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# Health Care Code Sets

## What's Changed?

Note: No substantive content updates.



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

Health care providers, suppliers, medical coders, and billing staff use health care code sets when submitting inpatient and outpatient claims for coding and reporting diagnoses, procedures, medical equipment, supplies, and drugs.

The Health Insurance Portability and Accountability Act (HIPAA) requires the reporting of 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 reflect the reason a patient required or sought health care
- ICD-10-PCS procedure codes, which reflect the inpatient services used to diagnose or treat the patient's diseases, injuries, and impairments
- CPT (HCPCS Level I) codes, which reflect the outpatient services used to diagnose or treat the patient's diseases, injuries, and impairments
- HCPCS (Level II) codes, which reflect the equipment, drugs, and supplies used to treat 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 and suppliers use this code set in U.S. health care settings<br>• Providers document diagnoses in the patients' medical records, and coders assign codes based on that documentation<br>• Suppliers include diagnosis codes when submitting medical claims<br>• CDC develops and maintains this code set | • Report ICD-10-CM diagnosis codes on all inpatient and outpatient health care claims<br>• Medicare Administrative Contractors (MACs) use them to determine benefits and coverage, not the amount we pay for services provided<br>• Inpatient acute care providers report ICD-10-CM diagnosis and ICD-10-PCS procedure codes on claims that group to the appropriate Medicare Severity Diagnosis-Related Group (MS-DRG) used for 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<br>• Providers document procedures or other services used to diagnose or treat diseases, injuries, and impairments, and coders assign codes based on the patients' medical record documentation<br>• CMS develops and maintains this code set<br>• 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 relative weight to calculate payment |
| HCPCS | CMS develops Level II codes and modifiers to report products, supplies, and services not included in Level I CPT codes (for example, ambulance services, drugs, devices, and DMEPOS) | Providers and suppliers 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 |

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

| Code Sets | Definition | Payment Information |
|---|---|---|
| Level I HCPCS: CPT | • Level I codes and modifiers are American Medical Association (AMA) CPT copyrighted codes<br>• Providers and suppliers use this code set to report medical procedures and professional services provided in ambulatory and outpatient settings, including physician offices and inpatient visits<br>• AMA develops, copyrights, and maintains this code set | • When providers and suppliers 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<br>• Outpatient providers like physicians, hospital outpatient departments, ambulatory surgical centers, and suppliers:<br>  • Report and get paid for services provided, including inpatient physician visits, using CPT codes<br>  • Use ICD-10-CM diagnosis codes, **not** ICD-10-PCS procedure codes, on outpatient claims<br>  • Follow our guidance when reporting CPT codes, including CPT modifiers |

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

| Code Sets | Definition | Payment Information |
|---|---|---|
| Level II HCPCS: Alphanumeric | • CMS maintains this code set, except for the Current Dental Terminology (CDT) codes<br>• The American Dental Association develops, copyrights, and maintains CDT codes | • When providers and suppliers 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<br>• Physicians, suppliers, outpatient facilities, and hospital outpatient departments:<br>  • Report and get paid for provided services using HCPCS codes<br>  • Use ICD-10-CM diagnosis codes, **not** ICD-10-PCS procedure codes, on outpatient claims<br>  • Follow our guidance when reporting HCPCS codes, including HCPCS modifiers |

## Resources

- American Dental Association: CDT Codes
- HCPCS
- ICD-10: Medicare Fee-for-Service Provider Resources
- ICD-10: Statute and Regulations