CY2015 Final Rule Summary
Radiation Oncology
Hospital Outpatient Prospective Payment System (HOPPS)

Prepared by:
Revenue Cycle Inc.

Prepared On:
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Introductory Summary
On October 31, 2014, the Centers for Medicare and Medicaid Services (CMS) issued the final rule for the Hospital Outpatient Prospective Payment System (HOPPS) for CY2015.

HOPPS Final Rule
The CY2015 final rule may be located in its entirety by following the link below:

This document in PDF form is 1052 pages in length. The format of the information on the following pages is intended to serve as highlights, and readers are encouraged to view the document in its entirety for further details. Within the summation, which follows, Revenue Cycle Inc. has provided examples of potential reimbursement based on the interpretation of the published ruling. It is important to note, coding information is provided as an example and actual practice patterns may differ from facility to facility and provider to provider. It is imperative for actual coding to coincide with documentation within the medical record, medical necessity information provided by the physician(s) and actual services provided on behalf of the patient.

CY2015 HOPPS Final Rule Highlights
The highlights of the Final Rule are provided below in a succinct manner. More details are provided in the summary which follows.

- Payment rates – overall 2.2% increase in OPPS payments to providers, estimated total OPPS payments to be approximately $56.1 billion, increase of approximately $5.1 billion compared to CY2014 payments.
  - Urban hospitals approximately 2.3% increase and rural hospitals 1.9% increase
  - ASCs 1.4% increase to payment rates
  - 2.0% point reduction for hospitals failing to meet the hospital outpatient quality reporting requirements
- Conversion Factor – final full conversion factor for CY2015 $74.144
- Wage Index – Frontier States to continue with 1.000, if when calculating the wage index the value is below 1.000. The wage index adjustment for a hospital located in a frontier state will also apply to the affiliated HOPD
  - IPPS finalized wage indexes are used for HOPPS
  - CBSA has been updated and changes are reflected in the new localities for 2015
- Cancer hospital payment adjustments – will continue and payment to-cost ratio (PCR) of 0.89 will be used to determine the final CY2015 cancer hospital payment adjustment
• Payment of Drugs, Biologicals, and Radiopharmaceuticals – those which do not have pass-through status will be set at statutory default of average sales price (ASP) plus 6 percent.

• Outlier Payments – Fixed dollar threshold set at $2,775, multiple threshold still at 1.75 times and payment made at 50% of the amount by which furnishing service is more than 1.75 times the APC reimbursement.

• New codes or code changes – CMS has asked the RUC to deliver any new code changes for the coming year to CMS prior to delivery of proposed rules. Any codes not received in time to value will be designated with a G code and the new codes will not be implemented for a year.
  o RUC given deadline of February 10th each year to submit code changes to CMS for inclusion in the coming year’s application.

• Status indicator “X” will be deleted and replaced with status indicator “J1” as part of the comprehensive APC policy, or “Q1” status indicator for ancillary services.

• Packaging Policies – when services are integral, ancillary, supportive, dependent, or adjunctive to a primary service, those services which have a final APC geometric mean cost (prior to application of status indicator Q1) of less than or equal to $100 will be packaged.

• Implementation of Comprehensive APCs
  o Total of 25 C-APCs were established for CY2015, including formerly device dependent APCs.
  o C-APC is defined as – “…comprehensive APC as a classification for the provision of a primary service and all adjunctive services and supplies provided to support the delivery of the primary service. We continue to consider the entire hospital stay, defined as all services reported on the hospital claim reporting the primary service, to be one comprehensive service for the provision of a primary service into which all other services appearing on the claim would be packaged. This results in a single Medicare payment and a single beneficiary copayment under the OPPS for the comprehensive service based on all included charges on the claim.”
  o Comprehensive APC (C-APC 0067) - single-session cranial stereotactic radiosurgery (SRS) finalized
    ▪ Final national reimbursement for C-APC 0067 $9,765.40
  o IORT codes 77424 and 77425 finalized to be reassigned to 0648 (Level IV Breast and Skin Surgery) along with CPT codes 19296 and 19298 for placement of breast catheter or tube/catheter
    ▪ Final national reimbursement for C-APC 0648 $7,461.40
    ▪ APC 0648 will require a device code to be reported on the claim when the procedure is assigned to the APC
    ▪ CPT® code 19297 is assigned to a device-dependent APCs for CY2014 and packaged in CY2015, it will also be evaluated for complexity adjustment
  o Brachytherapy services to be excluded from payment bundling
- Composite APC 8001 for brachytherapy LDR will continue with final geometric mean cost of $3,745.00

- APC re-assignments and changes
  - APC 0066 (includes code 77373) Level V Radiation Therapy exception to the 2 times rule for CY2015
  - To correct the 2 times rule violation in APC 0664, proton CPT code 77520 is moved to APC 0412 (Level III Radiation Therapy) and Proton CPT code 77522 reassigned to APC 0667 and renamed (Level IV Radiation Therapy) instead of (Level II Proton Beam Radiation Therapy) to match the pattern of other APC names.
  - Delete APC 0065 (IORT, MRgFUS, and MEG) since the services are final to be reassigned to other APCs.
  - CPT code 77373 will continue to be assigned to APC 0066 along with MRgFUS HCPCS codes 0071T, 0072T, 0301T, and C9734
  - Code 57155 moved from APC 0193 to APC 0192, this is approximately a 63% reduction in reimbursement. The change was made due to the mean geometric cost reported for the code.
  - MEG CPT code 95965 and 95966 moved from APC 0065 to APC 0446 (Level IV Nerve and Muscle Services)
  - Intraoperative Radiation Therapy (IORT) CPT codes 77424 and 77425 to comprehensive APC 0648 (Level IV Breast and Skin Surgery).

- Off Campus Provider-Based –
  - For hospital claims, a HCPCS modifier will be created to be used with every code reported for outpatient hospital services furnished in an off-campus PBD of a hospital
    - “PO” – short descriptor “Serv/proc off-campus pbd,” or long descriptor “Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments.”
    - Voluntary for 1 year starting 1/1/15 and mandatory starting 1/1/16
  - For professional claims, POS code 22 will be deleted and two new POS codes to be established
    - One code to identify outpatient services furnished in on-campus, remote, or satellite locations of a hospital
    - One code to identify services furnished in an off-campus PBD hospital setting
    - New POS codes will be required to be reported as soon as they become available
    - New POS codes to be released by CMS by July 2015

- Brachytherapy sources – rates will continue be set and will be based upon the geometric mean costs
ASC change in payment indicator for CPT code 19296, placement of breast catheter to account for designation as office-based

ASC apply FB/FC policy to all device-intensive procedures includes code 19298 breast catheter/tube placement, to cover receiving devices at no cost/full credit or partial credit due to a device recall or warranty situation.

Payment Rates

Finalized payment rates under OPPS for outpatient departments (OPD) result in an overall increase by 2.2%, which includes a 2.3% increase for urban hospitals and a 1.9% increase for rural hospitals. Medicare estimates approximately 4,000 facilities will be paid under OPPS for CY2015. The estimated Medicare payments will be approximately $56.1 billion, an increase of approximately $5.1 billion compared to the CY2014 payments. Medicare is also continuing the 2% point reduction in payments for hospitals failing to meet the outpatient quality reporting requirements.

The conversion factor for CY2015 for OPPS payment was finalized at $74.144, which is slightly below the proposed $74.176 rate. This is related to the pass-through spending for drugs, biologicals and devices for CY2015 equaling approximately $82.8 million, which represents 0.15 percent of total projected CY2015 OPPS spending. As a result, the conversion factor was also adjusted by the difference between the 0.02 percent estimate of pass-through spending for CY2014 and the 0.15 percent estimate for CY2015. Payments for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals that do not have pass-through status will be paid at the statutory default average sales price (ASP) plus 6%.

The wage index for Frontier States will continue at 1.000 for those which qualify. For a hospital which qualifies the wage index will also be extended to the affiliated hospital outpatient departments (HOPD). The wage indexes for hospital outpatient departments were finalized in the Inpatient Prospective Payment System (IPPS) Final Rule which went into effect October 1, 2014. The IPPS rules and rates run on the fiscal year calendar. Additionally, the CBSA (Core-Based Statistical Area) designations have been updated. The Office of Management and Budget (OMB) revised the current labor market area delineations on February 28, 2013. The revisions include a significant number of changes in the CBSAs. Some urban counties have now been designated as rural, some rural designations are now urban and others have been split apart. Even though this was released in 2013, Medicare was using the interim to assess the new revisions and impacts of the changes before finalizing the changes effective for CY2015.

Outlier payments will continue to be available for those services which incur an extreme cost to a hospital to deliver or perform, and for which the reimbursement by Medicare may not offset the excessive cost. For those services which meet the established criteria Medicare will pay an additional reimbursement amount. The fixed dollar threshold was finalized at $2,775 for CY2015. The multiple threshold remains at 1.75 times
and the payment made continues at 50% of the amount by which furnishing the service is more than 1.75 times the APC reimbursement.

Brachytherapy source reimbursement will continue to be determined based upon the geometric mean cost. For those sources such as Iridium-192 which has a fixed active life and must be replaced every 90 days, when reporting the code the hospital is to calculate the cost of the source by the anticipated number of cases to be performed. This cost report is then provided to CMS who will calculate the geometric mean cost when setting the rates.

**Cancer Hospital Adjustment**

Cancer hospitals will continue receiving additional payments so the payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for other hospitals using the most recently submitted cost report data. A PCR of 0.89 was finalized and will be utilized for the CY2015 cancer hospital payment adjustment. The actual amount of the payment adjustment for each cancer hospital will be dependent on each hospital’s CY2015 payments and costs.

**Code Changes**

The timing of the release of new codes, code changes or deletions by the AMA and RUC is creating an issue for CMS. The current timeline has many of the code changes being announced after the proposed rules are released by Medicare. This prevents CMS from seeking comments from stakeholders and evaluating the impact of the code changes. Additionally, CMS cannot fully valuate or assign the new or changed code the appropriate APC.

CMS has requested the RUC to adjust their schedule when releasing new, changed and deleted codes. As outlined in the MPFS Final Rule for CY2015 CMS has set the date of February 10th as the cutoff date for any code changes to be provided to CMS. Any codes presented by the RUC prior to February 10th will allow CMS time to review and value the code, it will also allow for solicitation of comments before the final rules are released. In the event the RUC does not provide CMS with code changes prior to February 10th, Medicare will evaluate the change and possibly assign a G-code to replace the new or changed code. Any changes by the AMA will then be delayed one full year. The use of a G-code and delay of implementing the new codes by the AMA will allow for valuation of the code and placement in the correct APC. After one year of the use of the G-code the new or changed code as released by the AMA will be implemented.

**Packaging and Comprehensive APCs**

Medicare is finalizing packaging policies to be applied to services which are integral, ancillary, supportive, dependent, or adjunctive to a primary service which has a final APC geometric mean cost (prior to the application of status indicator Q1) of less than or equal to $100. This $100 geometric mean cost limit for the APC is part of the methodology of establishing an initial set of conditionally packaged ancillary service APCs, and does not represent a threshold above which a given ancillary service will not be packaged. Medicare had indicated this is a basis for selecting an initial set of APCs that will likely be updated and
expanded in future years. Medicare also has excluded brachytherapy services and pass-through drugs, biologicals and devices that are separately payable by statute.

Medicare is also continuing to define services assigned to Comprehensive APCs (C-APCs) as primary services and all adjunctive services and supplies provided to support the delivery of the primary service. Medicare has stated the entire hospital stay, defined as all services reported on the hospital claim reporting the primary service, is considered to be one comprehensive service for the provision of a primary service into which all other services appearing on the claim would be packaged. This results in a single Medicare payment and a single beneficiary copayment under the OPPS for the comprehensive service based on all included charges on the claim.

For CY2015 Medicare has established a total of twenty-five (25) C-APCs for 2015 and continue to package all add-on codes furnished as part of a comprehensive service. Medicare has defined exceptions to the C-APC methodology, including pass-through drugs and self-administered drugs. These exclusions are referenced with Table 6.

**TABLE 6.—COMPREHENSIVE APC PAYMENT POLICY EXCLUSIONS FOR CY 2015**

<table>
<thead>
<tr>
<th>Ambulance services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brachytherapy</td>
</tr>
<tr>
<td>Diagnostic and mammography screenings</td>
</tr>
<tr>
<td>Physical therapy, speech-language pathology and occupational therapy services - Therapy services reported on a separate facility claim for recurring services</td>
</tr>
<tr>
<td>Pass-through drugs, biologicals and devices</td>
</tr>
<tr>
<td>Preventive services defined in 42 CFR 410.2:</td>
</tr>
<tr>
<td>Annual wellness visits providing personalized prevention plan services</td>
</tr>
<tr>
<td>Initial preventive physical examinations</td>
</tr>
<tr>
<td>Pneumococcal, influenza, and hepatitis B vaccines and administrations</td>
</tr>
<tr>
<td>Mammography Screenings</td>
</tr>
<tr>
<td>Pap smear screenings and pelvic examination screenings</td>
</tr>
<tr>
<td>Prostate cancer screening tests</td>
</tr>
<tr>
<td>Colorectal cancer screening tests</td>
</tr>
<tr>
<td>Diabetes outpatient self-management training services</td>
</tr>
<tr>
<td>Bone mass measurements</td>
</tr>
<tr>
<td>Glaucoma screenings</td>
</tr>
<tr>
<td>Medical nutrition therapy services</td>
</tr>
<tr>
<td>Cardiovascular screening blood tests</td>
</tr>
<tr>
<td>Diabetes screening tests</td>
</tr>
<tr>
<td>Ultrasound screenings for abdominal aortic aneurysm</td>
</tr>
<tr>
<td>Additional preventive services (as defined in section 1861(ddd)(1) of the Act)</td>
</tr>
<tr>
<td>Self-administered drugs - Drugs that are usually self-administered and do not function as supplies in the provision of the comprehensive service</td>
</tr>
<tr>
<td>Services assigned to OPPS status indicator “F” (Certain CRNA services, Hepatitis B vaccines and corneal tissue acquisition)</td>
</tr>
<tr>
<td>Services assigned to OPPS status indicator “L” (Influenza and pneumococcal pneumonia vaccines)</td>
</tr>
<tr>
<td>Certain Part B inpatient services – Ancillary Part B inpatient services payable under Part B when the primary “J1” service for the claim is not a payable Part B inpatient service (for example, exhausted Medicare Part A benefits, beneficiaries with Part B only)</td>
</tr>
</tbody>
</table>
Of the 25 newly established C-APCs one of them is C-APC 0067, single-session cranial stereotactic radiosurgery (SRS). C-APC 0067 includes the treatment codes 77371, radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based and 77372, radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based. Any of the ancillary and integral services which are also performed on the same date and reported on the same claim as the SRS treatment, Medicare will only reimburse the actual treatment code. The other services which are considered ancillary, such as the clinic visit, any imaging, treatment planning codes (including the calculations and devices), and physics services will not be separately reimbursed. Each service will be reported on the claim for cost reporting purposes, but the designated C-APC payment will be for the treatment. The national average payment for C-APC 0067 is set at $9,765.40.

CPT® codes 77424, intraoperative radiation treatment delivery, x-ray, single treatment session and 77425, intraoperative radiation treatment delivery, electrons, single treatment session have been moved from APC 0065 into C-APC 0648 (Level IV Breast and Skin Surgery). This will place the intraoperative codes with codes 19296 and 19298, both placement codes for breast catheter or tube/catheter. Since the clinical data supports the intraoperative services of codes 77424 and 77425 for breast treatments CMS felt this was the most appropriate change for the codes. The national average payment for C-APC 0648 is $7,461.40.

Composite APC 8001 for low dose rate (LDR) prostate brachytherapy, which includes the CPT® codes 55875, Transperineal placement of needles or catheters into prostate for interstitial radionucleotide application, with or without cystoscopy and 77778, Interstitial radiation source application; complex are still included in this APC. When the services are performed together, rather than reporting the individual codes, the hospital will continue to report the composite APC 8001. In an ASC HCPCS Level II G-code G0458, low dose rate (LDR) prostate brachytherapy services, composite rate is the correct code to report in place of codes 55875 and 77778 when performed on the same date of service.

<table>
<thead>
<tr>
<th>CY2015 C-APC</th>
<th>CY2015 Long Descriptor</th>
<th>Includes CPT Codes</th>
<th>Final CY2015 APC Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0067</td>
<td>Single-session cranial stereotactic radiosurgery (SRS)</td>
<td>77371, 77372</td>
<td>$9,765.40</td>
</tr>
<tr>
<td>0648</td>
<td>Level IV Breast and Skin Surgery</td>
<td>77424, 77425, 19296, 19298</td>
<td>$7,461.40</td>
</tr>
<tr>
<td>8001</td>
<td>LDR prostate brachytherapy composite</td>
<td>55875, 77778</td>
<td>$3,844.64</td>
</tr>
</tbody>
</table>
APC Reassignments

Several codes were reassigned to different APCs effective January 1, 2015. Some of the changes will have a significant impact on the reimbursement for the codes. CPT® code 77373 will continue to be in APC 0066 with along with MRgFUS HCPCS codes 0071T, 0072T, 0301T, and C9734 even though this presents a 2 times rule violation between the codes. CMS expects to reevaluate the APC assignments for all SRS CPT codes for CY2016 rulemaking.

In order to fix a 2 times rule violation with the proton codes, code 77520, proton treatment delivery; simple, without compensation was moved from APC 0664 into APC 0412 (Level III Radiation Therapy). Code 77522, proton treatment delivery; simple, with compensation was also moved from APC 0664 into APC 0667 with the other proton treatment codes. Additionally, APC 0067 was renamed (Level IV Radiation Therapy) to match the pattern of other similar APCs.

CPT® code 57155, insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy, is once again moving. Since the creation of the code, 57155 has moved between APCs 0193 and 0192 on a near regular basis. It currently is in APC 0193; however, due to cost reporting it is being moved into APC 0192. The move into APC 0192 will result in an approximately 63% reduction in payment.

The hyperthermia treatment codes also changed APCs. CPT code 77600, hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less) moved from APC 0299 to 0301. This change resulted in a 53% reduction in payment. The remaining hyperthermia codes 77605, 77610, 77615 and 77620 and 77470, special treatment procedure also moved from APC 0299 to APC 0412. This resulted in a 23% increase in payment.

With the move of the IORT codes to a C-APC, MRgFUS codes now in APC 0066 and the MEG codes 95965 and 95966 moved from APC 0065 to APC 0446 (Level IV Nerve and Muscle Services), APC 0065 has been deleted.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>CY2014 APC</th>
<th>CY2014 Payment</th>
<th>CY2015 APC</th>
<th>CY2015 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>57155</td>
<td>Insert uterine tandem/ovoids</td>
<td>0193</td>
<td>$1,375.20</td>
<td>0192</td>
<td>$487.06</td>
</tr>
<tr>
<td>77373</td>
<td>SBRT Delivery</td>
<td>0066</td>
<td>$1,921.30</td>
<td>0066</td>
<td>$1,902.48</td>
</tr>
<tr>
<td>77520</td>
<td>Proton treatment w/o comp</td>
<td>0064</td>
<td>$872.37</td>
<td>0412</td>
<td>$507.55</td>
</tr>
<tr>
<td>77522</td>
<td>Proton treatment w/comp</td>
<td>0064</td>
<td>$872.37</td>
<td>0667</td>
<td>$1,071.95</td>
</tr>
<tr>
<td>77600</td>
<td>Hyperthermia treatment</td>
<td>0299</td>
<td>$413.22</td>
<td>0301</td>
<td>$193.17</td>
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<tr>
<td>77605</td>
<td>Hyperthermia treatment</td>
<td>0299</td>
<td>$413.22</td>
<td>0412</td>
<td>$507.55</td>
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<tr>
<td>77610</td>
<td>Hyperthermia treatment</td>
<td>0299</td>
<td>$413.22</td>
<td>0412</td>
<td>$507.55</td>
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<tr>
<td>77615</td>
<td>Hyperthermia treatment</td>
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<td>$413.22</td>
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</tbody>
</table>
No Cost/Full Credit and Partial Credit Devices
Medicare finalized the proposal to continue the existing policy of reducing payment for specific APCs when ASCs (Ambulatory Surgical Centers) furnished a specified device without cost or with a full or partial credit. ASCs continue to be required to report the amount of the credit on the claim when an ASC receives a credit for a replaced device that is 50 percent or greater than the cost of the device. This includes device HCPCS code C1728, catheter for brachytherapy seed administration.

Provider Based Status
As outlined within the Proposed Rule, the increased trend of hospital acquiring physicians and physician practices has posed concern with regard to effectively and accurately establishing payment rates for the facility based pricing. The total payment for services received by a patient in a hospital based system is typically higher than those received in an office-based or free-standing center.

The ability to accurately establish and set pricing information for both individual items and indirect PEs is critical in establishing accurate Practice Expense (PE) Relative Value Units (RVUs) for PFS services. Medicare indicated there are serious concerns in some of the information used to establish the PE RVUs. This includes concerns with the direct PE time allocations or assumptions and prices of services and equipment. In addition, for indirect PE the information used was collected several years ago and likely needs to be updated.

In was indicated a comparison of payment amounts for OPPS vs. PFS is not an accurate or appropriate means of ensuring the PFS payment rates are based on accurate cost assumptions. As published within the Proposed Rule Medicare was reviewing ways of collecting better data from physician practices including provider based and other non-facility entities that are paid through PFS. Medicare clarified the finalized adjustments were specific to the process of data collection and not adjustments to payments furnished in off-campus provider-based locations.

As published within the HOPPS Final Rule for CY2015 Medicare has created a two-digit HCPCS modifier to be reported with each code for hospital services furnished in an off-campus provider-based department of a hospital. The modifier will not be required for remote locations of a hospital, satellite facility of a hospital or emergency department. The two-digit modifier will be added to the HCPCS annual file as of January 1, 2015 with the label “PO”, the short descriptor “Serv/proc off-campus pbd” and the long descriptor “Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments”. The reporting of this modifier will be voluntary for 1 year with required reporting required beginning January 1, 2016.

For professional services, Place of Service (POS) code 22, Hospital Outpatient, will be deleted and two new POS codes will be established. One will represent outpatient services furnished in an on-campus, remote or satellite location of a hospital and the other will identify services furnished in an off-campus
provider-based department. At the writing of the CY2015 MPFS Final Rule, the new POS codes were not defined, and it is expected they will not be available prior to July 1, 2015. At the time the new codes are established, Medicare has indicated practitioners will be required to use them.

Collection of the data provided will begin the process of accurately assessing the PE data, including both the service-level direct PE inputs and specialty-level indirect PE information currently used to value PFS services. In addition, this data will provide better understanding of the growing trend towards hospital acquisition of physician offices and the impact of payments for these scenarios under PFS and beneficiary cost-sharing. Understanding which PE costs are actually incurred by the physician and which are incurred by the hospital is expected to provide a more accurate representation of the PE values.
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