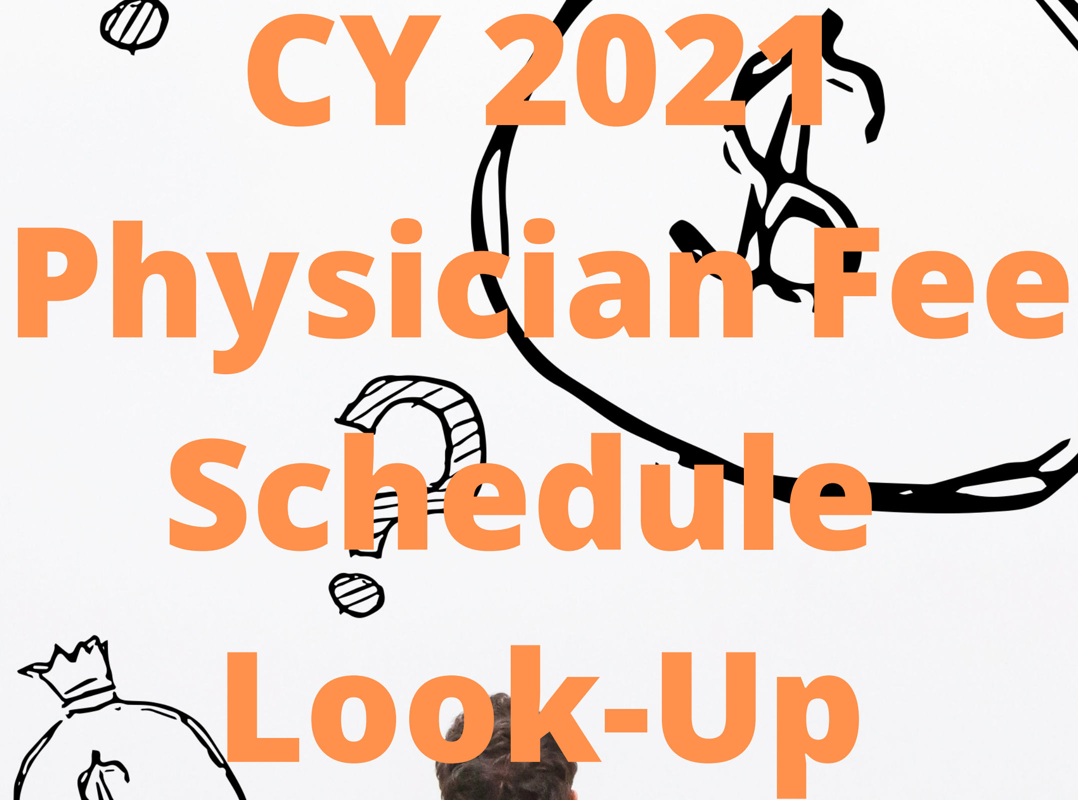
CY 2021 Physician Fee Schedule Look-Up



AAOE

American Alliance
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Thank you for purchasing the CY 2021 Physician Fee Schedule Look-Up!

We are proud to provide this resource to our members each year following publication of the annual Physician Fee Schedule. The data in the calculator comes from the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for administering the Medicare program. The calculator was originally created by Debra Mitchell, RN, BSN, MBA. AAOE is immensely grateful for Ms. Mitchell's assistance in preparing this year's calculator.

The calculator is composed of eight different sheets in one Microsoft Excel workbook:

Worksheet Name	Description
How to Use This Tool	Provides an introduction to the calculator.
GPCI	Provides a filterable list of Medicare Administrative Contractors, the jurisdiction they serve, and geographic practice cost indices that are used to determine geographically-adjusted reimbursements.
My_GPCI	Provides a space for users to enter their specific GPCIs in designated spaces that will auto-populate the calculator with the user's GPCI.
Medicare PFS 2020	This is the CY 2020 RVU calculator.
Medicare PFS 2020 – 2nd MAC	This is a second CY 2020 RVU calculator for practices that may be subject to a second MAC's jurisdiction in a different geographic area.
Medically Unlikely Edits Limit	Provides a list of searchable MUEs established by Medicare to limit improper Part B payments. An MUE is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.
DME 2020	Provides the October 2019 updates to the durable medical equipment, prosthetics, and orthotics supplies fee schedule.
Crosswalk Cast Application	Provides a crosswalk of HCPCS Level I codes to casting/splinting Q codes.

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Definitions

Acronyms and abbreviations are used throughout the calculator. Use the definitions below to translate any unknown acronyms.

GPCI

- PW GPCI – Physician Work Geographic Practice Cost Index
- PE GPCI – Practice Expense Geographic Practice Cost Index
- MP GPCI – Malpractice Geographic Practice Cost Index
- MACRA – *Medicare Access and CHIP Reauthorization Act of 2015*
- MIPPA – *Medicare Improvements for Patients and Providers Act of 2008*
- ACA – *Affordable Care Act of 2010*

Medicare PFS 2021/Medicare PFS 2021 – 2nd MAC

Abbreviation	Column Header/Abbreviated Word	Description
Non-Fac	Non-Facility	A setting identified as outside of the Medicare designated facility setting. Includes physician offices.
Fac	Facility	A setting identified by Medicare as a hospital, ASC, nursing home, etc.
HCPCS	Healthcare Common Procedure Coding System	CPT or Level 2 HCPCS codes for the stated service.
MOD	Modifier	For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: • --26 = Professional component • --TC = Technical component • --For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT modifier -53 indicates that separate RVUs and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy CPT code 45378, or with G0105 and G0121. Any other codes billed with modifier -53 are subject to carrier medical review and priced by individual consideration. • --53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or

		diagnostic procedure was started but discontinued.
	Status Code	Indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered. Only RVUs associated with status codes of "A", "R", or "T", are used for Medicare payment.
	Work RVU	Relative Value Unit (RVU) for the physician work in the service.
	Non-Facility Practice Expense RVU	RVU for the resource-based practice expense for the non-facility setting.
	Non-Facility NA Indicator	An "NA" in this field indicates that this procedure is rarely or never performed in the non-facility setting.
	Facility Practice Expense RVU	RVU for the resource-based practice expense for the facility setting.
	Facility NA Indicator	An "NA in this field indicates that this procedure is rarely or never performed in the facility setting.
	Malpractice RVU	RVU for the malpractice expense for the service.
	Total Non-Facility RVUs	Sum of work, non-facility practice expense, and malpractice expense RVUs.
	Total Facility RVUs	Sum of work, facility practice expense, and malpractice expense.
PCTC IND	PC/TC Indicator	• 0 = Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs. • 1 = Diagnostic Tests for Radiology Services--Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include

		values for physician work, practice expense, and malpractice expense. • 2 = Professional Component Only Codes--This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is CPT code 93010--Electrocardiogram; Interpretation and Report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. • 3 = Technical Component Only Codes--This indicator identifies stand- alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code 93005--Electrocardiogram; Tracing Only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. • 4 = Global Test Only Codes--This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

		• 5 = Incident To Codes--This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes. • 6 = Laboratory Physician Interpretation Codes--This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense. • 7 = Physical therapy service, for which payment may not be made-- Payment may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist. • 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies to CPT codes 88141, 85060 and HCPCS code P3001-26. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for CPT codes 88141, 85060 or HCPCS code P3001-26 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test. • 9 = Not Applicable--Concept of a professional/technical component does not apply.
GLOB DAYS	Global Surgery	Provides time frames that apply to each surgical procedure.

		• 000=Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable. • 010=Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable. • 090=Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount. • MMM=Maternity codes; usual global period does not apply. • XXX=The global concept does not apply to the code. • YYY=The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing. • ZZZ=The code is related to another service and is always included in the global period of the other service.
PRE OP	Preoperative Percentage	Percentage for preoperative portion of global package.
INTRA OP	Intraoperative Percentage	Percentage for intraoperative portion of global package, including postoperative work in the hospital.
POST OP	Postoperative Percentage	Percentage for postoperative portion of global package that is provided in the office after discharge from the hospital.
MULT PROC	Multiple Procedure (Modifier 51)	Indicates applicable payment adjustment rule for multiple procedures: • 0=No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure. • 1=Standard payment adjustment rules in effect before January 1, 1995 for multiple procedures apply. In the 1995 file, this indicator only applies to codes with a status code of "D". If procedure is reported on the same day as

		another procedure that has an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 25%, 25%, 25%, and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. • 2=Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. • 3=Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of this file. Apply the multiple endoscopy rules to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy. • 4=Special rules for the technical component (TC) of diagnostic imaging procedures apply if procedure is billed with another diagnostic imaging procedure in the same family (per the diagnostic imaging family indicator, below). If procedure is reported in the same session on the same day as another procedure with the same family indicator, rank the procedures by fee schedule amount for the TC. Pay 100% for the highest priced procedure, and 50% for each subsequent procedure. Base the payment for subsequent procedures on the lower of (a) the

		actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2018 and after). • 5=Subject to 50% of the practice expense component for certain therapy services. • 6=Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic cardiovascular services, effective for services January 1, 2013, and thereafter. • 7=Subject to 20% reduction of the second highest and subsequent procedures to the TC of diagnostic ophthalmology services, effective for services January 1, 2013, and thereafter. • 9=Concept does not apply.
BILAT SURG	Bilateral Surgery (Modifier 50)	Indicates services subject to payment adjustment. • 0=150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides and (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. • 1=150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when

		reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules. • 2=150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure. • 3=The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to

		the special payment rules for other bilateral surgeries. • 9=Concept does not apply.
ASST SURG	Assistant at Surgery	Indicates services where an assistant at surgery is never paid for per Medicare Claims Manual. • 0=Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. • 1=Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. • 2=Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid. • 9=Concept does not apply.
CO-SURG	Co-Surgeons (Modifier 62)	Indicates services for which two surgeons, each in a different specialty, may be paid. • 0=Co-surgeons not permitted for this procedure. • 1=Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure. • 2=Co-surgeons permitted and no documentation required if the two- specialty requirement is met. • 9=Concept does not apply.
TEAM SURG	Team Surgery (Modifier 66)	Indicates services for which team surgeons may be paid. • 0=Team surgeons not permitted for this procedure. • 1=Team surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report. • 2=Team surgeons permitted; pay by report. • 9=Concept does not apply.
ENDO BASE	Endoscopic Base Code	Code which identifies an endoscopic base code for each code with a multiple surgery indicator of 3.
CONV FACTOR	Conversion Factor	This is the multiplier that transforms relative values into payment amounts. This conversion factor reflects the MEI update adjustment.
	Physician Supervision of Diagnostic Procedures	This field is for use in post payment review. • 01 = Procedure must be performed under the general supervision of a physician.

		• 02 = Procedure must be performed under the direct supervision of a physician. • 03 = Procedure must be performed under the personal supervision of physician. • 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. • 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. • 06 = Procedure must be performed by a physician or a physical Therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. • 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. • 22 = May be performed by a technician with on-line real-time contact with physician. • 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. • 6A= Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. • 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. • 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. • 09 = Concept does not apply.
	Calculation Flag	Calculation flag for all HCPCS codes is “0”.
	Diagnostic Imaging Family Indicator	This field identifies the applicable diagnostic service family for that HCPCS codes with a multiple procedure

		indicator of ‘4’. For services effective January 1, 2011 and after, family indicators 01 – 11 will not be populated. The values are: • 01=Ultrasound (Chest/Abdomen/Pelvis-Non-Obstetrical) • 02=CT and CTA (Chest/Thorax/Abd/Pelvis) • 03=CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) • 04=MRI and MRA (Chest/Abd/Pelvis) • 05=MRI and MRA (Head/Brain/Neck) • 06=MRI and MRA (Spine) • 07=CT (Spine) • 08=MRI and MRA (Lower Extremities) • 09=CT and CTA (Lower Extremities) • 10=MR and MRI (Upper Extremities and Joints) • 11=CT and CTA (Upper Extremities) • 88=Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011 and after). • 99=Concept does not apply
	Non-Facility Practice Expense Used for OPPS payment Amount	The OPPS Payment Amount calculated using these values is compared to the Medicare Physician Fee Schedule to determine applicability of the OPPS Imaging Cap mandated by Section 5102(b) of the Deficit Reduction Act of 2005.
	Facility Practice Expense Used for OPPS Payment Amount	The OPPS Payment Amount calculated using these values is compared to the Medicare Physician Fee Schedule to determine applicability of the OPPS Imaging Cap mandated by Section 5102(b) of the Deficit Reduction Act of 2005.
	Malpractice Used for OPPS Payment Amount	The OPPS Payment Amount calculated using these values is compared to the Medicare Physician Fee Schedule to determine applicability of the OPPS Imaging Cap mandated by Section 5102(b) of the Deficit Reduction Act of 2005.

Medicare Unlikely Edits Limits

Abbreviation	Column Header/Abbreviated Word	Description
	HCPCS/CPT Code	CPT or Level 2 HCPCS codes for the stated service.
	MUE Adjudication Indicator	• -1-An MAI of “1” indicates that the edit is a claim line MUE. Appropriate use of NCCI modifiers (e.g., 59, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. Medical records must support the total units for the date of

		service and the use of the modifiers appended. • -2-MUE edits with an MUE Adjudication Indicator (MAI) of "2" (Date of Service Edit: Policy): o The MUE value is an absolute date of service limit that may not be overridden or bypassed with a modifier. o MUE edit limits with an MAI of "2" have been rigorously reviewed and vetted within CMS. o Units in excess of the MUE value on a date of service would be considered impossible because of the code definition, anatomical consideration, CMS statute, regulation or subregulatory guidance. • -3- MUE edit limits with an MUE Adjudication Indicator of "3" (Date of Service Edit: Clinical): o It would be possible but medically highly unlikely that more units than the MUE value would ever be performed on the same date of service for the same patient. CMS set these quantity limits based on clinical benchmarks and criteria (e.g., nature of service, prescribing information) combined with CMS data. Will need to appeal to get paid.
	MUE Rationale	Provides rationale for MUE Adjudication Indicator.

DME 2021

Acronym	Column Header/Abbreviated Word	Description
HCPCS	Healthcare Common Procedure Coding System	All current year active codes subject to DMEPOS fee schedule payment rules if covered.
MOD	1st Modifier	o NU--Purchased, New RR—Rented o UE--Purchased, Used o KM--Replacement of Facial Prosthesis including new impression/moulage o KN--Replacement of Facial Prosthesis using previous master mold o AU--Urological, ostomy or trach item AV--Item with prosthetic/orthotic device

		o AW--Item with a surgical dressing Equipment o KE--Bid Under Round I of the DMEPOS Competitive Bid Program For Use With Non-Competitive Bid Base Equipment o KF--Class III device o KL-- DMEPOS Item Delivered Via Mail o KC--Replacement of Special Power Wheelchair Interface o KU-- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3
MOD2	2nd Modifier	When two modifiers apply.
JURIS	Jurisdiction	o D-DME MAC Jurisdiction o L-Local Part B Carrier Jurisdiction o J-Joint DME MAC/Local Carrier Jurisdiction
CATG	Category	o IN--Inexpensive and Other Routinely Purchased Items o FS--Frequently Serviced Items o CR--Capped Rental Items o OX--Oxygen and Oxygen Equipment o OS--Ostomy, Tracheostomy & Urological Items o SD--Surgical Dressings o PO--Prosthetics & Orthotics o SU— Supplies o TE--Transcutaneous Electrical Nerve Stimulators o TS— Therapeutic Shoes o IL--Intraocular Lenses o SC--Splints and Casts
	Ceiling	Maximum fee schedule amount for certain items for areas within the contiguous United States. This field will be filled with zeros for codes adjusted using information from the competitive bidding program. Please note that since E0607 is priced via national Inherent Reasonableness, it is not priced using floors and ceilings. For E0607, this field will be filled with zeros. Since pricing amounts for E1405, E1406, and E0954 were developed by summing pricing amounts from source codes, they are not subject to ceilings and floors. Those items which are priced using special payment rules do not have floors and ceilings; these fields will be filled with zeros. This includes K0554 and non-mail order (no-KL) codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 that are priced using National Mail order single payment amounts. Splints, casts, and certain Intraocular Lenses (IOLs) are priced

		using national fee schedule amounts and not subject to ceilings and floors. Please note that the payment amounts for E0935 represent a daily rather than a monthly payment amount.
	Floor	Minimum fee schedule amount for certain items for areas within the contiguous United States. This field will be filled with zeros for codes adjusted using information from the competitive bidding program. Please note that since E0607 is priced via national Inherent Reasonableness, it is not priced using floors and ceilings. For E0607, this field will be filled with zeros. Since pricing amounts for E1405, E1406, and E0954 were developed by summing pricing amounts from source codes, they are not subject to ceilings and floors. Those items which are priced using special payment rules do not have floors and ceilings; these fields will be filled with zeros. This includes K0554 and non-mail order (no-KL) codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 that are priced using National Mailorder single payment amounts. Splints, casts, and certain Intraocular Lenses (IOLs) are priced using national fee schedule amounts and not subject to ceilings and floors. Please note that the payment amounts for E0935 represent a daily rather than a monthly payment amount.
NR	Non-Rural	Metropolitan statistical areas (MSA) excluding rural areas.
R	Rural	A geographic area represented by a postal ZIP code of at least 50% of the total geographic area included in the ZIP code that is estimated to be outside any metropolitan area. And/or, a geographic area represented by a postal ZIP code that is a low population density area excluded from a competitive bidding area.

Please email AAOE at info@aaoe.net with any questions pertaining to the RVU calculator or call 800-247-9699.

Note: CPT codes and descriptions only are copyright 2021 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.