Appendix 4.3.1
Common Reimbursement Codes Used to Support Inpatient/Outpatient and Facility/Non-Facility Charges

Code	What It Stands For	What It Is	How It Is Used For Reimbursement	Who Manages the System
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification	Codes for **classifying patient diagnoses** and mortality data from death certificates	ICD-10 codes are the international standard from which the U.S. clinical modifications are derived and used in the reimbursement process (see below)	Managed by the CMS and the National Center for Health Statistics (NCHS) in collaboration with the World Health Organization
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System	Codes for classifying morbidity data and **describing procedures** associated with utilization of health services in the U.S.	Used by physicians to justify the CPT and/or DRG codes they use to bill for a particular patient encounter (see below for more information on CPTs and DRGs); also used by public and private payers for auditing the use of healthcare codes by providers	Managed by the CMS and the National Center for Health Statistics in collaboration with the World Health Organization

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Code	What It Stands For	What It Is	How It Is Used For Reimbursement	Who Manages the System
CPT	Current Procedural Terminology; also known as HCPCS Level I codes (under the Health Care Financing Administration's Common Procedure Coding System)	Codes for **describing medical, surgical, and diagnostic procedures** (but not diagnoses themselves), regardless of whether they are performed in a clinic, inpatient hospital, or outpatient hospital setting	Used by Medicare for making physician reimbursement decisions, but not for covering facility-related reimbursement; does not include codes needed to report and cover medical items or services billed by suppliers other than physicians	Maintained by the American Medical Association (AMA) on behalf of the CMS
MS-DRG	Medicare Severity – Diagnosis Related Group	Codes for **describing the procedures and other services performed in a hospital** setting	Used by Medicare for making non-physician related reimbursement decisions for procedures performed in an inpatient hospital setting	Maintained by the CMS

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Code	What It Stands For	What It Is	How It Is Used For Reimbursement	Who Manages the System
APC	Ambulatory Payment Classification	Codes for **describing hospital outpatient services**, including diagnostic procedures, cancer therapies, ambulatory surgery, clinic and ER visits, partial psychiatric hospitalization, and surgical pathology	Used by Medicare for setting a specific, uniform amount that all hospitals will be paid for the same outpatient services	Maintained by the CMS
HCPCS Level II	Health Care Financing Administration's Common Procedure Coding System – Level II	Codes used **for supplies and services obtained outside the physician office that are not covered by a CPT code**, such as durable medical equipment, prosthetics, and orthotics	Used by hospitals, as well as other non-hospital and non-physician suppliers, to submit claims; also used by Medicare to make reimbursement decisions for procedures, services, equipment, and supplies utilized in an outpatient setting but not typically billed by physicians	Maintained by the CMS Note: HCPCS II codes may apply to supplies used as part of a procedure, but may not be separately reimbursable beyond the APC code

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