Independent Hospital Pricing Authority

Governance framework for the development of the admitted care classifications

Draft for Comment

October 2020

IHPA

Version history

Version	Effective Dates	Description
Draft for comment	October 2020	New framework incorporating previous documents ICD-10-AM/ACHI/ACS Governance and Consultation (September 2019) and AR-DRG Governance and Consultation Process (September 2017). Additional information has been incorporated in response to the *Consultation and review of the AR-DRG and ICD-10-AM/ACHI/ACS Classification Systems* (February 2020).

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Abbreviations

ABF	Activity based funding
ACE	Australian Classification Exchange
ADA	Australian Schedule of Dental Services and Glossary
ADRG	Adjacent Diagnosis Related Groups
APC NMDS	Admitted Patient Care National Minimum Data Set
AR-DRG	Australian Refined Diagnosis Related Groups
CCAG	Classifications Clinical Advisory Group
CHADx	Classification of Hospital Acquired Diagnoses
ECC	Episode Clinical Complexity
ECCS	Episode Clinical Complexity Score
ECL	Electronic code list
DCL	Diagnosis Complexity Levels
DRG	Diagnosis Related Group
DTG	Diagnosis Related Groups Technical Group
HAC	Hospital Acquired Complications
ICD-10	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
ICD-10-AM/ACHI/ACS	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)
ICD-11	ICD Eleventh Revision
ICD-O	International Classification of Disease (ICD) in Oncology
ICHI	International Classification of Health Interventions
IHPA	Independent Hospital Pricing Authority
ITG	International Classification of Diseases Technical Group
MBS	Medicare Benefits Schedule
MDC	Major Diagnostic Category
NHDISC	National Health Data and Information Standards Committee
NHRA	National Health Reform Agreement
WHO	World Health Organization

1. Purpose

The development of classifications for admitted patient care are undertaken by the Independent Hospital Pricing Authority (IHPA). In Australia, the classification and standards used for admitted patient care include:

- 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)
- Australian Refined Diagnosis Related Groups (AR-DRG).

The *Governance framework for the development of the admitted care classifications* (the Framework) outlines the classification development and approval process, the guiding principles and classification products that are the result of the classification development cycle.

The Framework will be updated with each new classification development cycle to ensure it, and the classifications that it governs, remain fit for purpose and relevant to the Australian healthcare system.

2. Background

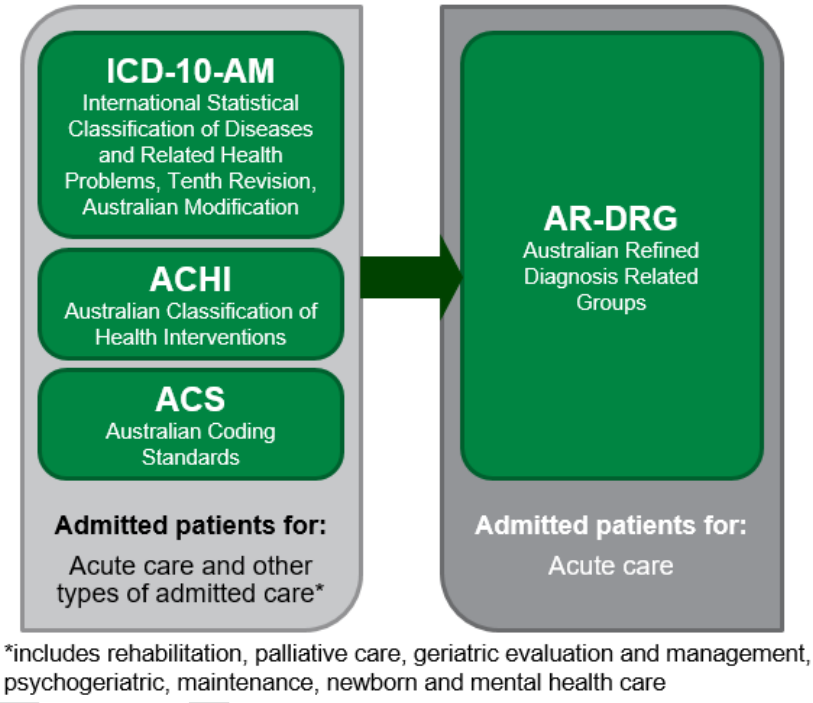
2.1 Admitted care classification systems

In Australia, the classifications and standards used for admitted patient care are:

- ICD-10-AM/ACHI/ACS that captures clinical activity in the admitted patient setting
- AR-DRGs that relate, or group, similar patient acute admitted episodes of care to the resources required in treatment.

These classifications are interrelated but have different use cases which is illustrated in **Figure 1**.

Figure 1. ICD-10-AM/ACHI/ACS, used for all admitted patient care, underpins AR-DRGs used for acute care.



The 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 is utilised to classify diseases and other health related problems, while the ACHI classifies procedures and interventions and was originally based on the Medical Benefits Scheme (MBS). The ACS are a set of instructions designed to be used to apply ICD-10-AM and ACHI to correctly classify episodes of care. Collectively known as the ICD-10-AM/ACHI/ACS classification system, it is used to capture clinical activity for admitted patient care, and is used for a number of purposes, including:

- identifying patterns and disease trends
- clinical research and management
- research into the quality of healthcare and patient safety.

The AR-DRG classification uses the ICD-10-AM/ACHI/ACS classification system along with other routinely collected data to classify episodes of acute care in public and private hospitals across Australia. AR-DRGs provide a clinically meaningful way of relating the number and types of acute admitted patients to the resources required by the hospital.

AR-DRGs are used for a number of purposes, including:

- benchmarking
- epidemiology
- facilitation of payment of services in the private healthcare sector
- health service planning
- performance management.

AR-DRGs and the underpinning ICD-10-AM/ACHI/ACS capture acute admitted activity and are utilised in calculating the National Efficient Price for public hospital funding.

2.2 Processes related to classification development

There are additional processes that are not covered in the Framework. Further information on these processes can be found on IHPA's website:

- Submission of classification queries: ace.ihpa.gov.au/Submissions.aspx
- Product purchase and distribution: ar-drg.laneprint.com.au
- Licencing arrangements: www.ihpa.gov.au/what-we-do/products/admitted-acute-care-products-and-licences

For further information on any other processes related to classification development please contact IHPA directly.

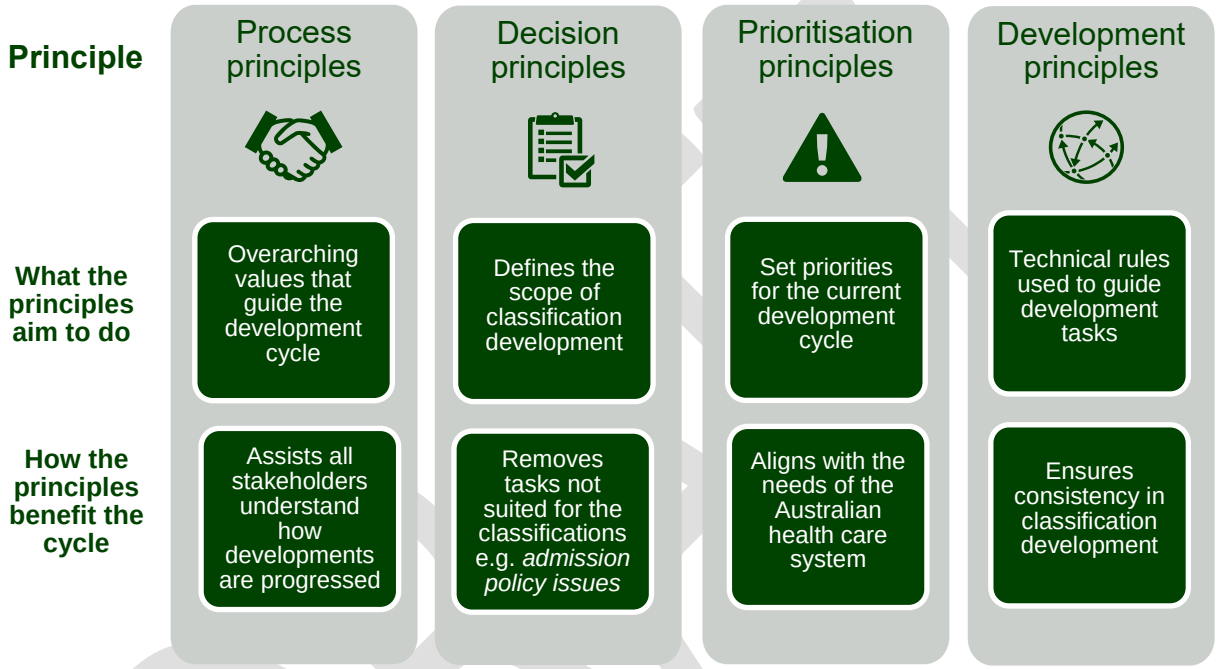
Email: enquiries.ihpa@ihpa.gov.au

Phone: (02) 8215 1100

3. Development principles

The admitted care classifications are developed using a principles-based approach. Four types of principles are used across the development cycle and ensure that the development of the classifications are fit for purpose. These principles are illustrated in **Figure 2**.

Figure 2. Four types of principles guiding the classification development cycle.



The process principles apply across all aspects of the classification development cycle.

The decision principles, prioritisation principles and development principles are made specific to the development of each classification system.

3.1 Process principles

The process principles identify the overarching values strived for, and the steps taken to achieve these values, during the process of reviewing and developing refinements to the acute care classifications.

3.1.1 Transparency

- Consult on the development of the work program by following the decision and prioritisation principles, and making the final work program available on the IHPA website.
- Seek and document input on the direction and development of technical development work at scheduled meetings or other forums.
- Display the status, outcome, and other necessary attributes of a submission or coding query by enhancing the ACE portal.
- Ensure the admitted care classifications are fit for purpose for its many uses.

3.1.2 Respect of process

- Meeting papers are provided to relevant members in advance of an advisory group meeting.
- Advisory group members will have appropriate opportunity to provide feedback.
- IHPA will make a final decision, informed by all factors informing the development process (i.e. development principles, technical group feedback and clinical feedback).
- IHPA will share the final decision with members, and notify members of any subsequent amendments before publication.
- Final decisions will remain independent and not favour a particular individual or single stakeholder group.

3.1.3 Decisions are evidence-based

- Development tasks will follow an evidence-based approach based on the decision, prioritisation and development principles.
- Clinical input will be sought from the CCAG, or a more specialised clinical authority, where necessary.

3.2 ICD-10-AM/ACHI/ACS principles

3.2.1 Decision principles

The decision principles identify submissions that are in scope for classification development. IHPA will seek advice from the CCAG or the appropriate advisory group where required. Where CCAG determines that a public submission is clinically incoherent, it will not proceed for classification development.

In scope:

- Change requests submitted through the ACE portal with evidence of materiality and significant impact on health services or epidemiology
- Mandatory updates relating to the MBS and the Australian Schedule of Dental Services and Glossary (ADA)
- Advice or instructions from World Health Organization (WHO).

Out of scope:

- Change requests seeking clarification to a coding challenge (query)
- Changes to the Hospital Acquired Complications (HAC) list
- Changes to the Classification of Hospital Acquired Diagnoses (CHADx) list
- Change requests relating to data quality audits that are not directly about classification development
- Change requests relating to metadata specifications, definitions and standards
- Major reconstruction of ICD-10-AM
- Major reconstruction of ACHI
- Major changes to the classification that may lead to significant instability in collected health data

- Submissions where the underlying cause of concern lies within the AR-DRG classification alone
- Submissions where the underlying cause of concern is directly related to admission policy.

3.2.2 Prioritisation principles

All in scope development submissions will be assessed against the prioritisation principles, or criteria for priority level, and assigned to one of the following categories:

- **High priority**: essential to ensure the integrity and currency of the core components and attributes of the classification
- **Medium priority**: has merit but is not critical for integration in the current development cycle
- **Low priority**: has merit, but is low priority; but may be developed in the progression of other related development tasks.

A development submission will be assigned a priority level if it meets at least one of the criteria defined within that priority level (**Table**). Where a development submission meets criteria from more than one priority level it will be assigned to the higher level. IHPA will seek advice from CCAG and/or the appropriate advisory group to determine a priority level if necessary.

Table 1. Priority criteria for ICD-10-AM/ACHI/ACS development tasks

Priority level	Criteria for priority level
High priority:	• Maintain alignment with parent classifications • Address significant gaps in the classification that do not reflect contemporary clinical or classification practice • Support safety and quality initiatives • Referrals from significant AR-DRG development proposals that also add value to ICD-10-AM/ACHI/ACS • Incorporation of errata
Medium priority:	• Support national or jurisdictional strategies, or high priority public interest issues • Changes to sex or age edits • Address conflicting or missing classification conventions that may restrict code assignment • Referrals from AR-DRG development that add value in a future edition
Low priority:	• Incorporating advice provided within coding rules into the classification • Incorporating additional index entries, nonessential modifiers, or synonyms

3.2.3 Development principles

The development principles identify the rules applied during the refinement and development process of the ICD-10-AM/ACHI/ACS classification system, as follows:

- Development must be evidence based with strong clinical support or proof of materiality
- Related items, irrespective of priority level, will be evaluated and incorporated where possible into a development task within a current development cycle
- ICD-10-AM codes will not exceed five characters
- The ACHI must adopt MBS item numbers where possible
- The ACS and coding rules must be informative and written in plain English to avoid ambiguity.
- Examples in the ACS must demonstrate application of the standard (i.e. if the examples were removed can it stand alone)
- Maintain alignment with the rubrics in ICD-11 and ICHI where possible
- Support logical classification of concepts by correctly applying conventions in ICD-10-AM or ACHI, without the need for explicit support from specialty standards in the ACS
- Inclusion terms must be indexed but Includes notes do not require indexing
- Essential modifiers and nonessential modifiers must not be indexed at the same level (i.e. subterms)
- Change requests for laterality or multiplicity for granularity must be supported by data or literature
- Scientific names must be used rather than eponyms for code titles, but may exist in the Alphabetic Index or listed as Inclusion terms for classification purposes
- Adhere to the specification and conventions outlined in the classification system (e.g. ACHI aims to be technique and provider neutral, avoid containing diagnostic concepts etc.).

3.3 AR-DRG principles

3.3.1 Decision principles

The decision principles identify submissions that are in scope for classification development. IHPA will seek advice from the CCAG or the appropriate advisory group where required. Where CCAG determines that a public submission is clinically incoherent, it will not proceed for classification development.

In scope:

Development proposals should address issues of:

- Clinical coherency, or
- Cost homogeneity, and be
- Measureable – to facilitate an informed evidence based decision (i.e. there must be data available to IHPA to allow statistical assessment, such as hospital activity and cost data).

Out of scope:

- Issues that are not classifiable
- Coding issue in the underpinning disease and intervention classification
- Issues unique to an AR-DRG version no longer supported by IHPA.

3.3.2 Prioritisation principles

All in scope development submissions will be assessed against the prioritisation principles and assigned to one of the following categories:

- **High priority**: essential to ensure the integrity and currency of the core components and attributes of the classification
- **Medium priority**: has merit but is not critical for integration in the current development cycle
- **Low priority**: has merit, but is low priority; but may be developed in the progression of other related development tasks.

A development submission will be assigned a priority level if it meets at least one of the criteria defined within that priority level (**Table 2**). Where a development submission meets criteria from more than one priority level it will be assigned to the higher level. IHPA will seek advice from CCAG and/or the appropriate advisory group to determine a priority level if necessary.

Table 2. Priority criteria for AR-DRG development tasks

Priority level	Criteria for priority level
High priority	There are a number of standard refinements that are undertaken with every revision. These are assigned as high priority and include: • Reviewing and refining the Episodic Clinical Complexity (ECC) model to maintain clinical currency and cost homogeneity, including: • Recalibrating and enhancing the precision of the Diagnosis Complexity Levels (DCLs) using most recent available cost and activity data • Review of splitting thresholds for end classes • Review of the intervention hierarchy using most recent available cost and activity data • Integration of changes emanating from the underpinning ICD-10-AM/ACHI/ACS classification system • Review of episodes that group to ADRG 801 *General Intervention Unrelated to Principal Diagnosis* for clinical currency Development submissions may fall within refinement of the core components/attributes of the AR-DRG classification and consequently assigned as high priority.
Medium priority	Development proposals are assigned as medium priority if they demonstrate significant material impact as defined by the following criteria: <u>Volume</u> A development proposal meets the volume criteria if it meets either criteria 1 or 2 below: 1. Volume of episodes affected is large 2. Aggregated cost of episodes affected is large <u>Growth rate</u> A development proposal meets growth rate criteria if it meets criteria 1 and either criteria 2 or 3 below: 1. Growth rate of number of episodes affected is high 2. Volume of episodes affected is relatively small 3. Aggregated cost of episodes affected is relatively small <u>Resource homogeneity</u> A development proposal meets the resource homogeneity criteria if it meets criteria 1 and either criteria 2 or 3 below: 1. Episodes affected have significantly different levels of resource consumption from other episodes within the same class 2. Volume of episodes affected is relatively small 3. Aggregated cost of episodes affected is relatively small
Low priority	A development proposal is assigned as low priority if it does not meet any of the principles in high or medium priority.

3.3.3 Development principles

The development principles identify the rules applied during the refinement and development process for the AR-DRG classification system, as follows:

Primary principles

- Clinical coherence: The AR-DRG classification must ensure that episodes within a class have similar characteristics with respect to diagnoses (both principal and additional diagnoses), interventions and treatment administered.
- Resource homogeneity: The AR-DRG classification must ensure episodes have a similar level of resource utilisation within a class, and a large variation in resource utilisation between classes.
- Classification soundness: The AR-DRG classification must have a manageable, balanced number of classes that are statistically robust and relatively stable over time.
- Statistical soundness: The statistical performance of the AR-DRG classes must be sound according to various statistical measures.
- Evidence based: Changes to the AR-DRG classification must be supported by hospital activity and cost data that can be accessed by IHPA.
- Integration with underpinning disease and intervention classification: The AR-DRG classification should be integrated with the underpinning ICD-10-AM/ACHI/ACS classification system, for example, there should be consistency between the admitted care classifications in relation to unacceptable principal diagnoses, sex and other demographic edits.

Pre Major Diagnostic Category (Pre MDC) principles

A Pre MDC class must meet both of the following criteria:

- Episodes are clinically considered to be more appropriately classified according to treatment provided than principal diagnosis
- There is an inherent high cost in the treatment provided.

Major Diagnostic Category (MDC) principles

- An MDC requires a balance of clinical coherence and resource homogeneity
- All episodes can be grouped into an MDC based on its principal diagnosis
- The majority of episodes within an MDC should be grouped to specific ADRGs rather than non-specific ADRGs (e.g. ADRG 801 *General Interventions (GIs) Unrelated to Principal Diagnosis* and residual, non-specific ADRGs).

Adjacent Diagnosis Related Group (ADRG) principles

- An ADRG requires a balance of clinical coherence and resource homogeneity
- An ADRG should contain at least 200 episodes per year, except for those designed to contain rare and high cost episodes
- For development proposals requesting new ADRGs, appropriate placement within a current ADRG must be considered in the first instance.

ADRG hierarchy principles

The intervention hierarchy is based on the following criteria:

- Intervention ADRGs must be sorted from high to low cost with decisions based on both mean and median cost
- Intervention ADRGs must be sorted from specific to non-specific ADRGs and before ADRG 801 *General Interventions (GIs) Unrelated to Principal Diagnosis*. This criterion may override the cost criterion[1]
- Intervention ADRGs must be sorted from the initial definitive intervention, to follow-up and supportive interventions and from major to minor or other interventions. This criterion may override the cost criterion
- Intervention ADRGs must be sorted from treatment to diagnostic interventions. This criterion may override the cost criterion.

Diagnosis Related Group (DRG) principles[2]

The following principles inform appropriate splitting into DRG end classes. In certain circumstances, the specific principles may be relaxed to cater for special case ADRGs.

1. A DRG must have at least 200 episodes per year, except for those within an ADRG with a limited number of episodes
2. A DRG must have a minimum total cost of $1 million per year
3. A DRG must have at least 10 per cent of episodes within the ADRG
4. The absolute change in mean cost between consecutive DRGs must be at least $3,700
5. The relative change in mean cost between consecutive DRGs should be at least 2 times
6. There should be an inverse trend between the number of episodes in a DRG and the complexity level of the DRG.

[1] Specific ADRGs are ADRGs designed for one or more specific interventions. Non-specific ADRGs are residual ADRGs designed to catch episodes not grouped to specific ADRGs but have interventions related to the principal diagnoses. Non-specific ADRGs normally start with the word 'Other'. For example. ADRG C02 *Enucleations and Orbital Interventions* is a specific ADRG, while ADRG C14 *Other Eye Interventions* is a non-specific ADRG. Non-specific ADRGs are normally at the bottom of the intervention hierarchy but before ADRG 801 *General Interventions* (*GIs) Unrelated to Principal Diagnosis*.

[2] The thresholds of DRG principles 1 to 5 were used in AR-DRG V8.0 and V9.0.

Principles for diagnosis exclusions from the complexity model

Codes are out of scope within the complexity model and excluded if they:

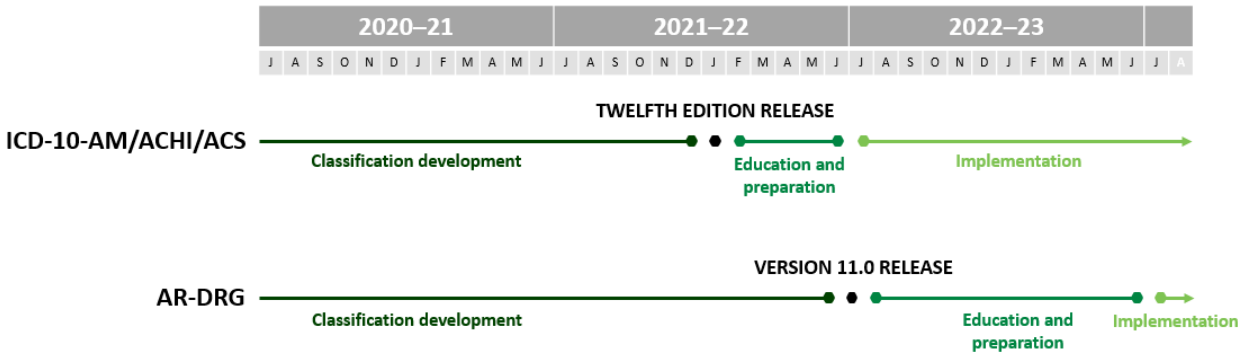
- represent undefined or ill-specified conditions
- represent symptoms and findings or transient conditions
- provide additional or contextual information only
- most unacceptable principal diagnosis codes
- represent asymptomatic or sub-clinical conditions (e.g. latent conditions)
- represent markers of other diseases (e.g. hypercholesterolaemia)
- represent minor conditions that do not generally result in admitted acute episodes of care
- represent an underlying cause of disease (e.g. tobacco dependence/use).

4. Classification development process

4.1 Development cycle

Historically the ICD-10-AM/ACHI/ACS and AR-DRG classification systems have generally been updated in a two-year development cycle. From 1 July 2019 the development cycle of both classification systems changed to a three-year cycle. This approach balances currency and stability, and reduces the administrative burden in implementing new editions. **Figure 3** shows an illustration of the three-year cycle applied to the current development cycle.

Figure 3. Illustration of current development cycle for ICD-10-AM/ACHI/ACS and AR-DRG.



There are key dependencies between the ICD-10-AM/ACHI/ACS and AR-DRG classification systems and both are developed concurrently to ensure these dependencies are maintained. ICD-10-AM/ACHI/ACS is released several months prior to AR-DRGs and its implementation is staggered one year after ICD-10-AM/ACHI/ACS.

4.2 Inputs

All change requests and classification queries for the ICD-10-AM/ACHI/ACS and AR-DRG classifications must be submitted on the Australian Classification Exchange (ACE) portal.

Users wanting to engage in the classification development process are required to read the guidelines for submission to ensure they provide adequate documentation to support the request or query. These guidelines can be found on the ACE website: https://ace.ihpa.gov.au/Submissions.aspx

Other sources are used for classification changes such as the Medicare Benefits Schedule (MBS), the Australian Schedule of Dental Services and Glossary, the International Classification of Disease (ICD) in Oncology (ICD-O).

International health classifications are used in the development process to ensure consistency in approach. These include the WHO's ICD Eleventh Revision (ICD-11) and the International Classification of Health Interventions (ICHI).

4.3 Advisory groups

Table 3. Key stakeholders in the admitted care classification development process

Group	Description	Role in development cycle
Classifications Clinical Advisory Group (CCAG)	Advisory group. Membership includes representation from IHPA's Clinical Advisory Committee (including the Chair) as well as medical, nursing and allied health professions with significant knowledge of the classification.	Provides expert clinical advice on development proposals across both admitted care classifications. Assists IHPA in applying development principles (see Section 3).
ICD Technical Group (ITG)	Advisory group. Membership includes representatives from all jurisdictions, public and private healthcare organisations, Australian health sector organisations and peak bodies.	Provides expert classification advice and technical input on ICD-10-AM/ACHI/ACS development by providing feedback on technical development tasks. Assists IHPA in applying development principles (see Section 3).
DRG Technical Group (DTG)	Advisory group. Membership includes representatives from all jurisdictions, public and private healthcare organisations, Australian health sector organisations and peak bodies.	Provides technical input on AR-DRG development by providing feedback on technical development tasks. Assists IHPA in applying development principles (see Section 3).
Technical Advisory Committee (TAC)	Advisory group. Membership includes representatives from all jurisdictions with expertise in clinical costing, classification, data processing and modelling that underpins the development of ABF.	Provides technical input on classification and data standards that underpin the classifications development.
Jurisdictional Advisory Committee (JAC)	Endorsement committee. Membership includes representatives from all jurisdictions	Reviews and endorses the classifications.
Clinical Advisory Committee (CAC)	Endorsement committee. Membership consists of specialists that are appointed by the Australian Government Minister for Health, and are drawn from a range of clinical specialties and backgrounds to ensure a wide range of clinical expertise	Provides clinical input on classification and data standards that underpin the classifications development. Reviews and endorses the classifications.

Group	Description	Role in development cycle
National Health Data and Information Standards Committee (NHDISC)	Endorsement committee A national committee run by the Australian Institute of Health and Welfare with technical and working knowledge of health classification and data standards.	Provides input on data standards that relate to data in ICD-10-AM/ACHI/ACS in the various health data collections, including the Admitted Patient Care NMDS (APC NMDS). NHDISC is responsible for endorsing changes to metadata standards as they pertain to new editions of ICD-10-AM/ACHI/ACS.

4.4 Consultation

IHPA's advisory groups listed in Table 3 are responsible for providing expert technical and clinical advice throughout the development cycle. Advisory groups use their networks to ensure comprehensive input is received on changes to the classification.

IHPA's endorsement committees are also listed in **Table 3** and provide strategic advice.

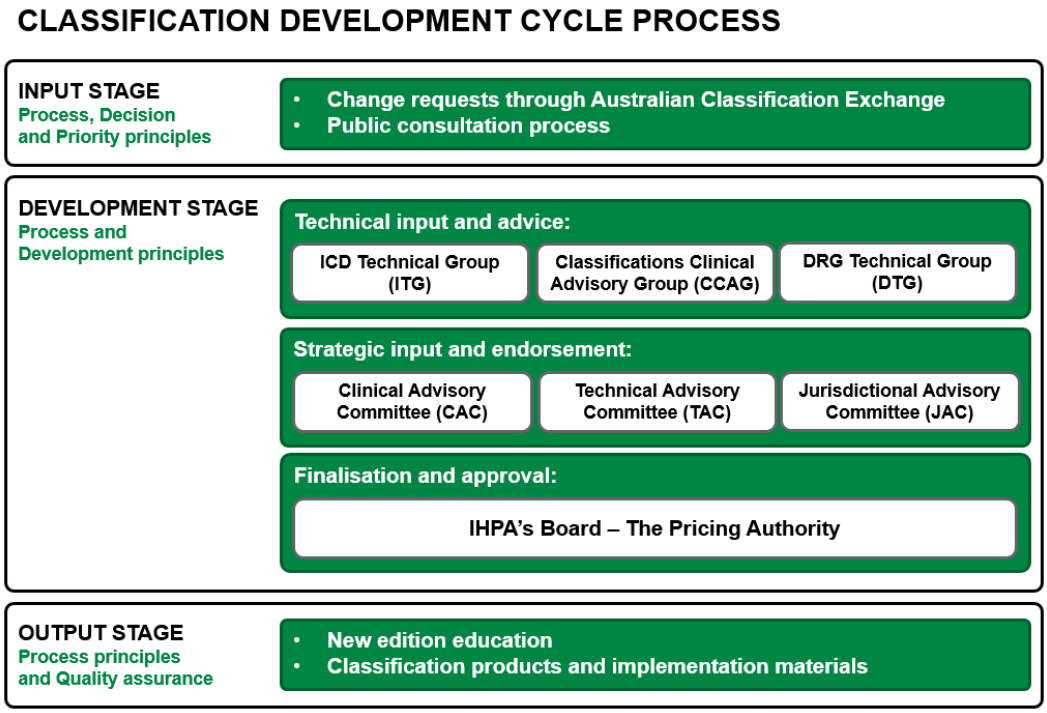
A public consultation process is conducted prior to finalising the admitted care classifications to ensure the broadest possible consultation across the public and private health sector. A draft final report for both ICD-10-AM/ACHI/ACS and AR-DRGs outlines key areas of change proposed for interested stakeholders and members of the public to provide feedback on new editions/versions of the classifications. IHPA uses feedback from the public consultation process and, where necessary, seeks advice from the advisory groups before progressing the classifications through the endorsement committees and finally to the Pricing Authority for approval.

4.5 Classification approval by the Pricing Authority

Following the public consultation on major classification changes, IHPA seeks endorsement of the finalised classifications from its technical and advisory groups. The final step is to seek approval from the Pricing Authority. The Pricing Authority (IHPA's Board) oversees IHPA's function and work and has ultimate responsibility to finalise and implement classifications under the *National Health Reform Agreement*.

Figure 4 illustrates the stages in the classification development process with key governance groups identified and the role of the Pricing Authority.

Figure 4. Overview of the classification development process.



5. Development cycle outputs

5.1 New edition education

Education is released with each new edition of ICD-10-AM/ACHI/ACS and AR-DRGs to familiarise users with the changes being implemented. The education is designed to highlight major changes in a comprehensive and accessible manner and may be provided in varying formats. Education is also supplemented by a number of accompanying documents that support implementation.

5.2 Classification products

The ICD-10-AM/ACHI/ACS and AR-DRG classification systems are licenced products. There are no restrictions for purchasing the books if you are located within Australia, however users from other countries require a licence agreement to purchase the relevant classification products.

Further information can be found on IHPA's website: www.ihpa.gov.au/what-we-do/products/admitted-acute-care-products-and-licences

5.2.1 ICD-10-AM/ACHI/ACS products

The following classification products were produced for ICD-10-AM/ACHI/ACS Eleventh Edition:

- **ICD-10-AM Alphabetic Index** is used to locate diagnostic terms to be coded. The ICD-10-AM Alphabetic Index contains diagnostic terms which do not appear in the ICD-10-AM Tabular List. The ICD-10-AM Alphabetic Index contains three sections:

  Section I: Alphabetic index of diseases and nature of injury

  Section II: External causes of injury

  Section III: Table of drugs and chemicals

- **ICD-10-AM Tabular List** contains the disease classification itself at the three, four and five character levels. A listing of the three character categories is included, as are four appendices:

  Appendix A: Morphology of neoplasms

  Appendix B: Special tabulation lists for mortality and morbidity

  Appendix C: Unacceptable principal diagnosis codes

  Appendix D: Classification of hospital acquired diagnoses.

  The Alphabetic Index and Tabular List are used in conjunction with each other. After locating the appropriate code in the Alphabetic Index, the corresponding code must be identified in the Tabular List. The Tabular List provides further guidance on the use of additional codes, sequencing, inclusion and exclusion criteria.

- **ACHI Alphabetic Index** is used to locate procedural terms to be coded. The ACHI Alphabetic Index contains many procedural terms which do not appear in the ACHI Tabular List.

- **ACHI Tabular List** contains the procedure classification itself and includes the following appendices:

  Appendix A: Mapping table for MBS items not included in ACHI

  Appendix B: ACHI codes listed in numerical order.

  Similar to ICD-10-AM, the Alphabetic Index and Tabular List are used together for accurate coding.

- **ACS** contains the Australian standards that provide guidance in the application of the ICD-10-AM and the ACHI codes.

- **Mapping tables for ICD-10-AM and ACHI** demonstrate the relationship between the codes in two concurrent editions of the ICD-10-AM/ACHI. The mapping tables provide a means of interpreting data using codes from either of the two concurrent editions of the classification with:

  - backward maps providing equivalent codes for new codes in the newer edition
  - forward maps providing equivalent codes for deleted codes in the newer edition.

  Both of these types of maps provide an equivalent code that best matches the concept from a clinical perspective in a tabulated form.

- **Electronic code lists (ECLs) for ICD-10-AM and ACHI** are electronic files that are used in the development of software or are integrated into existing patient software using the ICD-10-AM and ACHI codes for private or commercial purposes.

- The **Chronicle** is a reference tool to document changes between editions of ICD-10-AM/ACHI/ACS and aims to improve the understanding about changes made to the ICD-10-AM/ACHI/ACS, and reasons for changes. The chronicle is updated with each edition of ICD-10-AM/ACHI/ACS.

5.2.2 AR-DRG products

The following classification products were produced for AR-DRG Version 10.0:

- **AR-DRG 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 Definitions Manual comprise three volumes:

  Volume One: DRGs A13A – I180Z

  Volume Two: DRGs J01 – Z66Z

  Volume Three: Appendices.

  As there is no DCL information within the Definitions Manual, users are unable to identify the resulting DRG that requires Episode Clinical Complexity Score splits, therefore, it is not intended to serve as a substitute for the grouper. The DRG can only be accurately identified using certified grouper software.

- **Code descriptions** provide a full listing of long and short descriptions for MDCs, ADRGs and DRGs and are displayed in an excel format.

- **Technical specifications** for grouper software are used to define the electronic grouping of episodes of care, based on both clinical (underpinned by ICD-10-AM and ACHI) and demographic information for admitted episodes of care into MDCs and DRGs for casemix purposes.

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