Contrast Agent Reimbursement Guide

HOSPITAL INPATIENT AND OUTPATIENT

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Information provided in this resource is for informational purposes only and does not guarantee that codes will be appropriate or that coverage and reimbursement will result. Customers should consult with their payers for all relevant coverage, coding, and reimbursement requirements. It is the sole responsibility of the provider to select proper codes and ensure the accuracy of all claims used in seeking reimbursement. Neither this resource nor the Bayer HealthCare Reimbursement Helpline is intended as a legal advice or as a substitute for a provider's independent professional judgment.

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This reimbursement guide provides information about general coverage, coding, and payment for Bayer contrast agents and associated imaging procedures. Correct coding of all components of a service is necessary to obtain appropriate reimbursement.

All codes must be supported with adequate documentation in the medical record.

Please see Ambelvist® Important Safety Information on pages 14-15

Please see Full Prescribing Information for Ambelvist®

Insurance coverage overview

Introduction

Bayer HealthCare Inc. offers this reimbursement guide to provide information about general coverage, coding, and payment information for Bayer contrast agents and associated medical imaging procedures in the hospital inpatient and hospital outpatient settings. The following sections include an overview of the major public and private insurers' general coverage and reimbursement policies for radiology imaging services.

Coverage overview

Coverage refers to insurer provision of program benefits to patients for a specific product or medical service. Coverage policies, which vary by payer, typically specify whether a proposed course of treatment is medically necessary and, therefore, eligible for reimbursement under a patient's healthcare plan. Coverage policies are distinct from payment policies. While a product or service may be covered, if it is bundled or packaged, it is not paid for separately.

Medicare typically covers radiology imaging procedures and contrast agents when they are considered reasonable and necessary for the diagnosis or treatment of an illness or injury. Medicare often bases its coverage decisions on information submitted on claim forms, including diagnosis codes and procedure codes. In some cases, Medicare may also look at accompanying documentation that is submitted with a claim. In general, Medicare covers non-investigational uses of MRI that are reasonable and necessary.

Medicare's complete national coverage determinations for MRI procedures are available at: www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd.

Like Medicare, most private insurers cover radiology imaging procedures, and contrast agents when determined to be medically necessary and appropriate; however, benefits vary from payer to payer and also depend on the specific contract terms that a provider negotiates with a given plan. As a condition of coverage, some managed care plans may also require that providers obtain prior authorization before providing medical imaging services.

Check your patient's policy or call the Reimbursement Helpline for help determining specific policy limits or requirements that might apply to Bayer products or related imaging procedures.

Because decisions regarding Medicaid benefits are generally left to the states, Medicaid coverage policies will be determined on a state-by-state basis. While some policies may mirror coverage guidelines for contrast agents and associated imaging procedures from Medicare, others may limit benefits and may additionally require prior authorization requirements for such services.

For more specific information, check your state's Medicaid coverage policies, or call the Reimbursement Helpline if you need help researching specific guidelines or restrictions.

Coding overview

Correct coding of all components of a service is necessary to obtain appropriate reimbursement.

Hospitals bill for services and items using the Centers for Medicare & Medicaid Services (CMS)-1450 claim form, commonly known as the UB-04 claim form. Although specific coding requirements vary by insurer, Medicare and many other payers rely on various coding systems to process claims for hospital inpatient and hospital outpatient services:

- International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)
- Current Procedural Terminology (CPT®) code(s)
- Healthcare Common Procedure Coding System (HCPCS) codes
- Revenue codes

We describe each type of code on the following pages.

All codes must be supported with adequate documentation in the medical record; such documentation may be requested in the event of an audit or a retrospective claims review.

ICD-CM Codes

All claim forms must include at least one ICD-10-CM diagnosis code to describe the patient's condition. Because there are many possible circumstances that may require radiology imaging services, such services can be billed with a variety of diagnosis codes. Some payers have coverage policies that list specific covered diagnosis codes for imaging procedures; these codes will vary from payer to payer.

Providers should consult a complete listing of current ICD-10-CM diagnosis codes to determine which code(s) best reflect the condition of the patient for whom a claim is submitted and has the highest level of specificity.

Procedure Codes

Hospitals report inpatient services using ICD-10-PCS procedure codes for Medicare and many other payers. For hospital outpatient services, ICD-10-PCS procedure codes are not used on Medicare claims though coding requirements of other payers may vary.

There are dozens of ICD-10-PCS procedure codes that describe several types of radiology services. Providers should consult a complete listing of current ICD-10-PCS procedure codes to determine which code(s) appropriately describe the service(s) rendered to the patient.

CPT Codes

For hospital outpatient services, appropriate CPT codes describing the services performed must be included for Medicare claims and may need to be included for many non-Medicare claims. For Medicare hospital inpatient services, CPT codes are not used for Medicare but may be required by other payers. Many of these CPT codes specify whether an imaging study is performed without contrast material, with contrast material, or without contrast material followed by with contrast material. In many instances, it may be appropriate to use modifiers in conjunction with CPT codes to provide additional detail or to indicate that a service has been altered in some way.

Providers should consult a complete listing of current CPT codes to determine if an alternative code may be appropriate. The American Medical Association (AMA)—the organization that updates and maintains CPT codes— instructs providers to select a CPT code with a descriptor "that accurately identifies the service performed," rather than a code "that merely approximates the service provided." In the absence of a specific code that accurately identifies a service, providers should "report the service using the appropriate unlisted procedure or service code."[1]

Coding overview (cont'd)

HCPCS codes

Medicare, as well as many private payers and Medicaid plans, requires that hospital outpatient departments report many drugs, supplies, other items, and certain services using alphanumeric HCPCS codes, which are often highly specific in nature. Providers are not required to bill contrast agent(s) with HCPCS codes when reporting many contrast-enhanced radiology services but may do so for certain contrast agents in limited circumstances—for example, when reporting MRI contrast on Medicare claims in the hospital outpatient setting.

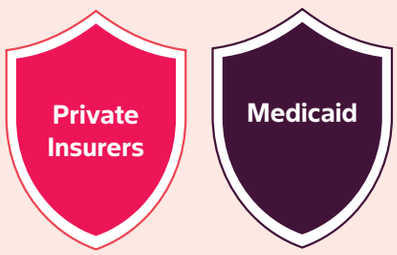
Please note that the availability of a HCPCS code for a particular product does not necessarily indicate that the product is separately reimbursable.

Depending on the insurer and the particular service and contrast agent administered, reimbursement for contrast agents may be included within the payment for the associated imaging procedure. When using HCPCS codes for contrast materials, providers should report correct units of service per the code descriptors.

HCPCS codes are not used on Medicare hospital inpatient claims*; however, the coding requirements of other payers may vary.

In situations that warrant the use of HCPCS codes, providers should consult a complete listing of current HCPCS codes and select the appropriate HCPCS code(s) with the highest level of specificity to describe the product(s) or service(s) furnished.

Hospital outpatient departments, when billing, must report the appropriate HCPCS codes despite payment for most contrast agents being packaged into the payment of the associated imaging procedure.



The coding requirements of non-Medicare payers will likely vary. Some insurers may not require providers to bill for contrast agents with HCPCS codes for many contrast-enhanced radiology imaging procedures.

If you are unsure whether a particular payer accepts contrast agent HCPCS codes, we encourage you to contact the payer directly or call Bayer's Reimbursement Helpline at 1-800-423-7539.

Coding overview (cont'd)

Revenue Codes

All claim forms must include a revenue code for each line item. Revenue codes are four-digit codes that allow hospitals to attribute services and supplies to specific cost centers within the hospital. Each service or supply provided during the patient's hospital inpatient stay or hospital outpatient visit must be associated with a revenue code.

Several revenue codes are relevant to imaging services and other diagnostic radiology procedures (Table 1).

Table 1

Revenue Code	Descriptor
061X	Magnetic resonance technology (MRT)
032X	Radiology–diagnostic

When a contrast agent is used and is not reported with an HCPCS code (for example, in the hospital inpatient setting for Medicare), hospitals may include the cost of the contrast agent in the charge for the associated imaging procedure using a revenue code from one of the series in Table 1. Alternatively, hospitals may report a separate charge for the contrast using one of the revenue codes in Table 2.

Table 2

Revenue Code	Descriptor
0254	Drugs incident to other diagnostic services
0255	Drugs incident to radiology

In situations where it is appropriate to report a contrast agent using an HCPCS code (for example, under the Outpatient Prospective Payment System [OPPS]) the appropriate revenue code is 0636 (Drugs Requiring Detailed Coding).

Providers should consult a complete listing of current revenue codes and select the appropriate revenue codes for the services rendered to the patient. Hospital billing staff members should determine which revenue codes to use at their facility by selecting the most appropriate code from each series.

Information provided in this resource is for informational purposes only and does not guarantee that codes will be appropriate or that coverage and reimbursement will result. Customers should consult with their payers for all relevant coverage, coding, and reimbursement requirements. It is the sole responsibility of the provider to select proper codes and ensure the accuracy of all claims used in seeking reimbursement. Neither this resource nor the Bayer HealthCare Reimbursement Helpline is intended as legal advice or as a substitute for a provider's independent professional judgment.

Payment overview

Payment

Payment methodologies often vary depending on where a procedure is performed. This is especially true of the Medicare program. The following sections outline the payment systems that different payers use to reimburse services furnished in the hospital inpatient and hospital outpatient settings.

Hospital Inpatient Departments

Medicare pays for hospital inpatient admissions using the hospital inpatient prospective payment system, commonly referred to as the DRG system. Under this system, each hospital inpatient case is assigned to a single DRG based on the patient's diagnosis(es) and the procedure(s) performed (as reported with ICD-10-PCS codes on the claim form). That DRG provides a fixed, hospital-specific payment that is intended to cover all facility costs during the inpatient stay.

The payment rate for each DRG is based on a relative weight (which measures the resource use associated with the DRG as compared to other DRGs) and is adjusted for each hospital to reflect geographic differences in hospital labor costs, indigent care, and teaching status. DRG payments do not cover the costs of physician services, as physician services are reimbursed separately under the MPFS.

As with most other drugs and supplies, Medicare currently does not provide separate payment for contrast agents and associated medical imaging procedures when furnished on an inpatient basis; rather, reimbursement for these items and services is packaged into the single payment rate for the DRG.

Additionally, most imaging procedures do not affect DRG assignment; instead, a case involving a radiology imaging service will generally be assigned to a DRG based on the other procedures or diagnoses on the claim form. For this reason, DRG assignments and payment rates for medical imaging procedures can vary greatly depending on the specifics of a particular case.

Most private insurers negotiate contracts, typically annually, with facilities regarding hospital inpatient payment methods. Many private payers use DRG systems to reimburse hospital inpatient services. Other common payment arrangements used by private insurers are per diems, percentage of allowable charges, and negotiated rates for specific treatments. Private insurers are unlikely to provide separate payment for contrast agent(s) or other drugs and supplies when furnished in the inpatient setting.

Each state Medicaid program determines the payment method for hospital inpatient services. The majority of state programs base reimbursement for hospital inpatient services on prospective payment systems, which include DRGs and per diems, and provide a single payment to the hospital with no separate payment for contrast agents or other drugs and supplies. Some, however, use other reimbursement methods, including cost-based payments.

Many Medicaid programs also adjust payments to reflect a hospital's case mix, or the intensity of care required by patients treated at the facility.

Payment overview (cont'd)

Hospital Outpatient Departments

Medicare reimburses most hospital outpatient services under the Hospital Outpatient Prospective Payment System (HOPPS), also known as the ambulatory payment classification (APC) system. Under HOPPS, separately payable items and services are assigned to APC groups based on the CPT and HCPCS codes included on the claim form. Each APC is associated with a fixed payment amount, adjusted for each geographic region to reflect local differences in labor costs, which is intended to cover the facility's costs for services described by the code and provided in the hospital outpatient setting.

HOPPS allows for payment for multiple APCs during a single hospital outpatient visit. In addition to receiving Medicare's portion of the APC payment, hospitals also receive a set co-payment from the patient. Physician services are reimbursed separately based on the Medicare Physician Fee Schedule (MPFS) and are not included in APC payments to hospitals.

Imaging Procedures

Medicare hospital outpatient payments for medical imaging procedures are based on the APCs to which the procedures are assigned. CPT codes for contrast-enhanced MR imaging procedures map to the following APC groupings (Table 3).

Table 3

MRI APC	Descriptor
0284	MRI with contrast
0337	MRI without contrast followed by with contrast

Bayer Contrast Agents

Medicare provides packaged payment for contrast agents under the HOPPS drug packaging methodology. This payment methodology packages the cost of drugs into the associated APC of the independent procedure. This payment policy applies to Bayer contrast agents.

Hospital providers have several ways to report contrast agents including:

- Noncoded charges on the revenue code line
- The cost for the contrast agent in the charge for the procedure (inpatient claims)
- Reporting the appropriate HCPCS code for the contrast agent when used (outpatient claims)

Hospital outpatient departments that provide contrast agents in association with independent procedures involving imaging must bill both services (imaging procedure and contrast agent) on the same claim so that the cost of the contrast agent can be appropriately packaged retrospectively into payment for the imaging procedure. Please refer to the appropriate product pages in this brochure for billing instructions.

It is important to note that the median costs for services in APC groups that include contrast are higher than median costs for services in APC groups that do not include contrast. Medicare publishes the payment rates of APC groups under the "Hospital Outpatient Regulations and Notices" tab on the HOPPS website. For access, visit www.cms.hhs.gov/HospitalOutpatientPPS, or call the Bayer Reimbursement Helpline at 1-800-423-7539 for assistance.

Payment overview (cont'd)

Private insurer payments for hospital outpatient services are often based on a percentage of billed or allowable charges, previously negotiated payment rates, or preset per-diem/per-visit rates. Whether a hospital outpatient department receives separate reimbursement for contrast agent(s) will depend on the specific plan, the particular agent and imaging service furnished, and the contract that the facility has negotiated with the plan. Facing increasing pressures to control costs, many private insurers are adopting bundled payment arrangements for services such as contrast-enhanced imaging studies.

Medicaid reimbursement for hospital outpatient services varies from state to state. Medicaid programs typically base hospital outpatient payments on state-specific fee schedules, preset per-diem/per-visit rates, or percentage of charges. While there is significant variation in Medicaid payment amounts among states, Medicaid programs typically pay less than other insurers. State-specific policies will determine whether contrast agents are separately reimbursed in hospital outpatient departments.

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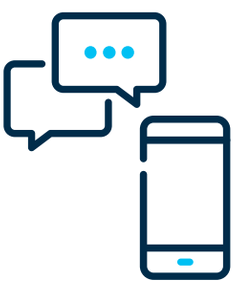

Bayer HealthCare also operates the Reimbursement Helpline to answer coverage, coding, and payment questions about its products and associated imaging procedures.

If you have a question about reimbursement, please contact the **Bayer Radiology Reimbursement Helpline** at **1-800-423-7539**.

Helpline hours are **Monday through Friday, 9:00 am to 5:00 pm, Eastern time.**

Payment overview (cont'd)

Summary of Medicare: Hospital Inpatient

Components of Reimbursement	MR Procedure	MRI Contrast Agent
ICD-10-PCS Procedure Codes	• See Coding section of the Reimbursement Guide for list of codes • Codes do not distinguish procedures with and without contrast	Generally not used to report contrast
Revenue Codes	**061X—MRT** **032X—Radiology-diagnostic**	Cost of the contrast agent may be included in the charge for the associated imaging procedure using revenue code 061X or 032X Alternatively, hospitals may report a separate charge for contrast using one of the following: • 0254—Drugs incident to other diagnostic services • 0255—Drugs incident to radiology
Payment	**Reimbursement for imaging procedure bundled into DRG payment** • MRI ICD-10-PCS procedure codes do not influence DRG assignment	Cost of the contrast agent may be included in the charge for the associated imaging procedure using revenue code 061X or 032X Alternatively, hospitals may report a separate charge for contrast using one of the following: • 0254—Drugs incident to other diagnostic services • 0255—Drugs incident to radiology

For information regarding the Bayer portfolio of contrast agents, please call your Bayer HealthCare Sales Consultant at 1-888-842-2937, option 5. For customer service or purchasing information regarding any Bayer contrast agent, please call 1-877-229-3750.

Payment overview (cont'd)

Summary of Medicare: Hospital Outpatient

Components of Reimbursement	MR Procedure	MRI Contrast Agent
CPT Codes	**See codes on following pages** • Many codes specify without contrast, with contrast, or without contrast followed by with contrast • Special C-codes must be used instead of CPT codes for certain MRI procedures	Generally not used to report contrast use
HCPCS Codes		**MR contrast use should be reported with a HCPCS code** See the following CPT code pages for appropriate codes
Revenue Codes	• **061X—MRT** • **032X—Radiology–diagnostic**	**0636—Drugs requiring detailed coding**
Payment	**Payment based on APC grouping to which the imaging procedure is assigned** • Imaging procedures with contrast are generally paid higher than those without contrast	**Packages payment into associated independent imaging procedure**

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Billing for Ambelvist®

Procedures and contrast agents must be coded correctly in order to obtain appropriate reimbursement from both the Centers for Medicare & Medicaid Services (CMS) and all other third-party payers.

A distinct Healthcare Common Procedure Coding System (HCPCS) code for Ambelvist is not yet available for use. During this period, a not-otherwise-classified (NOC) HCPCS code would be required when submitting a claim for reimbursement, along with additional information including the National Drug Code (NDC) number, drug name, cost, and units. See chart below for suggested NOC coding to report Ambelvist.

Applicable HCPCS Codes for Ambelvist (gadoquatrane)[1]

CODE	CODE DESCRIPTION
J3490	(injection, unclassified drugs)
A9579	(injection, gadolinium based magnetic resonance contrast agent, not otherwise specified)
C9399 Applicable only for Medicare patients treated in the hospital outpatient setting	(unclassified drugs or biologicals)

Please note that NOC drug codes always default to one unit whereas distinct HCPCS codes have units based on the dose administered, with each mL being one unit. Additional coding information required for reimbursement would include Current Procedural Terminology (CPT®) codes and International Classification of Diseases, Tenth Revision (ICD-10-CM) codes, among others potentially required by the payer.

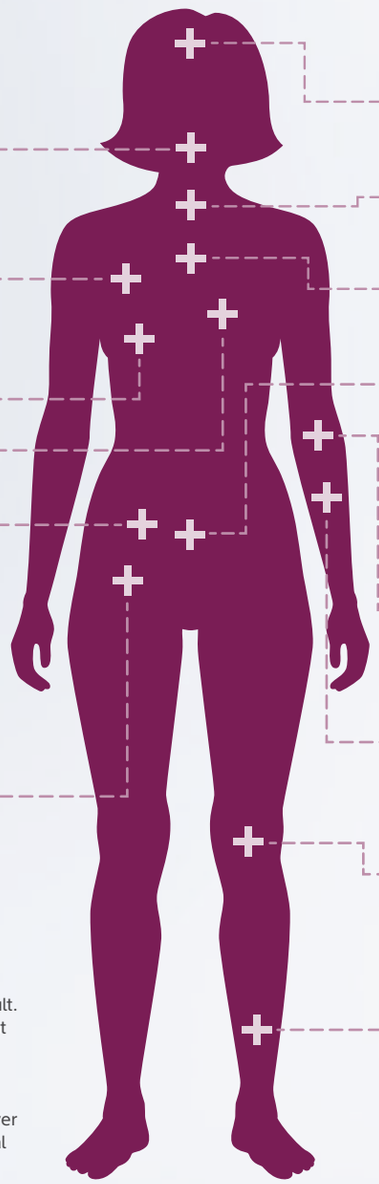
See Boxed Warning regarding Risk Associated with Intrathecal Injection and Nephrogenic Systemic Fibrosis, as well as additional Important Safety Information on pages 14 and 15.

INDICATIONS

Ambelvist® (gadoquatrane) is a gadolinium-based contrast agent indicated in adult and pediatric patients, including term neonates, for use with magnetic resonance imaging (MRI) to detect and visualize lesions with abnormal vascularity in:

- the central nervous system (brain, spine, and associated tissues)
- the body (head and neck, thorax, abdomen, pelvis, and musculoskeletal system)

MRI CPT Codes



HEAD & NECK

Orbit, Face & Neck
70542 With contrast
70543 With & without contrast

THORAX

Thorax
71551 With contrast
71552 With & without contrast

Breast
77048 With & without contrast; including CAD; unilateral
77049 With & without contrast; including CAD; bilateral

Cardiac
75561 With & without contrast

ABDOMEN
74182 With contrast
74183 With & without contrast

PELVIS
72196 With contrast
72197 With & without contrast

BRAIN, SPINE, & ASSOCIATED TISSUES

Brain
70552 With contrast
70553 With & without contrast

Cervical Spine
72142 With contrast
72156 With & without contrast

Thoracic Spine
72147 With contrast
72157 With & without contrast

Lumbar spine
72149 With contrast
72158 With & without contrast

MUSCULOSKELETAL SYSTEM

Shoulder, Elbow, Or Wrist
(Upper Extremity, Joint)
73222 With contrast
73223 With & without contrast

Humerus, Forearm, And/Or Hand
(Upper Extremity, Non-Joint)
73219 With contrast
73220 With & without contrast

Hip, Knee, And/Or Ankle
(Lower Extremity, Joint)
73722 With contrast
73723 With & without contrast

Thigh, Lower Leg, And/Or Foot
(Lower Extremity, Non-Joint)
73719 With contrast
73720 With & without contrast

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INDICATIONS and IMPORTANT SAFETY INFORMATION

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- the central nervous system (brain, spine, and associated tissues)
- the body (head and neck, thorax, abdomen, pelvis, and musculoskeletal system)

IMPORTANT SAFETY INFORMATION

WARNING: RISK ASSOCIATED WITH INTRATHECAL USE and NEPHROGENIC SYSTEMIC FIBROSIS

Risk Associated with Intrathecal Use

Intrathecal administration of gadolinium-based contrast agents (GBCAs) can cause serious adverse reactions including death, coma, encephalopathy, and seizures. AMBELVIST is not approved for intrathecal use.

Nephrogenic Systemic Fibrosis

GBCAs increase the risk for nephrogenic systemic fibrosis (NSF) among patients with impaired elimination of the drugs. Avoid use of AMBELVIST in these patients unless the diagnostic information is essential and not available with non-contrasted MRI or other modalities. NSF may result in fatal or debilitating fibrosis affecting the skin, muscle, and internal organs.

The risk for NSF appears highest among patients with:

- Chronic, severe kidney disease (GFR < 30 mL/min/1.73 m2), or
- Acute kidney injury

Screen patients for acute kidney injury and other conditions that may reduce renal function. For patients at risk for chronically reduced renal function (for example, age > 60 years, hypertension, or diabetes), estimate the glomerular filtration rate (GFR) through laboratory testing.

For patients at highest risk for NSF, do not exceed the recommended AMBELVIST dose and allow a sufficient period of time for elimination of the drug from the body prior to any re-administration.

Contraindication and Important Information about Hypersensitivity Reactions: Ambelvist® is contraindicated in patients with a history of severe hypersensitivity reactions to Ambelvist®. Serious hypersensitivity reactions have occurred with GBCAs. Before Ambelvist® administration, assess all patients for any history of a reaction to contrast media, bronchial asthma, and/or allergic disorders. These patients may have an increased risk for a hypersensitivity reaction to Ambelvist®.

Gadolinium Retention: Gadolinium is retained for months or years in several organs. Linear GBCAs cause more retention than macrocyclic GBCAs. At equivalent doses, retention varies among the linear agents. Retention is lowest and similar among the macrocyclic GBCAs. Consequences of gadolinium retention in the brain have not been established, but they have been established in the skin and other organs in patients with impaired renal function. While clinical consequences of gadolinium retention have not been established in patients with normal renal function, certain patients might be at higher risk. These include patients requiring multiple lifetime doses, pregnant and pediatric patients, and patients with inflammatory conditions. Consider the retention characteristics of the agent and minimize repetitive GBCA studies, when possible.

Please see more Important Safety information for AMBELVIST on page 15.

IMPORTANT SAFETY INFORMATION (cont'd)

Acute kidney Injury: In patients with chronic renal impairment, acute kidney injury sometimes requiring dialysis has been observed with the use of some GBCAs. Do not exceed the recommended dose; the risk of acute kidney injury may increase with higher than recommended doses.

Interference with Lesion Visualization
As with other GBCAs, Ambelvist® may obscure certain lesions that are visible on non-contrast MRI. When available, non-contrast MRI images should be reviewed during the interpretation of Ambelvist® MRI scans.

Adverse Reactions: The most frequently observed adverse reactions (incidence ≥ 0.2%) were dizziness, headache, injection site reactions, nausea, vomiting, feeling hot, paresthesia, and pruritus.

Please see Full Prescribing Information for Ambelvist®

Available Presentations*

SINGLE-DOSE VIALS (RUBBER-STOPPERED)	VIAL SIZE (mL)	NDC CODE	QTY
	**2.0 mL**	50419-321-11	Cartons of 3 vials
	7.5 mL	50419-322-11	Cartons of 10 vials
	10 mL	50419-323-11	Cartons of 10 vials

*Additional presentations will be available upon market availability.

Please see Important Safety information for AMBELVIST on pages 14 and 15.

Sample claim form UB-04/CMS-1450 for AMBELVIST Contrast-enhanced MRI

Hospital professionals bill claims for services provided in a hospital outpatient setting using the UB-04/CMS-1450 claim form. The UB-04 claim form requires information including patient demographics, insurance policy, appropriate codes to indicate the services rendered, and the National Provider Identifier (NPI).

Accurate completion of the UB-04 claim form is important for timely and appropriate reimbursement for AMBELVIST and associated services provided in a hospital outpatient setting. A sample UB-04 claim form for billing AMBELVIST is provided below:

Form Locator 42 (Rev. CD)

Enter Revenue Code:

0254 Drugs incident to diagnostic service

0636 Drugs requiring detailed coding

(Verify Revenue Code with Hospital Billing Department and Insurance Providers)

Form Locator 44 (HCPCS/Rates/ HIPPS Code)

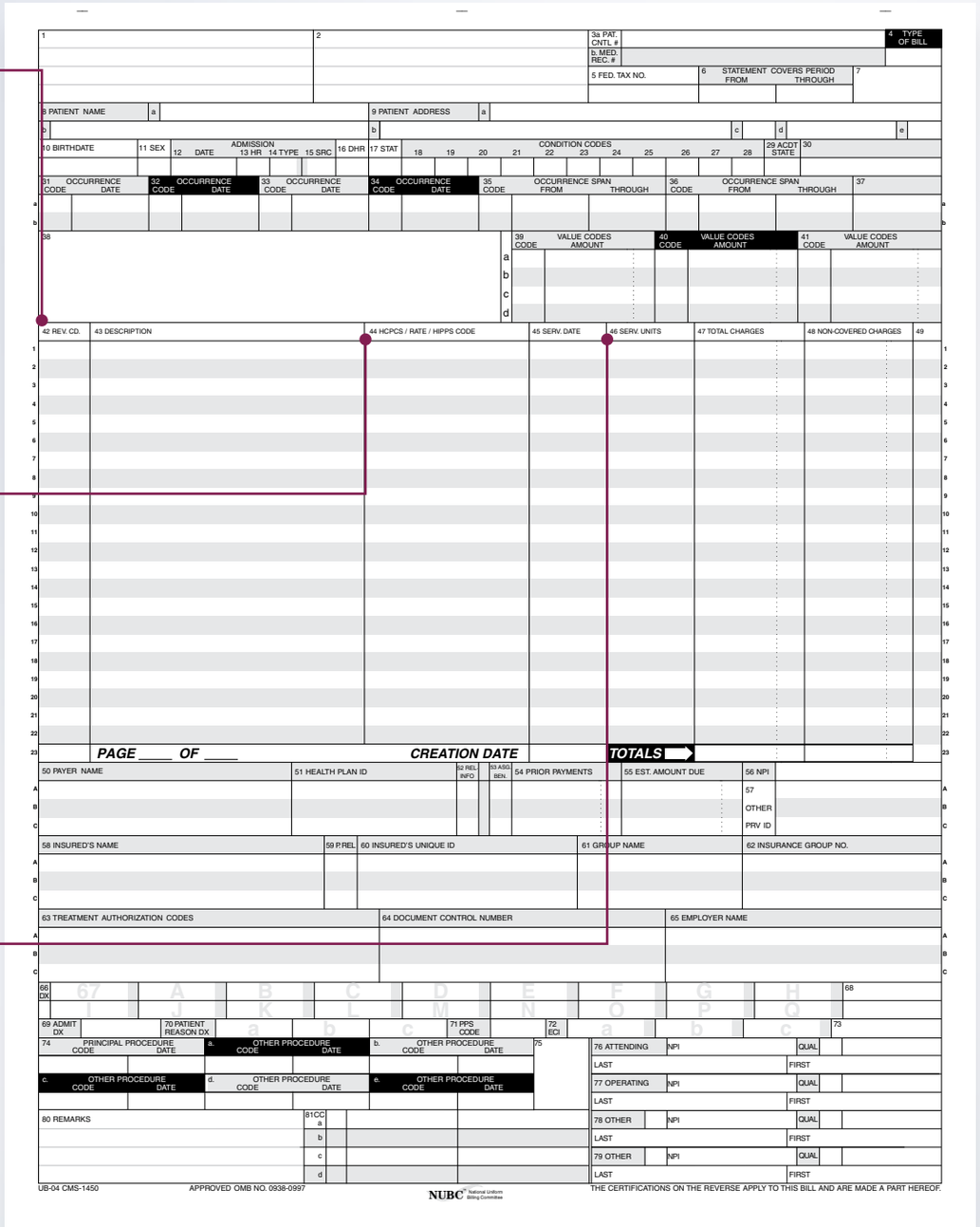
Enter CPT® or HCPCS code for procedure and contrast agent:

A9579, Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (nos), per mL

Form Locator 46 (Units of Service)

Enter number of units based on the HCPCS descriptor

Bayer cannot guarantee coverage or payment for products or procedures at any particular level



Please see Important Safety information for AMBELVIST on pages 14 and 15.

Purchasing resources

McKESSON

1-877-259-4624

Bayer in Radiology's collaboration with McKesson Specialty 3rd Party Logistics (3PL) (1-877-259-4624) combines Bayer's commitment to our customers with the drug distribution capabilities of McKesson. The benefits of purchasing through McKesson includes avoiding additional shipping charges and you may be eligible for a prompt pay discount of 2% when invoices are paid within 30 days.

Additional independent suppliers are listed below in alphabetical order.

BlueRidge X-ray Company, Inc.
Aden, NC 28704
828-681-9729 x139

Cardinal Health, Inc.
Dublin, OH 43017
866-551-0532

Cencora (fka AmerisourceBergen)
Valley Forge, PA 19087
610-727-7000

Cesar Castillo, LLC
Guaynabo, PR
787-999-1616

CMX Medical Imaging
Tukwila, WA 78188
425-656-1269

Concordance HealthCare Solutions
Tiffin, OH 44883
800-447-0225

Freedom Imaging
Anaheim, CA 82805
714-535-2520 x1

Henry Schein, Inc.
Melville, NY 11747
800-772-4346

Jefferson Medical & Imaging, Inc.
Oak Ridge, NJ 07438
973-697-5077

McKesson Medical Surgical
Richmond, VA 23228
800-866-9243

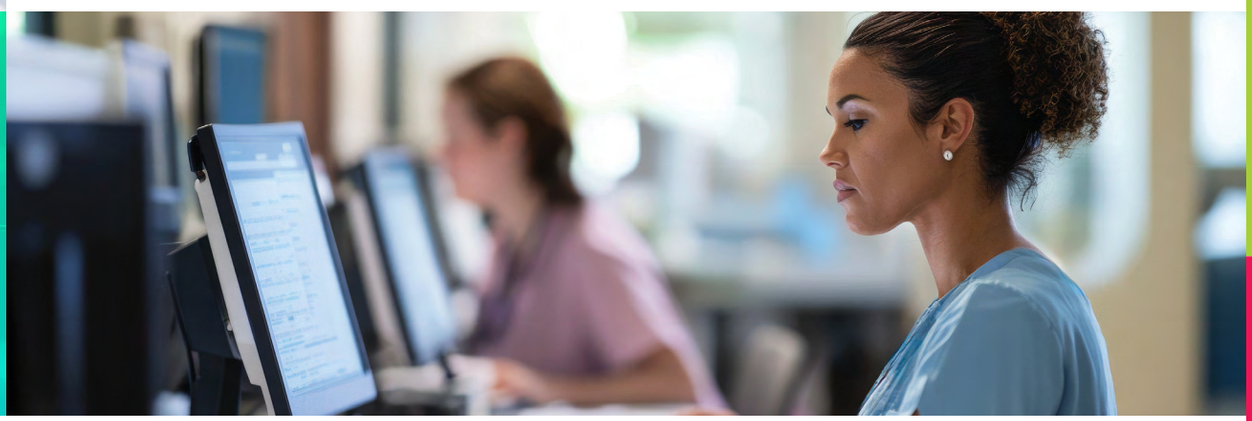
McKesson Pharma
San Francisco, CA 92123
800-811-9092

Medline Industries
Mundelein, IL 60060
847-949-5500

Merry X-ray/ Source One
San Diego, CA 92123
800-635-9729

Morris & Dickson Co., LLC
Shreveport, LA 71115
318-797-7900

Owens & Minor, Inc.
Mechanicsville, VA 23116
804-935-4180



Reference:

1. Ambelvist [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; Month 2026.

Bayer HealthCare LLC, 100 Bayer Boulevard, P.O. Box 915. Whippany, NJ 07981 U.S.A.
Phone: +1-412-767-2400, +1-800-633-7231 **Fax:** +1-412-767-4120

For more information visit radiologysolutions.bayer.com

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