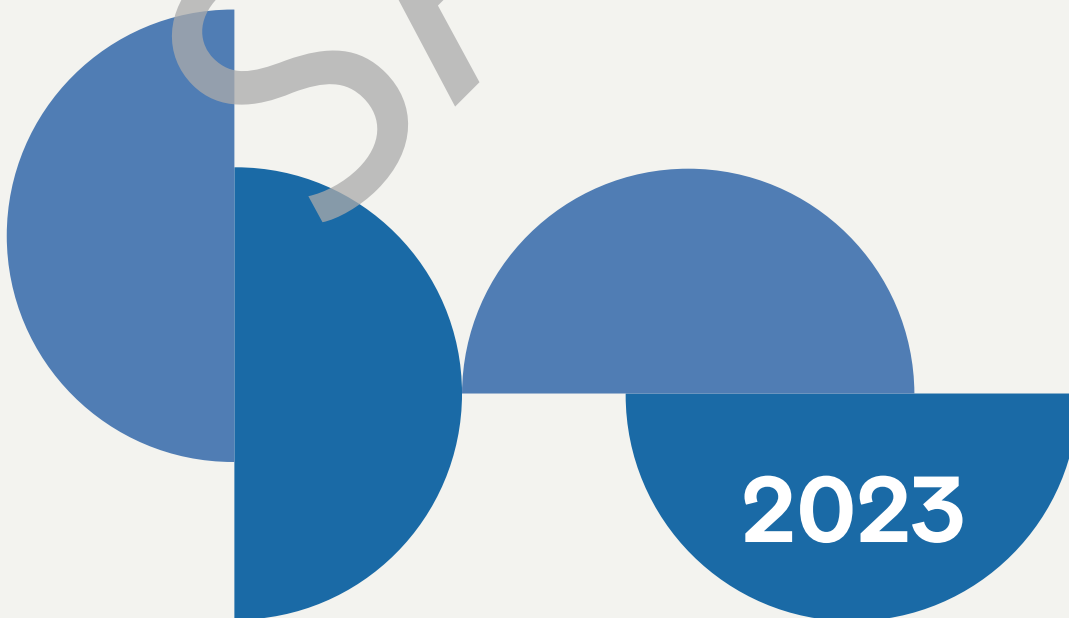


Cardiology/ Cardiothoracic/Vascular Surgery

A comprehensive illustrated guide to
coding and reimbursement



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SAMPLE

Getting Started with Coding Companion

Coding Companion for Cardiology/Cardiothoracic/Vascular Surgery 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 Cardiology/Cardiothoracic/Vascular Surgery 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:

32800 Repair lung hernia through chest wall
could be found in the index under the following main terms:

Hernia

Repair
Lung, 32800

Repair

Lung
Hernia, 32800

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.

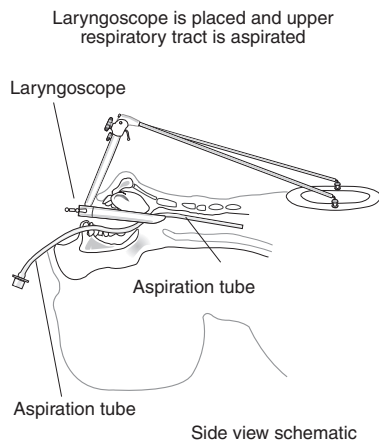
Professional and Technical Component

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.

31515

1

31515 Laryngoscopy direct, with or without tracheoscopy; for aspiration



2

Explanation

The physician uses an aspirator to remove excess saliva or semi-solid foreign material from the larynx. After applying topical anesthesia to the oral cavity and pharynx, the physician inserts the laryngoscope through the patient's mouth. An aspirator is fed through the laryngoscope and the larynx is cleared of saliva and semi-solid foreign material. If a tracheoscopy is performed, a bronchoscope is inserted through the laryngoscope for microscopic visualization of the trachea and bronchi. No other procedure is performed.

3

Coding Tips

Laryngoscopy code selection is dependent on two variables. Laryngoscopy procedures may be either direct or indirect, and they may be performed with either a rigid or flexible scope. A direct laryngoscopy allows the physician to see the larynx through a scope in the throat. In contrast, when an indirect laryngoscopy is performed, the physician uses mirrors to visualize the larynx. Code 31515 refers to direct visualization with a rigid laryngoscope. Report the appropriate endoscopy for each anatomic site examined. Surgical endoscopy includes a diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure.

4

ICD-10-CM Diagnostic Codes

- J04.0 Acute laryngitis
- J05.0 Acute obstructive laryngitis [croup]
- J38.3 Other diseases of vocal cords
- J38.7 Other diseases of larynx
- J39.0 Retropharyngeal and parapharyngeal abscess
- J39.8 Other specified diseases of upper respiratory tract
- J69.0 Pneumonitis due to inhalation of food and vomit
- J69.1 Pneumonitis due to inhalation of oils and essences
- J69.8 Pneumonitis due to inhalation of other solids and liquids
- J95.01 Hemorrhage from tracheostomy stoma
- J95.02 Infection of tracheostomy stoma
- J95.09 Other tracheostomy complication
- J95.859 Other complication of respirator [ventilator]

5

- J95.88 Other intraoperative complications of respiratory system, not elsewhere classified
- J95.89 Other postprocedural complications and disorders of respiratory system, not elsewhere classified
- O89.01 Aspiration pneumonitis due to anesthesia during the puerperium
- P24.01 Meconium aspiration with respiratory symptoms
- P24.11 Neonatal aspiration of (clear) amniotic fluid and mucus with respiratory symptoms
- P24.21 Neonatal aspiration of blood with respiratory symptoms
- P24.31 Neonatal aspiration of milk and regurgitated food with respiratory symptoms
- P24.81 Other neonatal aspiration with respiratory symptoms
- R04.1 Hemorrhage from throat
- R04.2 Hemoptysis
- R04.81 Acute idiopathic pulmonary hemorrhage in infants
- R04.89 Hemorrhage from other sites in respiratory passages
- R09.3 Abnormal sputum
- T81.41XA Infection following a procedure, superficial incisional surgical site, initial encounter
- T81.42XA Infection following a procedure, deep incisional surgical site, initial encounter
- T81.43XA Infection following a procedure, organ and space surgical site, initial encounter
- T81.44XA Sepsis following a procedure, initial encounter
- T81.49XA Infection following a procedure, other surgical site, initial encounter

Associated HCPCS Codes

- A4305 Disposable drug delivery system, flow rate of 50 ml or greater per hour

AMA: 31515 2020, Dec, 11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31515	1.8	4.3	0.25	6.35
Facility RVU	Work	PE	MP	Total
31515	1.8	1.16	0.25	3.21

	FUD	Status	MUE	Modifiers	IOM Reference
31515	0	A	1(3)	51 N/A N/A N/A	None

* with documentation

Terms To Know

direct laryngoscopy. Endoscopic instrument, such as a flexible or rigid fiberoptic scope, inserted into the larynx for direct viewing capabilities of the voice box and vocal cords.

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. Also called the voicebox, the larynx is composed of three single cartilages: cricoid, epiglottis, and thyroid; and three paired cartilages: arytenoid, corniculate, and cuneiform.

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

6

7

8

9

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:

- ▭ Newborn: 0
- ▭ Pediatric: 0-17
- ▭ Maternity: 9-64
- ▭ 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 (modifier 26) 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

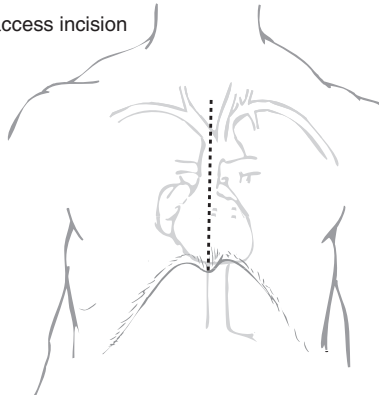
new patient. Patient who is receiving face-to-face care from a provider/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPSS hospitals, 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.

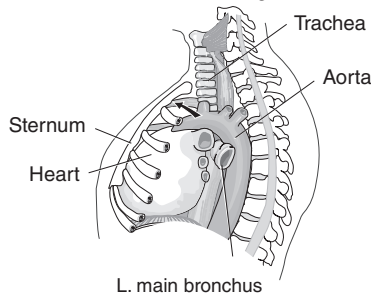
32160

32160 Thoracotomy; with cardiac massage

Typical access incision



The heart is accessed through a major thoracotomy and direct cardiac massage is initiated



Explanation

The physician opens the chest cavity widely to perform manual cardiac massage in the case of cardiac arrest. Using a scalpel, the surgeon makes a long incision around the side of the chest between two of the ribs. The incision is carried through all of the tissue layers into the chest cavity. Rib spreaders are inserted into the wound and the ribs are spread apart exposing the lung. Alternately, the chest cavity can be opened and the operation performed through a vertical incision in the center of the chest through the sternum. The skin incision is carried down to the sternum bone and a saw is used to split the sternum. With the sternum split in half, the chest is entered by spreading the sternum apart with a set of rib spreaders. Space is made in the chest by packing the uninvolved lung away from the operative field using large moist gauze sponges. The heart is exposed and squeezed rhythmically to mimic cardiac contractions, thus pumping blood through the body. The heart may be directly contra-shocked to produce spontaneous heartbeats. When the procedure is complete, the instruments and gauze sponges are removed. A chest tube(s) may be used to provide drainage for the chest cavity. If applicable, the sternotomy is repaired using wires to bring the two halves of the sternum together, and the operative wound is closed by sutures or staples.

Coding Tips

For closed cardiopulmonary resuscitation, see 92950. For other resections of the lung, see 32480–32504.

ICD-10-CM Diagnostic Codes

- I46.2 Cardiac arrest due to underlying cardiac condition
- I46.8 Cardiac arrest due to other underlying condition
- I46.9 Cardiac arrest, cause unspecified
- I97.120 Postprocedural cardiac arrest following cardiac surgery
- I97.121 Postprocedural cardiac arrest following other surgery

- I97.710 Intraoperative cardiac arrest during cardiac surgery
- I97.711 Intraoperative cardiac arrest during other surgery

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
32160	13.1	7.24	2.95	23.29
Facility RVU	Work	PE	MP	Total
32160	13.1	7.24	2.95	23.29

	FUD	Status	MUE	Modifiers			IOM Reference	
32160	90	A	1(3)	51	N/A	62*	80	None

* with documentation

Terms To Know

cardiac arrest. Sudden, unexpected cessation of cardiac action, including absence of heart sounds and/or blood pressure.

incision. Act of cutting into tissue or an organ.

massage. Systematic and patterned stroking, kneading, and therapeutic friction applied to soft tissue by hand.

resuscitation. Restoration to life or consciousness of one apparently dead, it includes such measures as artificial respiration and cardiac massage or electrical shock.

sternotomy. Incision into the sternum, the bone that forms the front of the chest cavity and connects with the ribs.

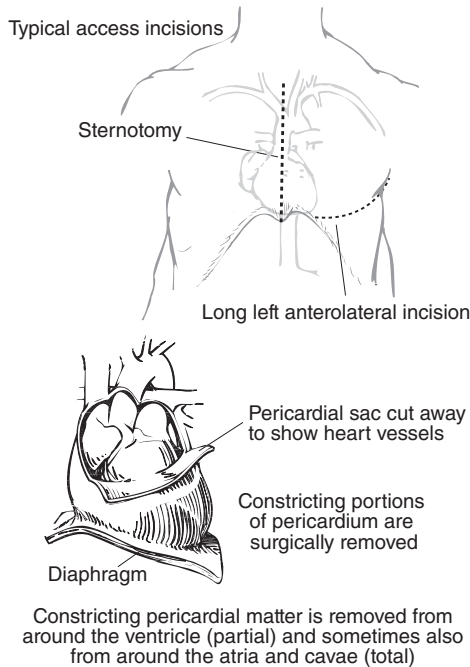
suture. Numerous stitching techniques employed in wound closure.

thoracotomy. Surgical procedure for opening the chest wall in order to access the lungs, esophagus, trachea, aorta, heart, and diaphragm.

33030-33031

33030 Pericardiectomy, subtotal or complete; without cardiopulmonary bypass

33031 with cardiopulmonary bypass



Explanation

The physician gains access to the pericardium through an incision through the sternum (median sternotomy). The physician cuts away most or all of the pericardial tissue while the heart is still beating (without cardiopulmonary bypass), taking care to leave the phrenic nerves intact. The physician closes the sternal or chest wall incision and dresses the wound. The physician may leave chest tubes and/or a mediastinal drainage tube in place following the procedure. Report 33031 if the procedure is performed with cardiopulmonary bypass.

Coding Tips

If this procedure is attempted thoracoscopically, but requires thoracotomy for completion, report 33030 or 33031 for the open portion of the procedure and report a diagnostic thoracoscopy, 32601, as a secondary procedure. Thoracotomy, thoracentesis, and ECG monitoring are included and should not be reported separately.

ICD-10-CM Diagnostic Codes

- A18.84 Tuberculosis of heart
- C38.0 Malignant neoplasm of heart
- C45.2 Mesothelioma of pericardium
- C79.89 Secondary malignant neoplasm of other specified sites
- C7B.09 Secondary carcinoid tumors of other sites
- C7B.8 Other secondary neuroendocrine tumors
- D15.1 Benign neoplasm of heart
- D48.7 Neoplasm of uncertain behavior of other specified sites
- I01.0 Acute rheumatic pericarditis
- I24.1 Dressler's syndrome
- I30.0 Acute nonspecific idiopathic pericarditis

- I30.1 Infective pericarditis
- I30.8 Other forms of acute pericarditis
- I31.0 Chronic adhesive pericarditis
- I31.1 Chronic constrictive pericarditis
- I31.2 Hemopericardium, not elsewhere classified
- I31.3 Pericardial effusion (noninflammatory)
- I31.8 Other specified diseases of pericardium
- M32.12 Pericarditis in systemic lupus erythematosus
- S26.01XA Contusion of heart with hemopericardium, initial encounter
- S26.020A Mild laceration of heart with hemopericardium, initial encounter
- S26.021A Moderate laceration of heart with hemopericardium, initial encounter
- S26.022A Major laceration of heart with hemopericardium, initial encounter
- T81.41XA Infection following a procedure, superficial incisional surgical site, initial encounter
- T81.42XA Infection following a procedure, deep incisional surgical site, initial encounter
- T81.43XA Infection following a procedure, organ and space surgical site, initial encounter
- T81.44XA Sepsis following a procedure, initial encounter

AMA: 33031 2017, Dec, 3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
33030	36.0	14.23	8.21	58.44
33031	45.0	17.04	10.32	72.36
Facility RVU	Work	PE	MP	Total
33030	36.0	14.23	8.21	58.44
33031	45.0	17.04	10.32	72.36

	FUD	Status	MUE	Modifiers			IOM Reference	
33030	90	A	1(2)	51	N/A	62*	80	None
33031	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

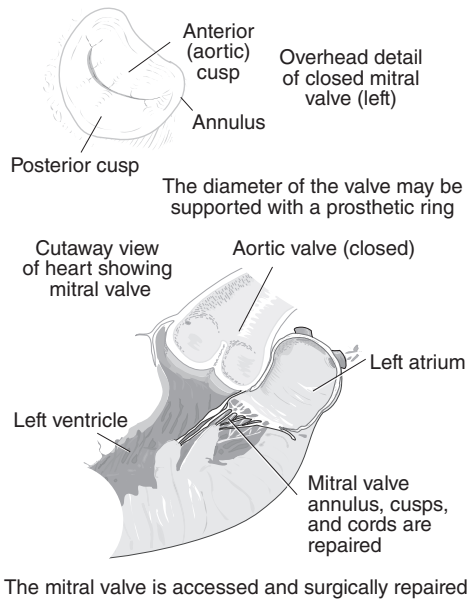
cardiopulmonary bypass. Venous blood is diverted to a heart-lung machine, which mechanically pumps and oxygenates the blood temporarily so the heart can be bypassed while an open procedure on the heart or coronary arteries is performed. During bypass, the lungs are deflated and immobile.

late effect. Abnormality, dysfunction, or other residual condition produced after the acute phase of an illness, injury, or disease is over. There is no time limit on when late effects can appear.

thoracotomy. Surgical procedure for opening the chest wall in order to access the lungs, esophagus, trachea, aorta, heart, and diaphragm.

33425-33427

- 33425** Valvuloplasty, mitral valve, with cardiopulmonary bypass;
- 33426** with prosthetic ring
- 33427** radical reconstruction, with or without ring



Explanation

This operation is done to improve the ability of the mitral valve to close completely when the ventricle contracts. It is done in patients whose mitral valve has lost the ability to close normally. In almost all cases, this is the result of a mitral valve prolapse in which the mitral leaflets and the cords that tether them on the ventricle have become elongated. Cardiopulmonary bypass is initiated. The left atrium is opened and the mitral valve is exposed. Redundant leaflet tissue is excised and defects in the valve leaflets are closed with sutures. The cords are also shortened with sutures. Valve closure is assessed after the repair. The left atrium is closed and cardiopulmonary bypass is discontinued when heart function returns. Report 33426 if the mitral valve diameter is enlarged requiring placement of a prosthetic ring. Report 33427 if a more extensive repair, including transfer of cords from the posterior leaflet to the anterior leaflet, is performed. A prosthetic ring may be required with extensive reconstruction.

Coding Tips

For reoperation on the mitral valve more than one month after the original procedure, report 33530 in addition to the code for the primary procedure. When more than one valve (aortic, mitral, tricuspid, pulmonary) is being repaired or replaced, report each procedure separately and append modifier 51 to the secondary valve procedures. For valvotomy of the mitral valve, see 33420–33422. For replacement of the mitral valve, see 33430. For percutaneous balloon valvuloplasty of the mitral valve, see 92987.

ICD-10-CM Diagnostic Codes

- 105.0 Rheumatic mitral stenosis
- 105.1 Rheumatic mitral insufficiency
- 105.2 Rheumatic mitral stenosis with insufficiency
- 105.8 Other rheumatic mitral valve diseases
- 108.0 Rheumatic disorders of both mitral and aortic valves
- 108.8 Other rheumatic multiple valve diseases

- I34.0 Nonrheumatic mitral (valve) insufficiency
- I34.1 Nonrheumatic mitral (valve) prolapse
- I34.2 Nonrheumatic mitral (valve) stenosis
- I34.8 Other nonrheumatic mitral valve disorders
- Q23.2 Congenital mitral stenosis
- Q23.3 Congenital mitral insufficiency

AMA: 33425 2018,Jan,8; 2017,Jan,8; 2017,Dec,3; 2016,Jan,13; 2015,Sep,3; 2015,Jan,16 33426 2018,Jan,8; 2017,Jan,8; 2017,Dec,3; 2016,Jan,13; 2015,Sep,3; 2015,Jan,16 33427 2018,Jan,8; 2017,Jan,8; 2017,Dec,3; 2016,Jan,13; 2015,Sep,3; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
33425	49.96	18.41	11.42	79.79
33426	43.28	16.43	9.81	69.52
33427	44.83	16.39	9.99	71.21
Facility RVU	Work	PE	MP	Total
33425	49.96	18.41	11.42	79.79
33426	43.28	16.43	9.81	69.52
33427	44.83	16.39	9.99	71.21

	FUD	Status	MUE	Modifiers			IOM Reference	
33425	90	A	1(2)	51	N/A	62*	80	None
33426	90	A	1(2)	51	N/A	62*	80	
33427	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

cardiopulmonary bypass. Venous blood is diverted to a heart-lung machine, which mechanically pumps and oxygenates the blood temporarily so the heart can be bypassed while an open procedure on the heart or coronary arteries is performed. During bypass, the lungs are deflated and immobile.

congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

hypothermia with cardiac bypass. Reduction of the body temperature using a bypass system to reduce the oxygen demands of tissue and to protect the myocardium during a procedure.

mitral valve. Valve with two cusps that is between the left atrium and left ventricle of the heart.

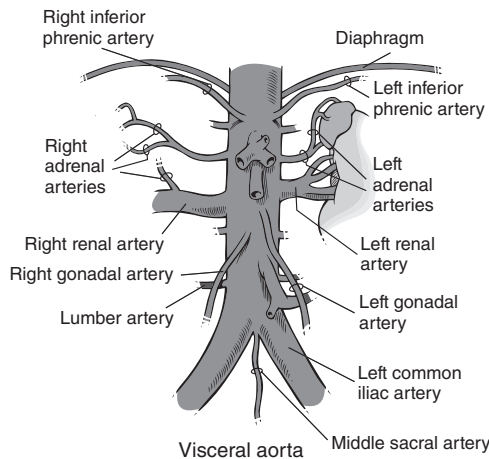
prolapse. Falling, sliding, or sinking of an organ from its normal location in the body.

reconstruction. Recreating, restoring, or rebuilding a body part or organ.

stenosis. Narrowing or constriction of a passage.

34841-34844

- 34841** Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)
- 34842** including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])
- 34843** including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])
- 34844** including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])



Explanation

Endovascular repair of an abdominal aortic aneurysm, pseudoaneurysm, or dissection, using a prosthesis, and involving visceral branches (superior mesenteric, celiac, and/or renal artery) requires the skills of a vascular surgeon and a radiologist. A small incision is made in the groin over both femoral arteries. Under fluoroscopic guidance, the physician inserts an aortic component through one femoral artery. These are contained inside a plastic holding capsule that is threaded through the arteries to the site of the aneurysm. The physician places the necessary extension prostheses and cuts fenestrations (holes) at each visceral artery orifice to allow side branch perfusion of these vessels. Next, catheters are used to place overlapping stents at each fenestration and vessel orifice to secure the junction. Once the graft components and stents are in place, the holding capsule and catheters are removed and the arteriotomy site is closed. Report 34841 when one visceral artery is included, 34842 for two, 34843 for three, and 34844 for four or more arteries.

Coding Tips

Do not report introduction of catheters and guidewires into the aorta and visceral and/or renal arteries separately in addition to these procedures. Balloon angioplasty within the target zone of the endograft is also not reported separately, whether prior to or after graft deployment. Fluoroscopic guidance is included in these procedures and not reported separately. Catheterization of the hypogastric arteries, arterial families outside of the treatment zone of the graft, exposure of the access vessels, extensive repair of the access vessels, and other separate interventional procedures outside of the target treatment zone performed at the time of this service may be reported separately. For endovascular treatment of the descending thoracic aorta, see 33880–33886

and 75956–75959. For endovascular infrarenal abdominal aortic aneurysm repair without the use of a graft, see 34701–34706. Do not report these codes with 34701–34706 or 34845–34848. Do not report these codes in addition to 34839 when planning is performed the day before or the day of the fenestrated repair. These codes should not be reported with 37236 or 37237 when covered or bare metal stents are placed into the visceral branches of the endoprosthesis target zone.

ICD-10-CM Diagnostic Codes

- A52.01 Syphilitic aneurysm of aorta
- I71.02 Dissection of abdominal aorta
- I71.03 Dissection of thoracoabdominal aorta
- I71.3 Abdominal aortic aneurysm, ruptured
- I71.4 Abdominal aortic aneurysm, without rupture
- I71.5 Thoracoabdominal aortic aneurysm, ruptured
- I79.0 Aneurysm of aorta in diseases classified elsewhere
- Q25.41 Absence and aplasia of aorta
- Q25.42 Hypoplasia of aorta
- Q25.43 Congenital aneurysm of aorta
- Q25.44 Congenital dilation of aorta
- Q25.48 Anomalous origin of subclavian artery
- Q25.49 Other congenital malformations of aorta
- S35.01XA Minor laceration of abdominal aorta, initial encounter
- S35.02XA Major laceration of abdominal aorta, initial encounter
- S35.09XA Other injury of abdominal aorta, initial encounter
- T82.818A Embolism due to vascular prosthetic devices, implants and grafts, initial encounter
- T82.858A Stenosis of other vascular prosthetic devices, implants and grafts, initial encounter
- T82.868A Thrombosis due to vascular prosthetic devices, implants and grafts, initial encounter

AMA: 34841 2018,Jan,8; 2017,Jul,3; 2017,Jan,8; 2017,Dec,3; 2016,Jan,13; 2015,Jan,16 34842 2018,Jan,8; 2017,Jul,3; 2017,Jan,8; 2017,Dec,3; 2016,Jan,13; 2015,Jan,16 34843 2018,Jan,8; 2017,Jul,3; 2017,Jan,8; 2017,Dec,3; 2016,Jan,13; 2015,Jan,16 34844 2018,Jan,8; 2017,Jul,3; 2017,Jan,8; 2017,Dec,3; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

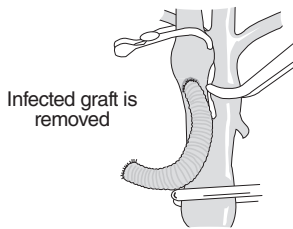
Non-Facility RVU	Work	PE	MP	Total
34841	0.0	0.0	0.0	0.0
34842	0.0	0.0	0.0	0.0
34843	0.0	0.0	0.0	0.0
34844	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
34841	0.0	0.0	0.0	0.0
34842	0.0	0.0	0.0	0.0
34843	0.0	0.0	0.0	0.0
34844	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers			IOM Reference
34841	N/A	C	1(2)	51	N/A	62 80	None
34842	N/A	C	1(2)	51	N/A	62 80	
34843	N/A	C	1(2)	51	N/A	62 80	
34844	N/A	C	1(2)	51	N/A	62 80	

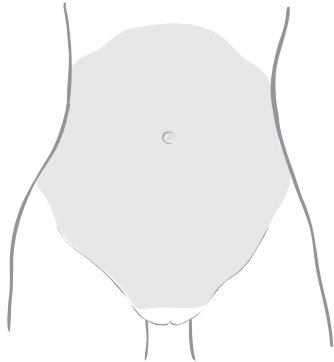
* with documentation

35907

35907 Excision of infected graft; abdomen



The physician removes an infected graft from the abdomen and repairs the blood vessel



Explanation

Through an incision in the skin of the abdomen overlying the graft, the physician dissects around any muscle, vessels or other structures to access the graft site. The physician dissects around the vessel, and applies vessel clamps above and below the graft. The physician excises above and below the existing infected graft. The blood vessel is repaired with sutures. A catheter may be left in place to help drain infection. The skin is loosely closed. If the excised graft is replaced with a new graft, report the appropriate revascularization code.

Coding Tips

Establishing both inflow and outflow by any method is included. That portion of the operative arteriogram performed by the surgeon is also included. Angioscopy performed during therapeutic intervention should be reported in addition to the code for the primary procedure, see 35400. For a thrombectomy of an arterial or a venous graft, see 35875–35876. For an initial placement of a bypass graft using a vein, see 35501–35571. For an initial in-situ vein graft placement, see 35583–35587. For an initial placement of a bypass graft other than vein, see 35601–35681.

ICD-10-CM Diagnostic Codes

- T81.44XA Sepsis following a procedure, initial encounter
- T82.7XXA Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, initial encounter
- T82.898A Other specified complication of vascular prosthetic devices, implants and grafts, initial encounter

AMA: 35907 1997,Nov,1

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
35907	37.27	9.15	8.96	55.38
Facility RVU	Work	PE	MP	Total
35907	37.27	9.15	8.96	55.38

	FUD	Status	MUE	Modifiers				IOM Reference
35907	90	A	1(3)	51	N/A	62*	80	None

* with documentation

Terms To Know

catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.

complication. Condition arising after the beginning of observation and treatment that modifies the course of the patient's illness or the medical care required, or an undesired result or misadventure in medical care.

excision. Surgical removal of an organ or tissue.

graft. Tissue implant from another part of the body or another person.

incision. Act of cutting into tissue or an organ.

infection. Presence of microorganisms in body tissues that may result in cellular damage.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

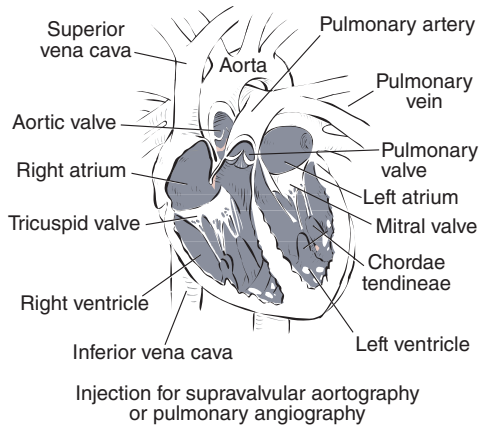
interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

93567-93568

- + **93567** Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)
- + **93568** for pulmonary angiography (List separately in addition to code for primary procedure)



Explanation

The physician injects dye into the coronary arteries to evaluate function during congenital or noncongenital heart catheterization procedures. Code 93567 is specific to the visualization of the valves just above the aorta and its branches, while 93568 is specific to that of the pulmonary vessels. These codes do not report the introduction of catheters, but do include any required repositioning of catheters or use of automatic power injectors, as well as radiological supervision, interpretation, and report.

Coding Tips

When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician, report 99155-99157. Report 93567 in addition to 33741, 33745, 93451-93461, and 93593-93597. Report 93568 in addition to 33741, 33745, 93451, 93453, 93456, 93457, 93460, 93461, 93580-93583, and 93593-93597. These procedures include any radiological supervision, interpretation, and report. Contrast administration performed during cardiac catheterization for congenital conditions is reported separately with 93563-93568. Injection procedures for right ventricular, right atrial, aortic, or pulmonary angiogram performed with cardiac catheterizations are reported separately with 93567-93568. Report 93567 for supravalvular ascending aortogram done at the same session as cardiac catheterization. Report 93568 with right heart catheterization codes when done at the same session as a pulmonary angiogram. Injection procedures do not include catheter placement when applicable; however, repositioning of the catheter and automatic power injections should not be reported separately. Do not report 93568 with 33289 or 0632T.

ICD-10-CM Diagnostic Codes

This/these CPT code(s) are add-on code(s). See the primary procedure code that this code is performed with for your ICD-10-CM code selections. Diagnostic code(s) would be the same as the actual procedure performed.

AMA: 93567 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Mar,5; 2016,Jan,13; 2015,Jan,16 93568 2019,Jun,3; 2019,Apr,10; 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Mar,5; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93567	0.97	2.33	0.21	3.51
93568	0.88	2.81	0.19	3.88
Facility RVU	Work	PE	MP	Total
93567	0.97	0.34	0.21	1.52
93568	0.88	0.32	0.19	1.39

	FUD	Status	MUE	Modifiers			IOM Reference	
93567	N/A	A	1(3)	N/A	N/A	N/A	80*	None
93568	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

aortography. Radiographic visualization of the aorta and its branches by injecting contrast medium through percutaneous puncture or catheterization technique.

congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

contrast material. Any internally administered substance that has a different opacity from soft tissue on radiography or computed tomograph; includes barium, used to opacify parts of the gastrointestinal tract; water-soluble iodinated compounds, used to opacify blood vessels or the genitourinary tract; may refer to air occurring naturally or introduced into the body; also, paramagnetic substances used in magnetic resonance imaging. Substances may also be documented as contrast agent or contrast medium.

supra. Above.

valve. Fold or membrane within a body canal or passageway that prevents backflow of fluids running through it.

Correct Coding Initiative Update

◆Indicates Mutually Exclusive Edit

- 0234T** 01924-01926,0213T,0216T,0596T-0597T, 11000-11006, 11042-11047, 34713-34716, 34812, 34820, 34833-34834, 35201-35206, 35226-35236, 35256-35266, 35286, 36000, 36002-36005, 36400-36410, 36420-36430, 36440, 36500, 36591-36592, 36600-36640, 37184, 43752, 49000-49002, 51701-51703, 61645-61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75893, 76000, 76942, 76998, 77002, 93000-93010, 93040-93042, 93050, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0471
- 0235T** 01924-01926,0213T,0216T,0596T-0597T, 11000-11006, 11042-11047, 34713-34716, 34812, 34820, 34833-34834, 35201-35206, 35226-35236, 35256-35266, 35286, 36000, 36002-36005, 36400-36410, 36420-36430, 36440, 36500, 36591-36592, 36600-36640, 37184, 43752, 49000-49002, 51701-51703, 61645-61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75726, 75736, 75774, 75893, 76000, 76942, 76998, 77002, 93000-93010, 93040-93042, 93050, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0471
- 0236T** 01924-01926,0213T,0216T,0596T-0597T, 11000-11006, 11042-11047, 32551, 32556-32557, 34713-34716, 34812, 34820, 34833-34834, 35201-35206, 35226-35236, 35256-35266, 35286, 36000, 36002-36005, 36400-36410, 36420-36430, 36440, 36500, 36591-36592, 36600-36640, 37184, 43752, 49000-49002, 51701-51703, 61645-61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75600, 75605, 75625, 75630, 75635, 75893, 76000, 76942, 76998, 77002, 93000-93010, 93040-93042, 93050, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0471
- 0237T** 01924-01926,0213T,0216T,0596T-0597T, 11000-11006, 11042-11047, 34713-34716, 34834, 35201-35206, 35226-35236, 35256-35266, 35286, 36000, 36002-36005, 36400-36410, 36420-36430, 36440, 36500, 36591-36592, 36600-36640, 37184, 43752, 51701-51703, 61645-61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75605, 75710, 75716, 75893, 76000, 76942, 76998, 77002, 93000-93010, 93040-93042, 93050, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0471
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