Volume-weighted Medicare payment rates by radiology outpatient procedure group (OPG) were calculated as follows:

Medicare Physician Fee Schedule (PFS):

1) Addendum B from the most recent PFS final rule is used to identify the work RVU, non-facility practice expense RVU, and malpractice RVU for every CPT/HCPCS code that falls into one of our Radiology OPGs. These rates are calculated only for the technical component ("TC") entry for each code.
2) The code-level PFS non-facility payment rate is calculated by summing the three components from step one above and multiplying the result by the conversion factor. No rate is calculated for the technical component of a given CPT/HCPCS code if that code is flagged with any of the following status indicators (more info on this here): E, X, B, I, N, or P.
3) A volume-weighted roll-up of the code-level payment rates is performed to arrive at an OPG payment rate for PFS. The code-level volumes used for this payment weighting are drawn from CMS's most recent Physician/Supplier Procedure Summary (PSPS) file, which contains all calendar-year Medicare Part B carrier and durable medical equipment fee-for-service claims. Denied codes are subtracted from total codes submitted in order to get a count of allowed codes submitted. The volume for a given code is multiplied by its PFS payment rate as calculated above, and the result is divided by the number of code volumes in each OPG. Codes with no RVUs or with a calculated rate of $0 (based on RVUs) are excluded from the weighting.

Outpatient Prospective Payment System (Neutral)

1) Addendum B from the most recent OPPS final rule is used to identify the APC and associated APC payment rate for all CPT/HCPCS codes (please note that not every code falls into an APC).
2) No rate is used for a given CPT/HCPCS code if that code is flagged with any of the following status indicators (more info on this here): B, I, N, or P.
3) A volume-weighted roll up is performed using the same PSPS volumes and weighting methodology as described in step 3 of the PFS process above.

Site-Neutral

1) Follows the same process as OPPS, but the rate calculated at the code level is multiplied by 40% before the volume-weighted OPG rate roll-up is performed (step 3 above).

Several rates have been further adjusted:

1) Since mammography services are not reimbursed under OPPS under the Social Security Act (and hence the relevant CPT codes are valued at $0 under OPPS), the rate for screening mammography and breast MRI in the OPPS column have been reset to equal the MPFS rates.
2) For CT, MRI, Ultrasound, and Nuclear Medicine services, MPFS rates in some cases exceed the rates paid under OPPS. Under the Deficit Reduction Act of 2005, MPFS reimbursement is capped at the corresponding OPPS rate. For this reason, where MPFS rates are higher than OPPS, the CPT reimbursement values underlying the MPFS columns have been reset to equal the OPPS column. This adjustment is reflected in the OPG weighted averages.