



ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about definitions and payment information on these code sets:

- International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
- International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)
- Current Procedural Terminology (CPT)
- HCPCS

DEFINITIONS AND PAYMENT INFORMATION

This chart provides definitions and payment information for the ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS code sets.

Code Set	Definition	Payment Information
ICD-9-CM	<ul style="list-style-type: none"> • The code set all providers, including physicians, used to report medical diagnoses and procedures in U.S. health care settings and hospital inpatient procedures on claims for services furnished through September 30, 2015. • Providers selected codes based on documentation in the patient’s medical record. • The World Health Organization developed ICD-9. The National Center for Health Statistics, Centers for Disease Control and Prevention (CDC), modified ICD-9 diagnosis codes for use in the U.S. and maintained the ICD-9-CM diagnosis code set (Volumes 1 and 2). The Centers for Medicare & Medicaid Services (CMS) developed and maintained the procedure code set (Volume 3). 	<ul style="list-style-type: none"> • When physicians reported ICD-9-CM diagnosis codes on claims, in general, the Medicare Administrative Contractor (MAC) used the codes to determine coverage, not to determine the amount CMS would pay for furnished services. • When inpatient providers reported ICD-9-CM diagnosis and procedure codes on claims, the MAC used the codes to assign discharges to the appropriate Medicare Severity-Diagnosis Related Group (MS-DRG).
ICD-10-CM (Diagnoses)	<ul style="list-style-type: none"> • The code set that replaces ICD-9-CM to report medical diagnoses on claims for services furnished on or after October 1, 2015. • All providers, including physicians, use it in U.S. health care settings. • Providers select codes based on documentation in the patient’s medical record. • CDC developed and maintains the code set. 	<ul style="list-style-type: none"> • When physicians report diagnosis codes on claims, in general, the MAC will use the codes to determine coverage, not to determine the amount CMS will pay for furnished services. • Inpatient providers report ICD-10-CM diagnosis and ICD-10-PCS procedure codes on claims, which the MAC will use to assign discharges to the appropriate MS-DRG.
ICD-10-PCS (Procedures)	<ul style="list-style-type: none"> • The code set providers use to report procedures performed only in U.S. hospital inpatient health care settings on claims furnished on or after October 1, 2015. • Physicians do not use the code set to report their services, including ambulatory services and inpatient visits. • Providers select codes based on documentation in the patient’s medical record. • CMS developed and maintains the code set. 	<ul style="list-style-type: none"> • Physicians, suppliers, outpatient facilities, and hospital outpatient departments: <ul style="list-style-type: none"> ○ Report and receive payments for furnished services, including physician visits to inpatients, based on CPT and HCPCS codes ○ Use only ICD-10-CM (diagnosis) codes, not ICD-10-PCS (procedure) codes, on claims • Inpatient providers report ICD-10-CM diagnosis and ICD-10-PCS procedure codes on claims, which the MAC will use to assign discharges to the appropriate MS-DRG.

Code Set	Definition	Payment Information
HCPCS	<ul style="list-style-type: none"> • Level I codes and modifiers are the CPT codes. • Level II codes and modifiers primarily identify products, supplies, and services not included in the CPT codes (such as ambulance services; drugs; devices; and durable medical equipment, prosthetics, orthotics, and supplies). 	<ul style="list-style-type: none"> • When providers report HCPCS codes on claims, the MAC uses the codes to either determine coverage or the amount CMS will pay for furnished services (less beneficiary coinsurance and copayments).
Level I HCPCS: CPT	<ul style="list-style-type: none"> • The code set providers use to report medical procedures and professional services furnished in ambulatory/outpatient settings, including physician visits to inpatients. • The American Medical Association (AMA) developed, copyrighted, and maintains the code set. 	<ul style="list-style-type: none"> • When providers report Level I HCPCS CPT codes on claims, the MAC uses the codes to determine the service performed. Claims are paid when the decision is made that Medicare can reimburse for the services (less beneficiary coinsurance and copayments). • Physicians, suppliers, outpatient facilities, and hospital outpatient departments: <ul style="list-style-type: none"> ○ Report and receive payments for furnished services, including physician visits to inpatients, based on CPT codes ○ Use only ICD-10-CM (diagnosis) codes, not ICD-10-PCS (procedure) codes, on claims ○ Follow CMS guidance when reporting CPT codes, including CPT modifiers for laterality
Level II HCPCS: Alphanumeric HCPCS	<ul style="list-style-type: none"> • The code set providers use to report medical items, supplies, procedures, and certain professional services that are not described by any CPT codes. • CMS maintains the code set, with the exception of the code set for dental services (D-codes). The American Dental Association (ADA) developed, copyrighted, and maintains the D-codes. 	<ul style="list-style-type: none"> • When providers report Level II HCPCS codes on claims, the MAC uses the codes to either determine coverage or payment for furnished items and services (less beneficiary coinsurance and copayments). • Physicians, suppliers, outpatient facilities, and hospital outpatient departments: <ul style="list-style-type: none"> ○ Report and receive payments for furnished services, including physician visits to inpatients, based on HCPCS codes ○ Use only ICD-10-CM (diagnosis) codes, not ICD-10-PCS (procedure) codes, on claims ○ Follow CMS guidance when reporting HCPCS codes, including HCPCS modifiers for laterality

RESOURCES

This chart provides resources for ICD-10-CM/PCS.

For More Information About...	Resource
ICD-10-CM/PCS	https://www.cms.gov/Medicare/Coding/ICD10/index.html
2017 ICD-10-CM and General Equivalence Mappings (GEMs) Updates	https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM-and-GEMs.html
2017 ICD-10-PCS and GEMs Updates	https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-PCS-and-GEMs.html
ICD-10-CM/PCS Information for Medicare Fee-For-Service Providers	https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html
ICD-10-CM/PCS Provider Resources	https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
ICD-10-CM/PCS Statute and Regulations	https://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html
All Available Medicare Learning Network® (MLN) Products	MLN Catalog
Provider-Specific Medicare Information	MLN Guided Pathways: Provider Specific Medicare Resources
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
MLN Catalog	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
MLN Guided Pathways: Provider Specific Medicare Resources	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf



The Medicare Learning Network® Disclaimers are available at <http://go.cms.gov/Disclaimer-MLN-Product>.

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).