CY2015 Final Rule Summary
Radiation Oncology

Medicare Physician Fee Schedule (MPFS)

Provided 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 Medicare Physician Fee Schedule (MPFS) for CY2015.

MPFS Final Rule Highlights

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


This document in PDF form is 1185 pages in length. The format of the information on the following pages is intended to summarize information contained within the final rules pertinent to radiation oncology services. 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 MPFS 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.

- Conversion Factor = $35.8013, January 1, 2015 – March 31, 2015
  - April 1, 2015 – December 31, 2015, without Congressional intervention it will be $28.2239. This is a 21.2% reduction, accounting for budget neutrality

- Estimated impact on total allowable change by specialty
  - Radiation Oncology 0%
  - Radiation Therapy Centers 1%

- Practice Expense Updates
  - Treatment room vault not changing from a direct practice expense to indirect, however, CMS will continue to evaluate for future rulemaking
  - CPT code 77373 – refinement of the direct PE inputs and adjusting equipment times to 104 minutes, same as CY2014
  - Hyperthermia – time allocated for hyperthermia equipment is appropriate, since there is no scope used in the procedure, time allocated in the PE for the cleaning of a scope is not necessary. CY2014 direct PE inputs for 77600 are finalized as established.
  - Brachytherapy CPT codes 77785, 77786 and 77787 CMS refined the RUC’s recommendations to remove “Emergency service container – safety kit,” as it is considered an indirect PE.
• Codes 77300, 77306 and 77307 accepted direct practice expense adjustments. Each has a direct cost change of -$3.10

• Work RVU Updates
  o CMS has finalized the RVUs established for CY2014 to also apply in CY2015 for CPT codes 19081, 19082, 19083, 19084, 19085, 19086, 19281, 19282, 19283, 19284, 19285 and 19286. CPT codes 19287 and 19288, were also finalized using CY2014 values, against RUC recommendations

• Potentially Misvalued Codes – 77263 and 77334 as identified through the high expenditure screen not finalized at this time

• Radiation Therapy code revisions – some of the radiation oncology CPT® code changes released by AMA in August 2014 will not be adopted until CY 2016. This will allow for the review of the impact on stakeholders and proper valuation.
  o Since codes have been deleted, G-codes have been created to allow practitioners to continue to report services to CMS in CY2015 as reported in CY2014, payments will be made in the same way.
  o All payment policies applicable to the CY2014 CPT codes will apply to the replacement G-codes.
  o The new and revised CY2015 CPT codes that will not be recognized by Medicare for CY2015 are denoted with an “I” (Not valid for Medicare purposes).

• CPT code 77401 – CMS is interested in information in whether new code set with the bundled codes typically reported with a superficial treatment are appropriate and accurately reviewed to base a decision to change the reporting of this code and services.

• G-codes for stereotactic radiotherapy (G0339 and G0340) will not be deleted. There is lacking information to make the decision to delete at this time. Will reconsider for future rulemaking

• Oncology Measures Group – 7 measures for Oncology for 2015 and beyond

• Physician Self Referrals – physicians are prohibited from referring patients for services to an entity where the physician has a financial relationship, unless an exception applies. There are four designated health services (DHS) categories which are updated annually to account for changes. One of the four DHS categories is “Radiation therapy services and supplies”. It includes the new treatment planning and delivery codes.

• CMS disagrees with the RUC work RVUs for new CPT code 77316. CMS believes CPT code 77316 should have been cross walked to similar simple planning code such as 77306. CMS has established an interim work RVU for code 77316.

• The clinical labor assigned to CPT code 77293 has been corrected to accurately reflect L152A as proposed.

• Off Campus Provider-Based Status
  o 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 codes 77387, G6001 and G6002 (all imaging codes) which replace deleted CPT imaging codes will also be subject to the cap on imaging codes defined by the DRA. This is open to public comment.

**Conversion Factor & SGR**

The CY2015 Conversion Factor (CF) was proposed to be $35.7977; however, was finalized at $35.8013 for January 1, 2015 – March 31, 2015. The Protecting Access to Medicare Act of 2014 (PAMA) has replaced the reduction in the PFS which would be expected for January 1, 2015, with a zero percent update for the first three months. It is noted; beginning April 1, 2015, the published CF is set at $28.2239, unless there is Congressional action taken for the remaining nine months. This would be considered a 21.2% reduction, intended to account for budget neutrality.

The payment for services under PFS is calculated with the following formula:

\[
\text{Payment} = \left[\left(\text{Work RVU} \times \text{Work GPCI}\right) + \left(\text{PE RVU} \times \text{PE GPCI}\right) + \left(\text{Malpractice RVU} \times \text{Malpractice GPCI}\right)\right] \times \text{CF}
\]

Based on the finalized CF and associated Relative Value Units (RVUs), it is estimated this will have a 0% impact on Radiation Oncology and 1% increase for Radiation Therapy Centers. This is significantly different from the proposed combined impact detailed in the proposed rules. The change is due to the proposed change of the treatment vault from a direct PE to indirect PE was not finalized. An excerpt of Table 93 is provided illustrating this estimate.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>(A) Allowed Charges (mil)</th>
<th>(B) Impact of Work RVU Changes</th>
<th>(C) Impact of PE RVU Changes</th>
<th>(D) Impact of MP RVU Changes</th>
<th>(E) Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>RADIATION ONCOLOGY</td>
<td>$1,794</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>RADIATION THERAPY CENTERS</td>
<td>$57</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

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Malpractice Updates
Medicare utilizes the Malpractice Relative Value Unit (MP RVU) to account for malpractice expenses involved in furnishing a particular service and requires review of RVUs no less than every 5 years. For CY2015, this represents the third comprehensive review and update of the MP RVUs since implementation in CY2000. The calculation required using information on specialty specific MP premiums linked to a specific service based upon the relative risk factors of the various specialties that furnish a particular service. As a result, the MP RVUs are based on specialty-specific data to determine the actual expense incurred by practitioners to obtain MP insurance, as well as CY2013 Medicare claims data.

CMS has finalized the proposed measure to combine neurology and neurosurgery surgical premiums to calculate a national average surgical premium and risk factor for neurosurgery.

Potentially Misvalued Codes
A new statutory category was established, “codes that account for the majority of spending under the physician fee schedule”, the list of 65 codes, two of which are utilized within Radiation Oncology, may be potentially misvalued.

The list of codes is prioritized as important to the Medicare program and beneficiaries, and account for a high level of Medicare expenditures. In order to identify potentially misvalued service or codes, Medicare periodically reviews the high expenditure services by specialty. The list for CY2015 was developed using the top 20 codes by specialty and allowed charges. The codes have not been reviewed since 2009 or earlier and have a significant impact on PFS payments at a specialty level. This review is meant to assess any changes in the physician work and update the direct PE inputs. The selected codes were included within Table 11 of the Final Rule and excerpt pertaining to oncology is provided.

TABLE 11: Potentially Misvalued Codes Identified Through the High Expenditure by Specialty Screen

- 77263 – Radiation Therapy Planning
- 77334 Radiation Treatment Aid(s)

Based on resources required over the next several years to revalue services with global periods, Medicare is not finalizing the codes identified through the high expenditure screening as potentially misvalued at this time. Medicare instructed they will re-run the high expenditure screen at a future date and further proposals for review will be provided at that time.

CPT® code 77293 Clinical Labor Input Error
In comments presented regarding the CY2014 PFS Final Rule, a clerical error was noted regarding the clinical labor type for CPT code 77293, (respiratory Motion Management Simulation (list separately in addition to code for primary procedure). The clinical labor type listed was L052A (Audiologist) instead of...
L152A (Medical Physicist), which has a higher cost per minute. CMS has finalized the correction to reflect Medical Physicist.

**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 value or assign the new or changed code the appropriate RVU valuations.

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 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 established RVUs. After one year of the use of the G-code the new or changed code as released by the AMA will be implemented.

For CY2015 the AMA included significant code changes to radiation oncology. The following CPT codes were deleted by the AMA effective January 1, 2015; 76950, 77305, 77310, 77315, 77326, 77327, 77328, 77421, 77403, 77404, 77406, 77408, 77409, 77411, 77413, 77414, 77416, 77418, 0073T, and 0197T. The listed codes were to be replaced with the following CPT codes 77306, 77307, 77316, 77317, 77318, 77385, 77386 and 77387. Treatment codes 77402, 77407 and 77412 were not deleted but changed and code 77014 was removed from use with IGRT for treatment delivery.

Upon review of the significant code changes and valuations by the RUC CMS determined a delay in activating the new CPT codes was needed until CY2016 for the treatment and imaging codes. The isodose planning codes were accepted and made final to be implemented effective January 1, 2015. The following table outlines the CY2014 CPT codes and the crosswalk to the new CPT codes for CY2015.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>77305</td>
<td>Teletx isodose plan simple</td>
<td>77306</td>
<td>Teletx isodose plan simple</td>
</tr>
<tr>
<td>77310</td>
<td>Teletx isodose plan intermed</td>
<td></td>
<td>No new code for 2015</td>
</tr>
<tr>
<td>77315</td>
<td>Teletx isodose plan complex</td>
<td>77307</td>
<td>Teletx isodose plan cplx</td>
</tr>
<tr>
<td>77326</td>
<td>Brachy isodose calc simp</td>
<td>77316</td>
<td>Brachy isodose plan simple</td>
</tr>
</tbody>
</table>
Since the daily treatment and imaging codes, except 77014, were deleted for CY2015 CMS, for freestanding cancer centers only, created G-codes to replace the deleted codes. Effective January 1, 2015 all freestanding cancer centers will report daily treatments and imaging performed to deliver the treatment with the corresponding G-codes created by CMS. This will vary and be very different than what is reported for hospital based systems. For hospitals CMS adopted and recognized all of the CPT code changes for CY2015. This variance will impact physicians working in a hospital based system as the physician code reported for imaging will not match the code for the hospital.

For CY2015 it will be very important when seeking guidance or assistance with coding and billing related to treatment delivery and IGRT, all providers need to be aware and cognizant of the changes and variances in reporting similar services in a freestanding cancer center vs. a hospital based system. Effective January 1, 2015 the hospital cannot report the technical component of any imaging for any IMRT course; however, in the freestanding center the imaging code for 77421 (now G6002) and 76950 (now G6001) are split out and reported both technically and professionally when supported for IMRT. In the freestanding cancer center code 77014 is still used as is the current practice for CY2014. In the hospital all imaging for treatment delivery is replaced by CPT code 77387.

For CY2015 the AMA also provided significant changes to the services which can be billed with code 77401, radiation treatment delivery, superficial and/or ortho voltage. The CPT manual indicates only the physician E&M is billable with treatment delivery 77401. All other simulation, planning, physics and physician management services are bundled into the treatment delivery code. CMS only indicated in the final rules an interest in obtaining more information since the RUC did not review superficial radiation therapy services before making the code changes.

The following table shows the current CPT code for CY2014 with the crosswalk to the corresponding G-code developed by CMS. The G-codes will be reported effective January 1, 2015 with the anticipated change to the new CPT codes taking effect in CY2016.
### TABLE 27: Radiation Therapy G-Codes Replacing CY 2015 CPT Codes

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>76950</td>
<td>G6001</td>
<td>Ultrasonic guidance for placement of radiation therapy fields</td>
</tr>
<tr>
<td>77421</td>
<td>G6002</td>
<td>Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy</td>
</tr>
<tr>
<td>77402</td>
<td>G6003</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5MeV</td>
</tr>
<tr>
<td>77403</td>
<td>G6004</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10MeV</td>
</tr>
<tr>
<td>77404</td>
<td>G6005</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19MeV</td>
</tr>
<tr>
<td>77406</td>
<td>G6006</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 MeV or greater</td>
</tr>
<tr>
<td>77407</td>
<td>G6007</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5MeV</td>
</tr>
<tr>
<td>77408</td>
<td>G6008</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10MeV</td>
</tr>
<tr>
<td>77409</td>
<td>G6009</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19MeV</td>
</tr>
<tr>
<td>77411</td>
<td>G6010</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam, up to 5MeV</td>
</tr>
<tr>
<td>77413</td>
<td>G6012</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam, 6-10MeV</td>
</tr>
<tr>
<td>77414</td>
<td>G6013</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam, 11-19MeV</td>
</tr>
<tr>
<td>77416</td>
<td>G6014</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam, 20MeV or greater</td>
</tr>
<tr>
<td>77418</td>
<td>G6015</td>
<td>Intensity modulated treatment delivery, single or multiple fields/arc, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session</td>
</tr>
<tr>
<td>0073T</td>
<td>G6016</td>
<td>Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session</td>
</tr>
<tr>
<td>0197T</td>
<td>G6017</td>
<td>Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment</td>
</tr>
</tbody>
</table>

**PQRS**

Seven specific Oncology Measure Groups were proposed for 2015 and beyond and finalized as a component of the CY 2015 Final Rule. A measure group is a subset of four or more Physician Quality Reporting System measures, which have a particular clinical condition or focus in common. By coding a measure in a measure group providers are identifying a condition or focus which is shared across the measures in a particular measure group. The following table outlines the seven finalized Oncology measures.
Direct PE for Stereotactic Radiosurgery Codes (77372 and 77373)

In the proposed rules for CY2015, CMS had proposed to delete the G-codes (G0339 and G0340) used to report robotic stereotactic radiotherapy treatments, which are carrier priced. The current CPT® codes 77372 and 77373 were felt to describe the services provided and the RUC stated the belief that the direct PE inputs for the CPT codes was accurately accounted for in 77372 and 77373.

After reviewing comments CMS finalized G0339 and G0340 will not be deleted and will remain available for reporting stereotactic radiotherapy treatments. The G-codes will continue to be carrier priced and the issue of potentially deleting the G-codes will be revisited in future rulemaking.

Practice Expense (PE) Updates

The treatment vault has been calculated as a direct PE (Practice Expense) when valuing the reimbursement of the daily treatment codes in radiation oncology. In several proposed rulings over the years Medicare has proposed to change the treatment vault from a direct PE to indirect PE, significantly impacting the reimbursements for the daily treatments.
Medicare has questioned whether the valuing the vault as a direct PE was consistent with the principles underlying the PE methodology. In comparing the treatment vault to other expensive medical equipment, such as diagnostic radiology machines, the building infrastructure costs appear to be similar.

In reviewing the comments presented, even though considering the treatment vault to be a direct PE does not follow the established PE methodology, Medicare has decided to not finalize this change. Further study is needed and will be performed to determine if this change will happen in future rulings.

PE updates were also made for CPT code 77373; the equipment time of 104 minutes was finalized instead of the proposed reduction to 86 minutes. The CY2014 interim equipment times for hyperthermia code 77600 were finalized. The time had accounted for a scope and cleaning of a scope; however, there is no scope as part of this procedure. The “Emergency service container – safety kit,” accounted for with HDR treatment codes 77785, 77786 and 77787 will remain an indirect PE and the CY2014 interim value was finalized. Lastly, for codes 77300, 77306 and 77307 the RUC recommended direct PE time value of 5 minutes for each code this was refined by CMS to 0 minutes. This resulted in a cost change of -$3.10 for each code.

**Work RVUs Updates**

Fourteen new breast placement codes were introduced in CY2014. Based on recommendations for RVUs valued by the RUC, CMS adopted the values on an interim basis. CMS has finalized the RVUs established for CY2014 to also apply in CY2015 for CPT codes 19081, 19082, 19083, 19084, 19085, 19086, 19281, 19282, 19283, 19284, 19285 and 19286. CPT codes 19287 and 19288, both which use MRI guidance were recommended to be adjusted. CMS expressed concern with the recommended change by the RUC for CY2015 to increase the work RVU. CMS instead finalized the interim CY2014 values which are lower that recommended.

**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) 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 CY 2015 Final Rule, 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 CY 2015 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.

**Physician Self Referrals**

Physicians are prohibited from referring a Medicare beneficiary for certain designated health services (DHS) to an entity where the physician has a financial relationship, unless an exception applies. There are four designated health services (DHS) categories which are updated annually to account for changes. The DHS categories defined and updated are:

- Clinical laboratory services
- Physical therapy, occupational therapy, and outpatient speech-language pathology services
- Radiology and certain other imaging services
Radiation therapy services and supplies

The following list of services in Table 90 of the MPFS Final Rule is new codes added effective January 1, 2015 and considered designated health services and prohibited from physician self-referral, unless an exception applies.

**TABLE 90: Additions to the Physician Self-Referral List of CPT1/HCPCS Codes**

**RADIATION THERAPY SERVICES AND SUPPLIES**

- A9606 Radium Ra223 dichloride ther
- C2644 Brachytx cesium-131 chloride
- 77306 Telethx isodose plan simple
- 77307 Telethx isodose plan cplx
- 77316 Brachytx isodose plan simple
- 77317 Brachytx isodose intermed
- 77318 Brachytx isodose complex
- 77385 Ntsty modul rad tx dlvr smpl
- 77386 Ntsty modul rad tx dlvr cplx
- G6001 Echo guidance radiotherapy
- G6002 Stereoscopic x-ray guidance
- G6003 Radiation treatment delivery
- G6004 Radiation treatment delivery
- G6005 Radiation treatment delivery
- G6006 Radiation treatment delivery
- G6007 Radiation treatment delivery
- G6008 Radiation treatment delivery
- G6009 Radiation treatment delivery
- G6010 Radiation treatment delivery
- G6011 Radiation treatment delivery
- G6012 Radiation treatment delivery
- G6013 Radiation treatment delivery
- G6014 Radiation treatment delivery
- G6015 Radiation tx delivery imrt
- G6016 Delivery comp imrt
- G6017 Intrafraction track motion
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