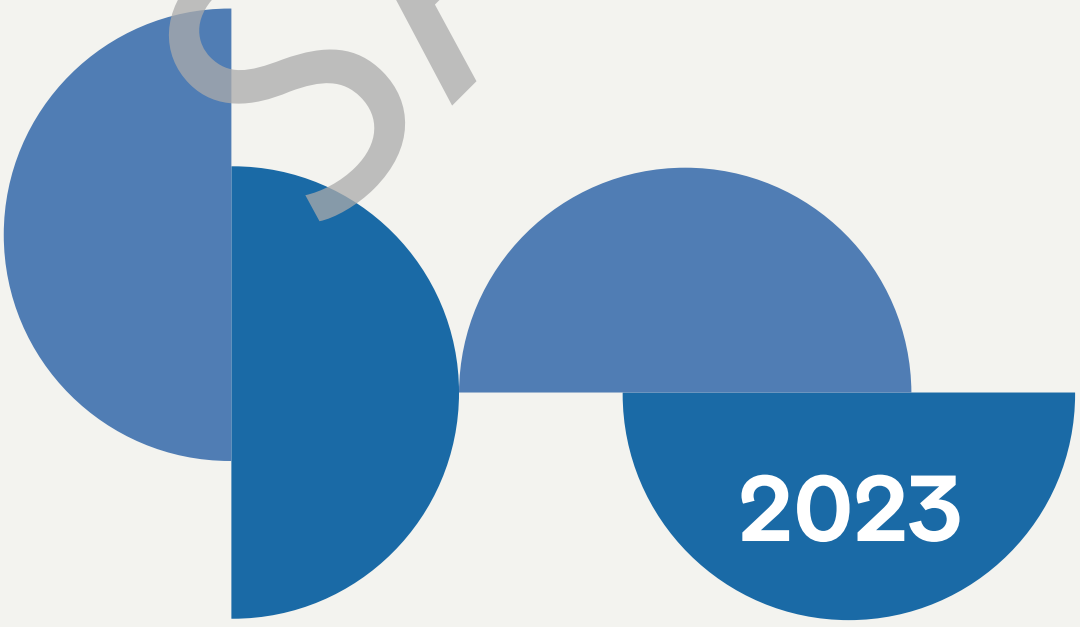
Optum

Coding Companion

ENT/Allergy/ Pulmonology

A comprehensive illustrated guide to coding and reimbursement



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Contents

Getting Started with Coding Companion

Coding Companion for ENT/Allergy/Pulmonology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT Codes

For ease of use, evaluation and management codes related to ENT/Allergy/Pulmonology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version XX.X, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is http://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXXX**. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

69501 Transmastoid antrotomy (simple mastoidectomy)

could be found in the index under the following main terms:

Antrotomy
Transmastoid, 69501

OR

Excision
Mastoid
Simple, 69501

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

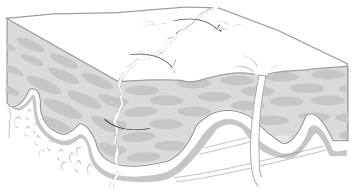
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

12001-12007

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002 2.6 cm to 7.5 cm
12004 7.6 cm to 12.5 cm
12005 12.6 cm to 20.0 cm
12006 20.1 cm to 30.0 cm
12007 over 30.0 cm



Example of a simple closure involving only one skin layer, the epidermis

Explanation

The physician performs wound closure of superficial lacerations of the scalp, neck, or trunk using sutures, staples, tissue adhesives, or a combination of these materials. A local anesthetic is injected around the wound and it is cleansed, explored, and often irrigated with a saline solution. The physician performs a simple, one-layer repair of the epidermis, dermis, or subcutaneous tissues. For multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length. Report 12001 for a total length of 2.5 cm or less; 12002 for 2.6 cm to 7.5 cm; 12004 for 7.6 cm to 12.5 cm; 12005 for 12.6 cm to 20 cm; 12006 for 20.1 cm to 30 cm; and 12007 if the total length is greater than 30 cm.

Coding Tips

Wounds treated with tissue glue or staples qualify as a simple repair even if they are not closed with sutures. When chemical cauterization, electrocauterization, or adhesive strips are the only material used for wound closure, the service is included in the appropriate E/M code. Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia, in addition to the skin, require closure. Intermediate repair is also reported for single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter. For extensive debridement of soft tissue and/or bone, not associated with open fractures and/or dislocations, resulting from penetrating and/or blunt trauma, see 11042–11047. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. For wound closure by tissue adhesive(s) only, see HCPCS Level II code G0168.

ICD-10-CM Diagnostic Codes

S01.01XA Laceration without foreign body of scalp, initial encounter
S01.03XA Puncture wound without foreign body of scalp, initial encounter
S01.05XA Open bite of scalp, initial encounter
S11.81XA Laceration without foreign body of other specified part of neck, initial encounter
S11.83XA Puncture wound without foreign body of other specified part of neck, initial encounter
S11.89XA Other open wound of other specified part of neck, initial encounter

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: **12001** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2017,Dec,14; 2016, 2015,Jan,16 **12002** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015, **12004** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **12005** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **12006** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **12007** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12001	0.84	1.77	0.15	2.76
12002	1.14	1.99	0.21	3.34
12004	1.44	2.18	0.26	3.88
12005	1.97	2.84	0.38	5.19
12006	2.39	3.22	0.45	6.06
12007	2.9	3.42	0.58	6.9
Facility RVU	**Work**	**PE**	**MP**	**Total**
12001	0.84	0.31	0.15	1.3
12002	1.14	0.37	0.21	1.72
12004	1.44	0.44	0.26	2.14
12005	1.97	0.46	0.38	2.81
12006	2.39	0.59	0.45	3.43
12007	2.9	0.81	0.58	4.29

	FUD	Status	MUE	Modifiers				IOM Reference
12001	0	A	1(2)	51	N/A	N/A	N/A	None
12002	0	A	1(2)	51	N/A	N/A	N/A	
12004	0	A	1(2)	51	N/A	N/A	N/A	
12005	0	A	1(2)	51	N/A	N/A	N/A	
12006	0	A	1(2)	51	N/A	N/A	N/A	
12007	0	A	1(2)	51	N/A	62*	N/A	

* with documentation

Terms To Know

closure. Repairing an incision or wound by suture or other means.

epidermis. Outermost, nonvascular layer of skin that contains four to five differentiated layers depending on its body location: stratum corneum, lucidum, granulosum, spinosum, and basale.

injury. Harm or damage sustained by the body.

laceration. Tearing injury; a torn, ragged-edged wound.

superficial. On the skin surface or near the surface of any involved structure or field of interest.

suture. Numerous stitching techniques employed in wound closure.

1. CPT Codes and Descriptions

This edition of *Coding Companion* is updated with CPT codes for year 2023.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum360 and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2022.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier26) component of a procedure is provided.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are no longer used when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3 **99205** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.1	0.09	2.12
99203	1.6	1.51	0.15	3.26
99204	2.6	2.04	0.23	4.87
99205	3.5	2.62	0.31	6.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.15	2.42
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

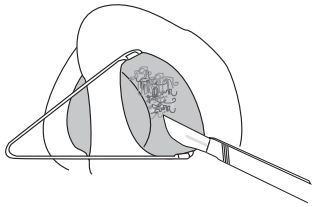
Terms To Know

new patient. Patient who is receiving face-to-face care from a provider/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider based clinic or emergency department, within the past three years.

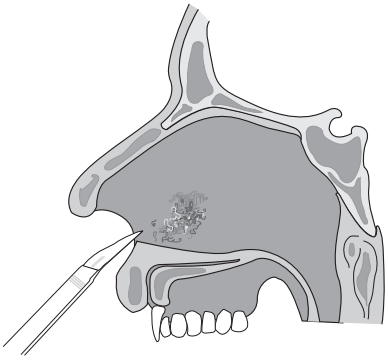
outpatient visit. Encounter in a recognized outpatient facility.

30100

30100 Biopsy, intranasal



Suspect tissue is excised for study; some adjacent normal tissue is excised for comparison



Only a wedge of tissue is removed for larger lesions

Explanation

The physician removes mucosa from inside the nose for biopsy. This biopsy is performed when the mucosa is suspicious for disease. Some normal tissue adjacent to the diseased mucosa is also removed during the biopsy. This allows the pathologist to compare diseased versus nondiseased tissues. The excision site may be closed primarily with sutures or may be allowed to granulate without closure.

Coding Tips

For a biopsy of the skin of the nose, see 11102–11107. If tissue is transported to an outside laboratory, report 99000 for handling and/or conveyance. If the entire lesion is excised, see 11440–11446 or 11640–11646.

ICD-10-CM Diagnostic Codes

C30.0	Malignant neoplasm of nasal cavity
C76.0	Malignant neoplasm of head, face and neck
C78.39	Secondary malignant neoplasm of other respiratory organs
D02.3	Carcinoma in situ of other parts of respiratory system
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
D23.39	Other benign neoplasm of skin of other parts of face
D38.5	Neoplasm of uncertain behavior of other respiratory organs
J31.0	Chronic rhinitis
J33.0	Polyp of nasal cavity
J34.0	Abscess, furuncle and carbuncle of nose
J34.1	Cyst and mucocele of nose and nasal sinus
J34.81	Nasal mucositis (ulcerative)
J34.89	Other specified disorders of nose and nasal sinuses
M31.30	Wegener's granulomatosis without renal involvement
M31.31	Wegener's granulomatosis with renal involvement
R22.0	Localized swelling, mass and lump, head

AMA: **30100** 2019,Jan,9

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
30100	0.94	3.2	0.13	4.27
Facility RVU	**Work**	**PE**	**MP**	**Total**
30100	0.94	0.88	0.13	1.95

	FUD	Status	MUE	Modifiers				IOM Reference
30100	0	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

granuloma. Abnormal, dense collections of cells forming a mass or nodule of chronically inflamed tissue with granulations that is usually associated with an infective process.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

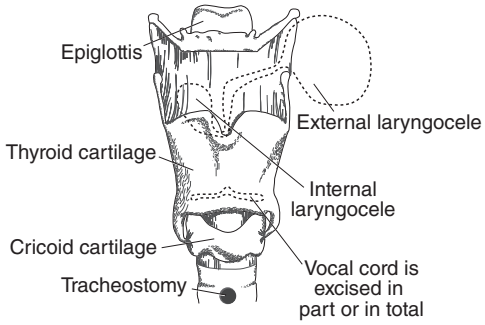
polyp. Small growth on a stalk-like attachment projecting from a mucous membrane.

secondary. Second in order of occurrence or importance, or appearing during the course of another disease or condition.

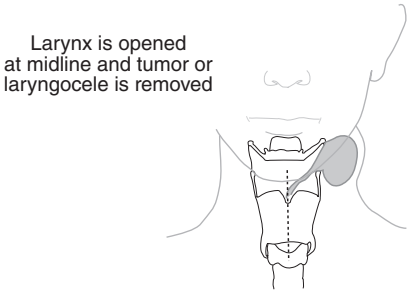
Wegener's granulomatosis. Uncommon, chronic necrotizing granulomatous inflammation of the respiratory tract manifested by sinus pain and purulent nasal discharge.

31300

31300 Laryngotomy (thyrotomy, laryngofissure), with removal of tumor or laryngocele, cordectomy



Vocal cord may be excised in part or in total



Explanation

A laryngocele is an air-filled dilation of the laryngeal ventricle that connects with the laryngeal cavity. The physician first performs a tracheostomy on the patient. Using a horizontal neck incision, the physician exposes the larynx and performs a thyrotomy and laryngofissure, opening the larynx at the midline of the thyroid cartilage. The laryngocele or tumor is isolated, dissected, and excised. A cordectomy, the excision of all or part of the vocal cord, may also be performed. The incision is repaired in sutured layers.

Coding Tips

When a laryngectomy (partial or total removal of the larynx) is performed, see 31360–31368 or 31370–31382. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. For laryngoscopy, direct, diagnostic, see 31520–31526; operative, with biopsy, see 31535–31536; with excision of tumor and/or stripping of vocal cords or epiglottis, see 31540–31541.

ICD-10-CM Diagnostic Codes

C13.1	Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
C32.0	Malignant neoplasm of glottis
C32.1	Malignant neoplasm of supraglottis
C32.2	Malignant neoplasm of subglottis
C32.3	Malignant neoplasm of laryngeal cartilage
C32.8	Malignant neoplasm of overlapping sites of larynx
C78.39	Secondary malignant neoplasm of other respiratory organs
D02.0	Carcinoma in situ of larynx
D14.1	Benign neoplasm of larynx
D38.0	Neoplasm of uncertain behavior of larynx
D49.1	Neoplasm of unspecified behavior of respiratory system
J38.1	Polyp of vocal cord and larynx
J38.2	Nodules of vocal cords
Q31.3	Laryngocele

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31300	15.91	19.16	2.2	37.27
Facility RVU	**Work**	**PE**	**MP**	**Total**
31300	15.91	19.16	2.2	37.27

	FUD	Status	MUE	Modifiers				IOM Reference
31300	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

dysphagia. Difficulty and pain upon swallowing. Common causes of dysphagia are esophagitis, Barrett's esophagus, or late effect of a stroke.

hemoptysis. Coughing up or spitting out blood or blood-streaked sputum.

laryngoscopy. Examination of the hypopharynx, larynx, and tongue base with an endoscope.

tracheostomy. Formation of a tracheal opening on the neck surface with tube insertion to allow for respiration in cases of obstruction or decreased patency. A tracheostomy may be planned or performed on an emergency basis for temporary or long-term use.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

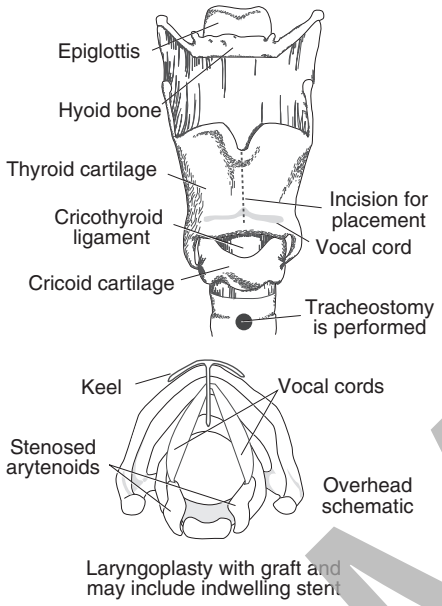
[31551, 31552, 31553, 31554]

31551 Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age

31552 Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older

31553 Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age

31554 Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older



Laryngoplasty with graft and may include indwelling stent

Explanation

The physician treats laryngeal stenosis. The physician performs a laryngotomy on the patient. Using a horizontal neck incision, the physician exposes the stenosis, in the affected area of the supraglottis, glottis, and/or subglottis. A cartilage graft is obtained and sewn to provide anterior and/or posterior stability to the larynx and adjacent trachea. The incision is sutured in layers. Report 31551 for procedures performed without placement of an indwelling stent on patients 12 years of age or younger and 31552 for patients older than age 12. Report 31553 for procedures that include placement of an indwelling stent on patients younger than 12 years of age and 31554 for patients over age 12.

Coding Tips

When the graft is harvested through the laryngoplasty incision, the graft is not reported separately. Do not report these codes with 31580 or with each other. For a tracheostomy, see 31600-31610. For stent removal, see 31599.

ICD-10-CM Diagnostic Codes

A52.73	Symptomatic late syphilis of other respiratory organs
J38.6	Stenosis of larynx
J99	Respiratory disorders in diseases classified elsewhere
Q31.1	Congenital subglottic stenosis
Q31.8	Other congenital malformations of larynx

AMA: **31551** 2020,Dec,11; 2018,Jan,8; 2017,Mar,10; 2017,Jul,7; 2017,Apr,5 **31552** 2020,Dec,11; 2018,Jan,8; 2017,Mar,10; 2017,Jul,7; 2017,Apr,5 **31553** 2020,Dec,11; 2018,Jan,8; 2017,Mar,10; 2017,Jul,7; 2017,Apr,5 **31554** 2020,Dec,11; 2018,Jan,8; 2017,Mar,10; 2017,Jul,7; 2017,Apr,5

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31551	21.5	20.58	2.95	45.03
31552	20.5	20.16	2.81	43.47
31553	22.0	24.58	3.03	49.61
31554	22.0	24.6	3.03	49.63
Facility RVU	**Work**	**PE**	**MP**	**Total**
31551	21.5	20.58	2.95	45.03
31552	20.5	20.16	2.81	43.47
31553	22.0	24.58	3.03	49.61
31554	22.0	24.6	3.03	49.63

	FUD	Status	MUE	Modifiers				IOM Reference
31551	90	A	1(2)	51	N/A	62*	80*	None
31552	90	A	1(2)	51	N/A	62*	80*	
31553	90	A	1(2)	51	N/A	62*	80*	
31554	90	A	1(2)	51	N/A	62*	80*	

* with documentation

Terms To Know

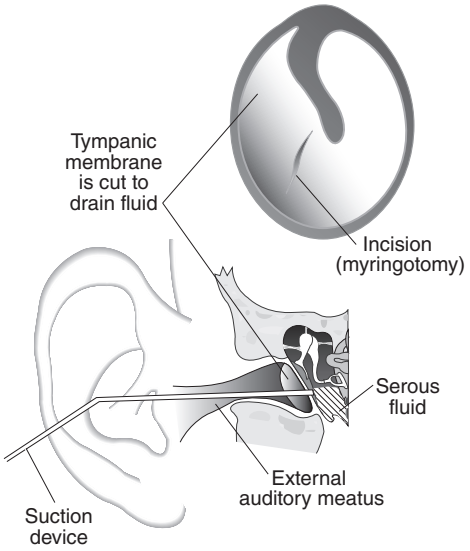
larynx. Musculocartilaginous structure between the trachea and the pharynx that functions as the valve preventing food and other particles from entering the respiratory tract, as well as the voice mechanism.

stenosis. Narrowing or constriction of a passage.

trachea. Tube descending from the larynx and branching into the right and left main bronchi.

69420-69421

69420 Myringotomy including aspiration and/or eustachian tube inflation
69421 Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia



Explanation

After the application of a local anesthetic (e.g., for 69420) or a general anesthetic (e.g., for 69421) and using a microscope for guidance, the physician makes an incision in the patient's tympanic membrane. Fluid is suctioned from the middle ear space and may be reserved for analysis. The Eustachian tube may be inflated. No closure is required.

Coding Tips

These are unilateral procedures. If performed bilaterally, some payers will require that the service be reported twice with modifier 50 appended to the second code while others will require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance.

ICD-10-CM Diagnostic Codes

H65.01 Acute serous otitis media, right ear ☑
H65.04 Acute serous otitis media, recurrent, right ear ☑
H65.111 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), right ear ☑
H65.114 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), recurrent, right ear ☑
H65.191 Other acute nonsuppurative otitis media, right ear ☑
H65.194 Other acute nonsuppurative otitis media, recurrent, right ear ☑
H65.21 Chronic serous otitis media, right ear ☑
H65.31 Chronic mucoid otitis media, right ear ☑
H65.411 Chronic allergic otitis media, right ear ☑
H65.491 Other chronic nonsuppurative otitis media, right ear ☑
H66.001 Acute suppurative otitis media without spontaneous rupture of ear drum, right ear ☑
H66.004 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear ☑
H66.3X1 Other chronic suppurative otitis media, right ear ☑
H69.81 Other specified disorders of Eustachian tube, right ear ☑
H70.001 Acute mastoiditis without complications, right ear ☑
H70.011 Subperiosteal abscess of mastoid, right ear ☑
H70.091 Acute mastoiditis with other complications, right ear ☑
H74.8X1 Other specified disorders of right middle ear and mastoid ☑
H90.11 Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side ☑
H90.A11 Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side ☑
H90.A21 Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side ☑
H90.A31 Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side ☑

AMA: **69420** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **69421** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
69420	1.38	4.06	0.2	5.64
69421	1.78	2.35	0.25	4.38
Facility RVU	**Work**	**PE**	**MP**	**Total**
69420	1.38	1.91	0.2	3.49
69421	1.78	2.35	0.25	4.38

	FUD	Status	MUE	Modifiers				IOM Reference
69420	10	A	1(2)	51	50	N/A	N/A	None
69421	10	A	1(2)	51	50	N/A	N/A	

* with documentation

Terms To Know

aspiration. Drawing fluid out by suction.

chronic. Persistent, continuing, or recurring.

eustachian tube. Internal channel between the tympanic cavity and the nasopharynx that equalizes internal pressure to the outside pressure and drains mucous production from the middle ear.

external auditory canal/meatus. External channel that leads from the opening in the external ear to the tympanic membrane (eardrum).

myringotomy. Incision in the eardrum done to prevent spontaneous rupture precipitated by fluid pressure build-up behind the tympanic membrane and to prevent stagnant infection and erosion of the ossicles.

tympanic membrane. Thin, sensitive membrane across the entrance to the middle ear that vibrates in response to sound waves, allowing the waves to be transmitted via the ossicular chain to the internal ear.

92552-92553

92552 Pure tone audiometry (threshold); air only
92553 air and bone

Explanation

Often physicians or technicians can diagnose a cause of hearing loss through tests using an audiometer. Many causes of hearing loss have characteristic threshold curves. In pure tone audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold, which is the lowest intensity of the tone that the patient can hear 50 percent of the time, is recorded for a number of frequencies on each ear. Bone thresholds (92553) are obtained in a similar manner except a bone oscillator is used on the mastoid or forehead to conduct the sound instead of tones through earphones. The air and bone thresholds are compared to differentiate between conductive, sensorineural, or mixed hearing losses.

Coding Tips

This service includes bilateral testing. If the test is performed unilaterally it may be appropriate to append modifier 52 to indicate a reduced service. Check with the payer for specific guidelines. When observation along with performance assessment is used to evaluate speech, language, and/or hearing issues, see 92521-92524. Medicare has provisionally identified these codes as a telehealth/telemedicine service. Current Medicare coverage guidelines, including place of service, should be reviewed. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to this procedure code and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

H69.81 Other specified disorders of Eustachian tube, right ear ☑
H83.3X1 Noise effects on right inner ear ☑
H83.3X2 Noise effects on left inner ear ☑
H83.3X3 Noise effects on inner ear, bilateral ☑
H90.0 Conductive hearing loss, bilateral ☑
H90.11 Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side ☑
H90.12 Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side ☑
H90.3 Sensorineural hearing loss, bilateral ☑
H90.41 Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side ☑
H90.42 Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side ☑
H90.6 Mixed conductive and sensorineural hearing loss, bilateral ☑
H90.71 Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side ☑
H90.72 Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side ☑
H90.A11 Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side ☑
H90.A12 Conductive hearing loss, unilateral, left ear with restricted hearing on the contralateral side ☑
H90.A21 Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side ☑
H90.A22 Sensorineural hearing loss, unilateral, left ear, with restricted hearing on the contralateral side ☑
H90.A31 Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side ☑
H90.A32 Mixed conductive and sensorineural hearing loss, unilateral, left ear with restricted hearing on the contralateral side ☑
H91.01 Ototoxic hearing loss, right ear ☑
H91.02 Ototoxic hearing loss, left ear ☑
H91.03 Ototoxic hearing loss, bilateral ☑
H91.11 Presbycusis, right ear ☑
H91.12 Presbycusis, left ear ☑
H91.13 Presbycusis, bilateral ☑
H91.21 Sudden idiopathic hearing loss, right ear ☑
H91.22 Sudden idiopathic hearing loss, left ear ☑
H91.23 Sudden idiopathic hearing loss, bilateral ☑
H93.011 Transient ischemic deafness, right ear ☑
H93.012 Transient ischemic deafness, left ear ☑
H93.013 Transient ischemic deafness, bilateral ☑

AMA: **92552** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16
92553 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92552	0.0	0.93	0.01	0.94
92553	0.0	1.14	0.01	1.15
Facility RVU	**Work**	**PE**	**MP**	**Total**
92552	0.0	0.93	0.01	0.94
92553	0.0	1.14	0.01	1.15

	FUD	Status	MUE	Modifiers				IOM Reference
92552	N/A	A	1(2)	N/A	N/A	N/A	80*	None
92553	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

audiometry. Measurement of hearing that can employ a number of methods to help diagnose the cause and type of hearing loss.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

G0237-G0239

G0237 Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)

G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring)

G0239 Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)

Explanation

These codes report therapeutic procedures, performed under the supervision of a therapist, for the treatment of respiratory disorders. These may include proper breathing techniques, respiratory education, and specialized exercises. Code G0237 reports procedures or exercises intended to increase the strength or endurance of the respiratory muscles, while G0238 reports those intended to improve respiratory function. Both are reported once for each 15 minutes of individual, one-on-one, face-to-face therapy time. Code G0239 includes the previously mentioned procedural components when provided in a group setting of two or more individuals. All codes include monitoring.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0237	0.0	0.27	0.01	0.28
G0238	0.0	0.28	0.01	0.29
G0239	0.0	0.34	0.01	0.35
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0237	0.0	0.27	0.01	0.28
G0238	0.0	0.28	0.01	0.29
G0239	0.0	0.34	0.01	0.35

G0424

G0424 Pulmonary rehabilitation, including exercise (includes monitoring), 1 hour, per session, up to two sessions per day

Explanation

Pulmonary rehabilitation (PR) is a program to help improve the quality of life for people with chronic breathing problems. PR may include psychological counseling, breathing strategies, exercise training, ways to conserve energy, and education on the patient's lung disease, including how to manage it. This code includes monitoring services and exercise. Medicare covers pulmonary rehabilitation items and services for patients who are diagnosed with moderate to severe COPD, when referred by the physician who is treating the chronic respiratory disease. Pulmonary rehabilitation items and services must be provided in a hospital outpatient setting or in a physician's office. A physician must be immediately available and accessible to provide medical consultations and emergency care in either setting.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0424	0.28	0.57	0.02	0.87
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0424	0.28	0.1	0.02	0.4

70100-70110

70100 Radiologic examination, mandible; partial, less than 4 views

70110 complete, minimum of 4 views

Explanation

The lower jaw bone is x-rayed. In 70100, three or less projections are taken for a partial view of the bone structure and in 70110, four or more projections are taken for a complete view of the bone structure.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
70100	0.18	0.92	0.02	1.12
70110	0.25	1.0	0.02	1.27
Facility RVU	**Work**	**PE**	**MP**	**Total**
70100	0.18	0.92	0.02	1.12
70110	0.25	1.0	0.02	1.27

70120

70120 Radiologic examination, mastoids; less than 3 views per side

Explanation

Films are taken of the mastoid processes, or lower portion of the temporal bone of the skull, which protrudes just behind the ear. Both mastoid processes are always examined for comparison purposes, and it is essential that the radiographs be exact duplicates in both positioning of the site and technical quality. Several varying views may be taken, but the key element of this procedure is that it reports less than three views per side.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
70120	0.18	0.91	0.02	1.11
Facility RVU	**Work**	**PE**	**MP**	**Total**
70120	0.18	0.91	0.02	1.11

70130

70130 Radiologic examination, mastoids; complete, minimum of 3 views per side

Explanation

Films are taken of the mastoid processes, or lower portion of the temporal bone of the skull, which protrudes just behind the ear. Both mastoid processes are always examined for comparison purposes, and it is essential that the radiographs be exact duplicates in both positioning of the site and technical quality. Several varying views may be taken, but the key element of this procedure is that it reports a complete exam, or minimum of three views per side.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
70130	0.34	1.47	0.02	1.83
Facility RVU	**Work**	**PE**	**MP**	**Total**
70130	0.34	1.47	0.02	1.83

70134

70134 Radiologic examination, internal auditory meati, complete

Explanation

Films are taken of the petrous portions of the skull to demonstrate internal auditory meati, or organs of hearing. Several different views may be taken, both with varying angulation of the x-ray beam, as well as varying the position of the patient's skull.

Correct Coding Initiative Update

❖Indicates Mutually Exclusive Edit

0208T 36591-36592, 69209-69210, 96523

0209T 0208T, 0211T, 36591-36592, 69209-69210, 92552, 96523

0210T 36591-36592, 69209-69210, 96523

0211T 0210T, 36591-36592, 69209-69210, 96523

0212T 0208T, 0209T, 0210T, 0211T, 36591-36592, 69209-69210, 92555-92556, 96523

0485T 36591-36592, 69209-69210, 92567-92568, 96523

0486T 0485T, 36591-36592, 69209-69210, 92567-92568, 96523

0559T 76376-76377

0560T 76376-76377

0561T 76376-76377

0562T 76376-76377

0673T No CCI edits apply to this code.

0001A No CCI edits apply to this code.

0002A No CCI edits apply to this code.

0003A No CCI edits apply to this code.

0004A No CCI edits apply to this code.

0011A No CCI edits apply to this code.

0012A No CCI edits apply to this code.

0013A No CCI edits apply to this code.

10004 0213T, 0216T, 10012, 10035, 19281, 19283, 19285, 19287, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 76000, 76380❖, 76942, 76998, 77001-77002, 77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, J2001

10005 0213T, 0216T, 10004, 10008, 10010-10012, 10021, 10035, 11102-11107, 19281, 19283, 19285, 19287, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 76000, 76380❖, 76942, 76998, 77001-77002, 77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, J2001

10006 0213T, 0216T, 10004, 10035, 19281, 19283, 19285, 19287, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 76000, 76380❖, 76942, 76998, 77001-77002, 77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, J2001

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