



# IDI Data Dictionary: Publicly funded hospital discharges – event and diagnosis/procedure information

November 2015 edition



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# 1 Purpose of this data dictionary

*IDI Data Dictionary: Publicly funded hospital discharges – event and diagnosis/ procedure information (November 2015 edition)* documents the content of these datasets the Ministry of Health (MOH) provides to Statistics New Zealand to use in the Integrated Data Infrastructure (IDI).

This dictionary gives information on the variables contained in the datasets from 1988 to 2013 – including technical information and descriptions.

Use this data dictionary if you are interested in understanding and accessing publicly funded hospital discharges – event and diagnosis/ procedure information in the IDI for your research.

## Background

The MOH seeks to improve, promote and protect the health of New Zealanders through: its sector leadership of New Zealand's health and disability system; advising the Minister of Health, and government as a whole, on health issues; directly purchasing a range of important national health and disability support services; providing health sector information and payment services for the benefit of all New Zealanders.

The objectives of the MOH's data and metadata are to: measure and 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.

## List of datasets

[Publicly funded hospital discharges – event information](#)

[Publicly funded hospital discharges – diagnosis/procedure information](#)

## 2 About the publicly funded hospital discharges – event information

### Coverage

**Reference period start:** 1988

**Reference period end:** 2013

**Geographic coverage:** New Zealand

**Target population:** Healthcare users

**Observed population:** People who were discharged from a publicly funded hospitalisation.

### Methodology

**Type of data:** Administrative data capture

**Data collector:** National Collections and Reporting, MOH

**Mode of data collection:** Data is provided by public hospitals and by those private hospitals who provide publicly funded services in an agreed electronic file format. Paper forms and a cut-down electronic file format are also forwarded by other private hospitals. The Ministry has a team of staff who manually process private hospital electronic and paper reports.

**Frequency of data collection:** Publicly funded hospital events are required to be loaded into the National Minimum Dataset (NMDS) within 21 days after the month of discharge.

### Quality information

**Other quality issues:** 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. [See the NMDS data dictionary on the MOH website](#) for further details.

Extra factors that will affect discharge numbers are identified in the table below:

Till 1987	No requirement to report daypatients
1992–	All daypatients are being reported
1991–1993	Healthy newborns (well babies) begin to be admitted as separate events
Dec 1993–	All healthy newborns (well babies) are admitted as separate events

**Short stay Emergency Department events (SSED)** - these events are considered as 'admitted inpatients' by the District Health Board (DHB) as opposed to 'non-admitted outpatients'. It was optional to report SSED events from 1998 onwards and mandatory to report these events from July 2009 (although reporting on SSED was not complete until July 2013). These events have been reported inconsistently from DHBs across time and we recommend that SSED events are excluded from any regional or longitudinal analyses. This issue impacts conditions that may only involve ED attendance and do not

require further hospitalisation eg injuries and alcohol-related conditions. Therefore, data for such conditions will be incomplete. SSED events are defined as those with a health speciality code in M05, M06, M07, M08 and a length of stay (LOS) less than 2 days. SSED events can be identified by using the SSED flag in this extract.

## Privacy, security, or confidentiality issues

The publicly funded hospital discharges – event information table that is accessible to researchers does not contain any name or address information to identify an individual. All researchers who have access to the publicly funded hospital discharges – event information data have had their research proposals assessed using Statistics NZ's microdata access protocols and only approved researchers who have been granted access by Statistics NZ and the Ministry of Health may view the publicly funded hospital discharges – event information data.

[Read Statistics NZ's microdata access protocols.](#)

All outputs produced from publicly funded hospital discharges – event data must be aggregated and counts suppressed if the underlying unrounded count is fewer than six.

### 3 Data dictionary for publicly funded hospital discharges – event information

#### Dataset description

**Contents of dataset:** This dataset contains a subset of fields from NMDS. Specifically it contains information about publicly funded hospital events reported for the population cohort. Information provided includes demographic data, where and when the hospitalisation occurred, as well as what diagnoses were made and procedures conducted during the event.

**Type of file:** txt

#### Summary table

IDI variable name	Primary key	Mandatory	Format	Classification name	Variable name
snz_uid			Int		
snz_moh_uid			Int		
moh_evt_event_id_nbr			int		Event ID
moh_evt_adm_src_code			Char, 1	admission_source_code	Admission source
moh_evt_adm_type_code			char, 2	admission_type_code	Admission type
moh_evt_nz_res_code			Char, 1	nz_resident_status_code	NZ resident status
moh_evt_birth_month_nbr			Tinyint		Date of birth
moh_evt_birth_year_nbr			Smallint		Date of birth
moh_evt_dob_flag_code			Char, 1	date_of_birth_flag_code	Date of birth flag
moh_evt_sex_code			Char, 1	gender_code	Sex
moh_evt_eth_priority_grp_code			char, 2	ethnic_code	Prioritised ethnicity
moh_evt_ethnicity_1_code			char, 2	ethnic_code	Ethnicity 1
moh_evt_ethnicity_2_code			char, 2	ethnic_code	Ethnicity 2
moh_evt_ethnicity_3_code			char, 2	ethnic_code	Ethnicity 3
moh_evt_dom_cd_code			Varchar, 4	domicile_code	Domicile code
moh_evt_dhb_dom_code			char, 3	dhb_code	DHB region domicile
moh_evt_event_type_code			char, 2	event_type_code	Event type
moh_evt_end_type_code			char, 2	event_end_type_code	Event end type
moh_evt_evst_date_text			char, 10		Event start date
moh_evt_even_date_text			char, 10		Event end date

IDI variable name	Primary key	Mandatory	Format	Classification name	Variable name
moh_evt_local_id_nbr			tinyint		Event local identifier
moh_evt_evnt_lvd_text			char, 3		Event leave days
moh_evt_los_nbr			int		Length of stay
moh_evt_agency_code			char, 4	Agency_code	Agency code
moh_evt_agency_type_code			char, 2	agency_type_code	Agency type
moh_evt_facility_code			char, 4	facility_code	Facility code
moh_evt_facility_type_code			char, 1	facility_type_code	Facility type
moh_evt_hlth_spec_code			char, 3	health_speciality_code	Speciality code
moh_evt_purchaser_code			char, 2	purchaser_code	Purchaser code
moh_evt_hours_on_cpap_nbr			int		CPAP hours
moh_evt_tot_icu_hours_nbr			int		Total ICU hours
moh_evt_hmvc_nbr			int		HMV hours
moh_evt_drg_31_code			char, 3		AN-DRG v3.1
moh_evt_ccl_code			char, 1	ccl_code	CCL
moh_evt_acc_flag_code			Char, 1	accident_flag_code	Accident flag
moh_evt_acmp_num_code			Varchar, 12		ACC claim number
moh_evt_drg_current_text			Varchar, 4		AR-DRG current
moh_evt_pccl_code			char, 1	pccl_code	PCCL
moh_evt_drg_grp_type_code			char, 2	drg_grouper_type_code	DRG grouper type
moh_evt_pur_unit_text			Varchar, 10		Purchase unit
moh_evt_mdc_code			char, 2	mdc_code	MDC code
moh_evt_mdc_type_code			char, 1	mdc_type_code	MDC grouper type
moh_evt_cost_weight_amt			decimal, 7.4		Costweight
moh_evt_cost_wgt_code			char, 2	Costweight_code	Costweight code
moh_evt_shrtsty_ed_flg_ind			Char, 1		Short Stay ED flag



## Detailed information

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**IDI variable name:** snz\_uid

**Definition:** a global unique identifier created by Statistics NZ. There is a snz\_uid for each distinct identity in the IDI. This identifier is changed and reassigned each refresh.

**Format:** Integer

**Name of classification:**

**Notes:**

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**IDI variable name:** snz\_moh\_uid

**Definition:** a local unique identifier derived by Statistics NZ from the source agency's unique identifier(s). This identifier will remain the same for an identity across refreshes. Where we receive more information during a subsequent refresh that indicates that two or more identities represent the same identity, the identifier may change.

The snz\_moh\_uid represents a distinct identity in all of MoH tables in IDI.

**Format:** Integer

**Name of classification:**

**Notes:**

---

**IDI variable name:** moh\_evt\_event\_id\_nbr

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

**Format:** int

**Name of classification:**

**Notes:** Serves as the primary key for all data tables. Therefore Event ID can be used to link between this dataset and the next one (Publicly funded hospital discharges – diagnosis/procedure information). Event ID is assigned by NMDS on load, so if an event is deleted and then reloaded, a new Event ID will be assigned.

---

**IDI variable name:** moh\_evt\_adm\_src\_code

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

**Format:** Char, 1

**Name of classification:** admission\_source\_code  
[See the MOH website](#) for the Admission Source code table

**Notes:** Healthcare users admitted from rest homes where the rest home is their usual place of residence are routine admissions, not transfers.

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

---

**IDI variable name:** moh\_evt\_adm\_type\_code

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

**Format:** char, 2

**Name of classification:** admission\_type\_code

[See the MOH website](#) for the Admission Type code table.

**Notes:** [See the data dictionary on the MOH website](#) for more detailed information about specific codes.

---

**IDI variable name:** moh\_evt\_nz\_res\_code

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

**Format:** Char, 1

**Name of classification:** nz\_resident\_status\_code

**Notes:** 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.

---

**IDI variable name:** moh\_evt\_birth\_month\_nbr

**Definition:** The month on which the person was born.

**Format:** Tinyint

**Name of classification:**

**Notes:** 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.

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

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**IDI variable name:** moh\_evt\_birth\_year\_nbr

**Definition:** The year on which the person was born.

**Format:** Smallint

**Name of classification:**

**Notes:** 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.

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

---

**IDI variable name:** moh\_evt\_dob\_flag\_code

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

**Format:** Char, 1

**Name of classification:** date\_of\_birth\_flag\_code

**Notes:** This is a derived data element. A partial date flag is 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'.

---

**IDI variable name:** moh\_evt\_sex\_code

**Definition:** The person's biological sex.

**Format:** Char, 1

**Name of classification:** gender\_code

**Notes:** 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). Because it is possible for a person's sex to change over time, NMDS collects sex information for each health event).

'U' (unknown) codes must be updated as soon as possible after admission.

'I' (indeterminate) codes are used in cases, usually new-borns, where it is not possible to determine the sex of the healthcare user – for example where sexual organs are not sufficiently developed to differentiate between male and female

Sex reported for transsexuals and transgender people should be based on their biological sex, therefore, healthcare users undergoing sexual reassignment surgery should have their sex at time of hospital admission reported.

---

**IDI variable name:** moh\_evt\_eth\_priority\_grp\_code

**Definition:** Ethnicity is the ethnic group or groups people identify with or feel they belong to. Thus, ethnicity is self-perceived and people can belong to more than one ethnic group. Where more than one ethnic group is reported in the ethnic code fields, the Statistics NZ prioritisation algorithm is used to report only a single ethnicity.

**Format:** char, 2

**Name of classification:** ethnic\_code

[See the MOH website](#) for the Ethnicity code tables.

**Notes:** [See the MOH website](#) for information about this algorithm and other aspects of the collection of ethnicity data.

---

**IDI variable name:** moh\_evt\_ethnicity\_1\_code, moh\_evt\_ethnicity\_2\_code, moh\_evt\_ethnicity\_3\_code

**Definition:** Ethnicity is the ethnic group or groups people identify with or feel they belong to. Thus, ethnicity is self-perceived and people can belong to more than one ethnic group.

**Format:** char, 2

**Name of classification:** ethnic\_code

[See the MOH website](#) for the Ethnicity code tables.

**Notes:** Up to 3 ethnic codes can be reported by the DHB in the NMDS extract. [See the MOH website](#) for information about this algorithm and other aspects of the collection of ethnicity data.

---

**IDI variable name:** moh\_evt\_dhb\_dom\_code

**Definition:** representing 4 digit code representing the healthcare user's usual residential address. Also used for facility addresses.

**Format:** Varchar, 4

**Name of classification:** domicile\_code

[See the MOH website](#) for the Domicile code table.

**Notes:** Usual residential address is defined as the address at which the person has been, or plans to be, living for 3 months or more (Statistics NZ definition of 'usually resident'). If a person usually lives in a rest home or a hospital, that is considered their usual residential address.

The domicile code is a compulsory field in the NMDS extract supplied by the DHBs. In reality DHBs usually get this information from the NHI, therefore the caveats associated with the quality of the domicile code in the NHI should also be considered here. For instance, it should be noted that before the NHI moved to its new platform in 2012, the address fields in the NHI were free-text with little validation. This meant there could be considerable variability in accuracy, which, in turn, meant addresses could not always be geocoded to a domicile code, or could result in rural addresses being assigned to an urban domicile code where there was insufficient data to generate the correct code. This is because the automated geocoding software relies on generating a post code in order to determine where in a related table it should look to find the code. However, a number of validation checks were included when the NHI moved to its new platform and the quality of address information should improve markedly.

[See the data dictionary on the MOH website](#) for more information about the domicile code field in NMDS.

**IDI variable name:** moh\_evt\_dhb\_dom\_code

**Definition:** The code of the district health board responsible for the domicile.

**Format:** char, 3

**Name of classification:** dhb\_code

[See the MOH website](#) for the District Health Board code table.

**Notes:**

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**IDI variable name:** moh\_evt\_event\_type\_code

**Definition:** Code identifying the type of health event.

**Format:** char, 2

**Name of classification:** event\_type\_code

[See the MOH website](#) for the Event Type code table.

**Notes:** [See the data dictionary on the MOH website](#) for information about specific event type codes.

---

**IDI variable name:** moh\_evt\_end\_type\_code

**Definition:** A code identifying how a healthcare event ended.

**Format:** char, 2

**Name of classification:** event\_end\_type\_code

[See the MOH website](#) for the Event Type code table.

**Notes:** [See the data dictionary on the MOH website](#) for information about when specific event end type codes were retired or added.

---

**IDI variable name:** moh\_evt\_evst\_date\_text

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

**Format:** char, 10

**Name of classification:**

**Notes:** [See the data dictionary on the MOH website](#) for more information about event start date.

---

**IDI variable name:** moh\_evt\_even\_date\_text

**Definition:** The date on which a healthcare user was discharged from a facility (i.e., the date the healthcare event ended)

**Format:** char, 10

**Name of classification:** event\_end\_date

**Notes:** The event end date is also known as the discharge date.  
[See the data dictionary on the MOH website](#) for more information about event end date.

---

**IDI variable name:** moh\_evt\_local\_id\_nbr

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

**Format:** tinyint

**Name of classification:**

**Notes:** Data domain 1 – 9. Use 9 first then '8, 7, ..., 1'

---

**IDI variable name:** moh\_evt\_evnt\_lvd\_text

**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.

**Format:** char, 3

**Name of classification:**

**Notes:** Where there is more than one period of leave during an episode, accumulated leave days should be reported.

This is not how leave is calculated for sectioned mental health healthcare users, 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 healthcare user 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.

---

**IDI variable name:** moh\_evt\_los\_nbr

**Definition:** Length of stay (LOS) in a facility in days.

**Format:** int

**Name of classification:**

**Notes:** This is a derived field. It is the event end date minus date portion of event start date minus event leave days. A value of 1 equates to midnights spent in hospital.

---

**IDI variable name:** moh\_evt\_agency\_code

**Definition:** A code that uniquely identifies the agency contracted directly to the Ministry of Health to provide the service.

**Format:** char, 4

**Name of classification:** Agency\_code  
[See the MOH website](#) for the Agency code table.

**Notes:** 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.

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

The code table is continually updated by the Ministry of Health as agencies open and close. The version on the MOH website is the most recent version.

---

**IDI variable name:** moh\_evt\_agency\_type\_code

**Definition:** A code that categorises agencies into particular types.

**Format:** char, 2

**Name of classification:** agency\_type\_code  
[See the MOH website](#) for the Agency Type code table.

**Notes:**

---

**IDI variable name:** moh\_evt\_facility\_code

**Definition:** A code that uniquely identifies a healthcare facility.

**Format:** char, 4

**Name of classification:** facility\_code  
[See the MOH website](#) for the Facility Type code table.

**Notes:** 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 healthcare user's usual place of residence.

The Ministry of Health allocates codes on request. The code table is continually updated by the MOH as facilities open and close.

---

**IDI variable name:** moh\_evt\_facility\_type\_code

**Definition:** A code that categorises facilities into particular types.

**Format:** char, 1

**Name of classification:** facility\_type  
[See the MOH website](#) for the Facility Type code table.

**Notes:**

---

**IDI variable name:** moh\_evt\_hlth\_spec\_code

**Definition:** A classification describing the health specialty or service to which a healthcare user was assigned at the time of discharge. It reflects the nature of the services being provided.

**Format:** char, 3

**Name of classification:** health\_speciality\_code  
[See the MOH website](#) for the Health Specialty code table.

**Notes:** [See the data dictionary on the MOH website](#) for more information about when specific health speciality codes were retired or added.

---

**IDI variable name:** moh\_evt\_purchaser\_code

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

**Format:** char, 2

**Name of classification:** purchaser\_code

**Notes:** Introduced on 1 July 1995. [See the data dictionary on the MOH website](#) for more information about when specific purchaser codes were retired or added.

[See the Guide to Eligibility for Publicly-Funded Personal Health and Disability Services](#) in New Zealand on the MOH website for more information about who is eligible for publicly funded health services.

---

**IDI variable name:** moh\_evt\_hours\_on\_cpap\_nbr

**Definition:** The total number of hours a neonate (less than 29 days, or more than 29 days and less than 2500g) is on CPAP (continuous positive airway pressure) during a perinatal episode of care.

**Format:** int

**Name of classification:**

**Notes:**

The definition of 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').

[See the data dictionary on the MOH website](#) for more information about CPAP hours.

---

**IDI variable name:** moh\_evt\_tot\_icu\_hours\_nbr

**Definition:** Total duration of stay (hours) in an Intensive Care Unit (ICU) during this hospital event.

**Format:** int



**Name of classification:**

**Notes:** An intensive care unit (ICU) is a specially staffed and equipped, separate and self-contained section of a hospital for the management of healthcare users 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.

[See the data dictionary on the MOH website](#) for more information about ICU hours.

---

**IDI variable name:** moh\_evt\_hmvc\_nbr

**Definition:** The total number of hours on mechanical ventilation.

**Format:** int

**Name of classification:**

**Notes:**

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 healthcare user is ventilated. If the healthcare user 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 healthcare user is in radiology or emergency care should be included in the total mechanical ventilation hours for reporting purposes.

[See the data dictionary on the MOH website](#) for more information about HMTV hours.

---

**IDI variable name:** moh\_evt\_drg\_31\_code

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

**Format:** char, 3

**Name of classification:**

**Notes:** 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.

---

**IDI variable name:** moh\_evt\_ccl\_code

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

**Format:** char, 1

**Name of classification:** ccl\_code

**Notes:** Relates only to DRG grouper versions 3.0 and 3.1.  
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 and 6.0x.

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.

---

**IDI variable name:** moh\_evt\_acc\_flag\_code

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

**Format:** Char, 1

**Name of classification:** accident\_flag\_code

**Notes:** For this accident flag to be 'Y', the healthcare user should have been 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 healthcare user has an accident in hospital. In this case the injury date must be between the Event start date and Event end date.

Events where the accident flag is set to 'Y' may or may not have claims that are supported by Accident Compensation Corporation (ACC).

---

**IDI variable name:** moh\_evt\_acmp\_num\_code

**Definition:** This is a separate field to record the M46/45, ACC45 or AITC claim number for the event.

**Format:** Varchar, 12

**Name of classification:**

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

[See the data dictionary on the MOH website](#) for more information about this code.

---

**IDI variable name:** moh\_evt\_drg\_current\_text

**Definition:** A diagnosis-related group (DRG) code produced by the DRG grouper program version which was current in that financial year.

**Format:** Varchar, 4

**Name of classification:**

**Notes:** The DRG code is calculated by NMDS. It is not sent by the DHBs.

A diagnosis-related group (DRG) code from version 4.1, 4.2, 5.0, 6.0 or 6.0x 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.

This field was introduced on 1 July 2001 and the version used for each financial year is shown below based on event end date:

- between 1 July 2001 and 30 June 2002, version 4.1 was used
- between 1 July 2002 and 30 June 2004, version 4.2 was used.
- between 1 July 2004 and 30 June 2011, version 5.0 was used
- between 1 July 2011 and 30 June 2013, version 6.0 was used.
- on or after 1 July 2013, version 6.0x was used.

[See the data dictionary on the MOH website](#) for more information about AR-DRG current.

---

**IDI variable name:** moh\_evt\_pccl\_code

**Definition:** Patient clinical complexity level (PCCL) comes out of the DRG grouper programme and identifies the clinical severity within the hospital event.

**Format:** char, 1

**Name of classification:** pccl\_code

**Notes:** Relates only to DRG grouper versions 4.1, 4.2, 5.0, 6.0 and 6.0x. Serves the same purpose for DRG grouper versions 4.1, 4.2, 5.0, 6.0 and 6.0x as CCL does for DRG grouper versions 3.1 and 3.2.

PCCL is a measure of the cumulative effect of a healthcare user'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.

---

**IDI variable name:** moh\_evt\_drg\_grp\_type\_code

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

**Format:** char, 2

**Name of classification:** drg\_grouper\_type\_code

**Notes:** DRG grouper type code should be the same as the MDC type.  
'02' (AN-DRG version 3.1) was used until 30 June 2000  
'03' (AR-DRG version 4.1) was used between 1 July 2000 and 30 June 2002  
'04' (AR-DRG version 4.2) was used between 1 July 2002 and 30 June 2005  
'05' (AR-DRG version 5.0) was used between 1 July 2005 and 30 June 2012  
'06' (AR-DRG version 6.0) was used between 1 July 2012 and 30 June 2013  
'07'(AR-DRG version 6.0x) is in use from 1 July 2013

The grouper software produces a number of DRG versions. NMDS is currently using software version 6.0x to produce DRG codes for versions 3.1, 4.1, 4.2, 5.0, 6.0 and 6.0x. This field describes the version.

---

**IDI variable name:** moh\_evt\_pur\_unit\_text

**Definition:** Purchase unit indicates which contract the event was funded under.

**Format:** Varchar, 10

**Name of classification:**

**Notes:** It is derived directly from the Health specialty.

Some events have a purchase unit of 'EXCLU' (ie, not eligible). [See the New Zealand Casemix Framework for Publicly Funded Hospitals including WIES methodology](#) and Casemix Purchase Unit Allocation document for the criteria.

---

**IDI variable name:** moh\_evt\_mdc\_code

**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.

**Format:** char, 2

**Name of classification:** mdc\_code

**Notes:**

---

**IDI variable name:** moh\_evt\_mdc\_type\_code

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

**Format:** char, 1

**Name of classification:** mdc\_type

**Notes:** It is derived from the version of the grouper used to create the DRG code.

---

**IDI variable name:** moh\_evt\_cost\_weight\_amt

**Definition:** A calculated value designed to weight a base rate payment

**Format:** decimal, 7.4

**Name of classification:**

**Notes:** 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.

[See the Technical Documentation page](#) on the MOH website for details.

---

**IDI variable name:** moh\_evt\_cost\_wgt\_code

**Definition:** Indicates the schedule by which the costweight and purchase unit are calculated for that financial year.

**Format:** char, 2

**Name of classification:**

**Notes:**

---

**IDI variable name:** moh\_evt\_shrtsty\_ed\_flg\_ind

**Definition:** The short stay ED (SSED) flag denotes those events where a healthcare user was treated in the emergency department, for more than three hours.

**Format:** Char, 1

**Name of classification:**

**Notes:** SSED events are considered as ‘admitted inpatients’ by the DHB as opposed to ‘non-admitted outpatients’. It was optional to report SSED events from 1998 onwards and mandatory to report these events from July 2009 (although reporting on SSED was not complete until July 2013). These events have been reported inconsistently from DHBs across time and we recommend that SSED events are excluded from any regional or longitudinal analyses. This issue impacts conditions that may only involve ED attendance and do not require further hospitalisation e.g. injuries and alcohol related conditions. Therefore, data for such conditions will be incomplete. SSED events are defined as those with a health speciality code in M05, M06, M07, M08 AND a length of stay (LOS) less than 2 days.

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## 4 About the publicly funded hospital discharges – diagnosis/ procedure information

### Coverage

**Reference period start:** 1988

**Reference period end:** 2013

**Geographic coverage:** New Zealand

**Target population:** Healthcare users

**Observed population:** People who were discharged from a publicly funded hospitalisation.

### Methodology

**Type of data:** Administrative data capture

**Data collector:** National Collections and Reporting, MOH

**Mode of data collection:** Data is provided by public hospitals and by those private hospitals who provide publicly funded services in an agreed electronic file format. Paper forms and a cut-down electronic file format are also forwarded by other private hospitals. The Ministry has a team of staff who manually process private hospital electronic and paper reports.

**Frequency of data collection:** Publicly funded hospital events are required to be loaded into the NMDS within 21 days after the month of discharge.

### Quality information

**Other quality issues:** There are duplicates in this dataset for year 2004 records.

### Privacy, security, or confidentiality issues

The publicly funded hospital discharges – diagnosis/ procedure information table that is accessible to researchers does not contain any name or address information to identify an individual. All researchers who have access to the publicly funded hospital discharges – diagnosis/procedure data have had their research proposals assessed using Statistics NZ's microdata access protocols and only approved researchers who have been granted access by Statistics NZ and the Ministry of Health may view the publicly funded hospital discharges – diagnosis/procedure data.

[Read Statistics NZ's microdata access protocols.](#)

All outputs produced from publicly funded hospital discharges – diagnosis/procedure data must be aggregated and counts suppressed if the underlying unrounded count is fewer than six.

## 5 Data dictionary for the publicly funded hospital discharges – diagnosis/ procedure information

### Dataset description

**Contents of dataset:** This dataset contains a subset of fields from NMDS. Specifically it contains diagnosis/procedure information for publicly funded hospital events reported for the population cohort.

**Type of file:** txt

### Summary table

IDI variable name	Primary key	Mandatory	Format	Classification name	Variable name
moh_dia_event_id_nbr			int		Event ID
moh_dia_clinical_sys_code			char, 2	Clinical_coding_system_code	Clinical coding system
moh_dia_submitted_system_code			char, 2	Clinical_coding_system_code	Submitted system ID
moh_dia_diagnosis_type_code			char, 1	diagnosis_type_code	Diagnosis type
moh_dia_diag_sequence_code			varchar, 5		Diagnosis sequence
moh_dia_clinical_code			varchar, 8	Clinical_code	Clinical code
moh_dia_op_date_text			char, 10		Procedure/external cause date
moh_dia_op_flag_ind			char, 1		Procedure/external cause date flag

### Detailed information

---

**IDI variable name:** moh\_dia\_event\_id\_nbr

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

**Format:** int

**Name of classification:**

**Notes:** Serves as the primary key for all data tables. Therefore Event ID can be used to link between this dataset and the previous one (Publicly funded hospital discharges – event information). Event ID is assigned by NMDS on load, so if an event is deleted and then reloaded, a new Event ID will be assigned.

---

**IDI variable name:** moh\_dia\_clinical\_sys\_code

**Definition** A code identifying the clinical coding system the corresponding diagnosis and procedure code(s) (i.e. clinical code[s]) are presented in

**Format:** Char, 2

**Name of classification:** Clinical\_coding\_system\_code

[See the MOH website](#) for the Clinical Coding System code table.

**Notes:** Note the clinical coding system may be different to the version the clinical code was submitted in (submitted system). Clinical code(s) will be most accurate in their submitted version. Because mappings between systems are not always completely accurate, the more mappings that occur, the more inaccuracies there are likely to be. A waterfall mapping process is used with health data. This means in order for a code to be mapped to ICD-9-CMA-II it is mapped through all intervening systems. For example, a code submitted in ICD-10-AM version 1 will only need to be mapped once to ICD-9-CMA-II, whereas a code submitted in ICD-10-AM version 6 will need to be mapped 4 times to get the ICD-9-CMA-II code.

Diagnoses and procedures are reported in NMDS using the International Statistical Classification of Diseases and Related Health Problems, Australian modification). The version used in each financial year are identified below.

1988–Jun 95	ICD 9 <sup>th</sup> revision, 2 (ICD-9-CMA-II). Data was submitted in ICD-9-CM and mapped to ICD-9-CMA-II.
Jul 99–Jun 01	ICD-10-AM version 1
Jul 01–Jun 04	ICD-10-AM version 2
Jul 04–Jun 08	ICD-10-AM version 3
Jul 08–Jun 14	ICD-10-AM version 6
Jul14–	ICD-10-AM version 8

All clinical codes in this dataset are provided both in the version they were submitted, and also in ICD-9-CMA-II. Although the data is most accurate in submitted version, all codes have also been provided in ICD-9-CMA-II because any analyses across time require all clinical codes to be in the same version to allow a fair comparison.

---

**IDI variable name:** moh\_dia\_submitted\_system\_code

**Definition:** The clinical coding system the corresponding diagnosis or procedure code(s) (ie clinical code[s]) was/were submitted in.

**Format:** char, 2

**Name of classification:** Clinical\_coding\_system\_code

[See the MOH website](#) for the Clinical Coding System code table.

**Notes:** As clinical codes can be mapped between systems, the submitted system may be different from the clinical coding system the corresponding clinical code(s) are presented in. In the example below the diagnosis was submitted in ICD-10-AM-VI (clinical system = 13) and then the record was back mapped to ICD-9-CMA-II (clinical system = 6).



Event ID	Clinical system	Submitting system	Clinical code
990232512	6	13	65221
990232512	13	13	O321

Note that clinical code(s) will be most accurate in their submitted version. Because mappings between systems are not always completely accurate, the more mappings that occur, the more inaccuracies there are likely to be. A waterfall mapping process is used with health data. This means in order for a code to be mapped to ICD-9-CMA-II it is mapped through all intervening systems. For example, a code submitted in ICD-10-AM version 1 will only need to be mapped once to ICD-9-CMA-II, whereas a code submitted in ICD-10-AM version 6 will need to be mapped 4 times to get the ICD-9-CMA-II code.

---

**IDI variable name:** moh\_dia\_diagnosis\_type\_code

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

**Format:** Char, 1

**Name of classification:** diagnosis type code

**Notes:** Clinical codes are provided by the DHBs in their NMDS extracts.

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

The principal diagnosis 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.

An additional diagnosis 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.

---

**IDI variable name:** moh\_dia\_diag\_sequence\_code

**Definition:** A sequencing number for clinical codes derived from the diagnosis number as part of the mapping process.

**Format:** varchar, 5

**Name of classification:**

**Notes:** 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.

---

**IDI variable name:** moh\_dia\_clinical\_code

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

**Format:** varchar, 8

**Name of classification:** clinical code

**Notes:** Clinical codes are reported in NMDS using the International Statistical Classification of Diseases and Related Health Problems, Australian modification. The number of codes that could be submitted per event for any given year is identified below.

1988-Jun95	Up to 3 diagnoses, 3 procedure codes, and 1 external cause code could be reported
Jul95-Jun98	Up to 25 codes of any type (e.g. diagnosis, procedure, external cause of injury) could be reported
Jul98-	Up to 99 codes of any type (e.g. diagnosis, procedure, external cause of injury) can be reported

ICD-10-AM 2ND EDITION (1 JULY 2001 ONWARDS)

With the introduction of ICD-10-AM-II the coding of anaesthesia became mandatory. Consequently there was a large increase in the number of these procedures reported from July 2001 onwards.

[See the data dictionary on the MOH website](#) for more information about this code.

---

**IDI variable name:** moh\_dia\_op\_date\_text

**Definition** The date when the accident/injury or procedure occurred.

**Format:** char, 10

**Name of classification:**

**Notes:** 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.

Use the Diagnosis type code to determine whether the date in this field is a procedure date or an injury date. For example, if the diagnosis type code is 'E' (external cause of injury) then the date refers to an injury, whereas if the diagnosis type code is 'O' (operation/procedure) then the date refers to an operation/procedure.

**IDI variable name:** moh\_dia\_op\_flag\_ind

**Definition:** Indicates whether the external cause date of occurrence stored is a partial date.

**Format:** Char, 1

**Name of classification:**

**Notes:** A partial date flag, set automatically.

As the system allows partial dates to be entered, this identifies what field(s) is 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'.

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