Vermont

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in this issue

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comments
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Radiology program re-design effective April 1, 2012

As announced in the November/December 2011 issue of *Healthy Practices*, MVP Health Care has contracted with CareCore National to manage the radiology utilization review process as of April 1, 2012 (pending regulatory approval).

Education/training opportunities

Representatives from CareCore National are organizing educational webinars for MVP health care providers to walk you through the steps of obtaining prior authorization by phone, fax, or by using the CareCore National website. Details about the webinars will be sent via FastFax and in the March/April issue of *Healthy Practices*. MVP Professional Relations Representatives also will be available to assist you and your office staff.

Answers to your questions

MVP Professional Relations and Customer Care representatives have logged your questions about the upcoming changes to MVP's radiology program. Please keep your questions coming! Many are specific and we will address them directly with the inquiring office. The answers to the questions published here, however, offer information that is pertinent to all offices.

- ***Will MVP's prior authorization requirements for radiology procedures change as of April 1?***
  All fully-insured products and most self-funded products require prior authorization for radiology services. The number of procedures that require prior authorization will change as of April 1, 2012 Prior authorization will be required for advanced imaging such as magnetic resonance (MRI/MRA), computed tomography (CT), positron emission tomography (PET) and nuclear cardiology. A list of specific CPT® codes requiring prior authorization for dates of service on or after April 1 was included with your November/December 2011 issue of *Healthy Practices* and is available on the MVP website when you log into your account and go to *Online Resources*.
- ***Will any functions related to radiology still be handled by MVP after April 1?***
  Yes. While MVP will outsource the utilization management component of its radiology program to CareCore National, MVP will continue to manage:
  - radiology claims for servicing providers;
  - appeals from Medicare members and providers;
  - all external appeals;
  - administrative law judge (ALJ) decisions;
  - fair hearings; and
  - regulatory complaints.
- ***If I already have a login to CareCore National's website, will I need to create a new login for MVP authorizations?***
  No. If you already have a username and password for the CareCore National website, you will not need to create a new one. You will simply update your user profile by adding MVP. If you have questions about how to do this, please consider attending one of CareCore National's upcoming educational webinars for MVP health care providers. Watch for details via *FastFax* and the March/April issue of *Healthy Practices*.
- ***Can all tests be requested online, or is there variability as to which procedures can be requested online, by phone or fax?***
  All requests can be initiated by either phone, web or fax. For more information on how to submit prior authorization requests to CareCore National, please consider attending one of CareCore National's upcoming educational webinars for MVP health care providers. Watch for details via *FastFax* and the March/April issue of *Healthy Practices*.
- ***Will CareCore National have real-time access to MVP members' eligibility information?***
  Yes. CareCore National will have real-time access to MVP's member eligibility records to help ensure accurate authorization processing.

MVP℠ HEALTH CARE

- ***How will emergency requests be handled when a patient is in a doctor's office and referred for emergency imaging, but is not sent to an emergency room? Will prior authorization be required?***
  Health care providers may call within three days of emergent treatment to obtain authorization.
- ***What happens if medical records are not provided with a prior authorization request (or if other additional information is needed); will the request deny or pend? How will request status be communicated to the requesting health care provider?***
  If CareCore National needs more information before a request can be processed, the request will pend and CareCore National will send a letter to the requesting provider for the additional information. Once a decision is reached, CareCore National will communicate the decision to providers and members with phone calls and letters, as MVP does today. You also will be able to check the status of all prior authorization requests for your practice on CareCore National's website.
- ***Currently, when a health care provider's request for a CT scan without contrast (70486) is approved, but the patient's actual procedure includes contrast, a new authorization request is not needed. Will this remain the same, or will health care providers need to request a new authorization due to changes like this at the time of service?***
  MVP Health Care maintains a list of "billable groupings" that allow approved authorizations to cover a certain set of CPT® codes and allow flexibility in treatment at the time of service. MVP has updated that list effective April 1, 2012. The revised list is included in this issue of *Healthy Practices* (see page 9). In the example above, a new authorization will not be needed if the claim is for a CT scan with contrast (70487), since it is part of the billable grouping for the originally-approved CPT code. However, please review the updated billable groupings list carefully, as some time-of-service procedure changes may require a new authorization (e.g. if the approved authorization is for an MRI of the head without contrast (70551) and the patient's actual procedure includes contrast, a new authorization must be obtained.
- ***If a claim is submitted without a prior authorization when one is required, what will the denial explanation be on the Explanation of Benefits (EOB) sent to the MVP member?***
  The explanation on the EOB will be *"Denied for no prior auth obtained."*
- ***Does CCN educate providers about radiation exposure? How and when is this done?***
  CareCore National offers information for both patients and health care providers about radiation safety on its website, including a radiation exposure calculator (visit **www.carecorenational.com/page/radiation-safety-and-calculator.aspx**). MVP helps educate its members by including articles in newsletters, particularly about radiation exposure from CT scans.

Not yet registered for an online account?

Registering for an account at **mvphealthcare.com** allows you a fast, easy way to get information you need about your MVP patients, our policies and procedures, newsletters and much more. If your practice has Internet access, visit **www.mvphealthcare.com/provider/register.html** to set up accounts for your staff. New features are constantly in development to make your online account a valuable tool for your practice!

Update your provider account profile

If your online account profile includes an outdated or personal email address, take a moment to update it with your current business email address. As MVP continues to explore ways of getting you the information you need via the technology you prefer, your valid email address and profile information will enable you to quickly and easily be part of our advancements! You can update your email address, password and security question at any time by clicking the *Change Profile* link (under your name) just after logging in at **www.mvphealthcare.com/provider**.

Code of ethics and business conduct summary

Introduction

MVP Health Care, Inc. ("MVP") has been and continues to be committed to conducting business with competence and integrity and in accordance with all federal state and local laws. To strengthen this commitment, MVP has established a Corporate Compliance Program. MVP's Code of Ethics and Business Conduct (the "Code") is a key component of our Corporate Compliance Program. This summary of the Code provides MVP's network providers, vendors, contractors and delegated entities with a formal statement of MVP's commitment to the standards and rules of ethical business conduct. All network providers, vendors, contractors and delegated entities are expected to comply with the standards in the Code as highlighted below.

Protecting Confidential and Proprietary Information

It is of paramount importance that MVP's member and proprietary information be protected at all times. Access to proprietary and member information should only be granted on a need-to-know basis and great care should be taken to prevent unauthorized uses and disclosures. MVP's contractors and delegated entities are contractually obligated to protect member and proprietary information.

Complying with the Anti-Kickback Statute

As a Government Programs Contractor, MVP is subject to the federal anti-kickback laws. The anti-kickback laws prohibit MVP, its employees, and contractors from offering or paying remuneration in exchange for the referral of Government Programs business.

Reviewing the Federal and State Exclusion Databases

MVP, its Government Programs contractors and delegated entities are required to review the exclusion databases maintained by the Department of Health and Human Services Office of Inspector General (OIG), the General Services Administration (GSA) and the New York State Office of Medicaid Inspector General (OMIG). These database reviews must be conducted to

determine whether potential and current employees, contractors and vendors are excluded from participation in federal and state sponsored health care programs. MVP, its contractors and delegated entities are required to comply with federal and state requirements regarding the employment of and contracting with any excluded individuals or entities.

Prohibiting the Acceptance of Gifts

The Code prohibits employees from accepting or soliciting gifts of any kind from MVP's current or prospective vendors, suppliers, providers or customers that are designed to influence business decisions.

Detecting and Preventing Fraud, Waste and Abuse

MVP has policies and processes in place to detect and prevent fraud, waste and abuse. MVP's Special Investigations Unit (SIU) is instrumental in managing the program to detect, investigate and recover loss of corporate, government and customer assets resulting from fraudulent and abusive actions committed by providers, members, subcontractors, vendors and employees. The SIU maintains a toll-free, 24-hour hotline, **1-877-835-5687**, where suspected fraud and abuse issues can be reported directly by internal and external sources.

Reporting Suspected Violations

MVP provides an Ethics & Integrity Hotline for reporting suspected violations of the Code or of its legal requirements. The Ethics & Integrity Hotline — **1-888-357-2687** — is available for employees, vendors, and contractors to report suspected violations anonymously. Ethics Point manages MVP's confidential reporting system and receives calls made to the Hotline. Ethics Point triages reports in a secure manner to MVP's Compliance Office. The Compliance Office promptly and thoroughly investigates all allegations of violations.

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the September and October meetings. Some of the medical policies may reflect new technology while others clarify existing benefits. All policy updates are listed online in the *Benefits Interpretation Manual* (BIM). Visit MVP online at **www.mvphealthcare.com**. Providers can directly access the online BIM through the *Reference* section of the *Provider* portal. The *Current Updates* page of the BIM lists all medical policy updates. If you have questions regarding the medical policies, or wish to obtain a paper copy of a policy, contact your Professional Relations representative.

Healthy Practices and/or *FastFax* will continue to inform your office about new and updated medical policies. MVP encourages your office to look at all of the revisions and updates on a regular basis in the *Benefit Interpretation Manual* (BIM) located on **www.mvphealthcare.com** in the *Reference* section.

Medical policy updates effective Feb. 1, 2012

Autism Spectrum Disorders Vermont – NEW Policy

This policy follows state mandates and the American Academy of Pediatrics guidelines for treatment of autism spectrum disorders. Note: This policy had provisional approval for an effective date of October 1, 2011.

Dynamic Splinting Devices – NEW Policy

This is a new medical policy. The policy includes criteria for low-load prolonged duration stretch devices and static progressive stretch devices. Coverage is allowed for a two-four month rental period as part of a formal physical/occupational therapy rehabilitation program with documented signs and symptoms of significant motion stiffness or loss from a contracture that interferes with activities of daily living.

Emergency Department Services – NEW Policy

This is a new medical policy. The policy address emergency medical services which complies with the Federal definition of a prudent lay person and emergency medical services. The policy has Provisional Approval effective 9/13/11.

Experimental or Investigational Procedures

The policy was updated to list language that has been added to list the National Government Services, Local Coverage Determination. Any Category III code is considered experimental/investigational unless National Government Services (Medicare) publishes a Local Coverage Determination. The policy was updated to include the current Medicare language for clinical trial coverage.

Hyaluronic Acid Derivatives

Sports Medicine physicians have been added to the list of providers allowed to order and administer Hyaluronic Acid. Providers must be credentialed from an ABMS recognized Board Certification Program.

Neuropsychological Testing

A Vermont Variation has been added stating that Vermont Law mandates that neuropsychological testing is medically necessary when it is required to aid in the assessment and diagnosis of autistic spectrum disorders for children beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first to coincide with the Vermont Autism policy.

Photodynamic Therapy for Pre-malignant & Malignant Indications

There are no changes to the policy. The criteria follow Medicare guidelines.

Private Duty Nursing

No changes have been made since last review. The policy follows Medicare guidelines.

Psychological Testing

Language has been added stating that computerized psychological testing is considered not medically necessary.

List of medical policies reviewed and approved in 2010 for approval without changes in November 2011

- Botulinum Toxin Treatment
- Hearing Aid Services
- Intraoperative Neurophysiologic Monitoring
- Tumor Markers OVA 1

Medical policy updates effective May 1, 2012

Radiofrequency Ablation (Rhizotomy) for Chronic Pain

The title has been changed to Radiofrequency Ablation (Rhizotomy) for "Chronic" Pain. Pancreatic cancer and trigeminal neuralgia have been added as indications. Sacroiliac joint/nerve denervation procedures are considered investigational and not medically necessary.

Please refer to the coding section on the policies to identify any code changes (e.g., new, deleted) or codes no longer requiring prior authorization for a specific policy. Each policy grid defines the prior authorization requirements for a specific product.

Quality Updates

HEDIS® and QARR data collection begins

In February 2012, the MVP Quality Improvement (QI) Department will begin its annual Healthcare Effectiveness Data and Information Set (HEDIS); and New York state Department of Health Quality Assurance Reporting Requirements (QARR) data collection.

HEDIS and QARR are sets of standardized performance measures designed to ensure that consumers and purchasers have the information they need to reliably compare managed health care plans. Managed care organizations are required to report their rates to the National Committee for Quality Assurance (NCQA), the New York state Department of Health, Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) and Centers for Medicare & Medicaid Services (CMS).

Every year, the collected HEDIS data is used to guide the design and implementation of our health management activities, measure MVP's health management programs' effectiveness, and measure our performance against other health plans.

MVP has again contracted with Interim Healthcare for registered nurses to help our QI staff collect data from medical records that measure clinical performance in the following areas:

- Adolescent Preventive Care
- Adult BMI Assessment
- Childhood Immunization Status
- Cholesterol Management for Patients with Cardiovascular Conditions
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Human Papillomavirus Vaccine for Female Adolescents
- Immunizations for Adolescents
- Lead Screening
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

MVP Quality Improvement staff or Interim Healthcare representative may contact your office to schedule the chart review. We appreciate your cooperation and will make every effort to minimize any impact the review may have on your office operations.

Please note: HEDIS/QARR are part of "health care operations" and, therefore, the Health Insurance Portability and Accountability Act (HIPAA) does not require authorization from the individuals to release their protected health information (PHI) for health care operations activities. MVP has strict standards for the collection and storage of this information.

Thank you in advance for your cooperation and support during these important quality activities. If you have questions, call Betsy LaRose, R.H.I.T. at **518-388-2290** or **1-800-777-4793, ext. 2290**.

Quality Improvement Manual (QIM) update

Clinical Guidelines Re-endorsed

The MVP Quality Improvement Committee (QIC) recently approved the following enterprise-wide clinical guidelines:

Adult and Adolescent Alcohol/Substance Abuse Screening in Primary Care

MVP's alcohol and substance abuse guidelines were re-approved to assist providers with screening adolescents and adults for alcohol and substance abuse in primary care. While MVP has had guidelines on this topic for several years, this update replaces the previous guidelines with the following:

- ***For adults:*** MVP has adopted the *Helping Patients Who Drink Too Much – a Clinician's Guide* which was developed by the National Institution on Alcohol Abuse and Alcoholism (NIAAA).
- ***For adolescents:*** MVP has adopted the American Academy of Pediatrics *Policy Statement - Alcohol Use by Youth and Adolescents: A Pediatric Concern.*

Both the adult and adolescent guidelines contain useful screening tools, recommendations for counseling and referrals to specialized services.

Depression

MVP Health Care continues to endorse its depression guideline. The guideline is based on Institute for Clinical Systems Improvement guideline, *Major Depression in Adults in Primary Care*. It reflects the current standard of care for the management of depression in the primary care setting. The complete guideline can be found at **www.icsi.org/depression_5/depression_major_in_adults_in_primary_care_3.html.**

Paper copies of these recommendations are available by calling MVP's Quality Improvement (QI) department at **1-800-777-4793, ext. 2602**. The recommendations will also be available in an update to the *MVP Provider Quality Improvement Manual*. Within this manual you can also find useful tools to assist providers in screening adolescents and adults for alcohol use and abuse and depression, such as a *Risky Teen Behavior* brochure, CRAFFT screening tools and the *Patient Health Questionnaire (PHQ-9)*.

The current edition of the manual is located on the provider home page of the MVP website at **www.mvphealthcare.com/provider/qim/index.html.**

UM Updates

Reminder: upcoming updates to Claims Xten clinical editing software

As announced in the November/December issue of *Healthy Practices*, MVP will upgrade its McKesson Claims XtenTM Clinical Editing software on April 1, 2012 to incorporate Waste and Abuse Knowledge Pack edits.

MVP has been utilizing Claims XtenTM since 2009 to audit claims more efficiently. The software applies a pre-determined set of rules to each claim so that as many claims as possible can be automatically approved or denied, rather than have to be manually reviewed.

The sources of ClaimsXten's coding edits include, but are not limited to:

- American Medical Association (AMA)
- Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- National Correct Coding Initiative (NCCI)

Some of these edits will include, but are not limited to:

DME edits

- Submission of a claim for maintenance and service of a DME item that is considered frequently serviced.
- A currently rented or beneficiary-owned item claim is submitted when the DME item is already owned.
- A currently rented or beneficiary-owned item claim is submitted when maintenance or replacement of that item is within the warranty period or when the maximum number of rental payments is reached.

Injection Quantity edits

- Editing for inappropriate diagnosis and quantity for certain pharmaceutical HCPCS codes.

Sleep Study edits

- Editing for attended sleep study codes when service is performed in a patient's home.

ICD-10 information coming to MVP website

MVP Health Care is committed to being ready for ICD-10 on October 1, 2013. Work is well underway to update our systems. MVP is involved in the work of national and regional agencies to make the switch to ICD-10 as smooth as possible for our participating health care providers.

MVP also is committed to keeping you informed about our progress, as well as the latest ICD-10 information that we think will be helpful to the provider community. To accomplish this, we will have a web page devoted to ICD-10, called *ICD-10 Central* available on the provider page of the MVP website at the beginning of January (visit **www.mvphealthcare.com** and click on *Providers*). You will be able to access ICD-10 Central from that web page, right next to 5010 Central. Be sure to visit the new page on a regular basis as we will routinely be adding new ICD-10 information throughout 2012 and 2013.

Pharmacy Updates

Gardasil use in males

For dates of service on and after October 25, 2011, MVP will cover Gardasil vaccine in males ages 9 to 26. This is a result of the recommendation by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) to routinely vaccinate against human papillomavirus in males.

Estimated generic availability of brand drugs

A significant number of brand drugs will be losing patent exclusivity in 2012. The table below provides the estimated dates when select brand name drugs are expected to be available as lower-cost generics or possibly over-the-counter. (The estimated dates are subject to change due to factors such as legal issues regarding patent protection.) MVP encourages generic drug use whenever possible. When a generic drug becomes available on the market, MVP will make the brand equivalent non-formulary, tier 3 upon notification to impacted members and providers.

PERIOD	BRAND NAME	GENERIC NAME
First quarter 2012		
	Avalide®	irbesartan/ hydrochlorothiazide
	Avapro®	irbesartan
	Clarinex® & Clarinex-D® (planning OTC prior to generic availability)	desloratadine and desloratadine/ pseudoephedrine
	Gabitril®	tiagabine
	Lexapro®	escitalopram
	Seroquel®	quetiapine
Second quarter 2012		
	Avandamet®	rosiglitazone/ metformin
	Avandaryl®	glimepiride/ rosiglitazone
	Avandia®	rosiglitazone
Third quarter 2012		
	Lescol® and Lescol® XL	fluvastatin
	Plavix®	clopidogrel
	Provigil®	modafinil
	Viramune®	nevirapine
	Actos®	pioglitazone
	Detrol®	tolterodine
	Diovan® and Diovan® HCT	valsartan and valsartan/ hydrochlorothiazide
	Femcon® Fe	ethinyl estradiol/ norethindrone
	Geodon®	ziprasidone

Effective January 1, 2012

Azor, Tribenzor and Twynsta

Prior authorization will be required for Azor, Tribenzor and Twynsta. All impacted members and providers have received notification.

Cialis

On October 6, 2011, the Food and Drug Administration approved Cialis 2.5mg and 5mg for the treatment of the signs and symptoms of benign prostatic hyperplasia (BPH). The dosing is 5mg daily. In order to determine the indication for use, MVP will require prior authorization for both the 2.5mg and 5mg strengths for members who have not been prescribed this dose in the past.

Crohn's Disease and Ulcerative Colitis

The indication for Remicade was updated to include the treatment of ulcerative colitis in children

Gout Treatment

Colcrys will be subject to a quantity limit of 60 doses every 30 days. In addition, Uloric and Krystexxa will require prior authorization. All impacted members and providers have received notification.

Government Programs OTC

Option and Option Family coverage was added.

Hypnotics

- Silenor criteria was added and includes failure of a non-benzodiazepine hypnotic.
- Option and Option Family variation was also added to reflect formulary coverage.

Immunoglobulin Therapy

- Medicare variation updated to state that when IVIG is administered in the home, claims must process through the PBM.
- Vivaglobin removed from the policy as it is no longer available.

Makena

New policy establishing criteria for coverage including identification of a singleton pregnancy within a specific gestation age, history of a singleton spontaneous preterm birth and satisfaction of criteria as established in the Orphan Drug policy.

Migraine Agents

Cambia criteria of failure on NSAIDs was added. Option and Option Family variation was also added to reflect formulary coverage.

Smoking Cessation

Option and Option Family variation added to include coverage for OTC nicotine replacement products with applicable quantity limits.

Tekamlo and Amturnide

Prior authorization will be required for Tekamlo and Amturnide. All impacted members and providers have received notification.

Thrombopoiesis-Stimulating Proteins

Language changes were made to this policy that more closely reflect the American Society of Hematology guidelines.

The following policies were reviewed and approved without any changes to criteria:

- Constipation and IBS
- Enteral Therapy New Hampshire
- Enteral Therapy Vermont
- Proton Pump Inhibitor Therapy
- Quantity Limits

Formulary updates for Commercial and Option members

The MVP Formulary is updated after each Pharmacy and Therapeutics Committee meeting. The most current version is available online at **www.mvphealthcare.com**. Simply visit the site's *Provider* section and under *Pharmacy*, click on *Formulary.* The MVP Formulary can be downloaded to a PDA device from **www.epocrates.com**. There is a link to ePocrates® on the MVP Web site. ***Note: The MVP Option & MVP Option Family Formulary is also available on ePocrates.***

New drugs *(recently approved by the FDA, prior authorization required, Tier 3 non-formulary for Option)*

Drug Name	Indication
Duexis	RA and OA
Firazyr	Hereditary angioedema
Xalkori	NSCLC
Zelboraf	BRAF mutation positive melanoma

Generic drugs added to Formulary (Tier 1)
atorvaquone/proguanil (generic Malarone, PA required)

Drugs removed from prior authorization^ *(all medications are non-formulary, Tier 3 unless otherwise noted)*
Tobradex ST

Drugs removed from the Formulary*
(change from Tier 2 to Tier 3) effective 1/1/2012:

Analpram-E	Proctfoam-HC
Cortifoam	Zyprexa

**Affected members will receive a letter if further action is required (i.e. contacting the prescriber for a formulary alternative)*

Formulary updates for Medicare Part D Members

2012 Formulary Tier Structure

For 2012, the Medicare Part D Formulary tiers are as follows:

- **Tier 1 – Preferred Generic Drugs**
  Tier 1 includes preferred generic drugs *(Note: Not all generic drugs will be Tier 1 drugs).*
- **Tier 2 – Preferred Brand Name Drugs**
  Tier 2 includes preferred brand drugs that have the lowest cost sharing for brand name drugs.
- **Tier 3 – Non-Preferred Brand Name and Non-Preferred Generic Drugs**
  Tier 3 includes non-preferred brand name and non-preferred generic drugs. In addition, Part D drugs excluded from our formulary must go through an exception process in order for MVP to cover them. If they are approved, they may be covered in Tier 3.

- **Tier 4 – Specialty Drugs**
  Tier 4 includes all drugs (brand name and generic) that cost $600 or more for a 30-day supply. Most drugs in this tier are restricted to a 30-day supply at retail and are excluded from the mail order program.
- **Tier 5 – No Cost Generic Drugs $0**
  Tier 5 includes select drugs for diabetes, blood pressure control, bone health, heartburn, and ulcers.

More detailed information can be found on our website at **www.mvphealthcare.com/medicare/2012PartD/partd_index.html.**

Medicare Part D Formulary available from ePocrates®

You can now access and download the MVP Medicare Part D Formulary for 2011 from ePocrates®. Simply follow the instructions on our website at **www.mvphealthcare.com/provider/pharmacy.html.**

Policies and formulary changes can be found on our website at **www.mvphealthcare.com/medicare**.

The following drugs will change from tier 2 to tier 3 effective January 1, 2012:

BRAND NAME

Actonel
Avandaryl
Avandamet
Avandia
Coreg CR
Exelon Patch
Nasacort AQ
Novolin insulins
Provigil
Rhinocort AQ
Tricor

The following drugs will require prior authorization effective January 1, 2012:

BRAND NAME

Tazorac
Tretinoin cream & gel
Xifaxan 200mg
Xyrem
Zetia

The following drugs will be subject to step therapy effective January 1, 2012:

BRAND NAME

Actonel
Atacand/HCT
Azor
Benicar/HCT
Exforge/HCT
Micardis/HCT
Teveten/HCT

The following drug will be subject to quantity limited as indicated below effective January 1, 2012. Quantities exceeding the limit will require a formulary exception.

DRUG NAME	QUANTITY LIMIT PER MONTH
Afinitor 2.5mg, 5mg	30 tablets
Afinitor 10mg	60 tablets
Caprelsa	30 tablets
dronabinol	60 tablets
ocetreotide 100mcg, 200mcg	60 mL
Sprycel	30 tablets
Sutent	30 tablets
voriconazole 50mg , 200mg	60 tablets
Xifaxan 200mg	9 tablets

The following drugs will not be included on the 2012 Medicare Part D Formulary.

DRUG NAME

Aczone
Adoxa
Atralin
Avita gel and cream
Benaclin
Caduet (when generic is available)
carisoprodol
carisoprodol/aspirin
carisoprodol/aspirin/codeine
chlordiazepoxide/amitriptyline
chlorpropamide
cyproheptadine
dicyclomine
Demerol
diphenhydramine capsules
Doryx 150mg
Epiduo
fexofenadine
Fosamax plus D
Fosamax soln
Lipitor
Lipofen
Keppra XR
meperidine
meprobamate
nifedipine (short-acting)
Oracea
orphenadrine citrate
orphenadrine compound ds
orphenadrine /asa/caffeine
pentazocine/acetaminophen
pentazocine /naloxone
propantheline
Sanctura XR
Solodyn
Vytorin
Xyzal
Zegerid
Ziana

Common Part D vaccine copays are $0 in 2012

The most common Part D vaccines: the Shingles vaccine (Zostavax) and the Tetanus/Diptheria/Pertussis vaccines will be included in Tier 5 on our 2012 Medicare Part D formulary. Tier 5 drugs will take a $0 copay during all benefit stages for MVP Part D members!

All Part D vaccines and vaccine administration fees must be billed through Medco, the MVP pharmacy benefits manager (PBM). There is an online tool called eDispense that you can use to bill vaccine claims directly to Medco. If the Part D vaccine is in Tier 5 and is billed through eDispense, it will process with a $0 copay! If the claim is for a vaccine that is not in Tier 5, it will process with the member's applicable Part D copay. It is important that you use this online tool to bill your Part D vaccine claims so you can avoid overcharging your patients. If you are not familiar with the eDispense tool, refer to our website at **www.mvphealthcare.com/provider** or call the Customer Care Center for Provider Services at **1-800-999-3920**.

National Drug Code (NDC) requirement

Effective 4/1/12 MVP will now require the National Drug Code (NDC) when submitting a claim where a medication is administered in the physician office, outpatient setting, or outpatient hospital setting. The NDC will not be required for medications administered to patients in the Inpatient Hospital setting. MVP is requiring this in compliance with state regulations.

The NDC will be required when submitting a drug associated with the following procedure codes:

Procedure Codes that require an NDC # (When valid NDC is available)
All J codes
All Q codes
All A Codes
B codes (B4100 - B4162)
C codes (C9100 - C9299)
S codes (S0012 - S0197)
Vaccine Codes (90371 – 90748)

INSTRUCTIONS FOR FILLING OUT CMS-1500 FORM

NDC should be entered in the shaded area of fields 24A – 24G for the corresponding procedure code

The following should be included in order

- Report the N4 qualifier (left justified) followed immediately by:
- 11 digit NDC (no hyphens)
- One space followed immediately by:
- Unit of measurement qualifier:
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN - Unit

  followed immediately by:
- Unit Quantity

  Quantity is limited to eight digits before the decimal and three digits after the decimal.

  If entering a whole number, do not use a decimal.

  Examples:
  - 1234.56
  - 2
  - 99999999.999

Example: N412345678901 UN1234.567

INSTRUCTIONS FOR FILLING OUT UB-04 FORM

- NDC should be entered into field 43
- The following should be included in order
  - Report the N4 qualifier (left justified) followed immediately by:
  - 11 digit NDC (no hyphens) followed immediately by:
  - Unit of measurement qualifier:
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN - Unit

    followed immediately by:
  - Unit Quantity (floating decimal, limited to three digits to the right).

Example: N412345678901UN1234.567

INSTRUCTIONS FOR ELECTRONIC CLAIM FORMAT

If you bill electronically, complete the drug identification and drug pricing segments in Loop 2410 following the instructions below.

Loop	Segment	Element Name	Information
2410	LIN 02	Product or Service ID Qualifier	Use qualifier N4 to indicate that entry of the 11 digit National Drug Code in 5-4-2 format in LIN03
2410	LIN 03	Product or Service ID	Include the 11-digit NDC (No hyphens)
2410	CTP 03	Unit Price	Include the unit price for the NDC billed in LIN03
2410	CTP 04	Quantity	Include the quantity for the NDC billed in LIN03
2410	CTP 05	Unit or Basis for Measurement Code	For the NDC billed in LIN03, include the unit or basis for measurement code using the appropriate code qualifier: • F2 – International Unit • GR – Gram • ML – Milliliter • UN - Unit

MVP will publish the policy on March 1, 2012 in the *Provider Resource Manual* and the requirement will be effective on April 1, 2012.

The NDC will be required in the field CMS-1500.

NDC Code:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N45914801665 UN1													N	1B	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N44950267230 UN1 50.00													N	1B	12345678901
10	01	05	10	01	05	11		J7603		1	50 00	2.5	N	NPI	0123456789

BILLABLE GROUPINGS FOR RADIOLOGY PROCEDURES Effective April 1, 2012

CPT CODE	PROCEDURE DESCRIPTION	ALLOWABLE BILLED GROUPINGS
	CT Scans	
70450	CT HEAD/BRAIN W/O CONTRAST	70460, 70470
70460	CT HEAD/BRAIN W/ CONTRAST	70450, 70470
70470	CT HEAD/BRAIN W/O & W/ CONTRAST	70450, 70460
70480	CT ORBIT W/O CONTRAST	70481, 70482
70481	CT ORBIT W/ CONTRAST	70480, 70482
70482	CT ORBIT W/O & W/ CONTRAST	70480, 70481
70486	CT MAXLLFCL W/O CONTRAST	70487, 70488
70487	CT MAXLLFCL W/ CONTRAST	70486, 70488
70488	CT MAXLLFCL W/O & W/ CONTRAST	70486, 70487
70490	CT SOFT TISSUE NECK W/O CONTRAST	70491, 70492
70491	CT SOFT TISSUE NECK W/ CONTRAST	70490, 70492
70492	CT SOFT TISSUE NECK W/O & W/ CONTRAST	70490, 70491
70496	CT ANGIOGRAPHY HEAD	N/A
70498	CT ANGIOGRAPHY NECK	N/A
71250	CT THORAX W/O CONTRAST	71260, 71270
71260	CT THORAX W/ CONTRAST	71250, 71270
71270	CT THORAX W/O & W/ CONTRAST	71250, 71260
71275	CT ANGIOGRAPHY CHEST, NON-CORONARY	N/A
72125	CT C SPINE W/O CONTRAST	72126, 72127
72126	CT C SPINE W/ CONTRAST	72125, 72127
72127	CT C SPINE W/O & W/ CONTRAST	72125, 72126
72128	CT T SPINE W/O CONTRAST	72129, 72130
72129	CT T SPINE W/ CONTRAST	72128, 72130
72130	CT T SPINE W/O & W/ CONTRAST	72128, 72129
72131	CT L SPINE W/O CONTRAST	72132, 72133
72132	CT L SPINE W/ CONTRAST	72131, 72133
72133	CT L SPINE W/O & W/ CONTRAST	72131, 72132
72191	CT ANGIOGRAPHY PELVIS	N/A
72192	CT PELVIS W/O CONTRAST	72193, 72194
72193	CT PELVIS W/ CONTRAST	72192, 72194
72194	CT PELVIS W/O & W/ CONTRAST	72192, 72193
73200	CT UPPER EXTREMITY W/O CONTRAST	73201, 73202
73201	CT UPPER EXTREMITY W/ CONTRAST	73200, 73202
73202	CT UPPER EXTREMITY W/O & W/ CONTRAST	73200, 73201
73206	CT ANGIOGRAPHY UPPER EXTREMITY	N/A
73700	CT LOWER EXTREMITY W/O CONTRAST	73701, 73702
73701	CT LOWER EXTREMITY W/ CONTRAST	73700, 73702
73702	CT LOWER EXTREMITY W/O & W/ CONTRAST	73700, 73701
73706	CT ANGIOGRAPHY LOWER EXTREMITY	N/A
74150	CT ABDOMEN W/O CONTRAST	74160,74170,
74160	CT ABDOMEN W/ CONTRAST	74150,74170
74170	CT ABDOMEN W/O & W/ CONTRAST	74150,74160
74175	CT ANGIOGRAPHY ABDOMEN	N/A
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL	72192, 74150, 74177, 74178
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL(S)	72192, 72193, 74150, 74160, 74176, 74178
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS;WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS IN ONE OR BOTH BODY REGIONS	72192, 72193, 72194, 74150, 74160, 74170, 74176, 74177
74261	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITHOUT CONTRAST MATERIAL	N/A
74262	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITH CONTRAST MATERIAL(S) INCLUDING NON-CONTRAST IMAGES, IF PERFORMED	74262, 74261
74263	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, SCREENING, INCLUDING IMAGE POSTPROCESSING	INVESTGATIONAL CODE (Non Medicare) NOT COVERED BY MEDICARE
75571	COMPUTED TOMOGRAPHY, HEART, WITHOUT CONTRAST MATERIAL, WITH QUANTITIVE EVALUATION OF CORONARY CALCIUM	INVESTGATIONAL CODE (Non Medicare) NOT COVERED BY MEDICARE
75572	CARDIAC CT FOR MORPHOLOGY	N/A
75573	CARDIAC CT FOR CONGENITAL HD	N/A
75574	CORONARY CTA	N/A
75635	CT ANGIOGRAPHY ABDOMINAL AORTA	N/A
76376 (Note: effective 7/1/12)	3D RENDERING WITH INTERPRETATION AND REPORTING OF COMPUTED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, ULTRASOUND, OR OTHER TOMOGRAPHIC MODALITY; NOT REQUIRING IMAGE POSTPROCESSING ON AN INDEPENDENT WORKSTATION	76376, 76377
76377 (Note: effective 7/1/12)	REQUIRING IMAGE POSTPROCESSING ON AN INDEPENDENT WORKSTATION	76377, 76376
76380	CT LIMITED OR LOCALIZED FOLLOW-UP STUDY	N/A
	MRA	
70544	MRA HEAD W/O CONTRAST	N/A
70545	MRA HEAD W/ CONTRAST	70544, 70546
70546	MRA HEAD W & W/O CONTRAST	70544, 70545
70547	MRA NECK W/O CONTRAST	N/A
70548	MRA NECK W CONTRAST	70547, 70549
70549	MRA NECK W & W/O CONTRAST	70547, 70548
71555	MRA CHEST (EXC MYOCARDIUM) W/ OR W/O CONTRAST	71275, C8909, C8910, C8911
72159	MRA SPINAL CANAL W/ OR W/O CONTRAST	NOT COVERED BY MEDICARE
72198	MRA PELVIS W/ OR W/O CONTRAST	N/A
73225	MRA UPPER EXTREMITY W/ OR W/O CONTRAST	NOT COVERED BY MEDICARE
73725	MRA LOWER EXTREMITY W/ OR W/O CONTRAST	INVESTGATIONAL CODE
74185	MRA ABDOMEN W/ OR W/O CONTRAST	N/A
	MRI	
70336	MRI TMJ	N/A
70540	MRI FACE, ORBIT, AND/OR NECK W/O CONTRAST	N/A
70542	MRI FACE, ORBIT, AND/OR NECK W/ CONTRAST	70540, 70543
70543	MRI FACE, ORBIT, AND/OR NECK W & W/O CONTRAST	70540, 70542
70551	MRI HEAD W/O CONTRAST	N/A
70552	MRI HEAD W/ CONTRAST	70551, 70553
70553	MRI HEAD W/ & W/O CONTRAST	70551, 70552
70554	MRI, BRAIN, FUNCTIONAL MRI; INCLUDING TEST SELECTION AND ADMINISTRATION OF REPETITIVE BODY PART MOVEMENT AND/OR VISUAL STIMULATION, NOT REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION	N/A
70555	MRI, BRAIN, FUNCTIONAL MRI; REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION OF ENTIRE NEUROFUNCTIONAL TESTING	N/A
71550	MRI CHEST W/O CONTRAST	N/A
71551	MRI CHEST W CONTRAST	71550, 71552

BILLABLE GROUPINGS FOR RADIOLOGY PROCEDURES Effective April 1, 2012

CPT CODE	PROCEDURE DESCRIPTION	ALLOWABLE BILLED GROUPINGS
71552	MRI CHEST W & W/O CONTRAST	71550, 71551
72141	MRI CERVICAL SPINE W/O CONTRAST	N/A
72142	MRI CERVICAL SPINE W/ CONTRAST	72141, 72156
72146	MRI THORACIC SPINE W/O CONTRAST	N/A
72147	MRI THORACIC SPINE W/ CONTRAST	72146, 72157
72148	MRI LUMBAR SPINE W/O CONTRAST	N/A
72149	MRI LUMBAR SPINE W/ CONTRAST	72148, 72158
72156	MRI C SPINE W/ & W/O CONTRAST	72141, 72142
72157	MRI T SPINE W/ & W/O CONTRAST	72146, 72147
72158	MRI L SPINE W/ & W/O CONTRAST	72148, 72149
72195	MRI PELVIS W/O CONTRAST	N/A
72196	MRI PELVIS W CONTRAST	72195, 72197
72197	MRI PELVIS W & W/O CONTRAST	72195, 72196
73218	MRI UPPER EXTREMITY W/O CONTRAST	73221
73219	MRI UPPER EXTREMITY W CONTRAST	73218, 73220, 73221, 73222, 73223
73220	MRI UPPER EXTREMITY W & W/O CONTRAST	73218, 73219, 73221, 73222, 73223
73221	MRI UPPER EXTREMITY JOINT W/O CONTRAST	73218, 73219
73222	MRI UPPER EXTREMITY JOINT W CONTRAST	73218, 73219, 73220, 73221, 73223
73223	MRI UPPER EXTREMITY JOINT W & W/O CONTRAST	73218, 73219, 73220, 73221, 73222
73718	MRI LOWER EXTREMITY W/O CONTRAST	73721
73719	MRI LOWER EXTREMITY W CONTRAST	73718, 73720, 73721, 73722, 73723
73720	MRI LOWER EXTREMITY W & W/O CONTRAST	73718, 73719, 73721, 73722, 73723
73721	MRI LOWER EXTREMITY JOINT W/O CONTRAST	73718, 73718, 73719, 73720, 73721, 73723
73722	MRI LOWER EXTREMITY JOINT W CONTRAST	N/A
73723	MRI LOWER EXTREMITY JOINT W & W/O CONTRAST	73718, 73719, 73720, 73721, 73722
74181	MRI ABDOMEN W/O CONTRAST	N/A
74182	MRI ABDOMEN W CONTRAST	74181, 74183
74183	MRI ABDOMEN W & W/O CONTRAST	74181, 74182
75557	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL	N/A
75559	CARDIAC MAGNETIC RESONAANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH STRESS IMAGING	75559, 75557
75561	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIALS(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	75557, 75559
75563	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; WITH STRESS IMAGING	75557, 75559, 75561
75565	CARDIAC MAGNETIC RESONANCE IMAGING FOR VELOCITY FLOW MAPPING (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	N/A
76390	MRI SPECTROSCOPY	INVESTGATIONAL CODE (Non Medicare) NOT COVERED BY MEDICARE
77021	MRI GUIDANCE FOR NEEDLE PLACEMENT	N/A
77058	MRI BREAST W/ AND/OR W/O CONTRAST	77059, C8903, C8904, C8905
77059	MRI BREAST BILATERAL	77058, C8906, C8907, C8908
77084	MRI BONE MARROW BLOOD SUPPLY	N/A

CPT CODE	PROCEDURE DESCRIPTION	ALLOWABLE BILLED GROUPINGS
	NUCLEAR CARDIOLOGY	
78451	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)	N/A
78452	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION	N/A
78453	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS ORGATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)	N/A
78454	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION	N/A
78466	MYOCARDIAL INFARCTION SCAN	N/A
78468	HEART INFARCT IMAGE EF	78466
78469	HEART INFARCT IMAGE SPECT	78466
78472	GATED HEART, REST OR STRESS	N/A
78473	CARDIAC BLOOD POOL MUGA SCAN	78472
78481	HEART FIRST PASS SINGLE	N/A
78483	CARDIAC BLOOD POOL IMAGING, MULTI	78481
78494	CARDIAC BLOOD POOL IMAGING, SPECT	N/A
78496	CARDIAC BLOOD POOL IMAGING, SINGLE AT REST (Use with 78472)	N/A
	PET SCANS	
78459	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) METABOLIC EVAL.	N/A
78491	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION; SINGLE STUDY AT REST OR STRESS	N/A
78492	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION; MULTIPLE STUDIES AT REST OR STRESS	78491
78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) METABOLIC EVALUATION	N/A
78609	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION EVALUATION	INVESTGATIONAL CODE (Non Medicare) NOT COVERED BY MEDICARE
78811	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; LIMITED AREA (EG, CHEST, HEAD/NECK)	78814, 78815, 78816
78812	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; SKULL BASE TO MID-THIGH	78811, 78814, 78815, 78816
78813	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; WHOLE BODY	78811, 78812, 78814, 78815
78814	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; LIMITED AREA (EG CHEST, HEAD/NECK)	78811, 78812, 78813

BILLABLE GROUPINGS FOR RADIOLOGY PROCEDURES Effective April 1, 2012

CPT CODE	PROCEDURE DESCRIPTION	ALLOWABLE BILLED GROUPINGS
78815	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; SKULL BASE TO MID-THIGH	78811, 78812, 78813, 78814
78816	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; WHOLE BODY	78811, 78812, 78813, 78814
C-CODES		
C8900	MRA WITH CONTRAST, ABDOMEN	See 74185
C8901	MRA WITHOUT CONTRAST, ABDOMEN	See 74185
C8902	MRA WITH AND WITHOUT CONTRAST, ABDOMEN	See 74185
C8903	MRI WITH CONTRAST, BREAST; UNILATERAL	See 77058
C8904	MRI WITHOUT CONTRAST, BREAST; UNILATERAL	See 77058
C8905	MRI WITH AND WITHOUT CONTRAST, BREAST; UNILATERAL	See 77058
C8906	MRI WITH CONTRAST, BREAST; BILATERAL	See 77059
C8907	MRI WITHOUT CONTRAST, BREAST; BILATERAL	See 77059
C8908	MRI WITH AND WITHOUT CONTRAST, BREAST; BILATERAL	See 77059
C8909	MRA WITH CONTRAST, CHEST (EXCLUDING MYOCARDIUM)	See 71555
C8910	MRA WITHOUT CONTRAST, CHEST (EXCLUDING MYOCARDIUM)	See 71555
C8911	MRA WITH AND WITHOUT CONTRAST, CHEST (EXCLUDING MYOCARDIUM)	See 71555
C8912	MRA WITH CONTRAST, LOWER EXTREMITY	See 73725
C8913	MRA WITHOUTH CONTRAST, LOWER EXTREMITY	See 73725
C8914	MRA WITH AND WITHOUT CONTRAST, LOWER EXTREMITY	See 73725
C8918	MRA WITH CONTRAST, PELVIS	See 72198
C8919	MRA WITHOUT CONTRAST, PELVIS	See 72198
C8920	MRA WITH AND WITHOUT CONTRAST, PELVIS	See 72198
C8931	MRA WITH CONTRAST, SPINAL CANAL AND CONTENTS	See 72159
C8932	MRA WITHOUT CONTRAST, SPINAL CANAL AND CONTENTS	See 72159
C8933	MRA WITHOUT & WITH CONTRAST, SPINAL CANAL AND CONTENTS	See 72159
C8934	MRA W/ CONTRAST UPPER EXTREMITY	See 73225
C8935	MRA W/O CONTRAST UPPER EXTREMITY	See 73225
C8936	MRA W/O AND W/ CONTRAST UPPER EXTREMITY	See 73225
G-CODES		
G0219	PET IMAGING WHOLE BODE; MELANOMA FORNON COVERED INDICATIONS	Crosswalks to 78811-78816 INVESTGATIONAL CODE (Non Medicare) NOT COVERED BY MEDICARE
G0235	PET IMAGING, ANY SITE NOT OTHERWISE SPECIFIED	Crosswalks to 78811-78816 NOT COVERED BY MEDICARE
G0252	PET IMAGING, FULL AND PARTIAL-RING PET SCANNERS ONLY, FOR INITIAL DIAGNOSIS OF BREAST CANCER AND/OR SURGICAL PLANNING FOR BREAST CANCER (E.G. INITIAL STAGING OF AXILLARY LYMPH NODES)	Crosswalks to 78811-78816 NOT COVERED BY MEDICARE
S-CODES		
S8037	MRCP	See 74183
S8042	MRI Low Field	See any MRI
S8080	SCINTIMAMMOGRAPHY (RADIOIMMUNOSCINTIGRAPHY OF THE BREAST), UNILATERAL, INCLUDING SUPPLY OF RADIOPHARMACEUTICAL	INVESTGATIONAL CODE (Non Medicare) NOT COVERED BY MEDICARE
S8085	FLUORINE-18 FLUORODEOXYGLUCOSE (F-18 FDG) IMAGING USING DUAL HEAD COINCIDENCE DETECTION SYSTEM. (Non-dedicated PET scan)	INVESTGATIONAL CODE (Non Medicare) NOT COVERED BY MEDICARE
S8092	ELECTRON BEAM COMPUTED TOMOGRAPHY (ALSO KNOWN AS ULTRAFAST CT, CINET)	INVESTGATIONAL CODE (Non Medicare) NOT COVERED BY MEDICARE
T-CODES		
0042T	CT PERFUSION BRAIN	INVESTIGATIONAL CODE
0159T	COMPUTER-AIDED DETECTION, INCLUDING COMPUTER ALGORITHM ANALYSIS OF MRI IMAGE DATA FOR LESION DETECTION/CHARACTERIZATION, PHARMACOKINETIC ANALYSIS, WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, BREAST MRI (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	INVESTIGATIONAL CODE
UNLISTED CPT CODES		
76497	UNLISTED COMPUTED TOMOGRAPHY PROCEDURE	All unlisted codes will be managed by directing the referring provider to the appropriate CPT code for the diagnostic objective for the case, so they can be crosswalked to any code in the modality specified.
76498	UNLISTED MRI PROCEDURE	

Excludes: Nuclear Medicine, Ultrasound, Unlisted Nuclear Med CPT codes

MVP HEALTH CARE

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newsletter is here!