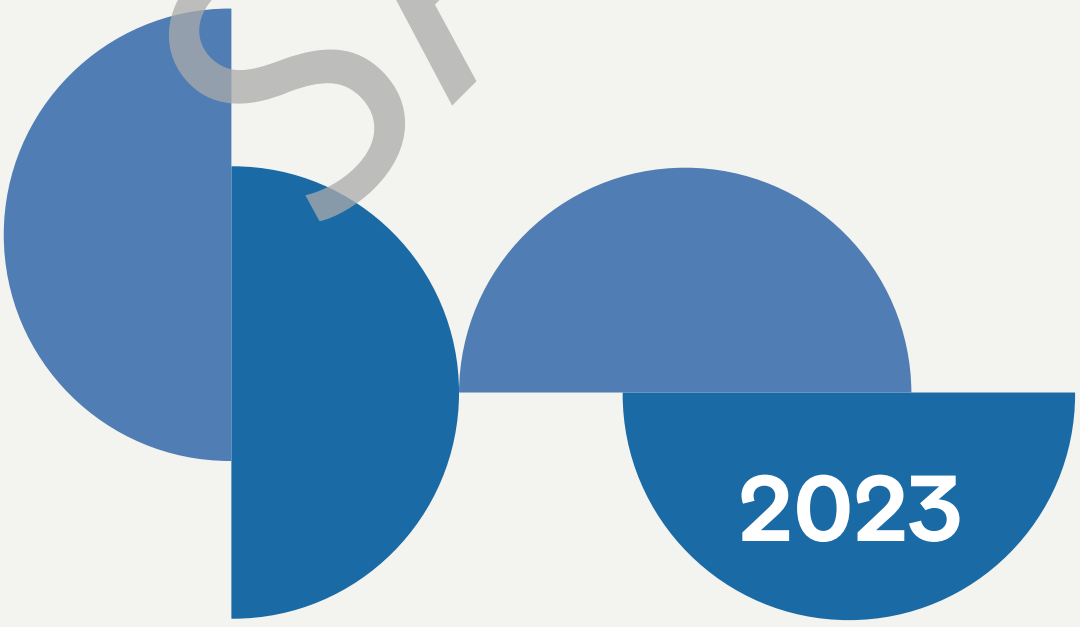
Optum

Coding Companion

Orthopaedics: Upper - Spine & Above

A comprehensive illustrated guide to coding and reimbursement



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Contents

Getting Started with Coding Companion

Coding Companion for Orthopaedics — Upper: Spine and Above 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 Orthopaedics — Upper: Spine and Above 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:

24138 Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process

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

Abscess
Excision
Olecranon Process, 24138

Excision
Abscess
Olecranon Process, 24138

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.

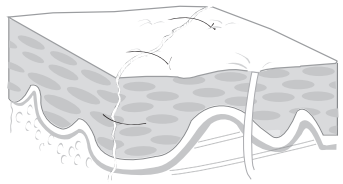
Professional and Technical Component

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.

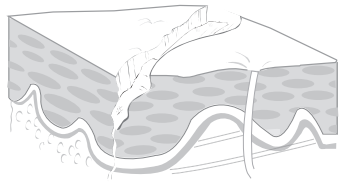
12020-12021 1

12020 Treatment of superficial wound dehiscence; simple closure
12021 with packing

2



Example of a simple closure involving only one skin layer



Example of a wound left open with packing due to infection

Explanation 3

There has been a breakdown of the healing skin either before or after suture removal. The skin margins have opened. The physician cleanses the wound with irrigation and antimicrobial solutions. The skin margins may be trimmed to initiate bleeding surfaces. Report 12020 if the wound is sutured in a single layer. Report 12021 if the wound is left open and packed with gauze strips due to the presence of infection. This allows infection to drain from the wound and the skin closure will be delayed until the infection is resolved.

Coding Tips 4

For extensive or complicated secondary closure of surgical wound or dehiscence, see 13160. Medicare and some other payers may require G0168 be reported for wound closure by tissue adhesives only. 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.

ICD-10-CM Diagnostic Codes 5

T81.31XA Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter

T81.32XA Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter

T81.33XA Disruption of traumatic injury wound repair, initial encounter

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only 6

AMA: 12020 2019,Nov,3; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 7
12021 2019,Nov,3; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits 8

Non-Facility RVU	Work	PE	MP	Total
12020	2.67	5.82	0.43	8.92
12021	1.89	2.97	0.3	5.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
12020	2.67	2.43	0.43	5.53
12021	1.89	1.91	0.3	4.1

	FUD	Status	MUE	Modifiers				IOM Reference
12020	10	A	2(3)	51	N/A	N/A	N/A	None
12021	10	A	3(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know 9

dehiscence. Complication of healing in which the surgical wound ruptures or bursts open, superficially or through multiple layers.

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

irrigation. To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

packing. Material placed into a cavity or wound, such as gels, gauze, pads, and sponges.

subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

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.

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.

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/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

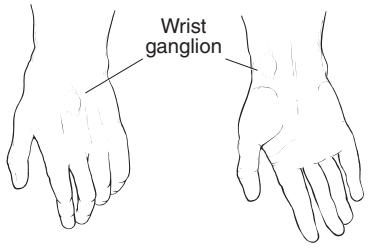
Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.1	0.09	2.12
99203	1.6	1.51	0.15	3.26
99204	2.6	2.04	0.23	4.87
99205	3.5	2.62	0.31	6.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.15	2.42
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	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*	

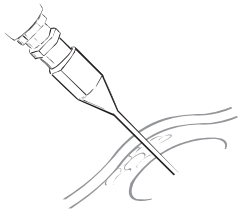
* with documentation

20612

20612 Aspiration and/or injection of ganglion cyst(s) any location



Ganglion cysts can be found in numerous sites, particularly on the hands and feet



The cyst is aspirated or injected

Explanation

The physician aspirates and/or injects a ganglion cyst. After administering a local anesthetic, the physician inserts a needle through the skin and into the ganglion cyst. A ganglion cyst is a benign mass consisting of a thin capsule containing clear, mucinous fluid arising from an aponeurosis or tendon sheath, such as on the back of the wrist or foot. A fluid sample may be withdrawn from the cyst or a medicinal substance may be injected for therapy. The needle is withdrawn and pressure is applied to stop any bleeding.

Coding Tips

Multiple ganglion cyst aspirations/injections may be reported by appending modifier 59 or an X{EPSU} modifier for second and subsequent ganglion cysts treated by aspiration/injection. For injection of a single tendon sheath or ligament, see 20550. For arthrocentesis, aspiration, and/or injection of a small joint or bursa, see 20600-20604; intermediate joint or bursa, see 20605-20606; major joint or bursa, see 20610-20611. For aspiration and injection of a bone cyst, see 20615. If imaging guidance is used, see 76942, 77002, 77012, or 77021. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Supplies used when providing this procedure may be reported with the appropriate HCPCS Level II J code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

M67.411 Ganglion, right shoulder ☑
M67.412 Ganglion, left shoulder ☑
M67.421 Ganglion, right elbow ☑
M67.422 Ganglion, left elbow ☑
M67.431 Ganglion, right wrist ☑
M67.432 Ganglion, left wrist ☑
M67.441 Ganglion, right hand ☑
M67.442 Ganglion, left hand ☑
M67.48 Ganglion, other site
M67.49 Ganglion, multiple sites

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20612	0.7	1.06	0.1	1.86
Facility RVU	**Work**	**PE**	**MP**	**Total**
20612	0.7	0.41	0.1	1.21

	FUD	Status	MUE	Modifiers				IOM Reference
20612	0	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

anesthesia. Loss of feeling or sensation, usually induced to permit the performance of surgery or other painful procedures.

aponeurosis. Flat expansion of white, ribbon-like tendinous tissue that functions as the connection of a muscle to its moving part.

aspiration. Drawing fluid out by suction.

benign. Mild or nonmalignant in nature.

cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

excision. Surgical removal of an organ or tissue.

ganglion. Fluid-filled, benign cyst appearing on a tendon sheath or aponeurosis, frequently connecting to an underlying joint.

injection. Forcing a liquid substance into a body part such as a joint or muscle.

joint capsule. Sac-like enclosure enveloping the synovial joint cavity with a fibrous membrane attached to the articular ends of the bones in the joint.

synovia. Clear fluid lubricant of joints, bursae, and tendon sheaths, secreted by the synovial membrane.

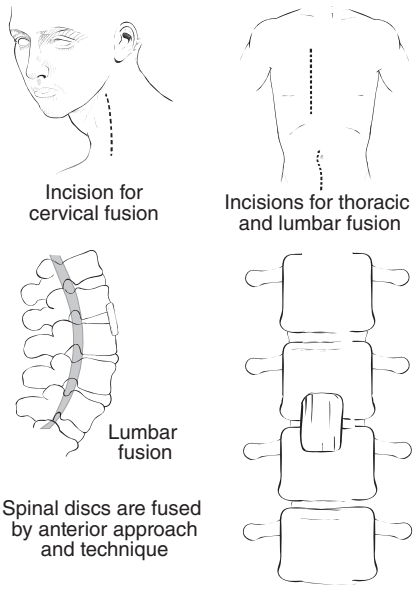
tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

therapeutic. Act meant to alleviate a medical or mental condition.

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

22554-22585

22554 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22556 thoracic
22558 lumbar
\+ **22585** each additional interspace (List separately in addition to code for primary procedure)



Explanation

Spinal arthrodesis, or fusion, may be done for conditions of herniated disc, degenerative, traumatic, and/or congenital lesions, or to stabilize fractures or dislocations of the spine. Skull tong traction is applied. The physician uses an anterior approach to reach the damaged vertebrae. For cervical vertebrae in 22554, an incision is made through the neck, avoiding the esophagus, trachea, and thyroid. Retractors separate the intervertebral muscles. A drill is inserted in the affected vertebrae and the location is confirmed by separately reportable x-ray. The physician incises a trough in the front of the vertebrae with a drill or saw. The physician cleans out the intervertebral disc spaces with a rongeur and removes the cartilaginous plates above and below the vertebrae to be fused. The physician obtains and packs separately reportable grafts of iliac or other donor bone into the spaces and trims them. Traction is gradually decreased to maintain the graft in its bed. The fascia is sutured. A drain is placed and the incision is sutured. Report 22556 if the spinal arthrodesis site is thoracic. Report 22558 if the spinal arthrodesis site is lumbar. Report 22585 for each additional interspace treated in conjunction with the code for the primary procedure.

Coding Tips

Arthrodesis codes are assigned according to the surgical approach used (e.g., anterior interbody, posterior or posterolateral, posterior interbody, lateral transverse process); if more than one approach is used, each is reported separately. Report 22585 in addition to 22554–22558. If spinal instrumentation (22840–22845 and 22859) or bone grafting (20930–20938) is performed, it is listed separately. Do not report 22554 with 63075.

ICD-10-CM Diagnostic Codes

M47.12 Other spondylosis with myelopathy, cervical region
M47.13 Other spondylosis with myelopathy, cervicothoracic region
M47.14 Other spondylosis with myelopathy, thoracic region
M47.15 Other spondylosis with myelopathy, thoracolumbar region
M47.16 Other spondylosis with myelopathy, lumbar region
M48.02 Spinal stenosis, cervical region
M48.03 Spinal stenosis, cervicothoracic region
M48.04 Spinal stenosis, thoracic region
M48.05 Spinal stenosis, thoracolumbar region
M48.061 Spinal stenosis, lumbar region without neurogenic claudication
M48.062 Spinal stenosis, lumbar region with neurogenic claudication
M48.07 Spinal stenosis, lumbosacral region
M54.13 Radiculopathy, cervicothoracic region
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M54.16 Radiculopathy, lumbar region
M54.17 Radiculopathy, lumbosacral region

AMA: **22554** 2020,May,13; 2018,Sep,7; 2018,May,3; 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2015,Apr,7 **22556** 2020,May,13; 2018,Sep,7; 2018,May,3; 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **22558** 2020,May,13; 2018,Sep,7; 2018,May,3; 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2017,Feb,9; 2016,Jan,13; 2015,Mar,9; 2015,Jan,16 **22585** 2020,May,13; 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
22554	17.69	14.17	5.27	37.13
22556	24.7	17.5	6.89	49.09
22558	23.53	15.54	6.05	45.12
22585	5.52	2.57	1.5	9.59
Facility RVU	**Work**	**PE**	**MP**	**Total**
22554	17.69	14.17	5.27	37.13
22556	24.7	17.5	6.89	49.09
22558	23.53	15.54	6.05	45.12
22585	5.52	2.57	1.5	9.59

	FUD	Status	MUE	Modifiers				IOM Reference
22554	90	A	1(2)	51	N/A	62	80	100-03,150.2
22556	90	A	1(2)	51	N/A	62	80	
22558	90	A	1(2)	51	N/A	62	80	
22585	N/A	A	5(3)	N/A	N/A	62	80	

* with documentation

Terms To Know

anterior. Situated in the front area or toward the belly surface of the body.

arthrodesis. Surgical fixation or fusion of a joint to reduce pain and improve stability, performed openly or arthroscopically.

bone graft. Bone that is removed from one part of the body and placed into another bone site without direct re-establishment of blood supply.

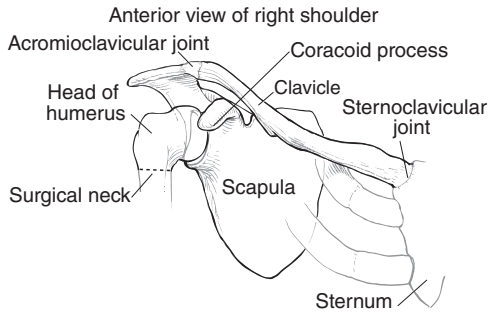
discectomy. Surgical excision of an intervertebral disk.

fusion. Union of adjacent tissues, especially bone.

interspace. Space between two similar objects.

23170-23174

23170 Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle
23172 Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula
23174 Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck



Explanation

The physician removes infected portions of the clavicle in 23170 due to a bone abscess or osteomyelitis. This infection often leaves open sinus tracts in the bone that require removal. The physician makes an incision overlying the sequestered area of bone in the clavicle. Once the skin and soft tissues are reflected, a small window is cut into the bone to gain access to the sequestrum, or necrosed piece of bone that has become separated from sound bone. All purulent material and scarred or necrotic tissue are removed. The remaining space is filled with surrounding soft tissues or free tissue transfer. The area is irrigated and an antibiotic solution is used to prevent further infection. The wound is closed loosely over drains if possible. The arm is positioned in a sling or splint and protected to prevent fracture of the clavicle. Report 23172 if the sequestrectomy is performed on the scapula and 23174 if this procedure is performed on the humeral head to the surgical neck.

Coding Tips

For partial excision of the clavicle, scapula, or humeral head, see 23180–23184. For radical resection of the clavicle, scapula, or humeral head for a bone tumor, see 23200, 23210, or 23220. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report.

ICD-10-CM Diagnostic Codes

M86.011 Acute hematogenous osteomyelitis, right shoulder ☑
M86.012 Acute hematogenous osteomyelitis, left shoulder ☑
M86.111 Other acute osteomyelitis, right shoulder ☑
M86.112 Other acute osteomyelitis, left shoulder ☑
M86.211 Subacute osteomyelitis, right shoulder ☑
M86.212 Subacute osteomyelitis, left shoulder ☑
M86.311 Chronic multifocal osteomyelitis, right shoulder ☑
M86.312 Chronic multifocal osteomyelitis, left shoulder ☑
M86.411 Chronic osteomyelitis with draining sinus, right shoulder ☑
M86.412 Chronic osteomyelitis with draining sinus, left shoulder ☑
M86.511 Other chronic hematogenous osteomyelitis, right shoulder ☑
M86.512 Other chronic hematogenous osteomyelitis, left shoulder ☑
M86.611 Other chronic osteomyelitis, right shoulder ☑
M86.612 Other chronic osteomyelitis, left shoulder ☑
M86.8X1 Other osteomyelitis, shoulder
M87.011 Idiopathic aseptic necrosis of right shoulder ☑
M87.012 Idiopathic aseptic necrosis of left shoulder ☑
M87.111 Osteonecrosis due to drugs, right shoulder ☑
M87.112 Osteonecrosis due to drugs, left shoulder ☑
M87.211 Osteonecrosis due to previous trauma, right shoulder ☑
M87.212 Osteonecrosis due to previous trauma, left shoulder ☑
M87.311 Other secondary osteonecrosis, right shoulder ☑
M87.312 Other secondary osteonecrosis, left shoulder ☑
M87.811 Other osteonecrosis, right shoulder ☑
M87.812 Other osteonecrosis, left shoulder ☑
M90.511 Osteonecrosis in diseases classified elsewhere, right shoulder ☑
M90.512 Osteonecrosis in diseases classified elsewhere, left shoulder ☑

AMA: **23170** 2018,Sep,7 **23172** 2018,Sep,7 **23174** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
23170	7.21	8.05	1.45	16.71
23172	7.31	8.1	1.46	16.87
23174	10.05	10.51	1.98	22.54
Facility RVU	**Work**	**PE**	**MP**	**Total**
23170	7.21	8.05	1.45	16.71
23172	7.31	8.1	1.46	16.87
23174	10.05	10.51	1.98	22.54

	FUD	Status	MUE	Modifiers				IOM Reference
23170	90	A	1(3)	51	50	N/A	N/A	None
23172	90	A	1(3)	51	50	N/A	80	
23174	90	A	1(3)	51	50	62*	80	

* with documentation

Terms To Know

aseptic necrosis. Death of bone tissue resulting from a disruption in the vascular supply, caused by a noninfectious disease process, such as a fracture or the administration of immunosuppressive drugs.

clavicle. Bone located between the sternum and scapula, connecting the arm to the body.

osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.

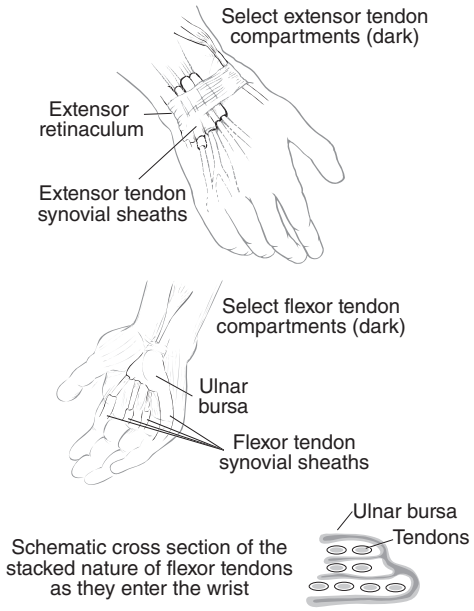
scapula. Triangular bone commonly referred to as the shoulder blade.

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

25115-25116

25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors

25116 extensors, with or without transposition of dorsal retinaculum



Explanation

Radical excision is removal of all diseased and/or inflamed tissue and may include removal of a portion of surrounding normal tissue. The physician excises the bursa, synovia of the wrist, or forearm tendon sheaths of the flexors in 25115 and extensors in 25116. The physician makes a longitudinal incision over the volar aspect of the distal forearm and wrist. Dissection exposes the flexor tendons of the wrist. The physician excises the bursa and any inflamed and hypertrophied tissues from around the tendons. The tendons are left intact, allowing them to glide better during wrist movement. In 25116, the physician may perform a transposition of the dorsal retinaculum if enough tissue is removed from the wrist extensors. A transposition makes a smooth gliding surface no longer present between the extensor tendons and carpal bones of the wrist. The dorsal retinaculum is incised in the mid-line, tucked underneath the extensor tendons, and closed with sutures. The incisions are repaired in layers with sutures, staples, and/or Steri-strips. The wrist may be placed in a splint.

Coding Tips

According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system. For incision and drainage of a bursa, forearm or wrist, see 25031. For finger synovectomy, see 26145.

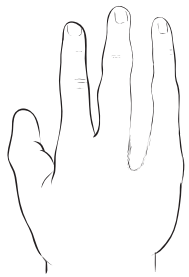
ICD-10-CM Diagnostic Codes

A18.02 Tuberculous arthritis of other joints
M00.031 Staphylococcal arthritis, right wrist ☑
M00.032 Staphylococcal arthritis, left wrist ☑
M00.131 Pneumococcal arthritis, right wrist ☑
M00.132 Pneumococcal arthritis, left wrist ☑
M00.231 Other streptococcal arthritis, right wrist ☑
M00.232 Other streptococcal arthritis, left wrist ☑
M00.831 Arthritis due to other bacteria, right wrist ☑
M00.832 Arthritis due to other bacteria, left wrist ☑
M02.331 Reiter's disease, right wrist ☑
M02.332 Reiter's disease, left wrist ☑
M05.031 Felty's syndrome, right wrist ☑
M05.032 Felty's syndrome, left wrist ☑
M05.431 Rheumatoid myopathy with rheumatoid arthritis of right wrist ☑
M05.432 Rheumatoid myopathy with rheumatoid arthritis of left wrist ☑
M05.531 Rheumatoid polyneuropathy with rheumatoid arthritis of right wrist ☑
M05.532 Rheumatoid polyneuropathy with rheumatoid arthritis of left wrist ☑
M05.731 Rheumatoid arthritis with rheumatoid factor of right wrist without organ or systems involvement ☑
M05.732 Rheumatoid arthritis with rheumatoid factor of left wrist without organ or systems involvement ☑
M05.831 Other rheumatoid arthritis with rheumatoid factor of right wrist ☑
M05.832 Other rheumatoid arthritis with rheumatoid factor of left wrist ☑
M06.031 Rheumatoid arthritis without rheumatoid factor, right wrist ☑
M06.032 Rheumatoid arthritis without rheumatoid factor, left wrist ☑
M06.231 Rheumatoid bursitis, right wrist ☑
M06.232 Rheumatoid bursitis, left wrist ☑
M06.331 Rheumatoid nodule, right wrist ☑
M06.332 Rheumatoid nodule, left wrist ☑
M06.831 Other specified rheumatoid arthritis, right wrist ☑
M06.832 Other specified rheumatoid arthritis, left wrist ☑
M12.231 Villonodular synovitis (pigmented), right wrist ☑
M12.232 Villonodular synovitis (pigmented), left wrist ☑
M65.031 Abscess of tendon sheath, right forearm ☑
M65.032 Abscess of tendon sheath, left forearm ☑
M65.131 Other infective (teno)synovitis, right wrist ☑
M65.132 Other infective (teno)synovitis, left wrist ☑
M65.831 Other synovitis and tenosynovitis, right forearm ☑
M65.832 Other synovitis and tenosynovitis, left forearm ☑
M67.331 Transient synovitis, right wrist ☑
M67.332 Transient synovitis, left wrist ☑
M70.031 Crepitant synovitis (acute) (chronic), right wrist ☑
M70.032 Crepitant synovitis (acute) (chronic), left wrist ☑
M71.031 Abscess of bursa, right wrist ☑
M71.032 Abscess of bursa, left wrist ☑
M71.131 Other infective bursitis, right wrist ☑
M71.132 Other infective bursitis, left wrist ☑
M71.331 Other bursal cyst, right wrist ☑
M71.332 Other bursal cyst, left wrist ☑

AMA: **25115** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16
25116 2018,Sep,7

26580

26580 Repair cleft hand



Cleft hand with missing digit

Explanation

The physician repairs a cleft hand. A cleft hand is a malformation where the division between the fingers extends into the metacarpus. The middle digits may be absent and remaining digits are abnormally large. The physician incises the overlying skin and dissects to the deformity. The tissues are brought together with sutures, and the tendons are approximated to produce tensor and extensor function. Following correction of the metacarpus, the skin is reapproximated, reduced, and sutured in layers.

Coding Tips

According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system.

ICD-10-CM Diagnostic Codes

Q71.61 Lobster-claw right hand ☑
Q71.62 Lobster-claw left hand ☑
Q71.63 Lobster-claw hand, bilateral ☑

AMA: **26580** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
26580	19.75	22.0	3.96	45.71
Facility RVU	**Work**	**PE**	**MP**	**Total**
26580	19.75	22.0	3.96	45.71

	FUD	Status	MUE	Modifiers				IOM Reference
26580	90	A	1(2)	51	50	N/A	80	None

* with documentation

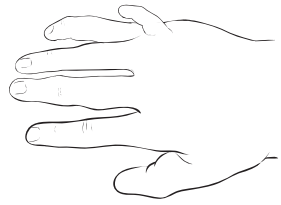
Terms To Know

cleft hand. Failure of the central ray of the metacarpals to fully develop, resulting in an extended separation between the fingers into the metacarpals or large fingers with absent middle fingers of the hand.

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

26587

26587 Reconstruction of polydactylous digit, soft tissue and bone



Supernumerary extra digit

Explanation

The physician reconstructs the hand by removing a polydactylous (extra) digit where the digit contains both soft tissue and bone. Excision of a digit containing soft tissue only is reported using 11200. The physician incises the skin at the base of the supernumerary digit. The bone is cut and the digit is resected. The skin is reapproximated, reduced, and sutured in layers.

Coding Tips

According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system. For excision of polydactylous digit, soft tissue only, see 11200.

ICD-10-CM Diagnostic Codes

Q69.0 Accessory finger(s)
Q69.1 Accessory thumb(s)

AMA: **26587** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

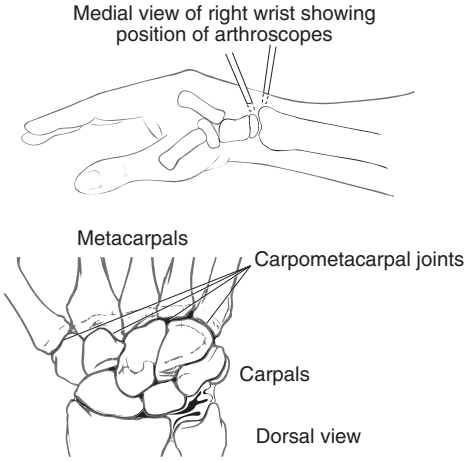
Non-Facility RVU	Work	PE	MP	Total
26587	14.5	13.4	2.89	30.79
Facility RVU	**Work**	**PE**	**MP**	**Total**
26587	14.5	13.4	2.89	30.79

	FUD	Status	MUE	Modifiers				IOM Reference
26587	90	A	2(3)	51	N/A	N/A	80	None

* with documentation

29840

29840 Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)



Articular spaces of the wrist. Synovial membranes line these surfaces and synovial fluid lubricates the joint actions

Explanation

The physician performs wrist arthroscopy. The joint is distended using finger traps on the index and long fingers that are attached to a 10 pound weight pulley. Counter traction is applied to the arm with a second 10 lb pulley. The joint is injected with lidocaine and epinephrine to distend the capsule. A wrap is applied to the forearm to prevent extravasation of fluid. Portal incisions are made. The scope is inserted. The physician inspects the wrist joint. The wrist is manipulated to allow visualization of all joint spaces and surfaces. In 29840, a diagnostic arthroscopy is performed. A synovial biopsy may also be obtained. The portal incisions are closed with sutures or Steri-strips.

Coding Tips

This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services, it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append 59 or an X{EPSU} modifier. When arthroscopy is performed in conjunction with arthrotomy, add modifier 51. Surgical arthroscopy always includes diagnostic arthroscopy. For arthrotomy of the wrist, with biopsy, see 25101. For arthroscopy, wrist, for lavage and drainage, see 29843. For arthroscopy, wrist, for partial synovectomy, see 29844; complete synovectomy, see 29845.

ICD-10-CM Diagnostic Codes

C40.11 Malignant neoplasm of short bones of right upper limb ☑
C40.12 Malignant neoplasm of short bones of left upper limb ☑
C47.11 Malignant neoplasm of peripheral nerves of right upper limb, including shoulder ☑
C47.12 Malignant neoplasm of peripheral nerves of left upper limb, including shoulder ☑
C49.11 Malignant neoplasm of connective and soft tissue of right upper limb, including shoulder ☑
C49.12 Malignant neoplasm of connective and soft tissue of left upper limb, including shoulder ☑
D16.11 Benign neoplasm of short bones of right upper limb ☑
D16.12 Benign neoplasm of short bones of left upper limb ☑
D21.11 Benign neoplasm of connective and other soft tissue of right upper limb, including shoulder ☑
D21.12 Benign neoplasm of connective and other soft tissue of left upper limb, including shoulder ☑
D48.0 Neoplasm of uncertain behavior of bone and articular cartilage
D48.1 Neoplasm of uncertain behavior of connective and other soft tissue
D48.2 Neoplasm of uncertain behavior of peripheral nerves and autonomic nervous system
E20.1 Pseudohypoparathyroidism
E83.52 Hypercalcemia
E83.59 Other disorders of calcium metabolism
G73.7 Myopathy in diseases classified elsewhere
M06.231 Rheumatoid bursitis, right wrist ☑
M06.232 Rheumatoid bursitis, left wrist ☑
M12.231 Villonodular synovitis (pigmented), right wrist ☑
M12.232 Villonodular synovitis (pigmented), left wrist ☑
M12.531 Traumatic arthropathy, right wrist ☑
M12.532 Traumatic arthropathy, left wrist ☑
M19.131 Post-traumatic osteoarthritis, right wrist ☑
M19.132 Post-traumatic osteoarthritis, left wrist ☑
M24.131 Other articular cartilage disorders, right wrist ☑
M24.132 Other articular cartilage disorders, left wrist ☑
M24.431 Recurrent dislocation, right wrist ☑
M24.432 Recurrent dislocation, left wrist ☑
M24.531 Contracture, right wrist ☑
M24.532 Contracture, left wrist ☑
M30.0 Polyarteritis nodosa
M34.1 CR(E)ST syndrome
M65.88 Other synovitis and tenosynovitis, other site
M65.89 Other synovitis and tenosynovitis, multiple sites

AMA: **29840** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
29840	5.68	6.66	1.02	13.36
Facility RVU	**Work**	**PE**	**MP**	**Total**
29840	5.68	6.66	1.02	13.36

	FUD	Status	MUE	Modifiers				IOM Reference
29840	90	A	1(2)	51	50	N/A	80*	None

* with documentation

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

Correct Coding Initiative Update

❖Indicates Mutually Exclusive Edit

0054T 0213T, 0216T, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 76000, 76380, 76942, 76998, 77001-77002, 77011-77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452

0055T 0213T, 0216T, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 76000, 76380, 76942, 76998, 77001-77002, 77011-77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452

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