



IHACPA

Development of IHACPA Classifications

Volume 3 AR-DRGs

Version 1.0
March 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 3 AR-DRGs – Version 1.0

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Abbreviations

Abbreviations	Full term
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADRG	Adjacent Diagnosis Related Group
AR-DRGs	Australian Refined Diagnosis Related Groups
CAC	Clinical Advisory Committee
CCAG	Classifications Clinical Advisory Group
CPB	Cardiopulmonary bypass
CSV	Comma-Separated Values
CVS	Continuous ventilatory support
DCL	Diagnosis Complexity Level
DRG	Diagnosis Related Group
DTG	Diagnosis Related Groups Technical Group
ECC Model	Episode Clinical Complexity Model
ECCS	Episode Clinical Complexity Score
ECMO	Extracorporeal membrane oxygenation
GI	General Intervention
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
IHACPA	Independent Health and Aged Care Pricing Authority
JAC	Jurisdictional Advisory Committee
MBS	Medical Benefits Schedule
MDC	Major Diagnostic Category
TAC	Technical Advisory Committee
WHO	World Health Organization

1. Purpose

The Australian Refined Diagnosis Related Groups (AR-DRGs) is a casemix classification system that groups patients into categories that are both clinically similar and expected to require similar levels of health care resources. It is used primarily for admitted patient care.

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 3 AR-DRGs** builds on the foundations set in Volume 1 and provides detailed guidance for developing AR-DRGs. It outlines the key development principles, the processes for development and approval, and the classification resources that are produced.



Volume 3 AR-DRGs

This volume should be read together with [Volume 1 Governance Framework](#). Together, volumes 1 and 3 comprise the full governance framework for the development of **AR-DRGs**.

[Volume 2 ICD-10-AM/ACHI/ACS](#) provides additional information about key foundational concepts that form part of AR-DRG development.

2. AR-DRGs

The 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, while in the private sector they are predominantly used in funding agreements between private hospitals and health care insurers. AR-DRGs are also used for service planning, epidemiology and health research.

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 ICD-10-AM/ACHI/ACS

The following classifications are an essential input to the AR-DRG classification:

- **International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (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.
- **Australian Classification of Health Interventions (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.
- **Australian Coding Standards (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, this classification system is referred to as ICD-10-AM/ACHI/ACS and is used for capturing clinical information for admitted patient care.

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 ICD-10-AM/ACHI/ACS, refer to [Volume 2 ICD-10-AM/ACHI/ACS](#).

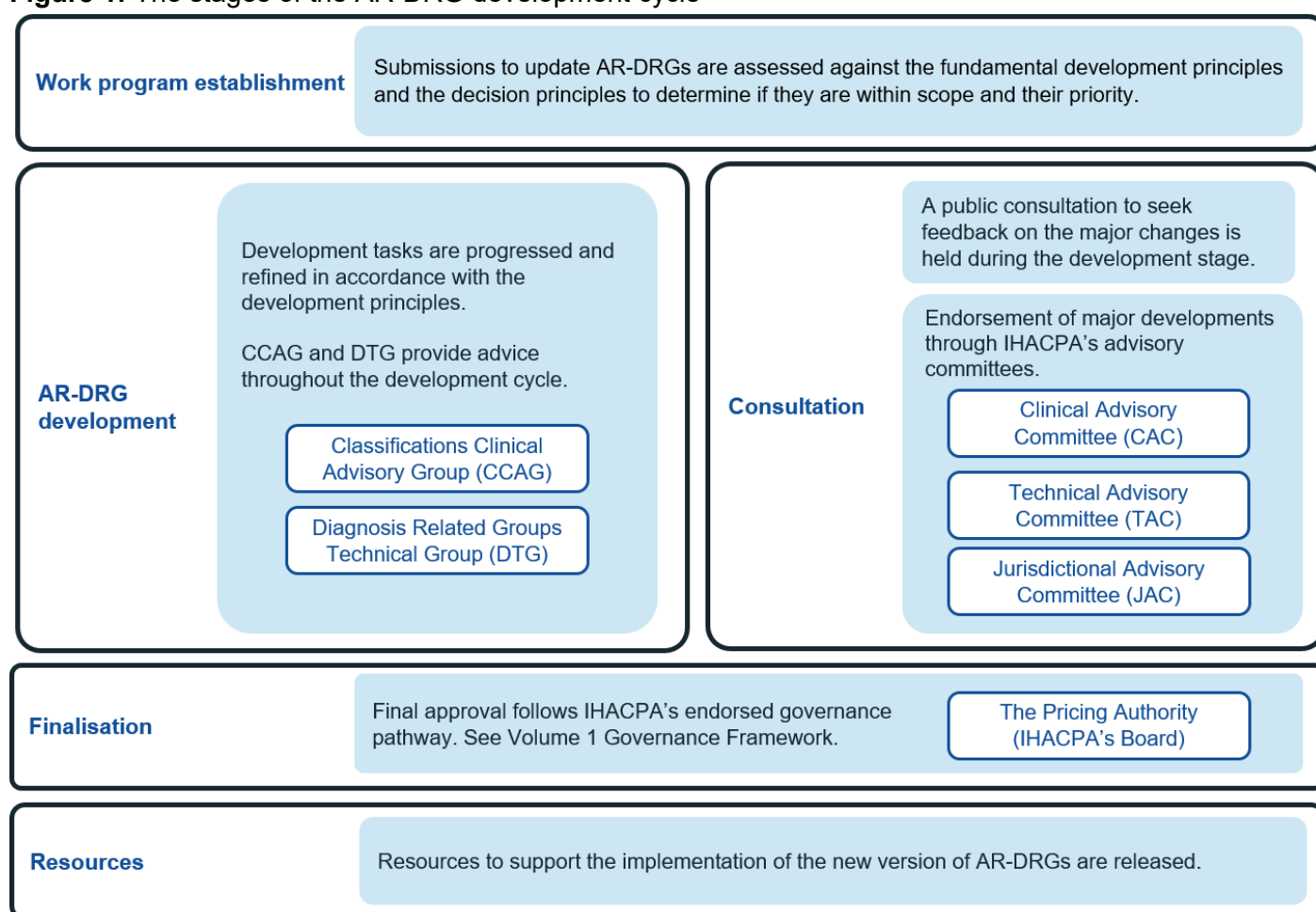
3. The development process

3.1. Stages of the development cycle

The development of AR-DRGs 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 and ensures the classifications remain stable and current.

Figure 1: The stages of the AR-DRG development cycle



3.1.1 Advisory groups

The Diagnosis Related Groups Technical Group (DTG), the Classifications Clinical Advisory Group (CCAG) and their broader networks provide expert input into AR-DRG development, as summarised in Table 1.

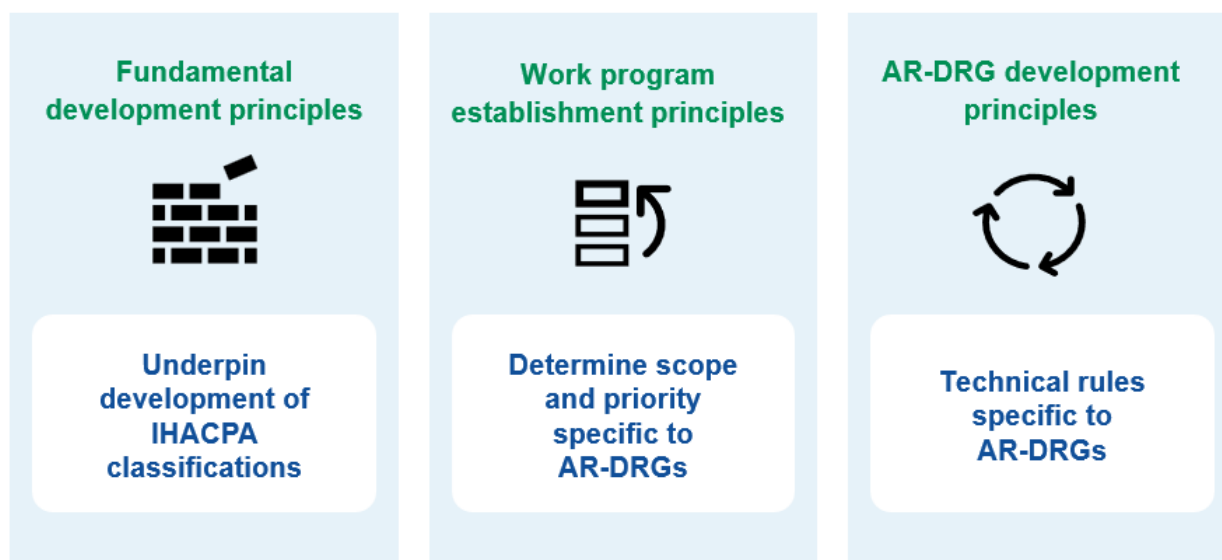
Table 1: Role of advisory groups

Group	Description
<u>Classifications Clinical Advisory Group (CCAG)</u>	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.
<u>Diagnosis Related Groups Technical Group (DTG)</u>	Provide expert classification and technical advice. Membership includes representatives from all jurisdictions, public and private healthcare organisations.

3.2. Principle based development

The AR-DRG classification 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.

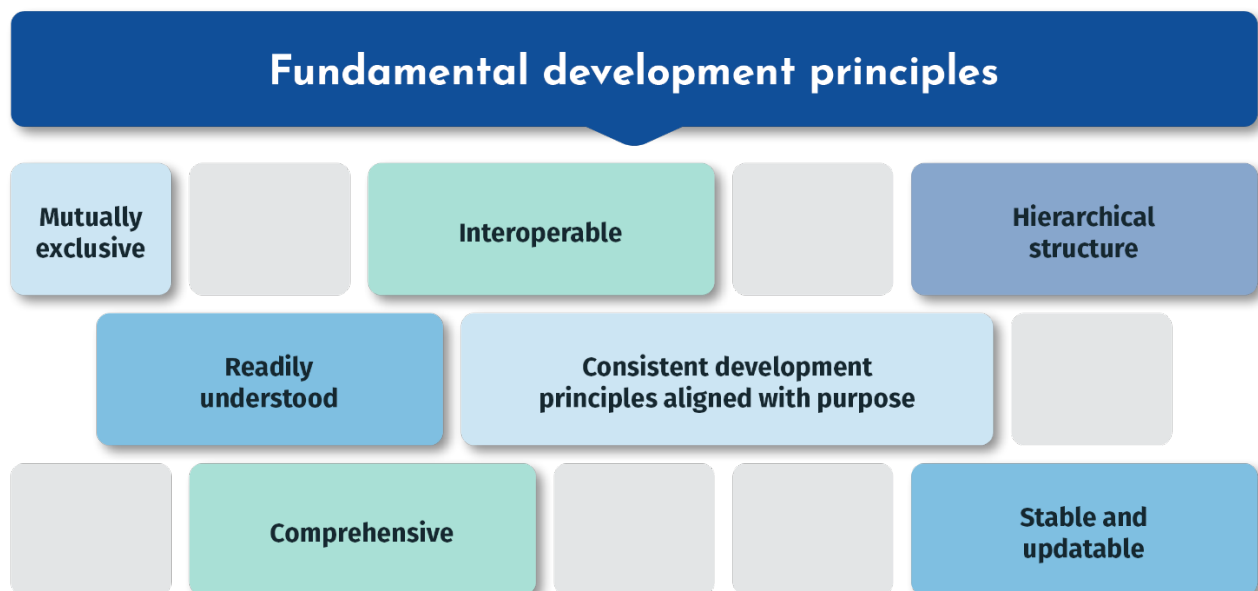
Figure 2: The 3 categories of principle based development



3.2.1 Fundamental development principles

The fundamental development principles are listed in the **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 AR-DRG development principles.

Figure 3: Fundamental development principles



4. Work program establishment

Stakeholder submissions to update AR-DRGs 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, service models and activity patterns, while maintaining conceptual consistency and stakeholder understanding over time
- **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 AR-DRG development.

Out of scope submissions include those that:

- are not clinically relevant
- are based on service provider characteristics rather than clinical characteristics
- cannot be evaluated using datasets accessible by IHACPA
- relate to pricing rather than AR-DRGs (for example, the Hospital Acquired Complications [HACs] List Specifications)
- relate to clinical coding issues in the underpinning disease and intervention classifications
- are unique to an AR-DRG version no longer supported by IHACPA. That is, [AR-DRG Version 8.0 and prior](#).

Concepts identified as out of scope may be better addressed by other IHACPA classifications, through policy development, education, enhancements to data collection systems, improved costing practice, or through pricing adjustments.

4.1.2 Prioritisation principles

All submissions deemed in scope are then assessed against the prioritisation principles.

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 AR-DRG development tasks

Priority	Criteria for priority level
High priority (standard refinements for each new version of AR-DRGs)	• performance monitoring of the existing classification to identify areas for review • review of public submissions and issues related to Adjacent Diagnosis Related Group (ADRG) 801 <i>General Intervention unrelated to principal diagnosis</i> that affect a relatively high number of episodes¹ • review of the intervention hierarchy using the latest cost and activity data • review and refinement of the Episode Clinical Complexity (ECC) Model to maintain clinical currency and cost homogeneity, including: - review of codes in scope for receiving a Diagnosis Complexity Level (DCL) - recalibration of the DCLs using the latest cost and activity data - review of splitting thresholds for end classes. • integration of changes emanating from the underpinning ICD-10-AM/ACHI/ACS classification system.
Medium priority	• issues that demonstrate significant material impact on the classification as measured by episodes affected or costs involved² • issues that affect a wide range of Major Diagnostic Categories (MDCs) or ADRGs • issues related to changes in clinical practice and technology that can be assessed using sufficient and available data • known limitations of the classification that warrant review due to the length of elapsed time from previous review and a review is timely due to clinical advances • issues that arise from observed changes in activity and cost data (for example, where increased uptake of a procedure may indicate the need for a new ADRG) • issues that relate to alignment of IHACPA classifications (for example, opportunities for harmonisation and improving consistency across IHACPA classifications).
Low priority	• a submission is assigned as low priority if it does not meet any of the principles in high or medium priority • are grouping anomalies that affect a limited number of episodes and are immaterial.

¹ Issues related to ADRG 801 *General Intervention unrelated to principal diagnosis* that affect more episodes will be prioritised when capacity is limited. Those affecting fewer episodes may be held over for a future development cycle.

² IHACPA will rank and select submissions based on their material impact on the classification and progress classification development accordingly.

5. AR-DRG development

AR-DRG updates are developed in line with the established classification development principles. Throughout this stage, we seek expert technical and clinical advice from our advisory groups. This ensures the updates are appropriate, reflect the intended classification logic and are fit for purpose.

5.1. AR-DRG development principles

The AR-DRG development principles (Table 3) outline 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.

Development is informed by the most recently available activity and cost data at the start of the development cycle.

Principles governing the development of AR-DRGs are outlined in Table 3–13.

Table 3: Primary AR-DRG classification development principles

Primary AR-DRG classification development principles	
Clinical coherence	• Episodes within a class must share similar characteristics, including principal and additional diagnoses, interventions and treatment.
Resource homogeneity	• Episodes within a class must have a similar pattern of resource utilisation, while variation in resource use between classes should be substantial.
Statistical validity	• The cost pattern within each AR-DRG class and the differences between classes, must be reliably explained by the clinical and demographic variables used in the grouping logic.
Evidence-based development	• Development will be informed by international best practice, specialist advice and data analysis. All changes to the AR-DRG classification must be supported by hospital activity and cost data that can be accessed by IHACPA.
Integration with underpinning disease and intervention classification	• The AR-DRG classification must align with the underpinning edition of ICD-10-AM/ACHI/ACS.
Stability	• The stability principle in the Volume 1 Governance Framework recognises the need for classifications to remain stable over time while enabling updates in response to changes in clinical practice, coding systems, and the

Primary AR-DRG classification development principles

prevalence or cost of services. In the context of the AR-DRG classification, this principle is interpreted as:

- Episodes may group to different end classes across AR-DRG versions, and the profile of an end class may change over time. However, such changes should arise only from:
 - improved adherence to the AR-DRG development principles in more recent AR-DRG versions
 - updates to ICD-10-AM/ACHI/ACS
 - changes in the underlying patterns of admitted patient activity and cost data.
- AR-DRG development is undertaken with a view to minimising change due to other factors, to preserve longitudinal comparability and system stability.

Table 4: Major Diagnostic Category (MDC) principles

MDC principles

MDCs are mutually exclusive categories into which all possible principal diagnoses fall. The diagnoses in each category correspond to a single body system or aetiology, broadly reflecting the specialty providing care.

The principles:

- An MDC must capture episodes of care relating to a particular body system or aetiology
- Every episode is grouped into an MDC as an initial step based on its principal diagnosis, referred to as the episode's native MDC
- The native MDC may only differ from an episode's final MDC if the episode:
 - includes insertion of an artificial heart device
 - includes a liver, heart, lung, kidney or bone marrow transplant
 - pertains to an infant younger than one year old with extreme prematurity
 - pertains to care for multiple major trauma
 - pertains to a patient with paraplegia or quadriplegia
 - is grouped to a Pre MDC end class
- Fewer than half of the episodes in each MDC should be grouped to either:
 - a residual ADRG, defined by the absence (rather than presence) of specific diagnoses or interventions; most residual ADRGs begin with the word 'Other' (for example, ADRG D12 *Other ear, nose, mouth and throat interventions*)
 - ADRG 801 *General Intervention unrelated to principal diagnosis*.

Table 5: Pre MDC end class principles

Pre MDC end class principles	
MDC 00 Pre MDC contains episodes that are more appropriately classified by interventions that are inherently very high cost (for example, ADRG A13 <i>Ventilatory support 336 hours or more</i>) where the intervention overrides the outcome of the principal diagnosis based MDC assignment.	
A Pre MDC end class must meet at least 2 of the following criteria	- episodes are clinically considered to be more appropriately classified according to treatment provided rather than principal diagnosis - there is an inherently high cost in the treatment provided - the end class does not relate exclusively to a particular body system or aetiology.

Table 6: ADRG principles

ADRG principles
ADRGs are clinically meaningful categories that are generally defined by the same principal diagnosis or intervention codes. The principles include:
- an ADRG must demonstrate both clinical coherence and resource homogeneity - an ADRG must contain enough episodes to allow for the assessment of statistical homogeneity, and a sufficient volume to support reliable benchmarking and performance management; an indicative minimum is 200 episodes per year, subject to review - for development submissions requesting new ADRGs, placement within an existing ADRG must be considered in the first instance - diagnosis codes for conditions that require similar clinical management and have comparable resource use may be grouped to the same medical ADRG, even when the underlying aetiology differs. For example, pre-existing hypertension complicating pregnancy is assigned to the same medical ADRG as gestational pregnancy-induced hypertension.

Table 7: Guiding principles for intervention type

Guiding principles for intervention type	
The guiding principles for intervention type determine whether an ACHI code is suitable to form part of the definition of an ADRG in the intervention partition. The category into which the ACHI code falls is called its intervention type.	
1. An intervention does not inform grouping to the intervention partition if it meets one of the following criteria	- the intervention is routinely performed as a part or component of another intervention - the intervention is an assessment, evaluation, examination, or radiological imaging - the intervention is a non-incisional insertion, removal or replacement of an implant or device - the intervention is pharmacotherapy or dialysis – ADRGs informed by these procedures are defined by ICD-10-AM codes - the intervention is represented by an ACHI placeholder code.
2. An intervention informs grouping to the intervention partition of certain MDCs if it meets one of these criteria	- the intervention is suitable to be performed in a specialist procedure suite, whether or not such a suite is available - the intervention is one that defines existing intervention ADRGs: - continuous ventilatory support (CVS) - extracorporeal membrane oxygenation (ECMO) - cardiopulmonary bypass (CPB) in open-heart surgery.

Guiding principles for intervention type	
3. An intervention is referred to as a General Intervention (GI) and generally informs the intervention partition of all MDCs, if it meets each of these criteria	- the intervention is invasive in nature - the intervention requires general anaesthesia or regional anaesthesia (for example, spinal or epidural anaesthesia). Excluding situations in which a patient's age or medical condition necessitates or prevents the use of a particular type of anaesthesia - the intervention requires specialised surgical training or skills.

Table 8: ADRG hierarchy principles

ADRG hierarchy principles	
Intervention ADRGs fall into one of the following ADRG types:	
- those relating to a defined procedure or single anatomical structure (for example ADRG I09 <i>Spinal fusion</i>) - those that do not encompass an entire MDC (for example, C14 <i>Other corneal, scleral and conjunctival interventions</i>) - those that do encompass an entire MDC (residual ADRGs) (for example, X06 <i>Other interventions for other injuries</i>) - is in ADRG 801 <i>General Intervention unrelated to principal diagnosis</i>.	
Intervention ADRGs are placed into hierarchically ordered groups, based on their similarity.	
Clinical ordering of interventions	In the intervention hierarchy interventions are ordered: - from most specific to least specific, in descending order of specificity - from the initial, definitive intervention, to follow-up and supportive interventions - from most invasive through to the least invasive interventions - from treatment to diagnostic interventions - those containing GIs are placed above ADRGs without GIs, except for ADRG 801 <i>General Intervention unrelated to principal diagnosis</i>, which is placed last in the intervention hierarchy within an MDC.
Cost ordering within each group	Within each hierarchical group, ADRGs are sorted from highest to lowest cost, considering: - measures of central tendency (for example, mean and median) - the overall distribution of costs for each ADRG.

Although cost is generally considered after the clinical and structural criteria above, the principles are applied pragmatically to ensure the final hierarchy remains clinically coherent and resource homogeneous.

Table 9: Diagnosis Related Group (DRG) principles (subject to review)

DRG principles	
DRGs are end classes within an ADRG that contain episodes with similar levels of resource utilisation.	
DRG principles inform how each ADRG is split into end classes. Sometimes, the principles may be applied flexibly (for example, high volume ADRGs such as ADRG O60 <i>Vaginal delivery</i>).	
A DRG must:	
• contain at least 200 episodes per year, except for ADRGs with inherently low episode volumes • have a minimum total cost of \$1 million per year • include at least 10% of episodes within the ADRG • meet at least one of the following cost based criteria: - absolute difference in mean cost between consecutive DRGs is $\geq \\$3,700$ - relative difference in mean cost between consecutive DRGs is ≥ 2-fold. • be an inverse trend between the number of episodes and the complexity level of the DRG, that is higher complexity DRGs should generally have fewer episodes.	

Table 10: Threshold selection principles

Threshold selection principles	
The Episode Clinical Complexity Score (ECCS) thresholds for DRG end classes are selected using these criteria	• AR-DRG V12.0 ECCS thresholds are selected when they meet DRG principles and perform comparably to the best available simulation • where AR-DRG V12.0 thresholds do not meet these requirements a simulation with the same number of DRGs as AR-DRG V12.0 is selected • if an ADRG is affected by a development task then the number of splits is revised based on the optimum statistical performance • if an ADRG split is recommended in 2 consecutive versions then the number of splits is revised based on optimum statistical performance.

Table 11: Principles for diagnosis exclusions from the complexity model

Principles for diagnosis exclusions from the complexity model	
Diagnosis codes may be:	
• unconditionally excluded (always removed) • conditionally excluded (removed only when co-occurring with certain diagnosis codes).	
Diagnosis codes are excluded from the ECC Model if they	• represent undefined or ill-specified conditions • represent symptoms, findings or transient conditions • provide additional or contextual information only • are unacceptable principal diagnosis codes • represent asymptomatic or sub-clinical conditions • represent markers of other diseases • represent minor conditions that do not generally lead to an admitted episode of care • represent an underlying cause of disease as defined by the dagger/asterisk convention in ICD-10-AM.

Table 12: Mapping principles

Mapping principles	
Historical mapping	• Historical mapping is the process of identifying equivalent ICD-10-AM and ACHI codes across different editions to support data analysis and DRG grouping when data is coded using different editions. • When a new ICD-10-AM or ACHI code is introduced, it is mapped backward to a corresponding code in the previous edition. • When a code is deleted, it is mapped forward to a relevant code in the new edition.
DRG mapping	• DRG mapping allocates new or revised ICD-10-AM and ACHI codes to an appropriate DRG while preserving key diagnostic and procedural attributes. • Although the DRG map usually matches the historical map, a different mapping may be selected where it results in more appropriate grouping outcomes. At a minimum, the following principles apply: - the intervention type of an ACHI code is preserved - a diagnosis code that is an unacceptable principal diagnosis is mapped backward and forward to another diagnosis code that is an unacceptable principal diagnosis - a diagnosis code that is unconditionally excluded is mapped backward and forward to another diagnosis code that is unconditionally excluded.

Table 13: Principles for new diagnosis codes used in the ECC Model

Principles for new edition diagnosis codes used in the ECC Model
• As data for new ICD-10-AM codes³ or activated placeholder codes will only be available after their implementation, new edition ICD-10-AM codes that are deemed in-scope within the complexity model cannot have an accurate DCL assigned due to the absence of data from which a DCL can be derived. Therefore, the DCL values for these codes must be estimated based on existing data. • Each new ICD-10-AM code or activated placeholder code that is in-scope within the complexity model is assigned the same DCL value as the code to which it is backward mapped.

³ For Fourteenth Edition, 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, refer to Volume 2 ICD-10-AM/ACHI/ACS.

6. Resources

When finalising a new version of AR-DRGs, we provide a range of resources to support implementation.

Licensing

AR-DRGs 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 and AR-DRG classification systems.

6.1 Classification resources

Definitions manual	Provides a high-level understanding of DRG grouping logic and assists with the identification of likely DRG assignments for individual episodes of care. The AR-DRG V12.0 Definitions Manual is made up of 3 volumes: • Volume One: DRGs A13A–I80Z • Volume Two: DRGs J01A–Z66Z • Volume Three: Appendices. The appendices found in volume 3 are also provided in Excel format on the IHACPA website. The definitions manual does not contain all data quality checks, or the necessary information to calculate the ECCS. Therefore, it does not function as a substitute for AR-DRG grouper software.
Final report	Details the refinement process, including the changes made and the rationale for those changes.
Technical specifications	Details the methodology and technical specifications used in the development of the new AR-DRG version, including: • data preparation and modification • ADRG intervention hierarchy review • derivation of the ECCS • ADRG splitting review.

Descriptions	A complete list of long and short descriptions for MDCs, ADRGs and DRGs displayed in an Excel format. These are available on the IHACPA website.
AR-DRG grouper specifications	Licensed reference files that facilitate the development of software to group episodes of care into DRGs, including: • logic tables in Comma-Separated Values (CSV) format • reference tables in CSV format • user guide for developers.

[Access current version classification resources](#)

6.2 Education resources

Learning resources are released before each new version of AR-DRGs is implemented. The education program is designed to familiarise users with the fundamental structure of the AR-DRG classification and the major changes introduced in the new version.

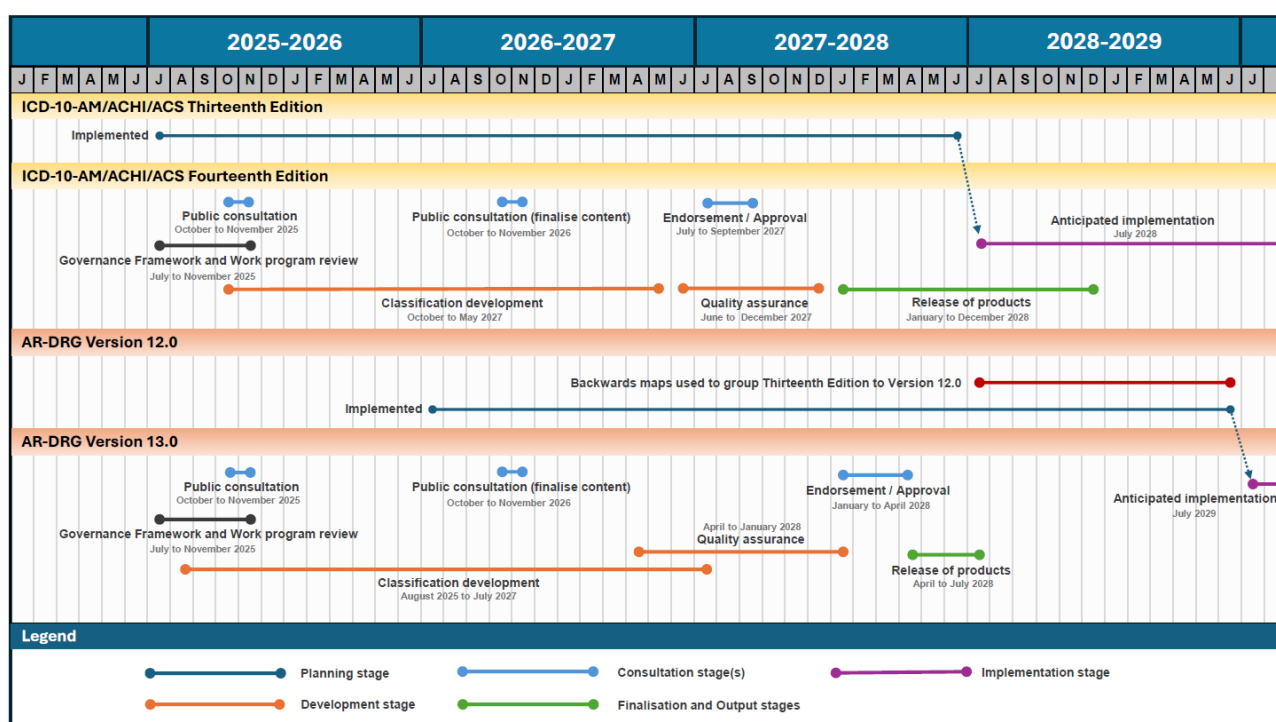
AR-DRG new version education	eLearning modules available on IHACPA Learn .
Fact sheet	Outlines key information and major changes for the new version of AR-DRGs.

7. AR-DRG Version 13.0

timelines and milestones

The development cycle of the ICD-10-AM/ACHI/ACS and AR-DRG classification systems operates on a 3-year cycle. This approach balances clinical currency with data stability, while minimising the administrative burden of implementing new AR-DRG versions. Figure 4 illustrates the 3-year development cycle for AR-DRG V13.0 and 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 and AR-DRG V13.0



Due to the key dependencies between the ICD-10-AM/ACHI/ACS and AR-DRG classifications, they are developed concurrently to ensure these dependencies are maintained.

ICD-10-AM/ACHI/ACS is released several months before the AR-DRG classification. However, the AR-DRG classification is generally implemented one year after the implementation of ICD-10-AM/ACHI/ACS.



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