IHACPA

Development of IHACPA Classifications

Volume 2 ICD-10-AM/ACHI/ACS

Version 1.1
September 2026

Acknowledgement of Country

We respect and acknowledge the Traditional Owners and Custodians throughout Australia and recognise their continuing connection to land, sky, waters and culture. We pay our respect to people, communities and Elders today and those who walk in spirit.

Artwork by Chern'ee Sutton

Development of IHACPA Classifications – Volume 2 ICD-10-AM/ACHI/ACS – Version 1.0

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Abbreviations

Abbreviations	Full term
ABF	Activity-based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AECC	Australian Emergency Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient classification
AR-DRGs	Australian Refined Diagnosis Related Groups
CAC	Clinical Advisory Committee
CCAG	Classifications Clinical Advisory Group
CHADx	Classification of Hospital Acquired Diagnoses
ECL	Electronic code list
EPD Short List	Emergency Care ICD-10-AM Principal Diagnosis Short List
FRIC	Frailty Related Index of Comorbidities
HACs	Hospital Acquired Complications
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 Statistical Classification of Diseases and Related Health Problems, Eleventh Revision
ICD-O	International Classification of Diseases for Oncology
IHACPA	Independent Health and Aged Care Pricing Authority
ITG	ICD Technical Group
JAC	Jurisdictional Advisory Committee
MBS	Medical Benefits Schedule
NHRA	National Health Reform Agreement
TAC	Technical Advisory Committee
WHO	World Health Organization

1. Purpose

ICD-10-AM/ACHI/ACS comprises the following:

- 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).

The Development of IHACPA Classifications – Volume 1 Governance Framework provides the overarching structure for creating, maintaining and updating IHACPA classifications, ensuring they remain accurate, clinically relevant and fit for purpose across the healthcare system. It sets out a unified and standardised approach to classification development that aligns with the IHACPA Strategic Plan 2025–30. The **Development of IHACPA Classifications – Volume 2 ICD-10-AM/ACHI/ACS** builds on the foundations set in Volume 1 and provides detailed guidance for developing ICD-10-AM/ACHI/ACS. It outlines the key development principles, the processes for development and approval, and the classification resources that are produced.

Volume 2 ICD-10-AM/ACHI/ACS
This volume should be read together with **Volume 1 Governance Framework**. Together, volume 1 and 2 include the full governance framework for the development of **ICD-10-AM/ACHI/ACS**.

2. ICD-10-AM/ACHI/ACS

ICD-10-AM is based on the World Health Organization's (WHO) International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) and classifies diseases, injuries and health related problems.

ACHI classifies surgeries, therapies and other health interventions and maintains alignment with the Medical Benefits Schedule (MBS) and the Australian Schedule of Dental Services and Glossary.

The **ACS** are a set of instructions that are applied in assigning ICD-10-AM and ACHI codes to promote consistency in the classification of admitted episodes of care. Collectively known as ICD-10-AM/ACHI/ACS, the classification system captures clinical information for admitted patient care.

The classification system is reviewed and updated over a 3-year development cycle to ensure it remains clinically relevant and fit for purpose.

2.1 Uses of ICD-10-AM/ACHI/ACS

ICD-10-AM/ACHI/ACS is used to classify all admitted episodes of care including acute, newborn, mental health, subacute and non-acute care. The classification system supports consistent reporting, performance measurement, health service research, and clinical information management. A trained clinical coding workforce applies the classification system for admitted episodes of care.

ICD-10-AM is the only classification used in multiple activity-based funding (ABF) classifications, enabling some interoperability across the patient care journey.

2.1.1 AR-DRGs

The Australian Refined Diagnosis Related Groups (AR-DRG) classification provides a clinically meaningful way to group together treatments and services provided to patients in admitted episodes of care. AR-DRGs enable public hospitals to be funded for admitted acute episodes of care using ABF, while in the private sector they are predominantly used in funding agreements between private hospitals and health care insurers.

ICD-10-AM and ACHI codes form the foundation of the AR-DRG classification system. The AR-DRG system uses the ICD-10-AM and ACHI coded information with other routinely collected data items to group admitted care episodes into clinically meaningful categories with similar patterns of resource use.

Because ICD-10-AM/ACHI/ACS underpins the AR-DRG classification both systems are developed in parallel, and finalised and released at the same time. However, the AR-DRG classification is generally implemented one year after ICD-10-AM/ACHI/ACS to allow time for system updates, testing and transition.

For further information on the development of AR-DRGs, refer to **Volume 3 AR-DRGs**.

2.1.2 AN-SNAP

The Australian National Subacute and Non-Acute Patient (AN-SNAP) classification is used to classify admitted subacute and non-acute patients. It incorporates a subset of ICD-10-AM, known as the Frailty Related Index of Comorbidities (FRIC), as one of its classification variables. With each new release of ICD-10-AM/ACHI/ACS, both the FRIC and AN-SNAP are updated to maintain alignment with ICD-10-AM.

For further information on the development of AN-SNAP, refer to **Volume 4 AN-SNAP**.

2.1.3 AECC

The Australian Emergency Care Classification (AECC) is used to classify emergency department presentations. It uses a subset of ICD-10-AM, called the Emergency Care ICD-10-AM Principal Diagnosis Short List (EPD Short List) as one of its classification variables. With each new release of ICD-10-AM/ACHI/ACS, both the EPD Short List and AECC are updated to maintain alignment with ICD-10-AM.

For further information on the development of the AECC, refer to **Volume 6 AECC**.

2.2 Supporting ICD-11 implementation by limiting updates to ICD-10-AM

Australia voted to adopt the International Statistical Classification of Diseases and Related Health Problems, Eleventh Revision (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. As a result, WHO no longer updates ICD-10, which forms the basis of ICD-10-AM.

As part of IHACPA's Framework for a decision to implement ICD-11, IHACPA will limit updates to ICD-10-AM and the ACS to prepare for a future implementation of ICD-11.

Only minor updates to the ICD-10-AM Tabular List and ICD-10-AM Alphabetic Index will proceed, with no new codes and no major ACS changes.

To address the lack of new ICD-10-AM codes, we will activate placeholder codes from block U75-U77 *Provisional assignment of diseases of national significance*.

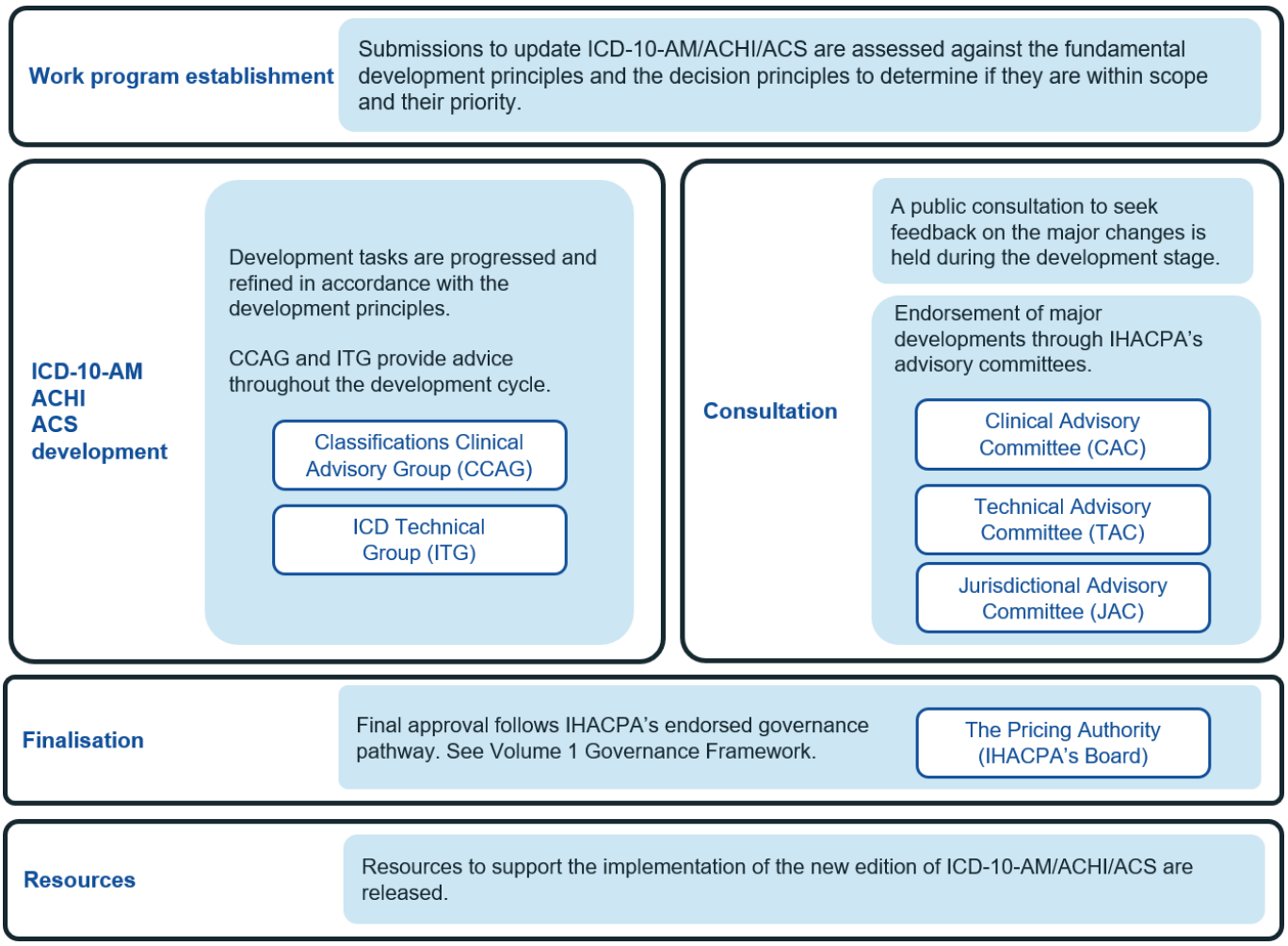
ACHI, however, will continue to be updated as usual.

3. The development process

3.1. Stages of the development cycle

The development of ICD-10-AM/ACHI/ACS is a 5-stage process (Figure 1), that aligns with IHACPA's standardised approach to classification development. This approach, outlined in **Volume 1 Governance Framework**, supports consistent decision making, transparency and accountability, while ensuring the classifications remain stable and current.

Figure 1: The stages of the ICD-10-AM/ACHI/ACS development cycle



3.1.1 Advisory groups

The ICD Technical Group (ITG), CCAG and their broader networks provide expert input into ICD-10-AM/ACHI/ACS development, as summarised in Table 1.

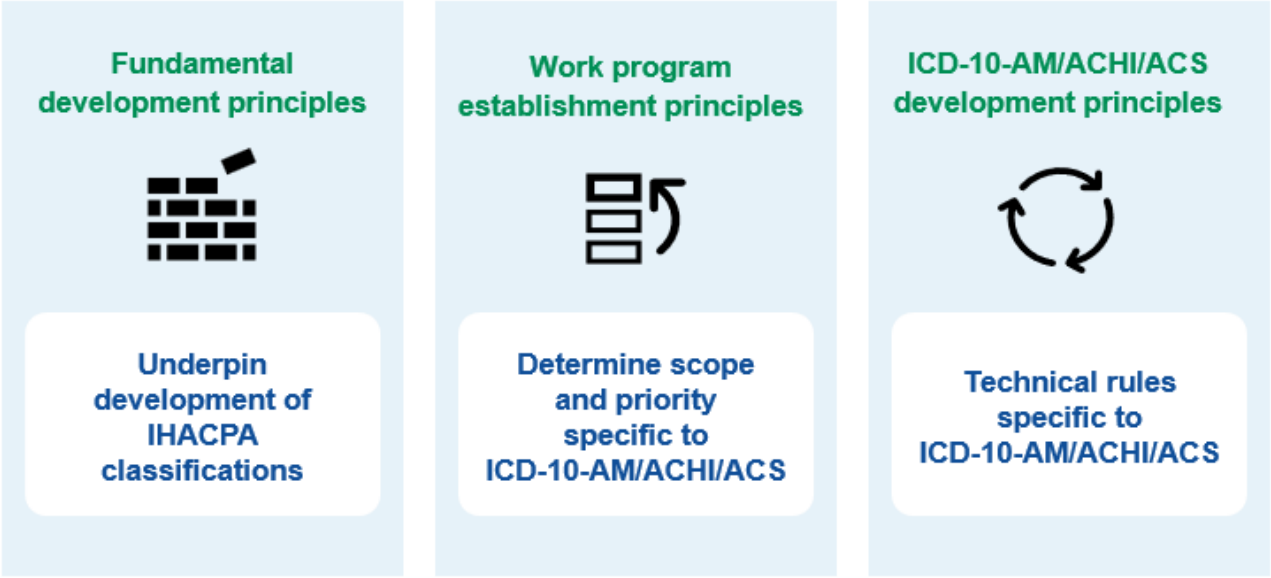
Table 1: Role of advisory groups during development

Group	Description
Classifications Clinical Advisory Group (CCAG)	Provide expert clinical advice. Membership includes representatives from IHACPA's Clinical Advisory Committee (CAC) and clinicians from medical, nursing and allied health professions with significant knowledge of the classifications.
ICD Technical Group (ITG)	Provide expert classification and technical advice. Membership includes representatives from all jurisdictions, public and private healthcare organisations, and key Australian health sector organisations and peak bodies.

3.2. Principle based development

ICD-10-AM/ACHI/ACS is developed using a principle-based approach, with these principles applied throughout the development cycle to ensure the classification system remains fit for purpose. These principles are organised into 3 categories, as shown in Figure 2.

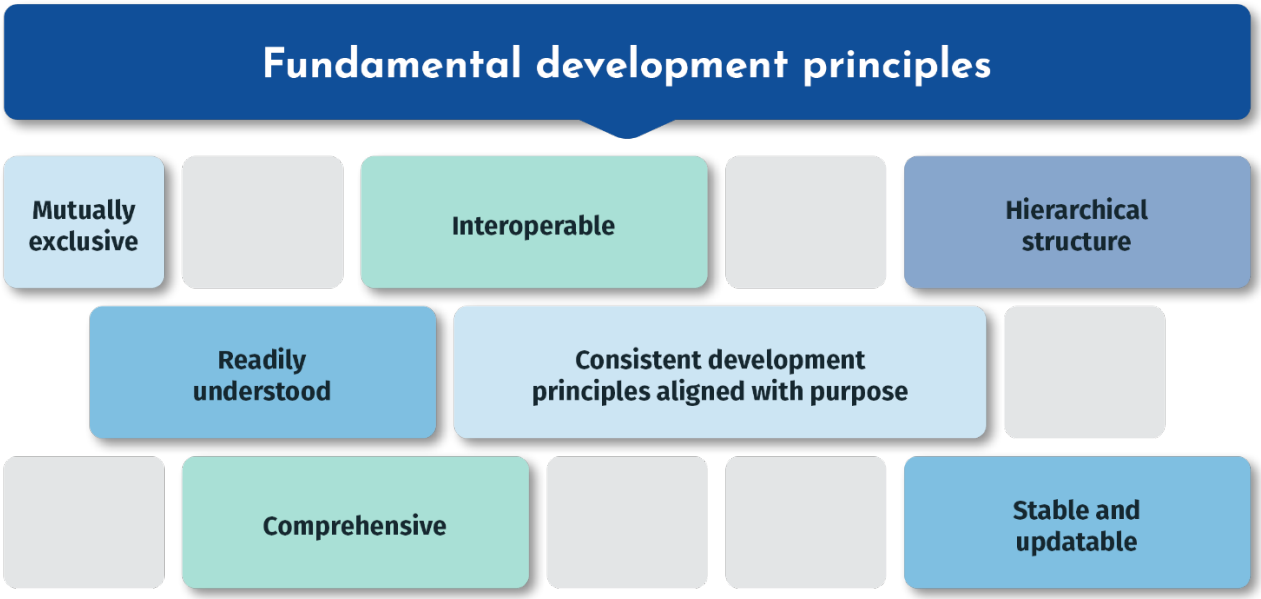
Figure 2: The 3 categories of principle based development.



3.2.1 Fundamental development principles

The fundamental development principles are listed in **Volume 1 Governance Framework** and shown in Figure 3. Their practical application is described in Section 4.1 Work program establishment principles and Section 5.1 ICD-10-AM/ACHI/ACS development principles.

Figure 3: Fundamental development principles



4. Work program establishment

Stakeholder submissions to update ICD-10-AM/ACHI/ACS are assessed against the work program establishment principles to determine whether they are within scope and, if so, their priority. Higher priority submissions inform the work program. However, not all high priority submissions can be progressed in each development cycle, and some may need to be deferred for future consideration.

4.1 Work program establishment principles

The work program establishment principles are informed by, and build on, the fundamental development principles (Figure 3). They include:

- **Stable and updatable** – balance need for updates to incorporate new clinical knowledge, technology and service models against stable data that supports longitudinal analysis.
- **Consistent development principles aligned with purpose** – the rules and decision criteria are applied systematically and transparently.

4.1.1 Scope principles

The decision principles define which submissions are considered in scope for ICD-10-AM/ACHI/ACS development.

Out of scope submissions include those that:

- require major updates to ICD-10-AM including introducing new codes or amending existing code titles[1]
- relate to the Classification of Hospital Acquired Diagnoses (CHADx)
- relate to the Hospital Acquired Complications (HACs) List Specifications
- relate to policies that do not apply nationally (for example admission policies, data quality audit programs).

Concepts identified as out of scope may be more appropriately addressed through policy development, education or enhancements to data collection systems.

4.1.2 Prioritisation principles

All submissions deemed in scope are then assessed against the prioritisation principles. These principles have been updated to reflect that only minor updates will be made to ICD-10-AM for the remainder of its lifecycle to support transition to ICD-11.

[1] This does not include minor code title amendments such as those for placeholder code activation.

A submission will be assigned a priority level if it meets at least one of the criteria defined within that priority level (Table 2). If a submission meets criteria across multiple levels, it is assigned the highest applicable priority level.

Table 2: Priority criteria for ICD-10-AM/ACHI/ACS development

Priority	Criteria for priority level
High priority	• MBS updates to ACHI • Australian Schedule of Dental Services and Glossary updates to ACHI • errata identified in the previous edition • minor refinements that correct issues identified by IHACPA • review of the introduction content for each classification volume • updates to ACHI where the current edition does not reflect contemporary clinical practice • updates to ACHI that support the implementation of initiatives under the National Health Reform Agreement (NHRA) • updates to ACHI identified by IHACPA in a previous development cycle as a priority • review of activated placeholder codes for: – new diseases of uncertain aetiology or emergency use (U00–U49) – disease of national significance (U75–U77) – new or emerging health technologies (block **[8888]**) – emergency use interventions (block **[8889]**)
Medium priority	• minor updates to ICD-10-AM/ACHI/ACS that support retirement of National Coding Advice • minor updates to the ACS that support application of the ACS standard template • International Classification of Diseases for Oncology (ICD-O) updates that do not result in new ICD-10-AM codes
Low priority	A submission is assigned as low priority if it does not meet any of the principles in high or medium priority.

5. ICD-10-AM/ACHI/ACS development

ICD-10-AM/ACHI/ACS updates are developed in accordance with the established classification development principles. Throughout this stage, we seek expert technical and clinical advice from our advisory groups to ensure the updates are accurate, appropriate and fit for purpose.

5.1 ICD-10-AM/ACHI/ACS development principles

ICD-10-AM/ACHI/ACS development principles set out the rules applied during the refinement and development process and are informed by the fundamental development principles (Figure 3). They include:

- **Comprehensive, mutually exclusive categories that are readily understood** – to ensure each concept is classifiable to only one well defined category.
- **Hierarchical and interoperable** – to support multiple and diverse uses and consistent data capture.
- **Consistent development principles aligned with purpose** – the rules and decision criteria are applied systematically and transparently.

ICD-10-AM/ACHI/ACS development principles align with the relevant classification volumes (Tables 3–7) and include the Tabular List conventions. They do not cover conventions used solely in the introduction section of the Alphabetic Indices or Tabular Lists for navigation and do not include punctuation, typeface or annotations.

Development is informed by the most recent 5 years of public and private hospital activity data available at the start of the development cycle. Where specific areas of development may require more current information, refinements may be initiated later in the development cycle using more recent data.

Table 3: Development principles for the ICD-10-AM Tabular List

Convention	Principles
Code	• between 3 and 5 characters long • utilise a dash to indicate a third, fourth or fifth character code in the Tabular List is required
Description	• spelling of terms are consistent with similar terms in the block range or chapter • terminology to align with ICD-11 • limited use of special characters and punctuation • preference to use scientific terminology over eponyms • 'and' implies 'and/or' • 'due to' implies causal relationship between conditions
Australian code	• flag to indicate if the code differs from the base classification of ICD-10
Unacceptable diagnosis flag	• unacceptable principal diagnosis codes align with ACS 0050 *Unacceptable principal diagnosis codes* • unacceptable diagnosis codes align with ACS 0049 *Disease codes that must never be assigned*
***Inclusion* terms**	• uses the same principles as Description, except eponyms may be used as *Inclusion* terms • *Inclusion* terms must appear in the Alphabetic Index
***Instructional* notes/terms**	• listed in the following order, then in alphabetic order within each *Instructional* note: – *Glossary description* – *Includes* – *Note* – *See* – *Code first, Code also, Use additional code* – *Excludes* • other: – Subdivisions only apply to the specified code range. Site subclassifications may apply to multiple specified categories. – *Excludes notes* are placed at the broader concept to redirect users to more specific concepts, if applicable. *Excludes notes* should not be duplicated at both codes/blocks.
Special signs/Annotations	• dagger symbol applied to an aetiology code concept subject to dagger/asterisk dual classification, denoting a full-time dagger • asterisk symbol applied next to the code of a manifestation concept, subject to dagger/asterisk dual classification • ACS symbol is applied to codes/categories/ranges/chapters that are specifically mentioned in the ACS *Directives, Notes* or *Exceptions*.
Residual codes	• for new fourth character level codes: – specific conditions – use characters 0 to 7 – specific conditions that are not classified elsewhere ('other') – use character 8 – unspecified conditions ('NOS') – use character 9 • for new fifth character level codes: – specific conditions – use characters 1 to 8

Convention	Principles
	– specific conditions that are not classified elsewhere ('other') – use character 9 – unspecified conditions ('NOS') – use character 0.
Placeholder codes	Diseases of national significance (U75–U77) are activated by IHACPA, in consultation with CCAG, by considering the following principles to inform decisions under the ICD-10-AM placeholder code activation framework: • **Classification gap** The disease, condition or external cause cannot be uniquely or adequately classified within existing ICD-10-AM/ACHI/ACS codes. • **System relevance and utilisation** The condition is expected to occur at sufficient frequency in admitted episodes of care to support consistent and meaningful code assignment. • **National significance** The condition is recognised as a priority at a national level, including emerging health threats or areas of significant clinical, public health or policy interest. • **Data value and necessity** Assignment of a placeholder code will provide data that is not available, or cannot be reliably derived, from other national data collections, and will support a clearly defined national purpose. Diseases of uncertain aetiology or emergency use (U00–U49) are activated on advice from WHO, consistent with international classification requirements.

Table 4: Development principles for the ICD-10-AM Alphabetic Index

Convention	Principles
Cross references	• cross references are used rather than duplicating the subterms at a different lead term • *See* is used for the preferred alternative indexing term; a code is never provided at a *See* cross reference • *See also* is used for an alternative indexing term where subterms provide more specificity • *See condition* is used where an alternative index pathway is required; a code is never provided at a *See condition* cross reference • *Code to* is used for a code range where the same fourth or fifth character code may be applied, and the three character category is defined within that code range; a code range or a fourth or fifth character is provided at a *Code to* reference
Structure	• essential modifiers: – listed in alphabetic order – list prepositional terms (including those in parentheses) in alphabetic order, then remaining terms in alphabetic order • nonessential modifiers: – must not appear as essential modifier at the same level under a lead term
Lead terms	• listed in alphabetic order
Subterms	• prepositional terms are sequenced immediately following the lead term • in (due to) indicates a causal link
Content decision	• It is not necessary for every item to be individually indexed. For example, where a drug is listed by its generic name, it is classifiable. Therefore, it is not necessary for every known variation to be separately indexed. If a drug is not listed, it is classifiable by the type (class) of drug.

Table 5: Development principles for the ACHI Tabular List

Convention	Principles
Chapter	• structure of the intervention classification is based on anatomy rather than surgical specialty • chapters generally align with the chapter headings of ICD-10-AM to maintain parity with the disease classification
Block	• nonsurgical interventions are listed separately from surgical interventions • codes are listed from most to least invasive within the block
Code	• seven characters in length • first five characters (the stem) should be used for similar concepts, with more specific intervention concepts differentiated with distinct codes for the final two characters (the extension) • extension of 'XX' is used for an ACHI code where a two character extension code is provided in detail in the Tabular List • provider neutral, where possible • diagnostic terms are avoided, where possible • for new codes, the following basic concepts apply: – Insertion/Implantation, Adjustment and Removal/Excision – Unilateral, or single interventions performed (e.g. code applied per session) • for enhancing existing codes, frequency data may be used to support refinement to include: – revision/replacement – bilateral, or ranges of interventions performed (for example, less than 10 sessions, 11-20 sessions) • new MBS items to replace 9-series codes are incorporated, resulting in renumbering of an existing ACHI concept • new MBS items which are already classified to a previous MBS item number where the classification concept remains unchanged, are not updated, but mapped instead • clinical advice may be required to determine if a new code should pre-coordinate open or endoscopic approaches • allied health interventions are limited to registered professions
Description	• spelling of terms are consistent with similar terms in the block range or chapter • preference to use scientific terminology over eponyms • 'and' implies 'and'; 'or' implies 'or'
***Inclusion* terms**	• uses the same principles as Description, except eponyms may be used as *Inclusion* terms • *Inclusion* terms must appear in the Alphabetic Index
***Instructional* notes/terms**	• listed in the following order, then in block number order within each Instructional note: – *Glossary description* – *Includes* – *Note* – *Code first, Code also, Code also when performed* – *Excludes* – *See* (within other Instructional notes) • other:

Convention	Principles
	– extensions only apply to the specified code range. Site extensions may apply to multiple specified blocks – diagnostic terms are located in the *Note* – *Excludes notes* are located at the broader concept to redirect users to more specific concepts, if applicable. *Excludes notes* are not duplicated at both codes/blocks
Placeholder codes	Provisional use codes for new or emerging health technologies (block **[8888]**) are activated by IHACPA, in consultation with CCAG, by considering the following principles to inform decisions under the ACHI placeholder code activation framework: • **Classification gap** The intervention cannot be uniquely or adequately captured within existing ACHI codes, including where an existing code does not distinguish a new technique or approach (for example, minimally invasive delivery). • **System relevance and utilisation** The intervention is currently delivered, or is expected to be delivered, in Australia with sufficient activity to support consistent and meaningful code assignment. • **National and system applicability** The intervention has applicability within the Australian health system, including anticipated uptake and relevance to clinical practice. • **Data value and necessity** Assignment of a placeholder code will generate data that is not otherwise available, or cannot be reliably identified, within existing classification or national collections, and will support a clearly defined purpose, including monitoring uptake and informing classification development. • **Potential clinical or patient impact** There is a reasonable expectation that the intervention may improve patient outcomes or experiences. Formal inclusion within ACHI will occur in a future edition once an MBS item is approved for the intervention or there is a clinical recommendation to do so based on activity. Emergency use codes (**block [8889]**) support the immediate capture of interventions where timely data collection is required for emerging health system priorities. Activation is determined by IHACPA.

Table 6: Development principles for the ACHI Alphabetic Index

Convention	Principles
Cross references	• *See* is used for the preferred alternative indexing term; a code is never provided at a *See* cross reference • *See also* is used for an alternative indexing term where a subterm provides more specificity • *See block* is used where the code assigned may be selected from the *Instructional* notes within the ACHI Tabular List • *Code specific procedure performed* is used where an alternative index pathway is required; a code is never provided at this cross reference • *Omit code* is used to indicate a code should not be assigned as it may represent an intervention component; a code is never provided at this cross reference • cross references are used rather than duplicating a subterm at a different lead term
Structure	• essential modifiers: – listed in alphabetic order – lists prepositional terms in alphabetic order, then remaining terms in alphabetic order • nonessential modifiers: – must not appear as an essential modifier at the same level under a lead term – well-known product names may be used, where applicable – well-known abbreviations are adjacent to the applicable code
Lead terms	• listed in alphabetic order

Table 7: Development principles for the ACS

Convention	Principles
Coding standard number	• reference for an ACS is four digits, with the first two digits representing the chapter to which the ACS belongs (general standards have the first two digits of 00)
Coding standard content	• coding standards must contain advice that cannot be covered by classification convention alone • existing ACS may be retired with the advice converted into classification convention or content in the Alphabetic Index or Tabular List as required • inclusion of clinical information should be minimised to support currency • title must have the expanded concept with any common abbreviation included in parentheses • ACS and relevant sub-sections must be indexed in the ACS Standards Index • codes are assigned to ACS 0049 *ICD-10-AM codes that must never be assigned* where they are deemed not relevant for the Australian health care setting but must be retained in the classification for legacy purposes.
Directives	• *Directives* are the main classification points, are numbered and written in the affirmative as action statements • *Directives* should flow in a logical sequence
Examples	• scenarios or examples provide context to the classification guidelines; they are not a complete representation of an entire episode of care and should not be inferred to have meaning beyond the specific guidelines • provided where necessary to illustrate coding directives and include a rationale as to why relevant codes are applied • *Examples* directly support applying the guidelines in that ACS, not a broader range of concepts • code titles use the Electronic Code List (ECL) description
Appendices	• support the application of the ACS • do not contain coding guidelines
Glossary	• terms must be specific to the application of the ACS • does not include clinical terms or definitions

6. Resources

When finalising a new edition of ICD-10-AM/ACHI/ACS there are a range of resources available to support implementation.

Licensing

ICD-10-AM/ACHI/ACS is a licensed classification system. Classification resources are available for access or purchase in Australia, however countries outside Australia must be licensed to use the ICD-10-AM/ACHI/ACS classification system.

6.1 Classification resources

Classification volumes ICD-10-AM Alphabetic Index ICD-10-AM Tabular List ACHI Alphabetic Index ACHI Tabular List ACS	The Tabular Lists contain the classification, the Alphabetic Indices are used to locate terms for code assignment, and the ACS provides guidance on the application of ICD-10-AM and ACHI.
Mapping tables for ICD-10-AM and ACHI	Demonstrate the relationship between the codes in 2 concurrent editions of ICD-10-AM/ACHI. Mapping tables are also available for: • ICD-10-AM and ICD-10 • MBS and ACHI • supplementary codes for chronic conditions.
Electronic code lists (ECLs) for ICD-10-AM and ACHI	Electronic files that are used in the development of software or are integrated into existing patient software.
The Chronicle	Documents changes and the rationale for change between editions of ICD-10-AM/ACHI/ACS.
Summary of updates	A high level summary of the changes for that edition and the submissions that were considered for development.
Errata	Issued post-publication to correct errors.
Unacceptable diagnosis codes	Electronic file that lists unacceptable diagnosis codes.

Access current edition classification resources.

6.2 Education resources

Learning resources are released before each new edition of ICD-10-AM/ACHI/ACS is implemented, to help users become familiar with the major changes. The education program is designed to be comprehensive and accessible and may be delivered in a range of formats. Additional supporting documents are also provided to assist with implementation.

ICD-10-AM/ACHI/ACS new edition education	eLearning modules available on IHACPA Learn
Reference to changes for ICD-10-AM/ACHIACS	Details ICD-10-AM/ACHI/ACS changes for that edition, including the Alphabetic Index
Frequently asked questions	Responses to queries to clarify new edition content
Fact sheets	Outlines key information and major changes for the new edition

6.3 Requests for classification guidance

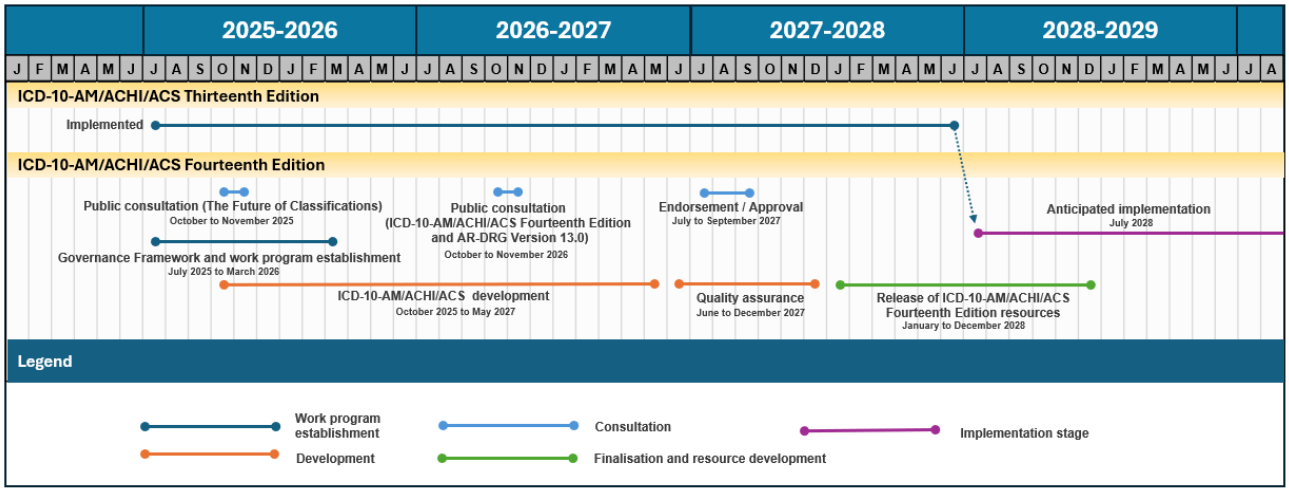
During the development cycle, classification guidance requests (coding queries) from jurisdictional coding advisory committee representatives are reviewed.

Queries that contribute to the broader understanding and correct application of ICD-10-AM/ACHI/ACS are published as the National Coding Advice. If existing conventions or advice already provide sufficient guidance, a response is provided directly without publication.

7. Fourteenth Edition timelines and milestones

ICD-10-AM/ACHI/ACS is developed over a 3-year cycle, balancing the need for clinical currency with the stability required for high-quality data, while minimising the administrative burden of implementing new editions of ICD-10-AM/ACHI/ACS. Figure 4 shows the development cycle for the ICD-10-AM/ACHI/ACS Fourteenth Edition, covering the period from 2025–26 to 2028–29.

Figure 4: Anticipated timelines for ICD-10-AM/ACHI/ACS Fourteenth Edition



There are key dependencies between ICD-10-AM/ACHI/ACS, AR-DRGs, AN-SNAP and the AECC classifications. To maintain alignment across these interrelated classifications, their development and updates occur concurrently throughout the cycle.

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