinical code type
Clinical code

Administrative attributes

Source document: Encoding software
Source organisation: NZHIS

Code end date

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Code end date

Name in database: code_end_date

Other names:

Element type: Data element

Definition: The date from which the code is no longer valid.

Context:

Relational and representational attributes

Data type: datetime   *Field size:*   *Layout:*

Data domain: Valid dates

Guide for use: If this field is blank or a future date, the code is valid.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Code start date

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Code start date

Name in database: code_start_date

Other names:

Element type: Data element

Definition: The date from which the code is valid.

Context:

Relational and representational attributes

Data type: datetime   *Field size:*   *Layout:*

Data domain: Valid dates

Guide for use: If this field is blank, and the Code end date is blank or in the future, presume the code is valid.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Death flag

Administrative status

Reference ID:
Version: 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Death flag

Name in database: death_flag

Other names:

Element type: Data element

Definition: A flag indicating which codes are likely to be a cause of death.

Context:

Relational and representational attributes

Data type: char *Field size:* 1 *Layout:* A

Data domain:
Y likely to be a cause of death
N unlikely to be a cause of death

Guide for use: If the Event end type (discharge type) code on an event record is 'DD' (died), then the record must contain at least one diagnosis code for which the Death flag has the value of 'Y', otherwise a warning message is generated.

Verification rules:

Collection method:

Related data: Clinical code
Event end type code

Administrative attributes

Source document:

Source organisation: NZHIS

External cause flag

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: External cause flag

Name in database: external_cause_flag

Other names:

Element type: Data element

Definition: A flag indicating that an external cause code is also required to describe the circumstances of injury.

Context:

Relational and representational attributes

Data type: char   *Field size:* 1   *Layout:* A

Data domain: Y   An external cause code is required
                         N, blank   An external cause code is not required

Guide for use: If the External cause flag for a diagnosis is set to 'Y' then there must be an external cause code
                         present in the event record, otherwise a warning message is generated.

                         This flag is only present for selected codes.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation: NZHIS

High age

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: High age
Name in database: high_age
Other names:
Element type: Data element
Definition: An age above which a disease or procedure is not expected to be reported.
Context:

Relational and representational attributes

Data type: int   *Field size:* 3   *Layout:* NNN
Data domain: 001 – 121
Guide for use: If the calculated age at discharge for an event record is higher than the value in the High age flag then a warning message is issued.
Verification rules:
Collection method:
Related data:

Administrative attributes

Source document:
Source organisation: NZHIS

Low age

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Low age

Name in database: low_age

Other names:

Element type: Data element

Definition: An age below which a disease or procedure is not expected to be reported.

Context:

Relational and representational attributes

Data type: int   *Field size:* 3   *Layout:* NNN

Data domain: 001 – 121

Guide for use: If the calculated age at discharge for an event record is lower than the value in the Low age flag then a warning message is issued.

Verification rules:

Collection method:

Related data: Date of birth
                     Event end type

Administrative attributes

Source document:

Source organisation: NZHIS

Normal NZ flag

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Normal NZ flag

Name in database: normal_nz_flag

Other names:

Element type: Data element

Definition: A flag indicating whether a diagnosis is likely to occur in New Zealand.

Context:

Relational and representational attributes

Data type: char   *Field size:* 1   *Layout:* A

Data domain: Y   the diagnosis is likely to occur in New Zealand
                        N   the diagnosis is unlikely to occur in New Zealand

Guide for use: If the Normal NZ flag is 'N' then a warning message will be generated if the Clinical code is found in an event record.

Verification rules:

Collection method:

Related data: Clinical code

Administrative attributes

Source document:

Source organisation: NZHIS

Operation flag

Administrative status

Reference ID: **Version:** 1.1 **Version date:** 15-Mar-2004

Identifying and defining attributes

Name:	Operation flag
Name in database:	operation_flag
Other names:	Op flag
Element type:	Data element
Definition:	A flag indicating whether an operation date is required for an operation/procedure.
Context:	

Relational and representational attributes

Data type: char *Field size:* 1 *Layout:* A

Data domain:	Y	Operation/procedure date is optional
	N	Operation/procedure date must be present
	blank	Operation/procedure date is not applicable
Guide for use:		Only relevant for Operation codes. If the code relates to a diagnosis record, this field will be blank. If the code has a 'Y', then an Operation date is optional. If the code has an 'N', then an Operation date is mandatory.
Verification rules:		Optional.
		Warning messages are generated.
Collection method:		
Related data:		External cause date of occurrence

Administrative attributes

Source document:

Source organisation: NZHIS

Sex flag

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Sex flag

Name in database: gender_flag

Other names: Gender flag

Element type: Data element

Definition: A flag indicating which sex is appropriate for each code.

Context:

Relational and representational attributes

Data type: char   *Field size:* 1   *Layout:* A

Data domain: M   Male
                         F   Female
                         B   Both

Guide for use: If the Sex flag is 'B', then an event record may contain either 'M' or 'F' or 'U' (unknown) or 'I'
                         (indeterminate) in the Sex field. The Sex code on the event record must correspond to the value of the
                         Sex flag in the code table, otherwise a warning message is generated.

Verification rules:

Collection method:

Related data: Sex
                         Clinical code

Administrative attributes

Source document:

Source organisation: NZHIS

Sub-category

Administrative status

Reference ID: *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: Sub-category

Name in database: sub_category

Other names:

Element type: Data element

Definition: A sub-category code that groups diagnosis codes together at the 4-character level.

Context:

Relational and representational attributes

Data type: char   *Field size:* 6   *Layout:*

Data domain:

Guide for use: Contains the first 4 characters of the Clinical code.

From ICD-10-AM 1st Edition onwards, all codes have sub-category numbers except for procedure codes. A list of sub-category codes and their descriptions is available from NZHIS on request.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation: National Centre for Classification in Health, University of Sydney, Australia

Unacceptable diagnosis flag

Administrative status

Reference ID:

Version: 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Unacceptable diagnosis flag

Name in database: unacceptable_diagnosis_flag

Other names:

Element type: Data element

Definition: A flag indicating that the code should not be used as the principal diagnosis.

Context:

Relational and representational attributes

Data type: char   *Field size:* 1   *Layout:* A

Data domain: Y   Code should not be used as the principal diagnosis
                  N, blank   Code may be used as the principal diagnosis

Guide for use: If the principal diagnosis for an event is a code for which the Unacceptable diagnosis flag is set to 'Y' then a warning message will be issued.

Verification rules:

Collection method:

Related data: Clinical code
                    Diagnosis type

Administrative attributes

Source document:

Source organisation:

Diagnosis Procedure table

Table name:	Diagnosis Procedure table
Name in database:	diagnosis_procedure_tab **Version:** 1.1 **Version date:** 15-Mar-2004
Definition:	Details relating to diagnoses and procedures associated with a health event.
Guide for Use:	Contains clinical information about the reason for admission to hospital, procedures carried out while in hospital, and incidental or concurrent diseases that were a factor in the treatment.

Also contains information about accidents that caused health events or occurred during a health event, including adverse reactions.

Diagnoses and procedures are held in multiple versions of the International Classification of Diseases. All events:
- are stored in ICD-9-CM-A
- with an Event end date on or after 1 July 1999 are stored in ICD-9-CM-A and ICD-10-AM 1st Edition
- with an Event end date on or after 1 July 2001 are stored in ICD-9-CM-A, ICD-10-AM 1st Edition, and ICD-10-AM 2nd Edition
- with an Event end date on or after 1 July 2004 are stored in ICD-9-CM-A, ICD-10-AM 1st Edition, ICD-10-AM 2nd Edition- and ICD-10-AM 3rd Edition.
 reported after 1 July 1995 contain the code and ICD version supplied by the provider.

See Clinical code type for more information.

The selection of codes is based on the Australian Coding Standards (ACS), as distributed by the National Centre for Classification in Health.

The principal diagnosis (refer to ACS 0001 vol 5 p2) is defined as the diagnosis established after study to be chiefly responsible for causing the patient's episode of care in hospital (or attendance at the healthcare facility). The phrase 'after study' in the definition means evaluation of findings to establish the condition that was chiefly responsible for the episode of care. Findings evaluated may include information gained from the history of illness, any mental status evaluation, specialist consultations, physical examination, diagnostic tests or procedures, any surgical procedures, and any pathological or radiological examination.

The condition established after study may or may not confirm the admitting diagnosis.

Additional diagnosis (refer to ACS 0002 vol 5 p5) is defined as a condition or complaint either co-existing with the principal diagnosis or arising during the episode of care or attendance at a healthcare facility.

For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:
- therapeutic treatment
- diagnostic procedures
- increased nursing care and/or monitoring.

Coding procedures carried out in A&E before admission:

If the patient is admitted, the time spent and the treatment carried out in A&E are included. Procedures carried out in A&E before admission are coded on the relevant inpatient event record. All hours on mechanical ventilation in A&E are coded, whether the patient is intubated in A&E or in the ambulance. If ventilation is commenced in the ambulance, it is counted only from the time of hospitalisation.

The structure of this table has been significantly changed from 1 July 2004.
- Prior to this change, the structure held each submitted diagnosis record received from a provider in the same row in the table as any records mapped to other clinical coding classifications. This necessitated the existence of sets of columns specifically for the ICD9, ICD10v1 and ICD10v2 clinical code classifications and the ongoing need to add additional sets of columns each time a new clinical coding classification is to be implemented.
- From 1July 2004, only one level of clinical code classification will be held per row in the table. Each new 'submitted' record will be loaded into a new row in the table, then a new row will be created for each record produced by mapping to another clinical coding classification version. These groups of rows are linked by common event id and diagnosis sequence values. The original submitted record is identified by the submitted system id value.
- Note: The new database structure still allows up to 99 diagnoses and procedures to be stored. Former file and database structures allowed fewer codes, so old records do not contain as many.

Primary Key:	event_id, diagnosis_sequence, clinical_code_system, clinical_code_type, clinical_code

Business Key:

Relational Rules: Links to the Event table

Batch ID

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Batch ID

Name in database: batch_id

Other names:

Element type: Derived data element

Definition: A unique identifier for each batch.

Context:

Relational and representational attributes

Data type: int   *Field size:*   *Layout:*

Data domain:

Guide for use: Generated by the load process. Used internally for reference to the file in which this record was loaded into the NMDS.

                      The Batch ID is used in place of the batch filename.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Clinical code

Administrative status

Reference ID: A0124   *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: Clinical code

Name in database: clinical_code

Other names: Diagnosis/procedure code

Element type: Data element

Definition: A code used to classify the clinical description of a condition.

Context: Clinical information within a health event.
Includes codes for diagnosis, injury, cause of intentional and unintentional injury, and procedure performed.

Relational and representational attributes   *Mandatory*

Data type: varchar   *Field size:* 8   *Layout:* See Collection method.

Data domain: Must be a valid code in one of the following systems:
- ICD-9-CM-A 2nd Edition – Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition
- ICD-10-AM 1st Edition – The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition
- ICD-10-AM 2nd Edition – The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition
- ICD-10-AM 3rd Edition – The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition
- DSM-IV – Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.

Guide for use: Depending on the context, this is also known as Diagnosis/procedure code (external cause), and Morphology code.

From 1 July 1995, this field contains the Clinical code as supplied by the provider.

ICD-9-CM (TO 30 JUNE 1995)
In ICD-9-CM all codes have at least 3 digits and most have 4 or 5. Standard practice was to use a filler 4th digit of '9' for codes with only 3 digits and for codes which have a 5th digit but no 4th digit.

ICD-9-CM-A (1 JULY 1995 ONWARDS)
In 1995 codes were mapped to ICD-9-CM-A, and the place of occurrence, which had been separate, was mapped onto the 5th digit of the E code.

Also, codes that only had 3 digits no longer required a filler digit: the fields for 4th and 5th digits could be left blank. ICD-9-CM-A codes which had a 5th digit but no 4th digit could have a filler 4th digit of '0' (zero) entered.

E codes were mandatory for codes between 800 and 999. The location field and code E849 were not used. Instead, the digit to indicate place of occurrence of external cause of injury was recorded as the 5th digit for the following ranges of 4 digit 'E' codes: E810-E829, E846-E848, E850-E869, E880-E928, E950-E958, E960-E968, E980-E988.

ICD-10-AM 1ST EDITION (1 JULY 1999 ONWARDS)
In ICD-10-AM, codes V01 to Y98 were used to classify environmental events and circumstances as the external cause of injury, poisoning and other adverse effects. (It was intended that the nature of the condition would be indicated separately using the appropriate code, usually codes between S00 and T98.)

1. Place of Occurrence Code
The following 4th-character subdivisions of the external cause code were used with categories W00 to Y34 (except Y06 and Y07) to identify where the external cause occurred:
0 = home
1 = residential institution
2 = school, other institution, and public administrative area
3 = sports and athletics area
4 = street and highway
5 = trade and service area

6 = industrial and construction area
7 = farm
8 = other specified places
9 = unspecified place

2. Activity Code
The following 5th-character subdivision of the external cause code was used with categories V01 to Y34 to indicate the activity of the injured person at the time the event occurred. (This subclassification was used in addition to the 4th-character subdivisions indicating place of occurrence of events classifiable to W00-Y34.)
0 = while engaged in sports activity
1 = while engaged in leisure activity
2 = while working for income
3 = while engaged in other types of work
4 = while resting, sleeping, eating or engaging in other vital activities
8 = while engaged in other specified activities
9 = during unspecified activity

3. Example of the external cause code, place of occurrence and activity code:
Diagnosis type allocated by provider system - Description - ICD-10-AM code
A - # L shaft tibia and fibula, closed - S82.21
B - Laceration L elbow - S51.0
B - Contusion scalp - S00.05
O - Closed reduction of # tibia and fibula - 47564-00
E - Tripped over hose while gardening at home - W01.03*

* The 4th character represents 'home' as place of occurrence; the 5th character represents 'gardening' as activity.

Notes:
1. From July 1999 both ICD-9-CM-A and ICD-10-AM 1st Edition are recorded. From July 2001, ICD-10-AM 2nd Edition is recorded. From July 2004, ICD-10-AM 3rd Edition is also recorded, ie, the clinical code is stored in all versions.
2. Clinical codes are reported without decimal points or hyphens. The formats above are how the codes appear in the coding manual.

Verification rules: Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.

Demographic and administrative data (eg, Sex, Date of birth, Event end type) is checked to ensure it is consistent with the Clinical code, as specified by the editing flags held against each Clinical code on the Clinical Code table.

Collection method: From ICD-10-AM 2nd Edition onwarrds, procedures are NNNNNNN, and diagnoses and injuries are ANNNN. In ICD-9-CM-A, procedures are NNNN, and all diagnoses except supplementary conditions are NNNNN.

Since 1 July 2004, the current ICD version is ICD-10-AM 3rd Edition.

Up to 99 diagnosis/procedure codes may be provided. No decimal points or extra characters should be included in the Clinical codes, for example, the ICD-10-AM 2nd Edition code 30496-02 should be sent as 3049602.

In the context of cancer patients, the NMDS will accept only the first four digits of morphology diagnosis codes. From 1 July 2000, morphology code M9990 will no longer be accepted: M8000 should be used instead.

EXTERNAL CAUSES OF MORBIDITY
An external cause code is mandatory with codes from S00 to T98, as well as for Z03.6 and Z04.1-Z04.5.

Place of occurrence and activity have unique codes rather than using 4th and 5th character extensions as was done with ICD-10-AM 1st Edition:
- Y92 (Place of occurrence) codes should be assigned in addition to all external codes in the range V01-Y89.
- Y93 (Activity) codes should be assigned in addition to all external cause codes in the range V01-Y34.
Note: Accident date is optional for Y92 and Y93 codes.

The Event supplementary information field can be used to record additional information about the accident location.

Related data: Diagnosis/procedure description
Clinical coding system ID
Clinical code type
Diagnosis type

Administrative attributes

Source document: Refer to the Official NCCH Australian Version of ICD-9-CM-A, Second Edition, Volumes 1 to 4, and the International Classification of Diseases for Oncology (ICD-O) Version 2.

For ICD-10-AM, refer to ICD-10-AM, the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, Ist Edition (4 volumes), 2nd Edition (4 volumes) or 3rd Edition (5 volumes).

Source organisation: National Centre for Classification in Health, University of Sydney, Australia

Clinical code type

Administrative status

Reference ID: A0125   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Clinical code type

Name in database: clinical_code_type

Other names:

Element type: Data element

Definition: A code denoting which section of the clinical code table the clinical code falls within.

Context: Clinical information.

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 1   *Layout:* A

Data domain: A   Diagnosis
                      B   Injury
                      D   DSM-IV
                      E   External cause of injury
                      M   Morphology (pathology)
                      O   Operation/procedure
                      V   Supplementary classification/health factors

Guide for use: Previously known as Clinical code table type.

                       This field is required to differentiate between different sections of the clinical code table. In ICD-9-CM-A code values could be repeated in different sections of the table. For example, '0101' is a diagnosis code as well as a procedure code.

Verification rules: Must be a valid code in the Clinical Code Type code table.

                       Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.

Collection method:

Related data: Clinical coding system ID
                       Diagnosis type
                       Clinical code

Administrative attributes

Source document:

Source organisation:

Clinical coding system ID

Administrative status

Reference ID: A0126   *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: Clinical coding system ID

Name in database: clinical_code_system

Other names:

Element type: Data element

Definition: A code identifying the clinical coding system used for diagnoses and procedures.

Context: Clinical information.

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 2   *Layout:* NN

Data domain: 01   ICD-9
                   02   ICD-9-CM
                   03   Read
                   04   ICPC
                   05   Old AMR codes
                   06   ICD-9-CM-A
                   07   DSM IV (for MHINC only)
                   10   ICD-10-AM 1st Edition
                   11   ICD-10-AM 2nd Edition
                   12   ICD-10-AM 3rd Edition

Guide for use: Previously known as Diagnosis coding system code.

Code '03' (Read) is used for primary care and not reported in the NMDS.

Code '02' (ICD-9-CM) was used between 1988 and 1995. When code '06' (ICD-9-CM-A) was introduced, the database was mapped to this new code. From July 1999 data was submitted in either ICD-9-CM-A or ICD-10-AM 1st Edition, and mapped so that it was held in both systems. Data for code '02' no longer exists in the database.

Between 1 July 2001 and 30 June 2004, data was submitted in '11' (ICD-10-AM 2nd Edition) and mapped to ICD-9-CM-A and '10' (ICD-10-AM 1st Edition). All records in '10' continue to be mapped back to earlier classification versions where mappings exist.

From 1 July 2004 data is submitted in '12' (ICD-10-AM 3rd Edition) and mapped to '11' (ICD-10-AM 2rd Edition). Mappings from '11' to '10' and '10' or earlier classifications continues to be performed, where mappings exist.

Verification rules: Must be a valid code in the Clinical Coding System code table.

Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.

Collection method: From 1 July 2004 data should be submitted using ICD-10-AM 3rd Edition, that is, the Clinical coding system ID should be '12'.

Related data: Diagnosis type
                      Clinical code type
                      Clinical code

Administrative attributes

Source document: Encoding software

Source organisation: NZHIS

Diagnosis number

Administrative status

Reference ID: A0127   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Diagnosis number

Name in database: diagnosis_number

Other names: Event diagnosis/procedure number

Element type: Data element

Definition: Sequential number for each clinical code in each event record to assist in unique identification.

Context:

Relational and representational attributes   *Mandatory*

Data type: integer   *Field size:* 2   *Layout:* NN

Data domain: 01 – 99

Guide for use: This is the number hospitals send in for their ordering of diagnoses. When the NMDS began mapping between different classification versions (eg, ICD-9-CM to ICD-10-AM) multiple mappings were sometimes required for single codes. The Diagnosis sequence field was introduced, which is derived from this field but allows multiple mappings to be accommodated.

Verification rules:

Collection method: Up to 99 clinical codes may be provided with each event.

Related data: Used to calculate Diagnosis sequence

Administrative attributes

Source document:

Source organisation:

Diagnosis sequence

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Diagnosis sequence
Name in database:	diagnosis_sequence
Other names:	
Element type:	Derived data element
Definition:	A sequencing number for clinical codes derived from the diagnosis number as part of the mapping process.
Context:	

Relational and representational attributes

Data type:	smallint *Field size:* 3 *Layout:* NNN
Data domain:	010 – 999
Guide for use:	When mapping diagnoses from one clinical coding system to another, the Diagnosis number is mapped to the Diagnosis sequence so that the order can be retained for many to one and one to many mappings. For example, if the original Diagnosis numbers were 1, 2, 3, 4, and diagnosis 2 mapped to 3 separate codes in the new clinical coding system, the Diagnosis sequence numbers would be 10, 20, 21, 22, 30, 40.
Verification rules:	
Collection method:	
Related data:	Diagnosis number

Administrative attributes

Source document:

Source organisation:

Diagnosis type

Administrative status

Reference ID:	A0123		***Version:*** 1.0	***Version date:***	01-Jan-2003

Identifying and defining attributes

Name: Diagnosis type

Name in database: diagnosis_type

Other names: Event clinical code type, Diagnosis type code, Clinical code type

Element type: Data element

Definition: A code that groups clinical codes, or indicates the priority of a diagnosis.

Context: Clinical information within a health event.

Relational and representational attributes   ***Mandatory***

Data type: char   ***Field size:*** 1   ***Layout:*** A

Data domain:
A	Principal diagnosis
B	Other relevant diagnosis
O	Operation/procedure
E	External cause of injury
M	Pathological nature of growth
D	Underlying cause of death
F	Selected contributory cause B1
G	Selected contributory cause B2
C	Non-contributory cancer
H	Main maternal disease in fetal or infant death
I	Other maternal disease in fetal or infant death
J	Other relevant disease in fetal or infant death
N	Nature of injury (mortality only)
P	Mental health provisional diagnosis (MHINC only)
S	Activity

Guide for use: Only codes 'A', 'B', 'O', 'E' and 'M' are found in the NMDS database.

Verification rules: Must be a valid code in the Diagnosis Type code table.

There must be one and only one type 'A' for each event.

Validation rules are held in the Event to Diagnosis Type table. Cardinality and optionality have been added. See Appendix E: Enhanced Event Type/Event Diagnosis Type Table.

Collection method: It is expected that the codes will be allocated by provider systems at the time of sending data to the national system.

Up to 99 diagnosis/procedure codes may be provided. Every record must have one (and only one) clinical code type 'A' principal diagnosis and may have up to a further 98 diagnosis/procedure/ external cause/morphology codes which accompany the appropriate clinical code type.

The principal diagnosis (refer to ACS 0001 vol 5 p2) is defined as the diagnosis established after study to be chiefly responsible for causing the patient's episode of care in hospital (or attendance at the healthcare facility). The phrase 'after study' in the definition means evaluation of findings to establish the condition that was chiefly responsible for the episode of care. Findings evaluated may include information gained from the history of illness, any mental status evaluation, specialist consultations, physical examination, diagnostic tests or procedures, any surgical procedures, and any pathological or radiological examination.

The condition established after study may or may not confirm the admitting diagnosis.

Additional diagnosis (refer to ACS 0002 vol 5 p5) is defined as a condition or complaint either co-existing with the principal diagnosis or arising during the episode of care or attendance at a healthcare facility.

For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:
- therapeutic treatment
- diagnostic procedures
- increased nursing care and/or monitoring.

Related data: Clinical code
Diagnosis/procedure description
Clinical coding system ID
Clinical code type
External cause date of occurrence

Administrative attributes

Source document:

Source organisation: NZHIS

Diagnosis/procedure description

Administrative status

Reference ID: A0122   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Diagnosis/procedure description

Name in database: diagnosis_description

Other names: Event diagnosis/procedure description

Element type: Data element

Definition: A free-text description of the diagnoses, injuries, external causes, and procedures performed. This should not be the standard description associated with the clinical code.

Context: Clinical information.

Relational and representational attributes   *Mandatory*

Data type: varchar   *Field size:* 50   *Layout:* Free text

Data domain:

Guide for use: Depending on the context, this is also known as Diagnosis description (external cause), Accident description, Operation description, and Morphology description.

It is recommended that free text be used for this field, as this aids the research process and assists with the quality audit of data sent to the NMDS. Free text should always be used with external cause codes.

Providers often automate this field using encoding programmes. This greatly detracts from the value of the data.

Verification rules:

Collection method: Agencies are encouraged to provide this information, particularly the description of the circumstances surrounding an injury, as it is used extensively in injury-prevention research. The Event supplementary information field may be used to expand the description.

The standard descriptions sent to NZHIS by hospitals are only 50 characters long, and often are the expanded description truncated at 50 characters. Many of these abbreviated descriptions are not specific, so their usefulness for research is limited. Your assistance is sought to report fully on the diagnosis, procedure, or circumstances of the injury in the Event supplementary information field.

Related data: Diagnosis type
                        Clinical code

Administrative attributes

Source document:

Source organisation:

Event ID

Administrative status

Reference ID:　　A0156　　　　　　　　　　*Version:* 1.0　　*Version date:* 01-Jan-2003

Identifying and defining attributes

Name:　　　　　　　Event ID

Name in database:　event_id

Other names:

Element type:　　　Data element

Definition:　　　　An internal reference number that uniquely identifies a health event.

Context:　　　　　Any event on the NMDS.

Relational and representational attributes

Data type:　　　　integer　　　　*Field size:* 12　　　*Layout:* NNNNNNNNNNNN

Data domain:

Guide for use:　　Serves as the primary key for all data tables. Event ID is assigned by NZHIS on load, so if an event is deleted and then reloaded, a new Event ID will be assigned.

　　　　　　　　　Unique link between the main tables in the database.

Verification rules:　Add 1 to the previous maximum number.

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

External cause date of occurrence

Administrative status

Reference ID: A0129   *Version:*   1.1   *Version date:*   15-Mar-2004

Identifying and defining attributes

Name:	External cause date of occurrence
Name in database:	procedure_acc_date
Other names:	Accident date, Injury date
Element type:	Data element
Definition:	The date when the accident/injury occurred.
Context:	Events resulting from an accident.

Relational and representational attributes

Data type:	datetime	*Field size:*	8	*Layout:*	CCYYMMDD
Data domain:	Valid dates				

Partial dates are permissible. At a minimum the century and year must be supplied. If day is provided but month is omitted then the day will not be recorded. Incomplete dates are stored as 'ccyy0101' or 'ccyymm01' and a partial date flag associated with the date is set to the appropriate value.

Guide for use: External cause date of occurrence and Operation/procedure date are sent in separately but both stored in the same field. If the diagnosis type is 'E' (ie, external cause event), the date is External cause date of occurrence.

Verification rules: Optional.

Must be on or before the date of load, the Event end date, and the Psychiatric leave end date.
Must be on or after the Date of birth.

Only permitted if Diagnosis type is 'E'.

Required for external cause of occurrence codes, but optional if Operation flag is set to 'Y'.

Collection method: This field is optional for ICD-10-AM 2nd Edition (and onwards) place of occurrence codes (Y92.x) and activity codes (Y93.x).

Related data: Diagnosis type
Accident date flag

Administrative attributes

Source document:

Source organisation:

External cause date of occurrence flag

Administrative status

Reference ID: *Version:*   1.0   *Version date:*   01-Jan-2003

Identifying and defining attributes

Name:	External cause date of occurrence flag
Name in database:	procedure_acc_date_flag
Other names:	
Element type:	Data element
Definition:	Indicates whether the External cause date of occurrence stored is a partial date.
Context:	Events resulting from an accident.

Relational and representational attributes

Data type:	char	*Field size:*	1	*Layout:*	
Data domain:	Y only the year is supplied				
	M the month and year were supplied				
Guide for use:	A partial date flag, set automatically.				
Verification rules:					
Collection method:					
Related data:	External cause date of occurrence				

Administrative attributes

Source document:

Source organisation:

Operation/procedure date

Administrative status

Reference ID: A0128   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Operation/procedure date

Name in database: procedure_acc_date

Other names: Op date

Element type: Data element

Definition: The date on which an operation/procedure was performed.

Context: Clinical information.

Relational and representational attributes

Data type: datetime   *Field size:* 8   *Layout:* CCYYMMDD

Data domain: Valid dates

Guide for use: Operation/procedure date and External cause date of occurrence are sent in separately but both stored in the same field within the NMDS. If the diagnosis type is 'O' (ie, an operation), the date is Operation/procedure date.

Verification rules: Optional. Mandatory if diagnosis type is 'O' unless Operation flag in Clinical Code table is set to 'Y'.

Must be on or before the date of load, the Event end date, and the Psychiatric leave end date.

Must be on or after the Event start date, the Date of birth, the Date of referral, the Date of first specialist consultation, and the Date surgery decided.

Only permitted if the diagnosis type is 'O'.

Collection method: Now optional for non-operating-room procedures. Required for surgical procedures.

Related data: Date of birth
Event start date
Event end date
Date of first specialist consultation
Date of referral
Date surgery decided

Administrative attributes

Source document:

Source organisation: National Data Policy Group

Transaction ID

Administrative status

Reference ID:

Version: 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Transaction ID

Name in database: transaction_id

Other names:

Element type: Derived data element

Definition: A sequential number within the batch. With the Batch ID, this forms a unique identifier for each transaction.

Context:

Relational and representational attributes

Data type: int *Field size:* *Layout:*

Data domain:

Guide for use: Generated by the load process. Used internally for reference.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Domicile Code table

Table name: Domicile Code table

Name in database: domicile_code_tab   ***Version:*** 1.0 ***Version date:*** 01-Jan-2003

Definition: Contains geographic information.

Guide for Use: Content is provided by Statistics NZ, initially based on 1991 census area unit codes. New values are added after each census, and some existing values are retired.

      Census area unit codes are based on meshblocks.

Primary Key: Domicile code

Business Key:

Relational Rules: Defines Domicile code on the Health Event table.

Area unit code

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 01-Jan-2003

Identifying and defining attributes

Name: Area unit code

Name in database: area_unit_code

Other names:

Element type: Derived data element

Definition: The census area unit code that corresponds to the Domicile code.

Context:

Relational and representational attributes

Data type: int   *Field size:*   *Layout:*

Data domain:

Guide for use: This field is mapped using Statistics NZ mappings.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation: Statistics NZ

DHB

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: DHB

Name in database: dhb

Other names: District Health Board

Element type: Data element

Definition: The code of the District Health Board responsible for the domicile.

Context:

Relational and representational attributes

Data type: char   *Field size:* 3   *Layout:* NNN

Data domain: 11   Northland
                     21   Waitemata
                     22   Auckland
                     23   Counties Manukau
                     31   Waikato
                     42   Lakes
                     47   Bay of Plenty
                     51   Tairawhiti
                     61   Hawke's Bay
                     71   Taranaki
                     81   MidCentral
                     82   Whanganui
                     91   Capital and Coast
                     92   Hutt
                     93   Wairarapa
                     101   Nelson Marlborough
                     111   West Coast
                     121   Canterbury
                     123   South Canterbury
                     131   Otago
                     141   Southland
                     999   Overseas

Guide for use:

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Domicile code

Administrative status

Reference ID:	A0023		*Version:* 1.0	*Version date:*	01-Jan-2003

Identifying and defining attributes

Name:	Domicile code
Name in database:	domicile_code
Other names:	
Element type:	Data element
Definition:	Statistics NZ Health Domicile Code representing a person's usual residential address. Also used for facility addresses.
	Usual residential address is defined as the address at which the person has been, or plans to be, living for 3 months or more. (Statistics NZ definition of 'usually resident'.)
	If a person usually lives in a rest home or a hospital, that is considered their usual residential address.
Context:	Required for demographic analyses. Domicile codes are key variables for determining the characteristics of the population that are using the health sector.

Relational and representational attributes

Mandatory

Data type:	char	*Field size:* 4	*Layout:* XXNN
Data domain:	See the Domicile code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.		
Guide for use:	Before July 1993, domicile was coded using the 1986 census Domicile codes. This data has been mapped to the 1991 codes.		

Care needs to be exercised when analysing pre-1993 data in terms of population, as the 1991 census split a large number of the 1986 codes into two or more new Domicile codes. As it was not possible to accurately attribute particular events to the correct new code, only one of the new multiple codes could be chosen for each old code. This can result in some areas showing no events for one code and an over-representation of events for the other domicile.

Since 1996, Domicile code has been automatically assigned on the NHI database using the address provided. This can result in rural addresses being assigned to an urban Domicile code where there is insufficient data to generate the correct code. This is because the automated software relies on generating a post code in order to determine where in a related table it should look to find the code. Most events in the NMDS contain a Domicile code that has been generated in this manner.

The Domicile code used for health collections is a four-digit Health Domicile Code specially created by Statistics NZ from their six-digit Census Area Unit Code. This field contains 3 versions of this Domicile code, one for each of the 1991, 1996 and 2001 censuses.

- The 1991 code was used from 1988 to 30 June 1998. (1986 codes were converted to 1991 codes on migration into NMDS in 1993.)
- The 1996 code was used from 1 July 1998 to 30 June 2003.
- The 2001 code has been in use since 1 July 2003.

The series of Domicile codes used depends on the Event end date. If an event does not have an end date, the Event start date is used.

Verification rules:	Must be a valid code in the Domicile code table.

If the Event end date (or, if the Event end date is blank, the Event start date) is less than 1 July 1998 and Year of census is 1996 then convert the new domicile back to old 1991 code.

For Event end dates on or after 1 July 1998 the 1996 codes apply. For Event end dates on or after 30 June 2003, the 2001 codes apply. (If the Event end date is blank, check the Event start date and that the status of the code is current. If not current, generate an error message.)

Collection method:	The code table contains current and retired codes (see status column: C = current and R = retired). Some of the codes from the 1991 census were replaced by new codes in the 1996 census, and these should not be used for events with an Event end date after 30 June 1998. The 1991 and 1996 Domicile codes made redundant by the 2001 census should not be used for events with an Event end

date after 30 June 2003.

New general codes have been added for DHBs from 1 July 2001. General DHB codes should be a last resort, used only if the correct Domicile code cannot be determined.

Care should be taken to record accurate and useful residential addresses, since Domicile codes may be automatically assigned using this information.

Related data: TLA of domicile

Administrative attributes

Source document:

Source organisation: Statistics NZ

Domicile code description

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Domicile code description

Name in database: domicile_code_description

Other names:

Element type: Data element

Definition: Name of domicile area.

Context:

Relational and representational attributes

Data type: char   *Field size:* 70   *Layout:*

Data domain:

Guide for use: Provided by Statistics NZ.

                       This is actually a description of the census area unit code that maps to the Domicile code.

                       The Domicile code descriptions are sourced from Statistics NZ and are not necessarily the same as the names by which the areas are generally known. Many suburbs are split over two or more domiciles.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Domicile code status

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Domicile code status

Name in database: domicile_code_status

Other names:

Element type: Data element

Definition: Indicates whether a Domicile code is current or retired.

Context:

Relational and representational attributes

Data type: char   *Field size:* 1   *Layout:*

Data domain:

Guide for use: The Domicile table was initially populated with the 1991 code set. When new codes were added as a result of the 1996 census boundary changes, some of them replaced existing 1991 codes. Similarly, changes in 2001 made some 1991 and 1996 codes redundant. The retired codes are retained for historical purposes, but flagged as being no longer applicable.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Retired year

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Retired year

Name in database: retired_year

Other names:

Element type: Data element

Definition: The year of the census that resulted in the Domicile code being retired.

Context:

Relational and representational attributes

Data type: smallint   *Field size:* 4   *Layout:* CCYY

Data domain:

Guide for use: Introduced on 1 July 2003 to distinguish between Domicile codes retired in 1996 and 2001. All events with Event end dates after 30 June 2003 must use current codes. Events with end dates between 1 July 1998 and 30 June 2003 may not use retired 1991 codes.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

TLA of domicile

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: TLA of domicile

Name in database: tla

Other names:

Element type: Derived data element

Definition: Territorial local authority of domicile.

Context: Geographical aggregation.

Relational and representational attributes

Data type: char   *Field size:* 3   *Layout:* NNN

Data domain: TLA   TLA name
                  001   Far North
                  002   Whangarei
                  003   Kaipara
                  004   Rodney
                  005   North Shore
                  006   Waitakere
                  007   Auckland
                  008   Manakau
                  009   Papakura
                  010   Franklin
                  011   Thames-Coromandel
                  012   Hauraki
                  013   Waikato
                  015   Matamata-Piako
                  016   Hamilton
                  017   Waipa
                  018   Otorohanga
                  019   South Waikato
                  020   Waitomo
                  021   Taupo
                  022   Western BOP
                  023   Tauranga
                  024   Rotorua
                  025   Whakatane
                  026   Kawerau
                  027   Opotiki
                  028   Gisborne
                  029   Wairoa
                  030   Hastings
                  031   Napier
                  032   Central Hawke's Bay
                  033   New Plymouth
                  034   Stratford
                  035   South Taranaki
                  036   Ruapehu
                  037   Wanganui
                  038   Rangitikei
                  039   Manawatu
                  040   Palmerston North
                  041   Tararua
                  042   Horowhenua
                  043   Kapiti Coast
                  044   Porirua
                  045   Upper Hutt
                  046   Lower Hutt
                  047   Wellington
                  048   Masterton
                  049   Carterton

050	South Wairarapa
051	Tasman
052	Nelson
053	Marlborough
054	Kaikoura
055	Buller
056	Grey
057	Westland
058	Hurunui
059	Waimakariri
060	Christchurch
061	Banks Peninsula
062	Selwyn
063	Ashburton
064	Timaru
065	Mackenzie
066	Waimate
067	Chatham Islands
068	Waitaki
069	Central Otago
070	Queenstown Lakes
071	Dunedin
072	Clutha
073	Southland
074	Gore
075	Invercargill
998/9999	Overseas/other

Guide for use: The TLA of domicile roughly equates to local council boundaries. Populated from 1988.

Derived from the NZHIS mapping of Domicile code to TLA. No code table exists.

Domicile code 3402 Oceanic - Chatham Islands is included in TLA 'other' as it is not a Land Authority and is classified as subregion 15 'Hawke's Bay' which is not shown in this table.

Verification rules:

Collection method:

Related data: Domicile code

Administrative attributes

Source document:

Source organisation:

Year of census

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Year of census

Name in database: year_of_census

Other names:

Element type: Data element

Definition: The year in which a Domicile code is introduced.

Context:

Relational and representational attributes

Data type:	int	*Field size:*		*Layout:*

Data domain: 1991
                         1996
                         2001

Guide for use: Most Domicile codes were introduced in 1991 and correspond to census area units as defined by the
                         1991 census. Later codes were added from the 1996 and 2001 census reviews.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Event Legal Status table

Table name:	Event Legal Status table
Name in database:	event_legal_status_tab ***Version:*** 1.3 ***Version date:*** 31-Aug-2004
Definition:	The legal status of a healthcare user under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1966, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, or the Criminal Procedure (Mentally Impaired Persons) Act 2003.
Guide for Use:	Links to the Health Event table through Event ID.
	Reported in accordance with the relevant Act.
	Legal status must be supplied for inpatient mental health events. The reporting timeframe for this information is 21 days post month of admission.
	The definition of a mental health patient is 'a patient who has a mental illness diagnosis'. Patients with an intellectual disability are no longer regarded as mental health patients. Mental health inpatient and day patient events are to be reported with the relevant health specialty codes.
	With the introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992 on 1 November 1992, it became possible for mental health patients, both informal (ie, voluntary) and formal, to be admitted to a general ward of any public hospital or psychiatric hospital. When a mental health patient is admitted to a general ward for treatment of a psychiatric illness, then the event type code of IP can now be used. An event type code of ID can be used for day patients. A legal status code and leave details must also be supplied for these patients if relevant. The default for legal status is 'I' (Voluntary).
	All changes to legal status made during the course of an inpatient event must be reported to NZHIS.
	Admission information for mental health inpatients is required to be supplied with legal status and provisional diagnoses. It is a requirement to update leave/discharge data, legal status and principal diagnosis as they are obtained. Those facilities with electronic transfer should update legal status changes immediately they occur.
	This table only contains legal statuses pertaining to inpatient and day patient events. For more complete legal status histories, see the Mental Health Information National Collection.
Primary Key:	Event ID, Legal status code, Legal status date
Business Key:	
Relational Rules:	

Batch ID

Administrative status

Reference ID:	***Version:*** 1.0 ***Version date:*** 01-Jan-2003

Identifying and defining attributes

Name:	Batch ID
Name in database:	batch_id
Other names:	
Element type:	Derived data element
Definition:	A unique identifier for each batch.
Context:	

Relational and representational attributes

Data type:	int	***Field size:***		***Layout:***	
Data domain:					
Guide for use:	Generated by the load process. Used internally for reference to the file in which this record was loaded into the NMDS.				
	The Batch ID is used in place of the batch filename.				

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Verification rules:

Collection method:

Event ID

Administrative status

Reference ID: A0156   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Event ID
Name in database: event_id
Other names:
Element type: Data element
Definition: An internal reference number that uniquely identifies a health event.
Context: Any event on the NMDS.

Relational and representational attributes

Data type: integer   *Field size:* 12   *Layout:* NNNNNNNNNNNN
Data domain:

Guide for use: Serves as the primary key for all data tables. Event ID is assigned by NZHIS on load, so if an event is
                        deleted and then reloaded, a new Event ID will be assigned.

                        Unique link between the main tables in the database.
Verification rules: Add 1 to the previous maximum number.
Collection method:
Related data:

Administrative attributes

Source document:
Source organisation:

Legal status code

Administrative status

Reference ID: A0181   *Version:* 1.4   *Version date:* 01-Jul-2005

Identifying and defining attributes

Name:	Legal status code
Name in database:	legal_status_code
Other names:	
Element type:	Data element
Definition:	Code describing a healthcare user's legal status under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1966, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, or the Criminal Procedure (Mentally Impaired Persons) Act 2003.
Context:	Used for mental health healthcare users in respect of the current period of institutional care.
	Defines a healthcare user's standing in terms of the Mental Health (Compulsory Assessment & Treatment) Act 1992, for example, compulsory treatment.

Relational and representational attributes

Data type:	char *Field size:* 2 *Layout:* AA (or A and a space)
Data domain:	See the Legal Status code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use:	Used only in the context of mental health admissions.
Verification rules:	At least one required for psychiatric inpatient events.
	Code must be present in the Legal Status code table. The provided Legal Status Date must be on/after the start date, or on/before the end date in the Legal Status code table, for the code provided.
Collection method:	From 1 July 1999 legal status can be reported with ID and IP events as well as IM event types.
	More than one legal status can be entered for a health event, but the Legal status code and the Legal status date must form a unique combination for that health event.
	Legal status can be reported outside of the period of an event. If this is done, all Legal status codes for the event will be taken into account when determining the DRG code. Any non-voluntary Legal status code changes the DRG version 4.1, 4.2 or 5.0 code.
	A Legal status code is required for each Legal status date provided.
Related data:	DRG code Legal status date

Administrative attributes

Source document:

Source organisation:

Legal status date

Administrative status

Reference ID: A0183   *Version:* 1.2   *Version date:* 24-May-2004

Identifying and defining attributes

Name: Legal status date

Name in database: legal_status_date

Other names: Health event legal status date

Element type: Data element

Definition: The date from which a healthcare user's legal status applies.

Context: Defines a healthcare user's standing under the appropriate section of the Mental Health (Compulsory Assessment & Treatment), for example, compulsory treatment.

Relational and representational attributes

Data type: datetime   *Field size:* 8   *Layout:* CCYYMMDD

Data domain: Valid dates

Guide for use: Only used in the context of mental health admissions.

Verification rules: Partial dates not allowed.

                        At least one required for psychiatric inpatient events.

                        Must be after the Date of birth. Must be on or before the Event end date.

                        For the Legal status code provided, the legal status date:
                        - Must be on or after the Legal Status start date, in the Legal Status code table.
                        - Must be on or before the Legal Status end date, in the Legal Status code table.

Collection method: From 1 July 1999 legal status can be reported with ID and IP events as well as IM event types.

                        More than one legal status can be entered for a health event, but the Legal status code and the Legal status date must form a unique combination for that health event.

                        Legal status can be reported outside of the period of an event. If this is done, all Legal status codes for the event will be taken into account when determining the DRG code. Any non-voluntary Legal status code changes the DRG version 4.1, 4.2 or 5.0 code.

                        A Legal status date is required for each Legal status code supplied.

Related data: DRG code
                        Legal status code

Administrative attributes

Source document:

Source organisation:

Transaction ID

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Transaction ID

Name in database: transaction_id

Other names:

Element type: Derived data element

Definition: A sequential number within the batch. With the Batch ID, this forms a unique identifier for each transaction.

Context:

Relational and representational attributes

Data type: int   *Field size:*   *Layout:*

Data domain:

Guide for use: Generated by the load process. Used internally for reference.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Facility table

Table name:	Facility table
Name in database:	facility_tab ***Version:*** 1.0 ***Version date:*** 01-Jan-2003
Definition:	A table identifying a place which may be a permanent, temporary or mobile structure, which healthcare users attend or are resident in, for the primary purpose of receiving healthcare or disability support services. This definition excludes supervised hostels, halfway houses, staff residences, and rest homes where the rest home is the patient's usual place of residence.
Guide for Use:	All facilities must belong to an agency.
	Although they are excluded from the definition, the Facility table includes some rest homes, for a number of reasons: some local patient management systems require a Facility code for the facility to whom the healthcare user is discharged, which may be a rest home; some rest homes are attached to hospitals; and rest homes may be identified as the place of death.
	Many primary care organisations, for example doctor's surgeries, are included.
	This table is common to many of the data collections at NZHIS.
Primary Key:	Agency code, Facility code
Business Key:	
Relational Rules:	

Agency code

Administrative status

Reference ID:	A0138 ***Version:*** 1.0 ***Version date:*** 01-Jan-2003

Identifying and defining attributes

Name:	Agency code
Name in database:	agency_code
Other names:	Health agency code, DHB
Element type:	Data element
Definition:	A code that uniquely identifies an agency. An agency is an organisation, institution or group of institutions that contracts directly with the principal health service purchaser to deliver healthcare services to the community.
Context:	

Relational and representational attributes   ***Mandatory***

Data type:	char ***Field size:*** 4 ***Layout:*** XXXX
Data domain:	See the Agency code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use:	Historically, also known as CHE (Crown Health Enterprise), HHS (Hospitals and Health Services) and AHB (Area Health Board).
	Between 1988 and 1993 the Agency code was assigned based on the original 1993 agency groupings.
	If the facility on an event does not belong to the agency, it means that the agency has contracted a facility belonging to a different agency to treat the patient.
	Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Data Access Policy on the NZHIS web site at http://www.nzhis.govt.nz/access/index.html.
Verification rules:	Must be a valid code in the Agency code table.
Collection method:	This is a key field for allocating purchase units.
	If agencies merge, a new code may be assigned or the new agency can negotiate with NZHIS to maintain the existing codes.
	NZHIS allocates codes on request. The code table is continually updated by NZHIS as hospitals open

and close. See the NZHIS web site for the most recent version.

Related data:

Administrative attributes

Source document:
Source organisation: NZHIS

Domicile code

Administrative status

Reference ID: A0023   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Domicile code

Name in database: domicile_code

Other names:

Element type: Data element

Definition: Statistics NZ Health Domicile Code representing a person's usual residential address. Also used for facility addresses.

Usual residential address is defined as the address at which the person has been, or plans to be, living for 3 months or more. (Statistics NZ definition of 'usually resident'.)

If a person usually lives in a rest home or a hospital, that is considered their usual residential address.

Context: Required for demographic analyses. Domicile codes are key variables for determining the characteristics of the population that are using the health sector.

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 4   *Layout:* XXNN

Data domain: See the Domicile code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.

Guide for use: Before July 1993, domicile was coded using the 1986 census Domicile codes. This data has been mapped to the 1991 codes.

Care needs to be exercised when analysing pre-1993 data in terms of population, as the 1991 census split a large number of the 1986 codes into two or more new Domicile codes. As it was not possible to accurately attribute particular events to the correct new code, only one of the new multiple codes could be chosen for each old code. This can result in some areas showing no events for one code and an over-representation of events for the other domicile.

Since 1996, Domicile code has been automatically assigned on the NHI database using the address provided. This can result in rural addresses being assigned to an urban Domicile code where there is insufficient data to generate the correct code. This is because the automated software relies on generating a post code in order to determine where in a related table it should look to find the code. Most events in the NMDS contain a Domicile code that has been generated in this manner.

The Domicile code used for health collections is a four-digit Health Domicile Code specially created by Statistics NZ from their six-digit Census Area Unit Code. This field contains 3 versions of this Domicile code, one for each of the 1991, 1996 and 2001 censuses.

- The 1991 code was used from 1988 to 30 June 1998. (1986 codes were converted to 1991 codes on migration into NMDS in 1993.)
- The 1996 code was used from 1 July 1998 to 30 June 2003.
- The 2001 code has been in use since 1 July 2003.

The series of Domicile codes used depends on the Event end date. If an event does not have an end date, the Event start date is used.

Verification rules: Must be a valid code in the Domicile code table.

If the Event end date (or, if the Event end date is blank, the Event start date) is less than 1 July 1998 and Year of census is 1996 then convert the new domicile back to old 1991 code.

For Event end dates on or after 1 July 1998 the 1996 codes apply. For Event end dates on or after 30 June 2003, the 2001 codes apply. (If the Event end date is blank, check the Event start date and that the status of the code is current. If not current, generate an error message.)

Collection method: The code table contains current and retired codes (see status column: C = current and R = retired). Some of the codes from the 1991 census were replaced by new codes in the 1996 census, and these should not be used for events with an Event end date after 30 June 1998. The 1991 and 1996 Domicile codes made redundant by the 2001 census should not be used for events with an Event end

date after 30 June 2003.

New general codes have been added for DHBs from 1 July 2001. General DHB codes should be a last resort, used only if the correct Domicile code cannot be determined.

Care should be taken to record accurate and useful residential addresses, since Domicile codes may be automatically assigned using this information.

Related data: TLA of domicile

Administrative attributes

Source document:

Source organisation: Statistics NZ

Facility address

Administrative status

Reference ID: A0145   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Facility address

Name in database: facility_address

Other names: Health agency facility address

Element type: Data element

Definition: The physical address of a health facility.

Context:

Relational and representational attributes

Data type: varchar   *Field size:* 85   *Layout:* Free text

Data domain:

Guide for use: A domicile code is derived from the address and stored on the Facility table.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Facility closing date

Administrative status

Reference ID: A0147   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Facility closing date

Name in database: facility_close_date

Other names: Health agency facility closing date

Element type: Data element

Definition: The date on which a health facility ceased to operate.

Context:

Relational and representational attributes

Data type: datetime   *Field size:*   *Layout:* CCYYMMDD

Data domain: Valid dates

Guide for use: Some of these dates are estimated.

                     Closing dates are also recorded when codes are retired, for example, when an agency changes its name and is assigned a new code.

Verification rules:

Collection method: Facilities are required to notify NZHIS of their closing dates.

Related data:

Administrative attributes

Source document:

Source organisation:

Facility code

Administrative status

Reference ID: A0143   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Facility code

Name in database: facility_code

Other names: Health agency facility code, Hospital, HAF code, HAFC

Element type: Data element

Definition: A code that uniquely identifies a healthcare facility.

A healthcare facility is a place, which may be a permanent, temporary, or mobile structure, that healthcare users attend or are resident in for the primary purpose of receiving healthcare or disability support services. This definition excludes supervised hostels, halfway houses, staff residences, and rest homes where the rest home is the patient's usual place of residence.

Context:

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 4   *Layout:* NNNN

Data domain: See the Facility code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.

Guide for use: Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Data Access Policy on the NZHIS web site at http://www.nzhis.govt.nz/access/index.html.

Verification rules: Must be a valid code in the Facility code table.

The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix F: Duplicate and overlapping event checking rules.

Collection method: NZHIS allocates codes on request. The code table is continually updated by NZHIS as hospitals open and close. See the NZHIS web site for the most recent version.

Related data: Birth location
                      Facility type

Administrative attributes

Source document:

Source organisation: NZHIS

Facility name

Administrative status

Reference ID: A0144   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Facility name

Name in database: facility_name

Other names: Hospital name, Health agency facility name, Fac name

Element type: Data element

Definition: The name of a health facility.

Context:

Relational and representational attributes

Data type: varchar   *Field size:* 50   *Layout:* Free text

Data domain:

Guide for use:

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Facility opening date

Administrative status

Reference ID: A0146   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Facility opening date

Name in database: facility_open_date

Other names: Health agency facility opening date

Element type: Data element

Definition: The date on which a health facility began operation.

Context:

Relational and representational attributes

Data type: datetime   *Field size:*   *Layout:* CCYYMMDD

Data domain: Valid dates

Guide for use: Some of these dates are estimated.

Verification rules:

Collection method: Facilities are required to notify NZHIS of their opening dates.

Related data:

Administrative attributes

Source document:

Source organisation:

Facility type

Administrative status

Reference ID: A0148 *Version:* 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Facility type

Name in database: facility_type

Other names:

Element type: Derived data element

Definition: A code that categorises facilities into particular types.

Context:

Relational and representational attributes

Data type: char *Field size:* 2 *Layout:* NN

Data domain:
01	Public hospital
02	Private hospital
03	Psychiatric hospital
04	GP practice
10	Health centre
11	Local cancer registry
12	Mental health outpatient service
13	Cervical screening programme
14	Drug and alcohol treatment facility
15	Mental health community skills enhancement facility
16	Kaupapa Maori service
17	Pacific Island service
18	Mental health community team
19	Child, adolescent and family service
20	Mental health day hospital
21	Mental health residential 1 to 5 facility
22	Mental health residential and skills enhancement facility
23	Forensic mental health treatment facility
24	Intellectual disability facility
25	Charitable trust facility
99	Other

Guide for use: Used with Principal health service purchaser in determining whether an event is publicly funded.

Verification rules:

Collection method:

Related data: Facility code
Birth location
Private flag

Administrative attributes

Source document: Create using the Facility type from the Facility table

Source organisation:

Region of treatment

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Region of treatment

Name in database: region

Other names:

Element type: Derived data element

Definition: The Health Funding Authority region of treatment.

Context:

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:* NN

Data domain:
01   HFA Northern region
02   HFA Midland region
03   HFA Central region
04   HFA Southern region

Guide for use: Created from NZHIS internal mapping.

For historical use only. The Health Funding Authority no longer exists.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Health Event table

Table name:	Health Event table
Name in database:	health_event_tab ***Version:*** 1.1 ***Version date:*** 01-Jul-2005
Definition:	The Health Event table contains non-diagnostic information about a patient's stay in hospital, such as demographic, administrative, and some summarised/grouped clinical and contracting information. It contains data for inpatient and day patient health events.
Guide for Use:	A hospital inpatient event is a contact between a healthcare user and an agency which involves the healthcare user being admitted and discharged.

NMDS contains secondary care events (that is, hospital inpatient and day-patient events), and some ambulatory care events.

NMDS also incorporates events from psychiatric hospitals, and some private hospital events since 1996.

Fields have been added to the Health Event table at various times as a result of policy or contracting requirements.

Primary Key:	Event ID
Business Key:	Encrypted NHI number, Facility code, Event type code, Event start date, Event local ID
Relational Rules:	

ACC claim number

Administrative status

Reference ID:	A0212 ***Version:*** 1.1 ***Version date:*** 15-Mar-2004

Identifying and defining attributes

Name:	ACC claim number
Name in database:	acc_claim_number
Other names:	
Element type:	Data element
Definition:	This is a separate field to record the M46/45, ACC45 or AITC claim number for the event.
Context:	Injury resulting from an accident.

Relational and representational attributes

Data type:	char ***Field size:*** 12 ***Layout:*** Free text
Data domain:	
Guide for use:	
Verification rules:	Optional.

If the first character of the Principal health service purchaser code is 'A' (eg, 'A0', 'A1', etc) then the Accident flag should be set to 'Y'.

If the Accident flag is set to 'Y' (for any Principal health service purchaser code), then the ACC Claim Number field should not be blank.

If the injury date is between the admission and discharge date (ie the accident happened while the patient was in hospital) then the ACC flag can be N and the ACC45 field populated.

Collection method:	This is a free-text field to allow historical claim numbers, which come in a variety of formats, to be provided.

This field is used to report the Accident Insurance Treatment Certificate (AITC) form number. Where hospitals can report the three-letter Insurance Company abbreviation, this should be entered as the first three characters of this field, separated by a hyphen (-) from the AITC form number. Where hospitals are putting the abbreviation in this field, and where the receiving insurer is later determined not to be the managing insurer, the abbreviation should be updated to reflect the managing insurer.

If the Principal health service purchaser code is any of the codes that start with 'A', then the Accident

flag must be set to 'Y'.

If the Accident flag is set to 'Y', then the ACC Claim Number field should not be blank.

If the Accident flag is set to Y then the ACC claim number field must be populated.

If the ACC claim number field is populated and the injury date is between the admission and discharge dates then the accident flag field can be N or Y.

If the ACC claim number field is populated and the injury date is before the admission date then the accident flag must be set to Y.

Related data: Accident flag
                      Principal health service purchaser

Administrative attributes

Source document:

Source organisation: Accident Compensation Corporation

Accident flag

Administrative status

Reference ID: A0211   *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: Accident flag

Name in database: accident_flag

Other names: ACC flag

Element type: Data element

Definition: A flag that denotes whether a person is receiving care or treatment as the result of an accident.

Context: Injury resulting from an accident.

Relational and representational attributes

Data type: char   *Field size:* 1   *Layout:* A

Data domain: Y   The health event/treatment is assumed to be or is assessed as the result of an accident

                     N   The health event/treatment is the result of an illness.

Guide for use:

Verification rules: Optional.

If the first character of the Principal health service purchaser code is 'A' (eg, 'A0', 'A1', etc) then the Accident flag should be set to 'Y'.

If the Accident flag is set to 'Y' (for any Principal health service purchaser code), then the ACC Claim Number field should not be blank.

If the injury date is between the admission and discharge dates (ie the accident happened while the patient was in hospital) then the ACC flag can be N and the ACC45 field populated.

Collection method: For this to be 'Y', the healthcare user should be admitted as a result of an accident. This would be either an acute case or someone returning for treatment (in which case an ACC Claim Number would be required).

The accident flag can be set to N and an ACC45 number reported if a patient has an accident in hospital. In this case the injury date must be between the admission and discharge dates.

Related data: ACC claim number

                     Clinical code (classifies the injuries and cause of accident)

Administrative attributes

Source document:

Source organisation: National Data Policy Group

Admission source code

Administrative status

Reference ID: A0169   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Admission source code

Name in database: admission_source_code

Other names:

Element type: Data element

Definition: A code used to describe the nature of admission (routine or transfer) for a hospital inpatient health event.

Context: Hospital inpatient or day patient health event.

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 1   *Layout:* A

Data domain: R   Routine admission
                   T   Transfer from another hospital facility

Guide for use:

Verification rules: Must be a valid code in the Admission Source code table.

Collection method: Patients admitted from rest homes where the rest home is their usual place of residence are routine admissions, not transfers.

Patients transferred using DW or DF event end type codes within the same facility should be readmitted with an admission source code of R.

Related data: Event end type code

Administrative attributes

Source document:

Source organisation: National Data Policy Group

Admission type code

Administrative status

Reference ID: A0171   *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: Admission type code

Name in database: admission_type

Other names: Admission type

Element type: Data element

Definition: A code used to describe the type of admission for a hospital healthcare health event.

Context:

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 2   *Layout:* AA

Data domain: CURRENT
                AA   Arranged admission
                AC   Acute admission
                AP   Elective admission of a privately funded patient
                RL   Psychiatric patient returned from leave of more than 10 days
                WN   Waiting list/booking list

                RETIRED
                ZA   Arranged admission, ACC covered (retired 30 June 2004)
                ZC   Acute, ACC covered (retired 30 June 2004)
                ZP   Private, ACC covered (retired 30 June 2004)
                ZW   Waiting list, ACC covered (retired 30 June 2004)

Guide for use: 'WU' (Waiting list - urgent) code not used from 20 August 1993.

                From July 2004, Admission types 'ZA', 'ZC', ZP' and 'ZW' were replaced by the use of the Accident
                Flag and where it is 'Y', the warning validation to provide an acc claim number

Verification rules: Code must be present in the Admission Type code table.

                The event end date must be on or prior to the Admission type end date (if populated).

                As from 1 July 2004, using a retired code will generate an error message.

Collection method: AA - ARRANGED ADMISSION (introduced in 1995)
                A planned admission where:
                - the admission date is less than seven days after the date the decision was made by the specialist
                that this admission was necessary, or
                - the admission relates to normal obstetric cases, 36 to 42 weeks gestation, delivered during the
                event. In these cases, patients will have been booked into the admitting facility and the health
                specialty code will always be P10 Delivery Services (Mothers).

                AC - ACUTE ADMISSION (introduced in 1994)
                An unplanned admission on the day of presentation at the admitting healthcare facility. Admission
                may have been from the Emergency or Outpatient Departments of the healthcare facility or a transfer
                from another facility. Note that the Accident Insurance Act defines Acute as Acute plus Arranged.

                AP - ELECTIVE (introduced in 1996)
                Elective admission of a privately funded patient in either a public or private hospital.

                RL - PSYCHIATRIC PATIENT RETURNED FROM LEAVE (introduced in 1994)
                A sectioned mental health patient, returning from more than 14 days leave.

                WN - WAITING LIST/BOOKING LIST (introduced in 1994)
                A planned admission where the admission date is seven or more days after the date the decision was
                made by the specialist that this admission was necessary.

Related data:

Administrative attributes

Source document:

Source organisation: National Data Policy Group

Age at admission

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Age at admission

Name in database: age_at_admission

Other names:

Element type: Derived data element

Definition: The age of a patient on admission to hospital.

Context: Demographic information.

Relational and representational attributes

Data type: integer   *Field size:* 3   *Layout:* NNN

Data domain: 000 – 120

Guide for use: Event start date minus date of birth, expressed in completed years.

                         Age at discharge (not Age at admission) is used in official NZHIS publications from the NMDS.

Verification rules:

Collection method:

Related data: Event start date
                         Date of birth

Administrative attributes

Source document:

Source organisation:

Age at discharge

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Age at discharge

Name in database: age_at_discharge

Other names:

Element type: Derived data element

Definition: The age of a patient on discharge from hospital.

Context: Demographic information.

Relational and representational attributes

Data type: char   *Field size:* 3   *Layout:* XXX

Data domain: 000 – 120, XXX

Guide for use: Event end date minus date of birth expressed in completed years. If the event end date is not entered then this field will contain 'XXX'.

Age at discharge (not Age at admission) is the age most often used for analysis.

Verification rules:

Collection method:

Related data: Date of birth
Event end date

Administrative attributes

Source document:

Source organisation:

Age of mother

Administrative status

Reference ID: A0107   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Age of mother

Name in database: age_of_mother

Other names:

Element type: Data element

Definition: Age of mother in years at time of birth of infant.

Context: Birth event.

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:* NN

Data domain: 00 – 99
00 is default value if mother's age is not known.

Guide for use:

Verification rules: If outside 12 to 54 years, will only be accepted on confirmation.

Mandatory for birth events. Must not be supplied for other event types.

Collection method: Only required for babies born in hospital.

Found only on the baby's 'BT' (birth) event.

Related data: Event type code

Administrative attributes

Source document:

Source organisation:

Agency code

Administrative status

Reference ID: A0138 *Version:* 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Agency code

Name in database: agency_code

Other names: Health agency code, DHB

Element type: Data element

Definition: A code that uniquely identifies an agency. An agency is an organisation, institution or group of institutions that contracts directly with the principal health service purchaser to deliver healthcare services to the community.

Context:

Relational and representational attributes *Mandatory*

Data type: char *Field size:* 4 *Layout:* XXXX

Data domain: See the Agency code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.

Guide for use: Historically, also known as CHE (Crown Health Enterprise), HHS (Hospitals and Health Services) and AHB (Area Health Board).

Between 1988 and 1993 the Agency code was assigned based on the original 1993 agency groupings.

If the facility on an event does not belong to the agency, it means that the agency has contracted a facility belonging to a different agency to treat the patient.

Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Data Access Policy on the NZHIS web site at http://www.nzhis.govt.nz/access/index.html.

Verification rules: Must be a valid code in the Agency code table.

Collection method: This is a key field for allocating purchase units.

If agencies merge, a new code may be assigned or the new agency can negotiate with NZHIS to maintain the existing codes.

NZHIS allocates codes on request. The code table is continually updated by NZHIS as hospitals open and close. See the NZHIS web site for the most recent version.

Related data:

Administrative attributes

Source document:

Source organisation: NZHIS

Batch ID

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Batch ID

Name in database: batch_id

Other names:

Element type: Derived data element

Definition: A unique identifier for each batch.

Context:

Relational and representational attributes

Data type: int   *Field size:*   *Layout:*

Data domain:

Guide for use: Generated by the load process. Used internally for reference to the file in which this record was loaded into the NMDS.

The Batch ID is used in place of the batch filename.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Birth location

Administrative status

Reference ID: A0104 *Version:* 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Birth location

Name in database: location_code

Other names: Birth location code, Birth/death location code

Element type: Data element

Definition: The location of the birth delivery of a healthcare user.

Context: Birth event.

Relational and representational attributes

Data type: char *Field size:* 1 *Layout:* N

Data domain:
1	Public hospital
2	Private hospital
3	Psychiatric hospital
4	Other institution
5	Private residence
6	Other
9	Default value

Guide for use:

Verification rules: Mandatory for birth events. Must not be supplied for other event types.

Must be a valid code in the Location code table.

Must match the Facility type code on the Facility table.

Collection method:

Related data: Facility code
Facility type

Administrative attributes

Source document:

Source organisation: NZHIS

Birth status

Administrative status

Reference ID: A0102 **Version:** 1.0 **Version date:** 01-Jan-2003

Identifying and defining attributes

Name: Birth status

Name in database: birth_status

Other names:

Element type: Data element

Definition: Field which records whether an infant was still or liveborn.

Context: Birth event.

Relational and representational attributes

Data type: char **Field size:** 1 **Layout:** A

Data domain: L Liveborn
S Stillborn

Guide for use: Effectively only livebirths are reported to the NMDS.

Verification rules: Mandatory for birth events. Must not be supplied for other event types.

Collection method: Information about fetal deaths (still births) is obtained from death registration records, death certificates and autopsy reports, and is entered directly by NZHIS staff in the Ministry of Health. Provider systems will therefore only report information about livebirths that occur in their facilities. Provider systems may default to 'L' (Liveborn).

The World Health Organization definition of a livebirth is:
'The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which after such separation, breathes or shows other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered liveborn.'

For liveborn infants who die in hospital without ever going home, record the mother's address.

Related data:

Administrative attributes

Source document:

Source organisation:

Birthweight

Administrative status

Reference ID: A0100   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Birthweight
Name in database: birth_weight
Other names: Birth weight
Element type: Data element
Definition: Weight of infant at time of birth, in grams.
Context: Birth event.

Relational and representational attributes

Data type: char   *Field size:* 4   *Layout:* NNNN
Data domain: 0001 – 9999
Guide for use:
Verification rules: Mandatory for birth events. Must not be supplied for other event types.

Records reporting 0001 to 0399 grams will be returned with a warning message that birthweight is unusually low. Hospitals will need to confirm this value before the record will be loaded into the NMDS.

Must contain 4 characters. For infants under 1000 grams, the field must be supplied with a leading zero.

No negative numbers.

Collection method: Record as soon as practicable after the birth event. If not known, the default is '9000'.

For birth events, Weight on admission will be identical to the Birthweight.

Related data: Weight on admission

Administrative attributes

Source document:
Source organisation: NZHIS

CCL

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: CCL

Name in database: ccl

Other names:

Element type: Derived data element

Definition: Complication/co-morbidity class level. This comes out of the DRG grouper program and identifies the clinical severity within a DRG code.

Context: DRG version 3.1

Relational and representational attributes

Data type: char   *Field size:* 1   *Layout:* N

Data domain: 1   minor CC or non-CC
                       2   moderate CC
                       3   major CC
                       4   extreme CC

Guide for use: Relates only to DRG Grouper versions 3.0 and 3.1.

                        Serves the same purpose for DRG Grouper clinical versions 3.0 and 3.1 as PCCL does for DRG Grouper clinical versions 4.1, 4.2 and 5.0.

                        The AR-DRG v4.1 Definitions Manual says CCLs 'are severity weights given to ALL additional diagnoses. They range in value from 0 to 4 for surgical and neonate episodes, and from 0 to 3 for medical episodes, and have been developed through a combination of medical judgement and statistical analysis. CCL values can vary between adjacent DRGs.'

Verification rules:

Collection method:

Related data: DRG code version 3.1
                        PCCL

Administrative attributes

Source document: See the AN-DRG manual

Source organisation: The logic for the DRG software is specified by the Health Services Division of the Commonwealth Department of Health and Ageing, Australia

Client system identifier

Administrative status

Reference ID: A0216   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Client system identifier

Name in database: client_system_identifier

Other names:

Element type: Data element

Definition: An identifier for the corresponding record stored within the health provider's system.

Context:

Relational and representational attributes

Data type: varchar   *Field size:* 14   *Layout:* Free text

Data domain:

Guide for use: With the PMS unique identifier, this replaced the previous Local system health event identifier field in 2000. This field is used to supplement the PMS unique identifier to identify individual records sent to the NMDS.

                         This field is used as a reference field for checking data quality.

Verification rules: Optional.

Collection method: For security reasons, do not use the healthcare user's NHI number.

Related data: Replaces the field previously known as Local system health event identifier.
                         Related to PMS unique identifier.

Administrative attributes

Source document:

Source organisation:

Costweight

Administrative status

Reference ID:　　　　　　　　　　　　　　*Version:* 1.0　　*Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Costweight
Name in database:	cost_weight
Other names:	Cost weight, Case weight
Element type:	Derived data element
Definition:	Calculated value designed to weight a base rate payment.
Context:	

Relational and representational attributes

Data type: numeric　　　　*Field size:* 9　　　　*Layout:* NNNNN.NNNN

Data domain:

Guide for use: Costweight is calculated using the Weighted Inlier Equivalent Separation (WIES) method, according to different schedules each financial year. The Costweight code indicates the schedule.

Every event is given a Costweight, calculated from:
- the DRG code and associated variables
- Length of stay
- Total hours on mechanical ventilation
- some procedure codes and diagnosis codes.
For details, see the Technical Documentation page on http://www.nzhis.govt.nz/.

It is used with Financial year for calculating payments based on the year of Event end date in the patient record.

Verification rules:

Collection method:

Related data: DRG codes
Costweight code
Purchase unit
DRG grouper type code
Health specialty code

Administrative attributes

Source document: See http://www.nzhis.govt.nz.

Source organisation: National Centre for Classification in Health, University of Sydney, Australia (modified for New Zealand contracting)

Costweight code

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Costweight code

Name in database: cost_weight_code

Other names:

Element type: Derived data element

Definition: Indicates the schedule by which the Costweight and Purchase unit are calculated for that financial year.

Context:

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:*

Data domain:

Guide for use:

Verification rules:

Collection method:

Related data: Costweight
                      DRG codes
                      Purchase unit

Administrative attributes

Source document:

Source organisation: DHBNZ

Country of birth code

Administrative status

Reference ID: A0198   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Country of birth code
Name in database:	country_code
Other names:	
Element type:	Data element
Definition:	Coded value for the country of birth as assigned from the Statistics NZ Country Code list (NZSCC86).
Context:	Also reported to the Cancer database. Primarily used for epidemiological studies.

Relational and representational attributes

Data type:	char *Field size:* 3 *Layout:* NNN
Data domain:	004 – 999. See the Country of Birth code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use:	Mandatory for cancer patients until 1 July 2001.
	With the introduction of the Cancer Registry Act, pathologists were given responsibility to ensure that all specified primary cancer cases are reported, and the pathology report became the principal source of information identifying new cases of primary cancer.
	Because pathology reports do not contain all the information required to complete cancer registrations, Section 6 of the legislation also authorises the Cancer Registry to seek additional information from medical practitioners or hospitals. Information not available from laboratories is: Occupation code, Country of birth code, and Extent of cancer disease code.
Verification rules:	Optional.
Collection method:	
Related data:	

Administrative attributes

Source document:	
Source organisation:	Statistics NZ

Date of birth

Administrative status

Reference ID: A0025   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Date of birth
Name in database:	date_of_birth
Other names:	DOB, HCU date of birth, Birth date
Element type:	Data element
Definition:	The date on which the person was born.
Context:	Required to derive age for demographic analyses.

Relational and representational attributes   *Mandatory*

Data type: datetime   *Field size:* 8   *Layout:* CCYYMMDD

Data domain: Valid dates

Partial dates are permissible. At a minimum the century and year must be supplied. If day is provided but month is omitted then the day will not be recorded. Incomplete dates are stored as 'ccyy0101' or 'ccyymm01' and a partial date flag associated with the date is set to the appropriate value.

Guide for use: In 1993 the option to submit partial dates using the partial date flag was introduced.

For events before 1993, there was no partial date option or partial date flag. The default date was 15/6 or 15/month (if the month was known). The 15/6 model of partial dates should only occur in data before 1994/1995.

Used, for example, for analysis by age at a point in time and for use to derive a Diagnosis Related Group (for admitted patients).

Verification rules: Must be on or before the Event start date.

Must be consistent with diagnoses and procedure codes for the record to be loaded. Otherwise it will result in a warning.

Collection method:

Related data: DRG codes
Event start date
Event end date
Operation/procedure date
Age at admission
Age at discharge
Date of birth flag

Administrative attributes

Source document:

Source organisation: National Data Policy Group

Date of birth flag

Administrative status

Reference ID: **Version:** 1.0 **Version date:** 01-Jan-2003

Identifying and defining attributes

Name: Date of birth flag

Name in database: date_of_birth_flag

Other names:

Element type: Derived data element

Definition: Indicates whether the date of birth stored is a partial date.

Context:

Relational and representational attributes

Data type: char *Field size:* 1 *Layout:*

Data domain: Y Only the year is supplied
M The month and year were supplied

Guide for use: A partial date flag, set automatically.

Verification rules:

Collection method:

Related data: Date of birth

Administrative attributes

Source document:

Source organisation: NZHIS

Date updated

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Date updated

Name in database: last_updated_date

Other names: Audit date

Element type: Derived data element

Definition: The date and time an event was loaded into the NMDS.

Context:

Relational and representational attributes

Data type: datetime   *Field size:*   *Layout:*

Data domain: Valid dates

Guide for use: If there are errors in a record, the whole record is deleted and a new record loaded. Therefore this date does not necessarily show when a record was first loaded into the NMDS.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Domicile code

Administrative status

Reference ID: A0023   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Domicile code

Name in database: domicile_code

Other names:

Element type: Data element

Definition: Statistics NZ Health Domicile Code representing a person's usual residential address. Also used for facility addresses.

Usual residential address is defined as the address at which the person has been, or plans to be, living for 3 months or more. (Statistics NZ definition of 'usually resident'.)

If a person usually lives in a rest home or a hospital, that is considered their usual residential address.

Context: Required for demographic analyses. Domicile codes are key variables for determining the characteristics of the population that are using the health sector.

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 4   *Layout:* XXNN

Data domain: See the Domicile code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.

Guide for use: Before July 1993, domicile was coded using the 1986 census Domicile codes. This data has been mapped to the 1991 codes.

Care needs to be exercised when analysing pre-1993 data in terms of population, as the 1991 census split a large number of the 1986 codes into two or more new Domicile codes. As it was not possible to accurately attribute particular events to the correct new code, only one of the new multiple codes could be chosen for each old code. This can result in some areas showing no events for one code and an over-representation of events for the other domicile.

Since 1996, Domicile code has been automatically assigned on the NHI database using the address provided. This can result in rural addresses being assigned to an urban Domicile code where there is insufficient data to generate the correct code. This is because the automated software relies on generating a post code in order to determine where in a related table it should look to find the code. Most events in the NMDS contain a Domicile code that has been generated in this manner.

The Domicile code used for health collections is a four-digit Health Domicile Code specially created by Statistics NZ from their six-digit Census Area Unit Code. This field contains 3 versions of this Domicile code, one for each of the 1991, 1996 and 2001 censuses.

- The 1991 code was used from 1988 to 30 June 1998. (1986 codes were converted to 1991 codes on migration into NMDS in 1993.)
- The 1996 code was used from 1 July 1998 to 30 June 2003.
- The 2001 code has been in use since 1 July 2003.

The series of Domicile codes used depends on the Event end date. If an event does not have an end date, the Event start date is used.

Verification rules: Must be a valid code in the Domicile code table.

If the Event end date (or, if the Event end date is blank, the Event start date) is less than 1 July 1998 and Year of census is 1996 then convert the new domicile back to old 1991 code.

For Event end dates on or after 1 July 1998 the 1996 codes apply. For Event end dates on or after 30 June 2003, the 2001 codes apply. (If the Event end date is blank, check the Event start date and that the status of the code is current. If not current, generate an error message.)

Collection method: The code table contains current and retired codes (see status column: C = current and R = retired). Some of the codes from the 1991 census were replaced by new codes in the 1996 census, and these should not be used for events with an Event end date after 30 June 1998. The 1991 and 1996 Domicile codes made redundant by the 2001 census should not be used for events with an Event end

date after 30 June 2003.

New general codes have been added for DHBs from 1 July 2001. General DHB codes should be a last resort, used only if the correct Domicile code cannot be determined.

Care should be taken to record accurate and useful residential addresses, since Domicile codes may be automatically assigned using this information.

Related data: TLA of domicile

Administrative attributes

Source document:

Source organisation: Statistics NZ

DRG code current

Administrative status

Reference ID: A0165   *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: DRG code current

Name in database: drg_code_current

Other names:

Element type: Derived data element

Definition: A diagnosis-related group (DRG) code of clinical version 4.1, 4.2 or 5.0 produced by invoking the current DRG grouper program version 5.0 which takes up to 30 diagnoses and 30 procedure codes in a health event and assigns a DRG code based on a complex algorithm. The version 4 groupers used 20 codes. This provides another way of analysing event information based on classifying episodes of inpatient care into clinically meaningful groups with similar resource consumption.

Context: Clinical demographic and administrative information within a health event.

Relational and representational attributes

Data type: char   *Field size:* 4   *Layout:* ANNA

Data domain: 901Z – 963Z, A01Z – Z65Z

Guide for use: Introduced on 1 July 2001 for DRG clinical version 4.1.

If the Event end date is between 1 July 2001 and 30 June 2002, this field contains a DRG code of clinical version 4.1.

If the Event end date is between 1 July 2002 and 30 June 2004, this field contains a DRG code of clinical version 4.2.

If the Event end date is on or after 1 July 2005, this field contains a DRG code of clinical version 5.0.

Calculated from:
- personal information (eg, Sex, Date of birth), and
- event information (eg, Admission date, Event end type), and
- diagnosis and procedure information in the appropriate ICD code for the DRG Grouper (ICD-10-AM 3rd Edition).
- Between 1 July 2004 and 30 June 2005, most hospitals will supply diagnosis and procedure information using ICD-10-AM 3rd Edition codes. As AR-DRG version 5.2 requires ICD-10-AM 2nd Edition codes, NZHIS will map the 3rd edition codes supplied by hospitals to 2nd edition codes and use these to assign an AR-DRG 4.2 code.
- From 1 July 2005, most hospitals will supply diagnosis and procedure information using ICD-10-AM 3rd Edition codes. AR-DRG version 5.0 requires no additional mapping.

Verification rules:

Collection method: The current DRG grouper is AR-DRG version 5.0, which uses up to 30 ICD diagnoses and up to 30 procedures. External cause codes are not used by the grouper. It is recommended that hospitals prioritise diagnoses and procedure codes in order to present the grouper with the most severe diagnoses and operations.

The DRG code is calculated by NZHIS. It is not sent in to the NMDS by hospitals.

Related data: Costweight code
Costweight
Purchase unit
PCCL
MDC code
MDC type
DRG grouper type code

Administrative attributes

Source document:

Source organisation: The logic for the DRG software is specified by the Health Services Division of the Commonwealth Department of Health and Ageing, Australia.

DRG code version 3.0

Administrative status

Reference ID: A   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: DRG code version 3.0
Name in database: drg_code_v30
Other names:
Element type: Derived data element
Definition: Diagnosis-related group code produced by version 3.0 of AN-DRG.
Context:

Relational and representational attributes

Data type: char   *Field size:* 3   *Layout:* XXX
Data domain:
Guide for use: Not used.
Verification rules:
Collection method:
Related data:

Administrative attributes

Source document:
Source organisation:

DRG code version 3.1

Administrative status

Reference ID: A *Version:* 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: DRG code version 3.1

Name in database: drg_code_v31

Other names:

Element type: Derived data element

Definition: Diagnosis-related group code produced by clinical version 3.1 of AN-DRG Grouper.

Context: Clinical demographic and administrative information within a health event.

Relational and representational attributes

Data type: char *Field size:* 3 *Layout:* NNN

Data domain: 001 – 956

Guide for use: A diagnosis-related group (DRG) produced by invoking a DRG program that compares all diagnostic codes in a health event and assigns a DRG code based on a complex series of decision trees.

This classifies the episodes of inpatient care into clinically meaningful groups with similar resource consumption.

Until 1 July 2001 the clinical version of AN-DRG 3.1 was produced by running 3M version 3.1 AN-DRG Grouper Program over ICD-9-CM-A version II diagnosis and procedure codes. Since July 2001, 3M AR-DRG version 4.2 of the Grouper Program has been used to generate clinical version 3.1 codes in this field. The current version (4.2) uses up to 20 diagnoses and 20 procedure codes. The previous version (3.1) used up to 15 diagnoses and 15 procedures.

Before 1 July 1995 for DRG v3.1 data providers mostly reported only 4 diagnosis and 3 procedure codes, so that was all that was available for DRG assignment.

DRG codes of clinical version 3.1 are stored for all events, as this field is often used for analysis.

Verification rules:

Collection method: The current DRG grouper is AR-DRG version 4.2, which also produces codes in versions 3.1 and 4.1 or 4.2 as appropriate. The grouper accepts up to 20 diagnoses and 20 procedure codes for clinical version 3.1. External cause codes are not used by the grouper. Hospitals can report up to 99 diagnosis and procedure codes for each event, therefore it is recommended that hospitals prioritise diagnoses and procedure codes in order to present the grouper with the most severe diagnoses and operations.

Related data: CCL
Costweight code
Costweight
Purchase unit
MDC code
MDC type
DRG grouper type code

Administrative attributes

Source document:

Source organisation: The DRG code version 3.1 is currently calculated by NZHIS using the AR-DRG Grouper Program version 4.2. It is not sent in to the NMDS by hospitals.

DRG grouper type code

Administrative status

Reference ID: A0167   *Version:* 1.1   *Version date:* 01-Jul-2005

Identifying and defining attributes

Name: DRG grouper type code

Name in database: drg_grouper_type

Other names:

Element type: Derived data element

Definition: A code to describe the clinical version of the DRG calculation used.

Context:

Relational and representational attributes

Data type: varchar   *Field size:* 2   *Layout:* NN

Data domain: 01   Medicare version 4.0 Secondary Care (retired)
                  02   AN-DRG version 3.1
                  03   AR-DRG version 4.1
                  04   AR-DRG version 4.2
                  05   AR-DRG version 5.0

Guide for use: DRG grouper type code should be the same as the MDC type.

'02' was used until 30 June 2000.
'03' was used between 1 July 2000 and 30 June 2002.
'04' was used between 1 July 2002 and 30 June 2005
'05' will be used from 1 July 2005.

The grouper software version produce a number of clinical versions. NZHIS is currently using software version 5.0 to produces DRG codes of clinical versions 3.1, 4.1, 4.2 and 5.0. This field describes the clinical version.

Verification rules:

Collection method:

Related data: DRG codes
                   MDC type
                   MDC code

Administrative attributes

Source document:

Source organisation:

Encrypted NHI number

Administrative status

Identifying and defining attributes

Name:	Encrypted NHI number
Name in database:	encrypted_hcu_id
Other names:	Encrypted HCU identifier, Encrypted NHI, etc. See other names for the NHI number under 'Guide for use' below.
Element type:	Derived data element
Definition:	The NHI number in encrypted form.
Context:	The NHI number is the cornerstone of NZHIS's data collections. It is a unique 7-character identification number assigned to a healthcare user by the National Health Index (NHI) database. The NHI number uniquely identifies healthcare users, and allows linking between different data collections. It is encrypted in the NMDS to ensure privacy of individual records.

Relational and representational attributes   *Mandatory*

Data type:	char *Field size:* 11 *Layout:*
Data domain:	System-generated
Guide for use:	THE NHI NUMBER The NHI number is also known as National Health Index, HCU identifier, NHI, HCU, HCU Number, Healthcare User identifier, HCU identification number, NMPI number, Hospital Number, Patient Number. When duplicate records for a healthcare user are merged, one of their NHI numbers will be deemed to be the master (or primary), and the others become event (or secondary) NHI numbers. This does not affect which NHI numbers are used in local systems. In the NMDS, the NHI number that is sent in by the data provider is encrypted during the loading process. Only this encrypted NHI number is stored. For the analysis of healthcare information relating to a unique individual, the master NHI number should be used. Please contact an NZHIS information analyst for further information on how to obtain the master encrypted NHI number if you are performing your own data extraction. The Privacy Commissioner considers the NHI number to be personally identifying information (like name and address) so, if it is linked to clinical information, it must be held securely and the healthcare user's privacy protected. The Encrypted NHI number is not considered personally identifying. NZHIS will return data containing unencrypted NHI numbers to providers who have sent it in. Information with unencrypted NHI numbers may be disclosed to researchers on a case-by-case basis. VALIDATION The first three characters of an NHI number must be alpha (but not 'I' or 'O'). The 4th to 6th characters must be numeric. The 7th character is a check digit modulus 11. ENCRYPTION The NHI number is encrypted using a one-way encryption algorithm. The aim is to provide an encrypted number that can be sent across public (unsecured) networks.
Verification rules:	Must be registered on the NHI database before the NHI number can be used in the NMDS. There is a verification algorithm which ensures that the NHI number is in the correct format and is valid. The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix F: Duplicate and overlapping event checking rules.
Collection method:	NHI numbers are often included on patient notes and other patient documentation. New numbers can be allocated by health providers who have direct access to the NHI Register. New NHI numbers are also allocated by HealthPAC for GPs and other primary care providers.
Related data:	

Administrative attributes

Source document: http://www.nzhis.govt.nz/nhi/

Source organisation: NZHIS

Ethnic group codes

Administrative status

Reference ID: A0027,A0208,A0209   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Ethnic group codes
Name in database:	ethnic_code, ethnic_code_2, ethnic_code_3
Other names:	Ethnicity
Element type:	Data element
Definition:	A social group whose members have one or more of the following four characteristics: - they share a sense of common origins - they claim a common and distinctive history and destiny - they possess one or more dimensions of collective cultural individuality - they feel a sense of unique collective solidarity.
Context:	Information on ethnicity is collected for planning and service delivery purposes and for monitoring health status across different ethnic groups. Ethnic group codes are key variables for determining the characteristics of the population that are using the health sector.

Relational and representational attributes

Mandatory

Data type: char   *Field size:* 2   *Layout:* NN

Data domain:		
	10	European not further defined
	11	NZ European
	12	Other European
	21	NZ Maori
	30	Pacific Island not further defined
	31	Samoan
	32	Cook Island Maori
	33	Tongan
	34	Niuean
	35	Tokelauan
	36	Fijian
	37	Other Pacific Island (not listed)
	40	Asian not further defined
	41	South East Asian
	42	Chinese
	43	Indian
	44	Other Asian
	51	Middle Eastern
	52	Latin American/Hispanic
	53	African
	54	Other
	99	Not stated

Guide for use:	From 1 July 1996 up to 3 Ethnic group codes can be collected for each healthcare user and each event. Where more than 3 Ethnic group codes are reported, the Statistics NZ prioritisation algorithm is used to report only 3 values. Because ethnicity is self-identified, it can change over time. This is why NZHIS collects ethnicity information for each health event, rather than relying on the data in the National Health Index (which does not include historical data).
Verification rules:	Ethnicity 1 is mandatory. Ethnicity 2 and Ethnicity 3 are optional. Ethnicity 2 cannot be the same as Ethnicity 1 or 3. Ethnicity 3 cannot be the same as Ethnicity 2 or 1. Must be a valid code in the Ethnic code table.
Collection method:	Ethnicity should be self-identified wherever possible. If the Ethnic group code changes for this event, please update the NHI. Use of the code '54' (Other) is limited to only about 5 ethnic groups. It must not be used as a generic 'other' code. If a person chooses not to answer the ethnicity question, record their ethnicity as 'not stated'. See Appendix C: Collection of Ethnicity Data.

Each ethnic group as maintained by Statistics NZ has a 5-digit code. NZHIS collections use only the first 2 digits.

Related data: Prioritised ethnicity

Administrative attributes

Source document: Smith, Anthony. 1981. The Ethnic Revival. Cambridge University Press.

Source organisation: Statistics NZ, modified by the National Data Policy Group

Event end date

Administrative status

Reference ID: A0151   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Event end date
Name in database:	event_end_date
Other names:	Discharge date, Event end/leave date
Element type:	Data element
Definition:	The date on which a healthcare user is discharged from a facility (ie, the date the heathcare event ended) or the date on which a sectioned mental health patient is discharged to leave.
Context:	

Relational and representational attributes

Data type:	datetime	*Field size:* 8	*Layout:*	CCYYMMDD
Data domain:	Valid date			
Guide for use:				

Verification rules: Partial dates not allowed.

Optional for psychiatric inpatient events. Mandatory for births, intended day cases and non-psychiatric inpatient events.

Must be on or before the date of load and the Psychiatric leave end date.

Must be on or after the Event start date, the Date of birth, the Operation/procedure date, and the External cause date of occurrence.

Collection method:

Related data: Event end type code
Date of birth
Event start date
Operation/procedure date
Event leave days
Age at discharge
Length of stay
Year of data
Month of data
Financial year

Administrative attributes

Source document:

Source organisation:

Event end type code

Administrative status

Reference ID: A0157   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Event end type code
Name in database:	event_end_type
Other names:	Discharge type
Element type:	Data element
Definition:	A code identifying how a healthcare event ended.
Context:	

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:* AA

Data domain:

DA	Discharge to an acute facility
DC	Psychiatric patient discharged to community care
DD	Died
DF	Statistical discharge for change in funder
DI	Self-discharge from hospital, indemnity signed
DL	Committed psychiatric patient discharged to leave for more than 10 days
DN	Psychiatric remand patient discharged without committal
DO	Discharge of a patient for organ donation
DP	Psychiatric patient transferred for further psychiatric care
DR	Ended routinely
DS	Self-discharge from hospital (no idemnity)
DT	Discharge of non-psychiatric patient to another healthcare facility
DW	Discharge to other service within same facility between the following types of speciality: AT&R, mental health, obstetric, and personal health. Not to be used for transfer between surgical and medical.

Guide for use: 'RO' was superseded on 1 July 1994.
'DA' and 'DW' were introduced in 1995.
'DO' was introduced in 1997.
'DF' was introduced in 2000.

Verification rules: Must be a valid code in the Event End Type code table.
Optional for psychiatric inpatient events.
Mandatory for all other event types.

Collection method: NOTES RE 'DA'
'DA' is only used in cases where the patient is being transferred within 5 days of admission, and:
- the patient being transferred has a principal diagnosis of stroke, or
- the discharge is directly due to the need for immediate treatment at a neonatal facility, a specialist burns unit, or a multiple trauma unit.

The code 'DA' is required for accurate classification to DRG for the following types of case:

1. An infant aged less than or equal to 28 days is required to be discharged directly to a specialist neonatal unit for acute care which is not available at the discharging facility.
For example, a newborn infant with a condition that cannot be treated adequately at the healthcare facility where the birth took place is transferred to the specialist neonatal unit at another healthcare facility for acute care. The discharge of the infant from the hospital of birth would be recorded as 'DA'.

2. A patient of any age required to be discharged directly to a specialist burns unit for acute care which is not available at the discharging facility.
For example, a person suffering burns in an accident is taken to the nearest healthcare facility for immediate treatment and assessment and then transferred to a specialist burns unit for acute care. The discharge of the patient from the hospital where immediate treatment and assessment took place would be recorded as 'DA'.

NOTES RE 'DW'
Discharge type 'DW' is available to be used for any internal transfers between any specialties except Surgical (S) and Medical (M) and vice versa. If the transfer is to another facility (using a different Facility code) then the discharge type 'DT' must be used.

Some examples showing the use of 'DW' are given below (this is not an exclusive list):

1. Assessment, Treatment and Rehabilitation Unit Services
Inpatient Assessment, Treatment and Rehabilitation (AT&R) care should be able to be identified separately. That is, all AT&R inpatient episodes of care should result in a discharge for which the Health Specialty Code is Geriatric AT&R (D00+D10) or Psychogeriatric AT&R (D20+D30), for the period in which the healthcare user was under the care of the inpatient AT&R service.

Healthcare users can arrive at an AT&R Unit by a number of means. Three examples follow:

a. The healthcare user is admitted to a healthcare facility with a medical (eg, acute stroke) or surgical (eg, fractured hip with reduction) problem. If a clinical decision is made to move the healthcare user to an AT&R unit within the same healthcare facility, then there must be a discharge from the Medical or Surgical Specialty with an Event end type of 'DW' and an admission to the AT&R unit.

b. The healthcare user is a Disability Support Service (DSS) resident. If the healthcare user develops a problem which requires AT&R unit services in the same healthcare facility, they should be discharged from the DSS Specialty with an Event end type of 'DW' and admitted to the AT&R unit.

c. The healthcare user, once admitted to an AT&R Specialty, develops the need for a significant medical or surgical intervention. When this need is above and beyond what would be expected to be delivered in an AT&R Specialty, the healthcare user should be discharged from the AT&R Specialty with an Event end type of 'DW' and admitted to the appropriate medical/surgical specialty. They may later be discharged (DW) and readmitted to AT&R for post-treatment care.

This example would result in three separate inpatient events (and three DRGs) during one continuing episode of inpatient care.

2. Health Agency DSS Long-term Resident Inpatient Services
Personal Health inpatient services provided to DSS long-term inpatients should be identified separately. That is, Personal Health episodes of care should result in a discharge using a Personal Health specialty code and Event end type 'DW', for the period in which the healthcare user was under the care of the Personal Health inpatient specialty. This applies to Personal Health inpatient services for people under the care of specialists within Geriatric and Psychogeriatric Long-term Care, Rest Home, IH, Physical Disability and Long-term Psychiatric.

When the responsibility for the care of eligible people who are long-term DSS 'residents' in a facility is to be reassigned to a Personal Health specialty within the same facility, they should be discharged from the DSS specialty and admitted to the relevant Personal Health Specialty. In most cases there will be a physical transfer of the person, but this is not the determining factor. Instead, the issue is the change in responsible clinician during the period in which the Personal Health treatment is undertaken.

At the time the responsibility for the person's care reverts back to the DSS specialty, the person should be discharged from the Personal Health specialty with an Event end type of 'DW' and admitted again to the DSS specialty. Refer to the ACC booklet 'Accident Services - Who Pays' available from http://www.acc.co.nz/for-providers/resources/.

NOTE RE 'DT'
Event end type 'DT' now includes discharge to another healthcare facility for care (except for discharges to a specialist neonatal unit or specialist burns unit; see 'DA'). Transfers to rest homes for convalescence or rehabilitation are included, provided that the rest home is not the usual place of residence.

NOTE RE 'DF'
'DF' may be used when the acute period of care for an accident case ends and the event continues but is funded by a private insurer. Refer to the ACC booklet 'Accident Services - Who Pays' for further information on these cases.

Related data: Event end date

Administrative attributes

Source document:

Source organisation: National Data Policy Group

Event ID

Administrative status

Reference ID: A0156

Version: 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Event ID

Name in database: event_id

Other names:

Element type: Data element

Definition: An internal reference number that uniquely identifies a health event.

Context: Any event on the NMDS.

Relational and representational attributes

Data type: integer   *Field size:* 12   *Layout:* NNNNNNNNNNNN

Data domain:

Guide for use: Serves as the primary key for all data tables. Event ID is assigned by NZHIS on load, so if an event is deleted and then reloaded, a new Event ID will be assigned.

Unique link between the main tables in the database.

Verification rules: Add 1 to the previous maximum number.

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Event leave days

Administrative status

Reference ID: A0155   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Event leave days
Name in database:	event_leave_days
Other names:	Leave days
Element type:	Data element
Definition:	The number of days an inpatient on leave is absent from the hospital at midnight, up to a maximum of three days (midnights) for non-psychiatric hospital inpatients for any one leave episode. Where there is more than one period of leave during an episode, accumulated leave days should be reported.
Context:	

Relational and representational attributes

Data type:	char *Field size:* 3 *Layout:* NNN
Data domain:	000 – 999
Guide for use:	
Verification rules:	Optional. Event leave days must be null or greater than zero. Event leave days must not be greater than the difference in days between Event start date and Event end date.
Collection method:	This is not how leave is calculated for sectioned mental health patients, and their leave days should not be accumulated under this field. If after three days for non-psychiatric hospital inpatients or 14 days for informal mental health inpatients the patient has not returned to care, discharge is effective on the date of leaving hospital. These days should not be recorded as Event leave days in this case.
Related data:	Event start date Event end date Length of stay

Administrative attributes

Source document:

Source organisation: National Data Policy Group

Event local identifier

Administrative status

Reference ID: A0156   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Event local identifier

Name in database: event_local_id

Other names: Local ID

Element type: Data element

Definition: Local system-generated number to distinguish two or more events of the same type occurring on the
                          same day at the same facility.

Context:

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 1   *Layout:* N

Data domain: 1 – 9

Guide for use:

Verification rules: The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a
                       unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix F:
                       Duplicate and overlapping event checking rules.

Collection method: Use 9 first then ' 8,7, …,1'.

Related data:

Administrative attributes

Source document:

Source organisation:

Event start date

Administrative status

Reference ID: A0150   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Event start date

Name in database: event_start_date

Other names: Admission date

Element type: Data element

Definition: The admission date on which a healthcare event began.

Context: Admitted patients.

Relational and representational attributes   *Mandatory*

Data type: datetime   *Field size:*   *Layout:* CCYYMMDD

Data domain: Valid date

Guide for use:

Verification rules: Must be on or before the Date of load and the Event end date. Must be the same as the Date of birth for Birth Events.

Partial dates not allowed.

The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix F: Duplicate and overlapping event checking rules.

Collection method:

Related data: Date of birth
Event end date
Operation/procedure date
Event leave days
Age at admission
Length of stay

Administrative attributes

Source document:

Source organisation:

Event summary suppress flag

Administrative status

Reference ID: A0175   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Event summary suppress flag
Name in database: suppression_flag
Other names:
Element type: Data element
Definition: A flag signifying that the healthcare user has requested that details of this event not be passed to the event summary extract for display in the MWS system.
Context:

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:*   1   *Layout:* A
Data domain: Y   suppress this event summary
                    N   allow this event summary to be displayed
Guide for use:
Verification rules:
Collection method: Providers should inform patients that their data will be sent to NZHIS for inclusion in the NMDS, and advise them that the event may also be viewed via the Medical Warning System. The patient must be given the option of suppressing the event from display on the NMDS, but the patient does not have the right to object to the information being stored on the NMDS.
Related data:

Administrative attributes

Source document:
Source organisation:

Event supplementary information

Administrative status

Reference ID: A0173   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Event supplementary information
Name in database: event_extra_information
Other names: Comment field, Free text field
Element type: Data element
Definition: Enables extra information concerning an event to be recorded in a free-text format.
Context:

Relational and representational attributes

Data type: varchar   *Field size:* 90   *Layout:* Free text
Data domain:
Guide for use: The field is currently used primarily for cancer events, as a place to record extra information about
                        primary tumours. It may also be used to supply extra information for external cause of injury where the
                        diagnosis description field is not long enough.
Verification rules: Optional.
Collection method:
Related data:

Administrative attributes

Source document:
Source organisation:

Event type code

Administrative status

Reference ID: A0159   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Event type code
Name in database: event_type
Other names: Event type
Element type: Data element
Definition: Code identifying the type of health event.
Context:

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 2   *Layout:* AA
Data domain: BT   Birth event (infants born in reporting hospital)
                 DT   Death event (NZHIS use only)
                 ID   Intended day case
                 IM   Psychiatric inpatient event (include day patients)
                 IP   Non-psychiatric inpatient event (include day patients)
                 GP   General practitioner event (NZHIS use only)
                 OP   Outpatient event (NZHIS use only)
Guide for use:
Verification rules: Must be a valid code in the Event Type code table.

Only one birth event is allowed for each NHI number. Babies born before mother's admission to hospital or transferred from the hospital of birth are recorded as IP.

The presence of some fields depends on the Event type code. See Appendix E: Enhanced Event Type/Event Diagnosis Type Table.

The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix F: Duplicate and overlapping event checking rules.

Collection method: 'ID' is to be used where the intention at admission is that the event will be a day-case event.

'IP': The definition of a mental health patient is 'a patient who has a mental illness diagnosis'. Patients with an intellectual disability are no longer regarded as mental health patients. With the introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992 on 1 November 1992, it became possible for mental health patients, both informal (ie, voluntary) and formal, to be admitted to a general ward of any public hospital or psychiatric hospital. When a mental health patient is admitted to a general ward for treatment of a psychiatric illness, then the event type code of 'IP' can now be used. This also includes day patients. A legal status code and leave details must also be supplied for these patients if relevant. The default for legal status is 'I' (voluntary patient).

Related data:

Administrative attributes

Source document:
Source organisation:

Facility code

Administrative status

Reference ID: A0143   *Version:* 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Facility code

Name in database: facility_code

Other names: Health agency facility code, Hospital, HAF code, HAFC

Element type: Data element

Definition: A code that uniquely identifies a healthcare facility.

        A healthcare facility is a place, which may be a permanent, temporary, or mobile structure, that healthcare users attend or are resident in for the primary purpose of receiving healthcare or disability support services. This definition excludes supervised hostels, halfway houses, staff residences, and rest homes where the rest home is the patient's usual place of residence.

Context:

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 4   *Layout:* NNNN

Data domain: See the Facility code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.

Guide for use: Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Data Access Policy on the NZHIS web site at http://www.nzhis.govt.nz/access/index.html.

Verification rules: Must be a valid code in the Facility code table.

        The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix F: Duplicate and overlapping event checking rules.

Collection method: NZHIS allocates codes on request. The code table is continually updated by NZHIS as hospitals open and close. See the NZHIS web site for the most recent version.

Related data: Birth location
        Facility type

Administrative attributes

Source document:

Source organisation: NZHIS

Facility type

Administrative status

Reference ID: A0148   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Facility type

Name in database: facility_type

Other names:

Element type: Derived data element

Definition: A code that categorises facilities into particular types.

Context:

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:* NN

Data domain: 01   Public hospital
            02   Private hospital
            03   Psychiatric hospital
            04   GP practice
            10   Health centre
            11   Local cancer registry
            12   Mental health outpatient service
            13   Cervical screening programme
            14   Drug and alcohol treatment facility
            15   Mental health community skills enhancement facility
            16   Kaupapa Maori service
            17   Pacific Island service
            18   Mental health community team
            19   Child, adolescent and family service
            20   Mental health day hospital
            21   Mental health residential 1 to 5 facility
            22   Mental health residential and skills enhancement facility
            23   Forensic mental health treatment facility
            24   Intellectual disability facility
            25   Charitable trust facility
            99   Other

Guide for use: Used with Principal health service purchaser in determining whether an event is publicly funded.

Verification rules:

Collection method:

Related data: Facility code
            Birth location
            Private flag

Administrative attributes

Source document: Create using the Facility type from the Facility table

Source organisation:

Financial year

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Financial year
Name in database: financial_year
Other names:
Element type: Derived data element
Definition: Field identifying which financial year data belongs to.
Context:

Relational and representational attributes

Data type: char   *Field size:* 8   *Layout:* CCYYCCYY
Data domain: Range from '19221923', XXXXXXXX.
Guide for use: Runs from 1 July to 30 June. For example, 1 July 1998 to 30 June 1999 would be entered as
                  '19981999'.

                  Almost all data requests are based on a time period, the main ones of which are calendar and fiscal
                  years.

                  XXXXXXXX is used for those events where there is no Event end date. Event end date is not
                  mandatory for mental health events.
Verification rules: Derived from Event end date where present. If Event end date is missing then set to 'XXXXXXXX'.
Collection method:
Related data: Event end date

Administrative attributes

Source document:
Source organisation:

Gestation period

Administrative status

Reference ID: A0101   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Gestation period
Name in database:	gestation_period
Other names:	Gestation
Element type:	Data element
Definition:	Time measured from the date of mother's last menstrual period to the date of birth and expressed in completed weeks.
Context:	Birth event.

Relational and representational attributes

Data type:	char *Field size:* 2 *Layout:* XX
Data domain:	XX = not stated 10 – 50 completed weeks
Guide for use:	
Verification rules:	Mandatory for birth events. Must not be supplied for other event types. If outside 17 to 45 completed weeks, will only be accepted on confirmation.
Collection method:	
Related data:	

Administrative attributes

Source document:

Source organisation:

Health specialty code

Administrative status

Reference ID: A0179   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Health specialty code

Name in database: health_specialty_code

Other names: HSC, Service code, Department code

Element type: Data element

Definition: A classification describing the specialty or service to which a healthcare user has been assigned, which reflects the nature of the services being provided.

Context: Healthcare user on discharge.

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 3   *Layout:* ANN

Data domain: See the Health Specialty code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.

Guide for use: Generalist and specialist subspecialty medical and surgical health specialty codes were retired from 1 July 2001.

Verification rules:

Collection method: The specialty reported to the NMDS should be the specialty for the patient at the time of discharge.

Related data: Purchase unit
                        Costweight

Administrative attributes

Source document:

Source organisation: National Data Policy Group

Length of stay

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Length of stay

Name in database: length_of_stay

Other names: LOS

Element type: Derived data element

Definition: Length of stay in a facility in days.

Context:

Relational and representational attributes

Data type: char   *Field size:* 5   *Layout:* NNNNN

Data domain: 00001 – 99999

Guide for use: Calculated for events with an Event end date as Event end date minus Event start date minus Event leave days. Equates to midnights spent in hospital.

Verification rules:

Collection method:

Related data: Event start date
                   Event end date
                   Event leave days

Administrative attributes

Source document:

Source organisation:

MDC code

Administrative status

Reference ID: A0163   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: MDC code

Name in database: mdc_code

Other names:

Element type: Derived data element

Definition: The Major Diagnostic Category (MDC) is a category generally based on a medical classification that is associated with a particular medical speciality. MDCs are assigned by the DRG grouper program.

Context:

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:* NN

Data domain: 00   Ungroupable
                  01   Diseases and disorders of the nervous system
                  02   Diseases and disorders of the eye
                  03   Diseases and disorders of the ear, nose, mouth and throat
                  04   Diseases and disorders of the respiratory system
                  05   Diseases and disorders of the circulatory system
                  06   Diseases and disorders of the digestive system
                  07   Diseases and disorders of the hepatobiliary system and pancreas
                  08   Diseases and disorders of the musculoskeletal system and connective tissue
                  09   Diseases and disorders of the skin, subcutaneous tissue and breast
                  10   Endocrine, nutritional and metabolic diseases and disorders
                  11   Diseases and disorders of the kidney and urinary tract
                  12   Diseases and disorders of the male reproductive system
                  13   Diseases and disorders of the female reproductive system
                  14   Pregnancy, childbirth and the puerperium
                  15   Newborn and other neonates
                  16   Diseases and disorders of blood, blood-forming organs and immunological disorders
                  17   Neoplastic disorders (haematological and solid neoplasms)
                  18   Infectious and parasitic diseases (systemic or unspecified sites)
                  19   Mental diseases and disorders
                  20   Alcohol/drug use and alcohol/drug-induced organic mental conditions
                  21   Injuries, poisoning and toxic effects of drugs
                  22   Burns
                  23   Factors influencing health status and other contacts with health services

Guide for use: Produced by running the grouper programs, which use data from the Health Event and Diagnosis Procedure tables.

Verification rules:

Collection method:

Related data: MDC type
                  DRG codes
                  DRG grouper type code

Administrative attributes

Source document:

Source organisation: National Centre for Classification in Health, University of Sydney, Australia

MDC type

Administrative status

Reference ID: *Version:* 1.1   *Version date:* 01-Jul-2005

Identifying and defining attributes

Name: MDC type

Name in database: mdc_type

Other names:

Element type: Derived data element

Definition: A code denoting which clinical version of a grouper a Major Diagnostic Category (MDC) code belongs
                           to.

Context:

Relational and representational attributes

Data type: char   *Field size:* 1   *Layout:* A

Data domain: A   AN-DRG version 3.1
                     B   AR-DRG version 4.1
                     C   AR-DRG version 4.2
                     D   AR-DRG version 5.0

Guide for use: Derived from the clinical version of the grouper used to create the DRG code.

Verification rules:

Collection method:

Related data: MDC code
                     DRG codes
                     DRG grouper type code

Administrative attributes

Source document:

Source organisation: National Centre for Classification in Health, University of Sydney, Australia

Month of data

Administrative status

Reference ID: *Version:* 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Month of data

Name in database: month_of_data

Other names:

Element type: Derived data element

Definition: Field to assist in compiling fiscal year datasets.

Context:

Relational and representational attributes

Data type: char *Field size:* 2 *Layout:* MM

Data domain: 01 – 12, XX

Guide for use:

Verification rules: Derived from the month of discharge. If Event end date is missing then set to 'XX'.

Collection method:

Related data: Event end date

Administrative attributes

Source document:

Source organisation:

NZ resident status

Administrative status

Reference ID: A0024   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: NZ resident status

Name in database: nz_resident_status

Other names: HCU resident status, Residency, Resident status, HCU NZ resident status

Element type: Data element

Definition: A code identifying resident status at the time of this event.

A permanent resident is defined as a person who:
- resides in New Zealand and
- is not a person to whom Section 7 of the Immigration Act 1987 applies or a person obliged by or pursuant to that Act to leave New Zealand immediately or within a specified time or deemed for the purposes of that Act to be in New Zealand unlawfully.

Context: Used to identify overseas residents treated in New Zealand. Tied to public funding of events.

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 1   *Layout:* A

Data domain: Y   permanent resident (New Zealand citizen or classified as 'ordinarily resident in New Zealand')
                   N   temporary (not a New Zealand citizen, does not have New Zealand 'ordinarily resident' status)

Guide for use:

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document: Immigration Act 1987

Source organisation: National Data Policy Group

Occupation code

Administrative status

Reference ID: A0134   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Occupation code
Name in database:	occupation_code
Other names:	
Element type:	Data element
Definition:	The current occupation of a healthcare user, classified according to the Statistics NZ Standard Classification of Occupations (NZSCO90).
Context:	At time of admission.

Relational and representational attributes

Data type: char   *Field size:* 4   *Layout:* NNNN

Data domain:	0111 – 9900. See the Occupation code table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use:	The code used is no longer the current Statistics NZ code. Only reported for cancer patients until 2001.
Verification rules:	Optional.
Collection method:	Optional for all health events. Must be a valid code in the code table. Occupation free-text is preferred.
Related data:	Occupation free-text Clinical code

Administrative attributes

Source document:

Source organisation:

Occupation free-text

Administrative status

Reference ID: A0215   *Version:*   1.0   *Version date:*   01-Jan-2003

Identifying and defining attributes

Name: Occupation free-text

Name in database: occupation_free_text

Other names:

Element type: Data element

Definition: Free-text description of the patient's occupation.

Context: At the time of admission

Relational and representational attributes

Data type: varchar   *Field size:*   70   *Layout:* Free text

Data domain:

Guide for use: Introduced on 1 July 1999.

                      With the introduction of the Cancer Registry Act, pathologists were given responsibility to ensure that all specified primary cancer cases are reported, and the pathology report became the principal source of information identifying new cases of primary cancer.

                      Because pathology reports do not contain all the information required to complete cancer registrations, Section 6 of the legislation also authorises the Cancer Registry to seek additional information from medical practitioners or hospitals. Information not available from laboratories is: Occupation code, Country of birth code, and Extent of cancer disease code.

Verification rules: Optional. May be sent for all events.

Collection method: Should be reported for cancer patients.

Related data: Occupation code

Administrative attributes

Source document:

Source organisation:

PCCL

Administrative status

Reference ID: *Version:* 1.1 *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: PCCL

Name in database: pccl

Other names:

Element type: Derived data element

Definition: Patient clinical complexity level comes out of the DRG grouper program and identifies the clinical severity within the record.

Context:

Relational and representational attributes

Data type: char *Field size:* 1 *Layout:*

Data domain:

Guide for use: Relates only to DRG Grouper versions 4.1, 4.2 and 5.0.

Serves the same purpose for DRG Grouper clinical versions 4.1, 4.2 and 5.0 as CCL does for DRG Grouper clinical versions 3.1 and 3.2.

Verification rules:

Collection method:

Related data: DRG code current

Administrative attributes

Source document:

Source organisation: The logic for the DRG software is specified by the Health Services Division of the Commonwealth Department of Health and Ageing, Australia

PMS unique identifier

Administrative status

Reference ID: A0238   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: PMS unique identifier

Name in database: pms_unique_identifier

Other names:

Element type: Data element

Definition: A unique local PMS identifier for a particular health event.

Context:

Relational and representational attributes   *Mandatory*

Data type: varchar   *Field size:* 14   *Layout:* Free text

Data domain:

Guide for use: This field is intended to be used to link NMDS events with the relevant booking system entry.

With the Client system identifier, this field replaced the Local system health event identifier field in 2000. The Local system health event identifier field was introduced in 1999.

Verification rules:

Collection method: This should be a unique event identifier in your patient management system. For security reasons, do not use the NHI number.

Related data: Replaces the field previously known as Local system health event identifier

Administrative attributes

Source document:

Source organisation:

Principal health service purchaser

Administrative status

Reference ID: A0203   *Version:* 1.1   *Version date:* 15-Mar-2004

Identifying and defining attributes

Name: Principal health service purchaser

Name in database: purchaser_code

Other names: Principal purchaser, Health purchaser, Purchaser code, PHP, Purchase code

Element type: Data element

Definition: The organisation or body that purchased the healthcare service provided. In the case of more than one purchaser, the one who paid the most.

Context:

Relational and representational attributes   *Mandatory*

Data type: char   *Field size:* 2   *Layout:* XN

Data domain: CURRENT
06   Privately funded NZ citizen
13   Base purchase
15   BreastScreen Aotearoa
16   Independent Practice Association
17   Accredited employer
18   DHB accident purchase - overseas patients, non-MVA, non-work-related
19   Overseas chargeable
20   Overseas eligible
55   Due to strike
98   Mixed funding where no Ministry of Health, DHB or ACC purchase is involved, eg, some hospice cases
A0   ACC - direct purchase
A1   FIS - direct purchase, Fusion Insurance Services
A2   NZI - direct purchase, NZ Insurance Ltd
A3   HIH - direct purchase, HIH Work Able Ltd
A4   MMI - direct purchase, MMI General Insurance (NZ) Ltd
A5   FMG - direct purchase, Farmers' Mutual Accident Care Ltd
A6   @WK or AWK - direct purchase, At Work Insurance Ltd
A7   CIG - direct purchase, Cigna Insurance Ltd

RETIRED
01   HFA Northern Office (retired 1 July 1999)
02   HFA Midland Office (retired 1 July 1999)
03   HFA Central Office (retired 1 July 1999)
04   HFA Southern Office (retired 1 July 1999)
05   ACC (direct) (retired 1 July 1999: use 'A0')
07   HFA Southern Office Waiting Times Fund (retired 30 June 2004)
08   HFA Central Office Waiting Times Fund (retired 30 June 2004)
09   HFA Midland Office Waiting Times Fund (retired 30 June 2004)
10   HFA Northern Office Waiting Times Fund (retired 30 June 2004)
11   Supplementary purchase (NB: does not include 'new money') (retired 30 June 2004)
12   Paediatric purchase (retired 30 June 2004)
14   HFA additional sustainable purchase (retired 30 June 2004)

Guide for use: Introduced on 1 July 1995.

From 1 July 1999, codes '01', '02', '03', and '04' were replaced by the code for base purchases ('13'), that is, the four Regional Health Authorities were integrated into one Health Funding Authority.

From 1 July 2004, codes '07', '08', '09', '10', '11', '12' and '14' were retired as they have been rolled into base funding and therefore are no longer required.

'A1' to 'A7' codes are only for health events resulting from workplace accidents that occurred in the one year for which the Accident Insurance Act 1998 applied.

See Appendix J for the allocation guide for NMDS Health Service Purchaser Codes.

Verification rules: Code must be present in the Purchaser code table.
The event end date must be on or prior to the Purchaser code end date (if populated).

If the Principal Health Service Purchaser Code is between 'A0' and 'A7', the Accident Flag should be set to 'Y'.

If the Accident Flag has been set to 'Y' then the ACC Claim Number field should not be blank.

As from 1 July 2004, using a retired code will generate an error message.

Collection method: Acute, arranged and booking list cases would normally be assigned the base funding code ('13').

Privately funded cases would normally be assigned '06' if the patient is a New Zealand citizen.

If a specified purchaser for the health event has been identified (eg, BreastScreen Aotearoa), use that code.

For elective cases, use the appropriate insurer code.

Where the employer has a risk-sharing arrangement with their insurer, the insurer must still be recorded as the principal purchaser.

Refer to the booklet 'Accident Services - Who Pays?' available from http://www.acc.co.nz/for-providers/resources/ for guidelines on coding acute accident patients.

OVERSEAS VISITORS
If the healthcare user is an overseas resident who:
- does not meet the eligibility criteria for publicly-funded health services, including overseas residents from non-reciprocal countries and patients with pre-existing conditions from reciprocal agreement countries, use code '19' (Overseas chargeable)
- meets the eligibility criteria for publicly-funded health services, including students from any country with a valid visa and patients from countries with reciprocal health agreements, use code '20' (Overseas eligible).

Note: Codes '19' and '20' will be excluded from funding if the Event end date is before 1 July 2003.

For further information, see the Guide to Eligibility for Publicly-Funded Personal Health and Disability Services in New Zealand on the Ministry of Health web site http://www.moh.govt.nz/.

Related data: ACC claim number
Private Flag

Administrative attributes

Source document:

Source organisation:

Prioritised ethnicity

Administrative status

Reference ID: A0321   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Prioritised ethnicity
Name in database: prioritised_ethnic_code
Other names:
Element type: Derived data element
Definition: The most highly prioritised ethnicity of the three ethnic groups recorded for the healthcare user, determined according to a Statistics NZ algorithm.
Context: Demographic information.

Relational and representational attributes

Data type: char   *Field size:* 2   *Layout:* NN
Data domain: See the Ethnic code table table on the NZHIS web site at http://www.nzhis.govt.nz/documentation/codetables.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use: Ethnic codes are ranked on the Ethnic code table from '1' (highest priority) to '21' (lowest priority), with '99' for not stated. Prioritised ethnicity is the healthcare user's ethnic code with the highest priority. Prioritising ethnic codes simplifies analysis.
Verification rules:
Collection method:
Related data: Ethnic group
                       Ethnic group 2
                       Ethnic group 3

Administrative attributes

Source document:
Source organisation: Statistics NZ

Private flag

Administrative status

Reference ID:

Version: 1.0

Version date: 01-Jan-2003

Identifying and defining attributes

Name: Private flag

Name in database: private

Other names:

Element type: Derived data element

Definition: Flag to indicate whether the health event was privately funded.

Context:

Relational and representational attributes

Data type: char

Field size: 1

Layout:

Data domain: 'Y' or 'N'

Guide for use:

Verification rules: Is 'Y' if:
- Principal health service purchaser is '06' or '19', or
- Principal health service purchaser is '98' or blank and Facility type is '02'.

Collection method:

Related data: Principal health service purchaser
Facility type

Administrative attributes

Source document:

Source organisation:

Psychiatric leave end code

Administrative status

Reference ID: A0185   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Psychiatric leave end code

Name in database: psychiatric_leave_end_type

Other names:

Element type: Data element

Definition: A code describing how a period of leave ended for a committed mental health patient.

Context: A healthcare user is discharged on leave, then the event ends by discharge or re-admission to hospital. Only for healthcare users committed under the Mental Health (Compulsory Assessment & Treatment) Act 1992.

Relational and representational attributes

Data type: char   *Field size:* 1   *Layout:* A

Data domain: D   Discharged
                     E   Died
                     R   Returned to the same psychiatric institution
                     T   Transferred to another psychiatric institution

Guide for use: Not reliably reported since 1993.

                     Healthcare users can be on leave for up to 2 years under the Act.

Verification rules: Optional. Must only be present if Event end type is 'DL'.

Collection method:

Related data: Psychiatric leave end date

Administrative attributes

Source document:

Source organisation:

Psychiatric leave end date

Administrative status

Reference ID: A0184   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Psychiatric leave end date
Name in database: date_psychiatric_leave_ends
Other names: Date psychiatric leave ended
Element type: Data element
Definition: The date on which a committed mental health patient's period of leave ended.
Context: A healthcare user is discharged on leave, then the event ends by discharge or re-admission to hospital. Only for healthcare users committed under the Mental Health (Compulsory Assessment & Treatment) Act 1992.

Relational and representational attributes

Data type: datetime   *Field size:* 8   *Layout:* CCYYMMDD
Data domain: Valid dates
Guide for use: Not reliably reported since 1993.

                        Healthcare users can be on leave for up to 2 years under the Act.
Verification rules: Optional. Must only be present when Event end type is 'DL'.

                        Must be on or before the date of load.

                        Must be on or after the Event start date, the Date of birth, the Date of referral, the Date of first specialist consultation, and the Date surgery decided.

                        Must be on or after the Event end date, and the Event end date must not be null.

                        Partial dates not allowed.
Collection method: Only required for committed patients who go on leave for a period of 14 days or more. The data should be provided when leave has ended.
Related data: Psychiatric leave end code

Administrative attributes

Source document: Mental Health (Compulsory Assessment & Treatment) Act 1992
Source organisation:

Purchase unit

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Purchase unit

Name in database: purchase_unit

Other names:

Element type: Derived data element

Definition: Purchase unit indicates which contract the event is funded under.

Context:

Relational and representational attributes

Data type: varchar   *Field size:* 10   *Layout:*

Data domain:

Guide for use: It is derived directly from Health specialty.

Some events have a purchase unit of 'EXCLU' (ie, not eligible). This depends on criteria available at http://www.nzhis.govt.nz/documentation/wies/index.html.

Verification rules:

Collection method:

Related data: DRG codes
                      Costweight
                      Costweight code
                      Health specialty code

Administrative attributes

Source document:

Source organisation: Cost Weights Working Group

Sex

Administrative status

Reference ID: A0028

Version: 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Sex

Name in database: gender_code

Other names: Sex type code

Element type: Data element

Definition: The person's biological sex.

Context: Required for demographic analyses.

Relational and representational attributes *Mandatory*

Data type: char *Field size:* 1 *Layout:* A

Data domain:
M Male
F Female
U Unknown
I Indeterminate

Guide for use: Stored as Gender code.

Because it is possible for a person's sex to change over time, NZHIS collects sex information for each health event, rather than relying on the data in the National Health Index (which does not include historical data).

Verification rules: Must be a valid code in the Gender code table.

The value in this field must be consistent with the diagnosis and procedures reported. If it is not, the record will be rejected from the NMDS with a warning.

Generate warning if Sex code is 'U'.

Collection method: 'U' codes must be updated as soon as possible after admission.

'I' codes are for use in cases, usually newborns, where it is not possible to determine the sex of the healthcare user.

The term sex refers to the biological differences between males and females, while the term gender refers to a person's social role (masculine or feminine).

Information collected for transsexuals and transgender people should be treated in the same manner, ie, their biological sex reported. To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at time of hospital admission reported.

Related data:

Administrative attributes

Source document:

Source organisation:

TLA of domicile

Administrative status

Reference ID: *Version:* 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: TLA of domicile

Name in database: tla

Other names:

Element type: Derived data element

Definition: Territorial local authority of domicile.

Context: Geographical aggregation.

Relational and representational attributes

Data type: char *Field size:* 3 *Layout:* NNN

Data domain:

TLA	TLA name
001	Far North
002	Whangarei
003	Kaipara
004	Rodney
005	North Shore
006	Waitakere
007	Auckland
008	Manakau
009	Papakura
010	Franklin
011	Thames-Coromandel
012	Hauraki
013	Waikato
015	Matamata-Piako
016	Hamilton
017	Waipa
018	Otorohanga
019	South Waikato
020	Waitomo
021	Taupo
022	Western BOP
023	Tauranga
024	Rotorua
025	Whakatane
026	Kawerau
027	Opotiki
028	Gisborne
029	Wairoa
030	Hastings
031	Napier
032	Central Hawke's Bay
033	New Plymouth
034	Stratford
035	South Taranaki
036	Ruapehu
037	Wanganui
038	Rangitikei
039	Manawatu
040	Palmerston North
041	Tararua
042	Horowhenua
043	Kapiti Coast
044	Porirua
045	Upper Hutt
046	Lower Hutt
047	Wellington
048	Masterton
049	Carterton

        050   South Wairarapa
        051   Tasman
        052   Nelson
        053   Marlborough
        054   Kaikoura
        055   Buller
        056   Grey
        057   Westland
        058   Hurunui
        059   Waimakariri
        060   Christchurch
        061   Banks Peninsula
        062   Selwyn
        063   Ashburton
        064   Timaru
        065   Mackenzie
        066   Waimate
        067   Chatham Islands
        068   Waitaki
        069   Central Otago
        070   Queenstown Lakes
        071   Dunedin
        072   Clutha
        073   Southland
        074   Gore
        075   Invercargill
        998/9999   Overseas/other

Guide for use: The TLA of domicile roughly equates to local council boundaries. Populated from 1988.

Derived from the NZHIS mapping of Domicile code to TLA. No code table exists.

Domicile code 3402 Oceanic - Chatham Islands is included in TLA 'other' as it is not a Land Authority and is classified as subregion 15 'Hawke's Bay' which is not shown in this table.

Verification rules:

Collection method:

Related data: Domicile code

Administrative attributes

Source document:

Source organisation:

Total hours on continuous positive airway pressure

Administrative status

Reference ID: A0240   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Total hours on continuous positive airway pressure

Name in database: hours_on_cpap

Other names: CPAP hours

Element type: Data element

Definition: The total number of hours a neonate (less than 29 days, or more than 29 days and less than 2500 g) is on CPAP during a perinatal episode of care.

Context:

Relational and representational attributes

Data type: char   *Field size:* 5   *Layout:* NNNNN

Data domain: 00000 – 99999

Guide for use: Hours on continuous positive airway pressure has been used in determining the DRG code since 1 July 2001.

A CPAP diagnosis is:
- an ICD-10-AM or ICD-10-AM 2nd Edition Clinical code of 9203800 (Clinical code type = 'O'), or
- an ICD-9-CM or ICD-9-CM-A Clinical code of 93.90 (Clinical code type = 'O').

Verification rules: Optional.

Generate warning if baby is:
- more than 364 days old at Event end date, or
- between 28 and 364 days old and Weight on admission is more than 2500 g at Event end date.

Generate warning if:
- more than 100, or
- more than calculated number of hours from Event start date to Event end date inclusive.

Generate warning if present and a CPAP diagnosis (as defined in Guide for use above) is not present.

Generate warning if not present when a CPAP diagnosis (as defined in Guide for use above) is present, unless:
- Total hours on mechanical ventilation is present, or
- age at Event end date is more than 364 days, or
- age is between 28 days and 364 days and Weight on admission is more than 2500 g.

Generate warning if present and Health specialty code not in the P30 and P40 ranges.

Collection method: Total hours on continuous positive airway pressure (CPAP) is used to capture the number of hours a patient is on CPAP during an episode of care. As in the Total hours on mechanical ventilation variable, part hours are rounded up. CPAP hours should not be collected when CPAP is used as a method of weaning from continuous ventilatory support or performed by intubation or tracheostomy. CPAP hours may be reported within the same event as MV hours. If CPAP is used to wean a patient from mechanical ventilation, the time on CPAP will be added to the hours on mechanical ventilation. Where CPAP is being used as a separate valid treatment modality in the same episode of care as mechanical ventilation, a CPAP procedure must be coded and CPAP hours recorded.

CLINICAL CODING GUIDELINES
The CPAP 92038-00 [568] procedure code should be assigned for any duration when required for infants. This code should not be assigned when it is used as a method of weaning from continuous ventilatory support or performed by intubation or tracheostomy.

Related data: Total hours on mechanical ventilation

Administrative attributes

Source document:

Source organisation:

Total hours on mechanical ventilation

Administrative status

Reference ID:	A0214		*Version:* 1.0	*Version date:*	01-Jan-2003

Identifying and defining attributes

Name: Total hours on mechanical ventilation

Name in database: hours_on_ventilation

Other names: Hours on mechanical ventilation, HMV

Element type: Data element

Definition: The total number of hours on mechanical ventilation while the patient was under the principal care of the ICU team.

Context: Total hours for the health event.

Relational and representational attributes

Data type: char   *Field size:* 5   *Layout:* NNNNN

Data domain: 00000 – 99999

Guide for use: Hours on mechanical ventilation has been used in determining the DRG code since 1 July 1999.

Verification rules: Optional.

Generate warnings if:
- not present when a Mechanical Ventilation diagnosis is present (ie, ICD-10 or ICD-10 2nd Edition Clinical Code = 1388200 or 1388201 or 1388202 (Clinical Code Type = 'O'); or ICD-9 or ICD-9-CM-A Clinical Code = 96.70 or 96.71 or 96.72 (Clinical Code Type = 'O')), and/or
- greater than the calculated number of hours from Event start date to Event end date inclusive.

Collection method: Include only ventilated hours received under the care of the ICU team. (In smaller hospitals there may not be an ICU team, in which case the definition should be applied if the EC specialist initiates the MV.) Include hours of weaning if under the care of the ICU team, regardless of the physical location in which the patient was treated. Exclude time spent being ventilated while undergoing surgery (the fact of being ventilated while undergoing surgery is not an indicator of severity), but hours where the patient is in radiology or emergency care should be included in the total MV hours for reporting purposes.

All hours on mechanical ventilation in A&E should be coded, whether the patient is intubated in A&E or in the ambulance. If ventilation is commenced in the ambulance, it will be counted only from the time of hospitalisation.

An incomplete hour is rounded up to the next hour; eg, if the time ventilated under the care of the ICU team is 98 hours 10 minutes, then the reported time will be '00099'. Time spent weaning with other types of ventilation such as continuous positive airways pressure (CPAP) or intermittent mechanical ventilation (IMV) is included if the patient is still intubated and under the care of the ICU team. Apart from weaning as described, other forms of ventilation should not be included (eg, non-intubated CPAP, IPPB, BiPAP).

CLINICAL CODING
1. If more than one period of mechanical ventilation occurs during the same hospitalisation, each period receives a separate procedure code.

2. ICD coding includes all time spent ventilated from time of arrival (or time of intubation), whether or not the patient is under the care of the ICU team.

3. For ICD coding the minimum number of completed hours is 24 (see ACS 1006.5, page 148). The minimum number for the field 'Total hours on mechanical ventilation' is 1.

4. Partially completed hours are not counted when allocating a procedure code, ie, they are rounded down for ICD procedure coding but rounded up for calculating this field.

WORKED EXAMPLE
Calculation of the 'Total hours on mechanical ventilation' field and MBS-E code:
A patient is admitted to ICU at 1200 h, and at 1300 h is intubated and started on CVS. On day two, the patient is transferred to theatre for a tracheostomy and other procedures. Total time in theatre is 4.8 hours. The patient returns to ICU and remains ventilated via trache until CVS ceases at 1200 h on day three.

Total ventilation hours: (Day 1) 11 + (Day 2) 24 + (Day 3) 12 = (Total) 47 hours

CODING:
CVS 25-96 h   13882-01 [569]
Initiation in ICU   13879-00 [569]
Tracheostomy   41883-00 [536]

Mechanical ventilation (MV) hours: 47 h minus 4.8 h in theatre = 42.2 h = 43 hours (rounded up).

Related data: Total hours on continuous positive airway pressure

Administrative attributes

Source document: See the AR-DRG manual

Source organisation:

Transaction ID

Administrative status

Reference ID: *Version:* 1.0 *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Transaction ID

Name in database: transaction_id

Other names:

Element type: Derived data element

Definition: A sequential number within the batch. With the Batch ID, this forms a unique identifier for each transaction.

Context:

Relational and representational attributes

Data type: int *Field size:* *Layout:*

Data domain:

Guide for use: Generated by the load process. Used internally for reference.

Verification rules:

Collection method:

Related data:

Administrative attributes

Source document:

Source organisation:

Weight on admission

Administrative status

Reference ID: A0207   *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name:	Weight on admission
Name in database:	weight_on_admission
Other names:	HCU weight on admission, Admission weight
Element type:	Data element
Definition:	The weight in grams at time of admission for infants less than 29 days old.
Context:	Used in DRG calculations.

Relational and representational attributes

Data type: integer   *Field size:* 4   *Layout:* NNNN

Data domain: 0001 – 9999 grams

Guide for use: A reported admission weight of less than 2500 grams for infants older than 28 days means these infants are allocated to the low-weight neonatal DRGs. Failure to supply Weight on admission data will result in inappropriate DRG code assignment.

Records reporting 0001 to 0399 grams are returned with a warning message that weight on admission is unusually low. Hospitals will need to confirm this value before the record will be loaded into the NMDS.

This is not the same field as Birthweight. In some instances the weight on admission of previously discharged neonates may be the same as the recorded birthweight, but this will not generally be the case. There will be instances when the weight on admission is lower than that recorded at birth.

NZHIS started collecting this information on 1 July 1995.

Verification rules: Mandatory if age at admission is less than 29 days.

Optional for all babies between 29 and 365 days old (inclusive) who weigh less than 2500 g.

Values between 0001 and 0399 generate a warning message.

Must be sent as 4 characters. For infants under 1000 grams, the field must be supplied with a leading zero.

No negative numbers.

Collection method: With the introduction of ICD-10-AM 2nd Edition, this field should be reported for all infants:
- aged less than 29 days, or
- aged between 29 and 365 days (inclusive) who weigh less than 2500 g.

It may be optionally sent for any infant less than one year old. For newborn infants, weight on admission will be identical to the birth weight. Newborn infants discharged and readmitted to the same or another healthcare facility after birth will need to have their weight on admission for the subsequent event recorded and reported.

If not known, the default is '9000'.

Related data: Birthweight
DRG code (used as key input for the AR-DRG grouper, so many of these rules are derived from the grouper logic)

Administrative attributes

Source document:

Source organisation: National Data Policy Group

Year of data

Administrative status

Reference ID: *Version:* 1.0   *Version date:* 01-Jan-2003

Identifying and defining attributes

Name: Year of data

Name in database: year_of_data

Other names: Calendar year

Element type: Derived data element

Definition: Field identifying which calendar year data belongs to.

Context:

Relational and representational attributes

Data type: char   *Field size:* 4   *Layout:* CCYY

Data domain: Range from 1960, XXXX.

Guide for use: Almost all data requests are based on a time period, the main ones being calendar year and fiscal
                              year.

                              The earliest year on the database in 1923.

Verification rules: Derived from year of discharge where present. If Event end date is missing then set to 'XXXX'.

Collection method:

Related data: Event end date

Administrative attributes

Source document:

Source organisation:

Appendix A: Data Dictionary Template

Introduction	This appendix explains how data element attributes are organised in the data dictionary template.

Order of elements	Within the dictionary, elements are organised by table, and then alphabetically. An alphabetical index at the back of the data dictionary (Appendix I) and the graphical data model are intended to assist the user in finding specific elements.

Template	This table explains the template.

Administrative status	The operational status (eg, CURRENT, SUPERSEDED) of the data element. No SUPERSEDED data elements will be included in the Dictionaries.
Reference ID	A code that uniquely identifies the data element. If the data element is used in more than one collection, it should retain its Reference ID wherever it appears.
Version number	A version number for each data element. A new version number is allocated to a data element/concept when changes have been made to one or more of the following attributes of the definition: – name – definition – data domain, eg, adding a new value to the field. Elements with frequently updated code tables, such as the Facility code table, will not be assigned a new version for changes to data domain.
Version date	The date the new version number was assigned.

Identifying and defining attributes

Name	A single or multi-word designation assigned to a data element. This appears in the heading for each unique data definition in the Dictionaries. Previous names for the data element are included in the Guide for Use section.
Data element type	DATA ELEMENT—a unit of data for which the definition, identification, representation and permissible values are specified by means of a set of attributes. DERIVED DATA ELEMENT—a data element whose values are derived by calculation from the values of other data elements. COMPOSITE DATA ELEMENT—a data element whose values represent a grouping of the values of other data elements in a specified order.
Definition	A statement that expresses the essential nature of a data element and its differentiation from all other data elements.
Context (optional)	A designation or description of the application environment or discipline in which a name is applied or from which it originates. This attribute may also include the justification for collecting the items and uses of the information.

Relational and representational attributes

Data type

The type of field in which a data element is held. For example, character, integer, or numeric.

Field size

The maximum number of storage units (of the corresponding data type) to represent the data element value. Field size does not generally include characters used to mark logical separations of values, eg, commas, hyphens or slashes.

Layout

The representational layout of characters in data element values expressed by a character string representation. For example:

- 'CCYYMMDD' for calendar date
- 'N' for a one-digit numeric field
- 'A' for a one-character field
- 'X' for a field that can hold either a character or a digit, and
- '$$$,$$$,$$$' for data elements about expenditure.

Data domain

The permissible values for the data element. The set of values can be listed or specified by referring to a code table or code tables, for example, ICD-10-AM 2nd Edition.

Guide for use (optional)

Additional comments or advice on the interpretation or application of the data element (this attribute has no direct counterpart in the ISO/IEC Standard 11179 but has been included to assist in clarification of issues relating to the classification of data elements). Includes historical information, advice regarding data quality, and alternative names for this data element.

Verification rules (optional)

The rules and/or instructions applied for validating and/or verifying elements, in addition to the formal edits.

Collection methods – Guide for providers (optional)

Comments and advice concerning the capture of data for the particular data element, including guidelines on the design of questions for use in collecting information, and treatment of 'not stated' or non-response (this attribute is not specified in the ISO/IEC Standard 11179 but has been added to cover important issues about the actual collection of data).

Related data (optional)

A reference between the data element and any related data element in the Dictionary, including the type of this relationship. Examples include: 'has been superseded by the data element…', 'is calculated using the data element…', and 'supplements the data element…'.

Administrative attributes

Source document (optional)

The document from which definitional or representational attributes originate.

Source organisation (if available)

The organisation responsible for the source document and/or the development of the data definition (this attribute is not specified in the ISO/IEC Standard 11179 but has been added for completeness). The source organisation is not necessarily the organisation responsible for the ongoing development/maintenance of the data element definition. An example of a source organisation is the National Data Policy Group (NDPG).

Appendix B: Glossary

Note: See *Appendix B: Glossary* in separate document.

Appendix C: Collection of Ethnicity Data

Introduction	This appendix contains information about collecting and coding ethnic group code data. To help with correct allocations of ethnicities, it includes a detailed list of ethnicities and their corresponding codes.
Points to remember	• Ethnicity is self-identified and can change over time. • NZHIS can record up to three ethnic group codes for a healthcare user. • An algorithm is used to automatically prioritise ethnic group codes if more than one is reported. • If a person chooses not to specify their ethnicity, it should be recorded as '99' (Not specified), not as '54' (Other). • The NHI database should be updated if a healthcare user provides a more specific or different specific ethnicity than that already held for that person.
About ethnicity	The term 'ethnic group' is defined as 'a group of people who have culture, language, history or traditions in common.' Ethnicity is not the same as race, ancestry, or country of birth. Because ethnicity is self-identified, it can change over time. This is why NZHIS collects ethnicity data whenever information is collected for different datasets, rather than relying on the National Health Index (which does not include historical data). Collecting ethnicity data has always been problematic because of the reluctance of some data providers to collect the information, the unwillingness of some healthcare users to label themselves, and the confusion between ethnicity, nationality, citizenship, and race.
Purpose	Information about ethnicity is used extensively in planning and resourcing health services, developing and monitoring health policies, and measuring health outcomes.

Collection of data   It is very important that the ethnicity data from the health sector is collected in the same way as the data in the Census because rates of hospitalisation are calculated by comparing the two datasets (to determine proportions of the population). The 2001 Census question is provided below as a guide.

Important: For NZHIS collections, up to three ethnic group codes can be collected for a healthcare user. Providers should make sure that healthcare users are aware of this. NZHIS stores all reported ethnic group codes, and also prioritises them based on a Statistics NZ algorithm.

Coding data   Use the Classification of Ethnicity table below to code the healthcare user's ethnic group.

If they have ticked one or more specific ethnicities, or if they have ticked 'other' and written in an ethnicity, look on the table to find the code.

If they have written an invalid ethnicity, such as 'Kiwi' or 'NZer', which does not map to any item on the code table, or if they have ticked 'other' but not stated an ethnicity, you can:
•   discuss this with them and encourage them to choose a valid ethnic group
•   ignore it if one or more other ethnicities are provided, or
•   code as '99' (Not specified).

If they have written 'pakeha', this can be coded as '11' (New Zealand European).

'Not Specified' and 'Other'   If a person chooses not to answer the ethnicity question, record their ethnicity as '99' (Not specified).

Important: The code '54' (Other) applied to only 0.024% of the New Zealand population in the 2001 census. It is limited to about 5 ethnic groups (such as Inuit/Eskimos, North, Central or South American Indians, Seychelles Islanders, and Mauritians). It must not be used as a generic 'other' code.

Recording ethnicity as 'Other' or 'Not specified' skews statistics on rates of hospitalisation and this affects health policy. Where possible, encourage healthcare users to choose a valid ethnic group.

Detailed code table   The codes used to report ethnicity to NZHIS are taken from the Statistics NZ Standard Classification of Ethnicity. This classification is a very detailed 5-digit code: only the first two digits (shown in the table below) are reported to NZHIS.

Use this table to code healthcare user's self-identified ethnicities.

NZHIS Ethnicity code	Country of Ethnicity Affiliation
37	Admiralty Islander
44	Afghani
53	African American
53	African nfd
32	Aitutaki Islander
12	Albanian
51	Algerian
12	American (US)
51	Arab
52	Argentinian
12	Armenian
40	Asian nfd
51	Assyrian
32	Atiu Islander
37	Austral Islander
12	Australian
37	Australian Aboriginal
12	Austrian
44	Bangladeshi
37	Belau/Palau Islander
12	Belgian
43	Bengali
37	Bismark Archipelagoan
53	Black
52	Bolivian
37	Bougainvillean
52	Brazilian
12	British nec
12	British nfd
12	Bulgarian
12	Burgher
41	Burmese
12	Byelorussian
12	Canadian
37	Caroline Islander
12	Celtic
54	Central American Indian
12	Channel Islander
52	Chilean
42	Chinese nec
42	Chinese nfd
52	Colombian
32	Cook Island Maori nfd
12	Cornish

NZHIS Ethnicity code	Country of Ethnicity Affiliation
12	Corsican
52	Costa Rican
52	Creole (Latin America)
53	Creole (US)
12	Croat/Croatian
12	Cypriot nfd
12	Czech
12	Dalmatian
12	Danish
12	Dutch/Netherlands
37	Easter Islander
52	Ecuadorian
51	Egyptian
12	English
12	Estonian
10	European nfd
12	Falkland Islander/Kelper
36	Fijian (except Fiji Indian/ Indo-Fijian)
43	Fijian Indian/Indo-Fijian
41	Filipino
12	Finnish
12	Flemish
12	French
12	Gaelic
37	Gambier Islander
12	German
12	Greek (incl Greek Cypriot)
12	Greenlander
37	Guadalcanalian
37	Guam Islander/Chamorro
52	Guatemalan
43	Gujarati
52	Guyanese
37	Hawaiian
52	Honduran
42	Hong Kong Chinese
12	Hungarian
12	Icelander
37	I-Kiribati/Gilbertese
43	Indian nec
43	Indian nfd
41	Indonesian (incl Javanese/ Sundanese/Sumatran)

NZHIS Ethnicity code	Country of Ethnicity Affiliation
54	Inuit/Eskimo
51	Iranian/Persian
51	Iraqi
12	Irish
51	Israeli/Jewish/Hebrew
12	Italian
53	Jamaican
44	Japanese
51	Jordanian
42	Kampuchean Chinese
37	Kanaka/Kanak
53	Kenyan
41	Khmer/Kampuchean/ Cambodian
44	Korean
51	Kurd
41	Lao/Laotian
52	Latin American/Hispanic nec
52	Latin American/Hispanic nfd
12	Latvian
51	Lebanese
51	Libyan
12	Lithuanian
12	Macedonian
37	Malaitian
41	Malay/Malayan
42	Malaysian Chinese
12	Maltese
52	Malvinian (Spanish-speaking Falkland Islander)
32	Mangaia Islander
32	Manihiki Islander
37	Manus Islander
12	Manx
37	Marianas Islander
37	Marquesas Islander
37	Marshall Islander
32	Mauke Islander
54	Mauritian
52	Mexican
51	Middle Eastern nec
51	Middle Eastern nfd
32	Mitiaro Islander
51	Moroccan
37	Nauru Islander
44	Nepalese
37	New Britain Islander
12	New Caledonian
37	New Georgian
37	New Irelander
11	New Zealand European

NZHIS Ethnicity code	Country of Ethnicity Affiliation
21	New Zealand Maori
52	Nicaraguan
53	Nigerian
34	Niuean
54	North American Indian
12	Norwegian
99	Not Specified
37	Ocean Islander/Banaban
51	Omani
12	Orkney Islander
53	Other African nec
44	Other Asian nec
12	Other European
54	Other nec
54	Other nfd
37	Other Pacific Island Groups nfd
37	Other Pacific Island nec
41	Other Southeast Asian nec
30	Pacific Island nfd
44	Pakistani
51	Palestinian
32	Palmerston Islander
52	Panamanian
37	Papuan/New Guinean/Irian Jayan
52	Paraguayan
32	Penrhyn Islander
52	Peruvian
37	Phoenix Islander
37	Pitcairn Islander
12	Polish
12	Portuguese
52	Puerto Rican
32	Pukapuka Islander
43	Punjabi
32	Rakahanga Islander
32	Rarotongan
12	Romanian/Rumanian
12	Romany/Gypsy
37	Rotuman/Rotuman Islander
12	Russian
31	Samoan
37	Santa Cruz Islander
12	Sardinian
12	Scottish (Scots)
12	Serb/Serbian
54	Seychelles Islander
12	Shetland Islander
43	Sikh
42	Singaporean Chinese
44	Sinhalese

NZHIS Ethnicity code	Country of Ethnicity Affiliation
12	Slavic/Slav
12	Slovak
12	Slovene/Slovenian
37	Society Islander (including Tahitian)
37	Solomon Islander
53	Somali
12	South African
54	South American Indian
12	South Slav (formerly Yugoslav groups) nfd
12	South Slav (formerly Yugoslav) nec
41	Southeast Asian nfd
12	Spanish
44	Sri Lankan nec
44	Sri Lankan nfd
44	Sri Lankan Tamil
12	Swedish
12	Swiss
51	Syrian
42	Taiwanese Chinese
37	Tahitian (including Society Islander)
43	Tamil
41	Thai/Tai/Siamese
44	Tibetan
35	Tokelauan

NZHIS Ethnicity code	Country of Ethnicity Affiliation
33	Tongan
37	Torres Strait Islander/Thursday Islander
37	Tuamotu Islander
51	Tunisian
51	Turkish (incl Turkish Cypriot)
37	Tuvalu Islander/Ellice Islander
53	Ugandan
12	Ukrainian
52	Uruguayan
37	Vanuatu Islander/New Hebridean
52	Venezuelan
41	Vietnamese
42	Vietnamese Chinese
37	Wake Islander
37	Wallis Islander
12	Welsh
53	West Indian/Caribbean
37	Yap Islander
51	Yemeni

nfd = Not further defined
nec = Not elsewhere classified

Appendix D: DRG Process

Introduction
This appendix describes the process by which the Diagnostic Related Grouping (DRG) and related fields are calculated.

Schedules not stored
For version 3, the Grouper Program stored schedules of:
- average cost weights (of a Cost Weight Code), and
- average length of stay for each of its DRG codes.

However, for versions 4.1, 4.2 and 5.0 no historical data is available, so no average values are stored.

Current software
The current DRG Grouper Program (software) is version 5.0. This can produce DRG codes in clinical versions 3.1, 4.1, 4.2 and 5.0.

Which DRG versions are stored
DRG codes of clinical version 3.1 are stored for all events.
For events with end dates between 1 July 2001 and 30 June 2002, DRG codes are also calculated and stored in clinical version 4.1.

For events with end dates between 1 July 2002 and 30 June 2005, DRG codes are calculated and stored in clinical version 4.2.

For events with end dates on or after 1 July 2005, DRG codes are calculated and stored in clinical version 5.0.

Note: The 4.1, 4.2 and 5.0 codes are both stored in the same field, health_event_tab: drg_code_current.

DRG Process
This table shows the DRG process for the NMDS.

Stage	Description
1	The diagnosis and procedure information are mapped to different ICD codes, so that codes are held in: • ICD-9-CM-A, and • ICD-10-AM 1st Edition, and • ICD-10-AM 2nd Edition, and • ICD-10-AM 3rd Edition **Note:** 1. The diagnosis_procedure_tab.submitted_system_id indicates which version of the ICD the clinical code was reported in. 2. For the 2004-2005 financial year, NZHIS will continue to apply ICD-10-AM 2nd Edition code to the Grouper 3. For the 2005-2006 financial year, NZHIS will apply ICD-10-AM 3rd Edition code to the Grouper.
2	The DRG Grouper Program version 5.0 processes information about an event for each grouper clinical version, including: • personal information (eg, Sex, Date of birth), and • event information (eg, Admission date, Event end type), and • diagnosis and procedure information in the appropriate ICD code for the DRG Grouper.
3	For each clinical version of the Grouper (3.1, 4.1, 4.2 and 5.0), the DRG Grouper Program version 5.0 calculates (for that event): • a DRG code (of the DRG grouper type) • an MDC code (of an MDC type that is the same as the DRG grouper type) • CCL or PCCL (as appropriate for that clinical version of the Grouper)

	4	NMDS processing calculates the Cost weight (using the WIES methodology) and Purchase unit from: • the DRG and associated variables • Length of stay • Total hours on mechanical ventilation • some diagnosis and procedure codes • Health specialty code For details, see the Technical documentation section of http://www.nzhis.govt.nz/.

Appendix E: Enhanced Event Type/Event Diagnosis Type Table

Event type	Event Type Description (not stored in table)	Diagnosis type	Diagnosis type description (not stored in table)	Cardinality	Optionality
BT	Birth event	A	Principal diagnosis	1	M
BT	Birth event	B	Other relevant diagnosis	N	O
BT	Birth event	E	E-code (External cause of injury)	N	O
BT	Birth event	O	Operation / Procedure	N	O
ID	Intended day case	A	Principal diagnosis	1	M
ID	Intended day case	B	Other relevant diagnosis	N	O
ID	Intended day case	E	E-code (External cause of injury)	N	O
ID	Intended day case	O	Operation / Procedure	N	O
ID	Intended day case	M	Morphology	N	O
IM	Psychiatric inpatient event	A	Principal diagnosis	1	M
IM	Psychiatric inpatient event	B	Other relevant diagnosis	N	O
IM	Psychiatric inpatient event	E	E-code (External cause of injury)	N	O
IM	Psychiatric inpatient event	O	Operation / Procedure	N	O
IM	Psychiatric inpatient event	P	Mental health provisional diagnosis	N	O
IM	Psychiatric inpatient event	M	Morphology	N	O
IP	Non-psychiatric inpatient event	A	Principal diagnosis	1	M
IP	Non-psychiatric inpatient event	B	Other relevant diagnosis	N	O
IP	Non-psychiatric inpatient event	E	E-code (External cause of injury)	N	O
IP	Non-psychiatric inpatient event	O	Operation / Procedure	N	O
IP	Non-psychiatric inpatient event	M	Morphology	N	O

Appendix F: Duplicate and overlapping event checking rules

Fatal duplicate events

Reject if:
- the same key fields exist.
- master_hcu_id, Event type, and Event start and end dates are all the same, facility is different, and Length of stay is greater than zero days.
- master_hcu_id, Facility, and the Event start and end dates are all the same, Event types are different, and Length of stay is greater than zero days.

Warnings

Generate warning if:
- master_hcu_id, Facility, Event start and end dates, and Event type are all the same, and Length of stay of both events is zero.

Fatal overlapping events

Reject if:
- master_hcu_id, Facility, Event start date, and Event type are all the same; and Length of stay of both events is greater than zero.
- master_hcu_id, Facility, and Event type (not "IM") are all the same; Event start date of one event is between the Event start and end dates of the other event; and Length of stay of both events is greater than zero.
- master_hcu_id, Facility, and Event start date are all the same; Event types are different (not "IM"); and Length of stay of each event is greater than zero.
- master_hcu_id, Event start date, and Event type (not "IM") are the same; Facilities are different; and Length of stay of each event is greater than zero.
- master_hcu_id is the same; Facilities and Event types are different (Event types not "IM"); Event start date of one event is between Event start and end dates of the other event; and Length of stay of each event is greater than zero.

In general (in plain English)

A day case (Event type either ID or IP and Length of stay 0 days) may occur within an IP or IM event for the same master_hcu_id where the Length of stay is not zero.

Two day cases (Event type = IP and Length of stay = 0, or Event type = ID and Event start date is the same as an IP or IM event) may exist on one day for the same master_hcu_id.

An IP or IM event where Length of stay is greater than zero may exist within an IM event for the same master_hcu_id.

If Length of stay is greater than zero for both events and the Length of stay for both events for the same master_hcu_id is the same then reject.

Appendix G: Logical Groups of Elements

Health Event (Administrative)
Admission source code
Admission type code
Client system identifier
Event end date
Event end type code
Event ID
Event leave days
Event local identifier
Event start date
Event summary suppress flag
Event supplementary information
Event type code
Health specialty code
Length of stay
Principal health service purchaser
Private flag
PMS unique identifier

Healthcare User
Age at admission
Age at discharge
Country of birth code
Date of birth
Date of Birth flag
Domicile code
Encrypted NHI number
Ethnic group codes
NHI number
NZ Resident Status
Occupation code
Occupation free-text
Prioritised ethnicity
Sex

DRG
AN-DRG grouper code version 3.1
CCL
Cost Weight Code
Cost Weights
DRG code
DRG grouper type code
MDC code
MDC type
PCCL
Purchase unit

Birth Event
Age of mother
Birth location
Birth status
Birthweight
Gestation period

Mental Health Events
Legal status code
Legal status date
Psychiatric leave end code
Psychiatric leave end date

Clinical
Clinical code
Clinical code type
Clinical coding system ID
Diagnosis number
Diagnosis sequence
Diagnosis type
Diagnosis/procedure description
Operation/procedure date
Total hours on mechanical ventilation
Total hours on CPAP
Weight on Admission

External Cause Events
ACC claim number
Accident flag
External cause date of occurrence

Common Groupings
Area unit code
Domicile code description
Domicile code status
Financial year
Month of data
Region of agency of treatment
Region of treatment
TLA of domicile
Year of census
Year of data

Agencies and Facilities
Agency address
Agency closing date
Agency code
Agency name
Agency opening date
Agency type code
Facility address
Facility closing date
Facility code
Facility name
Facility opening date
Facility type

File and Record Administration
Batch ID
Date updated
Transaction ID

Appendix H: Code Table Index

Code table	Location
Admission Source code table	See *Admission source code* on page 76.
Admission Type code table	See *Admission type code* on page 77.
Agency code table	See the NZHIS web site.
Agency Type code table	See *Agency type code* on page 6.
AR-DRG 4.2 code table	See the NZHIS web site.
Birth/Death Location code table	See *Birth Location* on page 84.
Clinical code table	See the NZHIS web site.
Clinical Code Table Type code table	See *Clinical code type* on page 16, 34.
Clinical Coding System code table	See *Clinical coding system ID* on page 17, 35.
Country of Birth code table	See the NZHIS web site.
Domicile code table	See the NZHIS web site.
DRG Grouper Type code table	See *DRG grouper type code* on page 100.
Ethnic Group code table	See *Ethnic group codes* on page 103 and Appendix C on page ix.
Event Clinical Code Type code table	See *Diagnosis type* on page 38.
Event Type code table	See *Event type code* on page 114.
Facility code table	See the NZHIS web site.
Facility Type code table	See *Facility type* on page 71, 116.
Health Specialty code table	See the NZHIS web site.
Legal Status code table	See the NZHIS web site.
MDC code table	See *MDC code* on page 121.
MDC Type code table	See *MDC type* on page 122.
Occupation code table	See the NZHIS web site.
Principal Health Service Purchaser code table	See *Principal health service purchaser* on page 129.
Psychiatric Leave End code table	See *Psychiatric leave end code* on page 133.
Sex Type code table	See *Sex* on page 136.

Code tables on web site   For code tables on the NZHIS web site go to http://www.nzhis.govt.nz/documentation/index.html. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.

Appendix I: Alphabetical Index of Data Elements

Appendix J: Guide for Use of NMDS Purchaser Codes