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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?

- Added simple code explanations in the introduction (page 3)
- Added HIPAA requirement (page 3)

You'll find substantive content updates in dark red font.

Introduction

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

HHS requires everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) report ICD-10 codes for diagnoses and inpatient hospital procedures. HIPAA requires providers and health plans use standard content, formats, and coding for health care transactions. Find code sets in the Resources section.

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement

ICD-10-CM diagnosis codes provide the reason for seeking health care; ICD-10-PCS procedure codes tell what inpatient treatment and services the patient got; CPT (HCPCS Level I) codes describe outpatient services and procedures; and providers generally use HCPCS (Level II) codes for equipment, drugs, and supplies for services and treatment.

The term patient means Medicare beneficiary.

Code Sets, Definitions, & Payment Information

Code Set	Definition	Payment Information
ICD-10-CM (Diagnoses)	• All health care providers use code set in U.S. health care settings. • Providers document diagnoses in medical records and coders assign codes based on that documentation. • CDC developed and maintains code set.	• Use ICD-10-CM diagnosis codes on all inpatient and outpatient health care claims. • Generally, when physicians report diagnosis codes on claims, MACs determine benefits and coverage using them, not in determining 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 Set	Definition	Payment Information
ICD-10-PCS (Procedures)	• Providers use code set to report procedures performed only in U.S. inpatient hospital health care settings. • Physicians **don't** use 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 developed and maintains code set.	• Inpatient acute care providers report ICD-10-CM diagnosis and ICD-10-PCS procedure codes on claims and MACs use MS-DRGs.
HCPCS	• Level I codes and modifiers, American Medical Association (AMA) CPT copyrighted codes. • CMS developed Level II codes and modifiers primarily to identify products, supplies, and services **not** included in Level 1 CPT codes—such as, 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, less patient coinsurance and copayments.

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

Code Set	Definition	Payment Information

Level I HCPCS: CPT	• Providers use code set to report medical procedures and professional services delivered in ambulatory and outpatient settings, including physician offices and inpatient visits.
	• AMA developed, copyrighted, and maintains code set.
		• When providers report Level I HCPCS CPT codes on claims, MACs use those codes to determine the service and decide if we can pay the claim, less patient coinsurance and copayments.
		• For example, outpatient providers such as 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 for laterality.

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

Code Set	Definition	Payment Information

Level II HCPCS: Alphanumeric	• We developed codes and modifiers to report medical items, supplies, procedures, and certain professional services not described by any Level 1 CPT codes—such as, ambulance services, drugs, devices, preventive services, and DMEPOS.
	• We maintain this code set, except the Current Dental Terminology (CDT) codes; Dental codes begin with D, followed by four numbers. The American Dental Association (ADA) developed, copyrighted, and maintains CDT codes.
		• When providers report Level II HCPCS codes on claims, MACs use those codes to determine the service and decide if we can pay the claim, less 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 for laterality

Resources

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