National Minimum Dataset (Hospital Events)

Data Dictionary

Version	7.9
Date	1 July 2018
Owner	Ministry of Health
Status	Final

Citation: National Health Board. 2014. National Minimum Dataset (Hospital Events) Data Dictionary. Wellington: Ministry of Health.
Published in 2014 by the
Ministry of Health
PO Box 5013, Wellington, New Zealand

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Published by Ministry of Health

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 Ministry of Health 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 Ministry of Health Data Dictionaries are data providers, software developers, and data users.

New format

All data element definitions in the Ministry of Health 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 Ministry of Health 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, e.g., 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 (New Zealand Cancer Registry 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 Ministry of Health Analytical Services team on ph 04 496 2000, fax 04 816 2898, or e-mail data-enquiries@moh.govt.nz or visit the Ministry of Health web site www.health.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 the Ministry of Health.

The Ministry has a team of staff who manually process private hospital electronic and paper reports.

Security of data

The NMDS is accessed by authorised Ministry of Health staff for maintenance, data quality, audit and analytical purposes.

Authorised members of the Ministry of Health and DHBs have access to the NMDS for analytical purposes, via the Business Objects reporting tool and the secure Health Information Network. Business Objects contains a subset of the data described in the Data Dictionary.

Privacy issues

The Ministry of Health is required to ensure that the release of information recognises any legislation related to the privacy of health information, in particular the Official Information Act 1982, the Privacy Act 1993 and the Health Information Privacy Code 1994.

Information available to the general public is of a statistical and non-identifiable nature. Researchers requiring identifiable data will usually need approval from an approved Ethics Committee.

National reports and publications

The Ministry of Health publishes an annual report *Selected Morbidity Data for Publicly Funded Hospitals* in hard copy and on the Ministry web site http://www.health.govt.nz. This publication contains summary NMDS information for a financial year.

Data provision

Customised datasets or summary reports are available on request, either electronically or on paper. Staff from the Ministry of Health Analytical Services team can help to define the specifications for a request and are familiar with the strengths and weaknesses of the data. New fields have been added to the collection since 1988, but wherever possible consistent time-series data will be provided.

The Ministry of Health Analytical Services team also offers a peer review service to ensure that health data is reported appropriately when published by other organisations.

There may be charges associated with data extracts.

Agency table

Table name: Agency table

Name in database: agency_tab ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 the Ministry of Health (MOH).

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 MOH 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 MOH. The table is continually updated. For the most recent version of the table, see the MOH web site health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/agency-code-table

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

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

Primary Key: Agency code

Business Key:

Relational Rules:

Agency address

Administrative status

Reference ID: A0139 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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:*** 100 ***Layout:*** Free text
Data domain:
Guide for use:
Verification rules:
Collection Collected when the Agency code is assigned. Agencies are required to notify MOH of any change of address.
Related data:

Administrative attributes

Source document:
Source organisation:

Agency closing date

Administrative status

Reference ID: A0141 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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:*** 7 ***Layout:***
Data domain: Valid dates
Guide for use: Some of these dates are estimated.
Verification rules:
Collection Agencies are required to notify MOH of their closing dates.

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

MOH allocates codes on request.

Related data:

Administrative attributes

Source document:
Source organisation:

Agency code

Administrative status

Reference ID: A0138 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: Refer to Appendix H for this code set. For further information contact Analytical Services. 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 Current Data Access Policy on the MOH web site at www.health.govt.nz/nz-health-statistics/access-and-use.

Verification rules: Must be a valid code in the Agency code table.
Collection 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 MOH to maintain the existing codes.

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

Related data:

Administrative attributes

Source document:
Source organisation: Ministry of Health

Agency name

Administrative status

Reference ID: A0137 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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, MOH 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
Related data:

Administrative attributes

Source document:
Source organisation:

Agency opening date

Administrative status

Reference ID: A0140 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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:*** 7 ***Layout:***
Data domain: Valid dates
Guide for use: Some of these dates are estimated.
Verification rules:
Collection Agencies are required to notify MOH 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
Related data:

Administrative attributes

Source document:
Source organisation:

Region of agency of treatment

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: varchar ***Field size:*** 64 ***Layout:***

Data domain:

01	HFA Northern region
02	HFA Midland region
03	HFA Central region
04	HFA Southern region

Guide for use: Created from MOH internal mapping.

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

Verification rules:
Collection
Related data:

Administrative attributes

Source document:
Source organisation:

Clinical Code table

Table name: Clinical Code table

Name in database: clinical_code_tab ***Version:*** 7.0 ***Version date:*** 01-Jul-2014

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-10-AM 6th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 6th Edition
- ICD-10-Am 8th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 8th 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:*** 1.1 ***Version date:*** 01-Feb-2011

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 MOH on request.

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

Verification rules:
Collection

Related data:

Administrative attributes

Source document: The Australian Classification of Health Interventions (ACHI)
Source organisation:

Category

Administrative status

Reference ID: ***Version:*** 1.2 ***Version date:*** 01-Feb-2011

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 MOH on request.

Verification rules:
Collection
Related data:

Administrative attributes

Source document: The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
Source organisation:

Chapter

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 26-Sep-2008

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
Related data:

Administrative attributes

Source document:
Source organisation:

Clinical code

Administrative status

Reference ID: A0124 ***Version:*** 7.1 ***Version date:*** 01-July -2014

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
- ICD-10-AM 6th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 6th Edition
- ICD-10-AM 8th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 8th Edition

All events reported after 1 July 1995 contain the code and ICD version supplied by the provider.

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 recorded. From July 2008, ICD-10-AM 6th Edition is recorded. From July 2014, the ICD-10-AM 8th 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 (e.g., 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 From ICD-10-AM 2nd Edition onwards, 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 2014, the current ICD version is ICD-10-AM 8th 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, 1st Edition (5 volumes), 2nd Edition (5 volumes), 3rd Edition (5 volumes), 6th Edition (5 volumes) or 8th Edition (5 volumes)

Source organisation:

Clinical code description

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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:*** 200 ***Layout:*** Free text
Data domain:
Guide for use: MOH's version of the long description of the Clinical code. The maximum available length for these descriptions was increased from 100 to 200 characters with effect from 1 July 2014 in order to accommodate the ICD-10-AM 8th Edition clinical code descriptions in full, without needing to truncate and abbreviate them as was the case for the descriptions in previous clinical coding systems.
Verification rules:
Collection Sourced from NMDS. If the information is not available from there, it is sourced from Analytical Services.
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

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:*** 7.2 ***Version date:*** 01-July-2014

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
13 ICD-10-AM 6th Edition
14 ICD-10-AM 8th 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.

Between 1 July 2004 and 30 June 2008, data was submitted in ‘12’ (ICD-10-AM 3rd Edition) and mapped to ‘06’ (ICD-9-CM-A), '10' (ICD-10-AM 1st Edition) and ‘11’ (ICD-10-AM 2nd Edition).

Between 1 July 2008 and June 30 2014 data was submitted in '13' (ICD-10-AM 6th Edition) and mapped to '12' (ICD-10-AM 3rd Edition). Mappings from '12' to '11', '10' or earlier classifications continue to be performed where mappings exist.

From 1 July 2014 data is submitted in ‘14’ (ICD-10-AM 8th Edition) and mapped to ‘13’ (ICD-10-AM 6th Edition). Mappings from '13' to ‘12’, '11', '10' or earlier classifications continue 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 From 1 July 2014 data should be submitted using ICD-10-AM 8th Edition, that is, the Clinical coding system ID should be '14' .

Related data:
Diagnosis type
Clinical code type
Clinical code

Administrative attributes

Source document:

Source organisation: Ministry of Health

Code end date

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 26-Sep-2008

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:*** 7 ***Layout:***
Data domain: Valid dates
Guide for use: If this field is blank or a future date, the code is valid.
Verification rules:
Collection
Related data:

Administrative attributes

Source document:
Source organisation:

Code start date

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 26-Sep-2008

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
Related data:

Administrative attributes

Source document:
Source organisation:

Death flag

Administrative status

Reference ID: ***Version:*** 1.2 ***Version date:*** 01-Feb-2011

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
U	Unknown

Guide for use:
Verification rules: If the Event end type (discharge type) code on an event record is 'DD' (Died) or 'ED' (Died while still in Emergency department acute facility), 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.
Collection
Related data: Clinical code
Event end type code

Administrative attributes

Source document:
Source organisation: Ministry of Health

External cause flag

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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
Related data:

Administrative attributes

Source document:
Source organisation: Ministry of Health

High age

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: number ***Field size:*** 22 ***Layout:***
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
Related data:

Administrative attributes

Source document:
Source organisation: Ministry of Health

Low age

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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
Related data: Date of birth
Event end type

Administrative attributes

Source document:
Source organisation: Ministry of Health

Normal NZ flag

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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
U	Unknown

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
Related data: Clinical code

Administrative attributes

Source document:
Source organisation: Ministry of Health

Operation flag

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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
Related data: External cause date of occurrence

Administrative attributes

Source document:
Source organisation: Ministry of Health

Sex flag

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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

Related data: Sex
Clinical code

Administrative attributes

Source document:
Source organisation: Ministry of Health

Sub-category

Administrative status

Reference ID: ***Version:*** 1.2 ***Version date:*** 01-Feb-2011

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 MOH on request.

Verification rules:
Collection
Related data:

Administrative attributes

Source document: The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
Source organisation:

Unacceptable diagnosis flag

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 26-Sep-2008

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 or 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
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:*** 7.1 ***Version date:*** 01-July-2014

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
- where the date portion of Event end datetime is on or after 1 July 1999 are stored in ICD-9-CM-A and ICD-10-AM 1st Edition
- where the date portion of Event end datetime is on or after 1 July 2001 are stored in ICD-9-CM-A, ICD-10-AM 1st Edition and ICD-10-AM 2nd Edition
- where the date portion of Event end datetime is 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
- where the date portion of Event end datetime is on or after 1 July 2008 are stored in ICD-9-CM-A, ICD-10-AM 1st Edition, ICD-10-AM 2nd Edition, ICD-10-AM 3rd Edition and ICD-10-AM 6th Edition.
- where the date portion of Event end datetime is on or after 1 July 2014 are stored in ICD-9-CM-A, ICD-10-AM 1st Edition, ICD-10-AM 2nd Edition, ICD-10-AM 3rd Edition, ICD-10-AM 6th Edition and ICD-10-AM 8th Edition.

See Clinical code type for more information.

The selection of codes are based on the guidelines provided in The Australian Coding Standards (ACS).

The principal diagnosis (refer to ACS 0001 p10) is defined as the diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or attendance at the healthcare establishment, as represented by a code.
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 p13) is defined as a condition or c complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a healthcare establishment, as represented by a code.

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

Coding procedures carried out in Emergency Department (ED) before admission:

If the patient is admitted as an ED short stay (three hours or more) or is admitted to an inpatient ward the time spent and the treatment carried out in ED are included in the short stay/inpatient event. Procedures carried out in ED meeting the criteria for clinical coding are to be coded on the relevant short stay/inpatient event.
All hours on mechanical ventilation in ED are to be included in the calculation of total hours on mechanical ventilation and have a procedure code assigned, whether the patient is intubated in ED 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

Clinical code

Administrative status

Reference ID: A0124 ***Version:*** 7.1 ***Version date:*** 01-July-2014

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
- ICD-10-AM 6th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 6th Edition
- ICD-10-AM 8th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 8th Edition.

All events reported after 1 July 1995 contain the code and ICD version supplied by the provider.

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.

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

Demographic and administrative data (e.g., 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 From ICD-10-AM 2nd Edition onwards, 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 2014, the current ICD version is ICD-10-AM 8th 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.

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 recorded. From July 2008, ICD-10-AM 6th Edition is recorded. From July 2014, ICD-10-AM 8th Edition is also record, 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.

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, 1st Edition (5 volumes), 2nd Edition (5 volumes), 3rd Edition (5 volumes), 6th Edition (5 volumes) or 8th Edtition (5 volumes)

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

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:*** 7.1 ***Version date:*** 01-Feb-2011

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
13	ICD-10-AM 6th Edition
14	ICD-10-AM 8th 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.

Between 1 July 2004 and 30 June 2008, data was submitted in ‘12’ (ICD-10-AM 3rd Edition) and mapped to ‘06’ (ICD-9-CM-A), '10' (ICD-10-AM 1st Edition) and ‘11’ (ICD-10-AM 2nd Edition).

Between 1 July 2008 and 30 june 2014 data was submitted in '13' (ICD-10-AM 6th Edition) and mapped to '12' (ICD-10-AM 3rd Edition). Mappings from '12' to '11', '10' or earlier classifications continue to be performed where mappings exist.

From 1 July 2014 data is submitted in ‘14’ (ICD-10-AM 8th Edition) and mapped to ‘13’ (ICD-10-AM 6th Edition). Mappings from '12' to '11', '10' or earlier classifications continue 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 From 1 July 2014 data should be submitted using ICD-10-AM 8th Edition, that is, the Clinical coding system ID should be '14'.

Related data: Diagnosis type
Clinical code type
Clinical code

Administrative attributes

Source document:

Source organisation: Ministry of Health

Condition onset flag

Administrative status

Reference ID: ***Version:*** 1.2 ***Version date:*** 1-July-2014

Identifying and defining attributes

Name: Condition onset flag
Name in database: Condition_onset_code
Other names: COF
Element type: Data element
Definition: The condition onset flag is a means of differentiating those conditions which arise during, or arose before, an admitted patient episode of care. Collection of this information will provide an insight into the kinds of conditions patients already have when entering hospital and what arises during the episode of care.
Context:

Relational and representational attributes

Data type: char ***Field size:*** 1 ***Layout:*** A
Data domain: 1 - condition with onset during episode of admitted patient care
2 - condition not noted as arising during the episode of care/unknown
9 - not reported (only for exempt facilities)

Guide for use: Condition Onset Flag (COF) implementation date is 1 July 2012. Facilities are required to notify MOH of the date from which the can supply COF values.
All events loaded in the NMDS up to 1 July 2012 will have COF set to null.
On and after 1 July 2012 any events loaded in a NMDS file version of v014.0 will have COF set to null.
Any events loaded on and after 1 July 2012 in a NMDS file version v015.0 will be populated with a COF value of 1, 2 or 9.

Condition onset flag must be reported on diagnosis records (HD) with a clinical code type of:
A (diagnosis), B (injury), V (supplementary classification/health factors), E (external cause of injury) or M (morphology (pathology)). On all other diagnosis records (HD) with clinical code type O (Operation/procedure) the COF field will be null. (Note: Clinical Code Type = D (DSM-IV) are not reported to NMDS).

Facilities may apply to be exempted from reporting COF in NMDS file version v015.0, however they will need to provide a date when they are likely to implement COF. Some facilities have indicated they are unable to implement COF 1 July 2012 due to their Patient Management System upgrade cycle.
The COF implementation dates will be maintained within the NMDS facility table.

If facilities require further exemption from the date provided apply to Data Management Services, National Collections and Reporting, email compliance@moh.govt.nz

Condition Onset Flag will be included on all back mappings of clinical code systems. For example a diagnosis reported in ICD-10-AM 8th Edition that has a condition onset flag value of 1 will be back mapped to each previous ICD-10-AM Edition.

With the implementation of COF 1 July 2012 event records that were reported with a COF value of 1 on the principal diagnosis were rejected with a warning. Form 1 July 2013 this validation will be retired.

Regular monitoring of the COF value on the principal diagnosis will be carried out and reported back to DHBs to ensure the principal diagnosis has the correct COF value of 2 for event records that are not neonatal or maternity.

Verification rules: The valid COF values in NMDS file version v015.0 are:
1 = condition with onset during the episode of admitted patient care
2 = condition not noted as arising during the episode of care/unknown
9 = not reported (only for exempt facilities)

For more details see Section 14.1 of NMDS File Specification.

Collection

Related data: Condition onset flag required from date
Clinical code type

Administrative attributes

Source document: The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), 8th Edition. Australian Coding Standards (ACS) 0048 *Condition onset flag*

Source organisation:

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 (e.g., 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 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
Related data: Diagnosis number

Administrative attributes

Source document:
Source organisation:

Diagnosis type

Administrative status

Reference ID: A0123 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 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 0001p10) is defined as the diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or attendance at the healthcare establishment, as represented by a code. 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 p13) is defined as a condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a healthcare establishment, as represented by a code.

For coding purposes, additional diagnoses should be interpreted as conditions that affect patient

management in terms of requiring any of the following:
- commencement, alteration or adjustment of therapeutic treatment
- diagnostic procedures
- increased clinical 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: Ministry of Health

Diagnosis/procedure description

Administrative status

Reference ID: A0122 ***Version:*** 1.2 ***Version date:*** 01-Feb-2011

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:*** 100 ***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 mandatory 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 coding programmes. This greatly detracts from the value of the data.

Verification rules:
Collection Agencies are required 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.

From July 1 2008, the standard descriptions sent to MOH by hospitals may be up to 100 characters long. Prior to 1 July 2008, descriptions were 50 characters long. 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:*** 1.1 ***Version date:*** 01-Feb-2011

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: number ***Field size:*** 22 ***Layout:***
Data domain:
Guide for use: Serves as the primary key for all data tables. Event ID is assigned by NMDS 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
Related data:

Administrative attributes

Source document:
Source organisation:

External cause date of occurrence

Administrative status

Reference ID: A0129 ***Version:*** 1.2 ***Version date:*** 01-Feb-2011

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' (i.e., external cause event), the date is External cause date of occurrence.

Verification rules: Optional.

Must be on or before the date of load, the date portion of Event end datetime, 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 This field is optional for ICD-10-AM 2nd Edition place of occurrence codes (Y92.x) and activity codes (Y93.x).
This field is optional for ICD-10-AM 3rd Edition (and onwards) place of occurrence codes (Y92.xx) and activity codes (U50 – U73.xx).

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: D Where the day portion of the date is missing, default to '01'
M Where both day and month portions of the date are missing, default to '01/01'
Guide for use: A partial date flag, set automatically.

As the system allows partial dates to be entered, this identifies what field(s) are missing if a partial date is entered.

For example, if a date is entered as '00/00/2005', then the date is stored as '01/01/2005' and the partial indicator would be set to 'M'.

Verification rules:
Collection
Related data: External cause date of occurrence

Administrative attributes

Source document:
Source organisation:

Operation/procedure date

Administrative status

Reference ID: A0128 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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:*** 7 ***Layout:***
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' (i.e., 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 date portion of Event end datetime, and the Psychiatric leave end date.

Must be on or after the date portion of Event start datetime, the Date of birth.

Only permitted if the diagnosis type is 'O'.

Collection Now optional for non-operating-room procedures. Required for surgical procedures.
Related data: Date of birth
Event start datetime
Event end datetime

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
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
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
Related data:

Administrative attributes

Source document:
Source organisation:

Domicile code

Administrative status

Reference ID: ***Version:*** 1.2 ***Version date:*** 01-July-2014

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 of the dwelling where a person considers himself or herself to usually reside, except in the circumstances listed in the guidelines." The guidelines are available on the Department of Statistics website

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:***
Data domain: Refer to Appendix H for this code set. For further information contact Analytical Services. 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 was used from 1 July 2003 to 30 June 2008
- The 2006 code has been in use since 1 July 2008.

The series of Domicile codes used depends on the date portion of Event end datetime. If Event end datetime is null, the date portion of the Event start datetime is used.

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

Where the date portion of Event end datetime is:
- before 1 July 1998, the 1991 codes apply
- between 1 July 1998 and 30 June 2003, the 1996 codes apply
- on or after 1 July 2003, the 2001 codes apply.

If the Event end datetime is blank, check the date portion of Event start datetime and the status of the code is current. If not current, an error message is generated.

If the date portion of Event end datetime (or, if the Event end datetime is blank, the date portion of Event start datetime) is less than 1 July 1998 and Year of census is 1996 or 2001 then convert new domicile back to the 1991 code. If the date portion of Event end datetime (or, if the Event end datetime is blank, the date portion of Event start datetime) is between 1 July 1998 and 30 July 2003 and Year of census is 2001, then convert new domicile back to the 1996 code.

Collection 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 where the date portion of Event end datetime is after 30 June 1998. The 1991 and 1996 Domicile codes made redundant by the 2001 census should not be used for events where the date portion of Event end datetime is 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
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
Related data:

Administrative attributes

Source document:
Source organisation:

Retired year

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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, 2001, and 2008. All events where the date portion of Event end datetime is after 30 June 2003 must use current codes. Events where the date portion of Event end datetime is between 1 July 1998 and 30 June 2003 may not use retired 1991 codes.
Verification rules:
Collection
Related data:

Administrative attributes

Source document:
Source organisation:

TLA of domicile

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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

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

Derived from the MOH 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

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
2006
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
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:*** 1.5 ***Version date:*** 27-Feb-2013

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 (i.e., 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 should be used. An event type code of ID can be used for day patients who are discharged on or before 30 June 2013. Event type code ID will be retired from use 1 July 2013. 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 MOH.

Admission information for mental health inpatients is required to be supplied within 28 days of admission with legal status and provisional diagnoses. Note the requirement to report open mental health (IM) event records to the NMDS was made optional from 1 September 2012. Reporting complete mental health (IM) event records when the patient is discharged or transferred from a facility is mandatory.
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 Programme for the Integration of Mental Health Data (PRIMHD).

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: number ***Field size:*** 22 ***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
Related data:

Administrative attributes

Source document:
Source organisation:

Event ID

Administrative status

Reference ID: A0156 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: number ***Field size:*** 22 ***Layout:***
Data domain:
Guide for use: Serves as the primary key for all data tables. Event ID is assigned by NMDS 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
Related data:

Administrative attributes

Source document:
Source organisation:

Legal status code

Administrative status

Reference ID: A0181 ***Version:*** 1.8 ***Version date:*** 1-July-2017

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: Refer to Appendix H for this code set. For further information contact Analytical Services. 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 From 1 July 1999 legal status can be reported with ID and IP events as well as IM event types (although events with end dates on or after 1 July 2013 may not be reported with event types of ID).

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, 5.0, 6.0, 6.0x or 7.0 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:*** 1.5 ***Version date:*** 1-July-2017

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 date portion of Event end datetime.

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 From 1 July 1999 legal status can be reported with ID and IP events as well as IM event types (although event records with an event end date on or after 1 July 2013 may not be reported with the event type of ID).

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, 5.0, 6.0, 6.0x or 7.0 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
Related data:

Administrative attributes

Source document:
Source organisation:

Facility table

Table name: Facility table

Name in database: facility_tab ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 Ministry of Health.

Primary Key: Agency code, Facility code

Business Key:

Relational Rules:

Agency code

Administrative status

Reference ID: A0138 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: Refer to Appendix H for this code set. For further information contact Analytical Services. 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 Current Data Access Policy on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/access-and-use.

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

Collection 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 MOH to maintain the existing codes.

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

Related data:

Administrative attributes

Source document:
Source organisation: Ministry of Health

Condition onset flag required from date

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 01-Jul-2012

Identifying and defining attributes

Name:
Name in database: condition_onset_code_reqd_from
Other names: COF Implementation Date
Element type: Data element
Definition: Date when the facility implements the Condition Onset Flag in its Patient Management System (PMS) and reports to the NMDS.
Context:

Relational and representational attributes

Optional

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

Guide for use: Condition Onset Flag (COF) implementation date is 1 July 2012. Facilities are required to notify MOH of the date from which they can supply COF values.

Facilities may apply to be exempted from reporting COF in NMDS file version V015.0; however they will need to provide a date when they are likely to implement COF. Some facilities have indicated they are unable to implement COF due to their Patient Management System upgrade cycle.

The COF implementation dates will be maintained within the NMDS facility table. This table can be found on the following link under the heading NMDS Facility Code Table.
http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables

If facilities require further exemption from the date provided apply to Data Management Services, National Collections and Reporting, email compliance@moh.govt.nz

Verification rules:

Collection

Related data: Condition onset flag

Administrative attributes

Source document:
Source organisation: Ministry of Health

Domicile code

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 of the dwelling where a person considers himself or herself to usually reside, except in the circumstances listed in the guidelines." The guidelines are available on the Department of Statistics website

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:***
Data domain: Refer to Appendix H for this code set. For further information contact Analytical Services. 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 was used from 1 July 2003 to 30 June 2008
- The 2006 code has been in use since 1 July 2008.

The series of Domicile codes used depends on the date portion of Event end datetime. If Event end datetime is null, the date portion of the Event start datetime is used.

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

Where the date portion of Event end datetime is:
- before 1 July 1998, the 1991 codes apply
- between 1 July 1998 and 30 June 2003, the 1996 codes apply
- on or after 1 July 2003, the 2001 codes apply.

If the Event end datetime is blank, check the date portion of Event start datetime and the status of the

code is current. If not current, an error message is generated.

If the date portion of Event end datetime (or, if the Event end datetime is blank, the date portion of Event start datetime) is less than 1 July 1998 and Year of census is 1996 or 2001 then convert new domicile back to the 1991 code. If the date portion of Event end datetime (or, if the Event end datetime is blank, the date portion of Event start datetime) is between 1 July 1998 and 30 July 2003 and Year of census is 2001, then convert new domicile back to the 1996 code.

Collection 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 where the date portion of Event end datetime is after 30 June 1998. The 1991 and 1996 Domicile codes made redundant by the 2001 census should not be used for events where the date portion of Event end datetime is 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
Related data:

Administrative attributes

Source document:
Source organisation:

Facility closing date

Administrative status

Reference ID: A0147 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 it's name and is assigned a new code.

Verification rules:
Collection Facilities are required to notify MOH of their closing dates.
Related data:

Administrative attributes

Source document:
Source organisation:

Facility code

Administrative status

Reference ID: A0143 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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:*** XXXX
Data domain: Refer to Appendix H for this code set. For further information contact Analytical Services. 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 Current Data Access Policy on the Ministry web site at http://www.health.govt.nz/nz-health-statistics/access-and-use

Verification rules: Must be a valid code in the Facility Code table for events with the date portion of event start datetime ending on or after 01 July 2009.

The NHI number, Event type code, Event start datetime, 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 The Ministry of Health allocates codes on request. The code table is continually updated by the Ministry as hospitals open and close. See the Ministry web site for the most recent version.

Related data: Birth location
Facility type

Administrative attributes

Source document:
Source organisation: Ministry of Health

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
Related data:

Administrative attributes

Source document:
Source organisation:

Facility opening date

Administrative status

Reference ID: A0146 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 Facilities are required to notify MOH of their opening dates.
Related data:

Administrative attributes

Source document:
Source organisation:

Facility type

Administrative status

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

Identifying and defining attributes

Name: Facility Type
Name in database: facility_type
Other names:
Element type: Data element
Definition: A code that categorises facilities into particular types.
Context:

Relational and representational attributes

Data type: char ***Field size:*** 2 ***Layout:***
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
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:*** 1.1 ***Version date:*** 01-Feb-2011

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 Ministry of Health internal mapping.

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

Verification rules:
Collection
Related data:

Administrative attributes

Source document:
Source organisation:

Health Event table

Table name: Health Event table

Name in database: health_event_tab ***Version:*** 1.2 ***Version date:*** 01-Feb-2011

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 datetime, Event local ID

Relational Rules:

ACC claim number

Administrative status

Reference ID: A0212 ***Version:*** 1.2 ***Version date:*** 01-Jul-2008

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' (e.g., '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 (i.e. the accident happened while the patient was in hospital) then the ACC flag can be N and the ACC45 field populated.

Collection 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.

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 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:*** 01-Jun-2011

Identifying and defining attributes

Name: Accident flag
Name in database: accident_flag
Other names:
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.
U	Unknown.

Guide for use:

Verification rules: Optional.

If the first character of the Principal health service purchaser code is 'A' (e.g., '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 Accident Claim Number field should not be blank.

If the injury (accident) date is between the Event start datetime and Event end datetime (i.e. the accident happened while the patient was in hospital) then the accident flag can be N and the Accident Claim Number field is to be populated.
The definition of an in-hospital accident is when the patient is an inpatient or a day patient and is physically within the hospital grounds and buildings when the accident occurs.

Collection For this accident flag 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 Accident Claim Number would be required).

The accident flag can be set to N and an Accident Claim Number reported if a patient has an accident in hospital. In this case the injury date must be between the Event start datetime and Event end datetime. Events where the accident flag is set to 'Y' may or may not have claims that are supported by Accident Compensation Corporation (ACC).

Related data: ACC claim number
Clinical code (classifies the injuries and cause of accident)

Administrative attributes

Source document:
Source organisation:

Admission source code

Administrative status

Reference ID: A0169 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 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:

Admission type code

Administrative status

Reference ID: A0171 ***Version:*** 1.3 ***Version date:*** 27- Feb-2013

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 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' = Admitted from DHB booking system (used to be known as 'waiting 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 date portion of Event end datetime 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.

Refer to Glossary for admission definition.

Collection 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 maternity cases, 37 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 for records where the date portion of Event end datetime is before 1 July 2008 will always be P10 Delivery Services (Mothers). For records where the date portion of Event end datetime is on or after 1 July 2008 the health specialty code will always be P60 Maternity Services-Mother (no community LMC) or P70 Maternity Services-Mother (with community LMC).

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 Compensation Act, 1998 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.

Inter-hospital transfers are generally arranged to facilitate the on-going care or treatment of a patient. Some examples are identified below.

- An acute admission for a patient requiring more complex treatment (e.g., a patient with acute coronary syndrome, being transferred to a cardiac centre for angiogram or surgery)
- A transfer for an elective patient who experiences a complication post operatively, that requires treatment in another facility (e.g., a patient undergoing surgery who experiences vascular damage intra-operatively)
- An acute trauma patient requiring tertiary treatment (e.g., a patient with head or chest injuries stabilised in one facility and transferred to a neurosurgery or cardiothoracic centre).

In these circumstances the steps are generally:
1. A decision is made to seek treatment at another facility
2. The receiving hospital is contacted to agree to receive the patient (clinician to clinician transfer of care)
3. The receiving hospital confirms the transfer based on patient stability and bed availability - this would generally be expected to occur within a few days.

It is unlikely that a patient will be held in the referring hospital for more than seven days **unless** the receiving hospital has insufficient capacity to accept the patient earlier.

The principle to apply is that if an inter-hospital transfer is for the urgent treatment of a patient, and in clinically optimal circumstances, the transfer would occur within a timeframe of less than seven days, then the transfer will be ‘arranged’, regardless of whether this takes longer than seven days.

Related data:

Administrative attributes

Source document:
Source organisation:

Age at admission

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: Date portion of Event start datetime minus date of birth, expressed in completed years.

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

Verification rules:
Collection
Related data: Event start datetime
Date of birth

Administrative attributes

Source document:
Source organisation:

Age at discharge

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: number ***Field size:*** 22 ***Layout:***
Data domain: 000 – 120, XXX
Guide for use: The date portion of Event end datetime minus date of birth expressed in completed years. If the event end datetime 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
Related data: Date of birth
Event end datetime

Administrative attributes

Source document:
Source organisation:

Age of mother

Administrative status

Reference ID: A0107 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: Age of mother
Name in database: age_of_mother
Other names: Age at delivery
Element type: Data element
Definition: The mothers age in years at the time of birth of the infant.
Context:

Relational and representational attributes

Data type: integer ***Field size:*** ***Layout:***
Data domain: 00 – 99
00 is default value if mother's age is not known.
Guide for use:
Verification rules: This field is verified by NMDS.

If the mothers age is under 12 or over 60 years, this record will only be accepted on confirmation.
Collection
Related data: Event type code

Administrative attributes

Source document:
Source organisation:

Agency code

Administrative status

Reference ID: A0138 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: Refer to Appendix H for this code set. For further information contact Analytical Services. 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 Current Data Access Policy on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/access-and-use.

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

Collection 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 MOH to maintain the existing codes.

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

Related data:

Administrative attributes

Source document:
Source organisation: Ministry of Health

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: number ***Field size:*** 22 ***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
Related data:

Administrative attributes

Source document:
Source organisation:

Birth location

Administrative status

Reference ID: A0104 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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

Related data: Facility code
Facility type

Administrative attributes

Source document:
Source organisation: Ministry of Health

Birth status

Administrative status

Reference ID: A0102 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: Birth status
Name in database: birth_status
Other names:
Element type: Data element
Definition: This field records whether an infant was still or 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'.

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:
Collection Sourced from NMDS. If the data is not available there it is sourced from Analytical Services.
Related data:

Administrative attributes

Source document:
Source organisation:

Birthweight

Administrative status

Reference ID: A0100 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 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: Ministry of Health

Complication and comorbidity level (CCL)

Administrative status

Reference ID: ***Version:*** 1.3 ***Version date:*** 1-July-2017

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: AN-DRGs and AR-DRGs

Relational and representational attributes

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

0	no CC effect
1	minor CC
2	moderate CC
3	severe CC
4	catastrophic CC

Guide for use: Relates to all DRG grouper versions

Serves the same purpose for DRG grouper versions 3.0 and 3.1 as PCCL does for DRG grouper versions 4.1, 4.2, 5.0, 6.0, 6.0x and 7.0.

The AR-DRG 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
Related data: DRG
PCCL

Administrative attributes

Source document: AR-DRG Definitions Manuals
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:*** 1.2 ***Version date:*** 18-June-2015

Identifying and defining attributes

Name: Client system identifier
Name in database: client_system_identifier
Other names:
Element type: Data element
Definition: Used to store any record level identification that a provider's system may require in addition to the PMS unique identifier.

Context:

Relational and representational attributes

Data type: varchar ***Field size:*** 14 ***Layout:***
Data domain:
Guide for use:

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

Verification rules:
Collection
Related data: Related to PMS unique identifier.

Administrative attributes

Source document:
Source organisation:

Costweight

Administrative status

Reference ID: ***Version:*** 1.3 ***Version date:*** 27-Feb-2013

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:*** NNNNNNNNN
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. Costweights in use from 1 July 2008 have been developed from New Zealand costs.

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
www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations

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

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

Administrative attributes

Source document:
Source organisation: Australian Government Department of Health and Ageing

Costweight code

Administrative status

Reference ID: ***Version:*** 1.4 ***Version date:*** 1-July-2018

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:*** NN

Data domain:
01 = WIES5a
02 = WIES5a
03 = WIES8a
04 = WIES8B
05 = WIES8c
06 = WIES11a
07 = WIES11b
08 = WIES11c
09 = WIESNZ08
10 = WIESNZ09
11 = WIESNZ10
12 = WIESNZ11
13 = WIESNZ12
14 = WIESNZ13
15 = WIESNZ14
16 = WIESNZ15
17 = WIESNZ16
18 = WIESNZ17
19 = WIESNZ18

Guide for use:
Verification rules:
Collection
Related data: Costweight
DRG codes
Purchase unit

Administrative attributes

Source document:
Source organisation: DHB Shared Services

Country of birth code (Discontinued)

Administrative status

Reference ID: A0198 ***Version:*** 1.1 ***Version date:*** 01-July-2018

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.
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.

Refer to Appendix H for this code set.

Guide for use: **No longer required to be reported from 1 July 2018. Data will be sourced from the NHI**

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: No longer required to be reported from 1 July 2018
Collection
Related data:

Administrative attributes

Source document:
Source organisation: Statistics NZ

Date of birth

Administrative status

Reference ID: A0025 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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:*** 7 ***Layout:***
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 date portion of Event start datetime.

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

Collection

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

Administrative attributes

Source document:
Source organisation:

Date of birth flag

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: D Where the day portion of the date is missing, default to '01'
M Where both day and month portions of the date are missing, default to '01/01'

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

As the system allows partial dates to be entered, this identifies what field(s) are missing if a partial date is entered.

For example, if a date is entered as '00/00/2005', then the date is stored as '01/01/2005' and the partial indicator would be set to 'M'.

Verification rules:
Collection
Related data: Date of birth

Administrative attributes

Source document:
Source organisation: Ministry of Health

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
Related data:

Administrative attributes

Source document:
Source organisation:

Domicile code

Administrative status

Reference ID: ***Version:*** 1.2 ***Version date:*** 01-July-2014

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 of the dwelling where a person considers himself or herself to usually reside, except in the circumstances listed in the guidelines." The guidelines are available on the Department of Statistics website

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:***

Data domain: Refer to Appendix H for this code set. For further information contact Analytical Services. 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 was used from 1 July 2003 to 30 June 2008
- The 2006 code has been in use since 1 July 2008.

The series of Domicile codes used depends on the date portion of Event end datetime. If Event end datetime is null, the date portion of the Event start datetime is used.

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

Where the date portion of Event end datetime is:
- before 1 July 1998, the 1991 codes apply
- between 1 July 1998 and 30 June 2003, the 1996 codes apply
- on or after 1 July 2003, the 2001 codes apply.

If the Event end datetime is blank, check the date portion of Event start datetime and the status of the code is current. If not current, an error message is generated.

If the date portion of Event end datetime (or, if the Event end datetime is blank, the date portion of Event start datetime) is less than 1 July 1998 and Year of census is 1996 or 2001 then convert new domicile back to the 1991 code. If the date portion of Event end datetime (or, if the Event end datetime is blank, the date portion of Event start datetime) is between 1 July 1998 and 30 July 2003 and Year of census is 2001, then convert new domicile back to the 1996 code.

Collection 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 where the date portion of Event end datetime is after 30 June 1998. The 1991 and 1996 Domicile codes made redundant by the 2001 census should not be used for events where the date portion of Event end datetime is 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:*** 7.2 ***Version date:*** 1-July-2017

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 from version 4.1, 4.2, 5.0, 6.0, 6.0x or7.0 is produced by invoking the

current DRG grouper program 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. DRGs provide 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:*** XXXX

Data domain: 801A – 963Z, A01Z – Z65Z

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

Based on Event end datetime:

- From 1 July 2001 and 30 June 2002, this field contains a DRG code of clinical version 4.1.

- Between 1 July 2002 and 30 June 2004, this field contains a DRG code of clinical version 4.2.

- Between 1 July 2004 and 30 June 2005 most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. At that time AR-DRG version 4.2 required ICD-10-AM 2nd Edition codes so NMDS mapped the 3rd edition codes supplied by hospitals to 2nd edition codes and used these to assign an AR-DRG 4.2 code.

- Between 1 July 2004 and 30 June 2008 most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. AR-DRG version 5.0 used 3rd edition codes so no mapping was required.

- Between 1 July 2008 and 30 June 2011 this field contained a DRG from AR-DRG version 5.0 derived, if necessary, by mapping ICD-10-AM 6th Edition codes back to ICD-10-AM 3rd Edition codes.

- From 1 July 2011 this field contains a DRG from AR-DRG version 6.0 derived from ICD-10-AM 6th Edition codes.

- From 1 July 2013 this field contains a DRG from AR-DRG version 6.0x derived from ICD-10-AM 6th Edition codes.

- From 1 July 2017 this field contains a DRG from AR-DRG version 7.0 derived from ICD-10-AM 8th Edition codes

Verification rules:

Collection The current DRG grouper is AR-DRG version 7.0, which uses up to 30 diagnoses and 30 procedures codes. 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 NMDS. It is not sent in to the NMDS by hospitals.

The DRG is calculated from:
- personal information (e.g., Sex, Date of birth), and
- event information (e.g., Admission date, Event end type), and
- diagnosis and procedure

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

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
Related data:

Administrative attributes

Source document:
Source organisation:

DRG code version 3.1

Administrative status

Reference ID: A ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 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) is 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. Between July 2001 and June 2002, 3M AR-DRG version 4.1 of the Grouper Program was used to generate version 3.1 codes in this field. The version (4.1) used 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 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.

The DRG code version 3.1 is calculated by NMDS using the AR-DRG Grouper Program version 4.1. It is not sent in to the NMDS by hospitals.

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

Administrative attributes

Source document:
Source organisation: 3M HIS

DRG grouper type code

Administrative status

Reference ID: A0167 ***Version:*** 1.4 ***Version date:*** 1-July-2017

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 version of the DRG calculation used.
Context:

Relational and representational attributes

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

Data domain:

DRG Grouper Type code:	Drg Grouper Type description:	MDC type:
01	Medicare Version 4.0 Secondary Care	-
02	ANDRG Version 3.1	A
03	AR-DRG Version 4.1	B
04	AR-DRG Version 4.2	C
05	AR-DRG Version 5.0	D
06	AR-DRG Version 6.0	E
07	AR-DRG Version 6.0x	F
08	AR-DRG Version 7.0	G

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' was used between 1 July 2005 and 30 June 2011
'06' was used between 1 July 20011 and 30 June 2013
'07' was used between 1 July 20013 and 30 June 2017
‘08’ is in use from 1 July 2017
The grouper software produces a number of DRG versions. NMDS is currently using software version 8.0 to produce DRG codes for versions 3.1, 4.1, 4.2, 5.0, 6.0, 6.0x and 7.0. This field describes the version.

Verification rules:
Collection
Related data: DRG codes
MDC type
MDC code

Administrative attributes

Source document:
Source organisation:

Encrypted NHI number

Administrative status

Reference ID: A0319 ***Version:*** 1.1 ***Version date:*** 27-Feb -2013

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 the Ministry of Health'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 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 Analytical Services 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.

The Ministry 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 datetime, 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 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 Sector Services for GPs and other primary care providers.

Related data:

Administrative attributes

Source document: www.health.govt.nz/our-work/health-identity/national-health-index
Source organisation: Ministry of Health

Ethnic group codes

Administrative status

Reference ID: A0027,A0208,A0209 ***Version:*** 6.7 ***Version date:*** 01-Feb-2011

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	New Zealand European/Pakeha
12	Other European
21	Maori
30	Pacific Peoples not further defined
31	Samoan
32	Cook Island Maori
33	Tongan
34	Niuean
35	Tokelauan
36	Fijian
37	Other Pacific Peoples
40	Asian not further defined
41	Southeast Asian
42	Chinese
43	Indian
44	Other Asian
51	Middle Eastern
52	Latin American/Hispanic
53	African (or cultural group of African origin)
54	Other (retired 01/07/2009)
61	Other ethnicity
94	Don't know
95	Refused to answer
97	Response unidentifiable
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 MOH 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 Ethnicity should be self-identified wherever possible. If the Ethnic group code changes for this event, please update the NHI.

Code ‘54’ (Other) is retired from 01 July 2009 and should not be used after this date.
Use of the code '61' (Other Ethnicity) is limited to a very small number of 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 using an appropriate residual response. See Appendix C: Collection of Ethnicity Data. Must be a valid code in the Ethnic code table. Each ethnic group as maintained by Statistics NZ has a 5-digit code at level 4. MoH collections use ethnicity coded at level 2.

Related data: Prioritised ethnicity

Administrative attributes

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

Event elapsed time in minutes

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 18-Feb-2011

Identifying and defining attributes

Name: Event elapsed time in minutes
Name in database: event_elapsed_time_in_minutes
Other names:
Element type: Data element
Definition: The elapsed time in minutes from when the health event is reported to have started to when the same health event is reported to have ended. This will be calculated and presented in minutes only.
Context:

Relational and representational attributes

Data type: int ***Field size:*** ***Layout:***
Data domain:
Guide for use: Contains null if the Event end datetime is null otherwise it is the difference, in minutes, between Event end datetime and Event start datetime.

The calculation does not take into account any leave days that are reported in the patient record.
Verification rules:
Collection Derived field
Related data: Event start datetime
Event end datetime

Administrative attributes

Source document:
Source organisation:

Event end datetime

Administrative status

Reference ID: A0151 ***Version:*** 1.0 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

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

Relational and representational attributes

Data type: datetime ***Field size:*** 12 ***Layout:*** CCYYMMDDhhmm
Data domain: Valid date
Hours is in the range 00 to 23
Minutes is in the range 00 to 59
Midnight is the beginning of the calendar day ie. 201101280000 (which equates to 24:00 of 27/01/2011).

Guide for use: The time portion of Event end datetime has only been collected since 1 July 2011. For events that occurred before that date, the time portion of Event end datetime contains ’00:00’.

Verification rules: Partial dates not allowed.

Optional for psychiatric inpatient events. Mandatory for births, intended day cases and non-psychatric 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 datetime, the Date of birth, the Operation/procedure date and the external cause date of occurrence.

Collection : Event end time (Discharge time):

- The event end time will be the time the patient physically leaves the health care setting. The health care setting would include a ward based patient departure lounge (recliner chairs, cleared to be discharged but waiting for paperwork/clinical signoff). If a patient has all the relevant documentation and has been taken to a public waiting area to await their transport/relative etc. the time they left the ward would be the event end as they are no longer under the direct responsibility of any clinical staff.

- There needs to be consistency between the event end type and the end time. The definition above will apply to the following events end types:

DA	Discharge to an acute facility
DC	Psychiatric patient discharged to community care
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
DP	Psychiatric patient transferred for further psychiatric care
DR	Ended routinely
DS	Self discharge from hospital - No Indemnity
DT	Discharge of patient to another healthcare facility
DW	Discharge to another service within the same facility
EA	Discharge from Emergency department acute facility to specialist facility for neonates and burns only
ED	Died while still in Emergency department acute facility
EI	Self discharge from treatment in an Emergency department acute facility with indemnity

	signed
ER	Routine discharge from an Emergency department acute facility
ES	Self discharge from treatment in an Emergency department acute facility without indemnity
ET	Discharge from Emergency department acute facility to another healthcare facility

- For the following event end types:
DD Died or ED Died while still in Emergency department acute facility - The event end date on an event with a DD or ED event end type is the date of death from the hospital record of the death certificate or the date of completion of organ procurement. The event end time will be sourced from the same documentation.

DO Discharge of a patient for organ donation - The event end date for a patient statistically discharged for organ donation is the date the patient is declared brain dead from the hospital record of the death certificate. The event end time will be sourced from the same document. All events with a DO event end type will be followed with another event for the organ procurement. The subsequent event will have an event end type of DD and the event end date and time is to be when the organ procurement is completed.

DF Statistical Discharge for change in funder - This may occur when an arranged or elective admission is being funded by a private insurer or ACC. Some complication arises and the patient requires further hospitalisation beyond the care required for the privately funded event. The event end date and time for the privately funded event is what the clinician reports as the end of the required hospitalisation for the privately funded episode of care.

Related data:

Event end type code
Date of birth
Event start datetime
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:*** 1.4 ***Version date:*** 01-Jun-2011

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 indemnity)
DT Discharge of patient to another healthcare facility
DW Discharge to other service within same facility between the following types of specialty: AT&R, mental health, personal health and palliative care. Not to be used for transfer between surgical, medical and maternity services (with or without a LMC).
EA Discharge from Emergency department acute facility to specialist facility for neonates and burns only
ED Died while still in Emergency department acute facility
EI Self discharge from treatment in an Emergency department acute facility with indemnity signed
ER Routine discharge from an Emergency department acute facility
ES Self discharge from treatment in an Emergency department acute facility without indemnity
ET Discharge from Emergency department acute facility to another healthcare facility

Guide for use:
RO was superseded on 1 July 1994.
DA and DW were introduced in 1 July 1995.
DO was introduced in 1 July 1997.
DF was introduced in 1 July 2000.
EA, ED, EI, ER, ES and ET were introduced in 1 July 2007.

See Appendix J for the allocation Guide for Use of NMDS Emergency Department (ED) Event End Type Codes, Emergency Department scenarios and Event End Type Code mappings for 3M Codefinder™.

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

If the Event end type (discharge type) code on an event record is ‘DD’ (Died) or ‘ED’ (Died while still in Emergency department acute facility), 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.

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

Collection
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), Medical (M), maternity services (with or without a LMC) 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 (e.g., acute stroke) or surgical (e.g., 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, Intellectually Handicapped, 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.moh.govt.nz/notebook/nbbooks.nsf/0/9fecff85d44b17c8cc25709300001caa/$FILE/AccidentServices.pdf

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. DF may also be used when an arranged or elective admission is being funded by a private insurer or ACC. Some complication arises and the patient requires further hospitalisation beyond the care required for the privately funded event. The event end date and time for the privately funded event is what the clinician reports as the end of the required hospitalisation for the privately funded episode of care.

NOTE RE 'DO'
DO Discharge of a patient for organ donation - The event end date for a patient statistically discharged for organ donation is the date the patient is declared brain dead from the hospital record of the death certificate. The event end time will be sourced from the same document. All events with a DO event end type will be followed with another event for the organ procurement. The subsequent event will have an event end type of DD and the event end date and time is to be when the organ procurement is completed.

NOTE RE MATERNITY
From 1 July 2009 maternity events are casemix funded for designated secondary maternity facilities. This will lead to a change in the way that some facilities report maternity services to the NMDS. The following examples clarify the reporting requirements.

(a) Where a patient has an antenatal, delivery and post natal event at the same facility there will be internal transfers within the hospital but this should be reported as one NMDS event when the facility is designated as a secondary maternity facility. The clinical coding will capture all procedures and diagnoses from the time of admission to discharge.

(b) Where a patient is admitted under one of the maternity specialties and during her stay requires transfer to a medical or surgical specialty within the same facility (or conversely is admitted under a medical/surgical specialty and during her stay requires transfer to a maternity specialty within the same facility) this should be reported to the NMDS as one event. The NMDS record should capture all procedures and diagnoses from the time of admission to discharge.

Related data: Event end datetime

Administrative attributes

Source document:
Source organisation:

Event ID

Administrative status

Reference ID: A0156 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: number ***Field size:*** 22 ***Layout:***
Data domain:
Guide for use: Serves as the primary key for all data tables. Event ID is assigned by NMDS 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
Related data:

Administrative attributes

Source document:
Source organisation:

Event leave days

Administrative status

Reference ID: A0155 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 the date portion of Event start datetime and the date portion of Event end datetime.

Collection 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 datetime
Event end datetime
Length of stay

Administrative attributes

Source document:
Source organisation:

Event local identifier

Administrative status

Reference ID: A0156 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 datetime, 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 Use 9 first then ' 8,7, …,1'.
Related data:

Administrative attributes

Source document:
Source organisation:

Event start datetime

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 01-Jun-2011

Identifying and defining attributes

Name: Event start datetime
Name in database: event_start_date
Other names: Admission date and Admission time
Element type: Data element
Definition: The admission date and time on which a healthcare event began.
Context: Admitted patients.

Relational and representational attributes ***Mandatory***

Data type: datetime ***Field size:*** 12 ***Layout:*** CCYYMMDDhhmm

Data domain: Valid date
Hours is in the range 00 to 23
Minutes is in the range 00 to 59
Midnight is the beginning of the calendar day i.e. 201101280000 (which equates to 24:00 of 27/01/2011).

Guide for use: The time portion of Event start datetime has only been collected since 1 July 2011. For events that occurred before that date, the time portion of Event start datetime contains '00:00'.

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

Partial dates not allowed.

The NHI number, Event type code, Event start datetime, 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 Event start time (Admission time):
- For acute events meeting the three hour admission rule the event start time is when the patient is first seen by a clinician, nurse or other healthcare professional in the Emergency Department, Acute Assessment Unit, Admission Planning unit or the like. When determining the event start time exclude waiting time in a waiting room and triage time.
- For acute patients admitted directly to a ward/unit, e.g. direct admission to intensive care unit (ICU), admission via delivery suite then the admission time is the time the patient arrives in the ward/unit care setting.
- For non acute events - (i.e. elective/arranged patients, same day or inpatient), the event start time will be when the patient physically arrives in the ward/unit or day stay clinical area. This will not include the time they spend in a waiting area before any nursing/clinical care starts.
- For birth events (BT events) - the event start time will be the time of birth for in hospital births only. Babies born before mother's admission to hospital or transferred from the hospital of birth are recorded as IP (inpatient event) and the event start time will be the time the patient arrives in the ward/neonatal intensive care unit (NICU).
- For internal and external transfers the event start time is the time the patient physically arrives in the new health care setting. The event end time for a discharge to another service within the same facility (DW) or discharge to another facility (DT, DA) will be when the patient leaves the health care setting. There will be a gap between these events which is the time taken to transfer. We would not expect these events to be contiguous. This will also apply to patient retrievals where a retrieval team is sent to another hospital to retrieve and transport a patient back to their hospital.

Related data: Date of birth, Event end datetime, 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:*** 1.1 ***Version date:*** 01-Feb-2011

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 Medical Warning System (MWS).
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 Providers should inform patients that their data will be sent to MOH for inclusion in the NMDS, and advise them that the event may also be viewed via the MWS. 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
Related data:

Administrative attributes

Source document:
Source organisation:

Event type code

Administrative status

Reference ID: A0159 ***Version:*** 1.2 ***Version date:*** 27-Feb-2013

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
CM Community
CO Cultural setting, non-Māori
CS Cultural Setting
DM Domiciliary
DP Day patient
DT Death event
GP General Practitioner event
ID Intended day case (retired 1 July 2013)
IM Psychiatric inpatient event
IP Non-psychiatric inpatient event
MC Māori cultural setting
NP Non-psychiatric
OP Outpatient event

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 datetime, 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 'ID': For event records with an event end date on or before 30 June 2013 'ID' may be used where the intention at admission is that the event will be a day-case event. Intended Day Case (ID) event type will be retired for event records with an event end date on or after 1 July 2013. Records with an event end date on or after 1 July 2013 that are reported with ID as the event type will be rejected with an error - event type code is not valid

'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 (i.e., 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 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), and for Mental Health (IM) inpatient events the reporting timeframe is 21 days post month of admission.

Related data:

Administrative attributes

Source document:

Source organisation:

Excluded purchase unit

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 01-Jul-2008

Identifying and defining attributes

Name: exclu_purchase_unit
Name in database: exclu_purchase_unit
Other names:
Element type: Derived data element
Definition: For events that have a Purchase Unit of 'EXCLU', the Purchase Unit allocated by mapping the Health Specialty Code to a Purchase Unit from the National Service Framework Data Dictionary.
Context:

Relational and representational attributes

Data type: varchar ***Field size:*** 10 ***Layout:***
Data domain: Purchase Units in the National Service Framework Data Dictionary.
Guide for use: Derived using a mapping table of Health Specialty Codes to Purchase Units.
Verification rules:
Collection
Related data: Purchase Unit, Health Specialty Code

Administrative attributes

Source document:
Source organisation: Ministry of Health

Facility code

Administrative status

Reference ID: A0143 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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:*** XXXX
Data domain: Refer to Appendix H for this code set. For further information contact Analytical Services. 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 current Data Access Policy on the Ministry web site at www.health.govt.nz/publication/current-data-access-policy.

Verification rules: Must be a valid facility code in the Facility Code table. For events with the date portion of event start datetime ending on or after 01 July 2009 there are additional validations against the facility start and end date.

The NHI number, Event type code, Event start datetime, 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 The Ministry of Health allocates codes on request. The code table is continually updated by the Ministry as hospitals open and close. See the Ministry web site for the most recent version.
Related data: Birth location
Facility type

Administrative attributes

Source document:
Source organisation: Ministry of Health

Facility transfer from

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: facility_transfer_from
Name in database: facility_transfer_from
Other names:
Element type: Data element
Definition: For transfers, the facility that the healthcare user was transferred from.
Context:

Relational and representational attributes

Data type: char ***Field size:*** 4 ***Layout:*** XXXX
Data domain: Refer to Appendix H for the facility code set. For further information contact Analytical Services. 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 Current Data Access Policy on the Ministry of Health web site at www.health.govt.nz/nz-health-statistics/access-and-use.

Verification rules: Mandatory for Admission Source Code = 'T' (Transfer) for the events ending on or after 1 July 2008.

Must be a valid code in the Facility code table.

Collection
Related data: Facility Code, Admission Source Code

Administrative attributes

Source document:
Source organisation: Ministry of Health

Facility transfer to

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: facility_transfer_to
Name in database: facility_transfer_to
Other names:
Element type: Data element
Definition: For transfers, the facility that the healthcare user was transferred to.
Context:

Relational and representational attributes

Data type: char ***Field size:*** 4 ***Layout:*** XXXX
Data domain: Refer to Appendix H for the code set. For further information contact Analytical Services. 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 Current Data Access Policy on the Ministry of Health web site at www.health.govt.nz/nz-health-statistics/access-and-use.

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Verification rules: Mandatory for Event End Type Code = ‘DA’, ‘DP’, ‘DT’, ‘EA’ or ‘ET’ (Transfers) for the events ending on or after 1 July 2008.

Must be a valid code in the Facility code table.

Collection
Related data: Facility Code, Event End Type Code

Administrative attributes

Source document:
Source organisation: Ministry of Health

Facility type

Administrative status

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

Identifying and defining attributes

Name: Facility Type
Name in database: facility_type
Other names:
Element type: Data element
Definition: A code that categorises facilities into particular types.
Context:

Relational and representational attributes

Data type: char ***Field size:*** 2 ***Layout:***
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
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:*** 1.1 ***Version date:*** 01-Feb-2011

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 Event end datetime is null. Event end datetime is not mandatory for mental health events.

Verification rules: Derived from Event end datetime where present. If Event end datetime is null then set to 'XXXXXXXX'.
Collection
Related data: Event end datetime

Administrative attributes

Source document:
Source organisation:

Funding Agency

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 27-Feb-2013

Identifying and defining attributes

Name: Funding agency code
Name in database: Funding_agency_code
Other names:
Element type: Data element
Definition: The agency/DHB of the principal purchaser.
Context:

Relational and representational attributes

Data type: char ***Field size:*** 4 ***Layout:*** XXXX
Data domain: Refer to Appendix H for this code set. For further information contact Analytical Services. Contact details are given at the front of this dictionary.

Guide for use: The Funding Agency has been introduced from 1 July 2012. This field can be reported as a valid agency code or a given value or null based on the rules given for the validation.
The Funding Agency must be reported in all the events reported in the Version 15.0 files regardless of the event end date.
Funding Agency will be available for reporting in the warehouse and BO universes.
Funding Agency will be used to determine if a health event is included in casemix funding.
An IDF will occur when the DHB of domicile is not the same as the Funding Agency.
Electives volumes will be calculated using the Funding Agency.

Verification rules: Mandatory for Principal health service purchaser is 20, 33, 34, 35, 55, or A0 for the events reported in Version 15.0 files. This is regardless of the event end date reported in the Version 15.0 files.
Must be a valid code in the agency code table if the Principal health service purchaser is 06, 17, 19, 20, 35, 55, or 98.
Must be reported as 1236 if Principal health service purchaser is 33 or 34.
Must be reported as 1237 if Principal health service purchaser is A0.

For more details see Section 14.2 of the NMDS File Specification.

Collection
Related data:

Administrative attributes

Source document:
Source organisation:

Gender code

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: Gender code
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:***

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, NMDS 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 '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:

Gestation period

Administrative status

Reference ID: A0101 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: Death of infant before 1st birthday (includes stillbirths).

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 infant deaths and stillbirths.

If outside 17 to 45 completed weeks, will only be accepted on confirmation.

Collection For stillbirths sourced from the HP4721 Medical Certificate of Causes of Fetal and Neonatal Death.

For live births, taken from the babys' birth event on NMDS, which is checked against a calculation based on the mothers last menstrual period and the infants data of Birth on the HP4721 certificate.

Related data: Certificate.Last menstrual period (Mother).
Date of Birth (Infant).

Administrative attributes

Source document:
Source organisation:

Health specialty code

Administrative status

Reference ID: ***Version:*** 1.4 ***Version date:*** 27-Feb-2013

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:***
Data domain: Refer to Appendix H for this code set. For further information contact Analytical Services. 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.

On 1 July 2007 the following changes took place:

M20 Endocrinology and Diabetology
..was discontinued and replaced with..
M95 Endocrinology
M96 Diabetology

M24 Paediatric Endocrinology and Diabetology
..was discontinued and replaced with..
M97 Specialist Paediatric Endocrinology
M98 Specialist Paediatric Diabetology

The need to separate diabetes out from other endocrinology events is because diabetes is the strategic area that the government has targeted and there is no other way to differentiate outpatient activity.

On 1 July 2008 the following changes took place:

P00 Antenatal services
P10 Delivery services [mother]
P11 Primary delivery services [midwife]
P20 Postnatal services [mother]
P30 Postnatal services [well newborn]
P35 Primary postnatal services [specialist]

Were retired and replaced with:

P60 Maternity services - mother [no community LMC]
P61 Maternity services - well newborn [no community LMC]
P70 Maternity services - mother [with community LMC]
P71 Maternity services - well newborn [with community LMC]

'With a Community LMC' should be defined as:
At the time of the event, the woman and her baby(s) are registered with and under the care of a Lead Maternity Carer (LMC) under Section 88 Notice for primary Maternity Services (see subpart DA). Registered being as defined in the notice (clause DA2). For clarity, this should not include women or babies who have been transferred over to secondary maternity, tertiary maternity or specialist neonatal services (clause DA8).

Note:

- That this is the specialty on discharge
- Community means not employed by the DHB, i.e., a Section 88 claim will be made for this birth or postnatal care.

For 'Section 88 Notice for Primary Maternity Services' refer to the Ministry of Health website: www.health.govt.nz/our-work/life-stages/maternity-and-breastfeeding/maternity-services/primary-maternity-services-notice-section-88

New health specialty code for event records with a discharge date on or after 1 July 2008:
D55 Non-weight bearing and other related convalescence
This health specialty code is intended for use where a patient undergoes a period of convalescence at a step-down facility other than the facility where their main rehabilitation program will occur.

The following health specialty codes were re-activated from 1 July 2013 for the purposes of identifying intestinal failure specialist service (S11) and paediatric metabolic service (M24) events separately:

M24 Specialist Paediatric Endocrinology and Diabetology
S11 Allied health/community gastroenterological surgery.

The following health specialty code was renamed from 1 July 2014:

S05 renamed from Anaesthesia service(s) to Anaesthesia service(s) and Pain Management."

Verification rules: Validation was introduced on 1 July 2007. Events before 1 July 2007 having a Health Specialty Code with a start date before 1 July 2007 will not be rejected.

Must be a valid code in the Health Specialty code table.

The Health Specialty code must be current ie, the date portion of Event end datetime must be within the range of the Health Specialty Code's start and end date. For event type IM where Event end datetime is null, the date portion of Event start datetime is used when validating against the Health Specialty code's start and end dates.

Collection 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:

Length of stay

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 datetime.

Date portion of Event end datetime minus date portion of Event start datetime minus Event leave days.

Equates to midnights spent in hospital.

Verification rules:
Collection
Related data: Event start datetime
Event end datetime
Event leave days

Administrative attributes

Source document:
Source organisation:

Major diagnostic category (MDC) code

Administrative status

Reference ID: A0163 ***Version:*** 6.7 ***Version date:*** 01-Feb-2011

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	Pre-MDC
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
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
99	Error DRG's

Guide for use: Produced by running the grouper programs, which use data from the Health Event and Diagnosis Procedure tables.
Verification rules:
Collection
Related data: MDC type
DRG codes
DRG grouper type code

Administrative attributes

Source document: AR-DRG Definitions Manuals
Source organisation:

Major diagnostic category (MDC) type

Administrative status

Reference ID: ***Version:*** 1.4 ***Version date:*** 1-July-2017

Identifying and defining attributes

Name: MDC type
Name in database: mdc_type
Other names:
Element type: Derived data element
Definition: A code denoting which 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
E	AR-DRG version 6.0
F	AR-DRG version 6.0x
G	AR-DRG version 7.0

Guide for use: Derived from the version of the grouper used to create the DRG code.
Verification rules:
Collection
Related data: MDC code
DRG codes
DRG grouper type code

Administrative attributes

Source document:
Source organisation:

Month of data

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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:*** XX
Data domain: 01 – 12, XX
Guide for use:
Verification rules: Derived from the month of discharge. If Event end datetime is missing then set to 'XX'.
Collection
Related data: Event end datetime

Administrative attributes

Source document:
Source organisation:

Mother's encrypted NHI

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: mothers_encrypted_hcu_id
Name in database: mothers_encrypted_hcu_id
Other names: Mother's NHI
Element type: Derived data element
Definition: For birth events, the Mother's NHI in encrypted form.

Context: The NHI number is the cornerstone of Ministry of Health'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

Data type: char ***Field size:*** 11 ***Layout:***
Data domain: System-generated
Guide for use: Only reported for Birth events.

Verification rules: Must be registered on the NHI database before the NHI number can be used in the NMDS.

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.
Mother's NHI is mandatory for BT (birth) evens where the date portion of Event end datetime is on or after 1 July 2008.
Events where the date portion of Event end datetime is before 1 July 2008 and a value in the Mother's NHI field will be rejected with an error.

ENCRYPTION
The Mother's Encrypted NHI number is encrypted using a one-way encryption algorithm when the record is transferred from the NMDS transactional system to the data warehouse. The aim is to provide an encrypted number that can be sent across public (unsecured) networks.

Collection 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 Sector Services for GPs and other primary care providers.

Related data: Encrypted NHI Number

Administrative attributes

Source document: http://www.health.govt.nz/our-work/health-identity/national-health-index

Source organisation: Ministry of Health

NZ DRG code current

Administrative status

Reference ID: ***Version:*** 1.3 ***Version date:*** 1-July-2017

Identifying and defining attributes

Name: NZ DRG code current

Name in database: nz_drg_code_current

Other names:

Element type: Data element

Definition: A diagnosis-related group (DRG) code from version 4.1, 4.2, 5.0, 6.0, 6.0x or 7.0 is produced by invoking the current DRG grouper program version 7.0 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

Mandatory

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

Data domain: 801A-963Z, A01Z-Z65Z

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

Based on Event end datetime:

- From 1 July 2001 and 30 June 2002, this field contains a DRG code of clinical version 4.1.

- Between 1 July 2002 and 30 June 2004, this field contains a DRG code of clinical version 4.2.

- Between 1 July 2004 and 30 June 2005 most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. At that time AR-DRG version 4.2 required ICD-10-AM 2nd Edition codes so NMDS mapped the 3rd edition codes supplied by hospitals to 2nd edition codes and used these to assign an AR-DRG 4.2 code.

- Between 1 July 2004 and 30 June 2008 most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. AR-DRG version 5.0 used 3rd edition codes so no mapping was required.

- Between 1 July 2008 and 30 June 2011 this field contained a DRG from AR-DRG version 5.0 derived, if necessary, by mapping ICD-10-AM 6th Edition codes back to ICD-10-AM 3rd Edition codes.

- Between 1 July 20011 and 30 June 2013 this field contained a DRG from AR-DRG version 6.0 derived, if necessary, by mapping ICD-10-AM 6th Edition codes back to ICD-10-AM 3rd Edition codes.

- Between 1 July 20013 and 30 June 2017 this field contained a DRG from AR-DRG version 6.0x derived, if necessary, by mapping ICD-10-AM 6th Edition codes back to ICD-10-AM 3rd Edition codes.

- From 1 July 2017 this field contains a DRG from AR-DRG version 7.0 derived from ICD-10-AM 8th Edition codes.

Verification rules:

Collection The current DRG grouper is AR-DRG version 7.0, which uses up to 30 diagnoses and 30 procedure codes. External cause codes are not used by the grouper. It is recommended that hospitals pioritise diagnoses and procedure codes in order to present the grouper with the most severe diagnoses and operations.

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

The DRG is calculated from:

- personal information (e.g., Sex, Date of birth), and
- event information (e.g., Admission date, Event end type), and
- diagnosis and procedure information

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

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
Related data:

Administrative attributes

Source document: Immigration Act 1987
Source organisation:

Occupation code

Administrative status

Reference ID: A0134 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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.
Refer to Appendix H for this code set. For further information contact Analytical Services. 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 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 Should be reported for cancer patients.
Related data: Occupation code

Administrative attributes

Source document:
Source organisation:

Patient clinical complexity level (PCCL)

Administrative status

Reference ID: ***Version:*** 1.4 ***Version date:*** 1-July-2017

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:

0	no CC effect
1	minor CC
2	moderate CC
3	severe CC
4	catastrophic CC

Guide for use: Relates only to DRG grouper versions 4.1, 4.2, 5.0, 6.0, 6.0x and 7.0.

Serves the same purpose for DRG grouper versions 4.1, 4.2, 5.0, 6.0, 6.0x and 7.0 as CCL does for DRG grouper versions 3.1 and 3.2.

In the AR-DRG Definitions Manual it says 'PCCL is a measure of the cumulative effect of a patient's complications and comorbidities, and is calculated for each episode. The calculation is complex and has been designed to prevent similar conditions from being counted more than once'.

Verification rules:
Collection
Related data: DRG code current
CCL

Administrative attributes

Source document: AR-DRG Definitions Manuals
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 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:*** 1.3 ***Version date:*** 27-Feb-2013

Identifying and defining attributes

Name: Principal health service purchaser
Name in database: purchaser_code
Other names: Principal purchaser, Health purchaser, Purchaser code, PHP, PHS, 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
17 Accredited employer
19 Overseas chargeable
20 Overseas eligible
33 MoH Screening Pilot
34 MOH-funded purchases
35 DHB-funded purchases
55 Due to strike
98 Mixed funding where no Ministry of Health, DHB or ACC purchase is involved, e.g., some hospice cases
A0 ACC - direct purchase

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)
13 Base purchase (retired 30 June 2007)
14 HFA additional sustainable purchase (retired 30 June 2004)
15 BreastScreen Aotearoa (retired 30 June 2009)
16 Independent Practice Association (retired 1 July 2012)
18 DHB accident purchase - overseas patients, non-MVA, non-work-related (retired 30 June 2007)
A1 FIS - direct purchase, Fusion Insurance Services (retired 1 July 2012)
A2 NZI - direct purchase, NZ Insurance Ltd (retired 1 July 2012)
A3 HIH - direct purchase, HIH Work Able Ltd (retired 1 July 2012)
A4 MMI - direct purchase, MMI General Insurance (NZ) Ltd (retired 1 July 2012)
A5 FMG - direct purchase, Farmers' Mutual Accident Care Ltd (retired 1 July 2012)
A6 @WK or AWK - direct purchase, At Work Insurance Ltd (retired 1 July 2012)
A7 CIG - direct purchase, Cigna Insurance Ltd (retired 1 July 2012)

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.

On 1 July 2007, code ‘13’ Base Purchaser was retired and replaced with ‘34’ MOH-funded purchase and ‘35’ DHB-funded purchase.

'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.

From 1 July 2009, code ‘15’ BreastScreen Aoteroa was retired and replaced with ‘35’ DHB-funded purchases.

From 1 July 2013, code ‘33’ MOH Screening Pilot was introduced and may be used with event records funded under the Bowel Cancer Screening Pilot Programme with an event start date from 1 October 2011.

See Appendix I for the allocation guide for NMDS Health Service Purchaser Codes.

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

The date portion of Event end datetime 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.

As from 1 July 2007 the Principal health service purchaser code must be current ie. the date portion of Event end datetime must be within the range of the Principal health service purchaser code’s start and end date. For event type IM where End datetime is null, the date portion of Event start datetime is used when validating against the Principal health service purchaser code’s start and end dates.

Collection Prior to 1 July 2007 acute, arranged and booking list cases would normally be assigned the base funding code ('13').
On or after 1 July 2007 acute or arranged cases should be reported with purchaser code 35- DHB Funded.
The Additional Electives funding (Orthopeadics Initiative, Cataract Initiative and Additional Elective Services Initiative) should be reported as 35- DHB Funded. This is because the Ministry now pays the money to the DHB funder arm, who then contracts with the DHB provider arm, or makes IDF payments for the work.

All Accredited Employer acute treatment/visits should be reported with 35-DHB Funded purchaser code with the Accident Flag and ACC45 claim number. These are then included in the Acute Levy calculations the same as ACC patients.
Purchaser 17 (just like purchaser A0) is used for all post-acute/elective treatments or visits and should be invoiced directly to the Accredited Employer. Purchaser 17 activity is excluded from the Levy calculations because it is not acute and has been invoiced directly.

From 1 July 2013, code ‘33’ MOH Screening Pilot was used to identify bowel screening pilot colonoscopies.

Privately funded cases would normally be assigned '06'.

If a specified purchaser for the health event has been identified, 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.moh.govt.nz/notebook/nbbooks.nsf/0/9fecff85d44b17c8cc25709300001caa/$FILE/AccidentServices.pdf 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 date portion of Event end datetime 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.health.govt.nz.

Related data: ACC claim number
Private Flag

Administrative attributes

Source document:
Source organisation:

Prioritised ethnicity

Administrative status

Reference ID: A0321 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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: Refer to Appendix H for this code set. For further information contact Analytical Services. 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. Refer to Appendix C for further details.

Verification rules:
Collection
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:*** A
Data domain: 'Y' = Yes
'N' = No
Null
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
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
Related data: Psychiatric leave end date

Administrative attributes

Source document:
Source organisation:

Psychiatric leave end date

Administrative status

Reference ID: A0184 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 date portion of Event start datetime, 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 date portion of Event end datetime, and the Event end datetime must not be null.

Partial dates not allowed.

Collection 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:*** 1.1 ***Version date:*** 01-Feb-2011

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' (i.e., not eligible). See the New Zealand Casemix Framework for Publicly Funded Hospitals including WIES methodology and Casemix Purchase Unit Allocation document for the criteria.
http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations

Verification rules:
Collection
Related data: DRG codes
Costweight
Costweight code
Health specialty code

Administrative attributes

Source document: New Zealand Casemix Framework for Publicly Funded Hospitals including WIES methodology and Casemix Purchase Unit Allocation
Source organisation: Cost Weights Working Group

TLA of domicile

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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

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

Derived from the MOH 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

Related data: Domicile code

Administrative attributes

Source document:

Source organisation:

Total hours on continuous positive airway pressure

Administrative status

Reference ID: A0240 ***Version:*** 7.0 ***Version date:*** 01-Feb-2011

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: Total CPAP hours should not be reported for records where the date portion of Event end datetime is on or after 1 July 2009. Total NIV hours should be reported instead.

Hours on continuous positive airway pressure has been used in determining the DRG code since 1 July 2001.

A CPAP procedure is:
- an ICD-10-AM 6th Edition Clinical codes of 9220900,9220901,9220902 (Clinical code type = 'O') or
- an ICD-10-AM 1st, 2nd, 3rd 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').

There is no specific procedure code for CPAP in ICD-10-AM 6th edition; it is included in the non-invasive ventilation (NIV) codes:

9220900 [570]	Management of noninvasive ventilatory support, <= 24 hours
9220901 [570]	Management of noninvasive ventilatory support, > 24 and < 96 hours
9220902 [570]	Management of noninvasive ventilatory support, >= 96 hours

There is no specific procedure code for CPAP in the ICD-10-AM 8th edition. Event records encoded in this clinical code system with a CPAP Hours value are not required to contain any of the above procedure codes.

Note:
The logical back mapping tables (from 6th edition to 3rd edition) convert the three NIV procedure codes (above) to the CPAP procedure code 9203800. Therefore, any data extract based on the CPAP procedure code 9203800 for events where the date portion of Event end datetime is on or after 1 July 2008 will include bilevel positive airway pressure [BiPAP] and intermittent positive pressure breathing [IPPB] and continuous positive airway pressure [CPAP].

Verification rules: Optional.

Generate warning if infant is:
- more than 364 days old at Event end datetime, or
- between 28 and 364 days old and Weight on admission is more than 2500 g at Event end datetime.

Generate warning if:
- more than 100, or
more than the difference (calculated in hours) between the date portions of Event start datetime and Event end datetime.

For records where the date portion of Event end datetime is before 1 July 2008
Generate warning if present and a CPAP procedure (as defined in Guide for use above) is not present.

Generate warning if not present when a CPAP procedure (as defined in Guide for use above) is present, unless:
- Total hours on mechanical ventilation is present, or
- age at Event end datetime 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.

For records where the date portion of Event end datetime is on or after 1 July 2008
Generate error if present and a NIV procedure (as defined in Guide for use above) is not present. Records can be reported with an NIV procedure and no hours present if IPPB or BiPAP has been administered.

Generate warning if present and Health specialty code is not P61, P71 or in the P40 range.

Generate an error if CPAP hours is submitted with events ending on or after 1 July 2009 if the file version is 013.0.

Collection 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 endotracheal tube [ETT] or tracheostomy.

CPAP hours may be reported within the same event as mechanical ventilation 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 (NIV) procedure must be coded and CPAP hours recorded.

CLINICAL CODING GUIDELINES

When coding in ICD-10-AM 6th edition NIV procedure codes should be assigned for all cases and calculation of hours are to be in accordance with the coding standard (ACS 1006 page 176).

NIV should not be assigned when it is used as a method of weaning from continuous ventilatory support (CVS) or performed by endotracheal tube [ETT] or tracheostomy.

NIV should not be coded when the patient brings in their own ventilatory support devices (e.g., CPAP machine) into hospital.

The CPAP 92038-00 [568] 1st, 2nd and 3rd edition procedure code should be assigned for any duration when required for neonates/infants.

Related data: Total hours on mechanical ventilation, Total noninvasive ventilation hours

Administrative attributes

Source document:
Source organisation:

Total hours on mechanical ventilation

Administrative status

Reference ID: A0214 ***Version:*** 7.0 ***Version date:*** 01-Jun-2011

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
Context: Total hours for the health event irrespective of the specialty or team treating the patient.

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.
It may also trigger the mechanical ventilation co-payment for eligible DRGs.
Verification rules: Optional.

Generate warnings if:
- not present when a Mechanical Ventilation procedure is present (i.e., ICD-10-AM 1st, 2nd, 3rd, 6th, or 8th 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 difference (calculated in hours) between the date portions of Event start datetime and Event end datetime.

Collection When calculating the total hours on mechanical ventilation include all ventilated hours (excluding surgery). This includes all ventilation administered irrespective of the health specialty or team treating the patient. Calculation of the total hours on mechanical ventilation will commence from the time the patient is ventilated. If the patient has commenced ventilation prior to arriving to the hospital (e.g., on route in the ambulance), it will be calculated from the time of arrival.

Exclude time spent being ventilated while undergoing surgery (being ventilated while undergoing surgery is not an indicator of severity). Hours where the patient is in radiology or emergency care should be included in the total mechanical ventilation hours for reporting purposes.

Time spent weaning (regardless of the physical location in which the patient is treated) 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. Apart from weaning as described, other forms of ventilation should not be included (e.g., non-intubated CPAP, IPPB, BiPAP).

When reporting the total hours on mechanical ventilation an incomplete hour is rounded up to the next hour; e.g., if the time ventilated is 98 hours 10 minutes, then the total hours on mechanical ventilation reported will be '00099'. The minimum number of ‘total hours on mechanical ventilation’ reported is 1.

CLINICAL CODING
All hours on mechanical ventilation in the Emergency Department (ED) should be coded, whether the patient is intubated in ED or in the ambulance. If ventilation is commenced in the ambulance, it will be counted only from the time of hospitalisation.

Hours on continuous ventilatory support (CVS) (mechanical ventilation) should be interpreted as completed cumulative hours.

1. If more than one period of CVS (mechanical ventilation) occurs during the same hospitalisation when used for treatment (not weaning) should be added together. For example, if a patient is on CVS for the first day of their admission, then on CVS again on the fourth day of their admission, the CVS hours should be added together to arrive at the correct CVS procedure code.

2. ICD procedure coding includes all time spent ventilated from time of arrival to hospital (or time of

intubation).

3. For ICD procedure coding the minimum number of completed hours is 1.

4. Partially completed hours are not counted when allocating a procedure code, ie, they are rounded down for ICD procedure coding.

WORKED EXAMPLE
Patient brought in by ambulance at 10.32am. Patient goes into acute respiratory failure and was intubated and commenced ventilation in ED at 10.50am. Once the patient was stabilised he was admitted to ICUat 11.43am (day one). The next day (day two) the patient was transferred to theatre for surgery. Total time in theatre was 4 hours. The patient returned to ICU and remained ventilated until the next day (day three) when mechanical ventilation ceased and the patient was extubated at 12.32pm.

On day one patient commenced ventilation in ED at 10.50am and was extubated 12.32pm on day three. Total mechanical ventilation hours:
(Day 1) 13hrs 10mins + (Day 2) 24hrs + (Day 3) 12.32hrs
Total hours on mechanical ventilation = 49 hours 42 minutes

Reporting total hours on mechanical ventilation:
49.42 hours minus 4 hours in theatre = 45.42 hours (rounded up) = 46 hours.
46 hours is to be reported in the total hours on mechanical ventilation field.

Procedure code assignment:
13882-01 [569] *Management of continuous ventilatory support, > 24 and < 96 hours*
As per the coding guidelines the total hours used in order to assign the correct procedure code would be 49 hours.

Related data: Total hours on continuous positive airway pressure, Total noninvasive ventilation hours

Administrative attributes

Source document: See the AR-DRG manual
Source organisation:

Total hours on non-invasive ventilation

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: Total NIV Hours
Name in database: hours_on_noninvasive_ventilation
Other names: NIV hours
Element type: Data element
Definition: The total number of hours on noninvasive ventilation during an episode of care.
Context:

Relational and representational attributes

Data type: number ***Field size:*** 5 ***Layout:*** NNNNN
Data domain: 00001-99999 or NULL

Guide for use: Noninvasive ventilation (NIV) refers to all modalities that assist ventilation without the use of an ETT or tracheostomy. Noninvasive devices include: face mask, mouthpiece, nasal mask, nasal pillows, nasal prongs, nasal tubes and nasopharyngeal tubes.

Types/modes of noninvasive ventilatory support are:
- Bi-level positive airway pressure [BiPAP]
- Continuous positive airway pressure [CPAP]
- Intermittent mask [CPAP]
- Intermittent positive pressure breathing [IPPB]
- Intermittent positive pressure ventilation [IPPV]
- Noninvasive mask ventilation [NIMV]
- Noninvasive pressure ventilation [NIPV]

Total hours on noninvasive ventilation (NIV) is used to capture the number of hours a patient is on NIV during an episode of care. As in the total hours on mechanical ventilation variable, part hours are rounded up.

NIV hours should not be collected when NIV is used as a method of weaning from continuous ventilatory support (CVS) or performed by endotracheal tube (ETT) or tracheostomy. If NIV is used to wean a patient from CVS, the time on NIV will be added to the hours on CVS.

NIV hours may be reported within the same event as mechanical ventilation hours. Where NIV is being used as a separate valid treatment modality in the same episode of care as CVS, a NIV procedure must be coded and NIV hours recorded.

Subsequent periods of NIV when used for treatment (not weaning) should be added together.

CLINICAL CODING AND REPORTING GUIDELINES

When coding in ICD-10-AM 6th edition and ICD-10-AM 8th edition NIV procedure codes 92209-00, 92209-01 and 92209-02 [570] should be assigned for all cases and calculation of hours are to be in accordance with Australian Coding Standard (ACS 1006 page 176).

Hours on noninvasive ventilation (NIV) should be interpreted as completed cumulative hours.

For ICD coding the minimum number of completed hours is 1.
The minimum number reported for the field 'Total hours on noninvasive ventilation' is 1.

If more than one period of NIV occurs during the same episode of care when used for treatment (not weaning) should be added together. For example, if a patient is on NIV for the first day of their admission, then on NIV again on the fourth day of their admission, the NIV hours should be added together to arrive at the correct NIV procedure code.

Partially completed hours are not counted when allocating a procedure code, eg, they are rounded down for ICD procedure coding but rounded up for calculating the total NIV hours field.

NIV should not be assigned when it is used as a method of weaning from continuous ventilatory support (CVS) or performed by endotracheal tube (ETT) or tracheostomy.

NIV should not be coded when the patient brings in their own ventilatory support devices (e.g., CPAP machine) into hospital.

Verification rules: Optional. If reported, must be positive integer or null.

Generate warning if:
- not present when a noninvasive ventilation procedure is present (i.e., ICD-10-AM 6th edition Clinical Code = 9220900 or 9220901 or 9220902 (Clinical Code Type = 'O')
- present and noninvasive procedure is not present (i.e., ICD-10-AM 6th edition Clinical Code = 9220900 or 9920901 or 9920902 (Clinical Code Type = 'O')
- greater than the difference (calculated in hours) between the date portions of Event start datetime and Event end datetime.

Generate error if:
- NIV hours is submitted where the date portion of Event end datetime is before 1 July 2009
- CPAP hours is submitted with the events ending on or after 1 July 2009 if file version is 013.0.

Collection

Related data: Total hours on mechanical ventilation

Administrative attributes

Source document:

Source organisation:

Total intensive care unit (ICU) Hours

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: total_icu_hours
Name in database: total_icu_hours
Other names:
Element type: Data element
Definition: Total duration of stay (hours) in an Intensive Care Unit (ICU) during this episode of care.
Context: Total hours for the health event.

Relational and representational attributes

Data type: number ***Field size:*** 5 ***Layout:*** NNNNN
Data domain: 00001-99999 or NULL

Guide for use: An intensive care unit (ICU) is a specially staffed and equipped, separate and self-contained section of a hospital for the management of patients with life-threatening or potentially life-threatening conditions. Such conditions should be compatible with recovery and have the potential for an acceptable future quality of life. An ICU provides special expertise and facilities for the support of vital functions, and utilises the skills of medical nursing and other staff experienced in the management of these problems.

Smaller hospitals may have an ICU combined with an HDU and/or a CCU. Not all admissions to such a unit will be an Intensive Care admission and identification of intensive care patients is left to the discretion of the unit staff.

Verification rules: Optional. If reported, must be positive or zero
Events where the date portion of Event end datetime is before 1 July 2008 and a value in the Total ICU hours will not be loaded in to the NMDS.
Events where the date portion of Event end datetime is on or after 1 July 2008 must have a null value or positive for the field Total ICU hours.
A warning is generated if the total ICU hours reported in an NMDS event (where the date portion of Event end datetime is on or after 1 July 2008) is greater than the length of stay. If ICU treatment started in the ED before admission then it is possible that the hours are greater than the length of stay but this is unusual.

Collection If the patient has more than one period in ICU during this hospital episode, the total duration of all such periods is reported. Hours in a High Dependency Unit (HDU) and in a Neonatal Intensive Care Unit (NICU) are not to be included.

An incomplete hour is rounded up to the next hour; eg, if the time in the care of the ICU team is 98 hours 10 minutes, then the reported time will be '99'.

Related data:

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
Related data:

Administrative attributes

Source document:
Source organisation:

Weight on admission

Administrative status

Reference ID: A0207 ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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.

The Ministry of Health 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 grams 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 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:

Year of data

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

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 datetime is missing then set to 'XXXX'.
Collection
Related data: Event end datetime

Administrative attributes

Source document:
Source organisation:

Weighted Inlier Equivalent Separations (WIES) Agency table

Table name: WIES Agency table
Name in database: wies_agency_tab ***Version:*** 1.0 ***Version date:*** 01-Jul-2008

Definition: Stores the Agencies to be included in Casemix and the dates they were active.

Guide for Use: A combination of a range of Agencies and Facilities has been identified as the providers through which the MoH/DHBs will monitor base casemix agreements. All other facilities, historically designated as 'rural', are excluded. Note that with DHB's sub-contracting, the list of included Agencies and Facilities may require updating periodically.
Primary Key: wies_agency_code, from_date
Business Key:
Relational Rules:

WIES agency code

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: wies_agency_code
Name in database: wies_agency_code
Other names: Health agency code, DHB
Element type: Data element
Definition: A code that uniquely identifies an agency eligible for inclusion in Casemix.
Context:

Relational and representational attributes

Data type: char ***Field size:*** 4 ***Layout:*** XXXX
Data domain: See the WIES document on the Ministry of Health web site at
http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations

Guide for use: Agencies included in Casemix are determined by the National Pricing Programme Casemix Costweight Working Group.

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

Administrative attributes

Source document:
Source organisation: DHB Shared Services

WIES agency from date

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 01-Jul-2008

Identifying and defining attributes

Name: wies_agency_from_date
Name in database: wies_agency_from_date
Other names:
Element type: Data element
Definition: The start date for when the Agency was considered eligible for inclusion in Casemix.
Context:

Relational and representational attributes

Data type: datetime ***Field size:*** 8 ***Layout:*** CCYYMMDD
Data domain: Valid Dates
Guide for use: An agency may be eligible for inclusion in Casemix in more than one period.
Verification rules:
Collection
Related data:

Administrative attributes

Source document:
Source organisation: DHB Shared Services

WIES agency to date

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 01-Jul-2008

Identifying and defining attributes

Name: wies_agency_to_date
Name in database: wies_agency_to_date
Other names:
Element type: Data element
Definition: The end date for when the Agency was considered eligible for inclusion in Casemix.
Context:

Relational and representational attributes

Data type: datetime ***Field size:*** 8 ***Layout:*** CCYYMMDD
Data domain: Valid Dates
Guide for use: An agency may be eligible for inclusion in Casemix in more than one period.
Verification rules:
Collection
Related data:

Administrative attributes

Source document:
Source organisation: DHB Shared Services

WIES Facility table

Table name: WIES Facility Table
Name in database: wies_facility_tab ***Version:*** 1.0 ***Version date:*** 01-Jul-2008

Definition: Stores the Facility to be included in Casemix and the dates they were active.

Guide for Use: A combination of a range of Agencies and Facilities has been identified as the providers through which the MoH/DHBs will monitor base casemix agreements. All other facilities, historically designated as 'rural', are excluded. Note that with DHB's sub-contracting, the list of included Agencies and Facilities may require updating periodically.

Primary Key: wies_facility_code, from_date
Business Key:
Relational Rules:

WIES facility code

Administrative status

Reference ID: ***Version:*** 1.1 ***Version date:*** 01-Feb-2011

Identifying and defining attributes

Name: wies_facility_code
Name in database: wies_facility_code
Other names: Health agency facility code, Hospital, HAF code
Element type: Data element
Definition: A code that uniquely identifies a facility eligible for inclusion in Casemix.
Context:

Relational and representational attributes

Data type: char ***Field size:*** 4 ***Layout:*** XXXX
Data domain: Refer to Appendix H for this code set.

Guide for use: Agencies included in Casemix are determined by the National Pricing Programme Casemix Costweight Working Group.

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

Administrative attributes

Source document:
Source organisation: DHB Shared Services

WIES facility from date

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 01-Jul-2008

Identifying and defining attributes

Name: wies_facility_from_date
Name in database: wies_facility_from_date
Other names:
Element type: Data element
Definition: The start date for when the facility was considered eligible for inclusion in Casemix.
Context:

Relational and representational attributes

Data type: datetime ***Field size:*** 8 ***Layout:*** CCYYMMDD
Data domain: Valid Dates
Guide for use: A facility may be eligible for inclusion in Casemix in more than one period.
Verification rules:
Collection
Related data:

Administrative attributes

Source document:
Source organisation: DHB Shared Services

WIES facility to date

Administrative status

Reference ID: ***Version:*** 1.0 ***Version date:*** 01-Jul-2008

Identifying and defining attributes

Name: wies_facility_to_date
Name in database: wies_facility_to_date
Other names:
Element type: Data element
Definition: The end date for when the Facility was considered eligible for inclusion in Casemix.
Context:

Relational and representational attributes

Data type: datetime ***Field size:*** 8 ***Layout:*** CCYYMMDD
Data domain: Valid Dates
Guide for use: A facility may be eligible for inclusion in Casemix in more than one period.
Verification rules:
Collection
Related data:

Administrative attributes

Source document:
Source organisation: DHB Shared Services

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 G) 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 (e.g., 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.

Appendix B: Glossary

Note: See the Ministry of Health website for *Appendix B: Glossary*
http://www.health.govt.nz/publication/appendix-b-glossary

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.
- The Ministry of Health (MOH) 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 using a residual code such as '94' (Don't Know), '95' (Refused to Answer) or '99' (Not specified), not as '61' (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 MOH 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 MOH 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. MOH 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 'Mainlander', 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 write 'New Zealander', this can be coded as '11' (New Zealand European).

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 response with an appropriate residual code such as '95' (Refused to Answer) or '99' (Not specified).

Important: The code '61' (Other) applied to only 0.037% of the New Zealand population in the 2006 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.

Prioritisation of ethnicity

Many National Data Collections include Prioritised ethnicity. This is the most highly prioritised ethnicity where multiple ethnicity responses have been recorded for the healthcare user (either submitted with the health event/service or extracted from the NHI as part of the data load process). Priorisation is determined according to a Statistics NZ algorithm and prioritising ethnic codes simplifies analysis.

Each of the ethnic group codes is prioritised using the mappings in the table below.

Ethnic code	Ethnic code description	Priority
10	European not further defined	21
11	New Zealand European / Pakeha	22
12	Other European	20
21	Maori	1
30	Pacific Peoples not further defined	9
31	Samoan	7
32	Cook Island Maori	6
33	Tongan	5
34	Niuean	4
35	Tokelauan	2
36	Fijian	3
37	Other Pacific Peoples	8
40	Asian not further defined	14
41	Southeast Asian	10
42	Chinese	12
43	Indian	11
44	Other Asian	13
51	Middle Eastern	17
52	Latin American / Hispanic	15
53	African (or cultural group of African origin)	16
54	Other (retired on 01/07/2009)	19
61	Other Ethnicity	18
94	Don’t Know	94
95	Refused to Answer	95
97	Response Unidentifiable	97
99	Not stated	99

Detailed code table

The codes used to report ethnicity to MOH are taken from the Statistics NZ Statistical Standard for Ethnicity 2005. This classification is a very detailed 5-digit code: only the first two digits (shown in the table below) are reported to MOH.

Use this table to code healthcare user’s self-identified ethnicities.

MOH Ethnicity code	Country of Ethnicity Affiliation
37	Admiralty Islander
44	Afghani
53	African American
53	African nec
53	African nfd
12	Afrikaner
32	Aitutaki Islander
12	Albanian
51	Algerian
12	American (US)
51	Arab
52	Argentinian
12	Armenian
44	Asian nec
40	Asian nfd
51	Assyrian
32	Atiu Islander
37	Austral Islander
12	Australian
37	Australian Aboriginal
12	Austrian
37	Banaban
44	Bangladeshi
37	Belau/Palau Islander
12	Belgian
12	Belorussian
43	Bengali
37	Bismark Archipelagoan
52	Bolivian
12	Bosnian
37	Bougainvillean
52	Brazilian
12	British nec
12	British nfd
12	Bulgarian
12	Burgher
41	Burmese
12	Byelorussian
41	Cambodian
42	Cambodian Chinese
12	Canadian
37	Caroline Islander
12	Celtic nfd
61	Central American Indian
37	Chamorro
12	Channel Islander
52	Chilean
42	Chinese nec
42	Chinese nfd
52	Colombian
32	Cook Island Maori nfd
12	Cornish
12	Corsican
52	Costa Rican

MOH Ethnicity code	Country of Ethnicity Affiliation
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
53	Eritrean
12	Estonian
53	Ethiopian
44	Eurasian
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
53	Ghanian
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)
61	Inuit/Eskimo
51	Iranian/Persian
51	Iraqi
12	Irish
51	Israeli/Jewish/Hebrew
12	Italian
53	Jamaican
44	Japanese
51	Jordanian

MOH Ethnicity code	Country of Ethnicity Affiliation
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
61	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 Zealander
11	New Zealand European
21	New Zealand Maori
52	Nicaraguan
53	Nigerian
34	Niuean
61	North American Indian
12	Norwegian
99	Not Specified
37	Ocean Islander/Banaban
51	Omani
12	Orkney Islander
53	Other African nec

MOH Ethnicity code	Country of Ethnicity Affiliation
44	Other Asian nec
12	Other European
61	Other nec
61	Other nfd
41	Other Southeast Asian nec
37	Pacific Peoples nec
30	Pacific Peoples 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
61	Seychelles Islander
12	Shetland Islander
43	Sikh
42	Singaporean Chinese
44	Sinhalese
12	Slavic/Slav
12	Slovak
12	Slovene/Slovenian
37	Society Islander (including Tahitian)
37	Solomon Islander
53	Somali
61	South African coloured
12	South African nec
61	South American Indian
12	South Slav (formerly Yugoslav groups) nfd
12	South Slav (formerly Yugoslav) nec
41	Southeast Asian nfd
12	Spanish

MOH Ethnicity code	Country of Ethnicity Affiliation
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
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
12	Zimbabwean

nfd = Not further defined
nec = Not elsewhere classified

Appendix D: DRG Process

Introduction

This appendix describes the process by which the Diagnostic Related Groups (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, 5.0, 6.0, 6.0x and 7.0 no historical data is available, so no average values are stored.

Current software

The current DRG Grouper Program (software) is version 7.0. This can produce DRG codes in clinical versions 5.0, 6.0, 6.0x and 7.0. The previous DRG Grouper Program can produce DRG codes in clinical versions 4.1, 4.2, 5.0, 6.0 and 6.0x.

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.

For event records with an event end date on or after 1 July 2011, DRG codes are calculated and stored in clinical version 6.0.

For event records with an event end date on or after 1 July 2013, DRG codes are calculated and stored in clinical version 6.0x.

For event records with an event end date on or after 1 July 2017, DRG codes are calculated and stored in clinical version 7.0

Note: The 4.1, 4.2, 5.0, 6.0, 6.0x and 7.0 codes are all 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, and • ICD-10-AM 6th Edition, and • ICD-10-AM 8th 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, NMDS will continue to apply ICD-10-AM 2nd Edition code to the Grouper 3. For the 2005 to 2010 financial years, NMDS will apply ICD-10-AM 3rd Edition codes to the Grouper.

	4. For the 2011 financial year, NMDS will apply ICD-10-AM 6th Edition codes to the Grouper.
2	The DRG Grouper Program processes information about an event for each grouper version, including: • personal information (e.g., Sex, Date of birth), and • event information (e.g., Admission date, Event end type), and • diagnosis and procedure information in the appropriate ICD code for the DRG Grouper.
3	For each version of the Grouper (3.1, 4.1, 4.2, 5.0, 6.0, 6.0x and 7.0), the DRG Grouper Program 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 http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations

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

*Note: the event type ID is retired and may not be used with event records with an event end date on or after 1 July 2013.

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 elapsed time in minutes
Event end datetime
Event end type code
Event ID
Event leave days
Event local identifier
Event start datetime
Event summary suppress flag
Event supplementary information
Event type code
Health specialty code
Length of stay
Mother's encrypted NHI
Principal health service purchaser
Private flag
PMS unique identifier

Healthcare User
Age at admission
Age at discharge
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
Excluded purchase unit
MDC code
MDC type
NZ DRG code current
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
Total ICU hours
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 transfer from
Facility transfer to
Facility type
WIES agency code
WIES agency from date
WIES agency to date
WIES facility code
WIES facility from date
WIES facility to date

File and Record Administration
Batch ID
Date updated
Transaction ID

Appendix H: Code Table Index

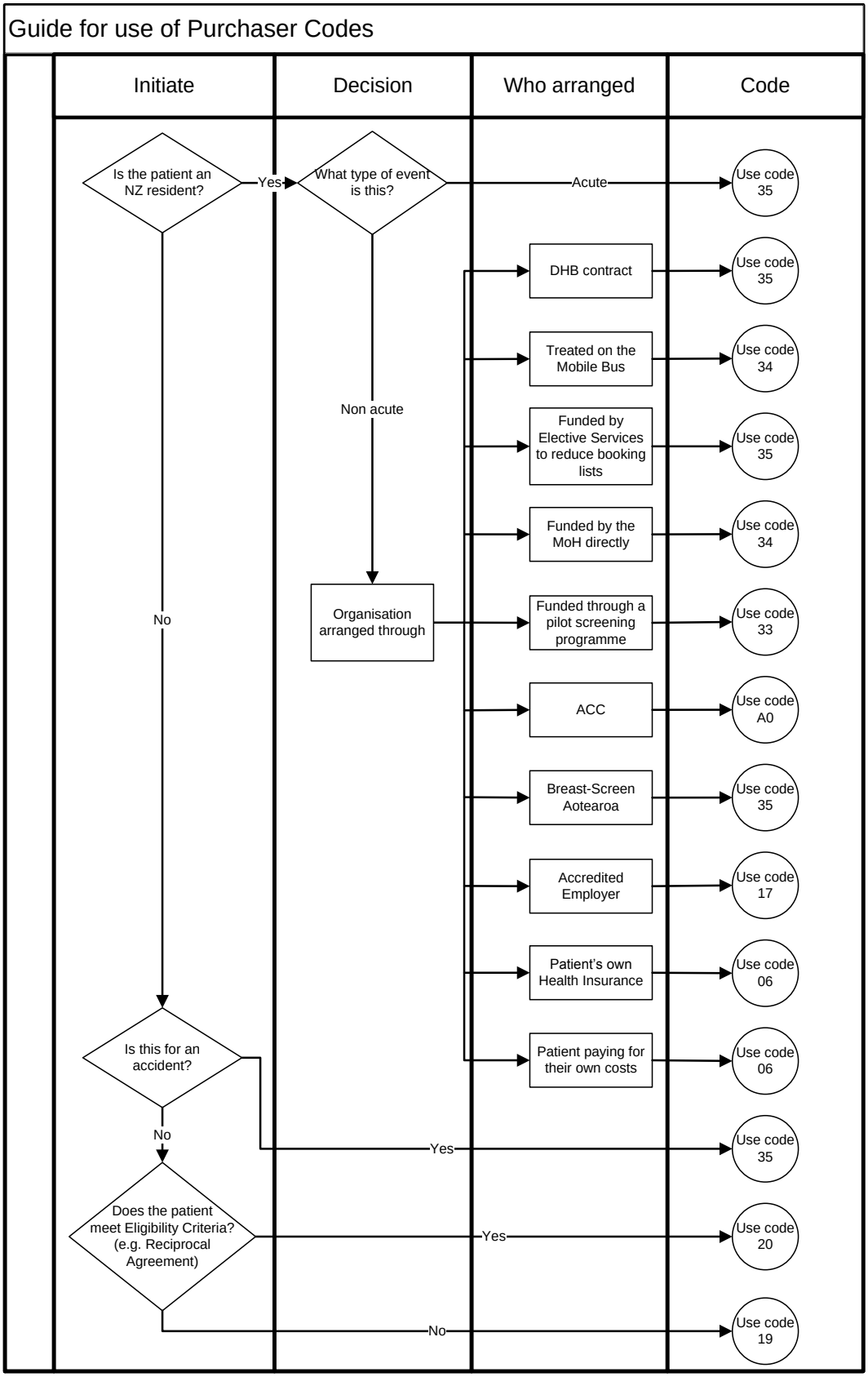
Code table	Location
Admission Source code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/admission-source-code-table
Admission Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/admission-type-code-table
Agency code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/agency-code-table
Agency Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/agency-type-code-table
Birth/Death Location code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/birth-death-location-code-table
Clinical code table	See *Clinical code* on page 16
Clinical Code Table Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/clinical-code-type
Clinical Coding System code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/clinical-coding-system-code-table
Country of Birth code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/country-birth-code-table
Domicile code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/domicile-code-table
DRG code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/drg-code-table
DRG Grouper Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/drg-grouper-code-table
Ethnicity code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/ethnicity-code-tables
Event Clinical Code Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/event-clinical-code-type-code-table
Event Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/event-type-code-table

Facility code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/facility-code-table
Facility Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/facility-type-code-table
Health Specialty code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/health-specialty-code-table
Legal Status code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/legal-status-code-table
MDC code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/mdc-code-table
MDC Type code table	See *MDC type* on page 144
Occupation code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/occupation-code-table
Principal Health Service Purchaser code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/principal-health-service-purchaser-code-table
Psychiatric Leave End code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/psychiatric-leave-end-code-table

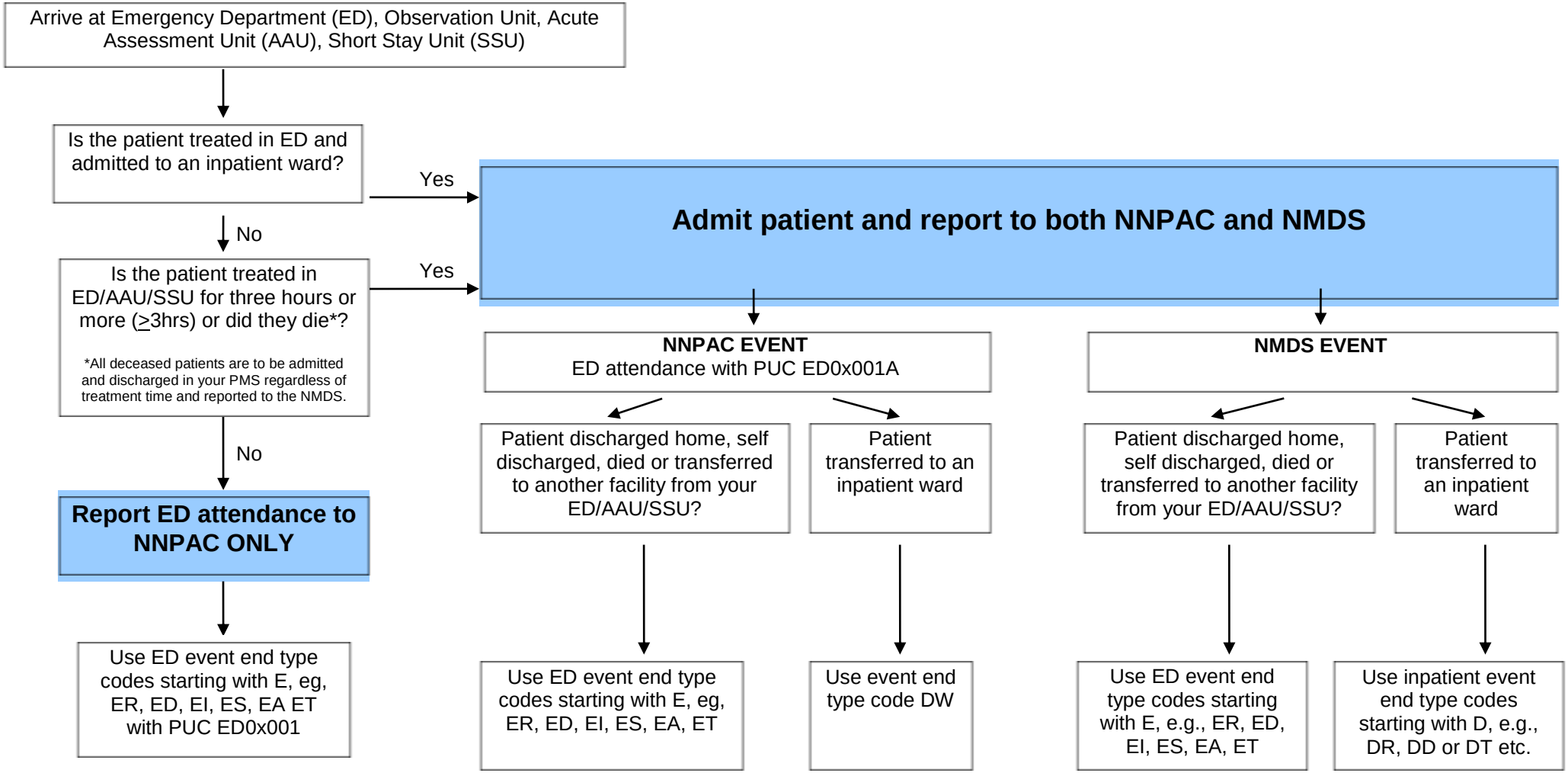
Code tables on web site

For code tables on the Ministry of Health web site go to http://www.health.govt.nz/nz-health-statistics/data-references/code-tables
For further information contact Analytical Services. Contact details are given at the front of this dictionary.

Appendix I: Guide for Use of NMDS Purchaser Code



Appendix J: Guide for Use of Emergency Department (ED) Event End Type Codes



PUC = Purchaser Unit Code
NNPAC = National Non Admitted Patient Collection
NMDS = National Minimum Dataset

***Please note:** when calculating the three hours, exclude waiting time in the waiting room, exclude triage and use only the duration of assessment/treatment. If part of the assessment/treatment includes observation, then this time contributes to the three hours. 'Assessment/treatment' is clinical assessment, treatment, therapy, advice, diagnostic or investigatory procedures from a nurse or doctor or other health professional.

Emergency Department (ED) Attendance ***NNPAC reporting***	**Emergency Department Short Stay (ED) Acute Assessment Unit (AAU) Short Stay Unit (SSU)** ***NMDS reporting***	**Hospital Inpatient Ward** ***NMDS reporting***
Patient arrives in ED via ambulance at 09.10am. Patient is stabilised and transferred (discharged) to another healthcare facility from ED at 10.27am ED attendance reported to NNPAC Purchase unit (ED0x001) Event end type = ET		
Patient presents to ED reception 01/03/2011 at 15.53pm. Triaged at 16.12pm returned to waiting room Patient taken through to ED 16.53pm. Assessment/treatment began at 16.48pm. Patient treated and discharged home 18.23pm ED attendance reported to NNPAC Purchase unit (ED0x001) Event end type = ER		
Patient presents to ED reception 01/03/2011 at 10.32am. Triaged at 10.56am returned to waiting room Patient was not willing to wait, therefore left at 12.32pm without being seen and did not want to sign indemnity ED attendance reported to NNPAC Purchase unit (ED0x001) Attendance code = DNW Event end type = ES		
Patient presents to ED reception 01/03/2011 at 22.53pm Triaged at 22.55pm and taken through to ED Assessment/treatment began at 23.02pm Patient stabilised, reviewed and requires diagnostic tests After review of results decision is to admit patient to inpatient ward Patient transferred to inpatient ward 02/03/2011 at 01.14am ED attendance reported to NNPAC for counting purposes only Purchase unit (ED0x001A) Event end type = DW		Patient transferred to inpatient ward from ED Patient discharged home 06/03/2011 at 13.32pm Report hospital inpatient event to the NMDS Event start datetime will be 01/03/2011 23.02pm Event end datetime will be 06/03/2011 13.32pm Event end type DR

Emergency Department (ED) Attendance ***NNPAC reporting***	**Emergency Department Short Stay (ED) Acute Assessment Unit (AAU) Short Stay Unit (SSU)** ***NMDS reporting***	**Hospital Inpatient Ward** ***NMDS reporting***
Patient presents to ED reception 01/03/2011 at 13.53pm Triaged at 14.02pm returned to waiting room Patient taken through to ED Assessment/treatment began at 14.48pm Patient reviewed, requires tests and observation/treatment Patient still present in ED at 18.10pm awaiting results and review	Patient meets 3 hour admission rule – admit patient as an ED short stay event Event start datetime will be 01/03/2011 14.48pm	
ED attendance reported to NNPAC for counting purposes only Purchase unit (ED0x001A) Event end type = ER	ED clinician reviewed results and cleared patient for discharge at 18.37pm. Discharged home from ED 18.53pm Event end datetime will be 01/03/2011 18.53pm, event end type will be ER Report ED short stay event to the NMDS	
Patient presents to ED reception at 01/03/2011 at 13.53pm Triaged at 14.02pm returned to waiting room Patient taken through to ED Assessment/treatment began at 14.48pm Patient reviewed, requires tests and observation/treatment Patient still present in ED at 18.10pm awaiting results and review	Patient meets 3 hour admission rule – admit patient as an ED short stay event Event start datetime will be 01/03/2011 14.48pm	
ED attendance reported to NNPAC for counting purposes only Purchase unit (ED0x001A) Event end type = DW	ED clinician reviewed results at 18.28pm and patient not improving, decision made to admit patient to hospital inpatient ward Patient transferred to inpatient ward - internal transfer only (no discharge)	Patient transferred to inpatient ward from ED Patient discharged home from inpatient ward 04/03/2011 at 11.10am Report hospital inpatient event to the NMDS Event start datetime will be 01/03/2011 14.48pm Event end datetime will be 04/03/2011 11.10am Event end type DR

***Note:** the event start date/time of admission will be from the commencement of assessment/treatment in ED (NNPAC = datetime of first contact).

EMERGENCY DEPARTMENT SCENARIOS	NNPAC REPORTING	NNPAC EVENT END TYPE [ED attendance]	NMDS REPORTING	NMDS EVENT END TYPE [ED/AAU/SSU short stay event]
Patient in ED receives treatment <3hrs discharged home	Yes	ER	No	N/A - ED attendance only
Patient in ED/AAU/SSU receives treatment ≥3hrs discharged home	Yes - only for counting purposes – PUC ED0x001A	ER	Yes – short stay event	ER
Patient in ED receives treatment <3hrs self discharges without indemnity signed	Yes	ES	No	N/A - ED attendance only
Patient in ED/AAU/SSU receives treatment ≥3hrs self discharges without indemnity signed	Yes - only for counting purposes – PUC ED0x001A	ES	Yes – short stay event	ES
Patient in ED receives treatment <3hrs self discharges with indemnity signed	Yes	EI	No	N/A - ED attendance only
Patient in ED/AAU/SSU receives treatment ≥3hrs self discharges with indemnity signed	Yes - only for counting purposes – PUC ED0x001A	EI	Yes – short stay event	EI
Patient in ED receives treatment <3hrs and dies	Yes - only for counting purposes – PUC ED0x001A	ED	Yes	ED
Patient in ED/AAU/SSU receives treatment ≥3hrs and dies	Yes - only for counting purposes – PUC ED0x001A	ED	Yes	ED
Patient in ED receives treatment <3hrs transferred (discharged) to another facility	Yes	ET	No	N/A - ED attendance only
Patient in ED/AAU/SSU receives treatment ≥3hrs transferred (discharged) to another facility	Yes - only for counting purposes – PUC ED0x001A	ET	Yes – short stay event	ET
Neonatal or burns patient in ED/AAU/SSU receives treatment <3hrs transferred (discharged) to another facility	Yes	EA	No	N/A - ED attendance only
Neonatal or burns patient ED/AAU/SSU receives treatment ≥3hrs transferred (discharged) to another facility	Yes - only for counting purposes – PUC ED0x001A	EA	Yes – short stay event	EA
Patient in ED receives treatment <3hrs admitted to inpatient ward or straight to operating theatre	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient in ED/AAU/SSU receives treatment ≥3hrs admitted to inpatient ward or straight to operating theatre	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient

EMERGENCY DEPARTMENT SCENARIOS	NNPAC REPORTING	NNPAC EVENT END TYPE [ED attendance]	NMDS REPORTING	NMDS EVENT END TYPE [ED/AAU/SSU short stay event]
Patient in ED receives treatment <3hrs admitted to geriatric AT&R inpatient ward	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient in ED/AAU/SSU receives treatment ≥3hrs admitted to geriatric AT&R inpatient ward with 'D' health specialty code (*see Note 1 below)	Yes -only for counting purposes – PUC ED0x001A	DW	Yes – short stay event [see Note 1]	DW
Patient in ED/AAU/SSU receives treatment ≥3hrs admitted to geriatric AT&R inpatient ward with a medical/surgical health specialty code	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient transfers from smaller hospital to ED at your bigger hospital, receives treatment <3hrs and is then admitted to inpatient ward or straight to operating theatre	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient transfers from smaller hospital to ED/AAU/SSU at your bigger hospital, receives treatment ≥3hrs and is then admitted to inpatient ward or straight to operating theatre	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient transfers from smaller hospital to ED at your bigger hospital, receives treatment <3hrs and is then transferred (discharged) back to smaller hospital	Yes	ET	No	N/A - ED attendance only
Patient transfers from smaller hospital to ED/AAU/SSU at your bigger hospital, receives treatment ≥3hrs and is then transferred (discharged) back to smaller hospital	Yes - only for counting purposes – PUC ED0x001A	ET	Yes – short stay event	ET
Mental health patient in ED receives treatment for an acute condition (e.g., self harm) <3hrs transferred (discharged) to inpatient psychiatric unit (within same facility)	Yes	DW	No	N/A - ED attendance only
Mental health patient in ED/AAU/SSU receives treatment for an acute condition (e.g., self harm) ≥3hrs transferred (discharged) to inpatient psychiatric unit (within same facility)	Yes - only for counting purposes – PUC ED0x001A	DW	Yes – short stay event	DW
Mental health patient in ED receives treatment for an acute condition (e.g., self harm) <3hrs transferred (discharged) to inpatient psychiatric unit (another facility)	Yes	ET	No	N/A -ED attendance only
Mental health patient in ED/AAU/SSU receives treatment for an acute condition (e.g., self harm) ≥3hrs transferred (discharged) to inpatient psychiatric unit (another facility)	Yes - only for counting purposes – PUC ED0x001A	ET	Yes – short stay event	ET
Mental health inpatient sustains an in hospital injury/accident/self harm etc. transferred to ED receives treatment <3hrs then transferred back to inpatient psychiatric unit	Yes	DW	No	N/A - ED attendance only

EMERGENCY DEPARTMENT SCENARIOS	NNPAC REPORTING	NNPAC EVENT END TYPE [ED attendance]	NMDS REPORTING	NMDS EVENT END TYPE [ED/AAU/SSU short stay event]
Mental health inpatient sustains an in hospital injury/accident/self harm etc. transferred to ED/AAU/SSU receives treatment ≥3hrs then transferred back to inpatient psychiatric unit	Yes - only for counting purposes – PUC ED0x001A	DW	Yes – short stay event	DW [Note 2]
Home hospital inpatient transferred to ED receives treatment <3hrs and is then transferred (discharged) back to home hospital services	Yes	ET	No	N/A - ED attendance only
Home hospital inpatient transferred to ED/AAU/SSU receives treatment ≥3hrs and is then transferred (discharged) back to home hospital services	Yes - only for counting purposes – PUC ED0x001A	ET	Yes – short stay event	ET

Short stay events where the patient is discharged from ED/AAU/SSU must have an 'E' event end type code reported to NNPAC and NMDS. The 'E' event end type code should be the same in both NNPAC and NMDS.

Where patients are admitted to an inpatient ward from ED/AAU/SSU the NNPAC event end type code will always be DW *Discharged to other service within same facility*.

Note 1:

'Patient in ED/AAU/SSU receives treatment ≥3hrs admitted to Geriatric AT&R inpatient ward with 'D' health specialty code'. Older persons who present to ED with an acute condition who are admitted as an acute inpatient to a geriatric AT&R (older persons) inpatient ward with a 'D' health specialty code is not common practice. However where this does occur the reporting requirements are that a separate ED short stay event is to be reported with an event end type of DW *Discharged to other service within same facility*.

Note 2:

For existing inpatients who are transferred from mental health or geriatric AT&R services to ED/AAU/SSU and meet the three (≥3) hour criteria who are then transfer back to these services, must have an ED/AAU/SSU short stay event reported to the NMDS with the health specialty code of **M05 Emergency Medicine**.

Event End Type Codes - Mapping to Separation Mode

Event End Type	Event End Type Description	Separation Mode Code
EA	Discharge from Emergency department acute facility to specialist facility for neonates and burns only	1 or 01
ED	Died while still in Emergency department acute facility	8 or 08
EI	Self-discharge from treatment in an Emergency department acute facility with indemnity signed	6 or 06
ER	Routine discharge from an Emergency department acute facility	9 or 09
ES	Self-discharge from treatment in an Emergency department acute facility without indemnity	6 or 06
ET	Discharge from Emergency department acute facility to another healthcare facility	4 or 04

3M™ Codefinder™ Separation Mode Codes and Descriptions

Separation Mode Code	3M Codefinder Separation Mode Description
1 or 01	Discharge/Transfer to an Acute Hospital
2 or 02	Discharge/Transfer to a Residential Ageing Service
3 or 03	Discharge/Transfer to a Psychiatric Hospital
4 or 04	Discharge/Transfer to Other Health Care Accommodation
5 or 05	Statistical Discharge – Type Change
6 or 06	Left Against Medical Advice
7 or 07	Statistical Discharge from Leave
8 or 08	Died
9 or 09	Home/Other