CareSource

REIMBURSEMENT POLICY STATEMENT
Nevada Medicaid

Policy Name & Number	Date Effective
Temporary Codes-NV MCD-PY-1627	11/01/2026
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. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are 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.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject
Temporary Codes

B. Background
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 services 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's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS/ICD-10 code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Temporary codes exist in both CPT and HCPCS manuals and are updated throughout the year. T codes (ie, Category III codes) are temporary CPT codes for emerging technologies, services, and procedures which support data collection to substantiate widespread use and/or provide documentation for the Food and Drug Administration (FDA) approval process. Many of these codes have not been proven medically necessary and are considered to be experimental or investigational based on a lack of peer-reviewed scientific literature. A variety of temporary HCPCS codes exist. Temporary HCPCS codes may be established by the Centers for Medicare and Medicaid Services (CMS) to report drugs, biologicals, devices, and procedures, to identify services and procedures under FDA review, or address miscellaneous services, procedures, and supplies. Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) may develop temporary HCPCS codes to report supplies and other products for which a national code has not yet been developed. Temporary HCPCS codes may also be developed by commercial payers to report drugs, services, and supplies. Coverage of these services is under the discretion of local carriers

C. Definitions
NA

D. Policy
I. CareSource considers temporary codes medically necessary when **ALL** the following criteria are met:
   A. Documentation in the medical record supports the use of the code.
   B. A more specific code is not available to describe the service/procedure.
   C. The service provided is within the scope of the member's benefit plan.

II. CareSource will use current industry standard procedure codes (HCPCS CPT I and Category II codes) throughout the processing systems. HIPAA Transaction & Code

Set Rule requires providers use the procedure code(s) that are valid at the time the service is provided.

III. Providers must use industry standard code sets and specific HCPCS CPT I and Category II codes when available unless otherwise directed through the provider's contract.

IV. If specific codes are not available, unlisted codes require plan preauthorization.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	07/30/2025	New market, approved at Committee
Date Revised	08/12/2026	Periodic review. Updated background. Approved at committee.
Date Effective	11/01/2026	
Date Archived		

H. References

1. CPT Category III Codes. American Medical Association. Accessed August 4, 2026. www.ama-assn.org
2. *CPT Professional 2026*. American Medical Association; *2026*.
3. HCPCS Codes - Temporary Codes for Use with Outpatient Prospective Payment System. Accessed August 4, 2026. www.hcpcs.codes
4. Understanding the HIPAA standard transactions: the HIPAA transactions and code set rule. American Medical Association. Accessed August 4, 2026. www.assets.ama-assn.org
5. What is HCPCS? American Academy of Professional Coders. Accessed August 4, 2026. www.aapc.com