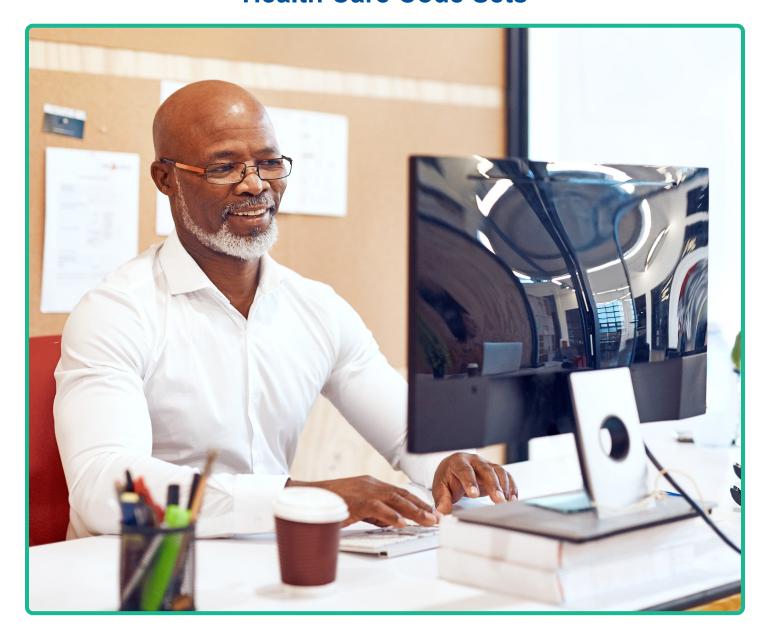




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Health Care Code Sets



What's Changed?

Note: No substantive content updates.





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
- <u>ICD-10-PCS</u> 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 Providers document diagnoses in the patients' medical records, and coders assign codes based on that documentation Suppliers include diagnosis codes when submitting medical claims CDC develops and maintains this code set 	 Report 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 that group to the appropriate Medicare Severity Diagnosis-Related Group (MS-DRG) used for payment



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

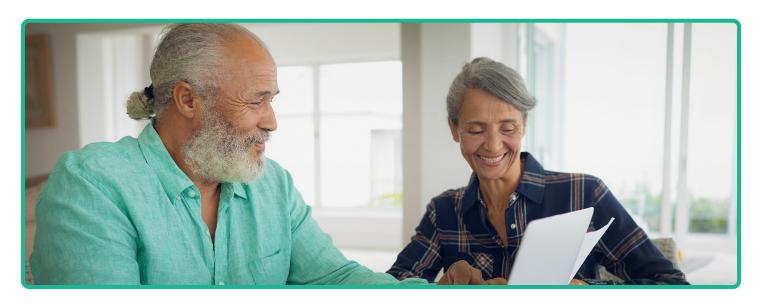
Code Sets	Definition	Payment Information
ICD-10-PCS (Procedures)	 Providers use this code set to report procedures performed only in U.S. inpatient hospital health care settings 	Inpatient acute care providers report ICD-10-CM diagnosis and ICD-10-PCS procedure codes on claims, and MACs use the MS-DRG relative weight to calculate payment
	 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 	
	CMS develops and maintains this code set	
	 Physicians don't use this code set to report their services, including ambulatory services and inpatient visits 	
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 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 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
		 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





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

Code Sets	Definition	Payment Information
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 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 Physicians, suppliers, outpatient facilities, and hospital outpatient departments: Report and get paid for provided services 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

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

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