

# PAREXEL Guide to Healthcare Coding Systems for Drugs and Biologicals

## Authors:

**Chris Mancill, MA, CCP**

*Director, Health Policy and Payer Relations*

**Jennifer Gruber**

*Senior Policy Advisor*

**Connie Mason, CPC**

*Reimbursement Analyst*

**Tom Snyder, MA**

*Senior Project Manager*

**Jacqueline Woodle, PhD, RN**

*Senior Policy Advisor*

## About PAREXEL Health Policy and Payer Relations...

As a new drug, biotechnology, or medical device product goes through the development process and approaches market launch, it is extremely important that its manufacturer possess an in-depth understanding of the public and private reimbursement environment that the product will face.

To assist our industry clients, PAREXEL's Health Policy and Payer Relations Group provides a comprehensive range of services that focus on removing the barriers to acceptance and framing a product's value proposition. We also distill broad health policy developments into their essential elements and provide strategic recommendations to our clients on how healthcare issues will impact the industry.

Additionally, we coordinate all of our services closely with PAREXEL's co-located Reimbursement Contact Centers, Patient Assistance Programs, and Phase IV Study Recruitment Programs to provide our clients with a single choice for a health policy and reimbursement services partner.

For information on PAREXEL Health Policy and Payer Relations services, visit <http://www.parexelonpolicy.com> or contact Cathy Townsend at 703/310-2055.

PAREXEL International Medical Marketing Services Inc. (PAREXEL) has prepared the *PAREXEL Guide to Healthcare Coding Systems for Drugs and Biologicals* to help our firm’s clients understand the healthcare code sets most commonly required for submitting claims for drug and biological products in various clinical care settings. These code sets include the following:

- Healthcare Common Procedure Coding System (HCPCS) codes;
- Current Procedural Terminology (CPT) codes;
- International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) codes;
- Revenue codes; and
- National Drug Codes (NDCs).

To receive payment for services and products, healthcare providers and suppliers must bill third-party payers using one or more of these coding systems. For example, a single procedure (*i.e.*, the administration

a drug) requires the use of several different code sets. This requirement can make understanding the field of coding difficult for anyone who is not experienced with third-party coding and reimbursement issues. Added to that complexity is the fact that coding guidelines vary from one clinical care setting to another. In addition, individual payers often set their own coding guidelines, which are subject to frequent changes.

The *PAREXEL Guide to Healthcare Coding Systems for Drugs and Biologicals* is intended to answer many of the basic questions that drug and biological product manufacturers have about the healthcare code sets that their customers use. However, the guide may not answer all questions, so please contact your PAREXEL Health Policy and Payer Relations consultant with any specific questions.

In Table 1, we briefly review the common uses of these code sets and identify the clinical care settings where they are most typically used. Please keep in mind

**TABLE 1: OVERVIEW OF COMMON CODE SETS AND THEIR USAGE BY SETTING**

Code Set	Usage	Settings
HCPCS Codes	To identify drugs, biologicals, medical supply products, and certain medical services	Hospital inpatient (for antihemophilia factors only), hospital outpatient, home health/infusion (for certain payers), skilled nursing facility, physician office
CPT Codes	To identify medical services, vaccines, and toxoids	Hospital inpatient (for physician services only), hospital outpatient (for physician and facility services), skilled nursing facility (for physician services only), physician office
ICD-9-CM Diagnosis Codes	To identify patient diagnoses and conditions	Hospital inpatient, hospital outpatient, home health/infusion, skilled nursing facility, physician office
ICD-9-CM Procedure Codes	To identify medical services	Hospital inpatient, hospital outpatient, home health/infusion, skilled nursing facility
Revenue Codes	To identify categories of facility services	Hospital inpatient, hospital outpatient, home health/infusion (for certain payers), skilled nursing facility
NDCs	To identify drugs and biologicals	Pharmacy, home infusion (for certain payers)

that this information is intended to summarize the most common coding practices and cannot address every possible use of codes.

In the following sections, we review each code set in detail and discuss how each is issued and updated. We also review how code sets are relevant to pharmaceutical and biological product manufacturers and their products.

*There are two primary healthcare claim forms that practitioners and facilities use to bill for services. As shown in Chart 1, physician services most commonly are billed on the CMS-1500 form, while facility services (for example, hospital inpatient and home health services) most commonly are billed on the UB-92 claim form.<sup>1</sup>*

**CHART 1: USE OF CLAIM FORMS BY CLINICAL CARE SETTING**

**CMS-1500**



**PHYSICIAN SERVICES**  
All Sites of Service

**UB-92**



**FACILITY SERVICES**

**HCPCS Codes**

There are three levels of HCPCS codes. Level I HCPCS codes are CPT codes, which we detail in a subsequent section. Level II HCPCS codes are required by most public and private payers for drugs, biologicals, and medical supplies. Level II codes are generally what

<sup>1</sup> Most retail pharmacies and some home infusion providers do not use either claim form. Instead, they most commonly use a purely electronic billing system based on NDCs.

providers and payers refer to simply as HCPCS codes. Level III HCPCS codes are most commonly called local codes and are created by payers to identify products and services not classified by other codes.

HCPCS Level II codes—herein referred to simply as HCPCS codes—are typically the most important type of codes for drug and biological product manufacturers. HCPCS codes are assigned by the HCPCS National Panel under the auspices of the Centers for Medicare and Medicaid Services (CMS). Each HCPCS code is a five-character, alpha-numeric code that identifies specific drugs, biologicals, medical supply products, and (in rare cases) medical services. As shown in Table 2, there are various types of HCPCS codes, but most drug and biological products are assigned HCPCS codes that begin with the letter C or the letter J. Some products, however, may be assigned codes beginning with other letters, such as K codes for immunosuppressives.

Below, we highlight important issues for HCPCS C-codes and J-codes.

**TABLE 2: EXAMPLES OF USAGE FOR VARIOUS HCPCS CODE TYPES**

Code Type	Examples of Drug and Biological Product Usage
A	Certain radiopharmaceuticals
K	Certain products paid through the Medicare program’s Durable Medical Equipment Regional Carriers (DMERCs)
P	Certain blood components and plasma derivatives
Q	Certain oral anti-emetics, end-stage renal disease (ESRD) products, and antihemophilia factors
S	Certain products primarily paid by private payers
T	Certain products primarily paid by state Medicaid programs

## HCPCS C-Codes

### Usage:

*HCPCS C-codes are typically used to identify certain new, provider-administered drug and biological products supplied to Medicare beneficiaries in the hospital outpatient setting.*

Once a new drug or biological product receives approval from the U.S. Food and Drug Administration (FDA), the product’s manufacturer may begin the process of obtaining one or more HCPCS C-codes for the new product. This process is necessary only if existing HCPCS C-codes or other HCPCS codes do not adequately and appropriately describe a particular product, or if the product appears to meet the requirements for transitional pass-through status.

To obtain a HCPCS C-code, a formal application for review of transitional pass-through eligibility is required. This application must be submitted to CMS, the federal agency that oversees the Medicare program. Upon receipt, CMS will review the product to determine its eligibility. If CMS deems the product eligible for transitional pass-through status, the agency assigns one or more new HCPCS C-codes to the product. Coding examples are provided in Table 3.

Transitional pass-through status and payments, however, are not effective immediately. Just as there are specified deadlines for submissions of new product requests, there also are specified implementation dates, which occur on a quarterly basis. These deadlines and implementation dates are shown in Table 4.

**TABLE 3: EXAMPLES OF HCPCS C-CODES**

HCPCS Code	HCPCS Code Description
C1022	plasma, frozen within 24 hours of collection, each unit
C1774	injection, darbepoetin alfa (non-ESRD), per 1 mcg
C9115	injection, zoledronic acid, injection, per 2 mg

The dates listed above show the expected implementation dates for products that CMS deems eligible, provided that the transitional pass-through request is complete and CMS has no questions about the product.

New HCPCS C-codes are activated solely on a quarterly basis, and the lag between submitting a request and receiving transitional pass-through payments has totaled more than seven months for several products. Use of new products that do not yet have a HCPCS C-code is not reimbursed by Medicare in the hospital outpatient setting.

**TABLE 4: HCPCS C-CODE APPLICATION DEADLINE AND IMPLEMENTATION DATES**

Filing Deadlines	Quarterly Implementation Dates (If Approved)
First business day of September	January 1
First business day of December	April 1
First business day of March	July 1
First business day of June	October 1

### REIMBURSEMENT CONSIDERATIONS FOR HCPCS C-CODES

Transitional pass-through reimbursement applies only to hospital outpatient utilization of eligible products under the Medicare program. Other payers—including Medicaid programs and private insurers—typically do not recognize HCPCS C-codes. HCPCS C-codes cannot be used in the physician-office setting under the Medicare program. In calendar year (CY) 2003, reimbursement for eligible transitional pass-through drugs and biologicals is set at 95 percent of average wholesale price (AWP).

## HCPCS J-Codes

### Usage:

HCPCS J-codes are used to identify certain provider administered drug and biological products. HCPCS J-codes are accepted by the vast majority of public and private payers and commonly are used for hospital outpatient and physician office claims, as well as for claims in many other healthcare settings.

After a new drug or biological product receives approval from the FDA and acquires six months of marketing data, the product's manufacturer may begin the process of obtaining one or more HCPCS J-codes for the new product. This process should be undertaken only if existing HCPCS J-codes do not adequately and appropriately describe the product.

A manufacturer may submit the request even if the product has one or more existing HCPCS C-codes, because HCPCS C-codes generally are applicable only in the hospital outpatient setting and typically are used by the Medicare program. The deadline for submitting HCPCS J-code applications is April 1 of each year, with approved HCPCS codes becoming effective at the beginning of the following calendar year. If CMS has questions about the product, the agency contacts the manufacturer for additional information. CMS strongly recommends submitting HCPCS J-code applications significantly in advance of the April 1 deadline since the agency frequently is inundated with last-minute requests. If CMS cannot review all requests submitted within one year, the agency places the excess applications on hold until the following year. Coding examples are provided in Table 5.

Prior to the assignment of a HCPCS J-code, physician offices may bill for many new drug and biological products using unspecified HCPCS J-codes—such as HCPCS code J3490 (unclassified drugs), HCPCS code J3590 (unclassified biologics), J7199 (hemophilia clotting factor, not otherwise classified), and J9999 (anti-neoplastic drugs, not otherwise classified). The Medicare program, however, does not recognize these codes in the hospital

TABLE 5: EXAMPLES OF HCPCS J-CODES

HCPCS Code	HCPCS Code Description
J2405	injection, ondansetron hydrochloride, per 1 mg
J9001	injection, doxorubicin hydrochloride, all lipid formulations, per 10 mg
J9206	injection, irinotecan, per 20 mg

outpatient setting, and will not make payment for drug use reported with these codes.

It is important to note that use of unspecified HCPCS codes sometimes can cause claim delays; however, drug and biological product manufacturers can educate their customers on how to avoid or minimize delays by supplying payers with additional information. For example, providers may indicate the National Drug Code for the product and write out the product's name, vial size, and dosage in the narrative or comments field of the electronic or manual claim form.

### REIMBURSEMENT IMPLICATIONS FOR HCPCS J-CODES

Most public and private payers recognize HCPCS J-codes for provider-administered drug and biological products. Under the Medicare program, reimbursement typically is set at 95 percent of AWP in the physician office setting. Other payers typically set reimbursement rates based on a percentage of AWP.

## CPT Codes

### Usage:

CPT codes most commonly are used to bill for hospital outpatient, physician, and certain non-physician practitioner services. CPT codes typically identify services related to the administration of drug and biological products, not the products themselves. CPT codes also identify numerous vaccine, immune globulin, antitoxins, and toxoid products.

CPT codes are maintained by the American Medical Association’s (AMA’s) CPT Editorial Panel, which makes annual revisions and modifications to the CPT code set. Coding examples are provided in Table 6.

The Editorial Panel is made up of fourteen physicians, ten nominated by the AMA and one each nominated by the Blue Cross and Blue Shield Association (BCBSA), the Health Insurance Association of America (HIAA), the American Hospital Association AHA, and CMS. Of the ten AMA seats, six are regular seats, with a maximum tenure of two three-year terms. The other four are rotating seats, with single three-year terms. The AMA Board of Trustees appoints all Editorial Panel members.

The CPT Editorial Panel is supported by the AMA CPT Advisory Committee, which is made up of physicians representing the national medical specialty societies in the AMA House of Delegates. The Advisory Committee’s main functions are to suggest revisions to CPT, to provide documentation to the Editorial Panel as to the medical appropriateness of medical and surgical procedures, and to advise the Editorial Panel on coding and nomenclature relevant to a particular member’s specialty.

The CPT Editorial Panel staff members review all CPT coding change requests. If the CPT Editorial Panel

**REIMBURSEMENT IMPLICATIONS FOR CPT CODES**

Most public and private payers assign fee schedule payments for CPT codes. For physician-office claims, the Medicare program’s payment system is the Medicare physician fee schedule, which is updated on an annual basis. The calculation of the update factor is fixed by statute.

Many other payers base reimbursement amounts on the Medicare program’s rates, but it is also common for payers to set payments based on their own contracted or negotiated rates. In addition, some payers continue to allow reimbursement based on usual and customary rates, but this type of payment system is becoming increasingly uncommon.

staff members determine that the AMA has already addressed a coding issue, the CPT Editorial Panel staff members inform the requester of the AMA’s current interpretation. However, if the CPT Editorial Panel staff members determine that the request is a new issue—or if significant new information is received on an item that the Panel reviewed previously—the request is referred to the appropriate Advisory Committee. If the Advisory Committee members agree that no new code or revision is needed, the CPT Editorial Panel staff members provide information to the requester on how to use existing codes to report the procedure. If there is disagreement among the advisors, or if the advisors agree that a change is indicated, the issue is forwarded to the CPT Editorial Panel, which makes the CPT coding determination.

In PAREXEL’s experience, and as confirmed through conversations with CPT Editorial Panel senior staff members, the AMA prefers to have information submitted by an organization that is not directly affiliated with the manufacturer. Also, the CPT Editorial Panel staff members emphasize that it is highly recommended that the new CPT code request be supported by a relevant specialty society.

**TABLE 6: EXAMPLES OF CPT CODES <sup>2</sup>**

CPT Code	CPT Code Description
90716	varicella virus vaccine, live, for subcutaneous use
90723	diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use
90780	intravenous infusion for therapy or diagnosis, administered by physician or under direct supervision of physician, up to one hour

<sup>2</sup>©2002. CPT Only. American Medical Association. All Rights Reserved.

## ICD-9-CM Codes

### Usage:

ICD-9-CM codes are most commonly used for two purposes. First, ICD-9-CM diagnosis codes identify patient conditions and are used in most health care settings. Second, ICD-9-CM procedure codes identify facility medical services and are used in most institutional healthcare settings.

There are two main types of ICD-9-CM codes. The first set describes diagnoses, and the second set describes procedures. Public and private payers most commonly require providers to use one set of ICD-9-CM codes to classify patient diagnoses and the other set to describe hospital medical services. In the United States, ICD-9-CM diagnosis codes, which may be purely numeric or alpha-numeric, are maintained by the National Center for Health Statistics. ICD-9-CM procedure codes, which describe medical services, are maintained by CMS. Coding examples are provided in Table 7.

It is important to note that—because most ICD-9-CM codes are not specific to a particular drug or biological product—it is unlikely that a product would require a new or revised ICD-9-CM code. If a product does require a new or revised ICD-9-CM code, the process is lengthy. The key dates in CY 2003 are outlined in Table 8 on page 9.

**TABLE 7: EXAMPLES OF ICD-9-CM CODES**

ICD-9-CM Code	ICD-9-CM Code Description
99.29	injection or infusion of other therapeutic or prophylactic
285.22	anemia in neoplastic disease
v10.62	history of myeloid leukemia

### REIMBURSEMENT IMPLICATIONS FOR ICD-9-CM CODES

All UB-92 and CMS-1500 claims normally must contain at least one valid ICD-9-CM diagnosis code, or the payer will deny the claims. Additionally, most public

and private payers subject claims to standard review processes frequently referred to as claim edits, which cross-reference the procedures performed and the products provided with the diagnoses indicated. If the payer determines that the procedures or the products generally are not considered medically indicated for the specified diagnoses, the payer may deny the claim or request additional information. All ICD-9-CM diagnosis codes should be coded to the highest level of specificity to help ensure coverage and to assist with medical necessity determinations.

For hospital inpatient claims, most payers require providers to use both ICD-9-CM diagnosis and procedure codes. For the Medicare program and many other payers, these codes are used to determine the diagnosis-related group (DRG) payment that is assigned for a particular patient’s inpatient stay. That DRG has a set reimbursement rate, which represents a lump-sum payment to the hospital for the facility services provided during the patient’s inpatient stay. The DRG typically is intended to cover the payments for most drug and biological products administered to the patient during the inpatient stay (with the exception of antihemophilic clotting factor).

## Revenue Codes

### Usage:

Revenue codes are used to identify the general types of services or products that facilities provide. For UB-92 claims, most public and private payers require providers to use revenue codes for all services billed.

Revenue codes, which are four-digit codes that identify the general types of services or products under broad revenue centers, are maintained by the National Uniform Billing Committee (NUBC).

The member organizations of the NUBC include the following:

*Continued on page 9*

**TABLE 8: IMPORTANT CY 2003 ICD-9-CM DATES**

Date	Action
December 6, 2002	ICD-9-CM Coordination and Maintenance Committee meeting held. Code revisions discussed were for potential implementation on October 1, 2003.
January 10, 2003	Deadline for receipt of public comments on proposed code revisions discussed at the April 18 and 19, 2002 and December 5 and 6, 2002, ICD-9-CM Coordination and Maintenance Committee meetings. These proposals were considered for implementation on October 1, 2003
February 3, 2003	Deadline for submitting requests to be discussed at the April 3 and 4, 2003 ICD-9-CM Coordination and Maintenance Committee meeting.
Month of April 2003	Medicare hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2004 to be published in the Federal Register. This rule will include the final decisions on ICD-9-CM diagnosis and procedure code titles that were discussed at the meetings held on April 18 and 19, 2002, and December 5 and 6, 2002. It will also include proposed revisions to the DRG system on which the public may comment, but will not include additional procedure codes that will be discussed at the April 3 and 4, 2003 meeting.
April 3 and 4, 2003	ICD-9-CM Coordination and Maintenance Committee Meeting. Diagnosis code revisions discussed are for potential implementation on October 1, 2004. Procedure code revisions may be for October 1, 2003 if they can be resolved quickly and finalized by April 30, 2003. Those procedure code proposals that cannot be resolved quickly will be considered for implementation on October 1, 2004.
August 1, 2003	Medicare hospital inpatient PPS final rule for FY 2004 to be published in the Federal Register. This rule will include all code titles included in the proposed notice as well as any other procedure code titles that were discussed at the April 3-4, 2003 meeting and resolved in time for implementation on October 1, 2003.
October 4, 2003	Deadline for submitting requests to be discussed at the December 5 and 6, 2003 ICD-9-CM Coordination and Maintenance Committee meeting.
Month of November 2003	Federal Register notice of and agendas for the December 4 and 5, 2003 ICD-9-CM Coordination and Maintenance Committee Meeting to be published.
December 5 and 6, 2003	ICD-9-CM Coordination and Maintenance Committee Meeting. Code revisions discussed are for potential implementation on October 1, 2004. December 5 will be devoted to discussions of procedure codes. December 6 will be devoted to discussions of diagnosis codes.

- American Hospital Association;
- American Association of Health Plans;
- Blue Cross and Blue Shield Association;
- Centers for Medicare and Medicaid Services;
- Federation of American Hospitals;
- Health Insurance Association of America;
- Healthcare Financial Management Association;
- and
- Several other healthcare industry organizations.

Each supply or service provided during the patient’s hospital inpatient admission or hospital outpatient visit typically is associated with a revenue code. Coding examples are provided in Table 10.

Revenue code change requests must be submitted in writing and must follow the specific format developed by the NUBC. Since revenue codes represent broad categories of services and products, it is unlikely that a new drug or biological product would require a new or revised revenue code.

Requests for change must provide sufficient documentation to show that the requested change is necessary because it affects a majority of the providers or payers. Change requests normally are accepted on a quarterly basis, and formal discussion of change requests is scheduled for the next regularly scheduled NUBC meeting or NUBC conference call. The NUBC holds frequent meetings and calls, but there is no mandated schedule.

If adopted, a change request is entered as a modification to the *National UB-92 Data Element Manual* and is

**TABLE 9: EXAMPLES OF REVENUE CODES**

ICD-9-CM Code	ICD-9-CM Code Description
0258	pharmacy, intravenous solutions
0263	intravenous therapy, drug and supply delivery
0636	pharmacy, drugs requiring detailed coding

published by the NUBC. If rejected, the change request decision may be appealed. In such cases, the NUBC appoints a special ad hoc committee to review the appeal.

**REIMBURSEMENT IMPLICATIONS FOR REVENUE CODES**

Most public and private payers require hospitals to file claims under revenue codes. Most drug and biological products are classified into broad revenue code categories, such as revenue code 0250 (pharmacy, general classification). If a product has transitional pass-through status, hospitals must bill for it under revenue code 0636 and include the relevant HCPCS code assigned to the product in order to receive separate reimbursement in the hospital outpatient setting under the Medicare program. Revenue code 0636—along with the appropriate HCPCS J- code or Q-code—is also required to report administration of antihemophilic clotting factor on hospital inpatient claims.

**NDCs**

**Usage:**

*NDCs most commonly are used to bill for prescription drugs and biologicals provided by pharmacies and some home infusion providers. NDCs normally identify prescription products, but there are some NDCs for over-the-counter, herbal, and medical supply products.*

NDCs are unique identifiers assigned to practically all prescription drug and biological products approved in the U.S. The FDA—in collaboration with manufacturers — has traditionally overseen the NDC system. CMS also maintains a separate NDC listing. However, the private companies that publish drug product and pricing listings (such as *Drug Topics® Red Book*) offer much more widely used NDC listings.

By regulation, NDCs are 10-digit codes that follow one of several different formats, including the following:

- Four digits plus four digits plus two digits (4+4+2);
- Five digits plus four digits plus one digit (5+4+1); or
- Five digits plus three digits plus two (5+3+2) digits.

The first set of digits, which is commonly referred to as the prefix, represents the labeler code and refers to the manufacturer or distributor. The second set of digits represents the product, and the last digit or set of digits represents the specific package. Due to the variability of the length of sub-codes within NDCs, almost all public and private payers require that NDCs be billed in an 11-digit format. The 11-digit NDC format is created by a system of zero filling so that each NDC is expressed in a five digits plus four digits plus two digits (5+4+2) format.

The NDC system specifies a drug to the level of its packaging. For example, there is no NDC for amoxicillin, Prozac®, or Prozac® 10 mg oral tablets. However, there are NDCs for amoxicillin marketed as Trimox® (500 mg oral capsule in a package of 100 as a non-unit dose item, distributed by Bristol-Meyers Squibb) and fluoxetine hydrochloride marketed as Prozac® (10 mg oral tablet in a package of 30 as a non-unit-dose item, distributed by Eli Lilly). Table 10 contains additional examples of NDCs.

An NDC cannot be assumed to remain the same over time. NDCs may be reused and reassigned to different drugs. This process may occur as often as every five years. In addition, if one manufacturer acquires another, or if a manufacturer sells the production rights to a drug to another entity, the new manufacturer or distributor typically changes the NDCs for all packages of the product. The FDA listing is generally updated on a quarterly basis.

The CMS listing is updated less frequently. Commercial NDC list vendors may update their listings as often as daily as new products are made available or other changes affect NDC usage.

**TABLE 10: EXAMPLES OF NDCS**

NDC	NDC Description
00004-6940-03	Cytovene®-IV (ganciclovir sodium for injection), supplied in 10 mL vials, with each vial containing 500 mg of ganciclovir sodium, packaged in cartons of 25, distributed by Roche
59676-0302-01	Procrit® (epoetin alfa for injection), supplied in 1 mL vials, with each vial containing 2000 units of epoetin alfa, packaged in cartons of 6 vials, distributed by Ortho Biotech
00026-0648-12	Gamimune® N 10% (immune globulin, human, for injection), supplied in 10 mL vials, with each vial containing 100 mg/mL of immune globulin, distributed by Bayer

### Conclusion

We hope that the *PAREXEL Guide to Healthcare Coding Systems for Drugs and Biologicals* has answered your basic questions about the healthcare code sets that your customers use. If you have additional questions or if you would like to discuss an issue specific to one of your company’s products, please contact your PAREXEL Health Policy and Payer Relations consultant directly or contact Cathy Townsend by email at [cathy.townsend@parexel.com](mailto:cathy.townsend@parexel.com) or by telephone at 703/310-2055.