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FACT SHEET
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Health Care Code Sets: ICD-10

What's Changed?

Note: No substantive content updates.

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 for information about the patient's reason for seeking health care
- ICD-10-PCS procedure codes for information about the inpatient procedures or other treatments for the patient's diseases, injuries, and impairments
- CPT (HCPCS Level I) codes for information about the outpatient services and procedures to treat the patient's diseases, injuries, and impairments
- HCPCS (Level II) codes for information about the equipment, drugs, and supplies 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 the patients' 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 provided - 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 • Providers document procedures or other treatment for diseases, injuries, and impairments, and coders assign codes based on the patients' medical record documentation • CMS develops and maintains this code set • Physicians **don't** use this code set to report their services, including ambulatory services and inpatient visits	• 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 DMEPOS)	• Providers report HCPCS codes on claims and MACs use those codes to determine coverage or the amount we pay for services provided, minus patient coinsurance and copayments

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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 provided 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 provided, 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 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 provided 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

• ICD-10: Medicare Fee-for-Service Provider Resources
• ICD-10: Statute and Regulations

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