

ICD-10-AM/ACHI/ACS Fourteenth Edition and AR-DRG V13.0 Development

Consultation paper



Acknowledgement of Country

We acknowledge the Traditional Owners and Custodians of Country throughout Australia, and recognise their continuing connection to land, sky, waters and culture. We pay our respects to them, and to Elders both past and present.

Artwork by Chern'ee Sutton

ICD-10-AM/ACHI/ACS Fourteenth Edition and AR-DRG V13.0 Development — October 2026

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Contents

Abbreviations	5
Consultation questions	6
1. Introduction	8
1.1 Admitted care classification systems	8
1.2 Governance framework for the Development of IHACPA Classifications	9
1.3 Scope and purpose of public consultation	9
2. ICD-10-AM/ACHI/ACS	11
2.1 Fourteenth Edition refinements	11
2.2 Future work programs	17
3. AR-DRGs	19
3.1 AR-DRG V13.0 refinements	19
3.2 Future work programs	24

Abbreviations

Abbreviations	Full term
ACE	Australian Classification Exchange
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADRG	Adjacent Diagnosis Related Group
AR-DRGs	Australian Refined Diagnosis Related Groups
DCID	Diagnosis cluster identifier
DRG	Diagnosis Related Group
ECCS	Episode Clinical Complexity Score
ICD-10	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICD-11	International Classification of Diseases, Eleventh Revision
ICHI	International Classification of Health Interventions
IHACPA	Independent Health and Aged Care Pricing Authority
MBS	Medicare Benefits Schedule
MDC	Major Diagnostic Category
NEP	National Efficient Price
WHO	World Health Organization

Consultation questions

Number	Question	Page
ICD-10-AM/ACHI/ACS		
1	Are there any clinical, classification or implementation issues that should be considered in relation to the proposed refinements for ACHI including for i. endovascular therapy? ii. interventions for burns?	15
2	Are there governance, transparency or implementation issues that should be considered when closing historic public submissions?	16
3	Do the ACHI development principles described in Development of IHACPA Classifications – Volume 2 ICD-10-AM/ACHI/ACS appropriately support consistent, transparent and sustainable classification development?	17
4	Are there areas of ACHI that you find particularly difficult, complex or cumbersome to apply or navigate? If so, what factors contribute to these issues and how could they be improved?	17
5	What clinical, operational, coding or data considerations should be taken into account in the future classification of non-invasive ventilation and high flow therapy? i. Does the current classification appropriately distinguish between non-invasive ventilation and high flow therapy? ii. Should ACHI continue to identify ventilatory support through duration-based coding, or should alternative approaches, including greater use of existing metadata collections, be considered?	18
AR-DRGs		
6	What aspects should be considered when reviewing the MDC 15 <i>Newborns and other neonates</i> classification structure, including: i. whether contemporary neonatal care is adequately represented in the current MDC 15 <i>Newborns and other neonates</i> classification structure? ii. whether specific neonatal conditions, therapies or clinical characteristics should be considered in identifying higher complexity neonatal episodes? iii. what clinical, operational or data considerations should be taken into account in the review?	20

Number	Question	Page
7	Are there additional endovascular procedures or other clinical factors relevant to the review of ADRG B08 <i>Endovascular clot retrieval</i> ?	21
8	Are there additional clinical or anatomical distinctions that should be considered to improve differentiation of dental procedures, oral surgery and salivary gland interventions in MDC 03 <i>Diseases and disorders of the ear, nose, mouth and throat</i> ?	22
9	Are there any clinical, data or implementation issues that should be considered in relation to the proposed refinements to MDC 22 <i>Burns</i> for AR-DRG V13.0?	23
10	Does your organisation currently use the AR-DRG short descriptors? i. If yes, please describe how they are used. ii. What impact, if any, would there be if AR-DRG short descriptors were no longer provided?	23
11	Are there clinical, operational, resource-use or activity-related factors that should be considered when reviewing endocrine, nutritional and metabolic intervention ADRGs: i. ADRG K01 <i>General Intervention for diabetic complications</i> ? ii. obesity-related ADRGs, particularly when assessing whether the current ADRG structure for obesity remains appropriate?	25
12	Should procedural complications continue to be grouped within MDC 21B <i>Injuries, poisoning and toxic effects of drugs</i> , or should greater emphasis be placed on the affected body system? If so, what clinical or classification considerations should be taken into account?	25
13	Should admitted same-day radiotherapy continue to be grouped within ADRG R62 <i>Other neoplastic disorders</i> , or are there clinical, operational or classification factors that support separate classification?	26
14	Are there cohorts currently assigned to MDC 23 <i>Factors influencing health status and other contacts with health services</i> that would be more appropriately classified according to body system, aetiology or another classification principle?	26
15	Are there additional areas where patient transfers should be considered in DRG grouping, including: i. where transfers are a prominent and integral part of patient care? ii. where clinical, operational or classification considerations indicate that transfer status may be relevant to AR-DRG assignment?	27

1. Introduction

1.1 Admitted care classification systems

The Independent Health and Aged Care Pricing Authority (IHACPA) develops and maintains healthcare classifications that provide a nationally consistent and clinically meaningful framework for describing patient care, treatments and associated resource use across the Australian healthcare system. These classifications support activity-based funding, consistent reporting, performance measurement, health service research and clinical information management.

The following classifications and standards are central to admitted care classification:

- International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- Australian Classification of Health Interventions (ACHI)
- Australian Coding Standards (ACS): collectively known as [ICD-10-AM/ACHI/ACS](#), and the
- Australian Refined Diagnosis Related Groups ([AR-DRGs](#)).

ICD-10-AM/ACHI/ACS captures diagnoses, interventions and coding standards for admitted episodes of care. AR-DRGs use ICD-10-AM and ACHI coded data, together with other routinely collected data items, to group admitted acute episodes into clinically meaningful and resource-homogeneous categories. Because of these dependencies, ICD-10-AM/ACHI/ACS and AR-DRGs are developed in parallel and released as aligned products, although AR-DRGs are generally implemented one year after the corresponding ICD-10-AM/ACHI/ACS edition.

This consultation provides stakeholders with information about proposed refinements for ICD-10-AM/ACHI/ACS Fourteenth Edition and AR-DRG Version 13.0 (AR-DRG V13.0) and seeks feedback on selected issues that may inform future classification development cycles.

The current development cycle also occurs in the context of IHACPA's broader work to prepare for a future implementation of the International Classification of Diseases, Eleventh Revision (ICD-11). In line with that strategy, updates to ICD-10-AM and the ACS are being limited, while ACHI and AR-DRGs continue to be reviewed and refined to ensure they remain clinically relevant and fit for purpose.

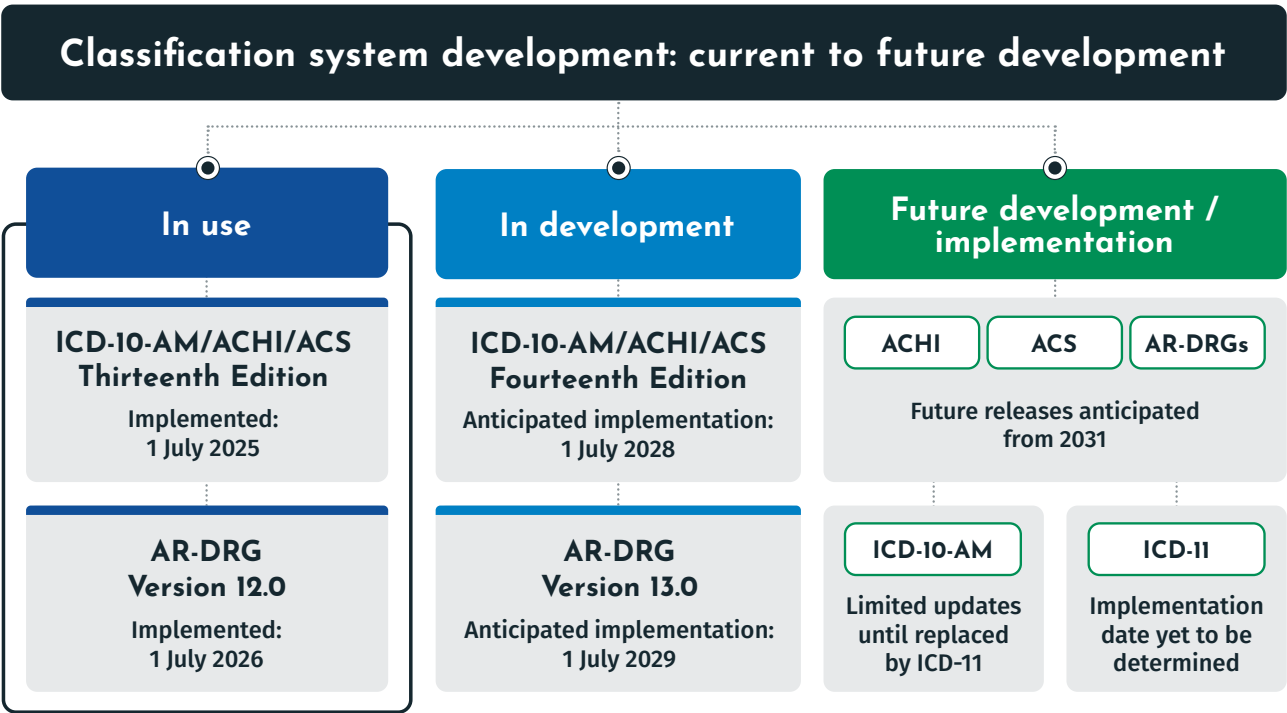
1.2 Governance framework for the Development of IHACPA Classifications

IHACPA develops ICD-10-AM/ACHI/ACS and AR-DRGs in accordance with the [Development of IHACPA Classifications](#) governance framework. Volume 1 provides the overarching framework for classification development, while Volume 2 provides classification-specific guidance for ICD-10-AM/ACHI/ACS and Volume 3 provides classification-specific guidance for AR-DRGs.

Under the framework, classification development occurs through a structured 3-year development cycle that includes work program establishment, classification development, consultation and finalisation, and release of classification resources. Submissions and proposed refinements are assessed against established scope, prioritisation and development principles to determine whether they should be progressed in the current or a future development cycle.

Expert clinical, classification, technical and jurisdictional advice is sought through IHACPA’s advisory groups and committees throughout the development cycle. This supports transparent, evidence-based decision making and helps ensure proposed refinements are clinically coherent, technically sound and fit for purpose.

Figure 1: Current and future development of ICD-10-AM/ACHI/ACS and AR-DRG



1.3 Scope and purpose of public consultation

IHACPA is undertaking public consultation to provide stakeholders with information about proposed refinements for ICD-10-AM/ACHI/ACS Fourteenth Edition and AR-DRG V13.0, and to seek feedback on selected issues that may inform future classification development cycles.

The consultation supports transparency by informing stakeholders about classification development work underway for the current cycle. It also provides an opportunity for stakeholders to identify issues, risks or priorities that may require consideration in future development cycles, particularly where longer lead times may be needed for assessment, planning or implementation. Stakeholders are encouraged to focus on questions and issues relevant to them, and submissions do not need to answer every question.

Feedback on future priorities will inform planning for subsequent development cycles and is not intended to alter items already well progressed in the current development cycle.

IHACPA is calling for submissions on this consultation paper until **13 November 2026**.



Key dates

Release of the consultation paper	6 October 2026
Submissions close	13 November 2026

Unless you specifically request that your submission or parts of your submission should not be released, all submissions will be published. We retain the right not to publish any submissions, or part thereof, where we consider it appropriate to do so.

Your submission will be carefully considered and IHACPA may contact some individuals or entities that make a submission for further information or insights.

IHACPA will not contact everyone who makes a submission, but we will ensure that all submissions are recorded, reviewed and used to inform the development of ICD-10-AM/ACHI/ACS and AR-DRGs.



Have your say

Submit your response by 13 November 2026:

- Online: Submission form
- Email: submissions.ihacpa@ihacpa.gov.au
- Mail: PO Box 483, Darlinghurst NSW 1300



Enquiries

Enquiries related to this consultation process should be emailed to submissions.ihacpa@ihacpa.gov.au.

2. ICD-10-AM/ACHI/ACS

2.1 Fourteenth Edition refinements

IHACPA is continuing to consult through its advisory groups on proposed refinements for ICD-10-AM/ACHI/ACS Fourteenth Edition. As consultation is ongoing, the proposals in this section are subject to change.

The Fourteenth Edition work program includes targeted refinements to support classification currency, consistency and usability. Consistent with IHACPA's broader transition planning for ICD-11, updates to ICD-10-AM and the ACS are limited. Proposed ACHI refinements continue to be progressed where changes are needed to reflect contemporary clinical practice, improve classification clarity or align with external updates such as changes to the Medicare Benefits Schedule (MBS).

Development proposals sourced from:

- MBS updates
- updates to ACHI where the current edition does not reflect contemporary clinical practice
- a review of activated placeholder codes
- public submissions and other stakeholder feedback
- errata identified by stakeholders or IHACPA.

Limiting updates to ICD-10-AM and ACS

ICD-10-AM is based on the World Health Organization's (WHO's) International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). IHACPA maintains ICD-10-AM under a licence agreement with WHO. While ICD-10-AM continues to support national admitted care reporting and classification in Australia, ICD-10 is an ageing classification and has been superseded internationally by ICD-11.

Australia voted to adopt ICD-11 at the 2019 World Health Assembly, and ICD-11 became the international standard for reporting diseases and health conditions on 1 January 2022. WHO no longer updates ICD-10, which limits the extent to which ICD-10-AM can continue to be developed as a contemporary diagnosis classification.

IHACPA is preparing for a future implementation of ICD-11. To support this transition and build capacity within IHACPA and the healthcare sector for ICD-11 development and implementation planning, updates to ICD-10-AM and the ACS have been limited for Fourteenth Edition. Only minor updates to the ICD-10-AM Tabular List and ICD-10-AM Alphabetic Index have progressed, with no new ICD-10-AM codes and no major ACS changes proposed.

IHACPA outlined its intention to limit updates to ICD-10-AM and the ACS through the October 2025 [Future of IHACPA Classifications](#) public consultation. Feedback indicated broad support for this approach. However, respondents also noted that, if implementation of ICD-11 is delayed, limiting ongoing development of ICD-10-AM may create classification gaps and increase the need for coding advice.

ICD-10-AM placeholder (provisional use) codes

To mitigate the impact of not introducing new ICD-10-AM codes for Fourteenth Edition, IHACPA developed a process for activating placeholder codes from the ICD-10-AM block U75-U77 *Provisional assignment of diseases of national significance*. These codes are reserved for diseases or health conditions determined to be of national significance and may be activated through National Coding Advice, in consultation with the Classifications Clinical Advisory Group. This approach provides a mechanism to respond to emerging or nationally significant conditions while limiting broader structural changes to ICD-10-AM during the transition toward ICD-11.

For Fourteenth Edition, IHACPA proposes to increase the number of placeholder codes available for activation. The existing block U75-U77 will be expanded to include the currently inactive category U74. All unused codes in the new block U74-U77 *Provisional assignment of diseases of national significance* will be expanded to fifth character codes. This will increase the number of codes available from 30 to approximately 400.

ACS

No major changes to the ACS are being progressed for Fourteenth Edition, consistent with IHACPA's approach to limiting updates to ICD-10-AM and the ACS during the transition toward ICD-11.

Some remaining work is required to standardise the ACS, after the introduction of the ACS template in Thirteenth Edition. As part of this work, a small number of superseded or no longer required ACS may be retired, consistent with the broader retirement of ACS undertaken in Thirteenth Edition.

Cluster coding

Cluster coding links related diagnosis codes through a diagnosis cluster identifier (DCID) that enhances the value of coded data by identifying clinically related conditions within an episode of care. Cluster coding was introduced using a staged approach, with the intention that additional conditions may become eligible for clustering through future classification development.

Cluster coding is currently limited to:

- conditions/manifestations assigned with an external cause code, including injuries, complications and adverse effects
- supplementary codes for chronic conditions.

Jurisdictions are continuing to implement cluster coding for all admitted episodes of care. It is expected national implementation will be completed prior to ICD-10-AM/ACHI/ACS Fourteenth Edition. IHACPA intends to allow the implementation of cluster coding to further mature before considering any expansion of the conditions eligible for clustering. No changes to cluster coding are therefore proposed for Fourteenth Edition.

ACHI

MBS updates

MBS updates are incorporated into ACHI as part of each new development cycle. For Fourteenth Edition, this includes MBS updates made between March 2023 and July 2025. Where a relevant new MBS concept is introduced, and is not already represented in ACHI, the MBS item number is used as the ACHI stem code. Where an MBS item number has changed, but the underlying classification concept remains unchanged, the existing ACHI code is retained and the relationship to the updated MBS item is managed through mapping.

Other ACHI concepts that are not represented in the MBS are allocated a code number in the 90000 series, known as 9-series codes.

The current governance framework indicates that 9-series ACHI codes may be replaced when an MBS item number becomes available for the same procedure concept. In developing ACHI for Fourteenth Edition, IHACPA has taken a more targeted approach, retaining existing 9-series ACHI codes where the procedure concept is already represented in ACHI and managing alignment with relevant MBS item numbers through mapping.

This approach supports classification stability and reduces the maintenance burden associated with replacing established ACHI codes where the underlying procedure concept is unchanged, particularly given the volume of recent MBS changes, including changes implemented following the MBS Review Taskforce.

Structure of ACHI Chapter 3 *Procedures on eye and adnexa*

A long-standing structural anomaly has been identified in ACHI Chapter 3 *Procedures on eye and adnexa*, where interventions on the posterior chamber of the eye are grouped in the same ACHI blocks as interventions within the posterior segment of the eye, despite the posterior chamber forming part of the anterior segment of the eye. This has contributed to inconsistent use of the terms anterior/posterior segment and anterior/posterior chamber in ACHI.

Procedures involving aqueous humour and vitreous humour have also been classified outside their respective anatomical segments.

IHACPA intends to amend the structure of ACHI Chapter 3 to correct these structural inconsistencies and improve anatomical clarity.

Radiotherapy

The classification of radiotherapy has evolved over multiple development cycles, with many ACHI codes originally developed to align with specific MBS items and historical treatment approaches. As radiotherapy techniques and clinical practice have evolved, this has resulted in inconsistencies in code structure and variable use of some ACHI codes. Updates to the MBS provided an opportunity to undertake a broader review of radiotherapy classification to improve consistency, usability and alignment with contemporary practice.

Relevant ACHI sections have been comprehensively reviewed to align with MBS updates. Changes include inactivation and creation of codes structured by treatment modality and complexity (kilovoltage, megavoltage).

Brachytherapy has been simplified and restructured by delivery type and anatomical site, with new codes for insertion and removal of applicators. Block titles and indexing have also been updated to improve clarity and consistency across radiation oncology procedures.

Endovascular therapy

Endovascular therapies are increasingly used in the management of stroke and other vascular conditions. As part of broader work examining the classification of endovascular therapy in AR-DRGs, IHACPA has identified a number of inconsistencies and limitations within ACHI that affect the identification and classification of these procedures. These include uncertainty in the classification of attempted embolectomy and thrombectomy, interventions on intracranial and extracranial vessels, distinctions between open and percutaneous approaches, anatomical specificity for percutaneous transluminal angioplasty, and endovascular repair procedures.

To support this work, IHACPA proposes to amend ACHI to improve classification clarity and consistency for endovascular therapies. Proposed refinements include improving indexing and instructional guidance for attempted interventions, refining the classification of interventions on intracranial and extracranial vessels, and clarifying distinctions between open and percutaneous approaches. Additional changes may include greater anatomical specificity for percutaneous transluminal angioplasty and angioplasty with stenting, and improvements to the classification of endovascular repair and revision of endovascular repair.

Also see Section [3.1 AR-DRG V13.0 refinements Endovascular interventions for stroke](#)

Interventions for burns

Burn-related interventions are used across both acute burn management and the treatment of burn sequelae. As part of broader work reviewing AR-DRG Major Diagnostic Category (MDC) 22 *Burns*, IHACPA has identified inconsistencies in the classification of burn-related interventions within ACHI. In some cases, burn-specific intervention codes duplicate codes used for non-burn conditions, creating uncertainty in code assignment and affecting the consistent classification of burn-related activity.

IHACPA proposes to amend ACHI by inactivating burn-specific intervention codes where an equivalent non-burn-specific intervention code exists. Table 1 demonstrates an example.

Table 1: Inactivation of burn-specific intervention codes

Example	Proposal
45451-10 [1648] <i>Full thickness skin graft to burn of eyelid</i>	Inactivated ACHI code
45451-00 [1649] <i>Full thickness skin graft of eyelid</i>	Concept expanded to include full thickness grafting for burn

This approach is intended to reduce duplication, improve coding consistency and support clearer application of ACHI, while continuing to capture information about the burn through ICD-10-AM codes.

Also see Section [3.1 AR-DRG V13.0 refinements MDC 22 Burns](#).



Consultation question 1

Are there any clinical, classification or implementation issues that should be considered in relation to the proposed refinements for ACHI including for

- i. endovascular therapy?
- ii. interventions for burns?

Retirement of National Coding Advice

National Coding Advice supports nationally consistent assignment of ICD-10-AM and ACHI codes. Over time, the volume of National Coding Advice has increased substantially. This creates an ongoing maintenance burden for IHACPA and can make it difficult for those involved in the clinical coding process to navigate, interpret and apply the advice consistently.

Through the October 2025 Future of IHACPA Classifications public consultation, IHACPA outlined its intention to retire National Coding Advice at the end of each development cycle. Feedback indicated in principle support for reducing the burden of National Coding Advice. However, respondents did not support automatic retirement at the end of the development cycle without process for review and transition.

In response to this feedback IHACPA intends to retire National Coding Advice where the content has been incorporated into the classification, has been superseded or is no longer relevant.

For Fourteenth Edition, current and recently retired National Coding Advice has been reviewed to identify opportunities for classification development, including enhancements to the Alphabetic Index or the Tabular List. Where advice can be integrated into the classification, it has been included in the Fourteenth Edition work program. This approach supports clearer and more sustainable classification maintenance by incorporating stable guidance directly into ICD-10-AM/ACHI/ACS wherever appropriate, while reducing the burden of application for those involved in the clinical coding process.

Closing public submissions

IHACPA receives more submissions than can be considered within a single development cycle and, over time, this has resulted in a backlog of historic submissions. Some of these submissions are no longer relevant to current classification development priorities, while others relate to matters that are more appropriately addressed through existing coding advice, consultation or jurisdictional processes. This work also occurs in the context of IHACPA's broader transition planning for ICD-11 and the decision to limit major updates to ICD-10-AM and the ACS. As a result, some historic submissions may no longer align with future classification development priorities.

Through the October 2025 Future of IHACPA Classifications public consultation, stakeholders broadly supported the development of a process for reviewing and closing historic public submissions, while emphasising the importance of transparency, good governance and assurance that the process would not create barriers to future public submissions.

The redevelopment of the Australian Classification Exchange (ACE) platform provides an opportunity to improve how submissions are managed, triaged and prioritised. Classification development priorities are considered through established governance processes, including the governance arrangements for ICD-10-AM/ACHI/ACS development. Outcomes of classification development are communicated through consultation reports, classification development documentation, release materials and other published resources.

Historically, the ACE platform supported direct correspondence with individual submitters. Over time, maintaining individual correspondence has become increasingly difficult as organisational structures, roles and contact details change. In addition, classification development decisions are considered through established governance processes rather than through individual submissions in isolation. Accordingly, IHACPA intends to move away from ongoing correspondence with individual submitters and instead communicate outcomes through its established governance, consultation and publication processes. This approach is intended to provide a more transparent, consistent and sustainable process for managing submissions and communicating outcomes.

IHACPA will review historic public submissions that have remained open across multiple development cycles and determine whether they should be progressed, retained for future consideration, or closed where they have been superseded, are no longer relevant, or do not align with current classification development priorities, in accordance with the established governance framework for ICD-10-AM/ACHI/ACS development. IHACPA will not routinely provide individual responses to historic submissions. Instead, outcomes of classification development are communicated through consultation reports, classification development documentation, release materials and other educational resources, which identify proposals that have been incorporated into a development cycle and the rationale for classification changes. This approach supports a more transparent, consistent and sustainable process for managing submissions and communicating outcomes.



Consultation question 2

Are there governance, transparency or implementation issues that should be considered when closing historic public submissions?

2.2 Future work programs

ACHI principles for development

ACHI has evolved over multiple editions and incorporates content from a range of sources, including the MBS, clinical advice, public submissions and classification development activities. Over time, different development approaches have contributed to variation in the level of detail across the classification. In some areas, highly specific intervention concepts have resulted in complex code structures that can be difficult to apply consistently or navigate efficiently. While successive editions have progressively refined and streamlined ACHI, opportunities remain to improve consistency, usability and alignment with contemporary classification design principles.

As part of broader work to improve the consistency, transparency and maintainability of ACHI, IHACPA has developed a set of ACHI development principles, which are documented in [Development of IHACPA Classifications – Volume 2 ICD-10-AM/ACHI/ACS](#). These principles describe the conventions used in the development and maintenance of the classification, including classification structure, code design, indexing and instructional content. They are intended to support consistent decision-making, improve transparency for stakeholders and provide a framework for future refinement activities, including review of areas of ACHI that may have become overly detailed, difficult to navigate or challenging to apply consistently.

While the WHO has developed the International Classification of Health Interventions (ICHI), IHACPA does not currently intend to replace ACHI as part of the transition from ICD-10-AM to ICD-11. The transition to ICD-11 represents a substantial classification reform in its own right. Maintaining and improving ACHI remains important to support ongoing classification development, data collections and activity-based funding arrangements. The ACHI development principles therefore provide a framework for continuing to improve the quality, consistency and usability of ACHI while broader classification reform activities progress.

Stakeholder feedback on both the proposed principles and areas of ACHI that may benefit from future refinement will help inform ongoing maintenance and development of the classification.



Consultation question 3

Do the ACHI development principles described in Development of IHACPA Classifications – Volume 2 ICD-10-AM/ACHI/ACS appropriately support consistent, transparent and sustainable classification development?



Consultation question 4

Are there areas of ACHI that you find particularly difficult, complex or cumbersome to apply or navigate? If so, what factors contribute to these issues and how could they be improved?

Non-invasive ventilation and high flow therapy

Ventilatory support has long been represented within ACHI through codes for continuous ventilatory support. Since these codes were first developed, clinical practice has evolved substantially, including increased use of non-invasive ventilation and high flow therapy. While clinical advice has supported classification of certain forms of high flow therapy as non-invasive ventilatory support, stakeholders have raised concerns regarding whether the current classification appropriately reflects contemporary clinical practice and the distinction between these therapies.

Table 2 illustrates the current duration-based approach to classification of non-invasive ventilatory support.

Table 2: Current classification of non-invasive ventilation

Classification of non-invasive ventilation (including HFT) in ACHI Thirteenth Edition	
92209-00 [570]	<i>Management of noninvasive ventilatory support, 24 hours or less</i>
92209-01 [570]	<i>Management of noninvasive ventilatory support, more than 24 hours but less than 96 hours</i>
92209-02 [570]	<i>Management of noninvasive ventilatory support, 96 hours or more</i>

Stakeholder feedback has raised questions regarding both the classification of high flow therapy and the continued use of duration-based coding for ventilatory support. IHACPA is therefore reviewing the classification of non-invasive ventilation and high flow therapy, including the role of duration-based coding, alignment with available metadata collections and options for improving consistency, usability and representation of contemporary clinical practice.



Consultation question 5

What clinical, operational, coding or data considerations should be taken into account in the future classification of non-invasive ventilation and high flow therapy?

- Does the current classification appropriately distinguish between non-invasive ventilation and high flow therapy?
- Should ACHI continue to identify ventilatory support through duration-based coding, or should alternative approaches, including greater use of existing metadata collections, be considered?

3. AR-DRGs

3.1 AR-DRG V13.0 refinements

IHACPA is continuing to develop and consult on proposed refinements for AR-DRG V13.0 through its advisory groups. Some refinements, including standard refinements, will undergo further consultation later in the development cycle. The proposals described in this section are therefore subject to change.

Standard refinements

Each new version of AR-DRG includes a standard set of refinements aimed at updating the classification for currency using the most recent activity and cost data. For AR-DRG V13.0 this includes:

- reviewing the Adjacent Diagnosis Related Group (ADRG) intervention hierarchy using up to date cost data
- reviewing episodes that group to ADRG 801 *General Intervention unrelated to principal diagnosis*
- reviewing codes in scope for contributing to episode complexity
- reviewing the splitting of ADRGs into Diagnosis Related Groups (DRG) end classes that reflect different levels of complexity
- performance monitoring.

Review of intervention type

During the development of AR-DRG Version 12.0 (AR-DRG V12.0), IHACPA developed Guiding Principles for Intervention Type in consultation with its clinical and technical advisory groups.¹ These principles facilitate consistency in determining which interventions should be used in DRG definitions. During AR-DRG V12.0 development, IHACPA proposed a staged approach to progressively applying the guiding principles. This ensures that the impacts are well understood before implementation.

In AR-DRG V13.0, IHACPA is undertaking the second stage of the intervention type review. This comprises a focussed review of biopsy and tissue sampling procedures. Changes in contemporary clinical practice, including the prevalence of minimally invasive techniques, may have contributed to inconsistencies in whether biopsy and sampling episodes group to the medical or intervention partitions. A particular focus is to ensure that procedures performed using different approaches, such as open, closed or endoscopic techniques are distinguished where appropriate. This work is intended to improve classification consistency and ensure that intervention type assignment remains clinically meaningful.

¹ IHACPA, '[AR-DRG Version 12.0 Final Report](#)' IHACPA website, 2025, accessed 23 August 2026.

Newborns and other neonates

IHACPA is undertaking a comprehensive review of MDC 15 *Newborns and other neonates*. The review was informed by stakeholder feedback and performance monitoring and is examining whether the current classification structure appropriately reflects contemporary neonatal care, complexity and resource use.

A key focus of the review is whether gestational age should be used as the primary measure of prematurity in place of admission weight. The review is also reassessing the classification variables currently used to differentiate neonatal episodes, including ventilatory support and neonatal interventions, to determine whether they continue to appropriately reflect contemporary clinical practice and resource use.

In addition, IHACPA is exploring whether other diagnoses, conditions or indicators of complexity may improve differentiation of neonatal episodes within MDC 15. This includes consideration of selected conditions originating in the perinatal period, congenital anomalies, infections and other indicators identified through clinical review and statistical analysis. These factors are being evaluated as part of the review and do not represent a proposed final set of classification variables.

This review will reassess MDC 15 classification variables and ADRG definitions to ensure they reflect contemporary neonatal care and appropriately distinguish neonatal complexity and resource use.



Consultation question 6

What aspects should be considered when reviewing the MDC 15 *Newborns and other neonates* classification structure, including:

- i. whether contemporary neonatal care is adequately represented in the current MDC 15 *Newborns and other neonates* classification structure?
- ii. whether specific neonatal conditions, therapies or clinical characteristics should be considered in identifying higher complexity neonatal episodes?
- iii. what clinical, operational or data considerations should be taken into account in the review?

Endovascular interventions for stroke

In AR-DRG Version 11.0 (AR-DRG V11.0), IHACPA introduced ADRG B08 *Endovascular clot retrieval* to contain episodes in which intracranial thrombectomy or embolectomy is performed. This ADRG was created to distinguish these interventions from the more expensive, open intracranial procedures in ADRG B02 *Cranial interventions*.

In response to stakeholder feedback, IHACPA is reviewing ADRG B08 *Endovascular clot retrieval* to determine whether a broader concept of endovascular revascularisation for ischaemic stroke would better reflect contemporary clinical practice. A broader definition may encompass other endovascular revascularisation procedures for ischaemic stroke, such as angioplasty or stenting, beyond the current definition which is restricted to mechanical clot retrieval.

This work responds to changes in stroke treatment, technology, procedure volumes and costs. The review will consider whether the current ADRG scope remains clinically appropriate and whether changes are needed to improve alignment with the underlying diagnosis (ICD-10-AM) and intervention (ACHI) classifications.



Consultation question 7

Are there additional endovascular procedures or other clinical factors relevant to the review of ADRG B08 *Endovascular clot retrieval*?

Dental procedures, oral surgery and salivary gland interventions

IHACPA is reviewing dental, oral surgery and salivary gland intervention ADRGs within MDC 03 *Diseases and disorders of the ear, nose, mouth and throat*. The review responds to stakeholder feedback that the current ADRG structure does not clearly distinguish the clinical complexity and anatomical focus of procedures involving the teeth, periodontium and the oral cavity.

IHACPA proposes to clarify the distinction between these categories as shown in Table 3. This work is intended to improve classification consistency by better aligning ADRG definitions with anatomical site, clinical intent and contemporary dental and oral surgery practice, before standard ADRG splitting refinements are undertaken for AR-DRG V13.0.

Table 3: Measures under consideration for the review of MDC 03 Diseases and disorders of the ear, nose, mouth and throat

Category	AR-DRG V12.0 (existing)	AR-DRG V13.0 (proposed)	Rationale
Salivary gland procedures	D05 <i>Parotid gland interventions</i>	D05 <i>Salivary gland interventions</i>	Consolidates all salivary gland interventions in a single ADRG
Oral surgery	D14 <i>Mouth and salivary gland interventions</i>	D14 <i>Oral surgery</i>	Distinguishes oral from salivary gland procedures and dental services
Teeth and the periodontium	D40 <i>Dental extractions and restorations</i>	D40 <i>Interventions on teeth and the periodontium</i>	Consolidates procedures on teeth and the periodontium and clarifies the anatomical structures captured by this ADRG.



Consultation question 8

Are there additional clinical or anatomical distinctions that should be considered to improve differentiation of dental procedures, oral surgery and salivary gland interventions in MDC 03 *Diseases and disorders of the ear, nose, mouth and throat*?

MDC 22 Burns

IHACPA is reviewing MDC 22 *Burns* for AR-DRG V13.0. The review follows performance monitoring that identified opportunities to improve statistical homogeneity and recognises that the MDC 22 has not been substantively updated for some time despite changes in contemporary burns management and treatment pathways.

The measures under consideration are summarised in Table 4.

Table 4: Measures under consideration for the review of MDC 22 Burns

Item	Rationale
Removal of ADRG Y01 Ventilatory support 96 hours or more or tracheostomy for burns or General Intervention for severe full thickness burns	This ADRG does not meet the indicative minimum sample of 200 episodes per year in the AR DRG development principles (Section 5.1 of Development of IHACPA Classifications Volume 3 AR-DRGs). Its continued use also results in inconsistent treatment of episodes with tracheostomy and extended invasive ventilatory support.
Create distinct ADRGs for skin grafts and flaps: • Y04 Skin grafts and flaps for burns of at least 10% total body surface area • Y05 Skin grafts and flaps for burns of less than 10% total body surface area	There is a substantial cost difference between skin graft and flap episodes for burns of at least 10% total body surface area and those of less than 10% total body surface area.
Removal of ADRG Y03 Other General Intervention for other burns	This ADRG is clinically and statistically heterogeneous because it contains both acute burn care and follow-up care for burn sequelae.
Create distinct ADRGs: • Y06 Surgical burn management • Y07 Restorative surgical procedures for burns • Y08 Carbon dioxide laser resurfacing and abrasive procedures for burns	This proposal distinguishes acute burn management from restorative procedures for burn sequelae, and separately identifies the higher-volume, more homogeneous episodes involving carbon dioxide laser resurfacing and abrasive procedures.



Consultation question 9

Are there any clinical, data or implementation issues that should be considered in relation to the proposed refinements to MDC 22 *Burns* for AR-DRG V13.0?

Review of AR-DRG short descriptors

IHACPA is seeking feedback on the current and future use of the AR-DRG short descriptors. Historically, short descriptors have been provided alongside long descriptors for the AR-DRG classification, however there is limited information available regarding their original purpose or current use.

The short descriptors contain inconsistent abbreviations and terminology and can be difficult to interpret due to the compression of clinically detailed AR-DRG titles into a 40-character limit. Maintaining short descriptors also requires ongoing effort as part of AR-DRG development.

IHACPA is seeking stakeholder feedback to better understand whether there is an ongoing need to provide the short descriptors as part of AR-DRG classification products and, if so, whether any improvements should be considered.



Consultation question 10

Does your organisation currently use the AR-DRG short descriptors?

- i. If yes, please describe how they are used.
- ii. What impact, if any, would there be if AR-DRG short descriptors were no longer provided?

3.2 Future work programs

Endocrine, nutritional and metabolic intervention ADRGs

General Interventions for diabetic complications

IHACPA is reviewing ADRG K01 *General Intervention for diabetic complications*. Analysis undertaken as part of NEP development identified opportunities to improve the clinical and resource homogeneity of episodes currently assigned to this ADRG. ADRG K01 contains a broad range of interventions for diabetic complications, ranging from procedures that may be performed as same-day interventions, such as debridement of skin and subcutaneous tissue, to major procedures requiring extended recovery and rehabilitation, such as lower limb amputations.

The diversity of procedures within ADRG K01 may limit the ability of the current ADRG structure and Episode Clinical Complexity Score (ECCS) splits to consistently differentiate resource use. Review of NEP Determination outcomes identified cohorts assigned to the minor complexity DRG that receive a higher price than similar cohorts assigned to the intermediate complexity DRG, suggesting that the current classification structure may warrant further review.

The review will examine whether refinements to ADRG K01 could improve clinical coherence, resource homogeneity and alignment with contemporary management of diabetic complications.

Interventions for obesity

IHACPA is considering whether the current AR-DRG structure for obesity-related interventions continues to reflect contemporary clinical practice and activity patterns. Obesity intervention activity has evolved over time, with most episodes now concentrated within ADRG K11 *Major laparoscopic interventions for obesity*, while several other obesity-related ADRGs contain relatively small numbers of episodes.

IHACPA's AR-DRG development principles indicate that ADRGs should generally contain at least 200 public hospital episodes per year. ADRGs K10 *Revisional and open interventions for obesity*, K12 *Other interventions for obesity* and K13 *Plastic General Intervention for endocrine, nutritional and metabolic disorders* do not currently meet this threshold. These ADRGs are more prevalent in the private sector, however there is evidence of low and decreasing volume in both sectors. Low-volume ADRGs may be more susceptible to statistical volatility and may reduce the ability of the classification to support pricing, analysis and service planning.

Future review may therefore be warranted to assess whether the current obesity-related ADRGs continue to support clinically meaningful and resource-homogeneous groupings, and whether the existing ADRG structure remains appropriate given contemporary obesity intervention activity.



Consultation question 11

Are there clinical, operational, resource-use or activity-related factors that should be considered when reviewing endocrine, nutritional and metabolic intervention ADRGs:

- i. ADRG K01 *General Intervention for diabetic complications*?
- ii. obesity-related ADRGs, particularly when assessing whether the current AR-DRG structure for obesity remains appropriate?

Procedural complications in MDC 21B *Injuries, poisoning and toxic effects of drugs*

MDC 21B *Injuries, poisoning and toxic effects of drugs* contains episodes with a principal diagnosis indicating traumatic injury, poisoning, toxic effects or environmental exposure. It also contains episodes with principal diagnoses indicating certain procedural complications, including puncture, laceration and haemorrhage.

In the current AR-DRG structure, these episodes are generally assigned to MDC21B *Injuries, poisoning and toxic effects of drugs* even where the diagnosis identifies a specific organ or body system. This differs from many other areas of the AR-DRG classification, where episodes are grouped according to the affected body system. As a result, episodes involving procedural complications may be classified differently from other clinically similar episodes affecting the same organ system.

Future review may therefore be warranted to assess whether some procedural complications would be more appropriately classified according to the affected body system rather than the nature of the complication itself. Such a review would have particular impact on ADRG X63 *Sequelae of treatment*.



Consultation question 12

Should procedural complications continue to be grouped within MDC 21B *Injuries, poisoning and toxic effects of drugs*, or should greater emphasis be placed on the affected body system? If so, what clinical or classification considerations should be taken into account?

Same-day radiotherapy

IHACPA is considering whether admitted same-day radiotherapy is sufficiently distinct from other episodes currently grouped to ADRG R62 *Other neoplastic disorders* to warrant separate classification in a future AR-DRG version.

Admitted same-day radiotherapy was previously assigned to ADRG R64 *Radiotherapy*. ADRG R64 was removed in AR-DRG Version 7.0 as it had a relatively small number of episodes and did not demonstrate a sufficiently distinct cost profile compared with other short-stay neoplasm episodes.

Since that time, the volume of admitted same-day radiotherapy has increased substantially. IHACPA is also undertaking related radiation oncology costing work, which may provide further insight into the resource profile of this activity. In addition, the broader review of intervention type assignment, including biopsy and tissue sampling procedures, may affect the composition of ADRG R62 *Other neoplastic disorders*. Together, these developments provide an opportunity to reassess whether admitted same-day radiotherapy remains appropriately grouped within ADRG R62 *Other neoplastic disorders*.

Future review may therefore be warranted to assess whether admitted same-day radiotherapy should once again be recognised through a dedicated ADRG.



Consultation question 13

Should admitted same-day radiotherapy continue to be grouped within ADRG R62 *Other neoplastic disorders*, or are there clinical, operational or classification factors that support separate classification?

Future AR-DRG structural reviews

MDC 23 *Factors influencing health status and other contacts with health services*

MDC 23 *Factors influencing health status and other contacts with health services* contains episodes that do not fit neatly within a body system or aetiology-based MDC. As a result, it includes a diverse range of activity, including signs and symptoms, follow-up care, screening, examinations and other contacts with health services.

IHACPA is considering whether the clinical coherence of MDC 23 could be improved through future review. In particular, future work may consider whether some cohorts currently assigned to MDC 23 would be more appropriately classified according to the affected body system or underlying condition, and whether existing ADRG definitions continue to reflect contemporary clinical practice. Such a review may include consideration of ADRGs such as Z01 *Other contacts with health services with General Intervention*, Z61 *Signs and symptoms* and Z64 *Other factors influencing health status*.

While the clinical heterogeneity of MDC 23 *Factors influencing health status and other contacts with health services* does not always result in poor statistical performance, future review may identify opportunities to improve both clinical coherence and cost homogeneity.



Consultation question 14

Are there cohorts currently assigned to MDC 23 *Factors influencing health status and other contacts with health services* that would be more appropriately classified according to body system, aetiology or another classification principle?

Transfer status in AR-DRG assignment

Transfer status is used in a small number of AR-DRGs to distinguish episodes where a patient is transferred to another acute facility within a specified period following admission as listed in Table 5.

Table 5: ADRGs or DRGs that currently use transfer status in their definitions

AR-DRG version 12.0 ADRG or DRG
B70D Stroke and other cerebrovascular disorders, transferred to acute facility in less than 5 days
B78C Intracranial injuries, transferred to acute facility in less than 5 days
F60B Circulatory disorders, transferred to acute facility in less than 5 days
F62C Heart failure and shock, transferred to acute facility in less than 5 days
I80 Femoral fractures, transferred to acute facility in less than 2 days
P01 Neonate with significant General Intervention or ventilatory support 96 hours or more, died or transferred to acute facility in less than 5 days
P60 Neonate without significant General Intervention or ventilatory support 96 hours or more, died or transferred to acute facility in less than 5 days
W60 Multiple significant trauma, transferred to acute facility in less than 5 days
Y60 Burns, transferred to acute facility in less than 5 days.

Transfer status is included in these definitions to distinguish episodes where transfer to another acute facility forms part of the expected treatment pathway and may be associated with different patterns of care and resource use.

A review of transfer status variables across AR-DRGs will examine whether the current use of transfer status continues to appropriately reflect contemporary models of care, inter-hospital transfer pathways and resource use.

Particular focus will be given to patient cohorts where transfer pathways are integral to care delivery, such as neonatal services and stroke care. The review aims to ensure that transfer-related variables appropriately distinguish episodes with different clinical pathways and resource use.



Consultation question 15

Are there additional areas where patient transfers should be considered in DRG grouping, including:

- where transfers are a prominent and integral part of patient care?
- where clinical, operational or classification considerations indicate that transfer status may be relevant to AR-DRG assignment?



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