REIMBURSEMENT POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Durable Medical Equipment (DME) Codes and DME Unlisted and Miscellaneous Codes-NV MP-PY-1760	08/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies.

In addition to this policy, reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

This policy does not ensure an authorization or reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject

Durable Medical Equipment (DME) Codes and DME Unlisted and Miscellaneous Codes

B. Background

The Centers for Medicare and Medicaid Services (CMS) establishes and maintains Health Care Common Procedure Coding System (HCPCS) codes. The code sets were established so providers can use the most specific and appropriate code when submitting claims for reimbursement of the item rendered to members.

Occasionally, a HCPCS code may not be available for durable medical equipment (DME) if it is rarely used, unusual, or new. Only then would providers use an unlisted, unclassified, not otherwise specified (NOS), not otherwise classified (NOC), miscellaneous, or generic code for any DME item or supply.

C. Definitions

- **Durable Medical Equipment (DME)** – Equipment and supplies ordered by a health care provider for everyday or extended use.
- **Miscellaneous (Unlisted, Unclassified, Not Otherwise Specified [NOS], or Not Otherwise Classified [NOC]) Codes)** – Submitted by a supplier for an item for which there is no existing or no specific HCPCS code that adequately describes the item being billed.
- **Provider Acquisition Cost** – The distributor or manufacturer invoice to the provider (provider's cost).
    - Provider invoice is the amount paid for an item by a DME provider to a distributor or manufacturer after the application of any discounts, rebates, and adjustments that are available to the provider at the time of claim submission.
    - Documentation of provider cost is subject to approval by CareSource
    - Suitable documents for substantiating provider cost include, but are not limited to, the following examples:
        - A standard distributor or manufacturer price list that can be independently verified by CareSource.
        - any figure that has been entered, superimposed, modified, obscured, or obliterated by the provider will not be accepted.
- **Relative Value Unit (RVU)** – A calculator assigned to each code which, when multiplied by the conversion factor (CF) and a Geographic Practice Cost Indices (GPCI) adjustment, creates the compensation level for a particular item.

D. Policy

I. The reimbursement for all DME codes and DME unlisted and miscellaneous codes is as follows:

A. CareSource first applies the rate specified for the item as specifically negotiated in the provider's contract. However, If the provider's contract does not specify

terms specifically for reimbursement of DME, then CareSource shall reimburse the provider per the methodology listed below:

1. 65% of the Medicare set cost/price for the item
2. Codes not covered on Medicare Fee Schedule, but which do have RVU values will be reimbursed at the amount calculated by multiplying the RVU (relative value unit assigned to that CPT code) x the conversion factor.
3. Essential RVU gap fill fee schedule
4. Codes not listed on the Medicare Fee Schedule and which do not have RVU values, shall be reimbursed at Provider's cost plus 5% after the application of any discounts, rebates, and adjustments available to the Provider and supported by invoice documentation and subject to applicable prior authorization requirements.
5. All other DME items not listed in the payment methodology above will be reimbursed at default percent of provider's billed charges.

II. All unlisted or miscellaneous codes for a DME items require a prior authorization and medical necessity review.
   A. Prior authorization requests submitted with unlisted or miscellaneous codes must contain the applicable information and/or documentation below for consideration during review:
      1. a complete description of the item, including, as applicable, the manufacturer, model or style, and size, a list of all bundled components, and an itemization of all charges, including a provider acquisition cost invoice
      2. statement that no other more appropriate code exists
      3. any other information requested by CareSource

III. Unlisted or miscellaneous codes should only be used when an established code does not exist to describe the item requested.

IV. Reimbursement is based on review of the unlisted or miscellaneous code(s) on an individual claim basis.

V. Unlisted/non-specific codes used for procedures deemed to be experimental and investigational will be reviewed for medical necessity.

VI. CareSource may request warranty information regarding the DME item(s) or supply when an unlisted or miscellaneous code is used. If the requested DME item(s) and/or supplies are covered by the supplier's or manufacturer's warranty, CareSource will deny the prior authorization.

E. Conditions of Coverage
   I. Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications.

Reimbursement will be established based upon a review of the actual item provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify member eligibility.

II. It is the responsibility of the submitting provider to submit the most accurate and appropriate HCPCS code(s) for the item that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee payment of claims.

III. Medical necessity review and authorization does not ensure payment.

IV. CareSource may verify the use of any code through post-payment audit. If a more appropriate code is discovered, CareSource may request recoupment.

F. Related Policies/Rules

Durable Medical Equipment (DME) Modifiers
Unlisted and Miscellaneous Codes
Claims Reimbursement Hierarchy

G. Review/Revision History

	DATE	ACTION
Date Issued	04/22/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	08/01/2026	
Date Archived		

H. References

1. Durable medical equipment (DME). Accessed March 09, 2026. www.healthcare.gov
2. Healthcare Common Procedure Coding System (HCPCS). Centers for Medicare & Medicaid Services. Accessed March 09, 2026. www.cms.gov