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FACT SHEET

KNOWLEDGE • RESOURCES • TRAINING

Health Care Code Sets: ICD-10

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network

What's Changed?

Note: No substantive content updates.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare code sets guide health care providers, suppliers, medical coders, and billing and claims staff when they're submitting inpatient and outpatient claims for diagnoses, procedures, medical equipment, supplies, and drugs.

The Health Insurance Portability and Accountability Act (HIPAA) requires you to report ICD-10 codes for patient diagnoses and procedures using standard content, formats, and coding for health care transactions. Code sets include:

- ICD-10-CM diagnosis codes, which provide information about the patient's reason for seeking health care
- ICD-10-PCS procedure codes, which provide information about the inpatient procedures or other actions taken for the patient's diseases, injuries, and impairments
- CPT (HCPCS Level I) codes, which provide information about the outpatient services and procedures taken for the patient's diseases, injuries, and impairments
- HCPCS (Level II) codes, which provide information about the equipment, drugs, and supplies provided for the patient's diseases, injuries, and impairments

Code Sets, Definitions, & Payment Information

Code Sets	Definition	Payment Information
ICD-10-CM (Diagnoses)	• All health care providers use this code set in U.S. health care settings • Providers document diagnoses in patient medical records and coders assign codes based on that documentation • CDC develops and maintains this code set	• Use ICD-10-CM diagnosis codes on all inpatient and outpatient health care claims • Medicare Administrative Contractors (MACs) use them to determine benefits and coverage, not the amount we pay for services delivered • Inpatient acute care providers report ICD-10-CM diagnosis and ICD-10-PCS procedure codes on claims to assign the appropriate Medicare Severity-Diagnosis Related Group (MS-DRG) codes used to calculate payment

Code Sets, Definitions, & Payment Information (cont.)

Code Sets	Definition	Payment Information
ICD-10-PCS (Procedures)	• Providers use this code set to report procedures performed only in U.S. inpatient hospital health care settings • Physicians **don’t** use this code set to report their services, including ambulatory services and inpatient visits • Providers document procedures or other actions taken for diseases, injuries, and impairments, and coders assign codes based on patient medical record documentation • CMS develops and maintains this code set	• Inpatient acute care providers report ICD-10-CM diagnosis and ICD-10-PCS procedure codes on claims, and MACs use the MS-DRG to calculate payment
HCPCS	• Level I codes and modifiers are American Medical Association (AMA) CPT copyrighted codes • CMS develops Level II codes and modifiers to report products, supplies, and services not included in Level 1 CPT codes (for example, ambulance services, drugs, devices, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies [DMEPOS])	• Providers report HCPCS codes on claims and MACs use those codes to determine coverage or the amount we pay for services delivered, minus patient coinsurance and copayments

Code Sets, Definitions, & Payment Information (cont.)

Code Sets	Definition	Payment Information

Level I HCPCS: CPT	• Providers use this code set to report medical procedures and professional services delivered in ambulatory and outpatient settings, including physician offices and inpatient visits
	• AMA develops, copyrights, and maintains this code set
		• When providers report Level I HCPCS CPT codes on claims, MACs use them to determine the service and decide if we can pay the claim, minus patient coinsurance and copayments
		• Outpatient providers like physicians, hospital outpatient departments, ambulatory surgical centers, and suppliers:
		  ◦ Report and get paid for services delivered, including inpatient physician visits, using CPT codes
		  ◦ Use ICD-10-CM diagnosis codes, **not** ICD-10-PCS procedure codes, on outpatient claims
		  ◦ Follow our guidance when reporting CPT codes, including CPT modifiers

Level II HCPCS: Alphanumeric	• CMS maintains this code set, except for the Current Dental Terminology (CDT) codes
	• The American Dental Association (ADA) develops, copyrights, and maintains CDT codes
		• When providers report Level II HCPCS codes on claims, MACs use them to determine the service and decide if we can pay the claim, minus patient coinsurance and copayments
		• Physicians, suppliers, outpatient facilities, and hospital outpatient departments:
		  ◦ Report and get paid for services delivered using HCPCS codes
		  ◦ Use ICD-10-CM diagnosis codes, **not** ICD-10-PCS procedure codes, on outpatient claims
		  ◦ Follow our guidance when reporting HCPCS codes, including HCPCS modifiers

Resources

- HCPCS Release & Code Sets: Alphanumeric HCPCS
- ICD-10: Medicare Fee-for-Service Provider Resources
- ICD-10: Resources
- ICD-10: Statute and Regulations

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