Pharmacy Revenue Cycle

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4/21/2023

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Objectives

1. Define medical coding

2. Understand the importance of accurate coding

3. Understand the components of pharmacy revenue cycle

4. Describe opportunities to optimize your pharmacy revenue cycle

What is medical coding?

“Accurate medical coding enables the insurance service provider to understand the illness or injury a patient is experiencing and the method of treatment being used to treat it, enabling them to make the appropriate payment. Medical coding is the process by which hospitals convert critical medical information related to each patient into straightforward codes for documenting medical records and for ease in medical billing and insurance reimbursement” (Aapc, n.d.).

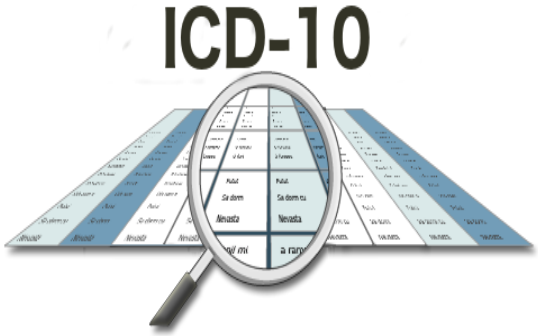
pc. (n.d.). What is Medical Coding? *www.aapc.com*. https://www.aapc.com/medical-coding/medical-coding.aspx

Introduction - Why is coding important?

- Accurately telling the patient story
  - Medical coding translates what diagnoses and treatments were performed during a patient's time at your institution
  - This documentation remains a part of the patient's medical record, so it is important for the protection of your patient that it is absolutely accurate
  - Inaccurate information can harm the patient and can harm the quality and accuracy of future care

- Inaccurate billing can result in:
  - Significant time spent on behalf of medical staff to update or correct information resulting in delayed patient care and satisfaction
  - Delay in submission of clean claims would cause financial instability for the institution
  - Not receiving the full amount entitled to from the patient and/or insurance company
  - Denial of the procedure or service under the patient's insurance policy
  - Financial burden to the patient

Coding



- International Classification of Diseases (ICD-10) codes
  - A system used by physicians to classify and code all diagnoses, symptoms, and procedures for claims processing

- Healthcare Common Procedure Coding System (HCPCS)
  - Level I: Current Procedure Terminology (CPT) codes and are numeric, representing medical procedures and services
  - **Level II:** The level II code list consists of alphanumeric codes and includes only non-physician products, supplies, and procedures that are excluded from CPT
  - Level III: Also called HCPCS local codes, this code set is developed by Medicare and Medicaid contractors, and private insurers to be used in specific scenarios and jurisdictions; therefore, they are not nationally recognized

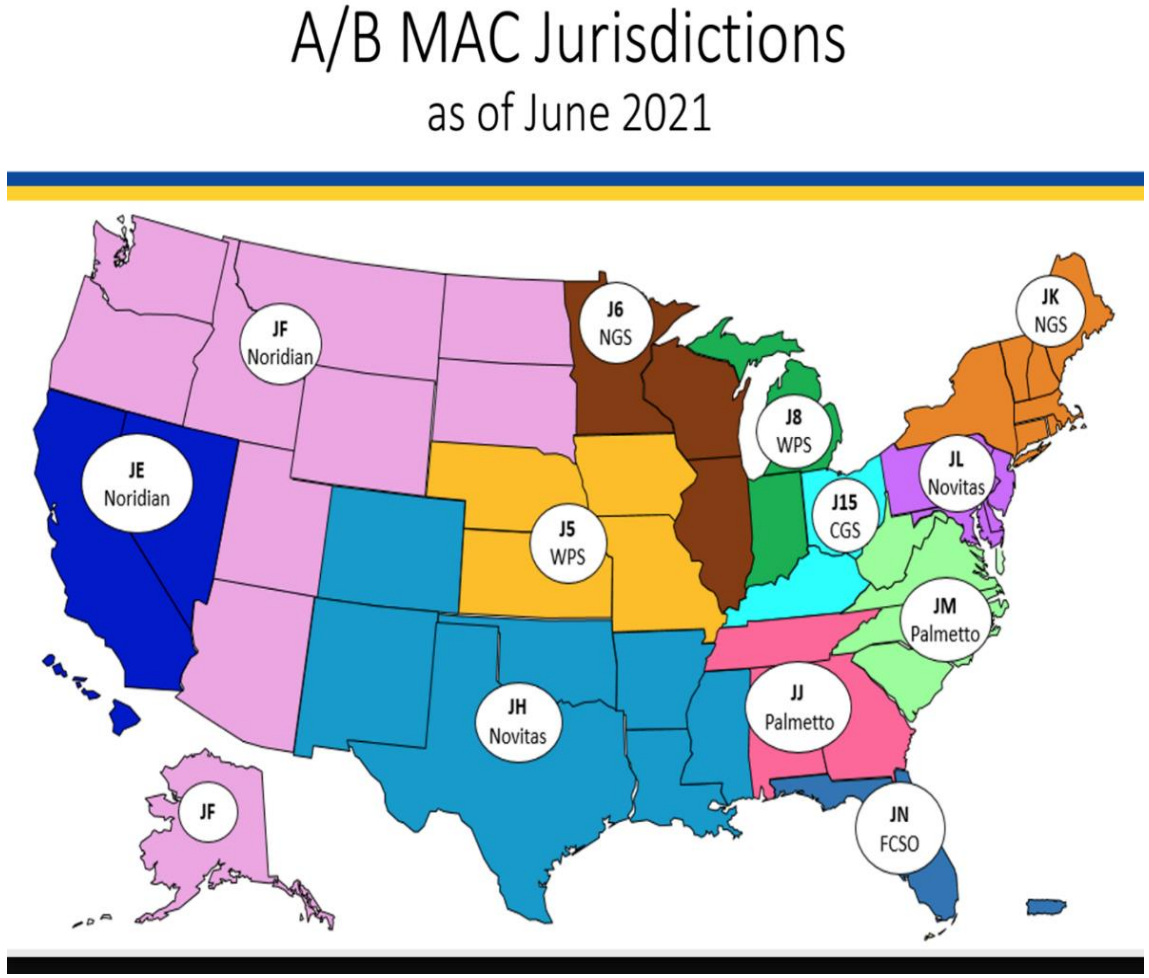
- Status Indicators (SI)
  - Does Medicare pay for these services?
  - How does Medicare pay for these services?

Major Payers

- Medicare
  - Federal program
  - Local considerations taken into account by your local Medicare Administrative Contractors (MAC)
- Medicare Advantage
  - Private health plans approved by Medicare
  - 288 plans available in New York as of January 2023
  - Not all plans are accessible, based on regions
- Medicaid
  - Both federal and state program
  - States customize plans to fit needs of population
- Commercial Insurance
  - Negotiated separately by managed care contract teams

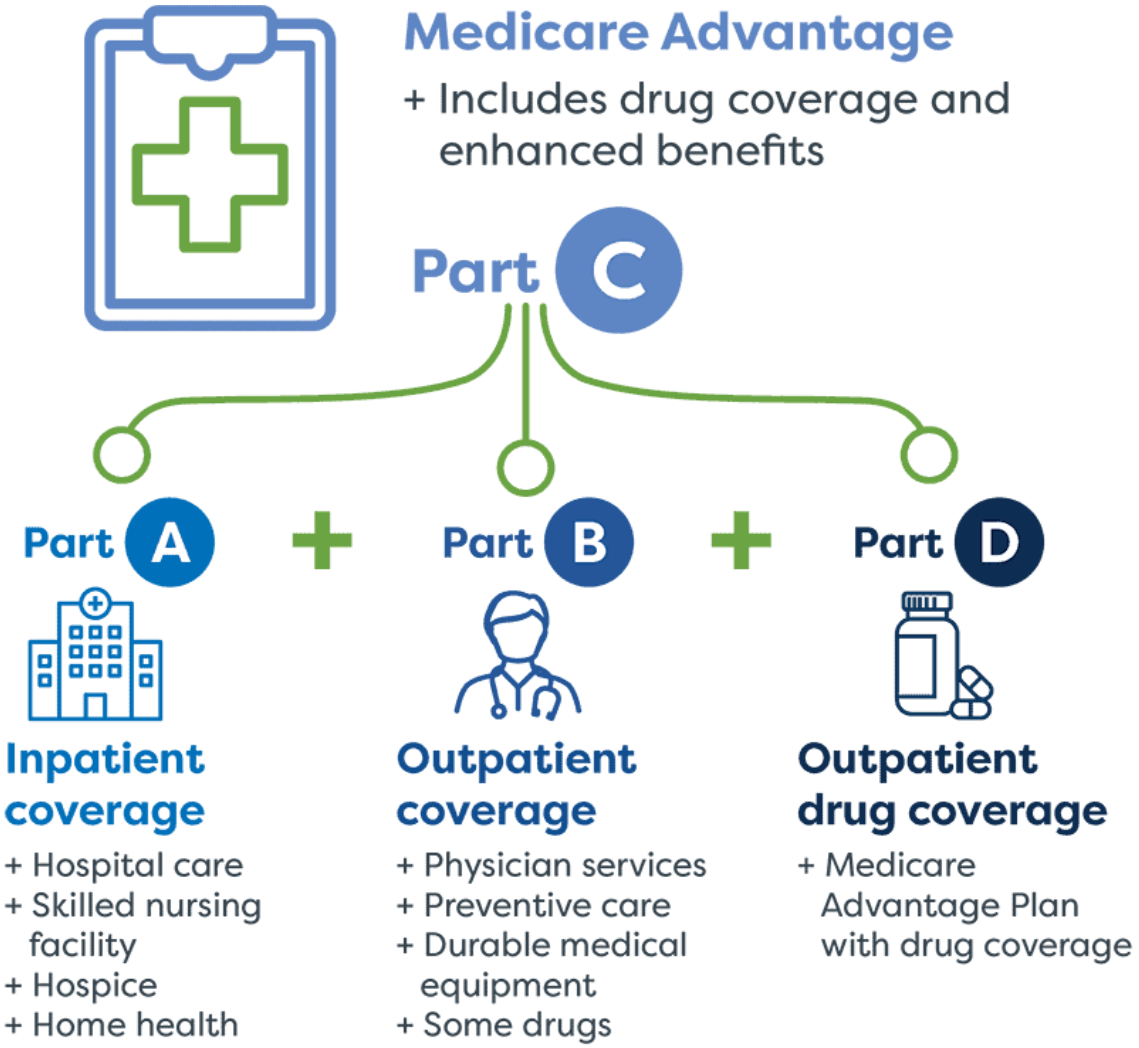
Medicare Administrative Contractors

- Process Claims on behalf of Medicare
- National Coverage Determinations (NCD)
- Local Coverage Determination (LCD)
  - Can be different coverage depending on the jurisdiction
  - Ensure you are looking at the correct LCD
    - Which one are we in NY?
- DME MAC Jurisdictions are not the same as A/B
- Separated into 12 Jurisdictions
  - NY is NGS-JK, not J6



CMS. Jurisdictions Map

Medicare Advantage



- Alternative to Medicare
- Provide added services
  - Typically, vision, dental, and better medication coverage are reasons for selecting Medicare Advantage
- Medication payments are similar to Medicare

Lets Talk About the Medications

Separately payable

- Inpatient
  - New Technology Add-on Payment (NTAP) payments

    New Medications FY 2023

    Continued Medications FY 2023
- Outpatient
  - Part B drugs

Inpatient - New Technology Add-on Payment (NTAP)

“Sections 1886(d)(5)(K) and (L) of the Social Security Act establish a process of identifying and ensuring adequate payment for certain new medical services and technologies (sometimes collectively referred to in this section of the CMS website as “new technologies”) under the IPPS.”

Criteria to be eligible:

- Newness criterion - the medical service or technology must be new
- Cost criterion - the medical service or technology must be costly such that the MS-DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate
- Substantial clinical improvement criterion - the medical service or technology must demonstrate a substantial clinical improvement over existing services or technologies

New technology add-on payments are limited to the lesser of 65% of the costs of the technology, or 65% of the amount by which the costs of the case exceed the standard MS–DRG payment (75% for a Qualified Infectious Disease Product (QIDP) or a product approved under FDA’s Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD)).

Applicants for NTAP must receive FDA marketing authorization for their new medical service or technology by **July 1** of the year prior to the beginning of the fiscal year (FY) for which the application is being considered, except for QIDP/LPAD applicants.

CMS. New Medical Services and New Technologies

NTAP - New Medication FY 2023

CMS approved 3 new medication NTAPs for FY 2023

MAC Implementation File 8 - FY 2023 New Technology Add-on Payment (NTAP) - Technologies Beginning to Receive NTAP			
Technology	**Maximum Add-on Payment**	**ICD-10-CM/PCS Codes Used to Identify Cases Eligible for NTAP**	**Alternative Pathways Status**
DefenCath™	$4,387.50	XY0YX28	QIDP
Carvykti™ (ciltacabtagene autoleucel)	$289,532.75	XW033A7 or XW043A7	
DARZALEX FASPRO®	$5,159.41	XW01318 **in combination with** E85.81	
Livtencity™ (maribavir)	$32,500.00	XW0DX38 or XW0G738 or XW0H738	
Hemolung Respiratory Assist System (RAS)	$6,500.00	5A0920Z	
Cerament® G	$4,918.55	XW0V0P7	Breakthrough Device
GORE® TAG® Thoracic Branch Endoprosthesis	$27,807.00	02VW3DZ **in combination with** 02VX3EZ	Breakthrough Device
iFuse Bedrock Granite Implant System	$9,828.00	XNH6058, XNH6358, XNH7058, XNH7358, XRGE058, XRGE358, XRGF058, or XRGF358	Breakthrough Device
Thoraflex™ Hybrid Device	$22,750.00	X2RX0N7 **in combination with** X2VW0N7	Breakthrough Device
ViviStim® Paired VNS System	$23,400.00	X0HQ3R8	Breakthrough Device

CMS. *FY 2023 IPPS Final Rule Home Page*

NTAP - Continued Medications FY 2023

CMS continues existing NTAP applications for 8 medications FY 2023

MAC Implementation File 8 - FY 2023 New Technology Add-on Payment (NTAP) - Technologies Continuing to Receive NTAP			
Technology	**Maximum Add-on Payment**	**ICD-10-CM/PCS Coding Used to Identify Cases Eligible for NTAP**	**Alternative Pathways Status**
Fetroja® (cefiderocol) (HABP/VABP)	$8,579.84	XW033A6 or XW043A6 **in combination with** Y95 and one of the following: J14, J15.0, J15.1, J15.5, J15.6, J15.8 OR XW033A6 or XW043A6 **in combination with** J95.851 and one of the following: B96.1, B96.20, B96.21, B96.22, B96.23, B96.29, B96.3, B96.5, B96.89	QIDP
RECARBRIO™ (HABP/VABP)	$9,576.51	XW033U5 or XW043U5 **in combination with** Y95 and one of the following: J14, J15.0, J15.1, J15.5, J15.6, or J15.8 OR XW033U5 or XW043U5 **in combination with** J95.851 and one of the following: B96.1, B96.20, B96.21, B96.22, B96.23, B96.29, B96.3, B96.5, B96.89	QIDP
Rybrevant® (amivantamab)	$6,405.89	XW033B7 or XW043B7	
Abecma® (idecabtagene vicleucel)	$289,532.75	XW033K7 or XW043K7	
Tecartus® (brexucabtagene autoleucel)	$259,350.00	XW033M7 or XW043M7	
Cosela™(trilaciclib)	$5,612.10	XW03377 or XW04377	
Veklury® (remdesivir)	$2,028.00	XW033E5 or XW043E5	
Zepzelca® (lurbinectedin)	$9,145.50	XW03387 or XW04387	

CMS. *FY 2023 IPPS Final Rule Home Page*

Outpatient - Part B Drugs

- Generally payable:
  - Antigens
  - Blood clotting factors
  - Medications given through infusion pumps or nebulizers
  - **Injectable and infused drugs**
  - Injectable osteoporosis drugs
  - Immunosuppressive drugs for organ transplant
  - Pneumococcal, influenza, and hepatitis B vaccines

HCPCS Codes

- Code set developed by CMS to help code procedures and medical equipment
- HCPCS II codes are 5 characters long
  - Each starts with a letter - the letter denotes which grouping the code is in
    - Begin with letters A-V, followed by four numbers
    - C -Temporary Hospital OPPS
    - J - most common
    - Q -temporary codes

CMS. HCPCS - General Information

HCPCS Level II

Code	Description
A	transportation, medical and surgical supplies, miscellaneous and experimental
B	enteral and parenteral therapy
C	**temporary hospital OPPS**
E	durable medical equipment
G	temporary procedures and professional services
H	behavioral health/substance abuse services
J	**drugs administered other than oral method, chemotherapy drugs**
K	temporary codes for durable medical equipment regional carriers
L	orthotic/prosthetic procedures
M	other medical services
P	pathology and laboratory
Q	**temporary codes (limited use and guidelines specific)**
R	diagnostic radiology services
S	temporary national codes (non-Medicare) codes
T	temporary state Medicaid agency codes
V	vision/hearing services

CMS. HCPCS - General Information

HCPCS - Level II

- Typically listed under the generic name
- Brand specific HCPCS codes - WATCH OUT!
    - Medications that were approved under separate New Drug Application (NDA) or the Biologics License Application (BLA) after October 2003
    - Not rated therapeutically equivalent to the reference drug listed in the FDA's Orange Book or listed reference product in an existing HCPCS code
    - Considered single-source products according to section 1847A(c)(6) of the Social Security Act
    - Each single source product should be assigned a unique billing and payment code, which now includes the brand name in the description to differentiate the HCPCS
    - Additionally, CMS is actively removing brand names from the HCPCS description when the code is used for multiple source drugs
- **36 Brand HCPCS** codes listed in Jan 2023
- Example of brand name products include biosimilars:
    - J1745 Injection, infliximab, excludes biosimilar, 10 mg
    - Q5103 Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
    - Q5104 Injection, infliximab-abda, biosimilar, (renflexis), 10 mg

HCPCS - Level II

Updates made quarterly - Can be found on CMS website and referenced frequently

- ASP-HCPCS-NDC Crosswalk
  - Crosswalk of NDC numbers to HCPCS codes and package sizes/quantity information
- Addendum A
  - ASP pricing file
  - Payment limits by HCPCS codes for the upcoming quarter
- Addendum B
  - Current HCPCS codes, Status Indicators, Hospital Outpatient Perspective Payment System (OPPS) rates
- Alpha Numeric HCPCS file
  - List of established HCPCS codes

CMS. 2023 ASP Drug Pricing Files
CMS. Addendum A and Addendum B Updates

HCPCS Modifiers

Modifiers provide a range of additional information about medical procedures

Two characters long - can be alphanumeric or alpha

- Route of administration modifiers - when multiple routes of administration exist
  - JA (intravenous infusion)
  - JB (subcutaneous injection)
- JW
  - HCPCS Level II modifier reported on a claim that a drug was discarded/not administered to any patient
  - Provide payment for the amount of discarded drugs or biologics
  - Single-dose or Single-use
  - Billed on a separate line
  - Must be smallest vial size or smallest combination of vials
  - Discarded amount must be recorded in the medical record
  - Not permissible if drug administered is less than the billing unit
  - Cannot be used to report discarded amounts of overfill

CMS. Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy
CMS. Billing and Coding: JW and JZ Modifier Billing Guidelines (Article A55932)

New Modifier - JZ

- JZ - *NEW!! July 2023*
  - JZ modifier is a HCPCS Level II modifier reported on a claim to attest that no amount of drug was discarded and eligible for payment
  - Required when there is no discarded amounts of a single dose container drug
  - All claims must have either a JW or JZ modifier
  - Starting October 1st, 2023, claims for drugs from single-dose containers that do not use the modifiers appropriately may be returned as unprocessed until the claims are properly submitted
  - Can start reporting JZ modifier now - available for use as of January 1, 2023

- JW and JZ modifiers policy applies for drugs that are separately payable only – SI, G, or K
- Tip: Set up rules in claims space to ensure that JZ modifiers are applied correctly before submission and do frequent audits

CMS. Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy
CMS. Billing and Coding: JW and JZ Modifier Billing Guidelines (Article A55932)

Status Indicators

Indicator	Service	Status
A	Durable Medical Equipment, Prosthetics and Orthotics (excluding implanted DME and prosthetics)	DMEPOS Fee Schedule
A	Physical, Occupational and Speech Therapy	Physician Fee Schedule
A	Ambulance	Ambulance Fee Schedule
A	EPO for ESRD Patients	National Rate
A	Clinical Diagnostic Laboratory Services	Laboratory Fee Schedule
A	Physician Services for ESRD Patients	Physician Fee Schedule
A	Screening Mammography	Physician Fee Schedule
C	Inpatient Procedures	Not Payable under OPPS; Admit Patient; Bill as Inpatient
D	Deleted Code	Deleted Effective Beginning of Calendar Year
E	Non-Covered Items and Services, Codes not Reportable in Hospital Outpatient Settings	Not Paid Under Medicare or When Performed in a Hospital Outpatient Setting
F	Corneal tissue acquisition; orphan drugs	Paid at Reasonable Cost
G	**Drug/Biological Pass-Through**	**Paid Under OPPS; Separate APC Payment Includes Pass Through Amount**
H	Device Category Pass-Through	Paid Under OPPS; Separate Cost Based Pass Through Payment
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Paid reasonable cost; not subject to deductible or coinsurance
K	**Non Pass-Through Drug/Biological, Certain Brachytherapy seeds**	**Paid Under OPPS; Separate APC**
N	**Items and Services Packaged into APC Rate**	**Paid under OPPS; Payment Is Packaged Into Payment for Other Services**
P	Partial Hospitalization	Paid under OPPS; Per Diem APC
S	Significant Procedure, Not Discounted When Multiple	Paid Under OPPS; Separate APC
T	Significant Procedure, Multiple Procedure Reduction Applies	Paid Under OPPS; Separate APC
V	Visit to Clinic or Emergency Department	Paid Under OPPS; Separate APC
X	Ancillary Service	Paid Under OPPS; Separate APC

Status Indicators

- Separately Payable
  - G - Drug/Biological Pass-Through
  - K - Non Pass-Through Drug/Biological
- Not Separately Payable
  - N - Items and Services Packages into APC rate

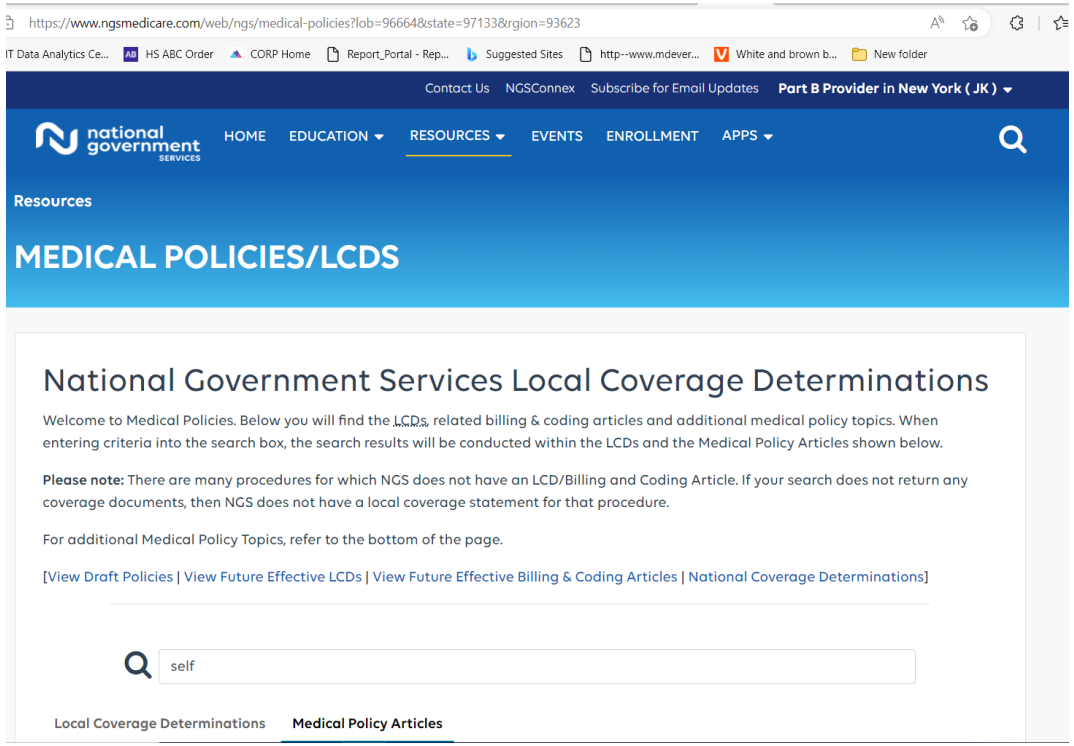
CMS. Addendum D1.— Payment Status Indicators

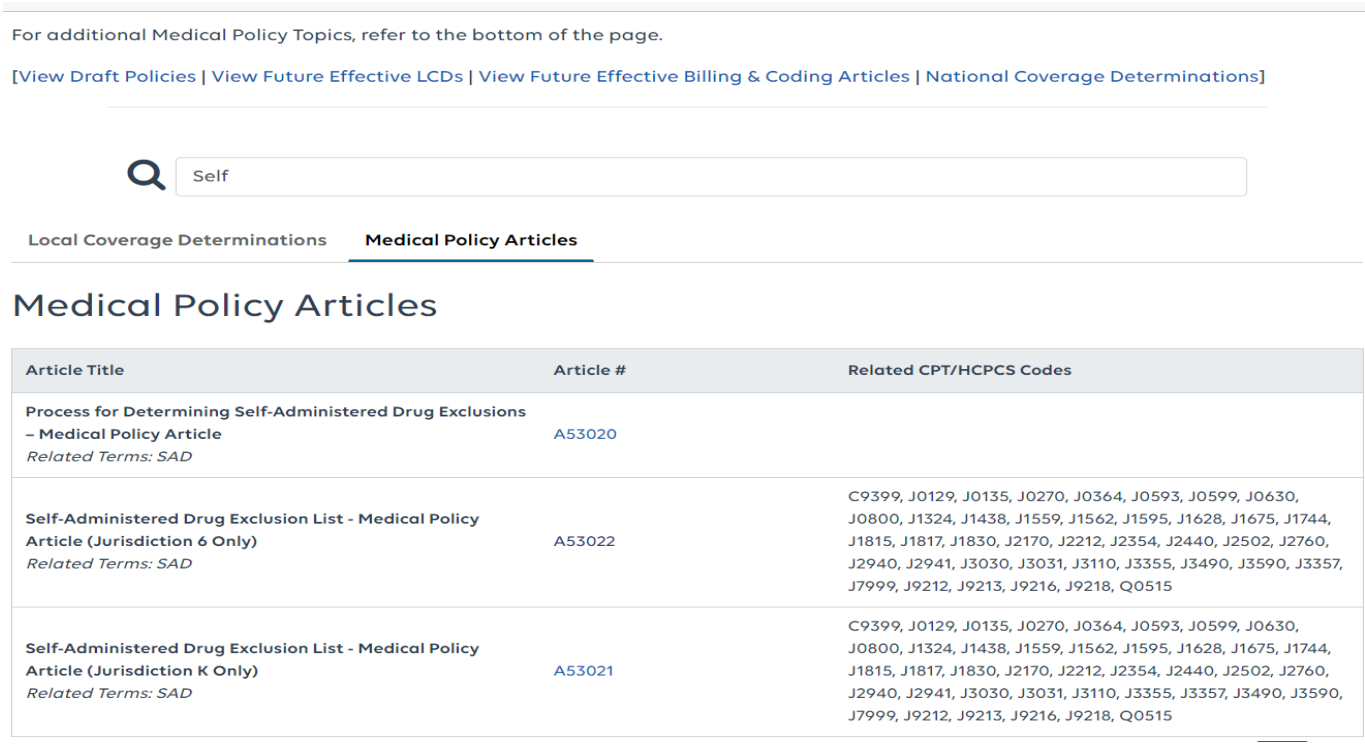
Part B Drugs - Self Administered Drug (SAD) List

- Medications are considered for the SAD list based on:
  - Peer reviewed medical literature
  - Standards of medical practice
  - Evidence-based practice
  - FDA approved label
  - Package insert
  - Drug compendia references

- Additional SAD considerations:
  - “Apparent on its face”
  - Acute or chronic condition
  - “Usually” - how many Medicare Beneficiaries Self Administer (50%)
  - Route of administration - subcutaneous, intravenous, or intramuscular

Navigating LCD





Billable Units

Billing units in a vial is not always equal to mgs in a vial

- Example:
  - J1745 is a vial comprised of 100 mg
  - 1 billable unit is equal to 10 mg, therefore each vial has 10 billable units

Billing units in a vial not always equal to mgs in a vial

- Example
  - J9047 comes in 20 mg, 30 mg, and 60 mg vials
  - 1 billable unit is equal to 1 mg, therefore each vial has 20, 30, and 60 billable units, respectively

ASP Drug pricing - J1745

Effective	Code Dosage	Payment Limit	Vaccine AWP %	Vaccine Limit	Ir
April 1, 2023 - June 30, 2023	10 MG	34.043	20%	-	
January 1, 2023 - March 31, 2023	10 MG	34.862	-	-	
October 1, 2022 - December 31, 2022	10 MG	35.022	-	-	
Jul 1, 2022 - Sep 30, 2022	10 MG	35.713	-	-	
April 1, 2022 - June 30, 2022	10 MG	36.513	-	-	

ASP Drug pricing - J9047

Effective	Code Dosage	Payment Limit	Vaccine AWP %	Vaccine Limit
April 1, 2023 - June 30, 2023	1 MG	44.764	20%	-
January 1, 2023 - March 31, 2023	1 MG	45.061	-	-
October 1, 2022 - December 31, 2022	1 MG	44.027	-	-
Jul 1, 2022 - Sep 30, 2022	1 MG	43.242	-	-
April 1, 2022 - June 30, 2022	1 MG	41.335	-	-

Billable Units

Billing units not always apparent

- J9316 is a combination product - pertuzumab, trastuzumab and hyaluronidase-zzxf
  - 600 mg, 600 mg
  - 1200 mg, 600 mg
- 1 billable unit is equal to 10 mg, therefore each vial has 120 and 180 billable units, respectively

ASP Drug pricing - J9316

Effective	Code Dosage	Payment Limit	Vaccine AWP %	Vaccine Limit	
April 1, 2023 - June 30, 2023	10 MG	68.44	20%	-	
January 1, 2023 - March 31, 2023	10 MG	69.061	-	-	
October 1, 2022 - December 31, 2022	10 MG	69.85	-	-	
Jul 1, 2022 - Sep 30, 2022	10 MG	70.371	-	-	
April 1, 2022 - June 30, 2022	10 MG	70.86	-	-	

Fundamentals - Billable Units

Effective date	Effective Jan 01, 2022
Date added	Added Jan 01, 2004
Termination date	Dec 31, 2021

AAPC Learn More >

HCPCS Coding Procedures

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ASP Drug pricing - J2505

Effective	Code Dosage	Payment Limit	Vaccine AWP %	Vaccine Limit	Infusion AWP %	DME infusion limit	Blood AWP %	Blood limit	Clotting factor	Note
	6 MG	2221.626	-	-	-	-	-	-		
	6 MG	2469.355	-	-	-	-	-	-		
	6 MG	2808.062	-	-	-	-	-	-		
	6 MG	3079.488	-	-	-	-	-	-		
	6 MG	3571.681	-	-	-	-	-	-		

Effective	Code Dosage	Payment Limit	Vaccine AWP %	Vaccine Limit	Infusion AWP %	DME infusion limit	Blood AWP %	Blood limit	Clotting factor	Note
April 1, 2023 - June 30, 2023	0.5 MG	109.685	20%	-	-	-	-	-		
January 1, 2023 - March 31, 2023	0.5 MG	135.166	-	-	-	-	-	-		
October 1, 2022 - December 31, 2022	0.5 MG	131.414	-	-	-	-	-	-		
Jul 1, 2022 - Sep 30, 2022	0.5 MG	155.827	-	-	-	-	-	-		
April 1, 2022 - June 30, 2022	0.5 MG	167.681	-	-	-	-	-	-		

Dose of the medication given is converted into billing units and submitted on the claim

Billing units can change:

- J2505 went from 1 billable unit per package to 12 billable units per package
- If updates made in a timely manner, it can result in significant underpayment

Charge Description Master

- Comprehensive list of all medications
- How we maintain our medication files - information here that will appropriately reflect charges on a claim
  - Billing/Charge descriptions
  - Procurement Cost
  - Mark Up
  - Implied units/how much of a particular product charges are being based of off
  - Revenue Codes
  - HCPCS Codes
- Impact of Inaccurate CDM
  - Overcharging/undercharging
  - Potential repayments
  - Impact billing KPIs

Medicare Hospital Outpatient Prospective Payment System (OPPS)

- Fee-for-service
- Outpatient perspective payment System (OPPS) final rule for YR 2023
  - Non-Pass through separately payable (340b purchased)→ ASP + 6%

    Previous was ASP -22.5% from 2018- 2022
  - New drugs not yet assigned HCPCS codes → 95% of Average Wholesale Price
  - No ASP information available → WAC + 3%
  - Biosimilars → ASP of biosimilar plus 6% ASP
  - Policy packaged by lower cost threshold → ≤ $135/day, SI N

CMS. Hospital OPPS and ASC Payment systems. Final Rules (November 2022.)
Kirschenbaum B. Presentation from ASP Midyear Clinical Meeting. Las Vegas ,NV; 2022 Dec

Inflation Reduction Act (IRA) of 2022

- Signed into law on August 16, 2022
- Major components related to prescription medications
  - Drug Price Negotiation Program
    - Applied to specified high Medicare spend drugs
    - Identified 2 years prior to negotiated price application
    - First set of medications to be identified in 2023 for applied year 2026
  - Medicare Part B and Part D Inflation Rebates
    - Manufacturers will be required to pay a rebate on a unit of drug where price increases faster than inflation
    - Part B: First rebate period begins in Q1 2023
    - Part D: First rebate period begins in Q4 2022
  - Medicare Part D Redesign
    - Beneficiary Out of Pocket threshold lowered to $2,000 starting in 2025
    - Coverage gap eliminated starting in 2025
    - Beneficiary cost sharing in catastrophic phase eliminated in 2024

Kirschenbaum B. Presentation from ASP Midyear Clinical Meeting. Las Vegas ,NV; 2022 Dec
Price Negotiation, Medicare Rebates, and Benefit Reform, n.d.

Currently working on

- Capturing all possible waste opportunities
  - High dollar medications
  - Large quantity of dispensations
  - Pyxis dispensed medications
  - Reportable VS chargeable
  - Optimizing reporting capabilities
- CDM accurate monthly/quarterly updates
  - Review workflows to identify optimal/timely updates
  - Audit 340B pricing accuracy for Medicaid Claims
- Audit high cost/high use meds in billing systems
- Medication denials
  - Implement appropriate workflows

Things to explore

- CDM governance
- Denial avoidance teams
  - That include pharmacy
- Revenue integrity and underpayment teams
- Revenue opportunities
- EOM considerations
- System surveillance
  - Work queues
  - Reports - unreconciled dispenses, waste reports
  - Dashboards

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Thank You/Any Questions?

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